**ITEM NO:** 78.00

| | |
|---|---|
| **TITLE** | Better Care Fund |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on 2 April 2014 |
| **WARD** | None Specific |
| **STRATEGIC DIRECTOR** | Stuart Rowbotham, Strategic Director Health and Wellbeing |

**OUTCOME / BENEFITS TO THE COMMUNITY**

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

**RECOMMENDATION**

1) That the Board notes and supports the outline of the Wokingham Better Care Fund Plan together with the progress made in relation to developing further detail to the earlier draft presented in February.

2) That the Board agrees the proposal for submission as the final plan for consideration by the Local Government Association (LGA) and NHS England on 4 April 2014.

**SUMMARY OF REPORT**

The attached reporting template details the Wokingham Better Care Fund Plan for integrating local health and social care services which the Health and Wellbeing Board are required to approve ahead of submission. The plan has been further developed in response to feedback from the Board and that from NHS England on the first draft plan submitted on 14 February.

## Background

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

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

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

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

In summary:

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

Better Care Fund plans must deliver on national conditions:

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

Pay for performance will be based on:

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

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

**Analysis of Issues**

Detailed analysis is contained within the planning guidance.

**FINANCIAL IMPLICATIONS OF THE RECOMMENDATION**

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

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

| **Other financial information relevant to the Recommendation/Decision** |
|---|
| As part of government's drive to provide improved local efficiencies across services and a more co-ordinated experience of care for patients, a national £3.8 billion Better Care Fund allocation has been made available in 2015/16 to support the integration of health and social care services locally.<br><br>The services outlined in this report are an integral part of the drive towards an increase in community based care which will result in cost reductions in acute and residential based services.<br><br>In addition to this a number of reforms proposed by the Care Bill which will place further financial pressure on key social care services.<br><br>The borough has received an allocation of £8,044m from the national total for 2015/16. The total includes £7,431m funding via Clinical Commissioning groups, together with |

| |
|---|
| £389k Disabled Facilities Grant and £224k Social Care Capital Grant.<br>Further work on the cost allocation to the various elements of the plan has been completed but there will be further adjustments pending the more detailed business plans and associated project costs and benefits. |

| **Cross-Council Implications** |
|---|
| N/A |

| **Reasons for considering the report in Part 2** |
|---|
| N/A |

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

| | |
|---|---|
| **Contact** Mike Wooldridge | **Service** Strategic Commissioning Division, Health and Wellbeing |
| **Telephone No** 0118 9746783 | **Email** mike.wooldridge@wokingham.gov.uk |
| **Date** 25 March 2014 | **Version No.** 1.0 |

Local Government Association

NHS England

# Better Care Fund planning template – Part 1

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

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

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

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **Wokingham Unitary Authority** |
| | |
| Clinical Commissioning Groups | **NHS Wokingham CCG** |
| | |
| Boundary Differences | There is one Wokingham CCG whose boundaries are mostly coterminous with that of the Wokingham Unitary Authority. There is one practice in the west of the borough which is part of Reading. Some schemes proposed will run across west of Berkshire authorities. |
| | |
| Date agreed at Health and Well-Being Board: | **2 April 2014** |
| | |
| Date submitted: | **4 April 2014** |
| | |
| Minimum required value of ITF pooled budget: 2014/15 | Pooled budget to be agreed in year for the integrated short term health and social care team. |
| 2015/16 | **£ 8,044,000** |
| | |
| Total agreed value of pooled budget: 2014/15 | £ to be confirmed (see above) |
| 2015/16 | **£ 8,044,000**<br>It is the intention to include other existing funds 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** | 2 April 2014 |

| | |
|---|---|
| **Signed on behalf of the Council** | |
| **By** | Stuart Rowbotham |
| **Position** | Strategic Director – Health and Wellbeing |
| **Date** | 2 April 2014 |

| | |
|---|---|
| **Signed on behalf of the Health and Wellbeing Board** | David Lee |
| **By Chair of Health and Wellbeing Board** | Leader of Wokingham Council |
| **Date** | 2 April 2014 |

**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.

A successful bid has been made by the ten organisations in the Berkshire West health

and social care economy to Health Education Thames Valley for funds to support the development of a cohesive integrated organisational development plan for the health and social care workforce. Included in the proposal is the development of Health Care Assistants, Support Workers and key worker roles as well as ensuring that the voluntary and independent sector workforce is an integral part of the whole system workforce design.

**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

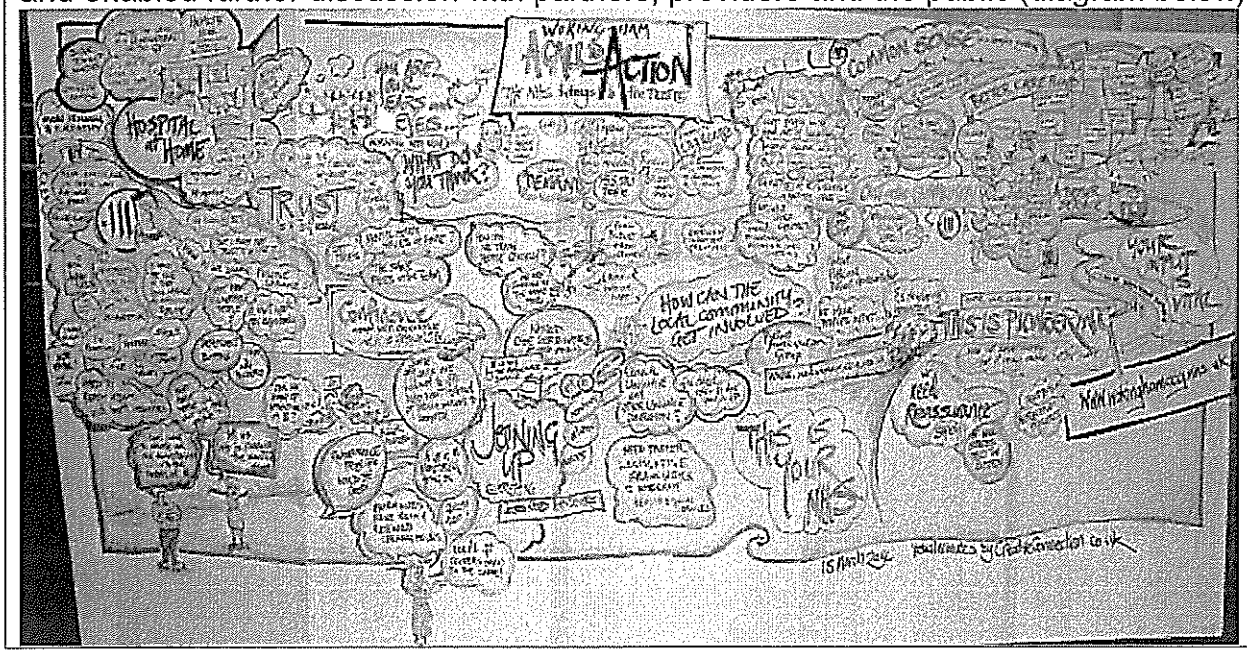
The plan has been developed in response to the views and experiences of local people, what they want from their services and what's important to them. This valuable feedback from patients, social care customers and carers has given us a very clear direction to create closer integrated services around 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 first NHS 'Call to Action' day has given very clear messages from the public and our partners that helped 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.

A second Call to Action event has been held to share the outline Better Care Fund plan and enabled further discussion with partners, providers and the public (diagram below).



The Call to Action event particularly highlighted the desire to provide greater support to Carers and minimise the impact on families.

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. |
| Berkshire West 10 Workforce Integration Strategy | An investment proposal to Health Education Thames Valley to develop an Integrated Workforce Strategy and whole system workforce redesign change programme. |
| Berkshire West Five Year Strategic Plan | Includes assessment of impact on the acute sector of the BCF |
| Wokingham two year operational plan | Includes further details of the BCF plan |

## 2) VISION AND SCHEMES

**a) Vision for health and care services**

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

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

**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.

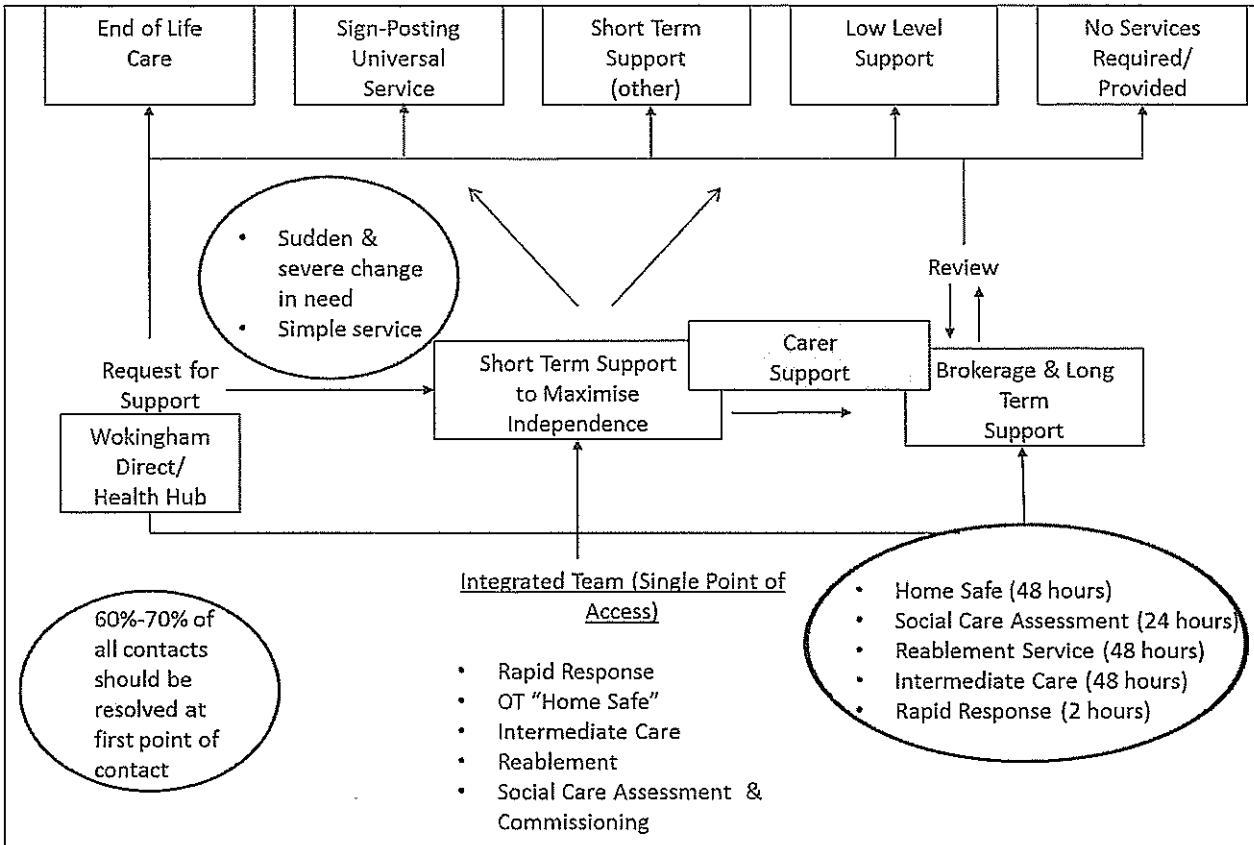
Integrated care is further reinforced by the development of whole system working to address the demands arising from an ageing population and increases in the number of people with multiple long term conditions.

**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**

The Hospital at Home 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.

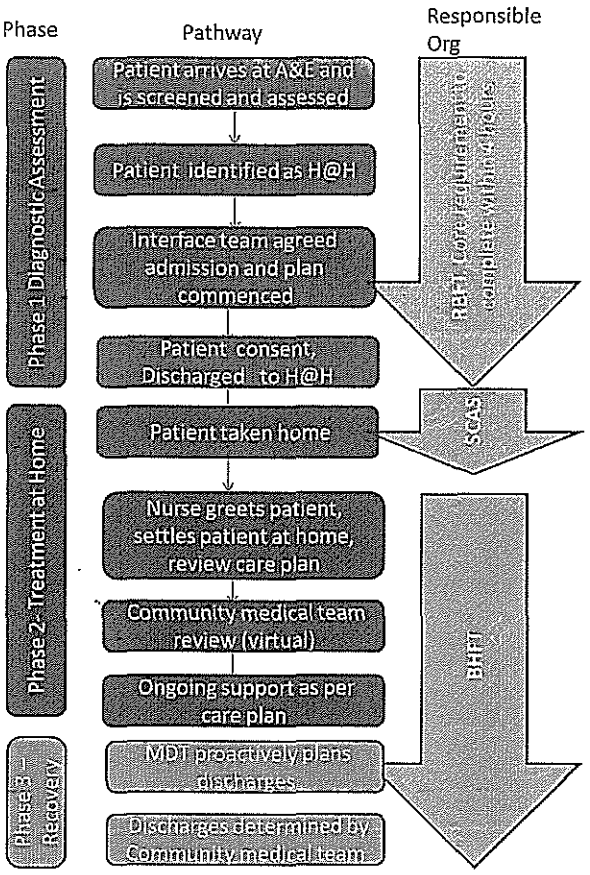
This scheme will offer a safe alternative to hospitalisation and prevent unnecessary admissions. The service will operate within each Berkshire West CCG, including Wokingham, supported by the Berkshire Healthcare Foundation Health Hub.

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 service will also provide support to families and carers throughout the period.

The principles of the service are:

- The service is open to anyone over the age of 18 years;
- The service will operate 365 days;
- Clinical responsibility for patients within the Hospital at Home service will be overseen by the Community Geriatrician;
- In-hours responsibility will held by Community Geriatrician, Out of hours responsibility will be held by WestCall (with support from medics at RBFT);
- Virtual ward rounds for patients within the H@H will be undertaken daily.
- All patients will have a dedicated "Ward" Matron assigned to their care, supported by additional "Ward" nurses.
- Wokingham will be assigned 10 beds initially, (rising to 20 beds)
- Max length of stay in the H@H ward will be 5-7 days.
- Discharge to existing Community Services.
- To reduce non-elective admissions

The pathway for the Hospital at Home service has been designed through three phases of diagnosis, treatment and recovery and across the Royal Berkshire Hospital Trust, South Central Ambulance Trust and the Berkshire Healthcare Foundation Trust.




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 medical 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 are likely to have 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.

This scheme will also include additional nurse trainers into care homes. Currently, the Royal Berkshire Healthcare Trust receives a high number of referrals for people who are living in care homes which turn out to be either inappropriate or avoidable if those making the referral had better knowledge or that the care home had greater healthcare service support in managing long term and complex conditions.

**Enhanced training to care home staff**

**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. Primary 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.

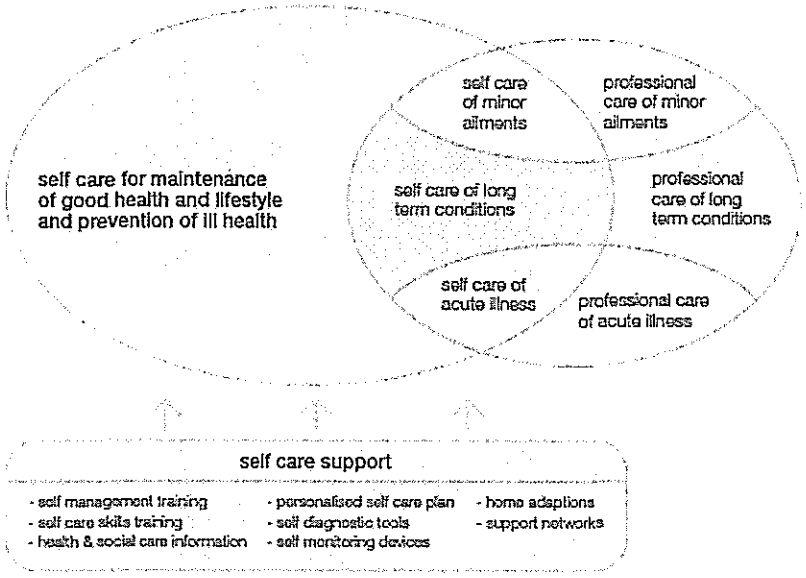
People with long term conditions are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days. Treatment and care of those with long term conditions accounts for 70% of the primary and acute budget in England.

More systematic primary prevention is essential in order to reduce the overall burden of the disease in the population and maintain the financial sustainability of the NHS. It's estimated that as much as 80% of heart disease, stroke and type 2 diabetes, and as much as 40% of cases of cancer could be avoided if common lifestyle risk factors were

eliminated (WHO 2005).

The focus of this element is to target those in high risk groups to reduce incidence or disease and health problems whilst at the same time supporting those that already have long term conditions to have greater choice and control and ability to manage their health and social care. Self-care can therefore 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.

A move to an effective self-care model of support requires a shift of values to a supportive and empowering environment and to a sharing of responsibility and rights over decision making. The principles are to be embedded in service delivery, learning and development planning across health and social care as a whole.




Source: adapted from 'Supporting People with Long Term Conditions to Self Care' (Department of Health 2006b)

## Neighbourhood working

As this scheme is also about reducing interventions it 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 supports improvements against 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 which is supported by predicted risk modelling to improve crisis responses services, and support pathways to enable assessment and review. The clusters are a chain of interlinked and connected activities which bring organisations together though enhanced 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 Care Service**

The Night Care Service has been identified as an essential element of the support to keep people at home. There are known examples where people have been admitted to residential care or hospital unnecessarily as a consequence of there not being an available night care service.

This service will provide a flexible support arrangements providing care for people throughout the night. There will be three different elements to the service:

- A carer to stay throughout the night when required. This service can be available for a maximum of three nights a week, with the aim of providing a break to the person who usually stays with you. The night care service will work in conjunction with the night nursing service currently provided as part of Intermediate Care Services and has the same remit of three calls per week.

- Night carers can visit the person at home up to three times during the night to provide vital personal care that cannot be provided in any other way.

- Carer availability throughout the night to support people who live in Extra Care Sheltered Housing scheme.

The service will provide people with essential care to help with getting in or out of bed, personal care tasks and/or assisting the main carer who may be struggling due to poor health or mobility.

The Night Carer Service will be part of short term service and provide support from 10pm to 7 am, seven days a week. It will enhance and support the current night nursing service provided by the Intermediate Care Service up to 3 nights a week (10pm to 7am). This is currently available short term to avoid admission. The night caring service may extend over a longer period if it is vital to avoid an admission to residential or nursing care.

Criteria have been developed which will follow and reflect those for the short term services. Referral and access to the service will be through the hub. The estimated

capacity of the service will be for approximately 4 or 5 people receiving this support on any night of the week (7 days a week). This service will provide essential service and carers support to people as part of a 24 hours service

**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 all local GP services from 8am-8pm Monday to Friday and 8am-1pm at weekends. (This will link with integrated short term team in 2.)

Practices will operate a mixture of pre-booked and emergency appointments in the extended hours which will provide flexibility for those patients who would prefer to book evening or weekend appointments but will also ensure that patients who might otherwise go to A&E, have access to a GP. Larger practices will expand their existing arrangements to meet demands of these extended hours whereas smaller practices will have greater resource constraints will deliver these extended hours from a single site or hub.

In opening up access to practices in evenings and weekends there are opportunities to provide other services such as health promotion clinics for chronic disease management. The increase in access to general practice and a wider range of services will drive significant improvements in health outcomes for our population as well as reduce the number of 111 and 999 calls and reduce unnecessary A&E visits in evenings and weekends.

The strategic vision is for primary care to a key role in meeting peoples' needs in the community wherever possible. This proposal is aligned to the vision and broader strategic objective to move to seven day working.

Primary care will take a systematic approach to responding to requests for urgent appointments and function within a multi-tiered urgent care system which ensures that patients have timely access to the right service provided in the most appropriate setting.

GPs will take on the role of the accountable clinician for those aged 75 and over working as part of an integrated system to support people at home. They will link with the Berkshire Healthcare Foundation Trust and other services to avoid admissions for vulnerable people during evenings and weekends.

**Carers services and support**

Carers commitments are briefly outlined within elements this submission of this draft plan.

Each of the schemes will have a commitment to improving support to carers that will be included in each business plan. This will include support to young carers and 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.

There is work currently underway across the West of Berkshire health and social care economy looking in more detail on consequential impact to the acute trust of the Better Care Fund plans across the area, which includes the work on the Frail Elderly pathway. The outcome of this will be completed in May 2014 when further detail of the impact on NHS delivery targets and anticipated cost savings will be clearer.

NHS commissioners will be working closely with partners towards the savings quantified in Everybody Counts, namely 15% reductions in non-elective activity and 20% efficiency savings in planned care.

In the case of the Royal Berkshire Hospital and Berkshire Healthcare Trust, the Berkshire West Partnership Board has established workstreams where NHS and social care commissioners will be developing long-term plans with providers, namely Urgent Care, Acute Care and Out of Hospital care. Individual schemes will together support the clinical and financial sustainability of the local Acute Sector.

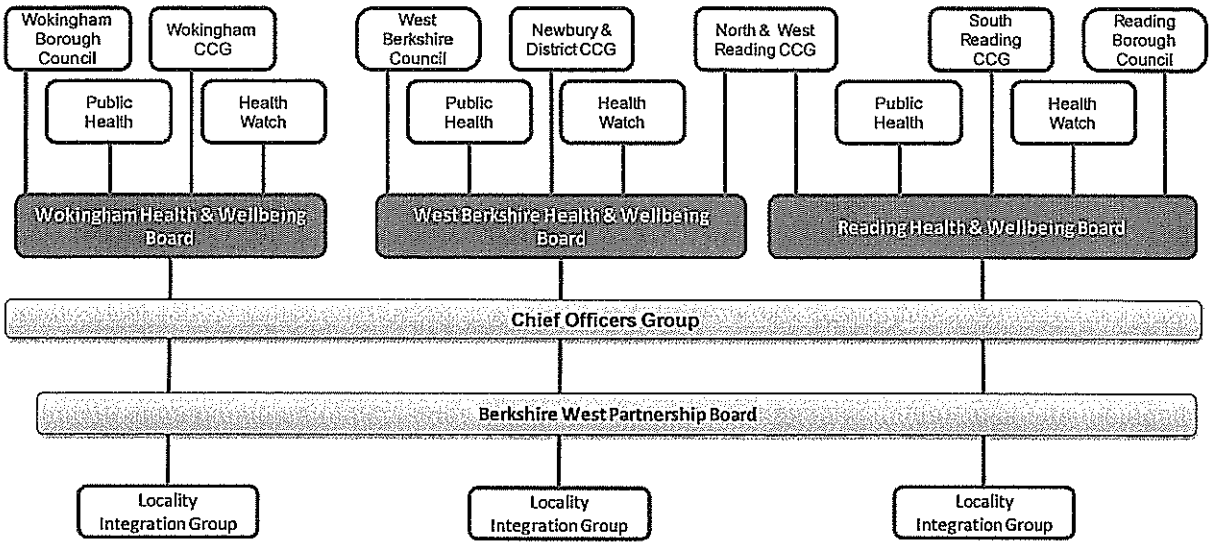
**e) Governance**

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

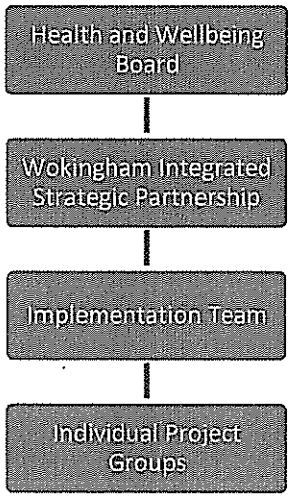
Wokingham has developed strong governance arrangements in preparation and establishment of the local Health and Wellbeing Board. One of the sub-committees has a specific remit for working towards the integration of health and social care services (The Wokingham Integrated Strategic Partnership) which 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.




Four parts of the plan will be co-ordinated through a west of Berkshire integration programme in partnership with other lead agencies whilst the other schemes will be local.

The pooled budget will be set up and managed through a Wokingham Alliance Agreement whereby each party will work together to deliver elements of the care pathway or service with one agreed set of core standards and metrics.

## 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

The local area will use the NHS number as the primary identifier for health and care services.

With regard to social care, the local authority's electronic case management system is already set up to hold this information and a project has commenced to enable the system to be populated. The project will cover two main strands: an initial upload of NHS numbers for all existing clients and the development of a process for the ongoing introduction of NHS numbers for new clients. The timescale for completion of this is within the financial year 2014/15 and clearer timescales will emerge with the development of the project plan.

Alongside this, APIs are being pursued via a multi-agency interoperability project across the west of Berkshire. A proposed IT solution has been identified and phases for connectivity determined. Appropriate information sharing agreements will be developed through this project. Connections with the individual social care systems have been agreed for consideration as part of phase 3 of the project.

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

We are committed to ensuring that there is joint assessment and accountable lead professionals and our further plans will detail how we will achieve this. In the Wokingham CCG areas joint care lead training will take place over the next year.

Monthly multi-disciplinary team (MDT) meetings in GP surgeries are used to identify people at high risk of hospital admission or of needing long term care, and to develop a preventative plan, with the appropriate organisation taking the lead for the plan. MDTs are attended by GPs, Community Health staff and social care staff and from April in Wokingham CCG area their work will be supported by the development of Neighbour

clusters.

We recognise the role of GP practices in taking the lead professional role, but also the importance of social care and health professionals in supporting co-ordinated care and support plans. We are working on plans to deliver a model of accountable lead professional, focused on those most in need. The Hospital at Home team and Integrated Short Term Health and Social care team developments will support those most at risk by providing a co-ordinated, timely care plan.

Work is underway to develop a joint care plan, which will facilitate information sharing, one set of customer outcomes, and our ambition that customers should only need to tell their story once.

## 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 | *To be determined* | | *613,000* | *613,000* | Further work in 14/15 will determine the overall contribution. Is likely to at least include the staffing and commissioning budgets for the short term services. |
| Wokingham Clinical Commissioning Group | *To be determined* | | *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.*

The plan will be monitored through close Project Governance to ensure that there is a phased approach with close financial oversight.

| 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) | | |

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* | 125 | N/A | 125 |
| | *Numerator* | 151 | | 151 |
| | *Denominator* | 120682 | | 120682 |
| | | 2013/14 estimated year end forecast | | |
| *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services* | *Metric Value* | 69.80% | N/A | 80% (pending outurn of 13/14) |
| | *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 | | 5 (pending final outurn of 13/14) |
| | *Numerator* | 7.6 | | |
| | *Denominator* | 131500 | | |
| | | 2012-13 | ( April - December 2014 ) | ( January - June 2015 ) |
| *Avoidable emergency admissions (composite measure)* | *Metric Value* | | | 50% (to be adjusted) |
| | *Numerator* | | | |
| | *Denominator* | 161519 | | 167040 |
| | | (TBC) | ( April - September 2014 ) | ( October 2014 - March 2015 ) |
| *Patient / service user experience - will develop a local short term service satisfaction survey. To test and measure benefits of integrated approach. Baseline measure to be collected summer 2014 then comparison after 12 months. Improvement targets to be set from 2014 outturn.* | | ( Insert time period ) | N/A | ( Insert time period ) |
| *Local Indicator*<br>*Numbers of patients going through reablement* | *Metric Value* | to be added | | to be added |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | ( Insert time period ) | ( Insert time period ) | ( Insert time period ) |

*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 | Berkshire Healthcare Foundation Trust | | | 406,623 | | 940,000 | | 2,280,000 | |
| BCF04 - Enhanced Care and Nursing Home Support | Berkshire Healthcare Foundation Trust | | | 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 | To be determined | | | | | 220,000 | | | |
| BCF08 - Primary Care Enhanced Hours | No single provider | | | | | 742,000 | | | |
| Protected Social Care services | Wokingham Borough Council | | | | | 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 | - |