NHS South of England

BCF Plan 2016/17 - Cover Sheet

Health & Wellbeing Board Name	Wokingham
Date of submission	1st draft submission 21st March 2016
Has the plan been signed by CCG(s)?	1st draft approved by CCG locality Director and formal sign off will happen later on final draft.
Date the plan was Signed off by HWB	1st draft not formally signed off by HWB this will occur on final draft.
Are the minutes of the HWB at which the plan was agreed attached to this submission?	Will happen with final draft

Section 1 – Confirmation of funding contributions

Requirement	Response
Describe how your BCF Plan meets the minimum contributions for: • CCG minimum contributions • DFG • Care Act monies • Formers 'Carers Breaks' funding • Re-ablement funding	The BCF plan Wokingham totals £9,491k and is made up from the CCG minimum contribution £7,640k plus the DFG allocation £733k in addition to the additional funding from the LA £1,065k described below. Included within the CCG minimum contribution is the inclusion of Care Act monies, Former "Carers Breaks" funding and Re-ablement funding.
Is any additional funding from the LA or CCG(s) included?	Included within the BCF plan for Wokingham is additional contribution from the LA for the inclusion of the Council's health liaison team to continue to deliver against DToC rates and also START team delivering a reablement service in the community.
Please confirm if this narrative plan, and the planning return template, has been signed by all parties and include the name, role, organisation and contact details of the authorising officer(s)	This will happen with final draft, but the BCF plan submitted on 2/3/16 was agreed by both the CCG and Council. In addition, this narrative plan has been co-produced by both organisations.
Your plan should provide a full overview of the funding contributions for 16/17 and set out any changes from 15/16. Please summarise here any changes from 15/16 and how these have been agreed.	The 2015/16 Wokingham BCF included a one-off additional funding of £300,000 from the CCG. Wokingham Borough Council has increased their contribution to the BCF for 16/17 by £37,000, which has been used to increase the available budget for the Integrated Short Term Health and Social Care Team (WISH). See table below:

<table>
<tr><th>Requirement</th><th>Response</th></tr>
<tr><td></td><td>

BCF Funding Contributions

<table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th></th></tr>
<tr><td>Local Authority Contribution(s)</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>Wokingham</td><td>£1,065,000</td><td>£1,185,000</td><td>-10.1%</td></tr>
<tr><td>DFG (inc SCCG in 15/16)</td><td>£733,000</td><td>£645,000</td><td>13.6%</td></tr>
<tr><td>Carry forward of 15/16 scheme underspends</td><td>£53,000</td><td>£0</td><td></td></tr>
<tr><td>Total Local Authority Contribution</td><td>£1,851,000</td><td>£1,830,000</td><td></td></tr>
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<table>
<tr><td>CCG Minimum Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>NHS Wokingham CCG</td><td>£7,640,291</td><td>£7,431,000</td><td>2.8%</td></tr>
<tr><td>Total Minimum CCG Contribution</td><td>£7,640,291</td><td>£7,431,000</td><td></td></tr>
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<table>
<tr><td>CCG Additional Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>NHS Wokingham CCG</td><td>£0</td><td>£300,000</td><td></td></tr>
<tr><td>Total Additional CCG Contribution</td><td>£0</td><td>£300,000</td><td></td></tr>
</table>

<table>
<tr><td>Total BCF pooled budget</td><td>£9,491,291</td><td>£9,561,000</td><td>-0.7%</td></tr>
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</td></tr>
<tr><td>Please summarise the impact assessment of any changes you have made</td><td>The above shows that there have been minimal changes since our BCF 15/16 and this years' plan is essentially a continuation of the previous with all schemes continuing. The only exception to this has been taking BCF09 Access to General Practice out of the BCF, this will now be funded by the CCG and is a continuation, and consequently there will be no negative impact. Given the additional £300K contribution from the CCG was agreed that this would be a one-off contribution to address pressures caused by the change in eligibility thresholds for Wokingham as part of the Care Act. This was only meant to be for one year whilst WBC challenged the DoH on the lack of funding for this new burden.</td></tr>
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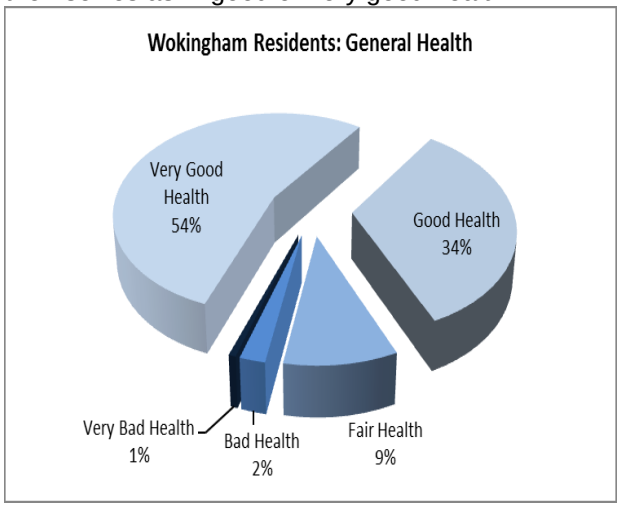
Section 2 – Narrative overview

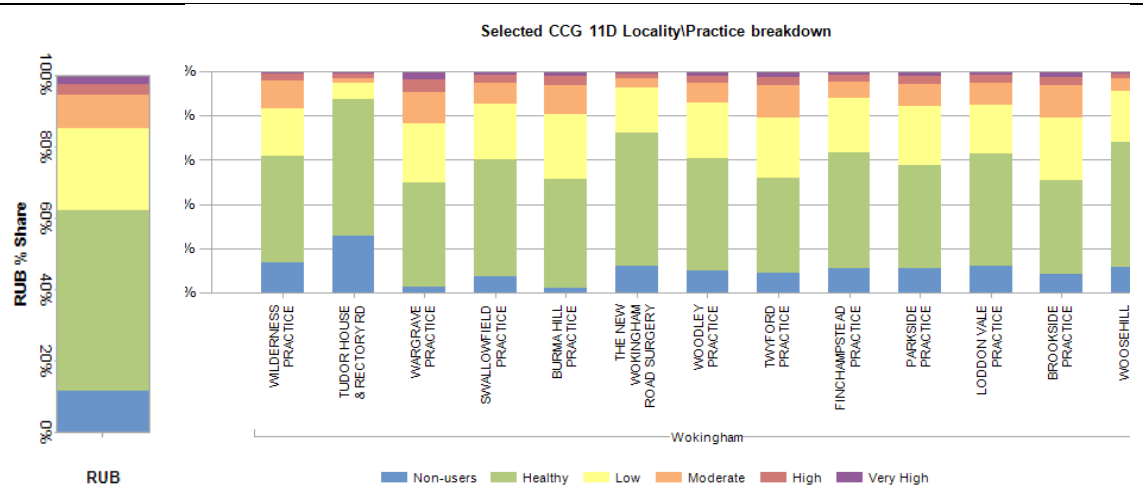
Please describe the local vision for health and social care services, including changes to patient and service user experience and outcomes.	We are delivering our BCF both locally and through a wider Berkshire West approach. The Berkshire West system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure (see below structure chart). The Berkshire West system first came together as an agreed footprint back in 2013, and has continued to with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign. An overview of Wokingham's 16/17 BCF can be seen in the below document.  Wokingham's BCF On a Page UNCLASS] Wokingham's 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 CCGs Five year Forward View. **Preventing ill health within a growing population and supporting people with more complex needs within the community** Wokingham Borough is one of six unitary authorities in Berkshire. It currently has a population of 155,000, but this is projected to increase to 186,000 by 2026.

The Borough is recognised as one of the healthiest areas in the country. 88% of residents describe themselves as in good or very good health.



Whilst general health in Wokingham is good, our services are caring for people with increasingly complex needs, resulting in the need for new models of out of hospital care. This is demonstrated from the data taken from the JSNA shown below.

There are small areas of the borough where economic, social and health prospects are noticeably worse than for the rest of the population. An analysis of health status in Wokingham as a whole then by general practice (using our risk stratification tool) is a good illustration of local inequalities.

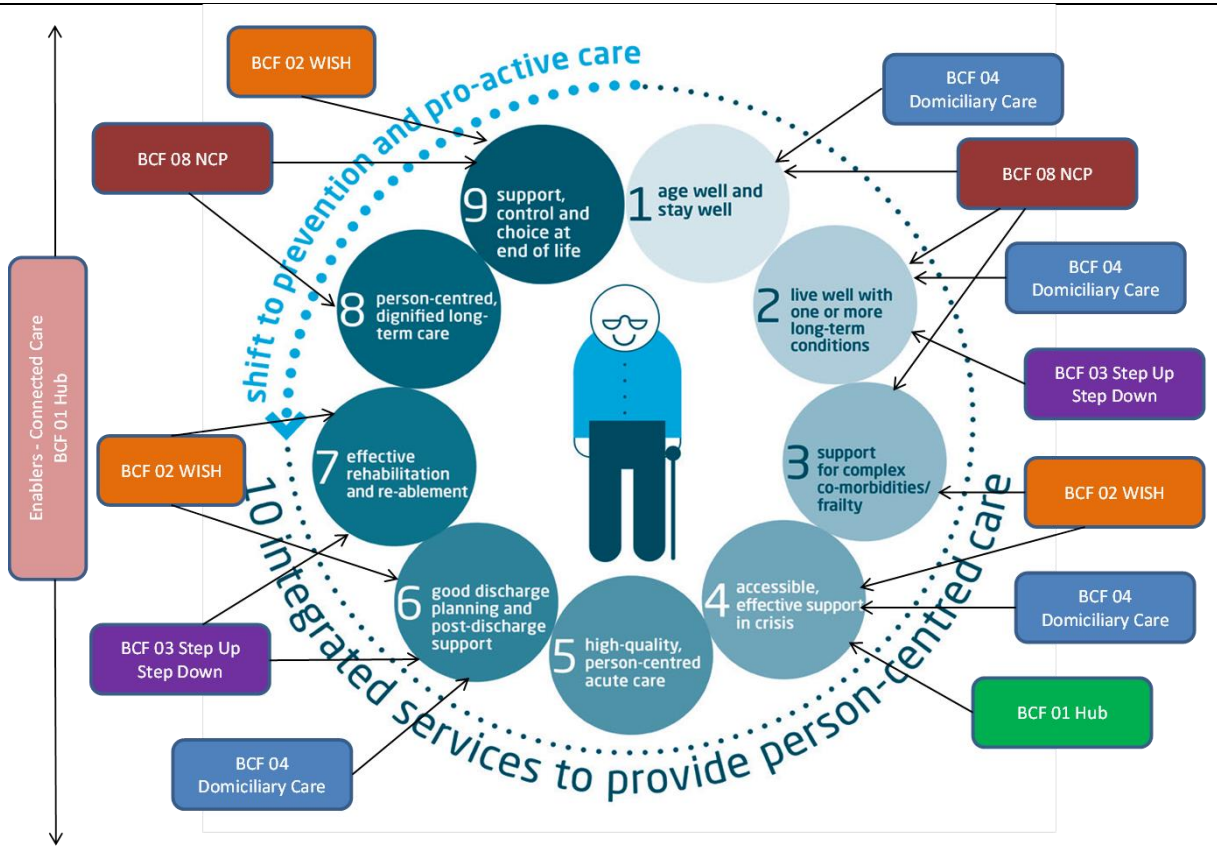


We have increasing rates of people with complex, multiple conditions and a growing frail elderly population. The table below shows current multi-morbidity by age band using our risk stratification tool. At Call to Action events, residents have told us about their difficulties in accessing health and social care services, including waiting times for appointments and telephone access. We have heard patient stories about fragmented service delivery. And we have received support for greater service integration and the sharing of information between health and social care at our Call to Action events.

"Better communication between organisations. Preparedness to work together other than jealously guarding their independence when others could help more effectively"

"It is too disjointed as each organisation does its own thing and the patients/clients/service users fall through the gaps. Each organisation needs to know what all the others are doing so they don't all reinvent the wheel"

We have used **"Sam's Story"** (by the King's Fund) throughout our Call to Action events to work with local people on a vision for integrated care. The messages contained within Sam's Story have been well received by public and professionals alike. Sam continues to play a role in the development of our BCF Plans, as illustrated in the diagram below:



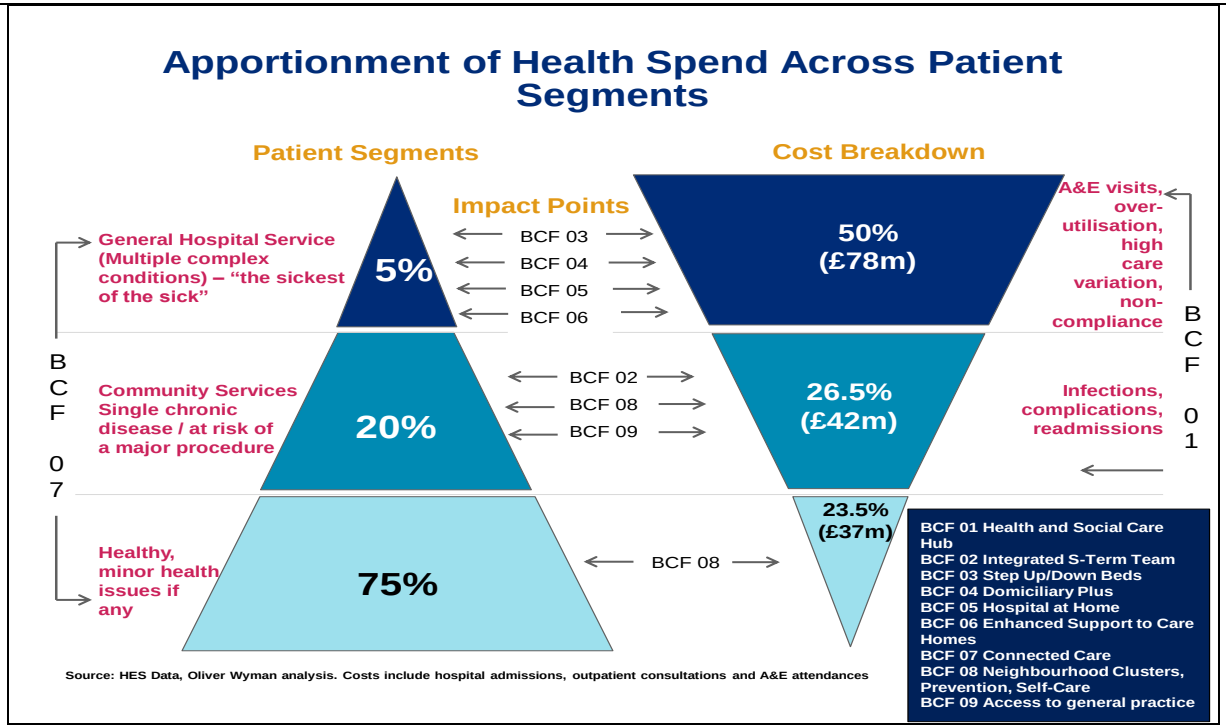
Additionally we have developed a Frail Elderly Pathway model across Berkshire West, which shows the challenge our health and social care system faces due to rising demographic pressure, The different interventions from our BCF will be able to be input to gauge the benefit they will have for our system.

Frail Elderly Pathway Key Messages Feb 20

Describe how the BCF contributes to the local implementation of the vision of the FYFV and the	This five year plan has been developed at a Berkshire West level, and has been informed by each of the local JSNAs and the respective Joint Health and Wellbeing Strategies. The below plan on a page

move towards fully integrated health and social care by 2020; and the aspects of the change the local area is intending to deliver using the BCF.	summarises the FYFV and the wider document is attached.  Final-submission Five-Year-Strategic-Pl  BW Plan on a Page 240214.docx
Please list the issues that the BCF will be used to address in the local area	The above iteration of Sam's story and Wokingham's BCF on a page illustrate where each BCF scheme will have an impact but in relation to the BW strategic plan see below where our schemes impact on the plan's their 7 ambitions: • Additional years of life for people with treatable physical and mental health conditions- BCF 02 WISH short term team, BCF 03 Step up /Step Down, BCF 04 Domiciliary Care Plus, BCF 06 Care Homes Project, BCF 08 Neighbourhood Clusters and Prevention • Improved quality of life for people with Long Term Conditions- BCF 02 WISH short term team, BCF 03 Step up /Step Down, BCF 04 Domiciliary Care Plus, BCF 06 Care Homes Project, BCF 08 Neighbourhood Clusters and Prevention • More integrated care outside hospital- BCF 02 WISH short term team, BCF 03 Step up /Step Down, BCF 04 Domiciliary Care Plus, BCF 06 Care Homes Project, BCF 08 Neighbourhood Clusters and Prevention • Increased proportion of older people living independently at home- BCF 02 WISH short term team, BCF 03 Step up /Step Down, BCF 04 Domiciliary Care Plus, BCF 06 Care Homes Project, BCF 08 Neighbourhood Clusters and Prevention • Positive experience of care outside hospital - BCF 02 WISH short term team, BCF 03 Step up /Step Down, BCF 04 Domiciliary Care Plus, BCF 06 Care Homes Project, BCF 08 Neighbourhood Clusters and Prevention • Increased positive experience of care in hospital • Progress towards eliminating avoidable deaths Additionally to meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and 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. The key characteristics of our ACS will be:

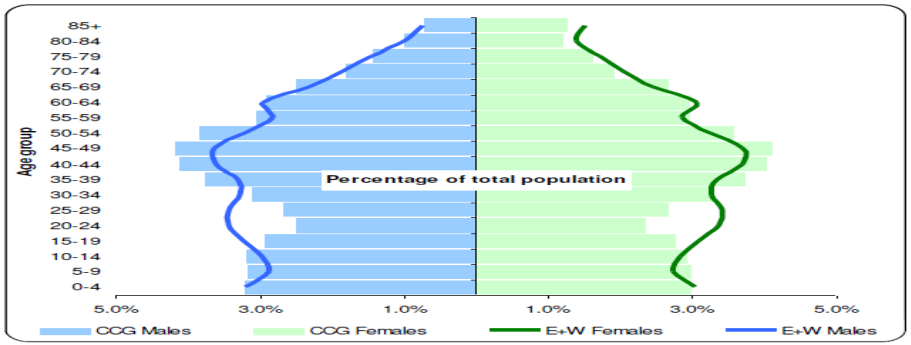
	• We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live. • We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy • We will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system • Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system. • Finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism. • We will develop and use long term contracts to promote financial stability of the providers • It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations. • We will seek to gain support from the three Local authorities in Berkshire West to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. • The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. • The implementation of the Five Year Forward View will see the production of Sustainability and Transformation Plan (STP) at a Thames valley footprint alongside the development of an ACS for Berkshire West. This will be our vehicle going forward for delivering the service transformation locally that will lead to wider financial sustainability. Further detail on our plans can be found in the Berkshire West CCGs Operational Plan 2016/17 *(ref: Berkshire West CCGs Operational Plan 2016/17)*.
Explain how the BCF will address quality and reduce costs based on segmented risk stratification. (Reference local issues and how integration will be used to drive improvement). If relevant please provide supplementary data to support the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery.	We have used the **ACG (Adjusted Clinical Groups) risk stratification tool** to identify the relative risk of patients in our population by analysis of their medical history. Dividing the population into groups of people with similar needs has helped us create models that are based on similar, individually-focused needs. Our intention is to transform the local health economy to support patients to manage their conditions at home, to keep well and remain out of hospital. As can be seen from the triangle of care needs below, small numbers of the population are associated with the highest cost and demand, whilst those lower down the triangle account for much lower cost impact per head of population.



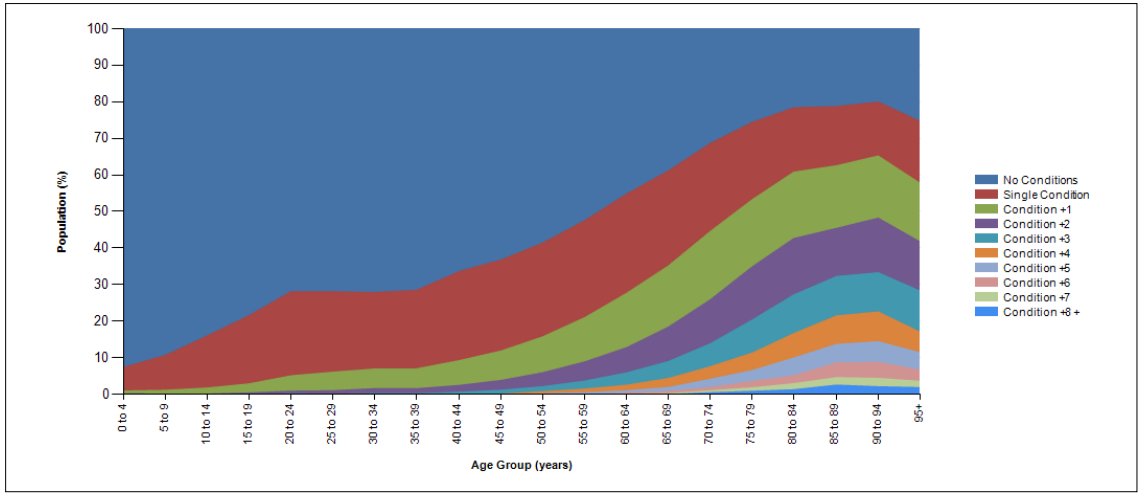
The following section summarises the analysis and risk stratification work we have undertaken, broken down by our key challenges, and how this has informed the development of our integration models.

Challenge 1: A growing population

The Wokingham Core (development) Strategy will deliver in excess of 13,000 new homes by 2026. This will result in a 22% growth in our population. There are four strategic development locations:
We predict that the development will accentuate the proportions of children and adults in their 30s, with a small net migration away from Wokingham of people between the ages of 45 and 80. But we expect a continued increase in the 85+ age group.



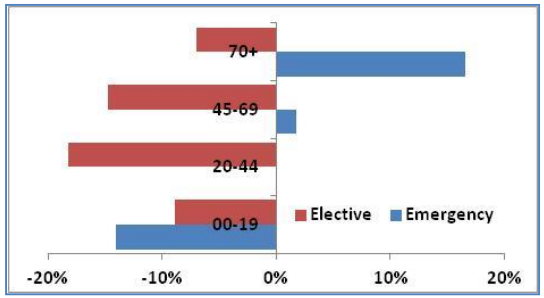
With people in Wokingham living longer, the very elderly will present multiple long term conditions and complex needs. The table below shows current multi-morbidity by age band using the ACG tool.



This table illustrates the need to provide effective management and maintenance of people with multiple long- term conditions, and greater self-care. Most patients in care homes have several long-term conditions, and as a result, a major impact on non-elective and social care spending. Wokingham has a relatively large number of care homes within the borough (32).

Emergency admissions for older people (70+) shows a greater increase than can be explained by

population change, reflecting the increasing clinical complexity of this age group:



Whist the overall population is predominately white (89%), this is changing and becoming more diverse. In our schools 25% of the children are from a BME background.

Solutions: Extensive work is already underway in the frail elderly pathway. This Berkshire West-wide work stream forms the backbone of system change, and our BCF schemes – notably BCF 06 Enhanced Care and Nursing Home Support - will be critical to delivering a number of elements of this. We need different ways of working at a neighbourhood level, to help provide services to a growing and changing population (BCF 08 Neighbourhood Clusters). We also need to promote prevention and support self care to help manage the growth in multiple conditions (BCF 08). Our integrated short term team (WISH BCF 02) has a more developed business case in 2016-17 that increases the number of frontline community nurse capacity in this team to prevent avoidable admissions.

Challenge 2: Non-Elective Admissions

Non-elective admissions are a pressure that health and social care in Wokingham has managed reasonably well in recent years.
Future projections suggest that this trend will continue unless there is system-wide change. Analysis has revealed two specific areas which could be amenable to change:
1. Non elective admissions with a medical event where patients are clinically stable and do not require diagnostic input such as acute infections, deteriorating long term conditions, and unstable COPD. Over 2012/13 there were 10,116 emergency admissions to hospital each year for Berkshire West residents with at least one long term condition, of which 4,590 would be possible to manage in the community.
2. Patients whose place of residence is a care home. In Wokingham during 2013/14 there were 387 non-elective admissions from care home residents costing £1.2m.

Solutions: The outcomes for both of these population groups can be dramatically improved by integrated

	care. As such we have allocated one of our Better Care Fund schemes to address these issues. Our Care Homes project provides an alternative to an acute admission. The Rapid Response and Treatment element of this service will keep the patient in the community, and providing treatment from a multidisciplinary team linking in with specialist nurses and therapists, to provide a patient-centric model of delivery, rather than the traditional disease specific organisation of care, to patients who are clinically stable. The enhanced support to care homes scheme (BCF06) provides a new model of high level health care support into care and nursing homes to improve consistency in the quality of care and outcomes for residents. Following review of the evidence we have gained from 15/16 performance the following savings for 2016/17 is recommended: • South Central Ambulance Service (SCAS) - Hear and Treat a 100% reduction • South Central Ambulance Service (SCAS) - See and Treat a 50% reduction • SCAS - See, Treat and Convey is reduced by 50% • Secondary Care NEL admissions are reduced by 30% in line with national evidence of similar project outcomes.
Please provide a description of the specifics of the overarching governance and accountability structures in place locally to support integrated care, including: • A description of the specifics of the management and oversight in place to support the delivery of the BCF plan?	The **Wokingham Health and Wellbeing Board** will have oversight of this Better Care Fund plan, governed through the **Wokingham Integrated Strategic Partnership** (or 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. Wokingham's governance structure and how it is integrated into the wider Berkshire West governance is attached. Because our local health and social care economy works across unitary authority boundaries, some of our BCF schemes are part of a Berkshire West federated programme. Therefore governance arrangements are also part of a **Berkshire West Delivery Group and above that a Berkshire West Integration Board**. Both Boards have representatives from each of the partner organisations. The Boards will: • Ensure that the programme delivers its agreed outcomes • Route information and decision-making to the appropriate governance structures and health and wellbeing boards. • 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. BW10 Integration Governance Map.doc

An articulation of the arrangements in place to support joint working?
 	
• Key milestones associated with the delivery of the plan of action in 2016-17?
 	
• A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally including:
  • A quantified pooled funding amount that is 'at risk'
  • Demonstration that this has been calculated using clear analytics and modelling
  • An articulation of any other risks associated with not meeting BCF targets in 2016-17
  • An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting
	Local project resources work across Health and social care reporting to the CCG, Council and other stakeholders through our local implementation board WISP.
	
	Key Milestones and Progress Plans 2016- Copy of 2016-17 Portal Implementatio Nb. The portal implementation spreadsheet is a very early draft and subject to change and revision.
	
	Wokingham Risk Register Mar 2016 Of
	
	Management of the risk share pot will be through monthly monitoring of the individual schemes, identifying the performance against target and assessing progress against plan. Funds will be released from the risk share based on achieving targets. Risks within individual projects will be monitored and manged through the Section 75 agreements, with reports being produced on material variances to seek appropriate action. A contingency fund is held in the first instance to address such risks, however if the schemes are failing, plans to wind up the schemes will be implemented. Consideration is being made from the outset in terms of contracting any longer term commitments.
	
	The table shows the allocation of risk share across the schemes. Modelling is based on levels of activity from the investment targeted specifically at HRG codes associated with the service and the likely benefit to be realised from avoidance of NELs. A weighting of the saving has been used to allocate the risk to reach the proposed target of £448k equivalent to the performance fund in 15/16 not achieved.

and payment arrangements

Scheme	Levels of activity	Average unit rates	NEL Avoidance savings £000's	Weighting	Allocation to Risk Share £000's
Step Up/Step Down Beds	53	£ 1,074	£57	9%	£41
Domiciliary Plus	46	£ 997	£46	7%	£33
Neighbourhood Clusters	45	£ 895	£40	7%	£29
Short Term Health and Social Care Team	57	£ 1,209	£69	11%	£50
Rapid Response & Treatment Care Homes	147	£ 2,761	£407	66%	£294
Total			£619	100%	£448

Section 3 - National Conditions

Plans Jointly Agreed	
Does the BCF Plan cover a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, and is it signed off by the HWB itself, and by the constituent Councils and CCGs?	The BCF plan does cover 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.
Explain how, in agreeing the plan, have you engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. Please illustrate: • There is joint agreement across commissioners and providers as to how the	Health and social Care providers evaluated the Wokingham 15/16 schemes along with other stakeholders and 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 and as previously mentioned. Our Better Care Fund projects have been developed and rolled out over a series of meetings of the Wokingham Integrated Strategic Partnership Board involving acute trust, community health providers, social care 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. Going forward with our Better Care Fund plans, we expect that the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospitals Trust, local GPs and the Adult Social Care Service will all continue to be part of the integration implementation teams. WISP report ref BCF evaluation - DRAFT.dc

BCF will contribute to a longer term strategic plan • This includes an assessment of future capacity and workforce requirements across the system	**1.** A Berkshire West workforce group is developing a workforce strategy that has the following Work streams **Workforce Planning**. How we will measure outcomes and contribution to the BW10 health and social care integration strategy that includes 7 day working, care co-ordination, joint assessments and care planning. **Communications and Engagement** – Assuring consistent and positive information to stakeholders. Plan for contributions and questions from stakeholders; Review of Generic Support Worker (GSW) trial impact and outcomes. **Learning and Development** – Requirements for GSW skills gap analysis; GSW training strategy; Clinician and Supervision support prior to and during GSW trials. Resource requirements and costs. **Clinical and Programme Governance** – Informed decision making and support to assure clinical and project risks are identified and mitigated. Any required change to policy, protocol or procedure is implemented. Progress monitoring and reporting. **Funding and Finance** – Use of HETV funds and implications; longer term BW10 finance; Contribution to Berkshire-wide Sustainability and Transformation Plans
• The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences?	The plan includes provision for both the Community Trust and Voluntary sector for expansion to meet the demands being requested from the providers. The budgets have been compiled in conjunction with the providers recognising the changes expected in service delivery from the BCF plan. Meetings have been held with Housing to develop the plan around the use of DFG to continue to meet the needs of residents in Wokingham in a joined up and integrated way with the wider BCF strategy to improve the outcomes across health, social care and housing.

As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, please confirm that local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.	
Maintaining the Provision of Social Care Please specify the total amount from the Better Care Fund that has been allocated for supporting of adult social care services and confirm: • That at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified • The amount of funding that will be dedicated to carer-specific support from within the BCF pool? Please describe how the local adult social care services will continue to be supported in a manner consistent with 2015-16. Has this support been agreed locally and, as a minimum, does the funding and services maintain in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16? In setting the level of protection for social care in your local area, please describe how you have ensured that any change does not destabilise the local social and health care system as a whole? Please include a comparison to the approach and figures set out in 2015-16 plans and confirm this approach is consistent with the 2012 Department of	The Wokingham figures for Protecting Adult Social Care are: **15/16** **16/17** £944,000 £944,000 plus additional CCG contribution to BCF £300,000 - Total £1,244,000 £944,000 (76%) In 15/16 the CCG was able to make an additional contribution to the Wokingham BCF of £300,000, over and above its minimum contribution to the BCF. The Local Authority opted to set this contribution against its Adult Social Care costs. It has not been possible for the CCG to repeat this additional contribution in 16/17 and this is understood by the Local Authority. However, the core funding for protecting Adult Social Care has been maintained year-on-year. Within the total funds available for 16/17 in the Local Authority hosted Pool, Wokingham have increased the investment in their Integrated Short Term Health & Social Care teams by £248k compared to 15/16. The Wokingham figures for Implementation of the Care Act duties are: **15/16** **16/17** Total £335,000 £180,639 The budget for 16/17 has been reduced from 15/16 to be in line with that anticipated to be required by the local authority to meet the on-going costs of implementation of the Care Act. The Wokingham figures for Carer Support are: **15/16** **16/17** Total £494,000 £402,000

Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14.	Support for Carers and voluntary sector providers has been maintained for 16/17 at the same level as in 15/16. The reduction of £92,000 in the budget represents correction of an incorrect figure in the BCF 15/16, which was only identified during the course of the 15/16 financial year.
7-Day Services Please detail your plans to deliver 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care, and how your approach to 7-day services will: • prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week • support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care • is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17	We recognise that people need health and social care services every day. As a result we are adopting a whole system whole week approach to ensure that a full range of health and social care services is available seven 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 weekends. We have made significant progress on achieving 7 day services access across a range of primary, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Berkshire West Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both NHS Provider Trust contracts for 15/16 (a core part of the 15/16 planning guidance). In addition to investments made via the BCF, through systems resilience and into Mental Health services all of which directly support 7 day access the Berkshire West CCGs have invested in an Enhanced Access CES for Primary Care. This has resulted in over 80% of the CCGs' population now being able to access routine appointments outside of core hours; the vast majority of which are provided by patients' normal practices across the geography of the four CCGs. Patients with urgent needs can already access primary care in the evenings and weekends through the Westcall Out of Hours (OOH) service. The Reading walk in centre is also open from 8am-8pm, seven days a week. In addition, the CCGs have worked with NHS England to jointly commission an Enhanced Access CES as an alternative to the Extended Hours DES. This has resulted in additional routine bookable appointments per week on Saturday mornings and outside of core hours on weekdays (i.e. late evenings or early mornings), covering over 80% of the Berkshire West CCG's population. To significantly expand capacity towards full 7 day access we will need to consider alternative provider models for Primary Care such as more systemic collaboration between providers. Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number for any health or social care referral. In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met

	their agreed actions on standards 7 and 9. We are in the process of finalising the requirements for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the national self-assessment tool on 7 days as required by the 25th April and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards. BHFT also had an SDIP which covered the respective elements of standard 7(MH on acute admission, PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning. Additionally we are developing a number of 7 day services, including our health and social care hub (BCF01) that is available to take referrals and pass onto relevant services seven days of the week, facilitating discharge over the weekend. Our Step Up/Step Down (BCF 03) units operate on a 24 hour, seven day a week basis and allow for planned discharge at weekends from hospital. 1. The Dom Care Plus service will provide a night response service and the business case has the associated benefits which support 7 day working; prevents unnecessary admissions and supports timely discharge. 2. 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. 3. The expansion of reablement (more clients going through reablement) will support timely discharge as there will be more capacity in the system – when a client needs a package to support discharge. Reablement frees up capacity in long term care support thereby providing capacity to meet clients who do have long term needs. 4. Development of services to support weekend discharge from acute beds – social care staff will have an increased presence on the acute site initially on a Saturday and reablement service (from START) is being realigned to accept referrals at the weekend to support discharge. 5. The development of integrated WISH team with a MDT of social workers; therapists and nurses will support the efficient assessment of need and coordination of care – by working together they focus on the whole patient need and deliver a joined up care plan. 6. The expansion of care support staff will enable more timely discharge as this has been identified as a current blockage in the current system. 7. The development of a more skilled ‘Generic Support Worker’ to provide both health and social care to support the client to be at home and to become more independent is a key development to supporting hospital avoidance and timely discharge. Care support is provided 8am to 10 pm 7 days a week. 8. There will be an improved interface with the Community Matron Service in BHFT so that we

	there is improved reactive services to clients in crisis alongside the proactive identification and management of clients at risk who need support to reduce the likelihood of needing a hospital admission.
Data Sharing on the NHS Number Please use this section to demonstrate that the right cultures, behaviours and leadership exists locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. In your response please confirm if:	Currently 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 culture, 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. What the Connected Care solution is offering the is 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
• you are using the NHS Number as the consistent identifier for health and care services, and if not, your plan to do so	Wokingham Borough Council have undertaken one batch load to achieve this and have planned following uploads and staff training around this requirement.
• you are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls	As part of the procurement there were a number of technical requirements which the preferred bidder has signed up to in relation to Open APIs. The benefit to the use of APIs. The APIs will define what data is shared between the various systems and is what will support the real time access to data. Open APIs will then future proof going forward data exchanges between the multiple systems any changes in technology and legislation.
• you have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when you plan for it to be in place	The Connected Care Implementation team consists of an Information Governance Group across Berkshire made up of the Caldicott Guardians, business representatives and technical people to ensure that the appropriate controls are put in place in the new solution. The guiding principles and development of the group were defined around the principles developed by Dame Fiona Caldicott, the Information Governance Oversight Panel and Information Governance Alliance. Copies of the ToR and the Principles have been attached for reference.

	IG Principles Terms of Reference
• you have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review)	All organisations are obliged to ask for consent to share and disclose information to other organisations and inform the person how and what data they will be sharing with what organisation. The Connected Care projected has an overarching Communication Work stream which is chaired through the NHS and made up of representatives from each of the organisations and members of various patient groups. Depending on the organisation there will be different points of consent models and again part of the IG work stream have developed a consent model which will be adopted by all organisations. Once the Connected Care projected is implemented all organisations who are involved will be updating their websites to direct the person to the guidance around the consent to share model and the opting out process. Attached for reference is the consent model and the communication plan Communication Plan Consent Model
Please also describe how these changes will impact upon the integration of services.	. Streamline and align business processes . Reduce duplication of information and data entry across multiple systems . Allow access to real time data for health and social care practitioners . Reduce the amount of time contacting multiple organisations for the appropriate information or the correct point of contact . The ability to create joint care plans across health and social care by using structured data across multiple systems . The ability to work mobile and more effectively with real time access to data . The roles and responsibilities will define that the appropriate teams will have access to the information they require to enable them to do their job rather than inundate them with lots of information they do not require.
Joint Approach to Assessment Please identify which proportion of the local population will be receiving case management and	a) Case management and named care coordinator Through the establishment of Neighbourhood Clusters, based around GP surgeries and approximately in line with the existing geography of the Council's ward-based localities, there will be a

named care coordinator and which proportion of the local population will be receiving self-management help - following the principles of person-centred care planning.	greater focus on service planning and delivery around local communities with the aim of more effectively coordinating care and support for vulnerable people with complex health and social care needs. Developing Neighbourhood Clusters will bring together previously separate services to provide an integrated, coordinated model of person-centred care. This will be delivered through a collaborative network of integrated community teams built around clusters of GP practices across the whole borough. It will involve partner organisations, and frontline professionals developing a shared approach to providing joined-up, personalised care with patients, service users and their carers, tailored to individuals' needs, supporting people to live and age well, with multi-agency wraparound support. Information sharing and joint assessment will be an important part of this approach, helping to build up a complete picture of an individual's needs for health and social care, in order to develop and provide coordinated care. The plans include further development of better integrated multi-disciplinary teams (MDTs). Within each Neighbourhood Cluster, Primary Care, Community and Social Care teams will work together to provide integrated out-of-hospital services in the right place at the right time to improve outcomes and will work closely with appropriate local voluntary and community organisations to support people, including helping them to self care and prevent further ill health where possible. In order to better support GPs in being accountable for co-ordinating patient centred care for people with complex needs, and to improve communication and coordinated care across the MDT, we are introducing a role of Cluster Care Coordinators. There are currently 2 MDT administrators working across Wokingham, who provide administrative support to the existing MDT. These roles will be expanded to provide 3 MDT Care Coordinators, one for each Neighbourhood Cluster, who will be responsible for coordinating the team of professionals caring for vulnerable patients with complex health and social care needs. The Care Coordinators will ensure that the accountable lead professional for each individual patient is known both to the patient themselves and their family as well as throughout the team. The patient will be provided with the contact details of their lead professional so they know who to contact and when; they will also be given the contact details of their Cluster Care Coordinator as an alternative contact in case their lead professional is unavailable at the time they are needed. Providing integrated care and support through Neighbourhood Clusters will address some of the issues and concerns that have been highlighted during recent engagement events with the public and staff. In particular, Neighbourhood Cluster working will facilitate better communication within and

across the wider multi-disciplinary team, resulting in a more co-ordinated provision of services at a local community level, with services being more responsive to local needs and improving people's experience of care. It will also provide opportunities for inter-cluster support and sharing of resources if required.
Anecdotally, progress in other parts of the country suggests that integrated teams based around localities know their patch well and have learned more about each organisation's services, including the services offered by multiple voluntary and community organisations. This has raised awareness amongst the integrated team of how they can support people better together, encouraging an emerging culture that shifts conversations from "I'll make a referral" to "I'll talk with my colleagues".

b) Self-management
In addition to improving case management for vulnerable patients and service users who have complex needs, Volunteer Community Navigators are being established within each Cluster to improve access to local voluntary and community resources for people who will benefit from information and support to self care and enhance their health & wellbeing; including low to moderate risk service users, their carers, families and the general public. This supports the requirements of the 5 Year Forward View by moving towards and emphasising self-care, early, targeted prevention and promoting positive behaviour change, taking into account what people *can* do, by treating people as active participants, not passive recipients of care, and developing shared outcomes and measures *with* them.

Through public engagement events, we know that local people perceive the existing provision of information to be inconsistent, unclear and difficult to understand. The Volunteer Community Navigators will provide targeted, up to date, easy to understand and accessible information to service users and their families, including signposting them to appropriate resources within the local community, that will support them to self care and maximise their wellbeing. In addition, this will:

- connect more residents of the borough to their communities
- support a reduction in the number of avoidable GP appointments and of people's reliance on health and social care services
- allow gaps in local provision to be identified and provide evidence to inform the future development of service provision
- provide additional opportunities for new volunteers across the borough by training to become Navigators

By supporting good health and well-being within each Neighbourhood Cluster through targeted, early prevention by integrated teams and focusing on supporting and empowering people to self-care and prevent ill health, the aim is to enable people to remain independent and out of hospital for as long as possible.

Please demonstrate if you plan to identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors). Please include a description of plans for health and social care teams to use a joint process to assess risk and plan care, and agreed milestones demonstrating how and when this condition will be fully complied with.	While dementia services are not a specific focus for this scheme, a number of patients with complex needs being cared for through case management will be dementia sufferers, or carers of people with dementia. Dementia advisors are already in post across Wokingham, providing advice and support to people diagnosed with dementia, their carers, families and friends. This role includes the provision of information on day activities, breaks, benefits, legal matters, services offered by Health and Social Services. The Neighbourhood Cluster MDT teams will liaise with the Dementia advisors to ensure that appropriate patients are provided with the necessary support.
Agreement on the Consequential Impact of Change Please describe how the impact of local plans has been agreed with relevant health and social care providers and whether there been public and patient and service user engagement in this planning, as well as plans for political buy-in. Your response should demonstrate that these align to provider plans and the longer term vision for sustainable services. Please also articulate how mental and physical health are considered equal, and that your plans aim to ensure these are better integrated with one another, as well as with other services such as social care. You should also demonstrate clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans.	Health and social Care providers evaluated the Wokingham 15/16 schemes along with other stakeholders and 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. The CCG and Local Authority have engaged in a range of consultation activity both at individual project level, patient/service user feedback is a key part of assessing the impact, Call to action events and with Councillors and Senior Health and Social Care Leaders through the Health & Wellbeing Board. The Wokingham health and care system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign. To meet our challenges and overcome the barriers to change in the current system, Berkshire West CCGs along with RBFT and BHFT are proposing to establish a New Model of Care and to operate as an Accountable Care System (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.

	The key characteristics of our ACS will be: • We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live. • We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy • We will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system • Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system. • Finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism. • We will develop and use long term contracts to promote financial stability of the providers • It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations. • We will seek to gain support from the three Local authorities in Berkshire West to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. • The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. • The implementation of the Five Year Forward View will see the production of Sustainability and Transformation Plan (STP) at a Thames valley footprint alongside the development of an ACS for Berkshire West. This will be our vehicle going forward for delivering the service transformation locally that will lead to wider financial sustainability. Further detail on our plans can be found in the Berkshire West CCGs Operational Plan 2016/17 (ref: Berkshire West CCGs Operational Plan 2016/17).
Agreement to invest in NHS out of hospital commissioned services Please detail your agreed plan for using your share of the £1 billion that had previously been used to create the payment for performance element of the	Included within the Wokingham plan is £2,171k of ring fenced funding for out of hospital commissioning and risk share element on NEL reductions. The plan includes spend totalling £3,644k on out of hospital commissioning and £448k on risk share, exceeding the ring fenced funding by £1,922k. The investment is being made predominantly in short term intervention activity, aimed to providing

fund, in line with the national condition guidance, linking back to the summary and expenditure plan tabs of your BCF planning return template.	greater support in the home and in care home settings to avoid NEL activity and allow for earlier discharge. In addition, the plan includes 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. A night response service will also be implemented in 16/17 to allow for support in the home and possible discharge out of hours. Additional investment in 7 day working is also being made for 16/17, providing social care professionals on site over the weekend in the Royal Berks Hospital, to allow for more integrated working and the ability to discharge patients over a weekend into a safe environment.
Please describe if you have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance. Please make reference to the consideration of the long term trend in admissions, and the success of schemes implemented to date. If a risk sharing arrangement has been agreed please explain how the decision was arrived at, and illustrate the conditions are appropriate and consistent with guidance.	A risk share element has been included within the plan for 16/17. The value set is consistent with the levels of NEL targeted reductions in 15/16 which were not achieved by a significant margin. Confidence is high in the ability of the schemes for 16/17 to deliver reductions in NELs, however given past under performance on schemes, the prudent planning approach is to make provision for the risk share. This may put some constraints on the schemes to deliver early wins in order for funding to be released, and in planning the resources for the individual schemes, the resources need to be flexible in nature if required to reduce costs as short notice in order to meet the risk share arrangements. The Rapid Response and Treatment and Step up Step Down schemes were partially implemented through 15/16. The results from both schemes have proved positive with professional opinion being a high success rate in line with expectation of the number of admissions avoided. Both schemes are not at full capacity as yet; as such expectation is for greater results to be generated during 16/17. Plans for monitoring of performance are still being drawn up, so the effects of the schemes can be monitored against the standard performance metrics. The risk share has been agreed between the CCG and LA, with the risks sat between both parties as commissioners and not with the providers. The risk share will be measured on the underlying performance of the individual schemes. The risk share funding has been allocated between schemes on a weighted basis against the value of savings expected from each scheme. The performance for each scheme will be monitored, and any over under spends within the schemes or the risk share element being addressed through S75 agreements and the appropriate governance as set out.
For NHS commissioned out-of-hospital services, and services that were previously paid for from funding made available as a result of achieving your non-elective ambition, please confirm if these continue in a manner consistent with 15-16 and provide evidence to support any changes to service provision from 15-16 plan.	As highlighted above, non-elective ambition was not achieved, therefore the performance fund has not been released for out of hospital commissioning, but has been set aside as a risk share pot.

Agreement on Local DToC Plan Please provide assurance, with supporting evidence that you have established a stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. Please describe how your plan sits within the context of an overall plan across the health and care system to improve patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge)?	We welcome the Better Care planning requirement to agree a local action plan to reduce delayed transfers of care and improve flow and are taking this opportunity to work with our partner CCGs and LAs in Berkshire West to agree a system wide approach to the development of our local action plans. The first part of this has been a situation analysis of current DTOC performance across the three localities as reported for BCF purposes and also an analysis of current "health performance" in relation to the national ambition to have no more than 3.5% bed days lost as proportion of total occupied bed days at acute trust provider level each month. This has highlighted the need to ensure that all partners understand these differences when considering what is a proportionate plan to improve DTOC performance. A report on this is going to the Delivery Group of the Berks West 10 Integration Board on 26th March. Following this we will agree our local target for Wokingham and develop an action plan which meets the KLOE requirements and includes the eight high impact actions that were agreed by ECIP. A copy of the draft report is appended for information. A recent review of the Step Up Step Down scheme in particular has indicated areas for development for 16/17 within the BCF plan to meet the change that has been seen in the customer groups accessing the services, which has included more people with Dementia.  DTOC DRAFT REPORT TO DELIVEF
Please confirm your target is reflected in the relevant CCG(s) operational plan, and that you have considered the use of local risk sharing agreements with respect to DToC, with clear reference to existing guidance and flexibilities and with reference to the track record of current performance	We have not included DTOC in our local risk sharing agreement as we are still developing our wider Berks West approach to our DTOC plan , as set out above.
In agreeing the plan, please detail you methods of engagement with the relevant acute and community trusts and confirm that the plan has been agreed with your providers. Please also detail any engagement with the independent and voluntary sector	As mentioned previously above
Please demonstrate clear lines of responsibility, accountabilities, and measures of assurance and monitoring, taking into account national guidance	Each project has a developed Business case for 2016/17 following on from their previous agreed PIDs from 2015/16, their progress is monitored by either our local integration board where performance dashboards and highlight reports are used to assess progress and impact , or for Berks

and best practice (as set out in technical guidance)	West schemes through their own project boards reporting into both the Berks West Delivery Group, Berks West Finance Sub-Group and updates to our local implementation board.
Scheme Level Spending Plan Please confirm if your scheme level spending plan, submitted as part of the BCF Planning Return template, accounts for the use of the full value of the budgets pooled through the BCF.	The scheme level spending plan does account in full for the value of budgets pooled through the BCF by the inclusion of a contingency fund of £232k. This provides a degree of assurance of being able to meet and variations in costs from the schemes.
National Conditions If you have not already done so, please include here an explanation of how the targets against the National Conditions have been set, and your plans for how these targets will be met, and whether they represent a realistic assessment of the impact of BCF initiatives on performance in 2016-17.	See above previous answers

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