ITEM NO: 64.00

TITLE	**Better Care Fund Plan Update**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 24 March 2014
WARD	None Specific

Local Government Association

NHS England

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Wokingham Unitary Authority**
Clinical Commissioning Groups	**NHS Wokingham CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**13 February 2014**
Date submitted:	**14 February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£ to be confirmed**
2015/16	**£ 8,044,000**
Total agreed value of pooled budget: 2014/15	**£ to be confirmed**
2015/16	**£ 8,044,000** It is the intention to include other existing into the BCF but detailed figures are to be confirmed.

b) Authorisation and signoff

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

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

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

The development of the draft plan has drawn together a number of existing programmes aiming at integrating local services and achieving better outcomes for patients and residents. These have involved health and social care providers at an early stage in both representation at the sub group governance of the Health and Wellbeing Board (the Wokingham Integrated Strategic Partnership) and in provider workshops to share ideas across all those involved in delivery of local services, including the voluntary and community sector, to further shape and develop the plan.

The local partners have recognised the need to develop a shared narrative to explain why integrated care matters. That is to identify causes of common difficulties and problems and to work together to overcome fragmentation between services and develop more integrated models of care.

The integration partnership has specifically worked to scope and define the integrated pathway and develop remodelled service designs to feed into service re-specification. In December Wokingham UA and Wokingham CCG shared that development plans through the Berkshire West Planning Unit, to include acute and community provider organisations.

d) Patient, service user and public engagement

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

The plan has been developed in response to the views and experiences of local people, what they want from their services and what's important to them. This valuable feedback from patients, social care customers and carers has given us a very clear direction to create closer integrated services around individual lives, wishes and choices. It builds on the reshaping of services that has already happened locally that puts the person at the heart of their health and social care services.

Through consultation and engagement in partnerships, workshops, survey and participation groups we know that people want to experience seamless transition between services; to be well informed and involved in decisions; to know who is involved in their care and that person has access to all the relevant information about them.

We have a network for engagement and participation across all our partner organisations and through this we will continue to keep the individual's experience and perspective as the organising principle of service design.

The NHS 'Call to Action' day has also given very clear messages to inform the integration planning agenda. As well the improved levels of integration across health and social care, local people also called for preventative care being improved and incorporate more self care and education; ensure that the vital contribution of the voluntary sector is more highly valued and put greater more focus on developing community services, particularly for those with long term conditions and older people.

The Learning Disability Partnership engagement work in preparing the Joint Health and Social Care self assessment also provided local voices and stories about people's direct experience of health and social care which has also shaped development of the plan.

e) Related documentation

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

Document or information title	Synopsis and links
Pioneer Application	Berkshire West 10 application to become an integration pioneer
Health and Wellbeing Strategy 2013-14	The joint Health and Wellbeing Strategy identifies the priorities and action that the Health and Wellbeing Board will deliver in the period 2013-14.
Joint Strategic Needs assessment	Outlines and profiles the demographic needs of the population of the borough to inform commissioning activity.
Hospital at Home business case	Outlines detail of the scheme, proposed model of working and anticipated costings and impact.
7 day working	As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary

	admissions at weekends
Medical Intra-operability Gateway business case	Better data sharing between health and social care, based on the NHS number
Wokingham case coordination Operation plan Wokingham Health Hub	Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Wokingham Call to Action report	Agreement on the consequential impact of changes in the acute sector
Integration of health and social care short term reablement services	Project Plan outlining the business case, scope and timescales for an integrated service.
Joint Health and Social Care Self Assessment Framework	Self assessment and the easy read report.

2) VISION AND SCHEMES

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

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

Wokingham's vision for health and social care services

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

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

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

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

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

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

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

The plan is built around what we want people to say about their experience of health and social care services in Wokingham. We call this 'Sam's Story' with Sam being a typical

child, young person, adult or older person in need care and support in their physical health and emotional wellbeing.

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

We have been listening and collecting other local stories which demonstrate where working across different services and organisations currently fails. These include examples of delays whilst many phone calls are made trying to find the right services where criteria are unclear or misunderstood or where lack of capacity in the service means referrals are restricted or turned away.

b) Aims and objectives

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

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

The outline plan

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

Integrated care makes sense for Wokingham patients and service users. It means a better customer experience, better patient outcomes, less confusion and complexity for patients (and carers) and because our model is mostly focused on providing care closer to home, it presents a real cost saving opportunity. We also know that continuing to service plan and try and make further efficiencies year on year without moving to a wholly integrated care model is simply not sustainable given the further reduction of funding to the local authority in the coming years.

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

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

Voices:

Objectives:

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

Against this we also know that the health and social care system has to move to a seven day economy in order for services to be reactive and immediate when they're needed as well as being closer to home. This includes the vital services that support people with their emotional health and wellbeing at times of crisis.

We also recognise to more closely plan and integrate the acute and community health services together with the many care providers in the private, voluntary and independent sectors that contribute to the system.

Whilst much of the focus of avoiding admissions and reducing delays is focused on the care pathway for elderly frail people it is also imperative that integration of health and social care brings improved outcomes for other groups, in particular younger people and the emotional and mental wellbeing of our borough residents. Our aim is to include these groups in key areas of the plan.

c) Description of planned changes

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

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

The proposed plan for Wokingham have been developed and agreed across partners as our priority areas for integration under the Better Care Fund that will improve local services for people living in Wokingham:
1. A Single Point of Access for local health and social care services in Wokingham
The establishment of Single Point of Access is vital to manage referrals efficiently and effectively whereby the responsibility and accountability for finding, accessing and transfer of cases sits within one integrated team. This will have a single telephone number which will do take on case co-ordination and management of all the referrals for

short term health and social care services. It will operate throughout the week providing a 7-day service, 24 hours a day, to ensure that the whole system is supported throughout the week.

Through this single point of contact it will be much easier for the public and professionals to access the right service. Currently these can be disjointed which both frustrates referrers in taking undue time to find the right service and confirm they accept and can transfer, and slows down the process of discharge or mobilising short term community based services to avoid an unnecessary admission. Active management of cases will prevent those circumstances when a case is batted between services due to differing referral criteria or lack of capacity.

Referrals are made to the already established Health Hub (which operates across the West of Berkshire) through which all referrals from professionals for healthcare services are now channelled. For example, all local authorities in west of Berkshire now receive their referrals from the Royal Berkshire Hospital through the Health Hub. This is proving effective and time saving as the referral arrives already screened leading to quicker allocation and assessment times.

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

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

2. Integrated short term health and social care team

This will provide effective and efficient intermediate care and reablement services in order to promote self-sufficiency and to reduce dependence. The aim is to have a comprehensive fast response of a skilled short term intervention to support a timely discharge and regain independence.

This project brings together the existing START (short term assessment and reablement team) with Intermediate Care into a single short term intervention team under a single manager and with a shared resource and budget. It will also consolidate the use of one-off funding to build a more sustainable service to manage peaks of activity throughout the year.

Currently short term services within the borough are fragmented although good joint working does exist at an operational level. Issues identified from patients and professionals indicate a lack of clarity about respective services and their criteria and sometimes being passed around with no service taking responsibility for taking charge and making arrangements.

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

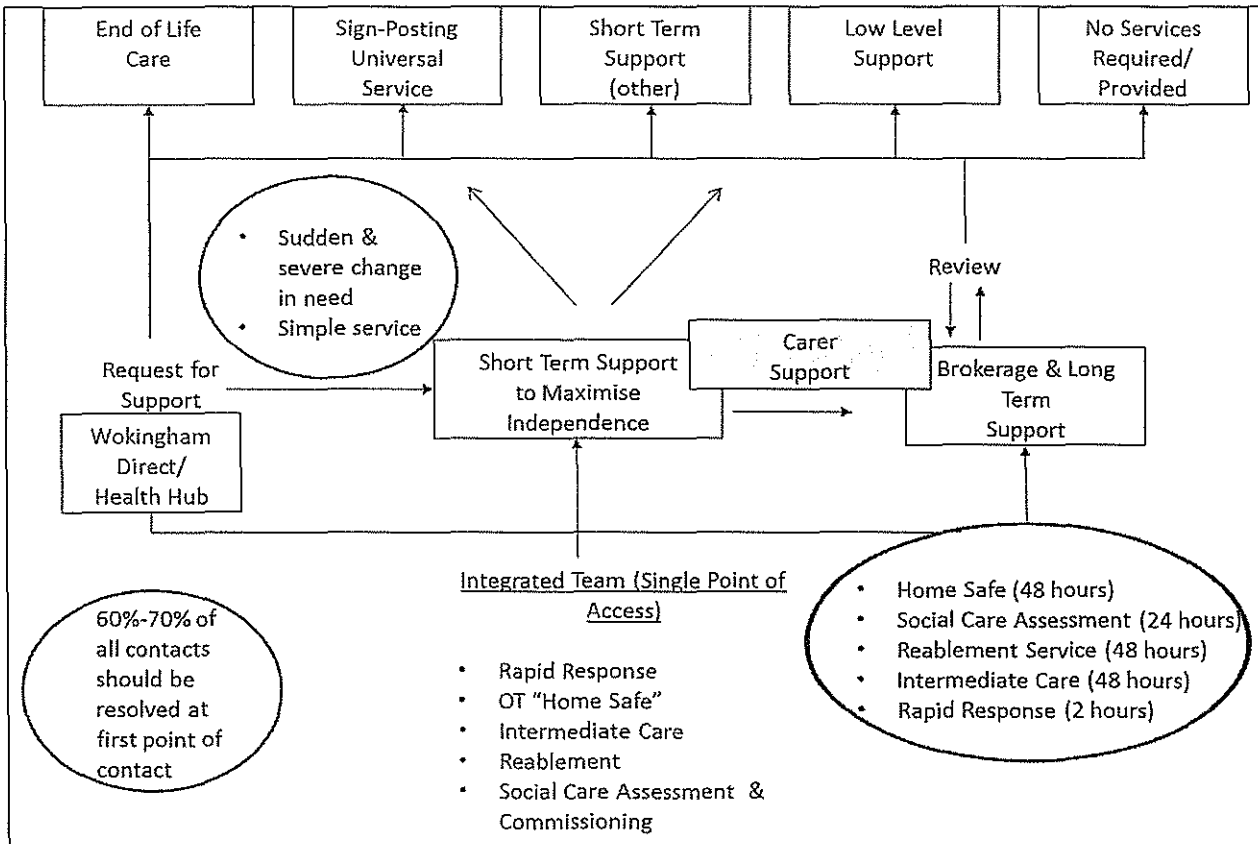
Integrated care is further reinforced by the development of whole system working to address the demands arising from an ageing population and increases in the number of people with multiple long term conditions.

Project objectives:

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

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

The service specification brings together NHS domiciliary rehabilitation, specialist rehabilitation and adult social care linked services under one single person-centred, outcome based pathway.



Working closer with the acute trust

Within the short term integrated team we will also be enhancing the partnership working between the hospital and the social care Health Liaison Team to have greater Social Work presence in the acute hospital.

Evidence has shown that early contact by Social Worker when required in A&E has very effectively facilitated and supported access into short term services by assist in pre-discharge discussions. The social work role will be present within and alongside the ECU (emergency care unit) and AMU (acute monitoring unit) within A&E. Whilst Wokingham already has this in place the plan would extend this presence into evenings and throughout the weekend.

The team would also continue its working supporting ward rounds throughout the hospital working alongside the service navigation team with discharge planning.

Step up facilities

As part of the development of short term services the plan also includes the creation of 'step up' facilities which can provide a period of intensive rehabilitation in community based accommodation. This would broaden the options of support that could be offered through the integrated short term team. It would provide support to those people that are medically fit for discharge from community or acute hospital beds but need ongoing assessment or are not yet able to return home. Work is in progress to identify potential sites within the borough to provide a number of step up beds.

3. Hospital at Home Service

This service will enable people with long-term health problems who are heavily

dependent on health and social care services to receive the best possible, affordable care in their own homes.

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

The benefits of the service will be:

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

4. **Enhanced Care and Nursing Home Support**

This scheme will provide a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents.

The aim is to reduce non-elective hospital admissions from care homes through Introducing a GP enhanced community service. It will do this through strengthening partnership working between care home providers, community geriatricians, health and care staff to improve the quality of life for residents by reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents.

Scope of the scheme

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

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

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

There will be regular contacts and visits by GPs with care home staff and community

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

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

Benefits of the scheme

Wokingham has chosen to target Better Care Fund resources on care home residents because their medical needs are complex and rapidly changeable. 80% will have mental health needs such as dementia, depression or a long term mental health diagnosis. They have higher needs than other patients for essential medical cover because not be able to attend their local GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions. Currently, however, the range, type, quality and consistency of overall care can vary widely between the individual care homes.

With more people being supported to live at home for longer, those who need 24 hour support in a care home likely to complex or multiple long term health conditions. This has growing cost implications for the health and social care economy. These costs can include Accident & Emergency attendances, emergency admissions to hospital, and readmissions. Some admissions are potentially avoidable, such as fractures or urinary tract infections.

Enhanced training to care home staff

This scheme will also include additional nurse trainers into care homes. Currently, the Royal Berkshire Healthcare Trust receives a high number of referrals from care homes which turn out to be either inappropriate or avoidable if there was better knowledge within the care home setting of how to manage long term conditions.

Introduction of an additional Community Pharmacist Resource

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

5. **Joint information and interoperability of IT systems**

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

- **signposting and advice**

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

consistent and of a high quality

- **performance management and shared intelligence**

  At both a strategic and operational level information and intelligence should be shared and discussed across services and partner agencies, including providers, public health, CCG and local authority. This should form the annual needs assessment process and commissioning activity. Service improvements and outcome monitoring will be based upon shared information and intelligence derived from existing health and social care information systems.

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

Health and Adult Social Care Services systems interoperability

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

Scope of the proposal

There are a number of technology solutions which facilitate wide-scale information sharing between the clinical systems used in different settings. The Berkshire West Federation of Clinical Commissioning Groups (which includes the Wokingham CCG) is currently looking at possible solutions that could support system interoperability across the local health and social care economy.

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

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

The aim of the project is to achieve real time access to data between GP Practices, wider healthcare settings and the adult social care record system. It presents information in existing clinical systems while meeting interoperability technical and security standards.

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

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

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

6. Prevention and Supporting People to Self Care

The majority of people are themselves best placed to make decisions about their own health and care needs provided they have capacity and are supported with good information and advice. This work builds on national pilots as well as the model of support that promotes citizenship and personalisation.

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

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

Neighbourhood working

The scheme is also about reducing interventions and so is linked closely to enhanced primary care and developing neighbourhood initiatives. By supporting health improvements earlier it can break social isolation, keep people active and prevent illness and falls. It also into our Public Health outcomes framework.

This part of the plan will also entail working closely with neighbourhoods and the plans for development of neighbourhood clusters in primary care. We recognise the need to develop a whole system health and case model within which component interventions can be located.

Wokingham are pilots of a neighbourhood based system offering case management and coordination supported by predicted risk modelling to improve crisis responses services, support pathways to enable assessment and review. The clusters are a chain of interlinked and connected activities which bring organisation together though enhances processes. The component parts are:

- Engagement with communities

  Community development is at the heart of primary prevention, encouraging and enabling healthy aging, so that Wokingham citizens can live active and

independent lives. Neighbourhood clusters will need to engage community groups and other public agencies to encourage and where necessary enable initiatives like community transport, volunteering and self-health approaches

- Integrated Care teams

  Building on the Integrated short team health and social care initiatives, with the GPs practices in the neighbourhood cluster working closely with the team

Children and young people

Building resilience and early intervention can reduce the number of children becoming mentally unwell. Supporting the mental health of children and young people is not just a task for specialist CAMHs. Universal and targeted services at Tiers 1 and 2 can provide cost-effective interventions such as parenting support, anti-bullying initiatives in schools, mental health first aid, counselling, brief alcohol screening and advice in general practice

7. **Night Sitting Carers Service**

The night sitting service has been identified as an essential element of the support to keep people at home. This will form part of longer team support to people at home and avoiding care home placement. It will offer night sitting support to approximately four people at any one time covering from 10pm- 8am. It will enhance and extend the current carers support which is currently available short term (up to 3-4 nights) as part of Intermediate Care to avoid admission.

8. **Primary Care Enhanced hours**

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

Carers services and support

Carers commitments are briefly outlined within elements this submission of the draft plan, further detail will be included in the final draft and will include support to Foster Carers.

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

The integration of enhanced primary care, community health services, the acute hospital services and social care will prevent ill health and better manage the demand on local services. People will complex health conditions will be supported to stay at home or in

the community and only be admitted to acute hospital when they require treatment that cannot be delivered elsewhere.

The initiatives outlined in the Better Care Plan for Wokingham have been conceived and developed together with our acute provider. They are focused on areas which will improve patient pathways in and out of the acute hospital service, avoid admission where possible, reduce length of stay and enable people to return home in a well-supported and timely way.

Successful delivery of the programme is expected to improve delivery of health and social care services and improve the individual's experience within the service and achieve better outcomes.

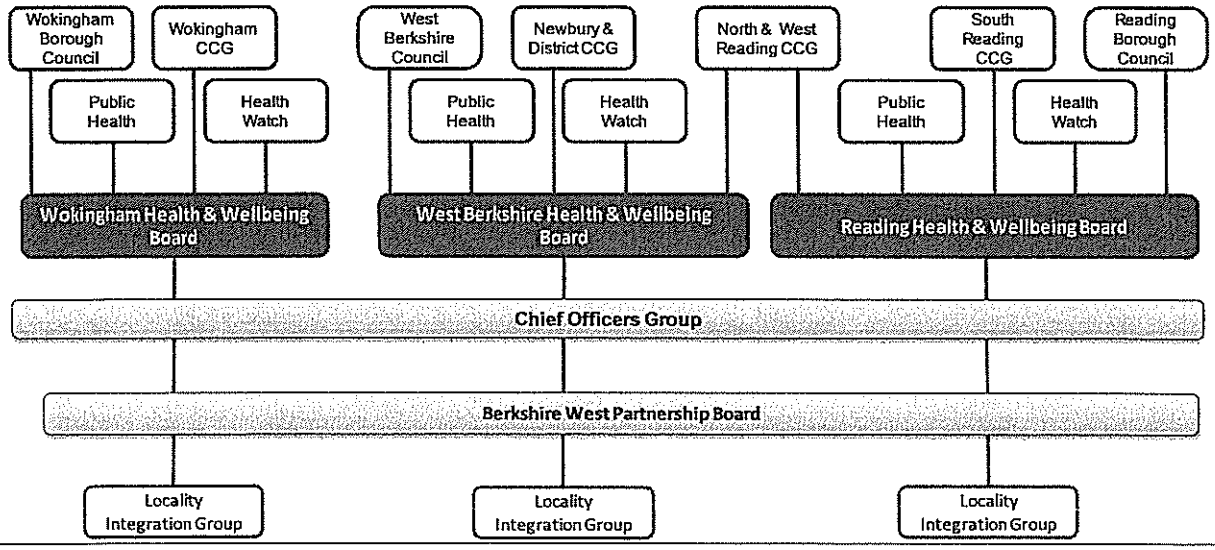
[Further detail of the impact on NHS delivery targets and anticipated cost savings to be added]

e) Governance

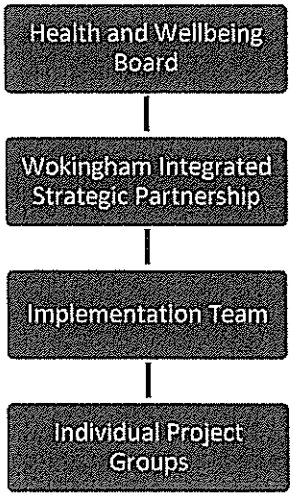
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Wokingham has developed strong governance arrangements in preparation and establishment of the local Health and Wellbeing Board. One of the sub-committees has a specific remit for working towards the integration of health and social care services (The Wokingham Integrated Strategic Partnership) which is looking at how we start to bring together management responsibilities and accountability across health and social care services locally.

Because the local health and social care economy works across our borough boundaries many of the schemes within the plan are part of a wider Berkshire West federated programme and therefore governance arrangements are also part of a Chief Officers group and the Berkshire West Partnership Board.



The Wokingham Health and Wellbeing Board will have oversight of this Better Care Fund plan governed through the Wokingham Integrated Strategic Partnership and delivered through a local implementation team.



[further details of governance to follow]

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Protection of social care services through the Better Care Fund is to ensure that vital care and support services delivered in our community is maintained and also sustainable for the long term. There will be growing demand on services as the population ages and grows in Wokingham, particularly given the new housing developments which will be seen in the next few years.

It's essential that we plan financially to meet and manage the requirements of the new Care Bill and that resources are protected for meeting our new liabilities under the act. This includes the implementation and operation of a new eligibility threshold for adult social care, new obligations to carers, implementation of a capped care cost system and setting up accounts for those funding their own care as well as enhanced information, advice and signposting services.

In moving to a critical threshold for eligibility Wokingham has already seen a significant investment in prevention services across the borough which starts 'upstreaming' of resource to prevent or delay the need for health and statutory social care services. We want to ensure that we can continue to support people at the earliest opportunity long before they have a critical social care need where possible. Working together with our voluntary and community sector partners is vital in recognition of the huge contribution they play in the health of our residents.

Where people do need statutory social care support we have to be able to respond quickly with professional assessment and personalised support planning to ensure that people are able to achieve good health and wellbeing outcomes and remain at home where possible.

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

Social care services have to be able to continue to provide support to people with critical care needs in a timely and sustainable way through professional social care assessment by social worker or occupational therapist, brokerage and longer term support and review. The care bill is anticipated to bring changes to the eligibility criteria for social care nationally which we have to able to respond to both for new customers and in reviewing those already receiving services. We need to develop additional capacity for this and also the additional responsibilities for carers and people funding their own care.

The Wokingham social care pathway and workforce have gone through significant review in recent years in order to manage significant reductions in budget whilst protecting essential services for those receiving care. It is proposed that part of the Better Care Fund will be put into additional social care support to deliver enhanced services throughout the week both in the acute hospital and in short term community based services. Enhancing and extending to 7 day services whilst taking some additional investment will bring benefits for avoiding admissions, supporting discharge and reducing care home placements.

b) 7 day services to support discharge

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

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

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

In Wokingham we currently have a number of services which are working extended hours. The Berkshire Healthcare Foundation Trust provide community nursing 24 hours a day, 7 days a week from the. Other services such as Intermediate Care, Rapid Response and START services run a 7-day service (but not 24hrs)

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

c) Data sharing

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

Yes, all health and social care systems will use the NHS number as the primary identifier for patients and customers that will enable and support the IT systems interoperability across the sector locally.

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

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

The Berkshire West Federation of Clinical Commissioning Groups has engaged with an IT development partners to undertake work on the feasibility of a 'medical interoperability gateway' which will provide a greatly enhanced information sharing of records providing access to live data on various systems in use across the local health and social care sector.
Wokingham has moved to a system of secure email for all communications within and across partner organisations in addition to the use of GCSX.

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

d) Joint assessment and accountable lead professional

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

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

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

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

4) RISKS

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

[Details of risks to follow]

Risk	Risk rating	Mitigating Actions
Failure to deliver a coherent, rigorous programme to implement the plan, including organisations ability to co-ordinate and manage change will lead to inefficient service models	High	Senior leadership directly involved, with strong programme governance arrangements and robust plans
A lack of detailed baseline data and the need to rely on current assumptions could make our financial and performance targets for 2015/6 onwards unachievable.	High	The BCF integrated care activity will include undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outline in our BCF submission a reality.	High	By understanding what we believe the investments might achieve there can be mechanisms to identify system stress, where there is success or where schemes are not delivering. By constructing clear metrics success can be accelerated and unsuccessful interventions reviewed.
Improvements in the quality of care, in preventative services and Hospital at Home will fail to translate into the required reductions in acute and nursing/care home activity by 2015/16, impacting on the overall funding available to support core services and future schemes.	High	We shall model our assumptions using a range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.
The introduction of the Care Bill currently going through Parliament and expected to receive Royal Assent in 2014 will result in a significant increase in the	High	Wokingham adult social care has undertaken an initial assessment of the effects of the Care Bill and we shall continue to refine our assumptions around this

cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact on the sustainability of current social care funding and plans.		as we develop our final BCF response, and begin to deliver upon the associated schemes.

Association

Finance - Summary

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

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Wokingham Borough Council			613,000	613,000
Wokingham Clinical Commissioning Group			7,431,000	7,431,000
BCF Total		0	8,044,000	8,044,000

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

Contingency plan:		**2015/16**	**Ongoing**
Nursing care homes	Planned savings (if targets fully achieved)	750,000	750,000
	Maximum support needed for other services (if targets not achieved)		
Hospital at Home	Planned savings (if targets fully achieved)	2,280,000	2,280,000
	Maximum support needed for other services (if targets not achieved)		
Frail and Elderly	Planned savings (if targets fully achieved)	1,650,000	1,650,000
	Maximum support needed for other services (if targets not achieved)		

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

BCF investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01 - Single Point of Access						150,000			
BCF02 - Integrated short-term health and social care						1,000,000		1,650,000	
BCF03 - Hospital at Home Service				406,623		940,000		2,280,000	
BCF04 - Enhanced Care and Nursing Home Support				218,879		144,000		750,000	
BCF05 - Joint information and interoperability of IT systems						100,000			
BCF06 - Prevention and supporting people to self care						500,000			
BCF07 - Night Sitting Carers Service						220,000			
BCF08 - Primary Care Enhanced Hours						742,000			
Protected Social Care services						944,000			
Existing S256 Spend						1,772,000			
Existing CCG reablement spend						641,000			
Existing CCG carers fund						278,000			
Disabled Facilities Grant							389,000		
Social Care Capital Grant							224,000		
Total		-	-	625,502	-	7,431,000	613,000	4,680,000	-

Association England

Outcomes and metrics

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

Rapid Response will be in place within two hours. Where patients need access to this service to avoid admission, and referring through the single point of access, the referral will be confirmed and contact made with the patient and intervention started within two hours from time of referral. This will be a 24/7 response time. These response times be collected by the single point of access and reported to the Integration Partnership and the Health and Wellbeing Board as part of the suite of performance measures monitoring progress against the Better Care Fund programme.
Benefits will be for more people to be supported to remain at home which will reduce avoidable admissions.
Hospital at Home will support people with medical needs in their own home for a short period (upto 7 days maximum) which will reduce hospital admissions activity. It is intended to provide upto 30 beds incrementally.
Reablement services will be in place within 24 hours from referral through to the Single Point of Access for short term health and social care services. This will support people to return home from hospital or remain at home for a short period of intensive rehabilitation to help regain and maximise independence. Within the short term team there will be the provision of 'step up' beds as a bridge between hospital and home.
Single Pint of Access for Health and Social Care services - will provide a single clearer route for people into local short term services so that cases are passed quickly and without delay helping reduced delays and improving experience of transition between services.
Reduced delayed transfers of care and fewer emergency admissions will be measured and monitored from existing collection and reporting processes.

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

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

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

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	97.8	N/A	
	Numerator	118		
	Denominator	120682		
		(April 2013 - December 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	63.80%	N/A	
	Numerator	44		
	Denominator	69		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	5.78		
	Numerator	7.6		
	Denominator	131500		
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator		445	869
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*