ITEM NO: 35.00

TITLE	**Better Care Fund Update**
FOR CONSIDERATION BY	Health and Wellbeing Board on 9 October 2014
WARD	None Specific
DIRECTOR	Katie Summers, Director of Operations Stuart Rowbotham, Director of Health and Wellbeing

OUTCOME / BENEFITS TO THE COMMUNITY

RECOMMENDATION

1) That the Health and Wellbeing Board note:

(a) the progress made in developing plans for health and social care integration in Wokingham
(b) The revised (September 2014) BCF submission as set out in the annexed documents:
Better Care Fund Planning Template – Part 1
Better Care Fund Planning Template – Part 1 – Annex 1
Better Care Fund Planning Template – Part 1 – Annex 2
Better care Fund Planning Template – Part 2

2) That the Health and Wellbeing Board note the impact on the Social Care Act

SUMMARY OF REPORT

The Better Care Fund (BCF) provides for local funding for health and social care services in ways which take forward the integration agenda. Funding comes via NHS England in 2014-15 and then as local pooled budgets from 2015-16.

In order to draw down the funding available through the BCF allocation, local authorities and clinical commissioning groups (CCGs) were required to submit agreed two-year plans for use of the BCF, which are approved by the Health and Wellbeing Board. This report sets out Wokingham revised (Sept 2014) BCF proposals, as shared with Health & Wellbeing Board members during development and prior to submission on 19 September

Background

Wokingham health and social care providers and commissioners have already set out an intention to streamline and integrate services for the benefit of patients and the public. The Wokingham BCF submission develops the vision and ideas set out in an earlier (unsuccessful) bid at a Berkshire West level to be an Integration Pioneer. The BCF submission also draws on and develops the strategic priorities set out in Wokingham Health and Wellbeing Strategy (2013). It supports the vision outlined in the Berkshire West Strategic plan 2014-2019 and the Wokingham CCGs operating plans 2014-2016 to 'keep people well and out of hospital in partnership'.

The BCF submission has drawn on Wokingham patient, service user and public feedback gathered recently across a range of health and social care involvement channels, particularly the NHS Call to Action events and feedback from the redesign of the intermediate care and re ablement services. This feedback indicates a strong appetite for better integrated health and social care, and also illustrates that maintaining independence and having choice and control over how they receive care is very important to the people of Wokingham.

Wokingham BCF submission sets out a shared commitment to ensure future service development involves and is centred on the individuals receiving care. The details of how this will operate will be part of the implementation plans for the various schemes identified.

A first draft of Wokingham BCF plan was approved by the Health & Wellbeing Board (HWBB) on 13th February, 2014. A further revised submission was made on the 2th April, 2014.

Following receipt of the initial bids, around 30 local areas were judged to have developed particularly strong proposals for use of the BCF and were invited to 'fast track' their bids through to the next stage. Reading was one of the areas included in this invitation, and negotiated the option of being fast tracked jointly with the neighbouring areas of Wokingham and West Berkshire, as a number of integration projects included in each of the Berkshire West BCF plans had been developed on a Berkshire West basis. Subsequently, Wokingham opted out of fast track timetable.

As part of the national support programme Wokingham received support from a 2 hour BCF clinic, facilitated by McKinsey, along with the sharing of Reading Fast Track submission.

The schemes within Wokingham revised BCF plan, as set out at a seminar hosted by Health and Wellbeing Board members on 11 September, are as follows:

1 Health and Social Care Hub (BW Scheme)
2 Integrated Short term team
3 Step up/ Step down
4 Domiciliary Plus
5 Hospital @ Home (BW Scheme)
6 Enhanced Support to Care Homes (BW Scheme)
7 Berkshire West Connecting Care (Intra-operability) (BW Scheme)
8 Neighbourhood Clusters/ Self Care/ Prevention
9 GP Access (BW Scheme)

- These are described in further detail in the Better Care Fund Planning Template – Part 1 – Annex 1 as annexed to this report.
- The revised BCF bid is currently being assessed through the BCF assurance process. Initial feedback, has indicated & Key lines of Enquiry seeking further clarification. It is anticipated that the additional information related to these key lines of enquiry will need to be supplied in October 2014 with a view to obtaining final ministerial sign off of the bid by the end of October 2014.

Care Act Impact

The Care Act requires that from April 2015 all social care authorities provide services to people whose needs meet the new national eligibility threshold (akin to the existing 'Substantial' eligibility criteria). Three authorities in the country took the decision some years ago to provide service for those whose needs were assessed as 'Critical', the highest level of need under the existing Fair Access to Care Services guidance. Wokingham, West Berkshire and Northumberland are the three authorities in question. Wokingham took this opportunity to invest in community-based, preventative services, provided through the voluntary sector and in micro-social enterprises, offering local employment. West Berkshire took the decision to adopt 'critical' in 2003 given the financial pressures it faces in providing care services in a largely rural district. The decision has been reviewed on a number of occasions but the cost of change has been prohibitive.

On the 15 September Wokingham learnt that a decision had been taken to allocate Care Act money across all 152 social care authorities. This is despite the Department of Health's (DH) own impact assessment clearly recognising that the costs would only fall on the 3 councils (Wokingham, West Berkshire and Northumberland). The advice from DH was Wokingham would have to deal with the eligibility shift out of the existing BCF allocation. This has a significant risk of the scheme outlined above. The CCG has significant savings resting on successful BCF implementation, and the DH expectation is that the BCF will deliver against the 7 national conditions (reduced non-elective admissions, 7-day working etc).

In preparing for Care Act implementation, the Department of Health conducted an Impact Assessment (copy available) in which it recognised the impact of the change in eligibility on the three authorities. A sum of £25m was set aside to address this financial pressure. The document was approved by the responsible Minister on the 23 May 2104.

Wokingham Health and Wellbeing Board have submitted BCF plans to the DH as required, but added a condition that unless this problem was resolved we would reserve the right not to submit a final version, or to conduct wholesale reallocation of the BCF scheme to address this unplanned funding gap.

Local MPs have been briefed on this issue and a meeting is planned for the 3 October to meet with the DH to seek clarification on the funding.

Supporting documentation:

Better Care Fund Planning Template – Part 1

Better Care Fund Planning Template – Part 1 – Annex 1

Better Care Fund Planning Template – Part 1 – Annex 2

Better care Fund Planning Template – Part 2

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)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

Contact Katie Summers	**Service** Wokingham Clinical Commissioning Group
Telephone No 01189299469	**Email** katie.summers2@nhs.net
Date 29.09.14	**Version No.** 1

Local Government Association

NHS England

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

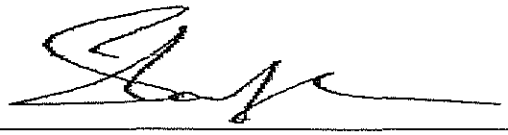
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Wokingham Unitary Authority**
Clinical Commissioning Groups	**NHS Wokingham CCG**
Boundary Differences	Wokingham CCG's boundaries are mostly coterminous with that of Wokingham Borough Council. One practice – Parkside – has one of its two sites is within the boundaries of Reading Borough Council. One South Reading CCG practice – Shinfield - is located within the boundary of Wokingham Borough Council. Many schemes proposed will run across west of Berkshire CCGS and local authorities.
Date agreed at Health and Well-Being Board:	**11 September 2014**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	£0
2015/16	£8,044,000
Total agreed value of pooled budget: 2014/15	£0
2015/16	£9,261,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	**Stephen Madgwick Wokingham CCG**
Position	**Clinical Chair**
Date	**11 September 2014**

The late advice regarding the funding for national minimum eligibility criteria indicates that the funding previously identified by the Department of Health for the 3 councils affected has been distributed across all social care councils, and that the impact of this change in criteria should be funded from the BCF. The Department of Health (in their own impact statement) had estimated the cost to be in the region of £4.5m for this council. The BCF fund is clearly inadequate to fund this enforced change and as a result

all schemes are deemed at risk of significantly reduced funding with obvious reduction in outcomes, should this proposed distribution by the Department of Health remain unchanged. Therefore, this is signed on the assumption that it may be necessary for the schemes outlined in this document to be modified to make up the shortfall in funding, *or for our submission to be withdrawn completely*. This will be identified once the impact of the revised funding is clarified, *and a decision will be taken if the funding position has not been corrected by 31 October 2014.*

Signed on behalf of the Council	
By	**Stuart Rowbotham**
Position	**Strategic Director – Health and Wellbeing**
Date	**11 September 2014**

Signed on behalf of the Health and Wellbeing Board	
By	**Julian McGhee-Sumner By Chair of Health and Wellbeing Board**
Date	**11 September 2014**

c) 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
Berkshire West 10 Pioneer Application	Berkshire West 10 application to become an integration pioneer.  Berkshire West Pioneer Bid Final Versi [Section 3]
Berkshire West 10 Blueprint	A model of future integrated organisation, its working practices and processes, the information it requires and the technology that supports its operations.  Blueprint.docx [Section 3]
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.  BWPB - Paper 8 HETV final 20 02 2014 1.doc [Section 3]
Berkshire West Partnership Programme Board Terms of Reference	 BWCP Draft TOR June 2012.doc [Various sections]
Wokingham Health and Wellbeing Strategy	Identified the priorities and action for the Health and Wellbeing Board will deliver in the period 2013-14. Health and Wellbeing Strategy 2013-14 [Section 2a]
Wokingham Health and Wellbeing Board guiding priorities 2014-16	Annual review of the Wokingham Health and Wellbeing Strategy.  DRAFT Refresh HWB Strategy.pdf [Section 2a]
Wokingham Needs Assessment	Outlines and profiles the demographic needs of the population of the Borough to inform commissioning activity. Wokingham Needs Assessment [Section 2a]
Wokingham Integration Strategic Partnership (WISP) Terms of Reference	 WISP draft TOR 13 08 14 - final.docx [Various sections]
Berkshire West Call to Action reports	These documents present the results from Call to Action events held by the four CCGs in Berkshire West in 2013/14.

Document or information title	Synopsis and links
	 WOK2014.BM.7 Call to Action report.docx  C2A_FINAL_REPORT_ 11June2014.docx [Section 2a and 8]
Wokingham Case Studies	A case study used at the Health and Wellbeing Board on the benefits of an integrated short-term service team.  Case Studies HW.docx [Section 2a]
Berkshire West CCGs Five Year Strategic Plan	Includes an assessment of the impact on the acute sector of the BCF  Final submission Strategic Plan V3.5.do [Section 6b]
Wokingham CCG Two Year Operational Plan	Includes further details of BCF plans.  Wokingham_CCG_Op erating_Plan_ V1.2.p [Section 6b]
Update on Strategic Development Locations and Primary Care Facilities	Report to Health Overview and Scrutiny  HOSC Report Grimes Report.docx [Section 2a and 3]
Wokingham Better Care Fund Change Programme Plan (PID)	Outlines programme governance strategies for delivery of the programme, including management processes, roles and responsibilities, stakeholder analysis and communications.  BCF Programme PID v2.0 02.06.14.doc [Section 4c]
Wokingham Better Care Fund Project Plan	 Better Care Fund Project Plan - Woking [Section 4a]
Wokingham Better Care Fund Programme Map	 BCF Programme Map v 0 6.xlsx [Section 4a]
Berkshire West Commissioning Intentions	Describes the Commissioning Intentions of the four Berkshire West CCGs for 2014/15. Aimed primarily at current and prospective providers, it describes how the CCGs will use their commissioning budgets to deliver the CCGs' strategic vision for healthcare services. Commissioning Intentions

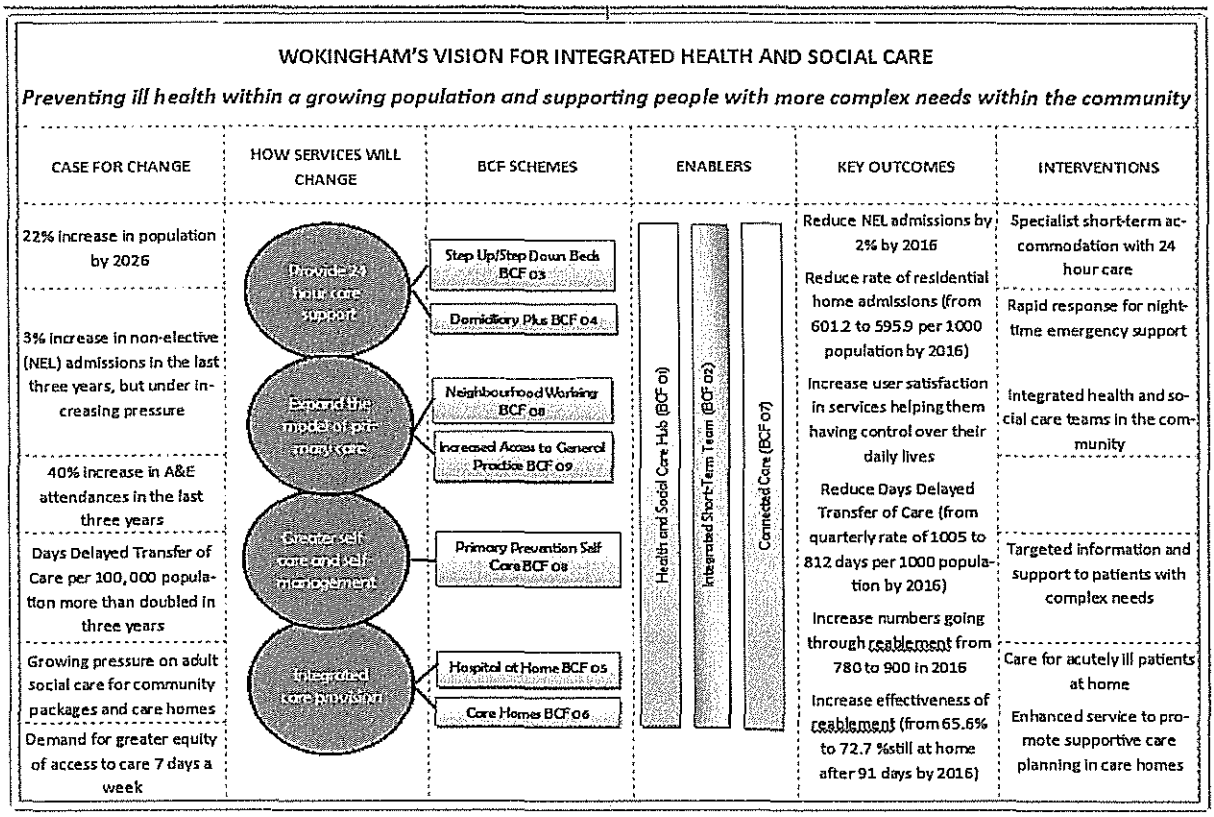
Document or information title	Synopsis and links
	[Section 2a]
Wokingham Adult Social Care Service Market Position Statement	Aimed primarily at providers and commissioners to help them better understand the current state and possible future development of the local market for Adult Social Care services. Market Position Statement [Section 2a]
Wokingham Project Initiation Document for the Care Act	Sets out how various work streams are being taken forward. The Council is currently revising its Prevention Strategy and Carers Strategy in the light of Care Act and BCF.  Care Act PID v5. 08.05.2014.docx [Section 6a]
Wokingham Integration of health and social care short term reablement services	Project Plan outlining the business case, scope and timescales for an integrated service.  Short term integrated service pr [BCF Scheme 02]
Berkshire West Hospital at Home Business Case	Outlines detail of the scheme, proposed model of working and anticipated costings and impact.  Hospital at Home FBC Final Draft.docx [BCF Scheme 04]
Berkshire West Hospital at Home Memorandum of Understanding	Captures the key principles that the partner organisations are committed to in the successful delivery of the project.  Memorandum of Understanding - Hosp [Section 4a; BCF Scheme 04]
Berkshire West Medical Intra-operability Gateway (now Connected Care Programme)	Business case for better data sharing between health and social care, based on the NHS number.  15a Health Economy Systems Interoperabili Benefit realisation document provides a summary of the benefits that are extrapolated from health & social care integration deployments across the UK  Orion Health Benefits Document July'14 CH. [BCF Scheme 06]
Berkshire West IM&T Strategy	 Berkshire West IMT Strategy Final v1.5a.
Berkshire West	http://www.cscsu.nhs.uk/berkspocisa/

Document or information title	Synopsis and links
Information Sharing Agreement	[Section 7c]
Older People's Housing Strategy 2014-19	Agreed by the council's Executive June 2014  OP Housing revised v6f.docx [Section 2 and 6]

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

We have developed a **Plan on a Page** to give an overview of Wokingham's Better Care Fund submission.

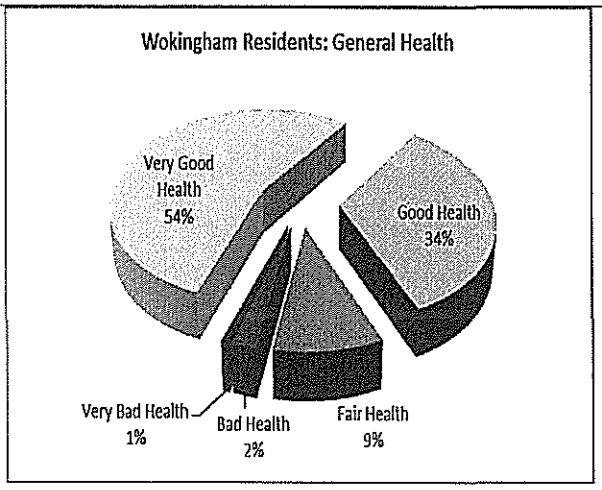


Wokingham's vision for integrated health and social care, as set out at the head of our Plan on a Page, is:

Preventing ill health within a growing population and supporting people with more complex needs within the community

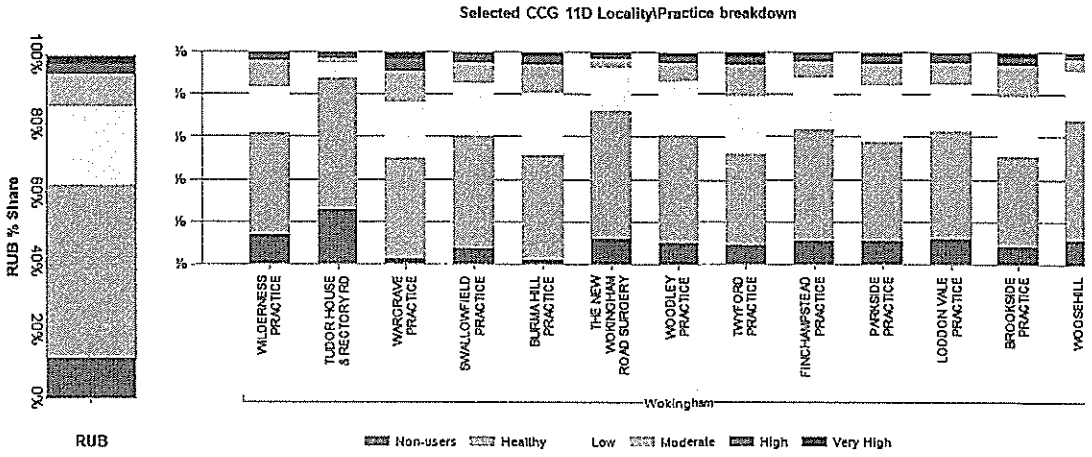
Wokingham Borough is one of six unitary authorities in Berkshire. It currently has a population of 155,000, but this is projected to increase to 186,000 by 2026.

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

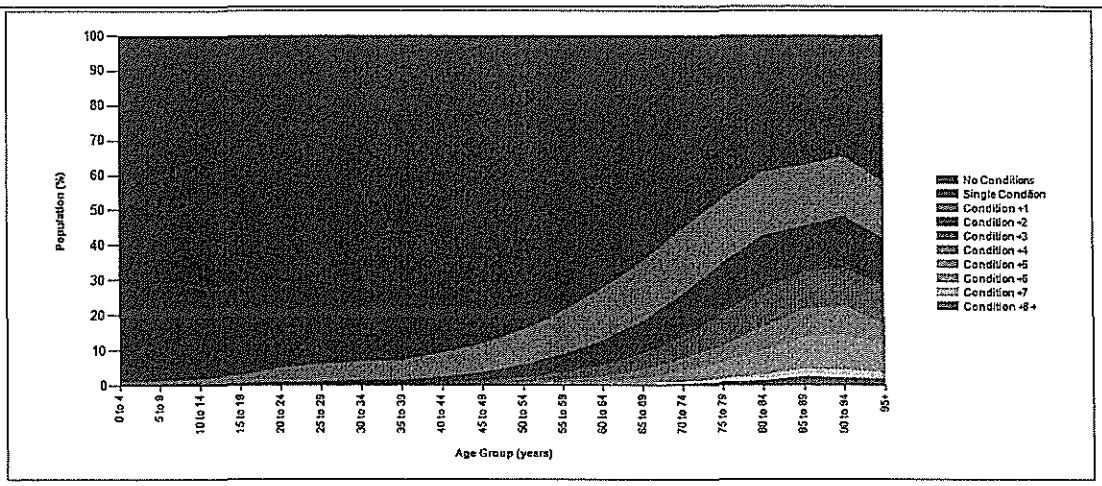


Whilst general health in Wokingham is good, our services are caring for people with increasingly complex needs, resulting in the need for new models of out of hospital care. This is demonstrated from the data shown below.

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



We have increasing rates of people with complex, multiple conditions and a growing frail elderly population. The table below shows current multi-morbidity by age band using our risk stratification tool.



At Call to Action events, residents have told us about their difficulties in accessing health and social care services, including waiting times for appointments and telephone access. We have heard patient stories about fragmented service delivery. And we have received support for greater service integration and the sharing of information between health and social care at our Call to Action events.

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

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

Further background to Wokingham and its population can be found in the Wokingham Needs Assessment, the CCG's Commissioning Intentions and the Council's Adult Care Market Position Statement.

The changing nature of Wokingham's population is putting pressures on health and social care in some key areas:

- Pressures on non-elective care
- Increasing A& E attendances
- Rising delayed transfers of care
- Increasing pressures on adult social care for community packages and care homes
- Increasing demand for planned (elective) care
- Inequality of access to services across the whole system and the whole week

Against this backdrop, our **Health and Wellbeing Strategy** articulates five objectives or themes:

1. Promote good health throughout life
2. Build health and wellbeing into new communities
3. Improve life chances

4. Improve emotional health and wellbeing
5. Ensure older people and those with long term conditions are able to live independently and self- manage their conditions through the joined up action of services and the community

Drawing on our challenges and the themes of the Health and Wellbeing Strategy, we have developed a vision for health and social care services of *"preventing ill health within a growing population and supporting people with more complex needs within the community."* This will mean that by 2019/20:

We provide the right care by the right people at the right time and in the right place

- Meet patients' needs and empower people to manage their health at home wherever possible.
- Services that respond to patients with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

We deliver more easily accessible care seamlessly, across health and social care

- Care providers will work together, breaking down organisational barriers to deliver patient-centric care.
- Care providers will share information, and use this to co-ordinate care and support in a way that is person centred using health and social care personalised budgets, reducing duplication and hand-offs between agencies.

We support people to manage their care and promote health and wellbeing

- Develop enhanced primary, community social care services and voluntary and community services which prevent ill-health within our local population and support patients with more complex needs to receive the care they need in their community.
- Support people to take more responsibility for their health and wellbeing and to make decisions about their own care

Make the experience of care a more positive one

- Improve communication between the individual, their family and carers, and health and social care professionals to improve the experience of the care that is given.
- Patients will have access to the services that they require every day of the week to ensure the best outcomes.

The financial challenge facing the local health and social care system is significant. The council continues to see significant decrease in the annual budget, demand for services is predicted to continue to rise with a growing frail elderly population, and it is clear that without wide-scale transformation there will not be enough money to fund health and social care services locally to meet this predicted additional demand. As part of this we recognise the need 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.

Many aspects of the health and social care system work well and we need to maintain

and build upon this. But this will only take us so far. Continuing to 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. Therefore we are also committed to developing, testing and implementing innovative approaches to service redesign co-produced through engagement with our local population and strong collaborative leadership.

Our vision ties in with a commitment to integration by all the partners in the Berkshire West health and social care economy (**"the Berkshire 10"**):

We, the ten organisations in the Berkshire West health and social care economy are committed to developing, testing and implementing innovative approaches to integration through strong collaborative leadership. In line with the National Voices narrative on integrated care we will work together with people, their families and communities to understand what works for them, with a real focus on early support, care and treatment. We are determined to challenge our own thinking about how to achieve this and will bring together the wide range of resources and services across our whole area to bring about locally determined solutions within a single strategic approach. The scale and breadth of services enables us to test a variety of integration options across geographies, care pathways and care groups: the programme maximises our opportunity for realising efficiency savings and testing new models of funding. We have a strong foundation in our shared vision and our track record, but we know that we need to adopt a revolutionary rather than an evolutionary approach if we are going to succeed in tackling the system pressures and demographic challenges facing us.

Overall, our collective objectives are focused on improving outcomes for users and patients, their carers and families, whilst achieving long-term financial sustainability.

b) What difference will this make to patient and service user outcomes?

We need to provide the right care by the right people at the right time and in the right place and keep the individual at the centre of a co-ordinated health and care system.

We have listened to local people through engagement events and designed our BCF plan to improve the outcomes that patients and service users most value. For Wokingham residents the BCF will help ...

...ensure that residents feel empowered and supported to live well for longer in their own home...

"I am cared for in my own home instead of going into hospital or into a care home"

Patients will receive support and treatment at home and then continue to be managed at home by being discharged into traditional community care provision (Hospital at Home service BCF 05).

"I am able to live as independently as possible in my own home for longer"

Patients will be able to return home with a support package instead of being admitted to a care home (Step Up/Step Down Beds BCF 03).

"While at home, my quality of life is much improved"

People who use care services will experience better quality care which addresses their needs holistically. They will be supported to live the fullest lives they can and, as far as possible, to plan for when they may need additional care (BCF Schemes 02, 03, 04, 05, and 06).

...improve communication between the individual , their family, carers and health and social care professionals...

"I feel better informed"

People will have the opportunity to make a better informed decision about their future care options (Step Up/Step Down Beds BCF 03).

"My medical, medication and social care records are available to those who need them"

Information held in health and social care systems will be made available to all who need to access them as a real-time data view (Connected Care BCF 07). This will improve clinical safety and efficiency, and speed up the transfer of patients/service users into the right part of the care system.

...provide a positive patient/service user journey and experience, consistently and efficiently through the whole system throughout the whole week...

"I do not have to stay in hospital longer than needed"

Step Up/Step Down Beds BCF 03 is designed to address a specific problem of delays in

discharge from hospital whilst individuals wait for a residential home bed to be available. BCF schemes 01, 03, 04, 08 and 09 will also allow individuals to be discharged in a timelier manner with appropriate support from the whole system across the whole week. Avoiding delays in discharge will help avoid hospital acquired infections and individuals losing their independence.

"I was dealt with by one team throughout my care"

Referrals will be managed at one point of entry (Health and Social Care Hub BCF 01) whereby the responsibility for cases sits within one integrated team with the patient/service user and their carer(s) actively involved in designing their own care plan. It will prevent those circumstances when a case is batted between services due to differing referral criteria or lack of capacity. It will make it much easier for the public and professionals to access health and social care services. Accessing the range of services will improve the process of discharge and mobilising short-term community based services (Integrated Team BCF 02) to avoid an unnecessary admission.

...provide easily accessible care, seamlessly across health and social care...

"I have been given my independence back"

Health and social care support will be organised around a re-abling approach to maximise the skills each individual can retain or regain. The integrated re-ablement service for people coming out of hospital will be offered to a wider group of patients than before (Integrated Team BCF 02).

"I have the support of a wider range of professionals"

Regular contact and patient visits will be made by GPs with care home staff and community geriatricians to monitor the health status of care home residents, reducing the need for emergency call outs and thereby non-elective admissions to hospital (Enhanced Support to Care Homes BCF 06).

"I have consistent access to services across the whole week"

BCF Schemes 04, 08 and 09 aim to deliver improved access to general practice, community and social care services. We are developing neighbourhood clusters that are focused around a group of GP practices, supported by complementary clustering of social care teams, and services commissioned from the third sector.

...and reduce avoidable unplanned admissions to hospital

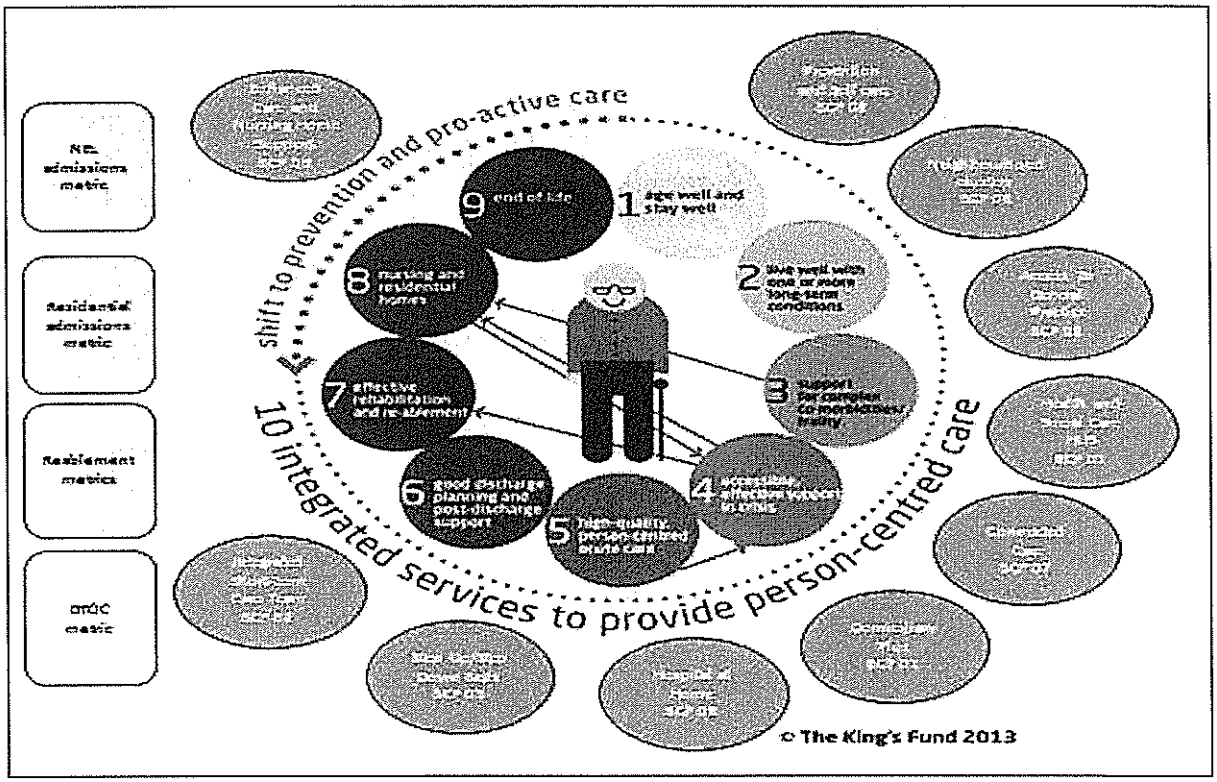
"I have my own individual care plan"

People who use health and social care services will have a plan setting out the support they need, tailored to their personal situation. Each care home resident will have a named GP as their principal point of contact along with a comprehensive assessment and Supportive Care Plan. By planning care in advance unplanned admission should be avoided or minimised (Enhanced Support to Care Homes BCF 06).

"Care home staff are much better trained"

A new level of support into care and nursing homes will develop staff awareness and knowledge, particularly in relation to medicine management, falls prevention and end of life care. Social care focused training will benefit from additional input from health professionals. This will improve consistency in the quality of care given and the outcomes for residents, including a reduction in unplanned admissions for Care Home residents (Enhanced Support to Care Homes BCF 06).

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



c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Over the next five years, the pattern and configuration of services will be changed in Wokingham to put the patient at the centre of care, and empower more people to live well at home. This will require a number of changes to the services that we provide. The Better Care Fund schemes will be critical to driving some of these changes.

Developing patient/service user centred care pathways across health and social care

We will continue to create joint system-wide integrated pathways that cross organisational boundaries in line with Sam's Story. We will also go beyond traditional

health and social care services to include wider determinants of physical and emotional wellbeing, to include services such as housing, transport and leisure.

The frail elderly pathway is already being developed to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health and are likely to need intensive social care support. As part of this, care will be delivered by generic care workers, supported by identified care co-ordinators and multidisciplinary teams structured around groups of local GP practices. In bringing key elements of the frail elderly programme together, we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

Two BCF schemes will be critical enablers of integrated pathways. Connected Care (BCF Scheme 7) will allow different organisations to all have access to the same patient record, and the Health and Social Care Hub (BCF Scheme 1) acting as a single point of contact for professionals, and eventually patients as well.

Expanding the role of services in the community

In order to keep the patient closer to home, the number of services delivered in the community will increase. This will include services to both prevent admission in the first place and facilitate discharge as quickly as possible to ensure that care can be delivered closer to home. In addition to healthcare provision, we will also develop more supported housing. Wokingham's Older People's Housing Strategy states the Council's commitment to ensure there is sufficient and diverse provision of specialist older people's accommodation across the Borough. Currently there are 125 Extra Care Housing Units and recent analysis indicates the requirement of a minimum of 300 and a maximum of 500 additional units of specialist housing by 2023. The model will be revised year on year in line with the growth in population to achieve the appropriate balance of provision for older people.

Better Care Fund schemes will allow more care to be delivered closer to home. Hospital at Home scheme (BCF 05) will keep patients out of hospital during an acute episode. Step Up/Step Down scheme (BCF 03) will create ten step-down beds, for patients who require a residential placement, and as a result often remain in the acute setting for longer than is necessary. We will also provide more proactive support to care and nursing homes with the provision of training to care home staff, and also an enhanced GP community service (BCF Scheme 06), with each care home being designated a named GP who is their principal point of contact, providing consistent care to reduce unplanned admissions and improve end of life care.

Modernising and expanding the model of primary care

New models and approaches to primary care are required to meet the workforce challenge and the new demands on the primary care sector in a transformed system. We will look to facilitate this through the development of primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care. The role of primary care will be increased, with GPs working in larger units that will strengthen integration with community and health and social care, building on the success of joint triage between GPs and the ambulance service.

Having successfully implemented practice-based risk stratification and multi-agency care

planning for high risk patients, our GPs are well placed to take on the role of accountable clinician for patients who may be at risk of admission. A number of Better Care Fund schemes will support the new role for primary care. The Neighbourhood clusters (BCF 08) will bring general practice, community services and social care together. We will also provide better access to primary care (BCF 09).

Access to care 7 days a week

We recognise that people need health and social care services every day. As a result we are looking to adopt a whole system whole week approach to ensure that a full range of health and social care services is available seven days a week. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, affecting admission rates and delaying discharge.

Promoting self-care

We will promote self-care and support people to take more responsibility for their health and wellbeing and make decisions about their own care (BCF 08). We have already deployed a web based tool to promote joint care planning between individuals and doctors and will build on this to deliver further self-care initiatives. We will also work with Wokingham's various condition specific support groups within the voluntary and community sector to enhance opportunities for peer support and learning from others' experiences.

Changing the way we commission care

We intend to work to overcome the challenges posed by the current Payment by Results payment system. We will explore moving away from this model of payment within the acute sector and look at alternatives such as a 'year of care' approach that is pathway based, with value based contracts focused on the achievement of improved outcomes for service users, capacity model funding and increasing the flexibility and blurring between health and social care.

Building on the learning from the successful implementation of personal budgets in Social Care, we will seek to enable a more personalised, flexible approach and greater control for individuals. Initially, we would offer personal health budgets to people currently in receipt of both Health and Social Care services.

In summary, the table below summarises how the Better Care Fund schemes will contribute to the changes that will take place in Wokingham over the next five years (enablers in red):

Local Ambitions – need for change	Better Care Fund Schemes								
		01 Hub	02 Inte-grated Team	03 Step Up/ Down Beds	04 Dom Plus	05 H@H	06 Care Homes	07 Con-nected Care	08 Neigh-bour Clusters/ Self- Care/ Prevention	09 GP Access
	Patient-centred pathways	O	O	O	O	O	O	O		
	Expanding community services		O	O	O	O	O		O	O
	Modernising primary care						O		O	O
	Access to care 7 days a week	O			O			O		
	Promoting self-care		O						O	
	Jointly commission services		O							

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Integrated care makes sense for Wokingham Borough residents. It means a better customer experience, better patient outcomes, less confusion and complexity for patients, service users and carers. As our model is mostly focused on providing care closer to home, it also presents a real cost saving opportunity. This view is shared across the Berkshire West 10 organisations. By working together, we will ensure that the funding for services is used flexibly across organisational boundaries. Together we can deliver end-to-end integrated care for our population, reducing the number of assessments and transactions individuals are subjected to and improving their experience of care.

In Wokingham **we have identified seven key challenges** which collectively drive the case for change:

1. 22% population growth, particularly in the age range of 45-60
2. Pressures on non-elective care
3. Increasing A& E attendances, and pressure on urgent and emergency capacity
4. Rising delayed transfers of care, and subsequent bed days lost
5. Increasing pressures on adult social care for community packages and care homes
6. Increasing demand for planned (elective) care
7. Inequality of access to services across the whole system and the whole week

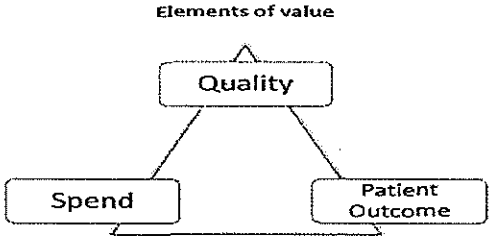
In developing our case for change, and subsequently our vision and plans, we have followed **an approach based upon three phases**:

Where to look  **What to change**  **How to change**

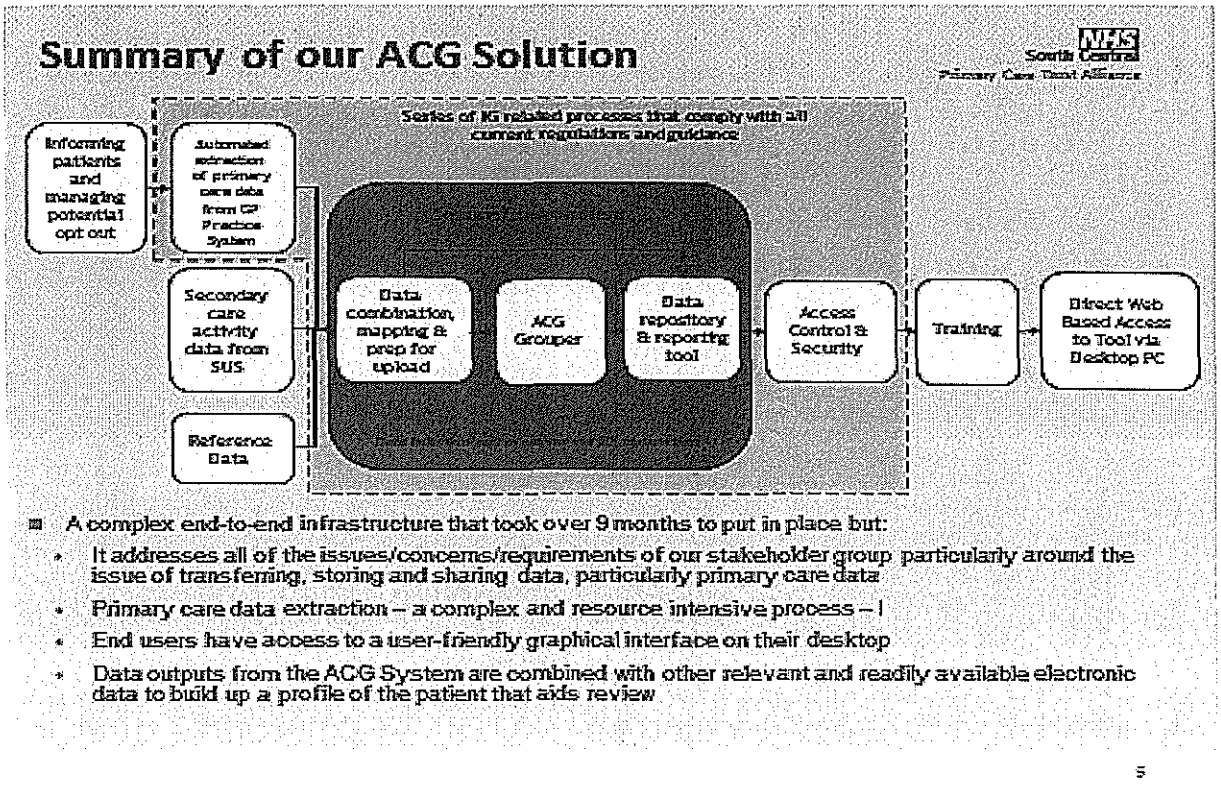
"Where to look" has been an analytically-driven phase that has taken the following steps:

1. Review of data (both "soft data" from patient and service user feedback and experience and "indicative" data from benchmarking) to highlight the top priorities for transformation and improvement.
2. Risk stratification to identify the relative risk of patients in our population by analysis of their medical history.
3. Triangulation of that data to indicate where we may gain the greatest improvement by focussing our reforms.
4. An examination of "outliers" that may be most likely to yield the greatest improvement to pathways and services.
5. A resulting focus on programmes and identification of value opportunities, as opposed

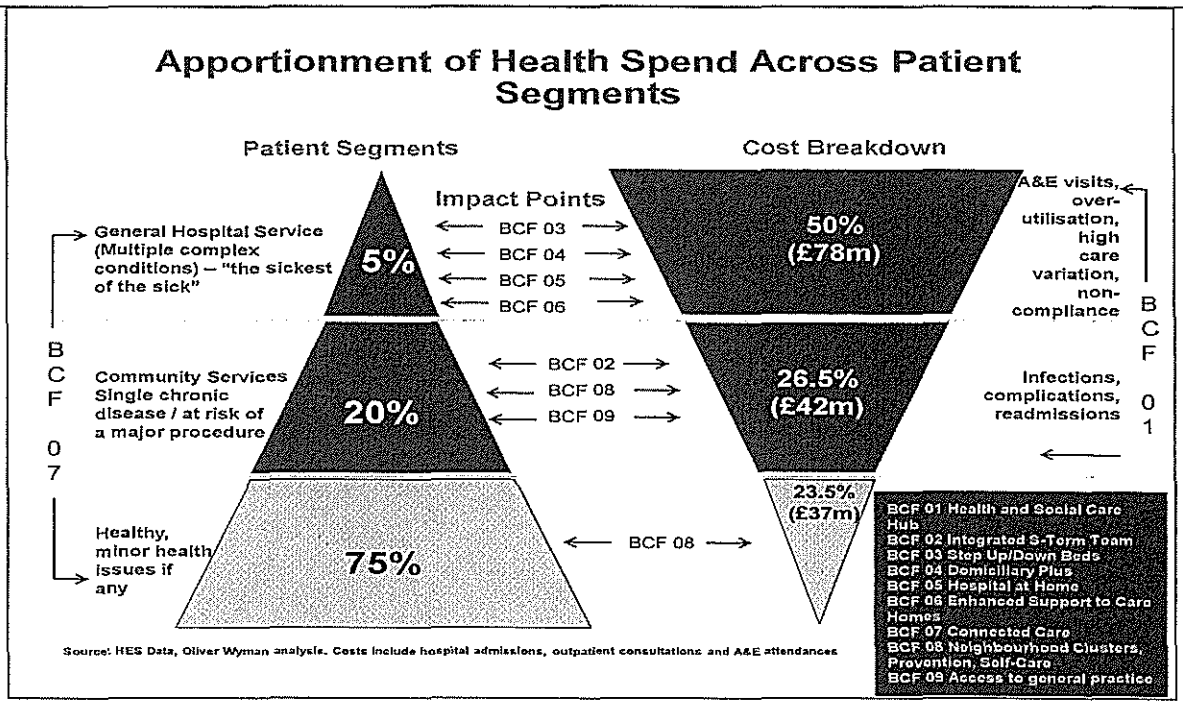
to focussing on organisational or management structures and boundaries.



As part of the data review, we have used the **ACG (Adjusted Clinical Groups) risk stratification tool** to identify the relative risk of patients in our population by analysis of their medical history. In 2009, nine PCTs in South Central decided to collaboratively procure the SCG tool which would support case finding for community health staff as well as supporting other programmes for patients with long term conditions. This tool has allowed us, in collaboration with our Berkshire Healthcare NHS Foundation Trust, to have a rich source of information about the health needs of the local population to inform both case coordination and service planning.



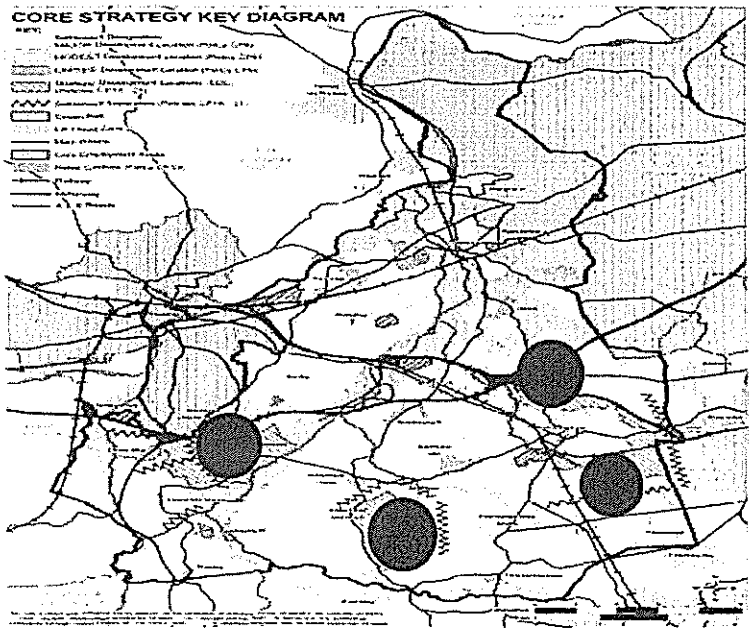
Dividing the population into groups of people with similar needs has helped us create models that are based on similar, individually-focused needs. Our intention is to transform the local health economy to support patients to manage their conditions at home, to keep well and remain out of hospital. As can be seen from the triangle of care needs below, small numbers of the population are associated with the highest cost and demand, whilst those lower down the triangle account for much lower cost impact per head of population.



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

Challenge 1: A growing population

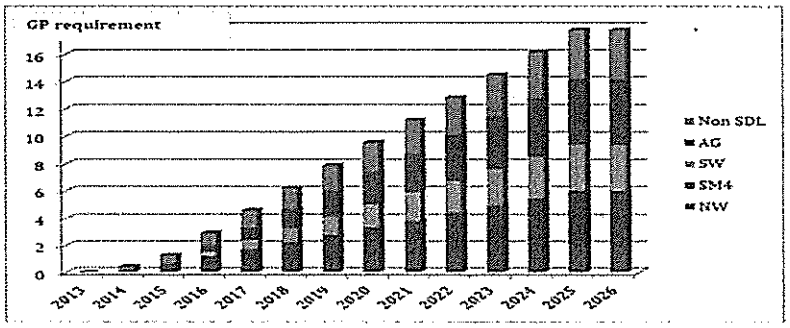
The Wokingham Core (development) Strategy will deliver in excess of 13,000 new homes by 2026. This will result in a 22% growth in our population. There are four strategic development locations:



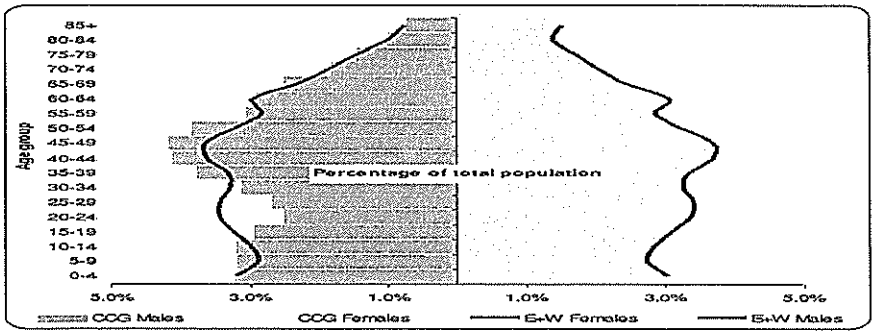
This development will provide challenges to service capacity, estate, and workforce

development, especially in relation to key health and social care professionals. The graph below projects the number of additional GPs required.

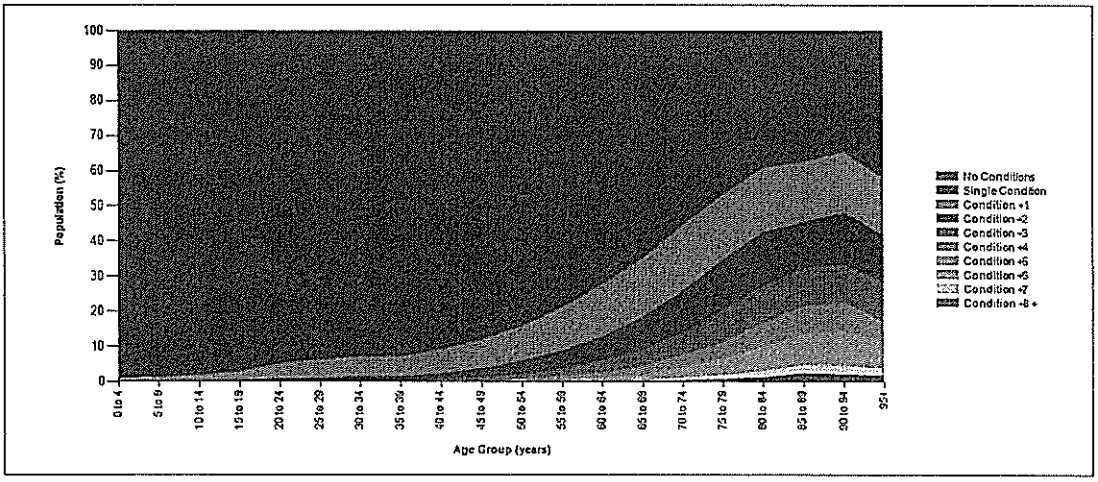
Figure 5.1: Growth in required whole time equivalent (WTE) GPs in Wokingham to 2026



We predict that the development will accentuate the proportions of children and adults in their 30s, with a small net migration away from Wokingham of people between the ages of 45 and 80. But we expect a continued increase in the 85+ age group.

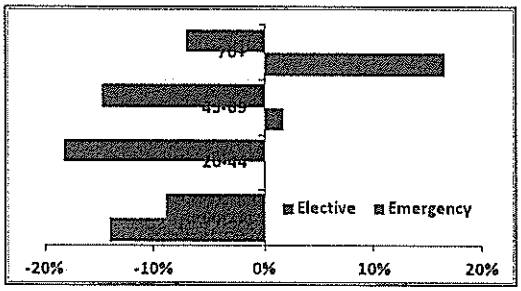


With people in Wokingham living longer, the very elderly will present multiple long term conditions and complex needs. The table below shows current multi-morbidity by age band using the ACG tool.



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

Emergency admissions for older people (70+) shows a greater increase than can be explained by population change, reflecting the increasing clinical complexity of this age group:

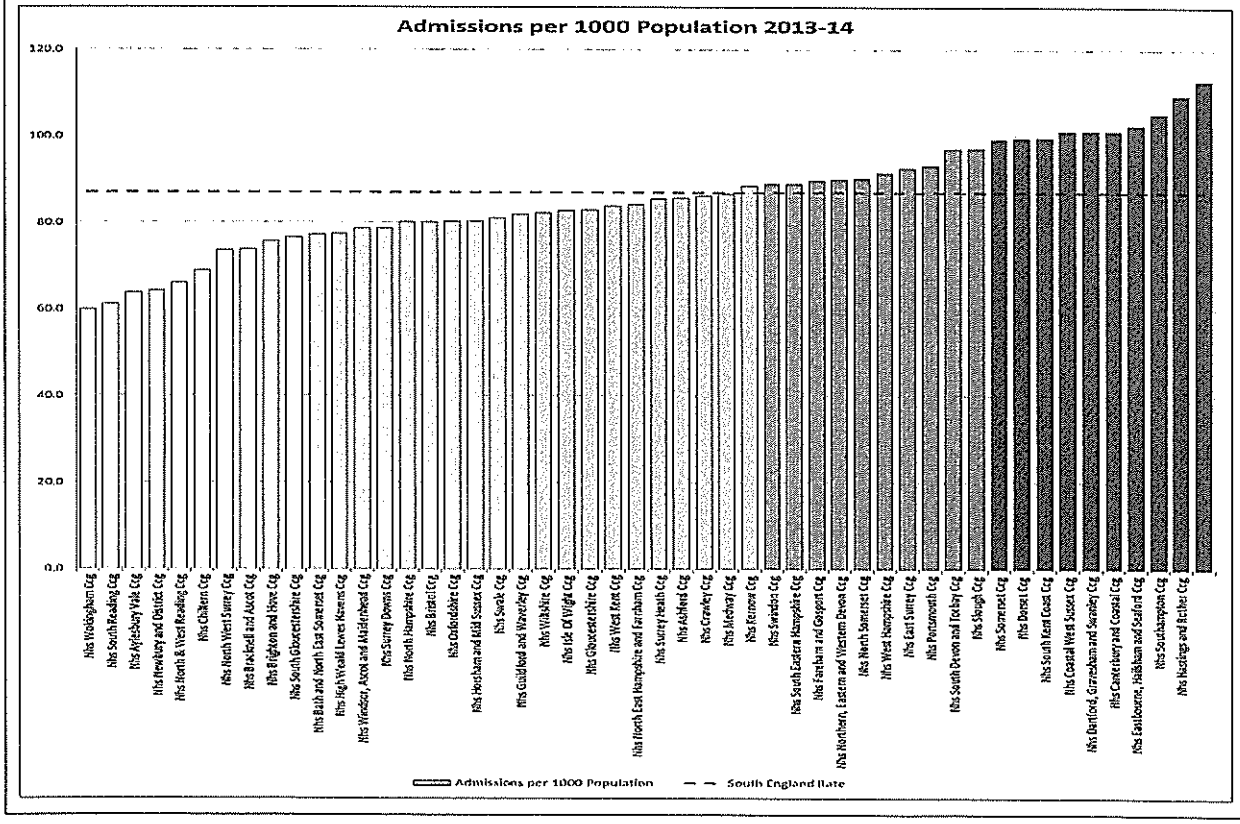


Whist the overall population is predominately white (89%), this is changing and becoming more diverse. In our schools 25% of the children are from a BME background.

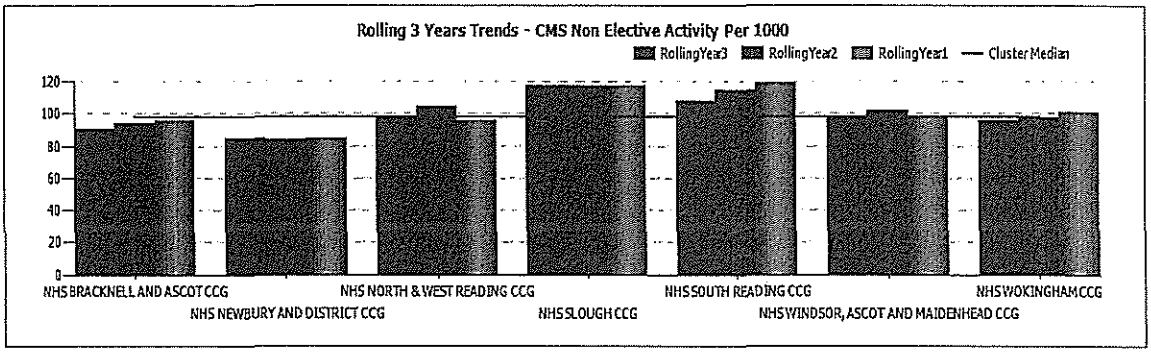
Solutions: Extensive work is already underway in the frail elderly pathway. This Berkshire West-wide work stream forms the backbone of system change, and our BCF schemes – notably BCF 06 Enhanced Care and Nursing Home Support - will be critical to delivering a number of elements of this. We need different ways of working at a neighbourhood level, to help provide services to a growing and changing population (BCF 08 Neighbourhood Clusters). We also need to promote prevention and support self care to help manage the growth in multiple conditions (BCF 08).

Challenge 2: Non-Elective Admissions

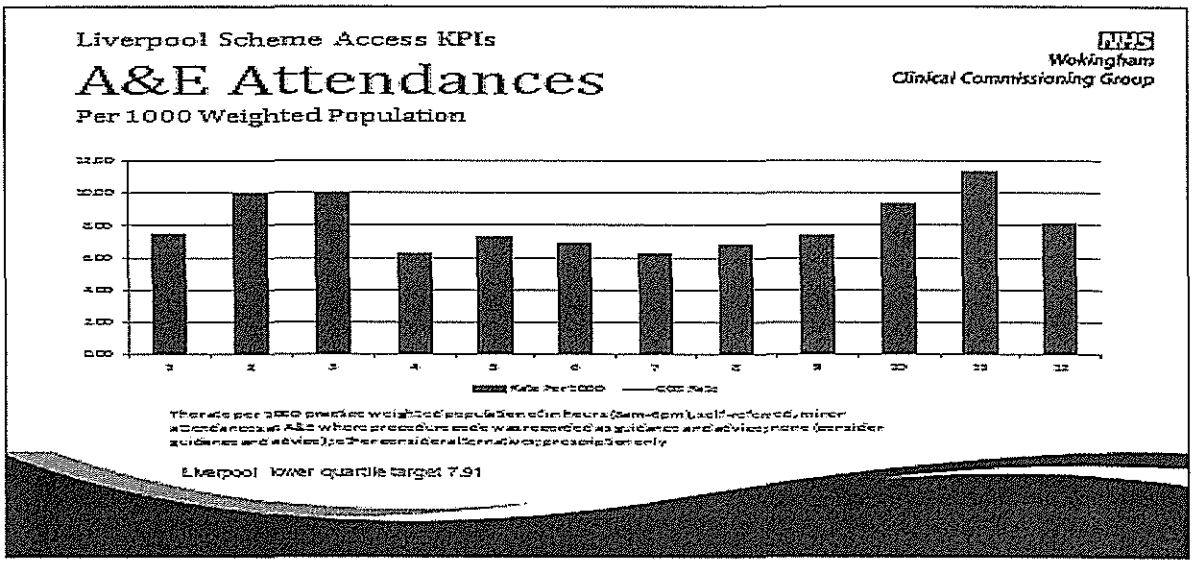
Non-elective admissions are a pressure that health and social care in Wokingham has managed well in recent years.



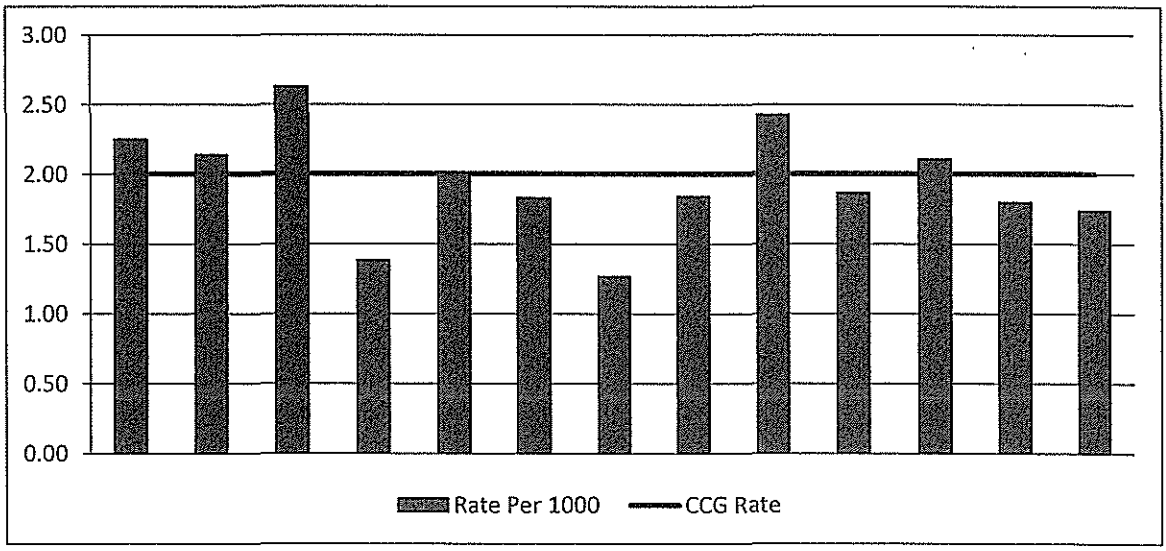
But we have still seen a 3% growth over the last three years due to changes in our age profile and increases in certain long term conditions.



The CCG has undertaken an audit of access to general practice, and has seen a variation in A&E attendance by practice:



A&E attendance in hours for those coded as advice and guidance has also been audited, again demonstrating variation in practice:



Future projections suggest that this trend will continue unless there is system-wide change. Analysis has revealed two specific areas which could be amenable to change:

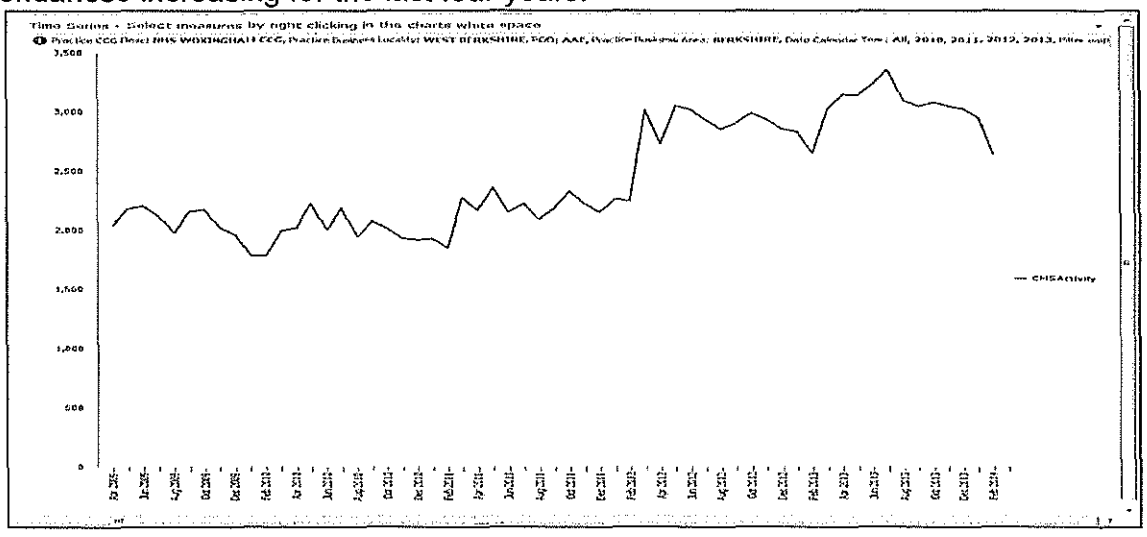
1. Non elective admissions with a medical event where patients are clinically stable and do not require diagnostic input such as acute infections, deteriorating long term conditions, and unstable COPD. Over 2012/13 there were 10,116 emergency admissions to hospital each year for Berkshire West residents with at least one long term condition, of which 4,590 would be possible to manage in the community.

2. Patients whose place of residence is a care home. In Wokingham during 2013/14 there were 387 non-elective admissions from care home residents costing £1.2m.

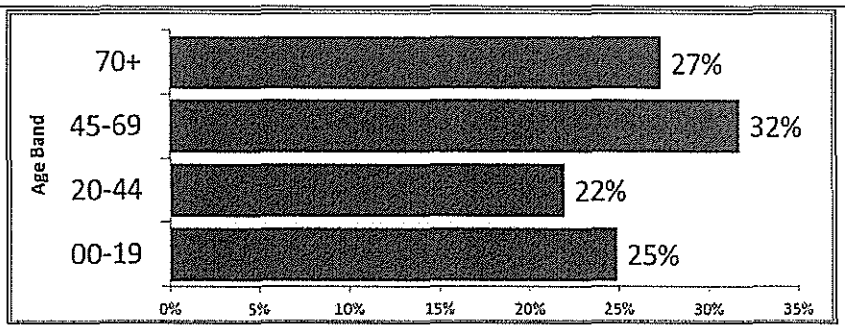
Solutions: The outcomes for both of these population groups can be dramatically improved by integrated care. As such we have allocated two of our Better Care Fund schemes to address these issues. Hospital at Home (BCF 05) will provide an alternative to an acute admission. The service will keep the patient in the community, and provide acute-level treatment from a multidisciplinary team including nursing, social care and linking in with specialist nurses and therapists, to provide a patient-centric model of delivery, rather than the traditional disease specific organisation of care, to patients who are clinically stable. It is estimated that this service will reduce non-elective admissions significantly (84% reduction for the patient cohort). The enhanced support to care homes scheme (BCF06) provides a new model of high level health care support into care and nursing homes to improve consistency in the quality of care and outcomes for residents. For 2014/15 we aim to reduce non-elective admissions of Wokingham care home residents by 40%. BCF 08 and 09 both aim to reduce unjustified variations between practices in areas such as A&E attendance.

Challenge 3: Increasing A&E Attendances and Pressure on Urgent Care Capacity

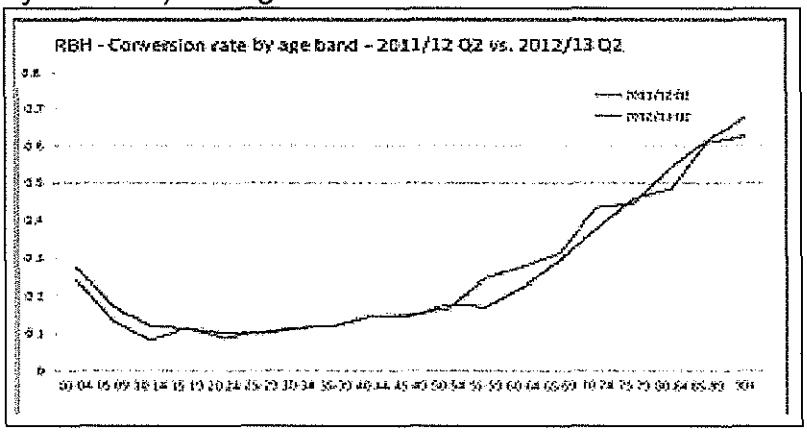
A&E is under increasing pressure in Wokingham, as the chart below shows, with attendances increasing for the last four years.



This has been further analysed to identify particular aspects of growth. The graph below shows the highest percentage growth amongst those aged 45-69.



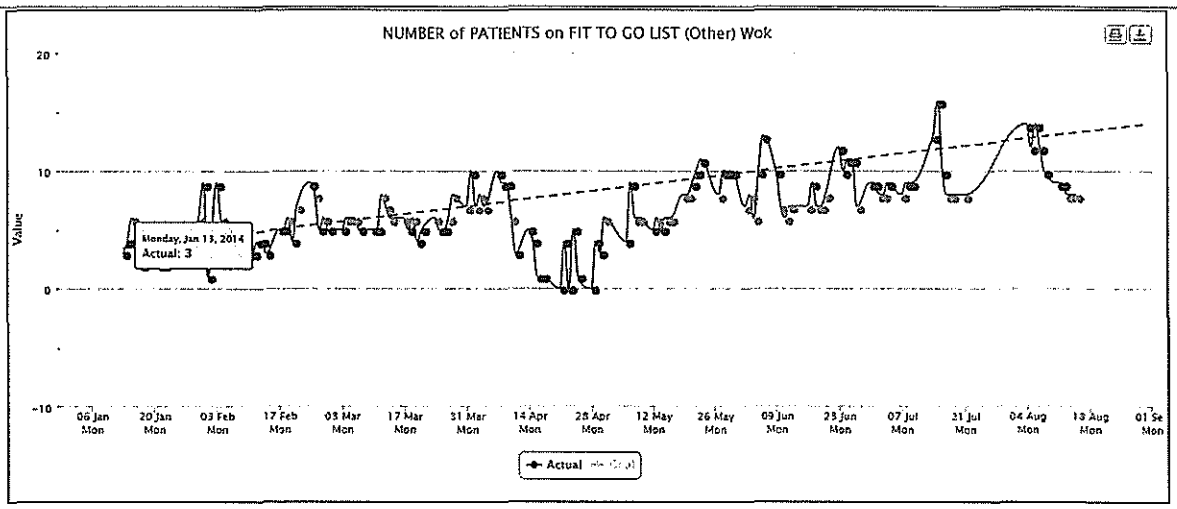
The following chart shows that a relatively low conversion rate (i.e. those attending A&E and subsequently admitted) amongst those in their 40s and 50s.



Solutions: In addition to work arising from a review by Capita on demand pressures on the urgent care system, a number of Better Care Fund schemes will also seek to target key populations at high risk of A&E attendance to reduce the pressure on urgent care. Those with long term conditions and frail elderly patients will benefit from the increased provision of care in the community, via the Hospital at Home scheme (BCF 05), and schemes providing extended availability of care throughout the week. Improved access to general practice (BCF 09) will be particularly valuable to people of working age. The Enhanced Care Home Support (BCF 06) will address the training of care home staff, and the maintenance of relevant, up-to-date care plans and reviews, to keep care home patients out of A&E.

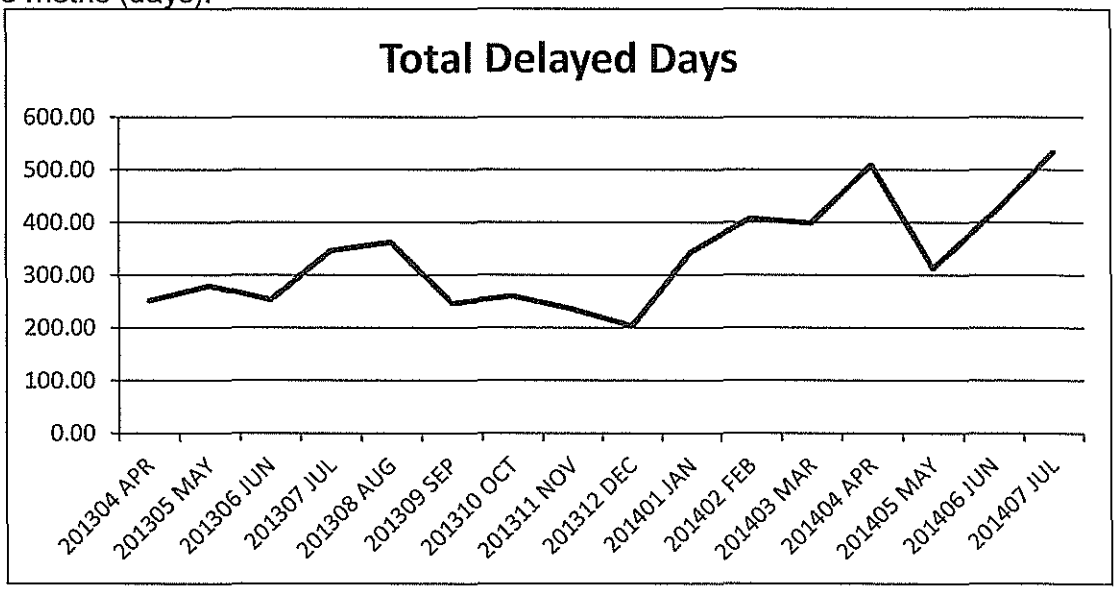
Challenge Statement 4: Rising Delayed Transfers of Care and Subsequent Bed Days Lost

An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have longer lengths of stay verses the average patient. The numbers on the "fit to go" list (a list documenting the numbers of patients who are medically fit to be discharged, but are still in hospital), have steadily increased.



The average length of time that patients remain on the list has remained significantly above the system-wide target of five days agreed as part of an A&E Recovery Plan and is currently above 10 days. This in turn contributes to the impeded flow through the inpatient beds.

The following chart shows recent and unprecedented growth in the Delayed Transfer of Care metric (days):



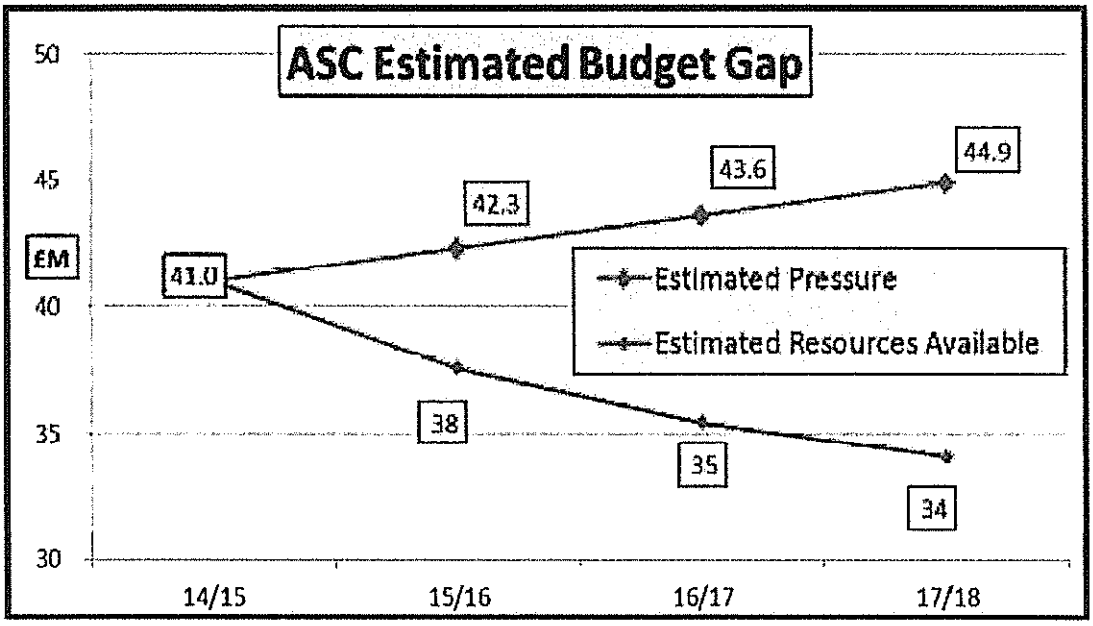
The number of patient discharges on an average weekend day is less than half the number of patients who are discharged on an average weekday. A key reason for this is access to health and social care in the community over the weekend. Another reason for delayed transfers of care is the cohort of patients who are waiting for social care packages, who often have to wait for their care, despite being fit to be discharged.

Solutions: We are developing a number of 7 day services, including our health and social care hub (BCF01) that will be available to take referrals and pass onto relevant services seven days of the week, facilitating discharge over the weekend. Our Step Up/Step Down Beds (BCF03) will reduce these delays by providing an onward destination for this cohort of patients, providing step down beds with a focus on

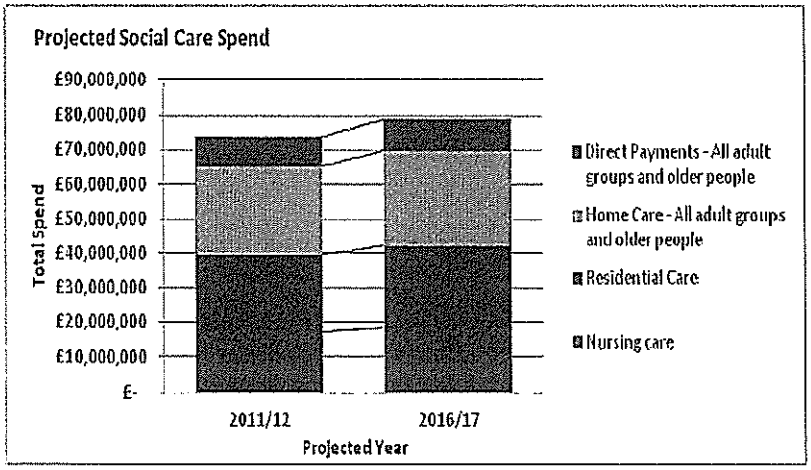
maximising independence. We forecast that BCF schemes will reverser the growth trend in the DTOC metric from April 2015.

Challenge Statement 5: Increasing Pressures on Adult Social Care for Community Packages and Care Homes

Like every other local authority in the country, Wokingham faces challenges in delivering its priorities against national government settlements. The Borough Council is committed to keep on delivering high-quality, good-value services that protect people who are most at risk, and provide the best public services it can. However, there is an acknowledgement of the need to work differently to avoid the consequences of a widening funding gap. The gap with respect to Adult Social Care is shown below:



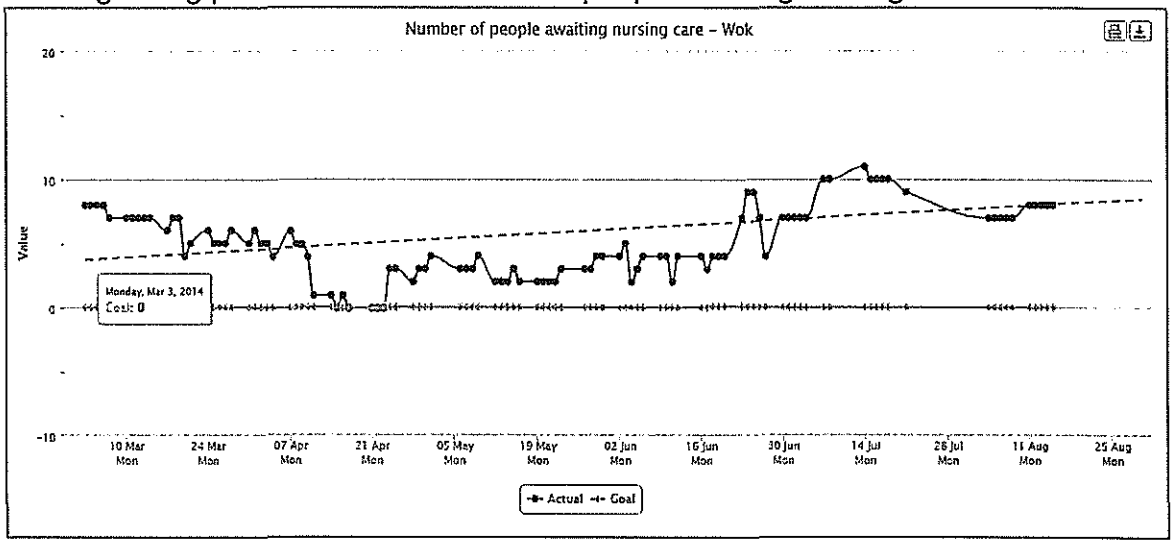
Around half of adult social care spend relates to care homes, as shown in the following graph for all three unitary authorities in Berkshire West:



Despite increases in the number of individuals in all age bands the numbers of individuals receiving care in their own home have decreased.

No. 65+ receiving home care	No. 65+ receiving direct payments	Total no. weeks 65+ res. and nursing care	Res. &nursing care residents 65+
-19%	0%	5%	7%

There is growing pressure on the number of people awaiting nursing homes:

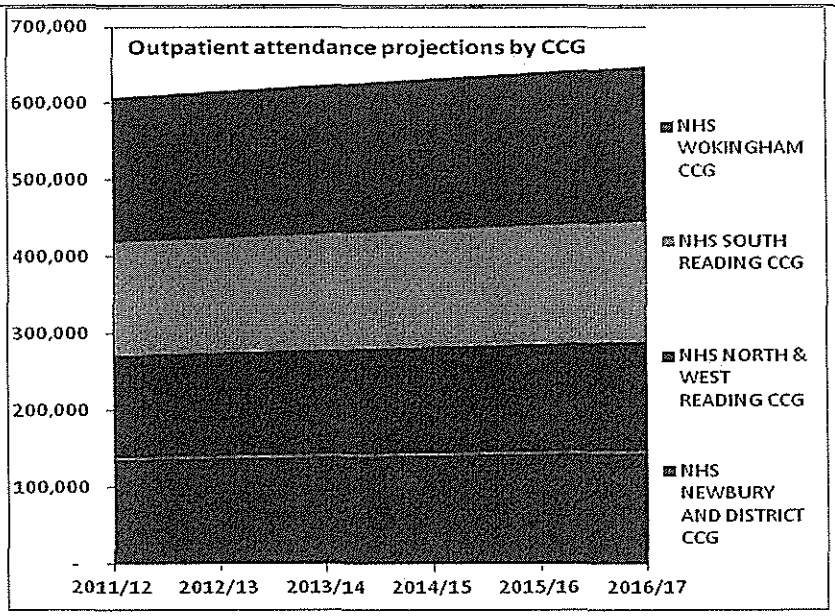


The frail elderly population and those with dementia have a longer than average length of stay due to waiting for nursing placements. As described under the previous challenge, the number of patients on the fit to go list continues to increase due to the increasing demand for nursing care, residential care and community reablement.

Solutions: Addressing the needs of these service users will reduce length of stay in acute hospitals, reduce the number of patients on the fit to go list, and in-turn reduce delayed transfers of care. In addition, if their needs are addressed, this will ultimately reduce the number of people admitted to residential care. The provision of integrated health and social care will greatly improve outcomes for patients who are medically fit to be discharged, but are awaiting further care. The Step Up/Step Down Beds scheme (BCF03) will ensure that users receive a full assessment and have the opportunity to reach their optimum level of independence which will ensure that their discharge destination is the right one for them. This service will be primarily for people who are highlighted as potentially requiring residential care as a discharge destination. This will reduce the amount of users waiting for onward care along with the length of stay for patients that are fit for discharge within the acute hospital. As individuals will have a longer period to recuperate and reach their optimum level of independence, the number of people discharged to residential care will reduce.

Challenge Statement 6: Increased Demand for Planned Care Services

Wokingham will see an increase in overall out-patient attendances of nearly 7%, as illustrated by the diagram below:

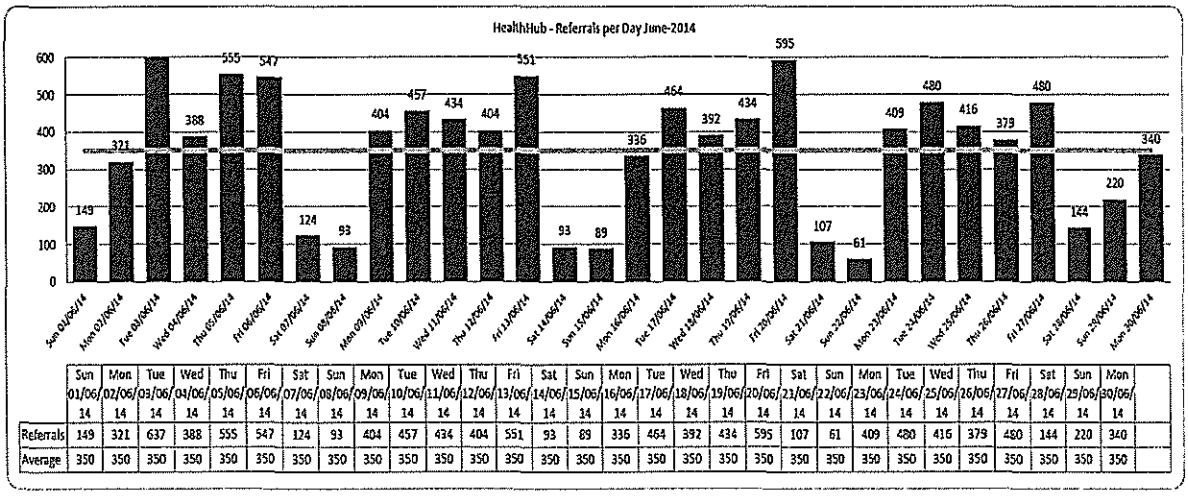


Work is currently underway across our health economy to address these issues and is outside the scope of our BCF.

Challenge Statement 7: Inequity in Access to Services 7 Days a Week

People need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients in hospital. Local acute data shows that there are far fewer discharges at the weekend verses during the week with less than half the weekday average number of discharges. This is in part due to the lack of provision in the community to hand over care and instigate care packages at the weekend.

Since all requests for discharge support (health and social care) from our main acute provider, as well as requests for community support, are processed through the current Health hub, the graph below demonstrates a marked reduction in referrals into the hub for these services at weekends which is likely to affect discharge rates and admission rates.



	Sun 01/06/14	Mon 02/06/14	Tue 03/06/14	Wed 04/06/14	Thu 05/06/14	Fri 06/06/14	Sat 07/06/14	Sun 08/06/14	Mon 09/06/14	Tue 10/06/14	Wed 11/06/14	Thu 12/06/14	Fri 13/06/14	Sat 14/06/14	Sun 15/06/14	Mon 16/06/14	Tue 17/06/14	Wed 18/06/14	Thu 19/06/14	Fri 20/06/14	Sat 21/06/14	Sun 22/06/14	Mon 23/06/14	Tue 24/06/14	Wed 25/06/14	Thu 26/06/14	Fri 27/06/14	Sat 28/06/14	Sun 29/06/14	Mon 30/06/14
	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Referrals	149	321	637	388	555	547	124	93	404	457	434	404	551	93	89	336	464	392	434	595	107	61	409	480	416	379	480	144	220	340
Average	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350

Solutions: In response to issues created by a lack of provision over the weekend, we

have developed a number of interconnected work schemes within our BCF to address this. These plans will support all patient cohorts but the provision is expected to be particularly effective for patients with complex needs. Improved access to general practice (BCF 09) will broaden access and help people to access the service when they need to. This should support admissions avoidance and reductions in A&E attendance. Neighbourhood Clusters (BCF 08) will include multidisciplinary teams of health and social care professionals allied to GP clusters across Wokingham. The Neighbourhood Cluster Teams will integrate health and social care teams across the week to respond to local patient/service user need providing early interventions through care planning to reduce the need for admission to hospital and facilitate discharge. In addition, the single point of access health and social care hub (BCF 01) will operate seven days a week to facilitate the GP and neighbourhood cluster working, but to also act as a point of contact for patients, signposting them throughout the week to the most appropriate service.

Delivering Change via the BCF

We need to adopt a revolutionary rather than an evolutionary approach if we are going to succeed in tackling the seven key challenges described above. We do not have the resources to meet the expected increases in demand over the next few years if we continue to provide services in the same ways as we do now. Unless we find better ways of supporting people who are frail or living with long term health conditions, costs will increase exponentially.

It is important to emphasise that without the Better Care Fund, some aspects of integration would be more challenging. This is most evident with respect to neighbourhood working. The Fund will enable us to resource the development of the neighbourhood project – for example, through back-fill - without a detrimental impact on front-line services. A Fund-based approach brings a broad understanding of community services, from district nursing to housing, to allow the development of a more comprehensive model.

In summary, the following chart illustrates how the BCF will address Wokingham's key challenges (enablers in red).

		Better Care Fund Schemes								
		01 Hub	02 Inte-grated Team	03 Step Up/ Down Beds	04 Dom Plus	05 H@H	06 Care Homes	07 Con-nected Care	08 Neigh-bour Cluster s/ Self Care/ Preven tion	09 GP Access
Local Challenges – need for change	Growing population						O	O	O	O
	Demand on NEL					O	O			
	Increasing A&E attendance		O			O	O	O	O	O
	DTOC	O		O					O	O
	Social care pressures	O		O	O			O		
	Inequity of access	O							O	O

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Our Better Care Fund **Project Plan** and **Programme Map** documents can be found in Section 1 Related Documentation. They form part of the suite of programme documents used for governance of the Wokingham's plan.

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mr	Apr	My	Jun	Jul	Aug	Sep
BCF 01 Health and Social Care Hub														
Design and planning														
Agree KPIs														
Agreement of implementation plan														
Project progress - to be determined once plan agreed														
Integrated Hub established														
Project review														
BCF 02 Integrated short term health and social care team														
Design and planning														
Agree KPIs														
Phase 1 implementation achieved														
Agree Phase 2 scope														
Project plan for Phase 2 agreed														
Implement project plan to achieve full integration by April 2016														
Project review and evaluation post April 2016														
BCF 03 Step Up/Step Down Beds														
Design and planning														
Agree KPIs														
Agree implementation plan														
Project implementation														
Step up/Step down beds established														
Project review and evaluation														
BCF 04 Domiciliary Plus														
Design and planning														
Agree KPIs														
Agree implementation plan														
Project implementation														
24/7 support established														
Project review and evaluation														
BCF 05 Hospital at Home														
Proof of concept														
Evaluation														

Finalisation of KPIs														
Recruitment complete														
Scheme launched														
Review of scheme														
BCF 06 Care Homes Support														
Scheme launched														
Training starts														
Review of GP uptake														
1st round of reviews complete														
Review of scheme														
BCF 07 Connected Care														
Data protection signed off														
Information sharing with acutes														
Information sharing with social care														
Decision to procure portal solution														
Full roll out														
BCF 08 Neighbourhood Clusters, Self-Care and Primary Prevention														
Design and planning														
Sign off initiative														
Agree KPIs & implementation plan														
Recruitment – to be confirmed once plan agreed														
Establish pilot & evaluate									TBC					
Go live / full roll out											TBC			
BCF 09 Access to General Practice														
Audit of GP capacity and access														
Approval of pilot scheme														
Implementation of scheme in individual practices														
Review of pilot														
Modifications of scheme for roll out														
All Schemes														
Reporting of milestones and metrics to WISP														
Updates to HWBB														

Progress on these milestones is detailed in an Integration Dashboard, monitored via the West of Berkshire Partnership Board. The Board holds the projects to account but there is also opportunity to identify any synergies between different projects, and where there can be shared learning and understanding.

A description of the **key partner interdependencies** can be found in the table below. The complexity of such interdependencies requires new ways of working. The Hospital at Home Project is the first project to work in such a joined up way. A Memorandum of

Understanding has been developed to ensure all partners are clear about the role they play in project delivery. A copy of the Memorandum can be found in Section 1 c.

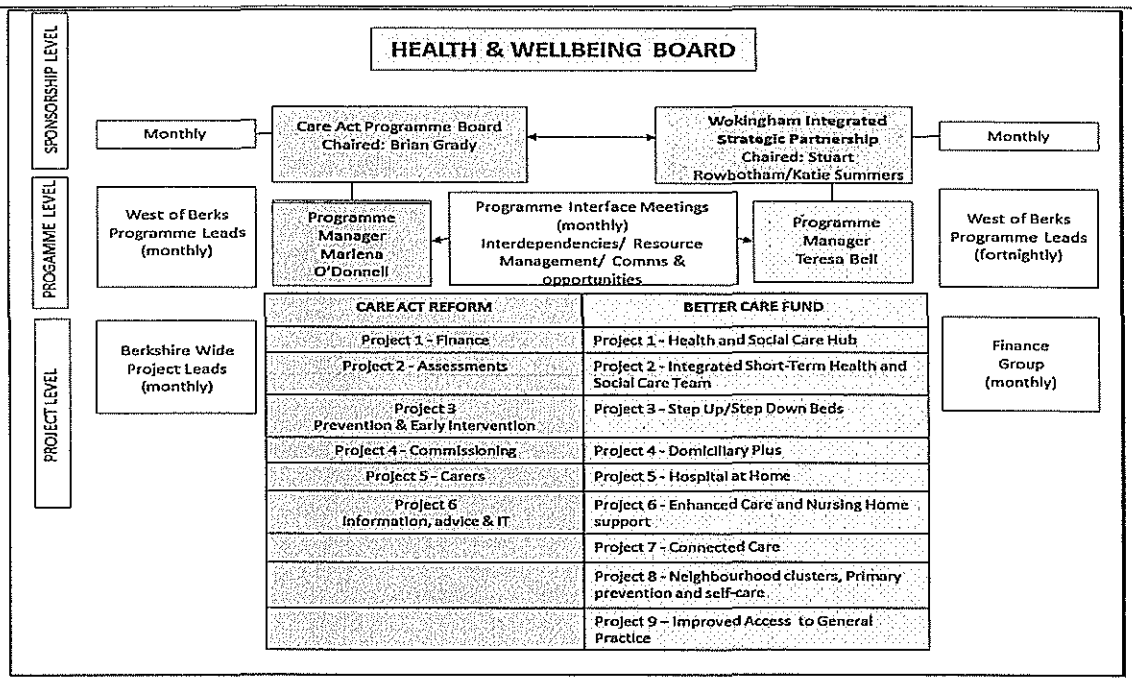
	Partner							
Project	**RBH**	**BHFT**	**SCAS**	**WBC**	**WBDC**	**RBC**	**Primary Care**	**Westcall**
Health and Social Care Hub	✓	✓	✓	✓	✓	✓	✓	✓
Short term Integrated Team	✓	✓		✓				
Step up/step down beds	✓	✓		✓				
Hospital @ Home	✓	✓	✓	✓	✓	✓	✓	✓
Care and nursing homes support	✓	✓	✓	✓	✓	✓	✓	✓
Connecting Care	✓	✓	✓	✓	✓	✓	✓	✓
Neighbourhoods, prevention and self-care		✓		✓			✓	✓
Night Care Service		✓		✓				

In terms of programme management, we have a **Better Care Fund Programme Manager** who works with the BCF project managers as well as those working on related developments such as the implementation of the Care Act.

b) Please articulate the overarching governance arrangements for integrated care locally

The **Wokingham Health and Wellbeing Board** will have oversight of this Better Care Fund plan, governed through the **Wokingham Integrated Strategic Partnership** (or WISP) and delivered through a local implementation team. WISP specifically looks at bringing together management responsibilities and accountability across health and social care services locally.

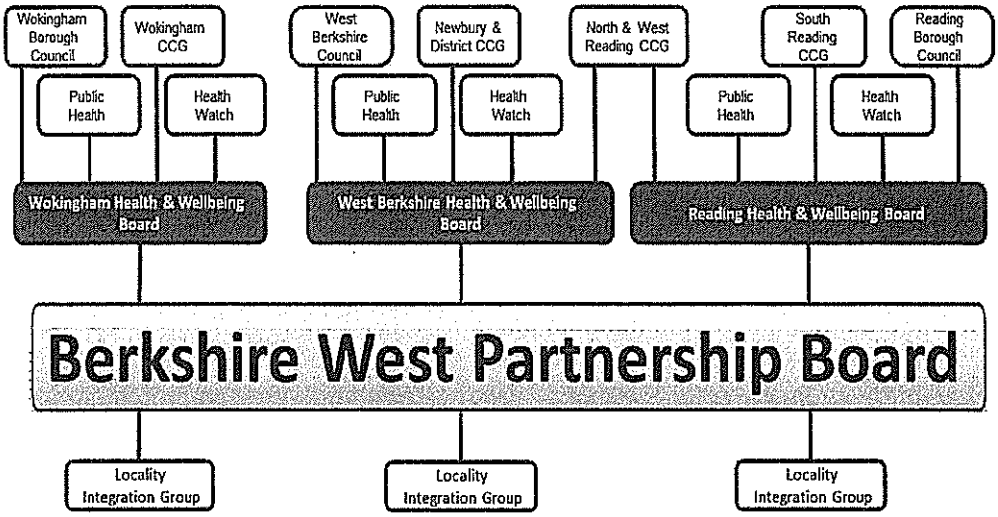
Wokingham's governance structure is illustrated below:



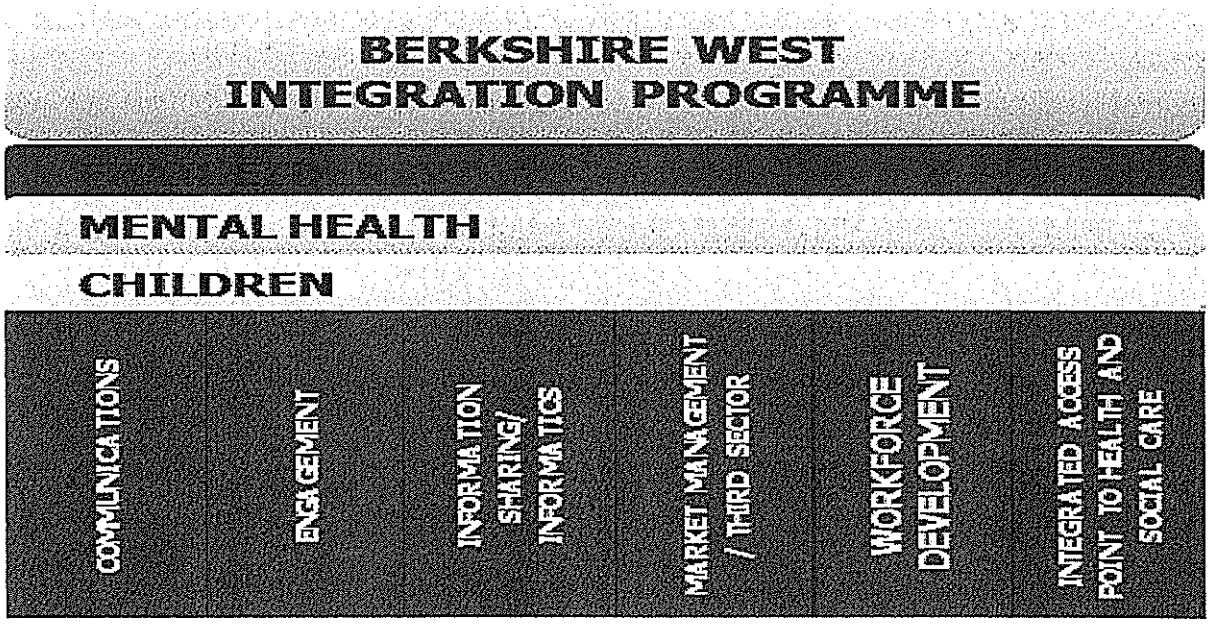
Because our local health and social care economy works across unitary authority boundaries, many of our BCF schemes are part of a Berkshire West federated programme. Therefore governance arrangements are also part of a **Berkshire West Partnership Board.** This Partnership Board has representatives from each of the partner organisations. The Board will:

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

The Berkshire West governance structure is illustrated below:



The structure and the relationship to the work streams within the Berkshire West integration programme is represented as follows:



A Programme Office across Berkshire West ensures there is capacity to deliver the schemes identified within this submission.

We will track and manage performance including taking action when required quality standards are not met. Quality will be fully integrated with performance and finance in assessing the delivery of this plan and will continue to be at the centre of all of our discussions with providers. Quality monitoring across the schemes will be reported into WISP and onwards to the Berkshire West Partnership Board. Specific quality issues will be escalated if necessary through to the quality teams and the **Berkshire West Quality Committee** in order to address issues and put in place any remedial action plans.

The pooled budget will be set up and managed through a **Wokingham Alliance Agreement** (model illustrated below) whereby each party will work together to deliver

elements of the care pathway or service with one agreed set of core standards and metrics.

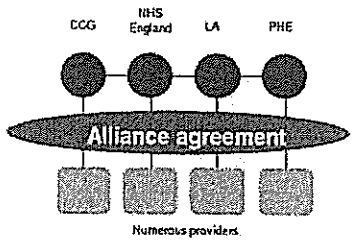
Summary — ***Commissioners seek to deliver a time limited project for example a reduction in emergency admissions.***

Why?

- *Commissioners wish to align commissioning intentions to achieve system outcomes*
- *Commissioners are seeking to deliver a particularly challenging project with well defined outcomes over a definite period of time*
- *Commissioners want to build on strong local relationships with all provider and wish to share the risk of provision*
- *Providers see the value in working closely with each other and the commissioner to deliver of a particular challenge*
- *Providers wish to retain their own corporate identity*

F

Alliance agreement for the delivery of a specific project



How?

- *Multiple commissioners collaborate*
- *Alliance project board established*
- *Existing commissioned contracts remain in place*
- *An agreement between all alliance partners is put in place*
- *Alliance agreement includes incentives and risk share across all parties*
- *Commissioners should be aware of procurement obligations*
- *Alliance to govern and incentivise delivery of the project*
- *Providers retain their own corporate identities*

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The primary accountable partnership for the Better Care Fund schemes across Wokingham is the **Wokingham Integration Strategic Partnership (WISP)**. At WISP, a programme synopsis of the activities undertaken is regularly presented evidencing progress, risks and issues, and any remedial action to be taken or any decisions required by the Partnership. WISP will also deal with issues that may impact on the risk sharing agreement. **Individual project reporting** will be in the form of highlight reports with a RAG rating, and any project which appears to be going off track will be given close scrutiny by the Partnership.

Monthly Highlight Report

Project:	Hospital at Home	**Planned Outcomes:** – Prepare for Proof of Concept – Patient inclusion and exclusion criteria agreed – Comms strategy agreed – IM&T approach agreed – Staffing Model to be approved – Service Contract being drafted – Financial impact due to service delays	Overall RAG Finance Status Activity Status Milestone Status
Report for month:	June 2014		
Period Covered:	June 2014		
Senior Responsible Officer / Project Lead:	Katie Summers SRO Dr Johan Zyistra – Clinical Lead David Lightemess – Project Manger		

Key achievements last month:

- Project Board agreed in principal for Proof of Concept to commence on 21 July'14
  Decision to be made at extraordinary board meeting on 15 July '14
  - 2 patients from each UA
  - Objective is to stress-test the system and ensure all parties understand the impact of go-live when it is scheduled
- IT System – Adastra will be the system used in RBH and OoH
  - Rio will continue to be used by BHFT and the UA's
- Subgroup meetings continue to run fortnightly
- Latest re-revised resource proposal under review – Contract meetings with CSCSU, BHFT and WCCG scheduled
- Memorandum of Understanding drafting commenced
- Datasets defined for local/SUS submission - agreement to be obtained from BHFT
- Job description for H@H consultant currently with the Deanery
- Agreement with RBH A&E on staffing and processes achieved

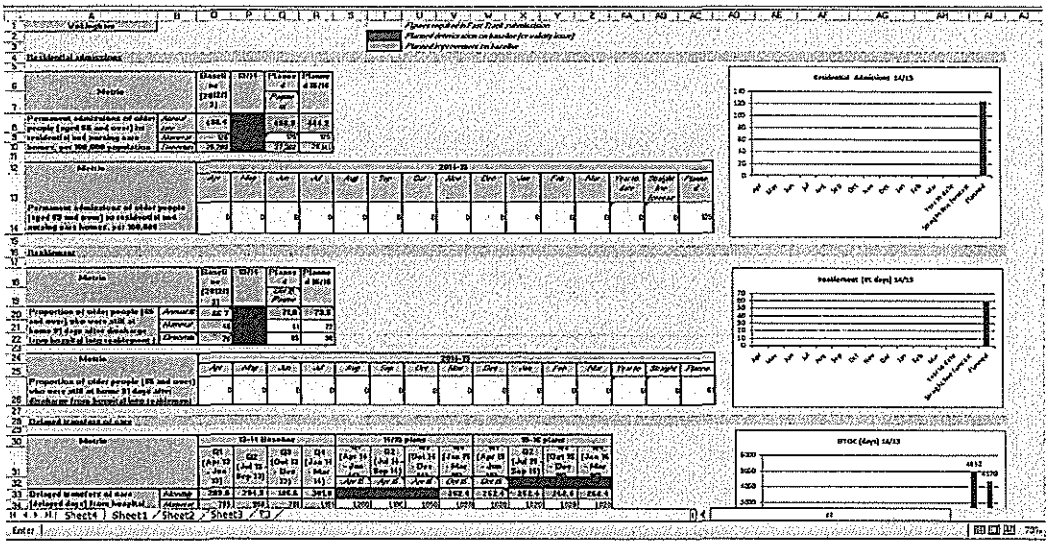
Key steps for next month:

- KPIs construction to be agreed
- Dataset collections to be agreed
- Benefits realisation to be agreed
- Contract Management to be agreed
- Revised Staffing model agreed
- Medicines process and responsibility agreed
- Prepare for Proof of Concept
- Deliver pre-PoC workshop
- Circulate H@H Operating Manual

Actions planned but NOT progressed from last month

Action	Reason not achieved	Next steps
Resourcing still an issue	Constantly under review and recalculation	Meetings are on-going.

WISP also receives regular updates on performance against BCF metrics using the **Metrics Dashboard** shown below.



Any significant **risks or issues** which require a system-wide review will be escalated to the Berkshire West Partnership Board or to the Wokingham Health and Wellbeing Board depending upon whether it is a Wokingham project or Berkshire West scheme.

The current programme risks are detailed in Section 5. Risks relating to the financial or performance of any scheme will initially be raised at WISP at the earliest opportunity to allow for transparent conversations and shared problem-solving. In the event of WISP not being in a position to remedy this action, the issue will be escalated to the Wokingham Health and Wellbeing Board. If the issue has wider connotations, impacting on the whole of Berkshire West, the issue will be addressed at the Berkshire West Partnership Board.

The **financial performance** against the elements of the pooled budget held by the CCGs (which will generally be the elements related to the CCG QIPP schemes and are set out in Annex 1 to the Risk Sharing Agreement) will be monitored through the CCG QIPP and Finance Committee which is a Committee of the CCG Governing bodies. Recommendations and decisions arising from that Committee will be made to the Berkshire West Partnership Board.

Quality will be fully integrated with performance and finance in assessing the delivery of this Plan. It will be at the centre of all of our discussions with providers. Quality monitoring across the schemes will be reported into WISP and onwards to the Berkshire West Partnership Board. Specific quality issues will be escalated if necessary through to the quality teams and the Berkshire West Quality Committee in order to address issues and put in place any remedial action plans.

We have aligned our Schemes with the BCF Metrics:

	Total non elective admissions in to hospital (general & acute), all age, per 100,000 population	Permanent admissions of older people to residential and nursing care homes, per 100,000 population	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Delayed transfers of care from hospital per 100,000 population	Patient/service user experience	Users through Reablement
BCF 01 H&SC Hub	Yes	Yes		Yes	Yes	Yes
BCF 02 Integrated Short Term Team	Yes	Yes	Yes	Yes	Yes	Yes
BCF 03 Step Up Step Down Beds	Yes	Yes		Yes	Yes	
BCF 04 Domiciliary Plus	Yes	Yes		Yes	Yes	
BCF 05 Hospital at Home	Yes	Yes		Yes	Yes	
BCF 06 Enhanced Home and Nursing Care Support	Yes		Yes	Yes	Yes	
BCF 07 Connected Care	Yes			Yes	Yes	
BCF 08 Neighbourhoods, Self-Care, Prevention	Yes		Yes		Yes	
BCF 09 Access to General Practice					Yes	

The rationale behind the targets we have set for the BCF Metrics and included in Part II is set out below:

Permanent Admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

The vast majority of older people want to live independently at home. Evidence for this is supported by a wide scale consultation carried out in Wokingham in 2012 for the **Older People's Housing Strategy**. Providing care and support into people's homes is generally a more cost effective way of supporting older people, promotes their independence and wellbeing and achieves better outcomes.

Our ambition is to make incremental improvements to the admission rate through the plan against the backdrop of increased demographic pressures; more older people with complex needs and a large number of wealth depleters who have been funding their own care and become the responsibility of the local authority when their funds fall below £23,250.

The target will be achieved through several elements of the plan. There will be greater focus on providing reablement and short-term support to everyone to try and support them to regain independence whether it's after an admission in hospital or a period of ill health at home. The plan will deliver and increase in capacity to support this including the integration and expansion of short- term services (BCF 02), access to step-down beds in the community (BCF 03), the availability of the night carers service (BCF 04) and support to self-care (BCF 08).

Proportion of older people (aged 65 or over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

This metric covers older people who have been discharged from hospital into the

community with short term reablement services. This could be their own home (private house or sheltered housing), into step down beds or into residential care if the intention is that the person would return home within three months. It is an indicator of how successful short term reablement services are.

The metric is a combination of intermediate care services and the short-term assessment and reablement service (START). Historically Wokingham has not performed well in this area compared to others in the South East or nationally (ranked 145 out of 149 in 2012/13).

The projected figures in the plan have been estimated primarily from an increase in the capacity of the START service by a third and an improved success rate. We are planning for 72.7% for those still at home 91 days later by 2015/16. The target will be achieved through bringing together of the short-term teams (BCF 02) and greater support and co-ordination between these services to achieve better outcomes.

Delayed Transfers of Care (delayed discharges) from hospital per 100,000 population (average per month)

Delays transfers of care occur when a patient is medically fit for transfer from an acute hospital bed. Delays can be due to a number of reasons including the need for further assessments, waiting for suitable accommodation, equipment or medication in order to ensure a safe discharge or when individuals or families might require more time to make further choices.

Historically Wokingham borough has performed s very well on this indicator both overall (attributable to health and social care) and on social care alone. Our outturn in 2012/13 was ranked 43 out of 151 in England. But we have seen a recent and unprecedented growth since then. This has been through a combination of a lack of availability of nursing home places and a capacity issue within Optalis. We now have a recovery board within Optalis and a person dealing with obtaining hospital places across the country. We predict growth to continue until our mitigating actions and BCF Schemes take effect, probably until Quarter 4 2014/15.

Achieving our planned turnaround will be through several elements of the plan. The single point of access (BCF 01) and integrated short term service (BCF 02) will ensure better integration and co-ordination of patients discharged from the acute hospital and are supported through reablement services, including step-down beds (BCF 03) which are community based. Services such as Rapid Response, the enhanced support to residential and nursing homes (BCF 06), Hospital at Home (BCF 05) and Domiciliary Plus (BCF 04) will also contribute to ensuring that people are not admitted unless necessary.

Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population

Extensive work has been done to model the impact of the BCF Schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by 2% in 2015/16 verses. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that Wokingham is already in the top performers for non-elective admissions in England. We have forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of schemes, ensuring that there is no double counting, these results in an expected net reduction of 2% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

Local Measure

Number of patients going through reablement services

This is a local measure which will reflect the development of the capacity within the short term services and greater numbers of people receiving reablement services before being assessed for longer term support. The metric is a combination of the START and Intermediate Care teams' activity.

For intermediate care in 2013/14 there were 780 packages of care delivered. We expect volumes to grow. In 2014/15, new investment has been given and capacity being extended across both services and they are also being combined into a single service. We forecast 900 packages of care delivered in 2015/16.

Local Measure
Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life?

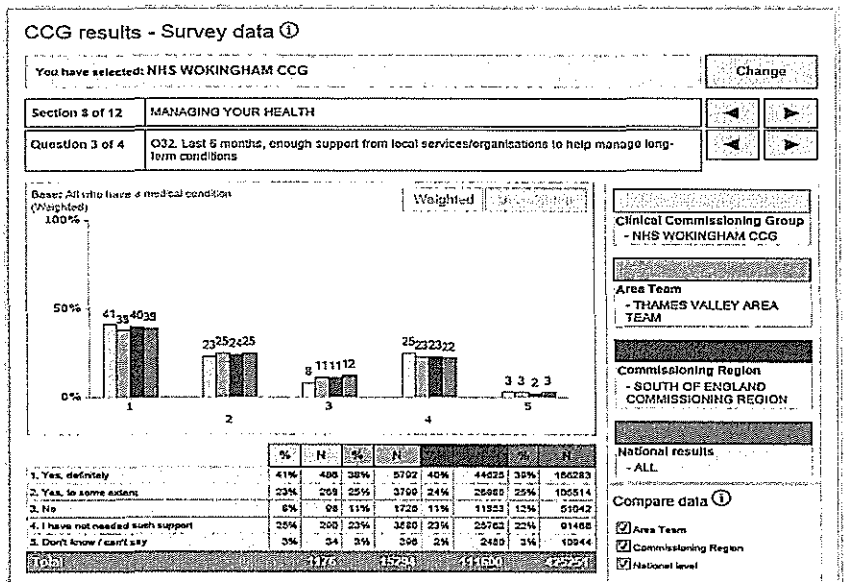
In January 2014 Picker published two reports commissioned by the Department of Health focusing on the measurement of people's experiences of integrated care (with Kings Fund, National Voices, & the Nuffield Trust) & concluded that **no single indicator was currently suitable for measuring user experience of integrated care** (see http://www.pickereurope.org/integrated-care/). The recommendation made was to add a small set of questions on integrated care to a range of existing national survey collections. The seven survey owners (including Community Mental Health Survey; Personal social services carers survey; Personal social services adult social care users survey; GP Patient Survey; and NHS Inpatient Survey) are now considering their options for inserting new questions into their respective surveys. The earliest that they expect baseline data from a survey is December 2014, and others will take until December 2015 to provide baseline data. We will keep abreast of these developments.

In light of this, we have selected the Adult Social Care User Experience Survey Question 3b: **Do care and support services help you in having control over your daily life?** This is a relatively broad measure which ties in with our vision of better supporting people in the community and their own homes. However, it is not possible to link a performance to the outcomes of specific BCG Schemes. The English average for 3b is 86.9% and the South East Region 88.4%. (Reading has 89.1% and West Berkshire 87.2%). Our baseline is 87.1% and we aim to improve to 87.7 with the ambition to move in line with the South East average beyond that. We have identified that we have a challenge because of rurality issues - this particularly impacts on how care is made available in early mornings and late evenings.

Locally, we will also use a health-related measure to complement the Adult Social Care User Experience Survey. The closest equivalent question to 3b on the national GP survey is Section 8 Question 32:
In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services.

For Wokingham CCG, the latest results are: (NB - data are from the July 2014 publication, collected during July-September 2013 and January-March 2014):

Our performance good, just ahead regional and national averages (and fairly consistent since 2011):



Like 3b, it is not possible to link a performance to the outcomes of specific BCG Schemes. But our key BCF aim of self-care does tie in with the management of long term conditions. We therefore aim to improve our "yes" scores (1+2) from 64% to 68% by 2015/16.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
01	Health and Social Care Hub
02	Integrated Short Term Health and Social Care Team
03	Step Up/Step Down Beds
04	Domiciliary Plus
05	Hospital at Home
06	Enhanced Care and Nursing Home Support
07	Connected Care
08	Neighbourhood clusters, Primary Prevention and Self-Care
09	Access to General Practice

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
Planning	The timescale of the requirements to deliver the BCF are challenging and as a result not all options will be fully developed at the time of submission. Therefore some uncertainty may exist in terms of project and efficiency delivery.	4	2	Medium	The relevant project teams are working through each scheme in detail and where full business cases require further detail, plans of action are in place which indicate where further work is required.
Finance	Pooled Budget arrangements - organisations do not reach agreement of who holds the budgets and the impact of any under or overspends.	5	2	Medium	The parties have developed a risk sharing agreement that sets out how the interdependencies and pooled budget arrangements will work across health and social care. Although this clearly has yet to be tested in practice both parties are in agreement that it will be implemented and reviewed during the course of 2015/16.
Finance: £448k perf. fund	The potential for increase in Unplanned activity may lead to overspends.	4	2	Medium	The BCF performance and contingency funds will be used to fund any overspends in RBFT due to non-delivery of NEL admission reductions. The CCG has a robust process for monitoring activity monthly through QIPP and Finance against contracted levels and actions taken to mitigate growth are also reviewed there.
Finance:	The overall BCF funding	4	4		The CCG has a programme

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
£2.8m QIPP gap	(£5.2m) is dependent on the CCG delivering on its overall QIPP programme Funding identified in the BCF will not be sufficient to cover the additional costs of the Care Act (on top of the money from DCLG to cover the impact)				of QIPP schemes which are monitored monthly via QIPP & Finance and where if a scheme is under performing then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already underway. Local agreement has so far identified £1.3m to support this area. The local authority is working to understand the impact of the Care Act. The late advice regarding the funding for national minimum eligibility criteria is significant. This advice indicates that the funding previously identified by the DH for the 3 councils affected has been distributed across all social care councils and that the decrease in criteria should be funded from the BCF. The DH had estimated the cost to be in the region of £4.5m for this council.
Performance	Schemes identified do not deliver expected reduction in activity	5	3		A clear performance framework with KPIs is in development to be monitored regularly and to track if there are issues proactively. The CCGs have a programme of QIPP schemes which are monitored monthly via QIPP and Finance and where if a scheme is going off then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already under way.
Governance	The governance of the BCF is too complicated to cover all issues	4	2	Medium	Separate operational and delivery and financial governance to ensure that there is adequate control.
Delivery	Plans do not go live on time and as such the	4	2	Medium	Programme management of the schemes overseen by a

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
	savings arising from the schemes are diminished				Programme Director. Reporting via strong governance.
Workforce	The schemes are delayed by delays in recruiting staff and so benefits are not realised.	4	2	Medium	Review skill mix to ensure the most appropriate grade of staff provides care.
Reputational risk	There is a risk to our reputation with patients and our providers if the BCF schemes are not successful	4	2	Medium	Ensure that all key stakeholders are engaged on the BCF on an ongoing basis, and monitor performance of schemes closely and escalate when necessary to avoid slippage.
Public engagement	Patients and the public are not adequately engaged with the BCF schemes and as a result there is dissatisfaction around the changes to services	4	2	Medium	Continue to engage patients and the public, and local Healthwatch on the Better Care Fund via existing Forums.
BCF 01 key risk	Lack of agreement, support and commitment for the scheme from all key stakeholders	4	3	Medium	Full engagement with all stakeholders from the early scoping phase and co-produced design of the Integrated Health & Social Care Hub
BCF 02 key risk	Staff across health and social care continue to work in silos rather than as 'one team', compromising the speed and responsiveness of the service and outcomes/metrics	4	2	Medium	Implement Phase 2 of scheme which will achieve a shared management structure with pooled budgets
BCF 03 key risk	Scheme is not managed so that people can be safely moved on from Step Up/Step Down after the optimum period, compromising the capacity of the service and ability to meet outcomes/metrics	4	2	Medium	Close management of the service with clearly understood pathways by staff and patients/users to ensure flow through the system is maintained
BCF 04 key risk	Lack of understanding and confidence in assistive technology amongst staff and users, compromising the take-up of the scheme and the ability to meet outcomes/metrics	4	2	Medium	Comprehensive training and communication plan to ensure we build confidence in the use of assistive technology
BCF 05 risk	Hospital at Home patients are recorded as an admission and despite the fact that they will be on a	2	4	Medium	Discussions are underway with RBFT to find an alternative way of recording the hospital at home cases,

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
	lower tariff, so the projected financials will be correct, the NEL activity will not be reduced to the same level, risking the performance against activity and the P4P				taking into account clinical governance requirements.
BCF 06 risk	GPs do not engage with the enhanced care home service reducing their impact	4	3	Medium	GP engagement at GP council and Primary Care Board to ensure GPs are on supportive of the plans. Regular reviews of uptake by practices of Care Homes.
BCF 07 risk	Not all suppliers are contractually obliged to open standards and there could be significant costs or delays for development work required to ensure a good level of integration.	5	3		This is mitigated by ensuring the portal solution can provide a web- based view but this would not be as beneficial for the end user.
BCF 08 risk	The success of increasing self-care and primary prevention requires high levels of 'patient activation' and staff with the necessary skills and training to support and empower people within a model of self-care.	3	3	Medium	Staff to be equipped with skills to support people in self-care; focus on building relationships between service users and practitioners and exploring the most effective strategies for encouraging behaviour change
BCF 09 risk	GPs do not engage with the Scheme	5	3		Develop a programme of engagement and an appropriate incentive scheme

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

We have taken a pragmatic approach to risk sharing and have considered the risk to the BCF program in three elements:

1. Funding availability
2. Delivery costs
3. Underachievement of benefit realisation

All plans for expenditure, scheme allocations and pooled budget amounts and hosting arrangements have been developed jointly and with full transparency with the HWBB and our local stakeholders. The HWBB reviewed risks and contingencies at a meeting held on 11th September 2014.

To address the risk of BCF funding availability, the CCG has undertaken a robust QIPP planning process which has developed a plan for 14/15 and 15/16 which will deliver sufficient resources to support the BCF and other CCG improvement plans. We also recognise that planning is just the beginning and have implemented a programme delivery approach tour work and will be monitoring delivery of the schemes monthly through our CCG programme boards as well as through the Wokingham Integration Strategic Partnership. Additionally, for year one of the BCF, the CCG may be able to draw upon non-recurrent funding to support delivery in order to address scheme slippage.

In order to address the risk under/over spend in relation to the operational delivery of the programme and the underachievement in benefit realisation (NEL admission reduction), the detail has been included in the risk share agreement and can be seen in Section 3 below.

Our Performance Fund linked to non-elective admission reduction is £448,000, as can be seen in the Payment for Performance tab in Part II. Our BCF schemes are intended to transform the pattern of activity, reducing non-elective admissions, delayed transfers of care and admissions into care placements. Extensive work has been done to model the impact of the schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by 2% in 2015/16 verses. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that Wokingham is already in the top performers for non-elective admissions in England. We have forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of schemes, ensuring that there is no double counting, these results in an expected net reduction of 2% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

Not meeting our target for reducing unplanned emergency admissions would also impact on the resources within the acute hospital, service pressure points such as A&E, and the overall financial position of the CCG. Such matters are subject to constant monitoring and review. Corrective plans are developed within the relevant part of the health and social care economy as required.

If we achieve the target we would consider (on a quarterly basis perhaps), the funding that this would leave available to fund other non-recurrent BCF projects.

We would like to note that we are looking towards alternative contracting methods with our providers in the future which will assist in increasing wider ownership of the BCF plans and distribution of risk to the system, but these are in early stages and will take time to develop. We feel this is the future of the program and contracting process and want to ensure that we enable the Berkshire West 10 to reach the end point collectively and in a positive manner.

The following draft risk sharing agreement draws upon our experience and existing risk share arrangement that we have in place in the Wokingham economy. This can be evidenced through the Hospital at Home Memorandum of Understanding, which includes our providers. A copy of this can be found in Section 1 c).

Draft Risk Share Agreement

Wokingham Borough Council and Wokingham Clinical Commissioning Group Better Care Fund Pooled Budget - Risk Sharing Agreement

1. Introduction

1.1 By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The general principles for risk-sharing are:

(i) The financial impact of unpredictable incidences on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effectively delivery of the schemes

(ii) Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.

2. Scope of Agreement

2.1 Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). E.g. where budgets are held locally for services outside the BCF but are for the same services as in the Better care Fund e.g. Carers).

2.2 Responsibility for the management of the Better Care Fund that is the Pooled budget is split between the CCG and The Local Authority by mutual agreement. The assigned responsibility for the different elements of the Pooled budget is shown in pooled budget responsibility table below.

2.3 All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual organisational budgets outside the Better Care Fund.

2.4 The principle risks to the CCG are those associated with failure to achieve the savings associated with the delivery of the QIPP schemes incorporated into the BCF and in particular the failure to reduce non elective activity in the acute sector which means that the CCG is also likely to incur additional costs in terms of financial over performance.

2.5 As most of the Better Care Fund has been provided from CCG budgets the principle financial risks to the Local Authorities include the failure to earn the performance elements of the fund. In order to fully mitigate this risk for the Local Authority the performance element of the fund is held by the CCG and is not factored into the Local Authority expenditure plans. This also avoids the opportunity costs and effort in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the 2% reduction in non-elective activity.

3. Risk Categories

(i) Financial Risk

- *Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation (as set out in the table below) and will not be funded through the BCF, unless agreed by all parties.*

- *Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end.*

- *Under achievement of planned savings and KPIs will be met from contingency and retained performance fund.*

(ii) Delivery Risk

Failure to deliver the inputs required to deliver KPIs should be borne by the organisation failing to deliver.

(iii) Performance Risk

- *Failure to achieve the non-elective admissions reduction will mean that the performance element of the fund is not payable to the LA.*

- *Achievement will be on a proportionate basis:-*
  - *100% achievement 100% performance fund payable*
  - *75-99% achievement 75% performance fund payable*
  - *50-74% achievement 50% performance fund payable*
  - *25-49% achievement 25% performance fund payable*
  - *< 25% achievement No performance fund payable*

- *The performance fund remaining for non/reduced performance will be used by the CCG to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector.*

(iv) Reputational Risk

Reputational risk will be managed through an aligned communications and engagement plan.

4. Risk Management Framework & Governance Arrangements

4.1 A comprehensive risk register will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan.

4.2 Resources to support the development and maintenance of the risk register will be identified by the parties.

4.3 The Risk Log will be reviewed by groups that are responsible for the individual identified risks – e.g. the finance risks will be reviewed on a monthly basis by the finance group who will update the Risk log for the Programme and provide these updates to the Programme manager for inclusion into the Master Risk Log. The Programme Manager has overall responsibility for ensuring the Risk Log is updated regularly and reported to the Integration Board. Significant risks will be escalated to the Partnership Board and the Health and Well Being Board as appropriate.

4.4 The Risk Log will also be reviewed in both health and social care individual governance frameworks.

5. Accounting Arrangements

5.1 In determining the pooled budget arrangements the following factors have been considered

(a) Whether the funds are being transferred or not from health to social care
(b) Who is commissioning ng the service associated with the budget
(c) Which organisation is providing the resources to run/manage the service
(d) Who are parties to any associated contracts
(e) Which organisation bears the risk of any overspend
(f) Where any cost savings benefit arise
(g) Which staff are involved

5.2 The appropriate accounting standards will apply in relation to any joint arrangements that are put in place.

5.3 The CCG and the Local Authority will recognise their share of the pooled budget in it individual accounts and memorandum accounts will be maintained.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Wokingham Borough Council's corporate **Vision Statement** sets out principles that run through our Better Care Fund Plan:

- Ensure financial viability to deliver the most effective services in the most efficient way through transformation and a new approach to the commissioning of services.
- Invest in prevention services that increase or maintain independence, ending the dependency culture and helping those who become dependent on our support to become self-sufficient and self-reliant.

The Councils' **Adult Social Care Service Plan** identifies priorities for 2014/15 which directly tie into schemes and themes in the Better Care Fund plan:

- Reduction in admission to long term residential and nursing care, through plans for housing. Under the council's **Older People's Housing Strategy**, additional extra care housing will be provided. Registered homes for those with Learning Disabilities will be decommissioned to provide supported living accommodation. Step Up/Step Down Beds (BCF 03) will link in directly with the provision of extra care housing.
- Reduction of delays in discharging medically fit patients from hospital, through by co-locating the health and social care re-ablement services and health liaison team with a health (BCF 02) and social care hub and single point of access (BCF 01).
- Reduction in unplanned hospital admissions, through single point of access (BCF 01) and Hospital at Home (BCF 05).
- Increased use of re-ablement to reduce dependency on long term care packages, with better understanding of outcome measures for staff Improved assessment skills in this area.
- Reduction of dependency on council-funded services, training staff in restorative practice model so they are confident in broader conversations with our customers to promote self-care and alternative means of support.

As outlined previously, an integrated **frail elderly pathway** has been developed and all our BCF schemes support this pathway at various points in the elderly patient's journey. The overall aim of the pathway is to achieve is an improvement in the care of older people with long-term conditions and those who are at highest risk of deteriorating health and needing intensive social care support. In bringing key elements of the frail elderly pathway together through our local projects, we will be able to assess the impact of various approaches, and use this as a template to inform planning for other pathways.

Building on the learning from the successful implementation of **personal budgets** in Social Care, we will seek to enable a more personalised, flexible approach and greater control for individuals. Initially, we would offer personal health budgets to people currently in receipt of both Health and Social Care services. It is proposed that a pilot is taken forward with Social Care as the lead agency, focusing on identifying groups of people where aligning or pooling budgets, e.g. for Continuing Health Care, could lead to improved outcomes. This approach would also enable inclusion and development of

input from the non-statutory sector e.g. voluntary sector bodies and private providers.

Our Better Care Fund plan is aligned with the vision that we have for **urgent care services** going forward. In his report on " Transforming Urgent and Emergency Care Services in England " Sir Bruce Keogh sets out a vision for the NHS to " *provide highly responsive , effective and personalised services outside of hospital for those people with urgent but non-life threatening conditions. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families....*" The CCG., through its' two year Operational Plan and five year 5 Year Strategic Plan, commits itself to achieving this vision in partnership with health and social care partners. Strategic oversight for this work is provided by the Urgent Care Programme Board (UCPB) which has representation from health and social care partner organisations. All UCPB partners have contributed to the development of a Berkshire West Operational Resilience and Capacity Plan 2014-15 (ORC) which confirms how the system will work together to manage operational resilience throughout 2014/15. The UCPB and its members have a key role in supporting improved integration between health and social care and improving outcomes for local people. The ORC Plan demonstrates the clear link between the BCF principles and the wider urgent care agenda. Many of the initiatives being funded from national resilience monies will act as a precursor to the BCF schemes.

The council and the CCG already deliver **technology enabled care services**. For example, remote monitoring currently occurs for selected patients with chronic obstructive pulmonary disease (COPD) and with heart failure. By closely monitoring the patient's condition, this reduces their demands for support from primary and secondary care services. The **IM&T Strategy** for the Berkshire West CCGs supports the roll out of technological solutions *where there is evidence of benefits.* The business cases for Domiciliary Plus (BCF 04) and Hospital at Home (BCF 05) have both demonstrated care benefits of technology and as such are included in plans.

The council and CCG jointly fund an **Better Care Fund Programme Manager** whole role includes ensuring ongoing communication and alignment between the Better Care Fund and other related initiatives.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Integration plays a key part in both the CCG's two year operational and five year strategic plans.

The CCG **Operating Plan** explicitly identifies the Better Care Fund as the platform for delivering out of hospital care. The Plan states:

"As part of the Better Care Fund, we intend to work with our local partners to deliver care across a broad range of initiatives that are centred on the individual patient at a time and location that is convenient to them. By working together we can ensure that the funding for services is used flexibly across organisational boundaries, regardless of organisational structure and form. We are committed to delivering end to end integrated care, radically reducing the number of assessments and transactions individuals currently experience to improve their care".

The Operating Plan sets out the foundations to what has become our Better Care Fund submission:

- Detailed improvement plans for the Hospital at Home (BCF05) and the Enhanced Care and Nursing Home Support (BCF 06) projects.
- Notes progress already made in working with the council to redesign the intermediate care service and reablement service to create a joint short-term health team (BCF 02). This team is the local model for delivering the increased investment in reablement detailed in the Operating Plan.
- Signals the CCG's intention to develop neighbourhood clusters (BCF 08).
- States the delivery of a Health Hub, a precursor to the development of an integrated Health and Social Care Hub (BCF 01), and its role as an enabler.
- Demonstrates the strong public feedback received about access to general practice and the need for extended primary care provision, which has been developed under the umbrella of the Better Care Fund (BCF 09).

No specific reference is made in the Operating Plan to Connected Care (BCF 07), but this project is featured in the CCG's Information Management and Technology Strategy, which was submitted to NHS England alongside the Operating Plan.

At the time of writing the Operating Plan, the local authority-led Step Up/Step Down Beds (BCF 03) and Domiciliary Plus (BCF 04) schemes had not been fully developed. But the Operating Plan does state the intention to develop approaches to discharge and seven day working:

"Where admissions occur there is a need to ensure that care packages can be instigated and patients discharged from hospital on whatever day of the week they are clinically fit to leave. We are therefore looking to ensure that the full range of health and social care services is available seven days a week".

Our unit of planning for the purposes of our five-year **Strategic Plan** has been agreed with NHS England to be Berkshire West. The Five Year Berkshire West Strategic Plan is our overarching strategy which aligns the Berkshire 10 organisations and our five year plan, this document clearly articulates that the Better Care Fund will act as a key vehicle to lever the transformation of health and social care services in the provision of integrated care and support.

The BCF has required the formulation of joint plans for integrated health and social care and these plans have been developed through Berkshire West's three local **Integration Steering Groups** (WISP in Wokingham's case) , which include representation from the CCGs, local authorities, health and social care providers and the voluntary sector, and the on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services both at a local and Berkshire wide level. Consequently, a number of our schemes also feature in the Integration programmes described in the BCF submissions for Reading and West Berkshire Unitary Authorities. Schemes such as Hospital at Home, Care Home support, Connected Care, and the Health and Social care Hub appear in all three BCF submissions. This clearly offers us the ability to take forward the integration agenda at pace and scale and provides a catalyst for change. It also allows us the unique opportunity to have the flexibility to design schemes which are specific to our local areas e.g. Domiciliary Plus scheme which is specific to Wokingham, whilst assuring alignment with our wider geographical strategic

plans.

As demonstrated in Section 2, Wokingham's **Health and Wellbeing Strategy** has a shared vision with the BCF plans, demonstrating that the BCF schemes underpin and support the delivery of the overall joint strategy.

Integration is also a key part of Wokingham Borough Council's **Corporate Vision**, which identifies the following principles which link directly to projects developed within our Better Care Fund submission:

- Look after the vulnerable
  - We will help our residents who are dependent on our support to become self-sufficient and self-reliant.
  - We will provide care to those residents who need our support.

- Improve health, wellbeing and quality of life
  - We will work with our partners to promote health, wellbeing and quality of life.
  - We will ensure our partnerships are focused on health and wellbeing outcomes and will drive the delivery of public health through the council's new role.
  - We will continue to ensure safe communities.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The Berkshire West CCGs have submitted an Expression of Interest to NHS England's Area Team to undertake co-commissioning of primary care services from 1st April 2015 with possible shadow arrangements in place in the interim. This was developed through the **Primary Care Programme Board** which includes GP representatives of each CCG who communicate with other GPs through GP councils. In addition, the Better Care Fund has also been discussed in both of these forums - at the Primary Care Programme Board and with our **GP council** to ensure the alignment of primary care.

It is envisaged that co-commissioning will underpin integration, encouraging the development of new models of service provision outlined in the BCF. In addition a number of BCF schemes link closely to the enhanced GP service that is to be delivered through **"Transforming Primary Care"**. For example, the Neighbourhood cluster BCF scheme (BCF 08), supports the changing role of the GP as the Accountable Clinician co-ordinating care and links to the Proactive Care programme as outlined in "Transforming primary care". In addition, the care home project (BCF06) will also facilitate the Proactive Care programme for over 75s living in residential care.

A further area of the BCF plan that will support the enhanced GP service is the scheme to improve access to GP services (BCF08). Co-commissioning will support the implementation of this scheme. There are opportunities to further pool funding with NHS England, such as that used for the current Extended Hours DES, to better incentivise practices to increase their availability, thereby also mitigating any potential risks

associated with practice engagement.

There are a number risks relating to the involvement of primary care with the BCF schemes. The main risk is around GP engagement in relation to the schemes – in particular the Care Home scheme, and the neighbourhood cluster teams. These schemes rely heavily on GP engagement. For example if GPs do not engage with the Care Home scheme, the non-elective admissions will not be realised as the service is contingent upon GP participation. To mitigate this risk, we are reviewing GP uptake of these schemes on an ongoing basis. Where take up is falling short, we will proactively engage GPs to ensure that they participate with the schemes. To help ensure participation, the BCF is an ongoing agenda item at the Primary Care Programme Board.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

For Wokingham, protection of social care services through the Better Care Fund is **to ensure that vital care and support services delivered in our community are maintained and also sustainable for the long term.**

The local definition of protecting adult social services is to focus upon prevention, early intervention and for health and social services delivery aimed at avoiding admissions to institutional care (especially care homes and hospitals) together with maximising people and their communities' capacity to self-care. It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.

Wokingham Borough Council is committed to delivering the good quality affordable services to residents who have care or support needs. The Council is committed to working with its partners (particularly the voluntary sector, local providers of care and the NHS) to develop services for residents that help people live as independently as possible with minimal interference.

We will deliver a fair system of Social Care where the resources that are offered relate to the level of assessed needs a person might have and where their contribution towards the costs of that care clearly relates to their ability to pay. On the 1st April 2015 Wokingham will make a significant move from its current eligibility threshold (set at supporting those who face a 'critical risk to their wellbeing or independence) to the new national eligibility criteria. This move will result in both more residents being supported and the level of such support being greater. In moving to a critical threshold for eligibility Wokingham has already seen a significant investment in prevention services across the borough which starts 'up streaming' 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.

We will draw on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living safely at home. We will give priority in our future service delivery to helping people recover, recuperate, and

rehabilitate so that they are able to live as independently as possible. We will ensure that all staff (Health and Social Care) and providers understand how to work with service users in ways that promote their independence, ensure their safety and support their recovery.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

There will be **growing demand on social care services** as the population ages and grows in Wokingham. The new housing developments will bring a 22% increase in the overall population by 2026. For social care, an expected increase of 39% in the 85+ age group from 2014 to 2020 is a key indicator for the demand for social care. Amongst this age group, 80% currently have at least one long-term condition and 30% have four or more. These changes will impact on social care demand in a number of ways:

- The demand for services to meet needs associated with older age, such as dementia, frailty and end of life care will increase.
- Whilst we want to support more people to remain in their own homes, this raises issues of social isolation for those who are living alone. We need to consider the range of services available to support people to access their local communities.
- There is a need to shift the emphasis from traditional residential care to alternatives such as extra care housing which will help an aging but healthy population remain independent for longer.
- The Council will need to provide further support to self-funders to help them find out about and purchase services which will meet their needs in cost effective ways.
- The role of prevention services to help those who currently enjoy good health to retain this will be important to reduce the growth in demand for more intensive services.
- More options are needed for carer support.

Wokingham's social care services have gone through significant review in recent years in order to manage significant reductions in budget whilst protecting essential services for those receiving care. 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, brokerage and longer term support and review. The Care Act 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.

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. The Step Up/Step Down Beds (BCF03) scheme will afford patients coming out of hospital a better opportunity to evaluate long-term care options. This is expected to reduce the number of permanent admissions to residential care, which are more costly care options than discharge back to a home setting. The Enhanced Care Home (BCF06) scheme will enhance the capacity of care home staff to support people with multiple health conditions and complex needs. Taken together, the various elements of the scheme will promote a shift towards more planned

and less reactive care, the latter being significantly more resource intensive.

There will be an increased focus on **preventative services**. These are services that can be accessed without the need for a statutory social care assessment and which are intended to prevent or delay people's health and wellbeing reaching the point where statutory services are needed. Prevention services will continue to be a key aspect of the Council's commissioning plans. The Council will increasingly be looking to fund those services which make maximum impact and which support people with particular needs or in specific areas where other support or opportunities might not be readily accessible. The Council will be looking for services which complement rather than duplicate statutory and other prevention or mainstream provision. Given the evidence demonstrating **the health impact of social isolation**, prevention services to vulnerable people living alone which offer opportunities for social contact and access to their local communities are particularly important. In addition, surveys have suggested that many people are unaware of the existence of many prevention services and we will develop an on-going process of promoting these services in the community. BCF scheme 08 will more broadly support good health within neighbourhoods, focusing in particular on supporting and empowering those with long term and complex conditions to self- care and on primary prevention.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£944k has been allocated for the protection of adult social care services and £335k has been allocated in the BCF for the implementation of the Care Act – (in line with our local proportion of the £135m).

However the late advice regarding the funding for national minimum eligibility criteria is significant. This advice indicates that the funding previously identified by the DH for the 3 councils affected has been distributed across all social care councils and that the decrease in criteria should be funded from the BCF. The DH (in their impact statement) had estimated the cost to be in the region of £4.5m for this council. The BCF fund is clearly inadequate to fund this enforced change and as a result all schemes are deemed at risk of significantly reduced funding with obvious reduction in outcomes, should this proposed distribution by the DH remain unchanged.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

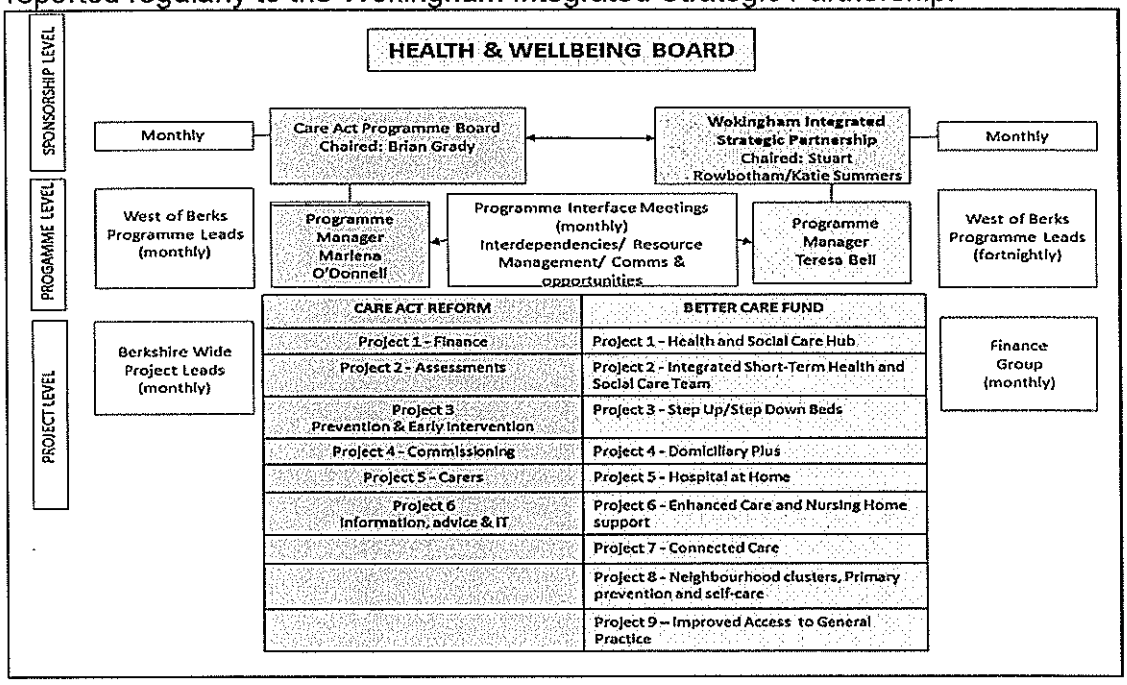
The Care Act represents a significant change to the way social care services are funded and will have a significant impact on the numbers of people for whom the Council will be required to provide, arrange and fund services, especially as there are a large number of self- funders in the Borough. There will also be an impact on the nature and range of services required. The Council will focus on support and prevention to assist people to maintain their independence and preserve their assets for longer.

It's essential that we plan financially to meet and manage the requirements of the new Care Act 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.

It should be noted that in relation to the Care Act duties this locality is one of the few in the country where the eligibility criteria will need to be adjusted from critical. The Partnership is aware that this may put additional pressure on the local authority which will need to be taken into account in the delivery of the integration programme.

The following diagram sets out how the changes arising from the Care Act are being overseen, and the relationship with the Better Care Fund work stream. Staff working on the implementation of the Care Act are linked into the integration programme through regular meetings at project, finance and programme levels. Progress, issues and risks are reported regularly to the Wokingham Integrated Strategic Partnership.



The implementation of the Care Act in Wokingham is governed through the Care Act Programme Board which brings together six projects to ensure that the new duties arising from the Care Act will be met. Each project is listed below along with a brief description of the main focus for each project.

Finance: reviewing existing policies to ensure they meet Care Act requirements, and systems and processes will change to adapt to new funding cap obligations.
Assessment: updating the council's approach to assessment and support planning for clients and carers to meet Care Act requirements.
Prevention: putting a greater emphasis on prevention.
Commissioning: providing the market with a clear steer of commissioning intentions for future years that will meet the requirements of our population.
Carers: responding to specific requirements (e.g. care account) for carers arising from the Act.
Information, advice & IT: arranging independent advocacy to support assessments, reviews and support planning

The Care Act and BCF work streams have a number of key interdependencies. This is particularly so with respect to preventative services (Care Act Project 3 and BCF 08). Both will share key messages, and coordinate approaches to common target groups. In addition to the specific projects within the Better Care Fund, the wider integration programme has been designed to take account of the new duties set out within the Care Act. There are work streams within the programme which specifically address the Care Act duties, including market management, carers commissioning, integrated personal budgets and integration of workforce development.

At a Berkshire West level we are part of an area-wide integration programme which aims to promote integrated commissioning and delivery across the whole health and social care system. The Better Care Fund is a source of funding within this wider integration programme. The full integration programme is underpinned by the need to address the duties of the Care Act. It also addresses work which has taken place within the whole system on the frail elderly care pathway. This process seeks to prevent, delay and, reduce needs and to reduce delayed discharge from care through a whole system response to care closer to home. It is thus closely interlinked with the Care Act duties.

v) Please specify the level of resource that will be dedicated to carer-specific support

We recognise the significance of supporting carers within an integrated care system, particularly through ensuring they are able to take breaks from caring. This is a key preventative service which helps keep carers themselves and those they support, well and out of hospital.

A total of **£494k** will be dedicated to carer-specific support from within the BCF pool.

In Wokingham, we have seen a 13% increase in the number of carers from 2001 to 2011. We recognise the significance of supporting carers within an integrated care system, particularly through ensuring they are able to take breaks from caring. This is a key preventative service which helps keep carers themselves and those they support, well and out of hospital.

Carers have comparatively poor health, which is recognised as a critical public health issue. They are a high risk population as they tend to neglect their own health; sometimes for practical reasons (like not being able to leave the home to attend appointments or hospital treatment) and sometimes simply because their sole focus is caring for the person they are looking after. They often do not even notice their own health is deteriorating. Carers may also forget to make or miss routine health appointments like 'flu vaccinations or check-ups with doctors or dentists. Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy. Emotional impacts such as worry, depression and self-harm have been identified in both adult and young carers.

We have already pooled budgets across health and social care to commission an information, advice and support service for carers across the West of Berkshire (covering three local authority areas, including Wokingham) and to deliver a range of services which support carers to take breaks from caring. Already £192k of health funding has been dedicated to carer specific support whilst the local authority has committed its current spending of £1100k on Carers Services including significant funding to local

voluntary and community sector carer support services. In addition it provides additional funding to the provision of Direct Payments to carers which enable them to purchase services to ease the strain of caring. Assessment and support to Carers will increase with the change in the Care Act.

A **Berkshire West Forum** has been established to oversee the future commissioning and development of carer support across Berkshire West. This is identified as one of the enabling work streams within our integration programme, and is being led by the CCG's Director of Joint Commissioning. This Forum will ensure that carer-specific resource identified within the Better Care Fund allocations is used effectively to improve outcomes for carers. The Forum will lead on the development of strategic plans and commissioning arrangements for supporting carers across Berkshire West, and also inform the development of other plans and arrangements which have the potential to improve outcomes for carers. Our aim is to move towards single pot funding for all carer support across the West of Berkshire and to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.

The Care Act 2014 and the Children and Families Act 2014 strengthen carers' rights from April 2015 onwards. We will develop co-designed plans for use of proposed additional Government funding which is expected to be made available on a phased basis over a 5 year period. We intend that these should focus on early intervention and prevention whilst ensuring that the statutory duties and responsibilities of relevant partners are discharged within jointly commissioned carer services, including safeguarding responsibilities and obligations which are placed on public bodies under the Equality Act 2010.

Carers Assessments: The Care Act introduces a new obligation on the local authority to offer all carers an assessment on the appearance of need, including additional entitlements for young carers and parent carers of disabled children to receive carer assessments. The carer assessment is an opportunity for the carer to consider how caring impacts on them, how they can be supported to care and to enjoy a life outside caring. It is an important element in ensuring that many people with care needs can be supported informally and so stay safe and well at home for longer.

We have used the **'Lincolnshire model'** to estimate the cost of delivering additional carer assessments to meet the local authority's extended duties in this respect from April 2015. The additional assessment costs are expected to be £117k p.a.

We are committed to promoting choice for carers as well as service users, the Care Act allows joint health and social care personal budgets and we will aim to use this flexibly. We also recognise that there is still a need for some joint services and we continue to jointly commission services where it makes sense to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

In light of this change all schemes have been subjected to review and the original proposed investments reduced by an amount equivalent to the value of the performance fund (£448k). This is now shown as a separate line in Part II.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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.

Building on previous shared aspirations, and through its approval of this submission, our Health and Wellbeing Board has affirmed its commitment to overseeing the development of 7-day health and social care services in Wokingham. We will strengthen provision and the availability of decision makers at evenings and weekends so that people can receive care in the most appropriate setting whenever they need that care.

In Wokingham we already have a number of services which are working 24/7 or with extended hours. These include:

- Emergency Duty Service (social care)
- Westcall out of hours GP service
- Rapid Response
- Community Nursing
- Intermediate Care and START (reablement service)

Our local development will build on these successful initiatives to expand 7 day working across a wider number of providers, and to draw on the skills which have been developed within multidisciplinary teams both to facilitate discharge from hospital and to avoid unnecessary admissions. We have worked across sectors and with users and carers to map out of hours pathways. This is driving the schemes described to harmonise services more effectively around individual need, whenever that need arises.

We have a 7 day working **CQUIN** with our main acute provider to deliver the following: 75% of patients admitted as an emergency by A&E or directly from the community must have been assessed face to face by a consultant and documented within 14 hours of admission to the hospital. This CQUIN will support a move towards an equitable service on weekends and weekdays in terms of consultant cover and assessment for patients.

We are also in the process of agreeing a **Service Development & Improvement Plan** (SDIP) with the main acute provider to ensure a clear and robust plan is in place to determine what level of services each department will be required to deliver 7 days a week by when with clear milestones and deliverables included.

We intend to increase the number of people who benefit from an integrated intermediate care and reablement service. This will offer a system of care that can respond to escalating need as and when that is needed. A collaborative approach will shift capacity into community based provision, the purpose being to ensure that more people are moved on in a timely fashion into rehabilitation support prior to decisions being made

about long-term care.

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.

A number of BCF schemes will help deliver 7 day working. Domiciliary Plus (BCF 04) will offer a short-term 24 hour support service until a longer term home support service can be put in place. The service will be able to provide a high level of care as well as low level support during this period. The service will contribute to the achievement of targets in relation to reduction of delayed discharges and overnight hospital admissions and reductions in admissions to nursing and residential care. We also intent to further expand the access to GP services (BCF 09). The eventual model to be commissioned will be shaped by the findings of the local pilots, national best practice including emerging results from the Prime Minister's Challenge Fund pilots, and a recently completed baseline audit of in-hours capacity and utilisation. The Primary Care Programme Board has a workshop on this issue scheduled in September 2014, supported by PCC which will look to further define our approach.

These schemes will be underpinned by our 7 day health and social care hub (BCF 01), a single point of access to health and social care that will signpost professionals and eventually patients, throughout the whole week.

A delivery plan for 7 day services is being developed with partners across the Berkshire West health and social care economy. It is recognised that in order to achieve seamless services, all partners must work together to ensure a coherent and safe delivery plan. All new projects are being designed with the requirement for access the whole week as an operating principle.

As such we are making strong progress to deliver clinical standards for seven day services. There are some risks associated with this, captured in the risk log – primarily being that 7 day working is contingent on participation and recruitment into these seven day services. We are engaging with GPs to ensure they are supportive and participate. In addition, we envisage that our plans to co-commission primary care to help work towards a move to 7 day services.

c) Data sharing

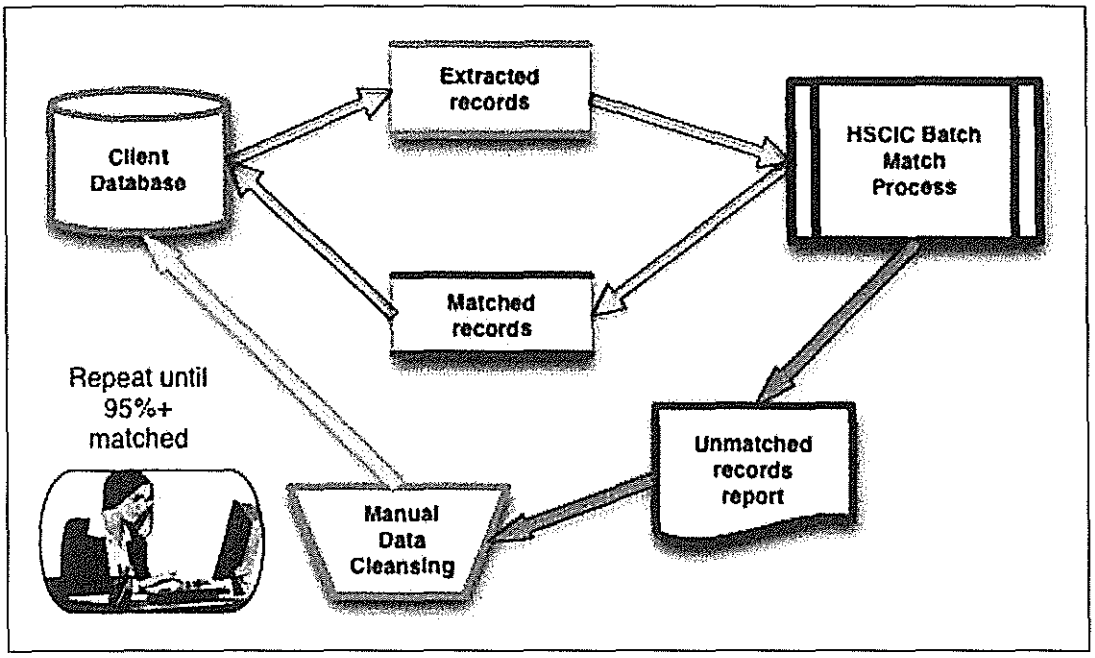
i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number as the primary identifier for correspondence will be implemented by April 2015. This will be critical to the success of our system wide Connecting Care BCF scheme (BCF06).

A **project group** has been established to oversee the implementation of NHS Number throughout the Berkshire West system, led by Reading Borough Council, reporting to the Berkshire West Interoperability Programme Board. This group will oversee the delivery of the plan and milestones.

The key actions in place for primary identifier are:

1. Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust to ensure all patient communication to include NHS Number by April 2015.
2. Reading, Wokingham and West Berkshire Local Authority Board adopt the process of Batch Matching through Demographic Batching System, commencing in October 2014, as demonstrated below:



The unitary authorities have recruited a project manager to facilitate the batch uploading of NHS numbers to all clients within the social care systems. This batch uploading will be a one-off process to ensure all records held within social care systems including Frameworki hold an NHS Number. The project has started and the planned completion date is March 2015.

Follow up work will be required to ensure that all new clients have an NHS number added to the record. One way this can be achieved is through access to the NHS spine application PDS (**person demographic service**). As part of the "registration" process when a new client is added, the PDS could be interrogated to provide the NHS number which would then be recorded. In order to gain access to the PDS, an N3 connection is required.

Key risks in our log include timescales for obtaining an N3 connection to be able to use the PDS; timescales for all organisations becoming IG Toolkit Level 2 accredited; and the process for recording NHS number in unitary authorities becoming embedded.

The use of the NHS number within all systems in use in Health and Social care organisations is critical for the proposed integration solutions to work. The NHS number is needed to ensure the correct records in each of the systems are interrogated to present a holistic view of the patient's record. The NHS number is already used in Health organisations in Berkshire West, and once social care organisation systems hold the NHS number, portal solutions will be able to accept data from all organisations in Berkshire West. This will be critical to the success of our system wide Connected Care

BCF scheme (BCF07), which seeks to ensure health and social care professionals have access to accurate and timely information regarding patients by facilitating the sharing of information. IT interoperability is critical to improving the quality and experience of care that patients receive, removing silos to ensure that health professionals have access to comprehensive records, and that patients only have to tell their story once.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the Berkshire West Interoperability Programme Board an Application Programming Interface (API) is being pursued, as part of the Better Care Fund Connecting Care scheme (BCF07). This scheme is designed to remove the IT silos that exist in health and social care and has the ultimate aim of ensuring that patient information and data will be accessible to all who need them.

The Interoperability programme Board has engaged with IT development partners (Central Southern Commissioning Support Unit) 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.

A proposed IT solution has been identified and phases for connectivity determined, starting with GPs and out of hours services in October 2014, followed by key NHS Trusts in December 2014, and then in phase 3. Connections with the individual social care systems have been agreed for consideration. Appropriate information sharing agreements are being developed through this project. The CCGs across Berkshire West have moved to a system of secure email for all communications within and across partner organisations in addition to the use of GCSX.

In primary care there is a contractual obligation for clinical system providers to have open API's to allow direct integration with their systems. This came about as part of GPSOCr in April and the first examples of integration should be implemented by the end of 2014. To facilitate information sharing without being dependent on suppliers opening their API's and waiting for the development work required by at least two suppliers, a third party system has been purchased- Medical Interoperability Gateway (MIG) by Healthcare Gateway which facilitates data sharing from GP Practice systems in use in Berkshire West. Longer term, integrated records portal solutions will be required to integrate directly with primary care systems using open API's as part of the core requirements when going through a formal procurement. The pilot phase using Orion will utilise the MIG to share primary care data.

Discussions with Cerner, Adastra and OpenRio indicate that they will work with other providers to facilitate information sharing although there is no national contractual obligation. To ensure information sharing can begin as soon as possible, a key requirement for the procurement of an integrated records portal solution will be for there to be examples of integration with these suppliers or evidence that they can utilise open API's to develop a good level of integration into these systems.

Further discussion need to take place with Frameworki and Raise to ensure that they will open their API's to ensure the systems can provide data and also allow for a portal

solution to be integrated within their systems.

Not all suppliers are contractually obliged to open standards and there could be significant costs or delays for development work required to ensure a good level of integration. This is mitigated by ensuring the portal solution can provide a web- based view but this would not be as beneficial for the end user.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

There is a firm commitment to ensuring appropriate Information Governance controls. We acknowledge and support the findings of the Caldicott 2 review and the inclusion of the new 7th Principle. In terms of the 26 recommendations arising from the report, the Berkshire West System partners (acute, community, CCG, and local authorities) already comply or we are working actively to address these areas together between and across health and social care. The key areas which require new protocols and information systems to support them are common to all UK Health services and Local Authorities and we are forward thinking in our approach to resolving them.

To ensure adherence to these controls each organisation operates its own Information Security Policy underpinned by legislation which details principles used for data sharing. This includes:

1. Protection against unauthorised access
2. Availability of information to authorised users when needed e.g. for the benefit of the service user or patient
3. Maintaining confidentiality of information
4. Integrity of information through protection from unauthorised modification.
5. Ensuring regulatory and legislative requirements will be met as a result of robust policies and procedures and training for staff

There is a commitment to creating a joint framework across the organisations by October 2014 through the establishment of joint Informatics governance group. This will build on the Berkshire NHS "Overarching Policy for sharing personal information Between Organisations 2010."

To date primary care data is being shared with the urgent care system in Berkshire West. An information sharing agreement has been established which lists the data items that can be shared and who can view the data. This has been signed by all participating organisations in Berkshire West (apart from one GP Practice). The system for viewing is based on role-based access and will ensure only those who are allowed to access, can access the data. There is also a full audit module that will enable organisations to check if a record has been accessed inappropriately.

An IG professional will be part of the procurement process to ensure that the selected portal solution fully complies with all IG standards and protocols. We will ensure we are compliant with NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice Caldicott 2.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

2,447 people Wokingham have been identified as being at high risk of hospital admission in 2014/15. The criteria defined within the national Directed Enhanced Service for Unplanned Admissions, the top 2% of registered patients aged over 18 and at the highest risk of an unplanned admission, has been used to identify these patients.

The risk stratification approach used to identify the 2% of patients at the highest risk of an unplanned admission was carried out using practice clinical systems or the ACG tool which identifies characteristics such as condition and utilisation of healthcare resources (excluding community and social care data) to stratify those at risk. The ACG model is underpinned by clinical algorithms and is driven by each patient's diagnostic and prescribing records. The ACG tool also clusters co-morbidity and compounded impact on resource needs. As can be seen from the table below, there is broad correlation between the top 2% methodology and the number clarified by ACG as very high resource utilisers.

RUB Group	No. Patients
[redacted]	[redacted]
High	4,739
Moderate	13,905
Low	33,911
Healthy	76,004
Non users	17,816
Total	149,239

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Locally, outside of the BCF programme, we are investing our £5/head funding for GP's as the accountable health professional for the over 75 year olds within practices to further drive and support this work. This will ensure all care plans are uploaded onto a central repository, for access by multiple organisations, provide further support in the form of administrators and health professionals for the delivery of the admissions avoidance DES and a commitment to develop 50% of care plans following a face to face consultation for over 75 year olds who are also in the top 2% risk category.

The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). The named GP will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary. A number of patients within this cohort will have dementia or mental health problems and the named accountable GP will

be responsible for ensuring that these patients have a personalised care plan and that they and their carers are closely involved in the development and implementation of the plan, as described above.

The lead professional will be supported in their role by a practice team made up of a mixture of clinical and administrative roles. They will act as the main point of contact for the patients and their families. They will support clinicians in following up referrals/results/investigations/letters and liaising with other health and social professionals and they will make regular telephone contact with patients, carers and families to update them on progress of their care plan (this might be general health status or after a particular acute event such a bereavement). This may be as agreed in healthcare plans or simply courtesy calls. Many frail elderly do not have family who live locally and this would improve the quality of care delivered and provide comfort to relatives that their loved ones are in safe hands.

This dedicated resource should provide focus and continuity of care for patients and their carers/families and provide them with assurance that their concerns and issues can easily be resolved with minimal fuss. They will facilitate navigation from the practice reception service to the right person who can take immediate action when required, and support the GP in prioritising responses, to ensure that any problems are dealt with appropriately. They will also ensure that care for the patient is coordinated across all health and social agencies involved in the care of the patient.

To date we have had a positive experience of developing the concepts of joint assessments are planning. We are continually looking at ways to ensure the process is effective and efficient, particularly in terms of time and resources required. The Neighbourhood cluster project (BCF 08) will support the further development of our approach with dovetailing organisational structures and processes.

Practices are required to assess the impact that the scheme has on the care of these vulnerable patients. It is expected that this will be discussed at regular practice meetings and there will be a specific practice review meeting, involving all clinicians in the practice at year end to assess the impact on patient care and outcomes. As part of this, the practice will consider the results of the annual patient/carer satisfaction survey which will be developed in consultation with the practice patient group.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

By 1 October 2014 we expect the minimum 2% number of patients (2447) to be on practice's case management register as part of the DES.

We currently have 601 individuals at high risk with joint care plans in place. This is the case load associated with the "specialist community nursing teams" i.e. Community Matrons, Care Homes, Heart Failure, End of Life and Respiratory teams. This represents 25% of the total high risk stratified population at risk of an unplanned admission.

In addition we also have a further 250 patients, lower down on the risk triangle with joint care plans in place as a result of work carried out in 2013/14 through our case co-ordination project and the national enhanced service for risk stratification.

In addition care plans will also be in place for those patients on the community nursing case load who are not in either risk category.

8) ENGAGEMENT

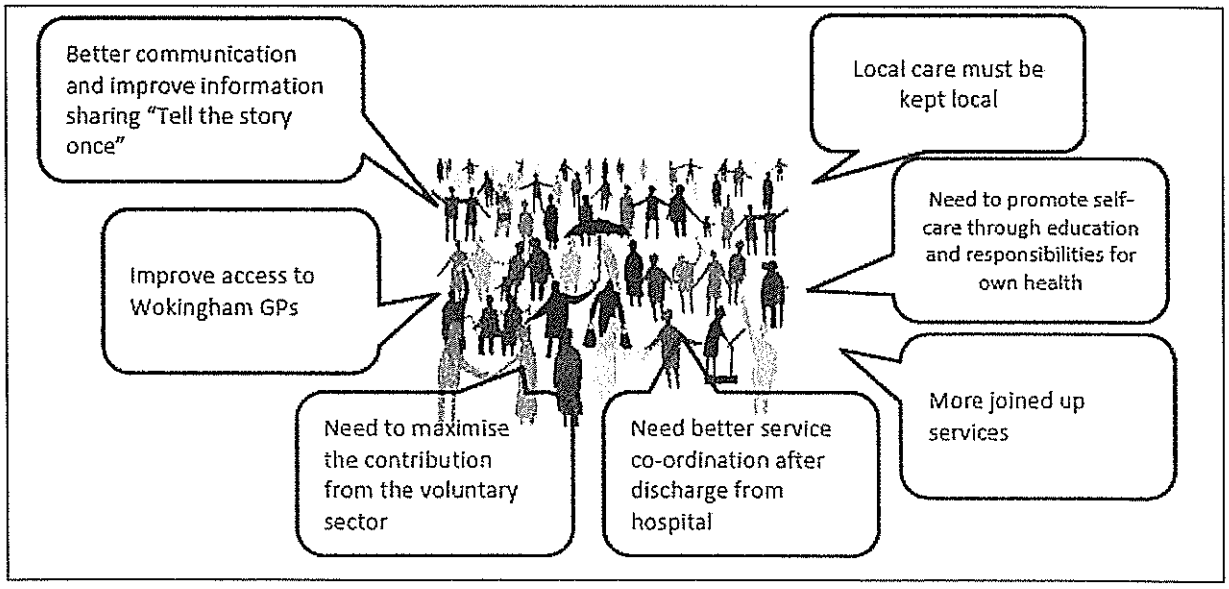
a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

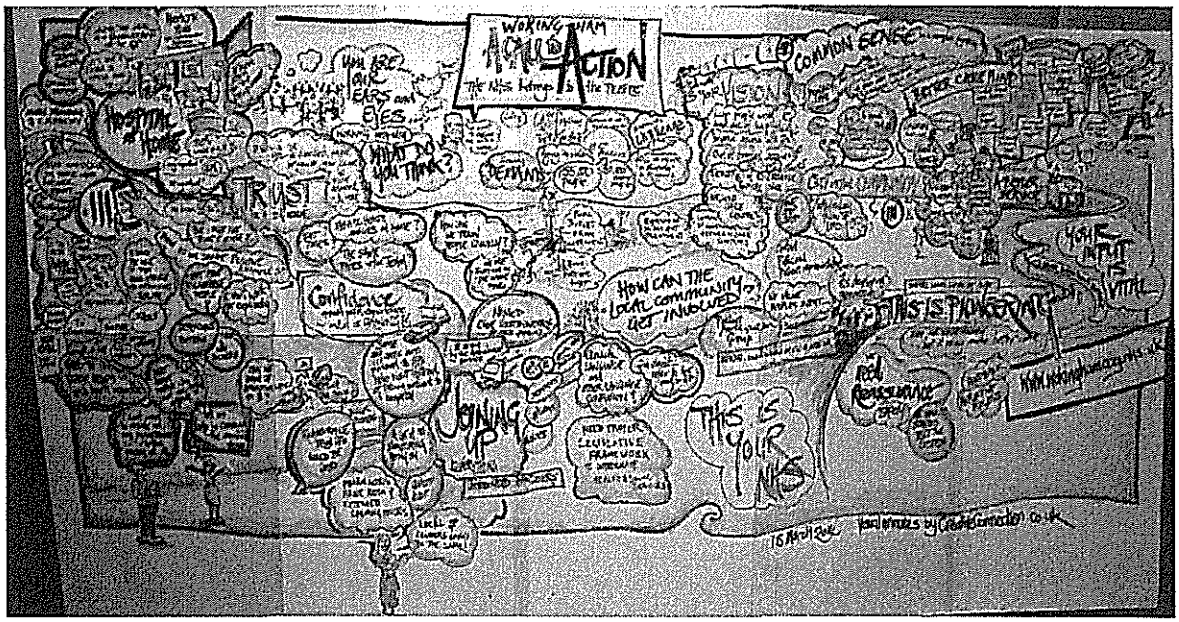
Patients, service users and members of the public have shared with us their experiences of local health and social care, and their aspirations for the future. This has given us a firm mandate to develop integrated services with the individual at the centre. The distinction between health and social care makes no sense to the people who need support. They perceive the hand-offs between Health and Social Care as unnecessary bureaucracy standing in the way of them receiving the services they need. Wokingham residents have also given commissioners a strong message that they are looking to statutory services to support them to support themselves and their families. Maintaining independence and having choice and control over how they receive care is clearly very important to the people of Wokingham.

Over the past year or so we have established a growing understanding of the experiences and needs for Wokingham resident. We began in July 2013 with the **Patient Revolution**. The event was an Open Forum, and provided an innovative approach to listening to patients' concerns. Over 30 conversations were undertaken, based on an agenda determined on the day. The significant message was the need to design more integrated and seamless services across Wokingham.

This event was subsequently followed up with a **Call to Action** meetings in November 2013 and March 2014. The purpose of the first meeting was to help determine the direction of the NHS with a rising population and to provide input into our local priorities. Overall, they wanted to see a more joined up health and social care service that uses the skills and expertise of the voluntary sector to full effect. They also want to see more of a focus on keeping people well and preventing ill health. Importantly they want to see improved communication between all health and social care systems. Other important themes were:



The second Call to Action event was held to share the outline Better Care Fund plan and enabled further discussion with partners, providers and the public. The Wall of Minutes is shown below:



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

Other means of consultation and engagement in partnerships, workshops, surveys and participation groups have shown 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. For example, our **Carers Survey** in 2013 gathered adult carers' views on their health and needs. Three main themes emerged from the survey:

- Improvement to GP Access
- Better Carer Identification
- Increased levels of Understanding, Support and Advice for Carers

In response, our member practices increased carer registration as part of the Quality Premium, information materials were prepared on our behalf by the Berkshire Carers organisation and plans developed to improve GP access, including BCF 09.

In Wokingham there is a **Patient Participation Group Forum**, attended by each practice PPG, Healthwatch and the CCG. The Forum allows for both patient groups and the CCG to raise issues and ideas for discussion and to design patient consultations. The Forum has twice considered the Hospital at Home project (BCF 05) in April and July 2014. Comments from the Forum have helped shaped public communications and information about the scheme

We have **community and voluntary sector** representation on our Wokingham Integration Strategic Partnership, helping to bring a service user perspective to health

and social care integration.

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.

Looking forward, we wish to adopt **co-production** as central component of future planning and alongside the Care Act implementation we will be developing how to achieve this ambition. Co-production is about a shift from the provision of services to passive recipients to recognising people as equal partners in the design and delivery of services. Professionals become facilitators rather than providers of services. This means that we need to reconsider how we work with customers and carers as well as other partners:

- We need to put patients, customers and carers at the centre of all we do
- Future models of coproduction may involve engaging organisations with relevant expertise such as Healthwatch and voluntary sector organisations
- Use new channels of communication (social media, emails, text messages, online feedback / forums, informal meetings, etc.)
- Use every opportunity, every contact we have to encourage coproduction
- Encourage and develop peer support networks
- Ensure that patients, social care customers and carers have their say on everything we do

We have specific group to **coordinate engagement**, with representation from the CCG, council, community and voluntary sector, Healthwatch, and foundation trusts.

As part of this approach, we are planning a shared engagement event with Healthwatch and other partner at Wokingham's Winter Fayre. We are also looking to run focus groups targeting particular segments of the population, including those seldom heard groups, to help shape our future plans.

Overall, our BCF 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 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.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We recognise the need to work across health and social care boundaries in order to move towards our vision of fully integrated health and social care for the residents of Wokingham. Commissioners and providers have come together to develop the vision and

schemes described in this plan, including developing our understanding of the behavioural and attitudinal shifts needed to achieve real and lasting change.

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This submission has been developed over a series of meetings involving community health providers, social care and primary care and also discussed at WISP. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

Wokingham Borough Council and Wokingham CCG have shared early development plans with **Royal Berkshire NHS Foundation Trust** through a Berkshire West planning meeting, which included acute and provider sector organisations and their input has been taken into account. We will continue to involve them in our plans going forwards.

The Royal Berkshire and the other local NHS provider - **Berkshire Healthcare Foundation Trust** - have been engaged in the development of all the BCF schemes, and have representation at both WISP, and are also members of the Berkshire West Partnership Board. Both clinicians and managers from the trusts have played into the development of business cases and models of care delivery.

Developing and refining our Better Care Fund projects will continue to be undertaken via whole system workshops including key stakeholders. This has been successful in terms of developing the scope of the Time To Decide service and the extension to intermediate care. Additionally, representation of the two main NHS providers on WISP and the Berkshire West Partnership Board ensures that both managers and clinicians from the trusts have played into the development of the business cases and models of care delivery.

The Royal Berkshire NHS Foundation Trust is aligned to the figures, as outlined in Annex 2. This will be reflected in the 2015/16 operational plan that is currently in development.

ii) primary care providers

General Practice has been engaged in the development of the BCF plan through discussion in our **GP council**. These discussions were informed by feedback from the GP lead who attends the Wokingham Integration Strategic Partnership. Likewise, the CCG GP council has a representative on the **Primary Care Programme Board**, through which the primary care aspects of the plan have been developed, particularly schemes such as Enhanced Support for Care Homes (BCF 06). These engagement mechanisms will continue as the plan moves into the implementation stage, and the various BCF schemes are discussed on an ongoing basis.

iii) social care and providers from the voluntary and community sector

The **Adult Social Care Service**, social care provider **Opalis**, other providers, residential and nursing **care homes**, **housing providers**, and **local voluntary and community sector** providers, have been engaged at various stages in discussing the detail underpinning this submission.

Lead Members within the local authority have been closely involved in the preparation of this submission. Through them, commitments have been secured from across the

Council to enable us to draw on a range of services which can support and promote wellbeing for local residents.

The local **community and voluntary sector** is represented on the Wokingham Integration Strategic Partnership.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Increasingly, enhanced primary, community and social care services in Wokingham will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise. All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical and social care needs.

People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital. People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery.

Royal Berkshire NHNS Foundation Trust is part of our integration programme and we are working closely with them on our plans. They were a key part of the previous submission by the **'Berkshire 10'** to receive support to integrate health and social care across Berkshire West - which this document builds on - and have affirmed their commitment to be involvement in the evolution of plans as we go forward.

In 2013 we commissioned Capita to undertake **demand and capacity modelling** for the Berkshire West health and social care economy. The review concluded:

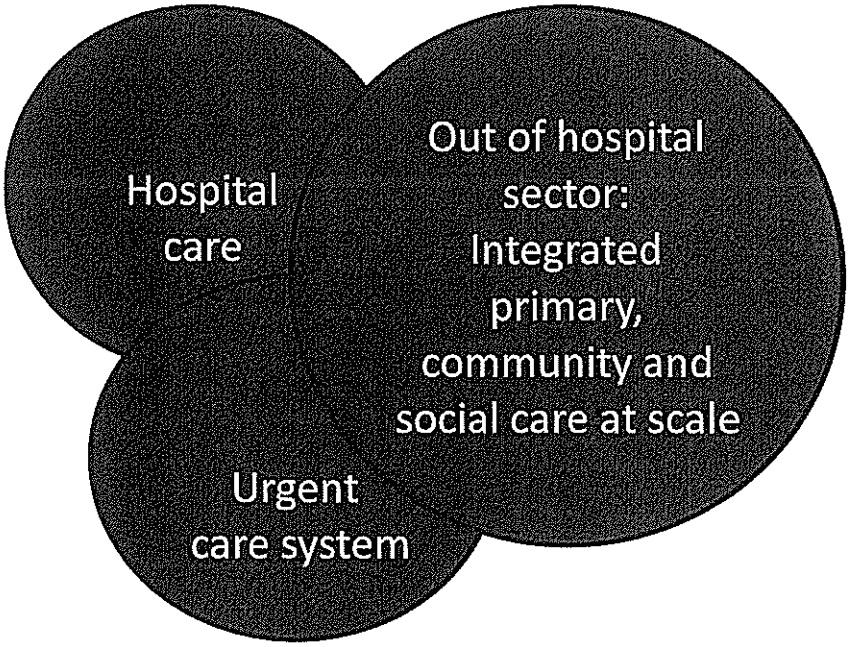
...by most standards the Berkshire West health and social care economy is performing well. We continue to categorise the economy as High Potential whilst fully understanding the pressures many elements of the economy are experiencing. Unlike more distressed economies, Berkshire West has the opportunity for planned and strategic innovation...

The review gave particular focus to work addressing emergency and unplanned care.

Proposals for a Berkshire West **Integrated Workforce Development Strategy**, to transform our workforce to meet the future challenges of health and social care provision, is included as a related document in Section 1c.

The Trust is working with commissioners to ensure that the cost associated with whole system change from hospital to community is well managed across providers and

commissioners. The Trust is involved in all integrated development initiatives together with the commissioners and the community trust so that risks and issues can be addressed at an early planning stage.



We have kept the Royal Berkshire NHS Foundation Trust fully engaged in our plans to reduced non elective admissions. This has been achieved through the sharing of our QIPP schemes and our 2 year Operational Plan as well as our 5 Year Strategic Plan. The Trust has reciprocated by discussing its own 5 year strategy so that we can gain alignment across the economy. Their commitment and understanding of our plans is evidenced in Annex 2. We have regular senior management meetings with our acute and community/mental health providers where these strategic issues are discussed and worked through.

Our BCF schemes are intended to transform the pattern of activity in Wokingham, reducing non elective admissions, delayed transfers of care and admissions into care placements. Extensive work has been done to model the impact of the schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by 2% in 2015/16 vs. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that the CCG is already in the top performers for non-elective admissions. We forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, these results in an expected net reduction of 2% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

The Risk Sharing Agreement set out in Section 5 states that the performance fund remaining for any non/reduced performance will be used to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector.

In addition to this there are a number of other metrics that the schemes will affect, which will impact on the income and activity of the acute providers, around key areas including

delayed transfers of care, reablement, and A&E attendances. In line with the in depth analysis that we have done to reach our non-elective reduction, we are now modelling the other impacts of all schemes, in granular detail in order to accurately model the impact on the acute sector. This is currently a work in progress, but we anticipate we will have this finalised with the acute sector in line with the business cycle. The 2014/15 impact has already been modelled into this year's contract, and we would expect through our contracting conversations for 2015/16. We would expect that where there is an indicated reduction in non-elective activity, we will be building these reductions into the RBH contract for next year, and we would expect that these would be reflected in their 2015/16 operating plan.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description (Wokingham)

Ref no.	Scheme
01	Health and Social Care Hub
02	Integrated Short Term Health and Social Care Team
03	Step Up/Step Down Beds
04	Domiciliary Plus
05	Hospital at Home Service
06	Enhanced Care and Nursing Home Support
07	Connected Care
08	Neighbourhood clusters, Primary prevention and Self-Care
09	Access to General Practice

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Scheme ref no.
Wokingham BCF 01
Scheme name
Integrated Health & Social Care Hub
What is the strategic objective of this scheme?
This Scheme aims to create an effective integrated single point of access for health and social care across West Berkshire, Reading and Wokingham by: • providing one centralised point of contact across the whole system for patients, service users and health/social care professionals, available 24/7; and, • developing a model that provides simplified processes, a consistent approach, equity of access to services, less bureaucracy and less duplication. This will allow the following objectives to be met: • Help fulfil our Vision of supporting people with more complex needs within the community • staff, patients and service users will be able to easily access, or be efficiently signposted to, the services and support, advice and information they require through just one call to one point of access • it will be easier for people to navigate the system anytime throughout a 24 hour / 7 day week and, along with other BCF schemes, will help to achieve a seamless and consistent patient and service user flow throughout the whole system • consistent referral criteria will assist active management of cases and help to prevent circumstances where a case is passed between services • working together, across organisational boundaries, hub staff will be better able to meet patient and service user's needs for support through an efficient and effective triage and referral system and improved communication which will assist in achieving improved outcomes • the creation of a more efficient system that provides the required support for patients and service users has the potential, in conjunction with other BCF schemes, to achieve better value for money through reduced duplication of services, reduced length of stay, reduced delayed discharges and reduced unnecessary admissions • patients and service users will report a better experience as their needs are responded to through more timely initial assessment and subsequent interventions so they receive the right service and high quality care safely and effectively from the right team in the right place at the right time. The Scheme will enable services to meet some of the population's needs as defined in our Needs Assessment and our Case for Change. Providing a 7 day service, it should contribute to addressing the challenges of discharge delays and access to service. The Scheme will also meet a number of the requirements of The Care Act and have the potential to meet some of the requirements of the NHS Constitution and The Health and Social Care Act 2012.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

There are currently multiple points of access to care across Berkshire West, all with different arrangements and resources, using different referral criteria for eligibility into specific services. Few of the existing points of access are available 24/7. This creates inconsistency, fragmentation and duplication which cause confusion, frustration and inefficiencies.

The current system does not necessarily meet the needs of patients, service users and staff. It does not provide a seamless pathway for patients and service users, who are often passed between services with the result that they might not receive the support they require at the right time.

The aim is to create a model of referral and assessment that moves from a fragmented set of health and social care services to a co-ordinated service based around people's needs, that is easily accessible through a single point. It will build on and integrate with the newly established Berkshire-wide Health Hub and on the "Berkshire 10" system wide approach to integration.

The Berkshire West Health Hub has recently been set up, hosted by **Berkshire Healthcare NHS Foundation Trust**, our local community and mental health provider. This has successfully reduced the 26 points of access for health care that existed previously down to just one, demonstrating that it is possible to integrate teams to improve communication across the three localities. The aim is to replicate this success into the new single point of access health and social care hub.

Detailed work is underway in consultation and engagement with all key stakeholders to scope out, plan and develop an integrated single point of access Health and Social Care Hub across Berkshire West. This will include mapping of existing patient flows with aim of improving efficiency and productivity.

It is likely that the development of an integrated health and social care hub will comprise a number of key elements which could include:

a) Bringing together all existing points of access for health and social care across the three localities in Berkshire West into a single integrated team with one single point of access (telephone or email). Such a service could, for example:
   - Be a first point of contact for all people (including health and social care professionals, patients/service users, their families, care home staff) for rapid triage into the appropriate service
   - Operate throughout the week providing a 7-day service, 24 hours a day
   - Ensure referrals are managed efficiently and effectively where the responsibility and accountability for case co-ordination and management of all referrals for health and social care services sits within one integrated team

b) The provision of resources within the hub to enable monitoring of 24 hour Technology Enhanced care and the provision of real-time advice as required, linking in closely with the Domiciliary Plus scheme (BCF 04) .

c) The provision of a single point of contact for providing information and support to both health and social care professionals and for patients / carers / members of the public. This could include assisting people to access self - care support, post

discharge support; information co-ordination (therefore linking in with the Neighbourhood Cluster schemes (BCF 08)); and navigation through the care system where this will add value and be complementary to, rather than duplicating, existing sources.

As part of the detailed scoping work, the Project Board will explore options relating to who will deliver the integrated health and social care hub and from where – e.g.: it could be incorporated into the existing health hub run by BHFT or into one of the existing points of access run by one of the local authorities

It is important to recognise that the development of an integrated single point of access health and social care hub will require a significant culture shift to achieve better collaboration, partnership working and integration, not only across local government and the local NHS at all levels but also across and between the three localities in Berkshire West. There will be a need for staff to embrace change and to focus on doing things differently and not just delivering more of the same (Appleby *et al* 2010).

This initiative will align with the frail elderly pathway and will be closely interrelated with a number of other proposed BCF schemes, for example:

- Connected Care (BCF 07): interoperability, including the electronic sharing of demographic information using the NHS number as the unique identifier, will significantly enhance the efficiency and effectiveness of the Hub,
- a 24/7 single point of access for health and social care will support the implementation of a number of other BCF projects across all three localities by providing an effective and timely resource for triage, provision of advice, information, support and signposting and so potentially reducing delay in the management of referrals.

It is proposed to target patients and services users most likely to benefit: i.e. those in high risk groups with complex health and social care needs and with multiple long term conditions with the intention of reducing the occurrence of additional health problems in this group and supporting them to achieve greater control and ability to manage their health and social care.

The volume of patients that will benefit from this Scheme is yet to be determined, as the detailed design of the integrated health and social care hub has not yet been agreed. However, it is anticipated that the 2% with high risk of unplanned admissions will be included. The baseline will be determined from the current activity through the health hub, each of the three councils and all other main points of entry into the system.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this Scheme will be designed, managed and controlled by a dedicated Integrated Health & Social Care Hub core steering group, reporting to the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board. The aim is to establish the Hub by June 2015; details regarding the anticipated "Hub" timelines are indicated on the GANTT chart in Section 5 of Part I.

A key part of the detailed planning will involve the key stakeholders, the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board agreeing the commissioner(s), budget, performance metrics and management structure for the Hub.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A lack of joined-up care has been described by **National Voices** as a huge frustration for patients, service users and carers. (National Voices 2011). Emerging evidence suggests that developing an integrated single point of access health and social care hub where services are co-located (either virtually or in reality) is more convenient for users, and has the potential to help enable more integrated and timely care (Imison *et al* 2008).

Reviews by **The King's Fund** and the **Nuffield Trust** of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

The **literature** confirms that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007) and that focusing on improving patient care helps to overcome professional boundaries for staff working in an integrated and collaborative structure (Heenan and Birrell, 2006). The provision of information and support for patients / carers / members of the public through a single point of contact will create better informed service users. Being informed is a prerequisite to being involved and engaged, and there is a growing consensus that more engaged patients experience better outcomes (Health Education England, 2014).

The establishment of a single point of access for health and social care in conjunction with other transformational improvement schemes is identified as being best practice, as demonstrated by **initiatives across the country**, e.g.: NHS North West London, Torbay & Southern Devon Care Trust, Dorset-area Partnership and Bridgewater Community Health NHS FT. However, many of these initiatives have yet to publish robust, evidence based evaluations of their impact. In addition, as most of the initiatives include a number of different improvement schemes, it is not yet possible to identify with certainty the unique impact of developing a single point of access health and social care hub.

Refs:

1. National Voices (2011) http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_20111021.pdf (retrieved 7-7-14)
2. Imison C, Naylor C, Maybin J (2008). *Under One Roof: Will polyclinics deliver integrated care?* London: The King's Fund.
3. Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011 - *Integrated care for patients and populations: Improving outcomes by working together* – a report to DH and NHS Future Forum from The King's Fund and Nuffield Trust: http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
4. Hofmarcher, Oxley and Rusticelli, 2007; Heenan and Birrell, 2006 - *Integration of health and social care - A review of literature and models - Implications for Scotland* (2010) Prepared for the RCN in Scotland by Hilary Robertson -

http://www.rcn.org.uk/__data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf
5. Health Education England Strategic Framework, (2014); http://hee.nhs.uk/wp-content/uploads/sites/321/2014/06/HEE_StrategicFramework15_final.pdf (retrieved 7-7-14)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total £200k, split pro rata between each of the three localities (Reading - £74k; Wokingham - £58k; West Berks - £68k).

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- the Hub will enable improvement through working in conjunction with other BCF schemes. Therefore it will be important to monitor, when the "Hub" goes live, did the impact of other schemes increase / by how much?
- existing points of access for health and social care will be reduced to just one and brought together to work around patient needs, rather than around organisational boundaries
- improved communication, transmission of information and data sharing within and between health and social care teams across all 3 localities
- faster response times which should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care (BCF Metric on Delayed Transfer of Care), although it is not possible to quantify a specific contribution
- a reduction in unnecessary admissions through efficiently mobilising short term community based services (BCF Metric on NEL admissions, although it is not possible to quantify a specific contribution)
- Reduction in admissions to care homes (BCF Metric; Benefits Plan Part II)
- co-ordinated management of cases with aligned referral criteria should prevent people from being lost between services
- contributing to enhancing patient and service user satisfaction as the difficulties and frustrations they experience in navigating a complex and un-coordinated health and social care system will be reduced if not removed entirely (BCF Metric on User Satisfaction, although it is not possible to quantify a specific contribution)
- a number of these potential outcomes could assist the acute hospital in achieving greater efficiencies through improved patient flows

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

During development of this Scheme, the Single Point of Access Health & Social Care Hub core steering group will undertake ongoing monitoring of progress. As part of implementation, the project board will determine the process for regular assessment, review and evaluation of the Hub.

It is likely to be agreed that providers working within the Integrated Health & Social Care Hub will be required to collect data around service utilisation and service user satisfaction; in particular from the perspective of whether the new model of service provision makes a difference to those on the receiving end and whether patients and service users report a better, more seamless, experience of care. A new survey for users and professionals has been drafted.

Project evaluation will involve both qualitative and quantitative evaluation to ensure that the Hub is operating effectively and is achieving its objectives. Key objectives will be agreed during development and will include delivering better customer experience for patients and service users and the Hub's contribution to the achievement of targets within the Better Care Fund metrics. Evaluation will be undertaken through analysis of data, e.g.; case notes audit and satisfaction surveys, and recorded on the project dashboard.

The findings from the reviews will be reported to The Health and Well Being Boards in all localities via the Berkshire West Partnership and also to the West of Berkshire Integration Programme Board.

What are the key success factors for implementation of this scheme?

The scoping, planning and development of an integrated single point of access health and social care hub will take place during 14/15 with the aim of having an agreed model of an integrated health and social care hub in place and operational by June 2015, although this might be in the form of a pilot across a smaller area initially, to ensure the success of the initiative prior to full roll-out.

Whatever the final design of the hub, there will be a need to:

- Achieve agreement, support and commitment for the Scheme from all key stakeholders, including agreement of project plan. This will include identifying risks and issues: any conflicting organisational priorities / different ways of working between the various organisations, any potential impact on the services required by other providers and any perceptions of professional boundaries that may hinder the project and agree action to address these
- Facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and patient-centred care
- Agree where/how the Hub is to be established, be that in a virtual or actual location
- Ensure that effective IT systems are in place to support delivery of care via the Hub and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on the development of the Hub
- Ensure appropriate governance processes are in place relevant to the integrated health & social care hub
- Ensure availability of staff in sufficient numbers with the right skills to provide adequate staffing for the hub in response to anticipated number of contacts, with staff resourcing often a challenge in the Berkshire West economy (link to Part I Section 5a Workforce Risk)
- Anticipate and address any impact that increasing the number of patients/service users accessing community support in their normal place of residence might have on the services required from other providers (i.e. – BHFT; independent domiciliary care providers, etc.)
- Provide the required education and training to equip the existing and future workforce for this new model of care.

Scheme ref no.
Wokingham BCF02
Scheme name
Short -Term Integrated Team
What is the strategic objective of this scheme?
The Scheme 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. The strategic objective will be to avoid unnecessary hospital admissions, prevent delayed transfers of care and reduce permanent admissions to residential and nursing care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme brings together the existing **START** (short-term assessment and reablement team provided by Wokingham Borough Council's Trading Company, Optalis) with **Intermediate Care** (Berkshire Healthcare NHS Foundation Trust) and the Council's **Health Liaison** team into a single short-term intervention team. The Scheme will be managed in two phases. Phase 1 will focus on achieving co-location and shared care pathways; phase 2 will work towards shared management arrangements and pooled budgets, by April 2016. This Scheme also includes the delivery and management of the Step Up/Step Down Beds (BCF 03) and Domiciliary Plus (BCF 04) as part of the short-term service to provide comprehensive residential reablement services to facilitate timely discharge from hospital and avoid unnecessary admissions. 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 objectives are: 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 modelling 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.
- Increase the number of patients and customers receiving no further intervention after reablement.
- Prevent admissions through a number of changes to how care is delivered in the short-term through the use of step down and overnight care 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.
- Deliver and manage a short-term residential therapeutic or assessment facility. This will 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.
- Provide a speedy response to referrals from the Hospital at Home Scheme (BCF05)

3. To develop and implement a shared assessment process

The service specification brings together NHS domiciliary rehabilitation, specialist rehabilitation and adult social care linked services under one single person-centred, outcome based pathway. The service is jointly commissioned by the council and the CCG.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence which informed the design of the Scheme has been heavily based upon learning from **user experience**, as well as the views of front line managers and staff. Real life case studies illustrating the problems caused by fragmentation of service delivery were used to clarify the challenges and inform the proposed solutions. The Scheme has been designed with the full involvement of the teams based on their day to day experience and motivated by their belief that more integrated working would make a positive difference to patient/user experience and outcomes.

Of course integrated care is not new and we have drawn on models and research from elsewhere in the country including Torbay and Northampton. A **King's Fund/Nuffield Trust** report (The Evidence Base for Integrated Care, Goodwin & Smith, 2011) has formed the basis for our approach and included the following messages:

- Integrated care is best understood as a strategy for improving patient care
- The service user is the organising principle of integrated care
- One form of integrated care does not fit all
- Organisational integration is neither necessary nor always sufficient; virtual or contractual integration can deliver many benefits
- Start by integrating from the bottom up
- Develop a systemic framework that aligns incentives so integrated care locally can be enabled, supported and driven

- Use a range of tools to support integrated care
- Undertake evaluation and build in quality improvement – it is only possible to improve what you measure
- Better care experiences, improved care outcomes, delivered more cost effectively are the keys by which integrated care should be judged

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Investment:
A total of £300k investment will be required in 15/16, with an additional contribution from Wokingham Borough Council of £900k for the staffing costs for social care. The investment of £200k will cover the costs of co-location of the three teams (£70k) as well as additional funds for progressing phase 2 of the scheme: developing shared management and Section 75 arrangements (£50k); staff training and development (£30k); development of shared process (£10k) and IT connectivity/equipment (£40k).
Expected impact on supporting Hospital at Home for Domiciliary Care.
Impact:

- A streamlined service should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care (BCF Metric on Delayed Transfer of Care), although it is not possible to quantify a specific contribution
- A reduction in unnecessary admissions through efficiently mobilising short term community based services (BCF Metric on NEL admissions), although it is not possible to quantify a specific contribution
- Reduction in admissions to care homes (BCF Metric; Benefits Plan Part II)
- More people using reablement and more effective outcomes from reablement (BCF and local metrics on reablement, although it is not possible to quantify a specific contribution)
- User satisfaction (BCF local metric, although it is not possible to quantify a specific contribution)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Use of data from the Alamac Kitbag on the 'Fit List' which will include numbers and length of stay
- User satisfaction feedback through a bespoke questionnaire
- Complaints and commendations from those using the service
- The metrics will be monitored via the dashboard at the Wokingham Integration Strategic Partnership

What are the key success factors for implementation of this scheme?

Deliverables in the second phase of the scheme includes a single shared budget; a shared management structure and shared performance metrics. To achieve this aim the following success factors will apply:

- Achieve agreement, support and commitment to shared management arrangements and pooled budgets from all key stakeholders.
- Identifying any conflicting organisational priorities / different ways of working between the various organisations and any perceptions of professional boundaries that may hinder delivery and agree action to address these
- Continue to foster a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and patient-centred care
- Ensure that effective IT systems are in place to support delivery of care and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on an integrated approach to better outcomes for individuals.

Scheme ref no.
Wokingham BCF 03
Scheme name
Step Up/Step Down beds
What is the strategic objective of this scheme?
A Step Up/Step Down facility will deliver a comprehensive re-ablement service including social care as well as an ongoing assessment service of someone's needs prior to them returning home. According to their needs residents will have a choice of service, step-up to support to prevent and unnecessary hospital or care home admission or step-down to support on discharge from hospital. The outcomes over time across health and social care systems will be to encourage residents to manage their own long-term condition in their own home. The service will contribute to the achievement of targets in relation to reduction of delayed discharges and overnight hospital admissions and reductions in admissions to nursing and residential care. It will particularly target patients with complex needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Step Up/Step Down scheme will aim to provide an appropriate environment for people who are experiencing a sudden and severe change in need requiring a period of more intensive support **(Step Up)** or for those who are on the 'Fit to Go' list and ready to be discharged from hospital but are not ready to return to their former home or level of independence **(Step Down)**. The scheme will provide short-term accommodation in the form of specially adapted flats/units within an existing extra care housing scheme where staff will be on hand 24 hours a day. Care will be provided with an emphasis on supporting the individual to return home when safe to do so or where such a return is not possible to have time to consider future care options. The scheme will be managed and co-ordinated by the Short-Term Integrated Team (BCF02).
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioning The service will be commissioned by Wokingham Borough Council Adult Social Services with input from relevant health commissioners. **Delivery Options** In relation to the residential element it is proposed that this starts initially with two designated units within Alexandra Place an existing extra care housing scheme with the intention to extend this to six over the next year. Additional support staff will be employed to provide enhanced cover where this is required.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence shows that admissions to the Royal Berkshire Hospital are increasing

significantly, particularly for those over 75 years of age and that the length of stay for this age group is much greater than for any other cohort of patients. Those with the longest length of stay are people who are waiting for a residential placement, rather than returning to their own home. Although the local strategy is to support people to live independently and to increase the availability of Extra Care Housing, the Council has seen a significant increase in the number of residential and nursing home placements made in the borough.

The hospital environment can be difficult, particularly for those with dementia, and this can have an impact on the assessment process and outcomes, with the likelihood of more intensive onward care solutions being higher than if the person was in calmer environment.

Once a placement is identified the current pattern of discharge is only between Mondays and Thursdays as care homes are reluctant to receive a resident directly from the hospital over the weekend. It is anticipated that the Step Up/Step Down scheme will also help to address this issue.

The Step Down option will aim to provide an appropriate environment for people who are on the 'Fit to Go' list and ready to be discharged from hospital but are not ready to return to their former home or level of independence. They may require a period of intensive short term care and therapy in order to move to being supported independently on a longer term basis.

The Step Up option will be available for people who are experiencing a sudden and severe change in need, and who need a period of intensive support and rehabilitation, in order to avoid the need for a hospital admission or permanent placement in a residential or nursing home.

Assessments for longer term support needs will be part of the care process.

There are similar models operating elsewhere in the country where evidence demonstrates that a period of residential rehabilitation and assessment will more often result in the person returning to their own home or moving to a sheltered housing scheme.

In designing this pathway, the Kings Fund research into good integration following **'Sam's Story'** is being used to ensure best practice in service design and delivery. The work has also drawn on the SCIE research: Maximising the potential of reablement, London: SCIE 2013. A Department of Health funded review showed that reablement is almost certainly cost-effective and improves outcomes for users. (www.york.ac.uk/inst/spru/pubs/rworks/2011-01 Jan.pdf)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Residential Element

Funding

£60k is available from the Call to Action Plan for 2014/15

Funding allocation for 2015/16 is estimated as £247K per annum

Costs
Basic accommodation costs - £149.53 per week per flat x 2 = £299.06 per week.
Annual costs = **£15,551** per annum.

Current units are unfurnished but white goods are included. Initial furnishing costs estimate **£5K** one–off with a further **£1K** per annum.

Support Staffing costs, the service will be supported by the integrated short term service who will visit from a central location. If enhanced day or night support is needed this can be commissioned from the current care provider (Optalis), additional day staff (paid at slightly enhanced rate to reflect their re-ablement skills and focus) will also be required.

The estimated cost of additional staff is £35K per staff member per annum.

Accordingly the first year costs would be as follows assuming 1 additional staff member for each 4 units:

Units	Equipment	Accommodation	Additional Staff	Total
2	£12,000	£31,102	£17,500	£60,602
4	£24,000	£62,204	£35,000	£121,204
6	£36,000	£93,306	£52,500	£181,806
8	£48,000	£124,408	£75,000	£247,408

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme will aim to support 120 plus people throughout the year, based on an average of a 3 week stay and allowing for sufficient time between placements to refurbish/prepare the units as needed. It should:

- Expedite discharge by facilitating the co-ordination of timely support and care (BCF Metric on Delayed Transfer of Care, although it is not possible to quantify a specific contribution)
- Reduce overnight hospital admissions (BCF Metric on NEL admissions, although it is not possible to quantify a specific contribution)
- Reduce admissions to care homes (BCF Metric; Benefits Plan Part II)
- User satisfaction (BCF local metric, although it is not possible to quantify a specific contribution)

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Use of data from the Alamac Kitbag on the Fit List which will include numbers and length of stay. This data is compiled by each partner in the health and social care system and is produced by the Royal Berkshire NHS Foundation Trust and circulated to partner agencies on a daily basis.
- User satisfaction feedback.

• Metrics outlined under scheme impact.
What are the key success factors for implementation of this scheme?
• A clear understanding of the Scheme's strategic objective across health and social care, to ensure optimum and appropriate use of the facility • Patient/family confidence • Competent, well-trained staff that are able to deliver reablement. • Shared vision and confidence from staff across the health and social care system • Dedicated social work support to provide advice and guidance to enable timely planning and discharge to the appropriate facility • Implementation of a trusted assessment process to enable timely decisions and discharges from the Step Up/Step Down Scheme.

Scheme ref no.
Wokingham BCF 04
Scheme name
Domiciliary Plus
What is the strategic objective of this scheme?
The service will contribute to the achievement of targets in relation to reduction of delayed discharges and overnight hospital admissions and reductions in admissions to nursing and residential care. The scheme will provide options for short term overnight care, support or supervision with use of assistive technology as well as scheduled visits, so that people who might otherwise need to be admitted to a residential service can be cared for at home.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service provides options where a person has care needs that require 24 hour support but where these can be met outside of a hospital or residential/nursing home setting. For people who can be safely supported at home with appropriate care, the service will offer a short term 24 hour support service until a longer term home support service can be put in place. The service will be able to provide a high level of care as well as low level support during this period. A key success factor will be the ability and capacity to respond at very short notice short notice to referrals. The service will work in conjunction with the night care service currently provided as part of Intermediate Care Services as well as other provision such as the Carers Emergency Support Service. A key part of the scheme is to roll out telecare provision to all older people with a focus initially on those over 85.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioning The service will be commissioned by Wokingham Borough Council Adult Social Services with input from relevant health commissioners. **Delivery Options** In relation to the support at home element as a minimum, for the service to achieve its aims there will need to be able address a range of potential care needs including the following elements:

- A rapid response service for emergency support. This will need to be on-call and able to respond within 15-30 minutes.
- A carer to 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.
- A carer to stay throughout the night when required. It is proposed that 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 cares for the individual.
- Creative commissioning and deployment of assistive technology **as a free universal service** to those most at risk of hospital or residential admission (e.g. people aged over 85 and for a limited period (up to 6 weeks) for those with short term needs.

Subject to the nature of the care required the service would be delivered through extending the capacity of the current night care and night nursing services, with additional providers being added to the current list.

It is essential that the integrated short term team will co-ordinate the deployment of the services to prevent duplication and that the correct service is deployed to meet the service users' needs.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

As part of the consultation on the local BCF plan, **staff** from across local health and social care services were asked to highlight areas from their practice which they believed to be current gaps in the aim to provide a whole week, whole system response.

Support through the night at home for people requiring 24/7 care was identified as an area which was currently underdeveloped. Staff were clear that if more options were available, this would help reduce the numbers of permanent admissions for residential care and may also prevent unnecessary admissions to hospital.

As described above, the proposed model will aim to provide more capacity for scheduled visits where needed, but also to expand the availability of technology enhanced support as a free universal offer to people over the age of 85. This will be developed through learning from national good practice examples.

For example, an evaluation of the experience of 195 service users of the Telecareline scheme at **Hillingdon** Council has found that in 48% of cases, telecare delayed the need for further services. A further 42% resulted in smaller homecare packages and in 10% of cases a delay in residential care placements occurred. Admissions of older people to residential placements have halved.

An impact overview of telecare services by the **LGA** states that it has the potential to provide a return on investment of 15:1.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The total allocation to the Domiciliary Plus scheme is £528k in 15/16. This will cover the costs of staff for scheduled visits ((£78k) and the expansion of telecare (£450k).

Night care staffing costs:
Home care services can be purchased for between £16 and £20 per hour (waking nights) and sleeping nights can be between £60 and £75 per night.

The following can be used as some indication of possible costs of services.

Waking nights

Up to 5 individuals supported each night for 200 nights per year (approx.1000 waking nights) would cost £60,000- 75,000 per year (£60-£75 per night). This is equivalent to 2.75 full time individuals being supported each night.

Home Visits

Up to 5 individuals supported each night with 3 30 minute calls for 300 nights per year would equal 2250 hours per year (1.5 x 5x 300) at a total cost of £45,000 per year (@£20 per hour) This is equivalent to 4.0 full time individuals being supported each night.

Wokingham's projected older people population for 2014, 2015 and 2016 are as follows

Age Range	2014	2015	2016
People aged 65-69	8,700	8,800	8,700
People aged 70-74	6,300	6,600	7,000
People aged 75-79	5,100	5,200	5,200
People aged 80-84	3,700	3,800	4,000
People aged 85-89	2,100	2,200	2,500
People aged 90 and over	1,300	1,400	1,500
Total pop aged 65 and over	27,200	28,000	28,900
Total pop aged 75 and over	12,200	12,600	13,200
Total pop aged 85 and over	3,400	3,600	4,000

Two levels of Telecare are envisaged. A basic provision including alarms and bed sensors at approx. £200 per person and an enhanced provision including door/entry/exit sensors at approx. £650.

Costs include provision of a responder service with on call professional carers.

£450k would therefore provide up to 2250 basic installations or 700 enhanced installations; in reality it will be a mix of the two provisions.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in admissions to care homes (BCF Metric; Benefits Plan Part II)
- Expedite discharge by facilitating the co-ordination of timely support and care (BCF Metric on Delayed Transfer of Care, although it is not possible to quantify a specific contribution)
- Reduce overnight hospital admissions (BCF Metric on NEL admissions, although it is not possible to quantify a specific contribution)
- User satisfaction (BCF local metric, although it is not possible to quantify a specific contribution)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- User satisfaction feedback
- Metrics outlined under scheme impact

What are the key success factors for implementation of this scheme?

- A clear understanding of the scheme's strategic objective across health and social care, to ensure optimum and appropriate use of the facility
- Patient/family confidence
- Competent well trained staff who are able to deliver reablement and apply optimum and appropriate use of assistive technology
- Shared vision and confidence from staff across the health and social care system
- Dedicated social work support to provide advice and guidance to enable timely referrals to appropriate longer term support.

Scheme ref no.

Wokingham BCF 05

Scheme name

Hospital at Home

What is the strategic objective of this scheme?

Hospital at Home will engage with three unitary authorities, one community services provider, one secondary care trust and an ambulance trust in the provision of care for acutely ill patients in their own home. The service will reduce non-elective admissions into the Acute Trust, and it is expected to improve the overall patient experience, being treated within the community, at home.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The service is being provided by **Berkshire Healthcare NHS Foundation Trust** (BHFT), a Community Services Provider, whose service model will change to include acutely-ill patients. Patients attending Royal Berkshire Emergency Department, that meet the inclusion criteria and are considered suitable for Hospital at Home will receive full diagnostics and treatment in Royal Berkshire NHS Foundation Trust (RBFT) and then will be transported home by South Central Ambulance Services, to be met at the home by the Matron from BHFT.

Daily virtual ward rounds including social services, BHFT medical team, and the clinicians responsible for the well-being of the patient will take place. Visits to the patient home will occur as necessary, and it is expected that there will be multiple visits per day. Social Services will support the patient where applicable.

This service is available to patients registered with a Berkshire West GP, are 18 years and older, and who require hospitalisation. Patients not suitable for Hospital at home are:

- Out-of-area patients
- Patients requiring two or more assistants
- Hemodynamically unstable
- Acute Stroke
- Unfavourable home circumstances as reported by relatives, social care team or ambulance crew
- Extreme electrolyte disturbance

Diagnosis Types that are included in the Hospital at Home Scheme (this list is not exhaustive):

- Acute infections e.g.
  - Cellulitis
  - ENT
  - Pyelonephritis/UTI
  - Pneumonia/influenza
- Chronic Obstructive Pulmonary disease
- Dehydration and gastroenteritis
- Decomposition of LTC
- Sliding scale Insulin
- Acute Pain with identified cause
- Acute exacerbation of inflammatory disease
- Dehydration (if clinically appropriate)

• Delirium
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Wokingham CCG is leading the commissioning of this service. RBFT is the secondary trust provider that will be identifying, diagnosing and treating the patient initially, before admitting the patient into the ward at home. BHFT is the provider of all clinical and medical staff that will support the patient during their admission, through to discharge, where BHFT re-ablement team will possibly be engaged, where necessary. Throughout, social care packages may be in place, and additional support may be provided where necessary.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
There is evidence to show that admissions to hospital are rising due to the increased age profile in Berkshire West and there is also an expected increase in long term conditions that will have an impact on services. Outlined below are relevant facts relating to the Wokingham local authority area. • Younger than the national and regional population, older than the Berkshire West average; • Population predicted to age over the next ten years faster than the national rate of increase; • Significant younger person population - 25% of the population aged less than 20 • Health issues include child health (obesity); unhealthy behaviours in young people (smoking, alcohol abuse, physical activity); older people's health; vulnerable groups (people with learning difficulties and disabilities); • Increasing rates of cardiovascular conditions such as heart disease, diabetes and stroke; • Prevalence of depression higher than the national, regional, and Berkshire West averages; • Wokingham has higher rates of A&E attendance than Berkshire West average. DSR = 25,136 per 100,000. Average of 14,250 attendances per year; • Wokingham significantly less likely to be admitted than Berkshire West average. DSR = 5,579 per 100,000. Average of 4,800 emergency admissions per year; • Wokingham based on DSR, less likely than Berkshire West average to be admitted as an emergency for any of the listed conditions: COPD; stroke; myocardial infarction; fractured neck of femur; all respiratory; diabetes; asthma; • Wokingham has a higher number of people admitted as emergencies for falls, if data are not standardised; • Wokingham admissions significantly lower than the national average (ISR). 1,225 admissions for chronic ACS conditions for people registered at GP Practices. ISR 994 per 100,000; • People aged over 75yrs: Average LoS = 12 days; • Dementia: Average LoS = 17 days; • Psychosis: Average LoS = 38 days (NHS BW average of 79 days; national average 100 days); • Wokingham is significantly less likely to be an elective inpatient compared with

the Berkshire West average. 24,424 elective hospital admissions per year. DSR = 12,216 per 100,000.

Hospital at Home will provide an alternative to an acute admission, by keeping the patient in the community, and providing Acute-level treatment.

Providing independence and supporting older people to manage their long term conditions: Older People stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.

The numbers of people requiring adult social care including services delivered in the community, and requiring residential or nursing home care in Berkshire West is predicted to increase at a more dramatic rate than the national increase.

A&E attendances at RBFT increased by 21% between quarter two of 2011/12 and quarter two of 2012/13. In the final five months of the period being reviewed the number of attendances was consistently higher than at any other time. Across the 18 month period between April 2011 and September 2012 there was a 20% increase in A&E attendances by Berkshire West residents (5,000 individuals rising to 6,000). All age groups have seen an increase in activity across the period, however the biggest increase in activity was seen in the 45 to 69 year age bracket where activity has increased by 36%. Wokingham-level data is set out in Case for Change, Part I Section 3.

To improve health and wellbeing, health and social care services need to work together to be effective enough to support people and their carers. By reducing barriers to increased levels of physical activity, mental wellbeing and social engagements particularly among excluded groups of older people, older people will experience a better quality of life.

Coordination of Social Services and Community: The Hospital at Home Service will be coordinated, both proactively and reactively, providing clear and integrated pathways of care. This means that for those patients that are already known to clinicians within Social Services and the community and are already receiving continuous care, would benefit from contacting a single point of access to the Hospital at Home Service when experiencing a crisis.

This change program would be mainly utilising current resources in a more integrated way (although investment in new staff will be inevitable). This would also mean utilising and linking in with specialist nurses and therapists, COPD, Community Nurse, etc. and case managers/care cordinators to provide a patient-centric model of delivery, not disease specific.

Why use Hospital at Home: The likelihood is that, even though RBFT will be using the Hospital at Home pathway as the default assessment protocol for Hospital at Home patients, they may not refer sufficient patients to the Hospital at Home service due to the following reasons:

- All staff at all times will not be aware of the pathway due to staff turnover;

- Some staff will be more risk averse and admit relevant patients to an acute ward;
- GPs will not always remember to highlight the patient as a potential H@H patient;
- Some patients will remain in the Hospital at Home service due to discharge challenges and block beds;
- SCAS will not always tick the Hospital at Home box; and
- Various other clinical and operational reasons.

Due to these reasons we have applied a 50% reduction in admissions which accounts for around 2,300 patients and with the additional issues that may arise, the monitoring, performance management and reporting of the service in the first few months will require a high degree of accuracy, as it will drive the direction and future modelling of the service. This is due to the lack of true reference sites and analytical data available from other models, across the UK and other parts of the world.

We need to recognise that this model is new and relies on all key stakeholders working effectively and efficiently together, with transparency and no-blame culture underpinning the provision.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Overall investment of £2,189,220 across Berkshire West, with £639k from Wokingham CCG.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduce non elective admissions by 648 (contributes to BCF Pay for Performance Metric; Benefits Plan Part II)
- Provide Intensive health support at home to those at highest clinical risk
- Provision of community based step up and step down facilitates between Hospital at Home Services and Integrated local teams (BCF Metric on Delayed Transfer of Care, although it is not possible to quantify a specific contribution)
- Reduced Length of Stay
- Measured increase in patient satisfaction: higher than 90% 'Family member or friend' test
- Successful discharge to Integrated community teams
- Assist integration, productivity & responsiveness of community services
- Provide a safe place for patients to get well.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurable for reporting actual benefits. Several of the KPIs that are designed are to record efficiencies in the service, with the view to identifying opportunities for service improvement. Monthly and Quarterly submissions to the Project Board as well as the Contracts board will ensure that KPIs are constantly monitored for opportunities to improve the service.

What are the key success factors for implementation of this scheme?

- Achieve agreement, support and commitment for the Scheme from all key stakeholders: an agreed project plan addressed d risks and issues, possible conflicting organisational priorities / different ways of working, potential impact on the services required by other providers, and perceptions of professional boundaries
- Ensuring specialist services available: has been capacity planning to understand where and when the greatest need is required
- The ability to share the patient record: Adastra is being used pending Connected Care
- Recruiting the right skills and competencies to resource service model: a phased approach has been taken using a soft launch to introduce the new pathway for a limited number of patients (link to Part I Section 5a Workforce Risk)

Scheme ref no.
Wokingham BCF 06
Scheme name
Enhanced Care and Nursing Home Support
What is the strategic objective of this scheme?
Our Care Home project is a Berkshire West wide project which aim to reduce non-elective admissions through: • Introducing a GP enabled Community Enhanced Service to promote Supportive Care Planning • Fund additional Nurse trainers to Care Homes across Berkshire West As the population ages, GPs and NHS providers face an increasingly difficult task managing the complex needs of care home residents at a time of increasing pressure through the system. The project aims to reduce emergency admissions, and in doing so improve the lives of those residing in care home establishments.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are two elements of the scheme: A GP-enabled **Community Enhanced Service** (CES) has been developed is to enhance the quality of medical cover for all residents of registered Care Homes in Berkshire West (excluding Care Homes for Learning Disability) over 18 years of age by: • Delivering pro-active health care based on regular visits and contacts with care homes to reduce further disability and reduce crisis management. • Providing high quality care in the care home setting, and improve communication between those involved in providing care and those receiving it. This will enable greater working in partnership with the care home providers, the community geriatricians, NHS staff, commissioners, the Commission for Social Care Inspection and the Care Quality Commission. • Improving the quality of service to patients in the form of a comprehensive and formalised assessment and formation of an individual Supportive Care Plan (SCP) for each resident, which includes the clinical management and monitoring. • Medication with support of Community Pharmacist. • Appropriate referral to secondary care, Hospital at Home and out of hours. • Where appropriate, choices about end of life plan following discussions with resident, carers and home staff. • Signposting and referral to appropriate community based alternatives to acute hospital care. • Ensuring equality of care across West Berkshire, via the use of a standardised Supportive Care Plan. • Increasing the quality and coordination of care given to patients, by improved organisation and planning. • Avoiding unnecessary emergency admissions and A&E attendances. • Reducing the incidence of falls by appropriate prescribing of medication and referral to Therapy Services.

- Reducing the impact of falls by appropriate identification and treatment of osteoporosis.
- Regular contacts and visits by GP'S 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.
- Prescribing interventions should maximise clinical benefit and minimise the potential for medicines related problems.
- Supporting the Nurse Education Teams to deliver a consistent message of education and awareness to care home staff.

Training and support to Care home staff. This focuses on education, awareness and staff management. Currently Royal Berkshire NHS Foundation Trust (RBHT) receive a high number of referrals from nursing homes and wards which can often turn out to be either inappropriate or avoided if knowledge of how to manage long term conditions was improved. The proposal is to:

- To enhance the current mental health training programme to nursing homes and wards by increasing general health training, symptom recognition, etc.
- To identify key workers in homes and wards to be trained up to be the 'go to' for dysphagia and other symptoms, this person would be then able to refer to SLT more appropriately.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Berkshire West CCGs will commission this enhanced service from local GP Practices. The key stakeholders are:

- GPs
- Nurses
- Berkshire Healthcare NHS Foundation Trust community nursing teams
- Care Homes
- Patients and their carers
- Pharmacists
- Unitary authorities

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In Wokingham there are 32 homes, with a total of 1539; average number of beds is 48 and the range is 3-192 beds. In 2013/14 there were 387 non-elective admissions for care home residents costing £1.2m. The admission incidence for shows little fluctuation between care homes, but highlights a number of care homes with a higher incidence of short and long stays
There are a significant number of care homes whose patients are admitted to hospital and die within 0 days of admission. There are several reasons why this may be occurring and further work needs to be done to highlight with the care home the options around end of life care including advanced care planning for end of life care.

The enhanced service aims to define the more specialised general medical services that need to be provided to residents in Care Homes. Evidence shows that:

- Residents in Care Homes have multiple complex medical needs.

- 80% of residents within care homes with nursing will have mental health needs such as dementia, depression or a long term mental health diagnosis.
- Residents in care homes have higher needs than other patients for essential medical cover because their medical needs are complex and rapidly changeable. Most will also find it difficult to attend their GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions.
- The range, type, quality and consistency of overall care can vary widely between the individual care homes.

In 2008 **Sheffield** PCT reported[1] that 'medical cover to care homes is haphazard, evident in a rising and variable rate of emergency admissions that is unacceptable'. In 2005, for example, Sheffield admissions rose by 30% and after a 2006 drop, peaked at 2,270 in 2007. A 2004 local bed usage survey showed 40% of these were for long term condition exacerbations and 25% of admissions from care homes were 'avoidable'. Analysis of non-elective admissions data showed a nearly ten-fold difference in admission rates between homes. If the level of savings evidenced in Sheffield is extrapolated to apply to the Berkshire West population the overall cost of secondary care admissions from Care Homes could be reduced by approximately £941,500.

The role of care and nursing homes was also identified as 'likely to increase in the future.' The number of people aged 80 or over is projected to rise by over 80% in **Yorkshire and the Humber** between 2005 and 2030.

The **Cornwall and Isles of Scilly** PCT project[2] to train nursing home staff resulted in:

- Reduction in falls and injuries;
- Reduction of hospital admissions by 50%; and
- Prescription savings of £100 per patient per year.

In **Walsall** 2011[3], no reference for this one below "90% of cases where a clinical indication for the admission from a care home was recorded, chest infection accounted for 31% of cases, a fall in 30% and urinary tract infection in 28% of the cases. A proportion of the chest infections were likely to have been acute exacerbations of chronic lung disease which are potentially amenable to diagnosis and treatment at an early stage by close monitoring of residents with known lung disease. Urinary tract infections are also potentially amenable to diagnosis and treatment at an early stage by close monitoring. Falls are potentially preventable".

Investment requirements

[1] Sheffield - Integrated care and supporting care homes, BGS March 2012
[2] Improving the Quality of Dementia Care, HSJ October 2012
[3] Nursing Homes in Walsall, Improving care for elderly people, December 2011

Costs	Year 1	Year 2	Year 3	Comments
GP CES	£	£	£	
Cost per new pt assessment	384,000	123,600	123,600	The CES will involve a review of all existing patients twice every year, and a full assessment of every new patient and existing patient (in year 1) within the 48 care homes, both nursing and non-nursing
Cost of annual pt review	96,000	130,200	130,200	
Total CES cost	**480,000**	**253,800**	**253,800**	
Enhanced Training	£	£	£	
Cost of each Band 7 nurse	49,886	99,772.68	149,659.02	
Non-pay costs	3,030	6,059.00	9,088.50	Enhancement of the exisitng Care Home training team to focus on health and LTC management of crisis. This will be phased starting with one locality initially.
Contribution @15%	5,901	11,802.50	17,703.75	
Total Cost of Training Resource	**58,817**	**117,634**	**176,451**	
	1 nurse	2 nurses	3 nurses	
Dysphagia Training (SALT)	£	£	£	
Cost of each Band 6 Therapist	42,472	42,472	42,472	
Non-pay costs	3,030	3,030	3,030	Enhancement of the exisitng Care Home training team to focus on dysphagia, using a senior speech and language therapist, across the 3 localities.
Contribution @15%	5,901	5,901	5,901	
Total Cost of SALT Resource	**51,403**	**51,403**	**51,403**	
Enhanced Community Pharmacy	£	£	£	
Cost of a Band 8a Pharmacist	57,918	57,918	57,918	
Non-pay costs	9,648	9,648	9,648	The new wte Pharmacist will support Estelle to undertake medicine reviews with patients and provide training to care home staff on medicines management.
Contribution @ 15%	10,135	10,135	10,135	
Total Cost of CP Resource	**77,701**	**77,701**	**77,701**	
Implementation				
CSU Project Management (30 days)	17,400	-	-	Dedicated project management is essential to ensuring key stakeholders are engaged and milestones achieved.
Total Cost of Implementation	**17,400**			
Full Cost Total (phased approach)	**685,321**	**500,538**	**559,355**	
with only one Training nurse	*685,321*	*441,721*	*441,721*	
without implementation	*667,921*	*441,721*	*441,721*	
Realistic Net Savings	**520,870**	**810,272**	**856,074**	

Wokingham CCG will be investing £145k.

Savings to be gained from training care home staff have been excluded as this work has already started.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

For 2014/16, the aim is to reduce the number of non-elective admissions by 196 (Benefits Plan Part II). Other impacts include:

- Contribute to ensuring that people are not admitted unless necessary, having a positive impact on discharge performance (BCF Metric Delayed Transfers of Care), although it is not possible to quantify a specific contribution
- Better trained workforce in nursing homes and wards leading to improved care for residents.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Indicator/Outcome	Baseline (Current Value)	Target Value	How Measured?	Frequency of Measurement
Number of patients assessed by GP by CH within 4 weeks of admission to CH	10%	< 80%	Adastra System	Monthly
Number of patients assessed by GP by CH within 8 weeks of admission to CH	50%	100%	Adastra System	Monthly
Number of staff trained by Nurses by CH within 6 months	10%	< 50%	BHFT Training Records	Monthly
Number of staff trained by Nurses by CH within 12 months	10%	< 95%	BHFT Training Records	Monthly
Number of dysphagia training sessions provided by CH in 12 months	0	48	BHFT Training Records	Monthly
Number of CH staff trained by Pharmacist by CH in 12 months	50%	< 95%	Pharma Training Records	Monthly
Number of patients reviewed by pharmacist by CH	50%	100%	Service Record	Monthly
Number of patients reviewed by GP by CH within 6 months of commencement	10%	< 50%	Adastra System	Monthly
Number of patients reviewed by GP by CH within 9 months of commencement	10%	100%	Adastra System	Monthly

The summary below shows Activity & Finances of CES implementation for NEL in Q1 2014.

		Activity			Finance		
	Data Set	M01	M02	M03	M01	M02	M03
Newbury	2013-14 Actual	8	12	14	£31,091	£36,097	£50,812
	2014-15 Actual	18	13	12	£37,950	£40,033	£34,800
	2014-15 Plan	5	7	8	£17,744	£20,601	£28,999
	Variation 2013-14	10	1	-2	£ 6,859	£ 3,936	-£16,012
	Variation 2013-14 %	125.0%	8.3%	-14.3%	22.1%	10.9%	-31.5%
	Variation Target	13	6	4	£20,206	£19,432	£ 5,801
	Variation Target %	294.2%	89.8%	50.2%	113.9%	94.3%	20.0%
	RAG	1	1	1	1	1	1
North & West Reading	2013-14 Actual	19	18	16	£82,812	£64,164	£42,942
	2014-15 Actual	14	19	13	£35,793	£58,120	£33,017
	2014-15 Plan	11	10	9	£47,262	£36,619	£24,508
	Variation 2013-14	-5	1	-3	-£47,019	-£ 6,044	-£ 9,925
	Variation 2013-14 %	-26.3%	5.6%	-18.8%	-56.8%	-9.4%	-23.1%
	Variation Target	3	9	4	-£11,469	£21,501	£ 8,509
	Variation Target %	29.1%	85.0%	42.4%	-24.3%	58.7%	34.7%
	RAG	1	1	1	5	1	1

		Activity			Finance		
	Data Set	M01	M02	M03	M01	M02	M03
South Reading	2013-14 Actual	7	11	12	£24,221	£34,298	£37,452
	2014-15 Actual	14	20	8	£38,745	£64,981	£35,055
	2014-15 Plan	4	6	7	£13,823	£19,574	£21,374
	Variation 2013-14	7	9	-4	£14,524	£30,683	-£ 2,397
	Variation 2013-14 %	100.0%	81.8%	-33.3%	60.0%	89.5%	-6.4%
	Variation Target	10	14	1	£24,922	£45,407	£13,681
	Variation Target %	250.4%	218.6%	16.8%	180.3%	232.0%	64.0%
	RAG	1	1	1	1	1	1
Wokingham	2013-14 Actual	27	24	24	£89,603	£75,934	£82,184
	2014-15 Actual	39	29	39	£98,492	£91,336	£88,635
	2014-15 Plan	15	14	14	£51,138	£43,337	£46,904
	Variation 2013-14	12	5	15	£ 8,889	£15,402	£ 6,451
	Variation 2013-14 %	44.4%	20.8%	62.5%	9.9%	20.3%	7.8%
	Variation Target	24	15	25	£47,354	£47,999	£41,731
	Variation Target %	153.1%	111.7%	184.7%	92.6%	110.8%	89.0%
	RAG	1	1	1	1	1	1

Measuring patient satisfaction can be challenging for the target cohort of patients covered by this scheme because of the nature and extent of their co-morbidities. We will work with stakeholders to consider the most appropriate approach.

What are the key success factors for implementation of this scheme?

The key success factors for implementation are:

- Engagement from GP practices and other relevant stakeholders to deliver the enhanced service
- Defining the care and support delivered by GPs to patients & care homes
- Supporting the establishment of standards for care planning, medicines reviews, information & communication
- Enhanced quality of life for patients in care homes through a reduction in emergency admissions
- Tailoring of the training of the care home staff
- Promotion of GP-led model of integrated care for patients
- Improve end of life experience through advanced care planning which in turn will improve the overall health and wellbeing of patients in homes.

Scheme ref no.
Wokingham BCF 07
Scheme name
Berkshire West Connected Care
What is the strategic objective of this scheme?
The strategic objective of this Scheme is to remove information silos in health and social care, and to ensure health and social care professionals have access to accurate and timely information regarding patients. By facilitating the sharing of information, **patients will only have to tell their story once** and there are many other examples of how patient experience and care should improve. These are expected to contribute to the realisation of substantial health and social care related financial savings on a recurring basis.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The overall objective of this initiative is to create a single instance of a holistic patient record. Currently information resides in silos in the organisation that has treated the patient with very little being shared. If the initiative is successful throughout the various phases, a portal will be rolled out that is embedded within the various systems already in use in Berkshire West that will break down the information silos and facilitate data sharing at a level never achieved before. The portal can be accessed by health and social care professionals involved in the direct care of the patient only though could be accessed directly by the patient in the future. This initiative is being split into multiple phases to ensure the expected benefits are being realised and appropriate controls are in place at all stages of the project . **Phase 1:** The Medical Interoperability Gateway (MIG) will be purchased and information sharing agreements put in place to enable GP Practices to share their data with Westcall (OOH), Reading Walk in Centre and Newbury Minor Injuries Unit. Currently these healthcare settings do not have access to any medical information from primary care and use systems that are compatible with the MIG meaning a quick implementation. No cohort of patient is being targeted during this phase as this will potentially benefit any West Berkshire resident who attends these care settings and gives consent for their record to be viewed. **Phase 2:** Implementation of a "quick-start" portal solution provided by Orion. This portal solution will be purchased for one year and will form the basis for a full business case for the next phase. The portal will be implemented with feeds from at least GP Practices via the MIG, Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and Out of Hours. There will also be the opportunity for other organisations to feed data into the portal, but is dependent on the use of the NHS number within the system and it being compatible with Orion. This limited rollout will be the first time that multiple healthcare systems have been linked up in Berkshire West and will provide a single point of access for health and social care workers. The viewing organisations will be both health and social care and the project will be looking for a wide range of clinicians and social care workers

to view the data and to compare expected benefits against those realised.

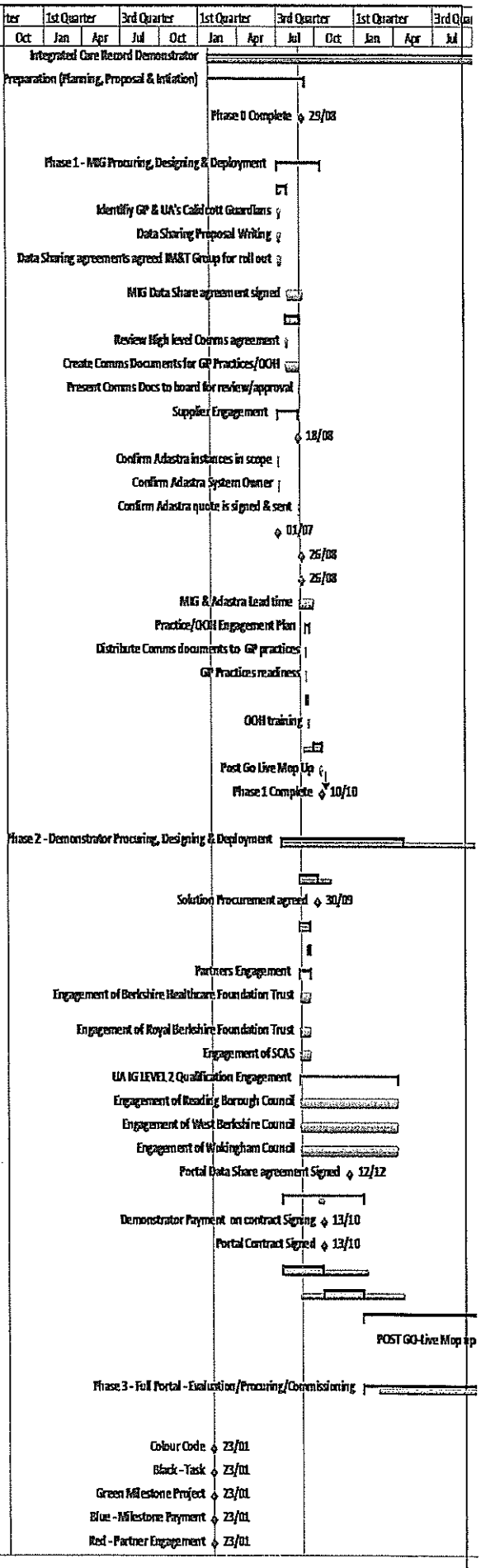
The teams that will make up the pilot will be focussed on the frail and elderly cohort of patients to ensure there is a maximum impact of this limited rollout.

Phase 3: Presuming that the expected benefits are realised, the third phase would be initiated, which would be to procure a full portal with feeds from all participating organisations in health and social care in Berkshire West. Access will being given to all health and social care staff that would benefit in the direct care of patients. During this phase, the scope of the project, or future projects would also be revisited, with patient access portals and mobile working potential further benefits of using a portal solution.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Procurement of the MIG (Berkshire West CCG's)
- Information sharing via MIG between GP Practices and Westcall and MIU (Berkshire Healthcare NHS Foundation Trust and Berkshire West CCG's)
- Information sharing via MIG between GP Practices and Reading Walk in Centre. (Virgin Health Care and Berkshire West CCG's)
- Information sharing between GP Practices to facilitate extended hours. (South Reading CCG).
- Information sharing via Orion between GP Practices, identified services within RBFT, BHFT and SCAS. (Berkshire West CCG's, Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and South Central Ambulance Service).
- As above but to include at least one unitary authority. (Reading Borough Council, Wokingham Borough Council and/or West Berkshire Council).
- Full procurement of a vendor neutral portal solution with rollout to all participating organisations.

ID	Task Name	Start	Finish	Duration
1	Integrated Care Record Demonstrator	Thu 23/01/14	Wed 28/01/16	521 days
2	Phase 0 - Project Preparation (Planning, Proposal & Initiation)	Thu 23/01/14	Fri 05/09/14	163 days
45	Phase 0 Complete	Fri 29/08/14	Fri 29/08/14	0 days
46				
47	Phase 1 - MIG Procuring, Designing & Deployment	Tue 01/07/14	Fri 10/10/14	74 days
48	Information Governance	Thu 03/07/14	Thu 24/07/14	16 days
49	Identify GP & UA's Caldicott Guardians	Thu 03/07/14	Wed 09/07/14	5 days
50	Data Sharing Proposal Writing	Thu 03/07/14	Wed 09/07/14	5 days
51	Data Sharing agreements agreed IM&T Group for roll out	Thu 03/07/14	Thu 10/07/14	6 days
52	MIG Data Share agreement signed	Thu 24/07/14	Fri 29/08/14	27 days
53	Comms strategy	Mon 21/07/14	Thu 21/08/14	24 days
54	Review High level Comms agreement	Mon 21/07/14	Fri 25/07/14	5 days
55	Create Comms Documents for GP Practices/OOH	Mon 21/07/14	Thu 21/08/14	24 days
56	Present Comms Docs to board for review/approval	Thu 21/08/14	Thu 21/08/14	1 day
57	Supplier Engagement	Tue 01/07/14	Mon 18/08/14	35 days
58	MIG Contract Negotiations	Tue 01/07/14	Mon 18/08/14	35 days
59	Confirm Adastra instances in scope	Wed 02/07/14	Wed 02/07/14	1 day
60	Confirm Adastra System Owner	Fri 04/07/14	Fri 04/07/14	1 day
61	Confirm Adastra quote is signed & sent	Mon 18/08/14	Mon 18/08/14	1 day
62	MIG Support confirmation	Tue 01/07/14	Tue 01/07/14	1 day
63	MIG Payment on contract signing	Tue 26/08/14	Tue 26/08/14	0 days
64	MIG Contract Signed	Tue 26/08/14	Tue 26/08/14	0 days
65	MIG & Adastra Lead time	Mon 18/08/14	Mon 22/09/14	26 days
66	Practice/OOH Engagement Plan	Wed 03/09/14	Fri 12/09/14	8 days
67	Distribute Comms documents to GP practices	Wed 03/09/14	Thu 04/09/14	2 days
68	GP Practices readiness	Fri 05/09/14	Fri 05/09/14	1 day
69	Check OOH proposal/readiness	Fri 05/09/14	Mon 08/09/14	2 days
70	OOH training	Mon 08/09/14	Fri 12/09/14	5 days
71	GO Live Rollout	Mon 22/09/14	Fri 10/10/14	15 days
79	Post Go Live Mop Up	Mon 06/10/14	Fri 10/10/14	5 days
80	Phase 1 Complete	Fri 10/10/14	Fri 10/10/14	0 days
81				
82	Phase 2 - Demonstrator Procuring, Designing & Deployment	Mon 07/07/14	Thu 16/04/15	284 days
83	Solution Procurement	Mon 18/08/14	Tue 30/09/14	32 days
95	Solution Procurement agreed	Tue 30/09/14	Tue 30/09/14	0 days
96	Information Governance	Mon 18/08/14	Fri 12/09/14	20 days
100	Communications	Mon 08/09/14	Fri 12/09/14	5 days
103	Partners Engagement	Mon 18/08/14	Fri 12/09/14	20 days
104	Engagement of Berkshire Healthcare Foundation Trust	Mon 18/08/14	Fri 12/09/14	20 days
105	Engagement of Royal Berkshire Foundation Trust	Mon 18/08/14	Fri 12/09/14	20 days
106	Engagement of SCAS	Mon 18/08/14	Fri 12/09/14	20 days
107	UA IG LEVEL 2 Qualification Engagement	Mon 18/08/14	Wed 01/04/15	163 days
108	Engagement of Reading Borough Council	Mon 18/08/14	Wed 01/04/15	163 days
109	Engagement of West Berkshire Council	Mon 18/08/14	Wed 01/04/15	163 days
110	Engagement of Wokingham Council	Mon 18/08/14	Wed 01/04/15	163 days
111	Portal Data Share agreement Signed	Fri 12/12/14	Fri 12/12/14	0 days
112	Portal Vendor Engagement	Mon 07/07/14	Tue 13/01/15	137 days
115	Demonstrator Payment on contract Signing	Mon 13/10/14	Mon 13/10/14	0 days
116	Portal Contract Signed	Mon 13/10/14	Mon 13/10/14	0 days
117	Infrastructure & Hosting	Mon 07/07/14	Fri 10/10/14	70 days
129	Portal Build Lead Time	Mon 13/10/14	Tue 13/01/15	67 days
176	Demonstrator GO-Live	Tue 13/01/15	Tue 13/10/15	196 days
178	POST GO-Live Mop up	Tue 13/10/15	Thu 29/10/15	13 days
179				
180	Phase 3 - Full Portal - Evaluation/Procuring/Commissioning	Tue 13/01/15	Tue 13/10/15	9.8 mons
192				
193	Colour Code	Thu 23/01/14	Thu 23/01/14	0 days
194	Black - Task	Thu 23/01/14	Thu 23/01/14	0 days
195	Green Milestone Project	Thu 23/01/14	Thu 23/01/14	0 days
196	Blue - Milestone Payment	Thu 23/01/14	Thu 23/01/14	0 days
197	Red - Partner Engagement	Thu 23/01/14	Thu 23/01/14	0 days



The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is significant evidence to support data sharing amongst organisations with NHS England supporting initiatives through the integrated digital technology fund. **The Kings Fund** highlight integrated care teams as a key priority and one of the enables for this is sharing data. A case study was also completed in **Cumbria** for data sharing through the MIG.

Other sources used for benefits estimates were:

- Health & Social Care NI Electronic Care Record Deployment
- NHS Greater Glasgow & Clyde EPR
- NHS Lanarkshire Clinical Portal deployment
- Walsall ERDIP programme - the "Fusion" project
- Connecting Care programme in South West of England
- Wrightington, Wigan & Leigh NHS trust EPR deployment
- Canterbury District Health Board in New Zealand
- Province of Alberta in Canada

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Wokingham CCG's contribution to the Berkshire West scheme is £209k.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The expected outcomes and benefits of the proposed programme can be summarised as follows:

- Enabling "the patient only having to tell their story once"
- More informed clinical decision making –"right information, right place, right time"
- Time saving by health and social care professionals
- Fewer unscheduled conveyances to A&E and A&E attendances
- Fewer unscheduled and emergency admissions to secondary care (BCF Metric on NEL admissions),
- Fewer admissions from care homes
- Reduced End of Life deaths in hospital
- Improved discharges and reduced excess bed days (BCF Metric on Delayed Transfer of Care, although it is not possible to quantify a specific contribution)
- Reductions in inappropriate referrals to outpatients and for repeat and otherwise unnecessary diagnostics tests
- Improved medication management.
- User satisfaction (BCF local metric, although it is not possible to quantify a specific contribution)

The following deliverables are expected as a result of this initiative:

1/1000 reduction in carries to A&E and A&E attendances (100 fewer per year)
10% reduction in elective day case activity (source range is 10-15%)
10% reduction in elective inpatient activity (source range is 10-15%)
2% reduction in elective excess bed days (source range is 2-4%) As this is currently performing better than plan a saving of £0 is carried into the cash releasing benefits total
2% reduction in non-elective excess bed days (source range is 2-4%)
2% reduction in non-elective non-emergency inpatient activity (source range is 2-4%) As this is currently performing better than plan a saving of £0 is carried into the cash releasing benefits total
5% reduction in first (repeat) outpatient appointments (source indication is that 6.8% is realisable). The assumptions include reflecting the cost avoided as representative of second outpatient appointments
10% reduction in pathology testing (source indication is that 10% is realisable)
10% reduction in diagnostic imaging (source indication is that 10% is realisable)

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Each Phase is broken into individual work streams where expected benefits will be measured before moving onto the next work stream. There is a significant change to clinical working so it is important to ensure the change management is sufficient to ensure the clinical transformation is safe and benefits are maximised.

Success will be measured using questionnaires that have been developed from other pilots, usage statistics and assessing secondary care data to check that the expected cost savings are achieved over the period of the pilot.

The success criteria for this project will be defined as engagement with each participating organisation is completed to confirm which services will benefit in the different phases of the project

What are the key success factors for implementation of this scheme?

- To achieve the expected cost savings as outlined
- To improve patient safety, care and experience
- To ensure the 10 strategic objectives are achieved as a result of the project
- All 54 GP Practices engaging with sharing primary care data
- Successfully engaging with all provider organisations and unitary authorities to share appropriate data with the wider system
- To configure the portal solution to be embedded within all organisations host systems to ensure usage is maximised.

Scheme ref no.

Wokingham BCF 08

Scheme name

Neighbourhood Clusters, Self-Care and Primary Prevention

What is the strategic objective of this scheme?

The objective of this scheme is to develop **Neighbourhood Cluster Teams** (NCTs) within primary care to:

- streamline the approach to case managing care for patients and service users, particularly those outlined in our Vision - the frail elderly and those with multiple long term conditions and complex health and social care needs - to ensure seamless accessible care is delivered that improves outcomes and experiences for individuals
- create one community-based multidisciplinary team in each of the smaller geographical areas working together to provide joint care planning and coordinated assessment of need for people in that community
- achieve greater consistency and standardisation of practice that will avoid duplication, so achieving more effective use of resources and more efficient and patient-centred service provision.

The NCTs will also more broadly support good health within the neighbourhood, focusing in particular on supporting and empowering those with long term and complex conditions to self-care and on primary prevention with the objective of:

- increasing people's ability to self-care i.e. providing information, support and advice to empower them to manage their condition, cope with their symptoms, adopt strategies to prevent ill health and know when to contact their lead healthcare professional when/if their condition worsens
- increasing targeted primary prevention services and improving the provision of high quality information, support and advice to promote health and wellbeing, both to those in high risk groups and those with lower support needs, to reduce incidence of additional health problems and disease.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

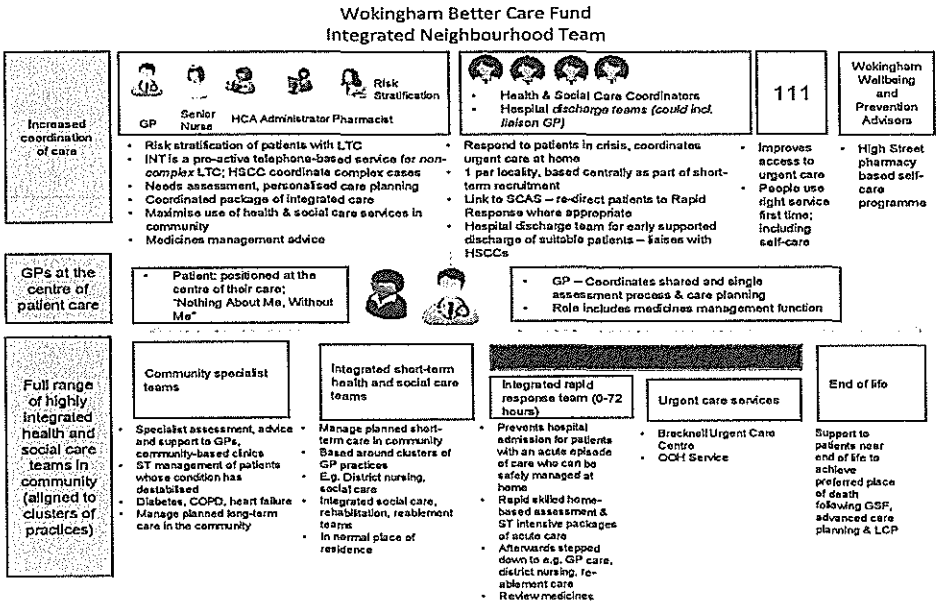
- What is the model of care and support?
- Which patient cohorts are being targeted?

The ambition is to develop NCTs, which will be multidisciplinary teams of health and social care professionals allied to one of the 5 General Practice Clusters in the CCG. The teams will share values and commitment to delivering care in collaboration, and be united to work together more effectively for the benefit of individuals.

The NCTs will be based around groups of GP practices with similar health demographic. Each cluster will have its own Needs Assessment that draws from the JSNA. The **5 General Practice Clusters** are:

1. Wargrave and Twyford.
2. Swallowfield and Brookside.
3. Finchampstead and New Wokingham Road.
4. Burma Hills, Wokingham Medical Centre and Woosehill.
5. Woodley, Parkside, Loddon Vale, and Wilderness Road.

The model envisaged of providing care and support through NCTs is presented in the attached diagram:



Detailed work is underway in consultation and engagement with key stakeholders (including health and social care professionals, local patients/social care clients, their families, respective support groups and organisations and the public) to further develop a vision for NCTs. Alongside this, work is ongoing to scope out and develop the best model of supporting people and enabling them to self-care, and of promoting primary prevention through the new NCT structures, along with timescales for achieving this. The NCTs will support joint assessments and risk planning, and structures will dovetail with those established for the Accountable named GPs and the unplanned admissions DES.

The scoping exercise will identify existing resources for prevention and supporting people to self-care; identify where there are gaps and plan to make improvements required to meet people's needs. The voices of those "seldom heard" within the population will be sought, and the potential challenges involved with meeting the needs of people with differing levels of health literacy and those whose first language is not English will be addressed.

It is anticipated that establishing NCTs will:

- Provide a full range of highly integrated **multi-disciplinary health and social care teams** in the community including, e.g. GP, practice nurse, community matrons, community nurses, health care assistants, social workers, community pharmacists and wider Allied Health Professionals, and possibly extending to voluntary services, housing, etc.
- Identify a GP as the **accountable lead professional** for each cluster, supported by a **Health and Social Care Coordinator**. The H&SC Coordinator will liaise with all teams and surgeries in the cluster, including supporting self- care and primary prevention, so acting as a "Neighbourhood Navigator" throughout the cluster for all users.
- Work together seamlessly within clusters to place patients at the centre of their care, with GPs coordinating a shared and single joint assessment process and personalised care

planning to provide coordinated packages of integrated care.

- Facilitate the development of a **generic worker role**.
- Use effective **risk stratification** to proactively identify people according to the complexity of their need; people who are, or could become the most regular users of hospital services in the future and allow their needs to be identified and met more effectively.
- Provide additional opportunities to seek input from the range of multidisciplinary **specialists** in the local area so that specific care and support required might be provided early to reduce the need for admission to hospital.
- Ensure the provision of **information and support** to empower patients to self-care and that targets primary prevention to reduce the incidence of additional health problems and disease.
- Ensure a **sustainable** neighbourhood model.

It is likely that, within this scheme, work will also include consideration of how Personal Health Budgets and direct payments might enable some patients and service users to commission their own care in ways that better meet their needs.

Strengthening the role of **community pharmacy** could also be included in this scheme, following the feedback from the national "Call to Action" (NHS England, December 2013), which emphasised pharmacy's unique accessibility for patients in particular. Local strategies for community pharmacy could be developed, enabling them to play a greater role in the management of long term conditions by supporting people to stay well, live healthier lives and to self-care. The strengths of community pharmacies include:

- People from deprived populations, who may not access conventional NHS services, do access community pharmacies
- Pharmacy's accessibility in terms of location and long opening hours is seen as a significant benefit to the public.

Part of this work will focus on providing information and advice that is "jargon-free", including consideration of the health literacy needs of service users, in particular for people who do not have English as a first language.

The establishment of NCTs might also facilitate consideration of the joint provision of clinical and **"back office" functions**, which would contribute to ensuring a sustainable neighbourhood model.

It is proposed that co-ordinated care through NCTs will be targeted towards individuals with the most complex problems and at a higher risk of deterioration in their health. This will include in particular: frail older people, those living with long-term chronic and mental health illnesses, and those with medically complex needs or requiring urgent care. However, although those with long term conditions will be the main focus, there will be people with other conditions who could benefit from self-care / prevention of ill health, such as early intervention for children to reduce incidence of those becoming mentally unwell. The volume of patients that benefit from this scheme is yet to be determined, as the detailed design of services to be provided through this scheme has not yet been agreed.

This scheme will align with the following existing programmes:

- Care Act implementation – especially regarding provision of co-ordinated care and enhancing the provision of comprehensive information and advice about care and support services in the local area.

- Frail Elderly pathway
- Public Health outcomes framework and development of the Public Health prevention strategy

and will be closely interrelated with a number of other proposed BCF schemes, e.g. Connected Care (BCF 07): interoperability, including the electronic sharing of demographic information using the NHS number as the unique identifier, will significantly enhance the efficiency and effectiveness of the NCTs.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this scheme will be designed, managed and controlled by a dedicated project team, reporting to the Wokingham Integration Strategic Partnership, which reports into the Wokingham Borough Health and Wellbeing Partnership Board.

The scoping, planning and further development of NCTs will take place during 14/15 with the aim of having an agreed model of NCTs in place and operational by October 2015, although this might be in a phased approach. This could be either in the form of a pilot across a smaller area initially, to ensure the success of the initiative prior to full roll-out, or by bringing additional professionals into the cluster teams in a phased manner to enable evaluation of each phase in turn. Details regarding the anticipated project timelines are indicated in Section 4a of Part II.

Once implemented, the provision of coordinated services though the NCT scheme is likely to be commissioned by Wokingham CCG in conjunction with Wokingham Borough Council and provided through integrated teams of multi-disciplinary professionals within the Wokingham area.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence has shown:

- A lack of an integrated management of community and practice nursing teams.
- Under-developed relationships between health and social care, housing and the voluntary sector.
- Variations in practice and in levels of patient satisfaction.
- A significant number of people with long term conditions want to remain as independent as possible and live as healthily as they can. Their feedback suggested that they need more information to enable them to achieve this.

In addition, work commissioned by the Berkshire West health and social care economy, undertaken in 2013 by **Capita**, identified a number of options to address specific areas of pressure being experienced throughout the area. Two options related to NCTs – i.e.: "enhanced use of risk stratification to support multidisciplinary working" and "the creation of health and social care coordinators". Therefore a scheme of case coordination across health and social care was developed, to work specifically with those of a risk stratification score of 3-4 – i.e. a future likelihood of requiring an unplanned admission. The development of NCTs will be a natural progression of this and also aims to address the shortcomings listed above.

By pro-actively identifying high risk individuals, and appropriately targeting interventions, there is evidence that care quality can be improved. (Goodwin *et al* 2010).

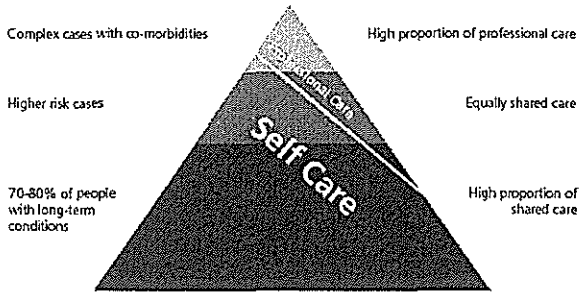
Examples of where schemes similar to NCTs are in place and are being shown to be effective include:

- **North Somerset** - As one of 29 sites involved in the Department of Health Partnership for Older People Project (POPP), four fully integrated and co-located multi-disciplinary teams based around clusters of GP practices provide case management and self-care support to older people. The aim is to prevent complications in diseases and deterioration in social circumstances.(Windle *et al* 2010 – cited in Goodwin, N; Smith, J; The Evidence Base for Integrated Care; King's Fund and Nuffield Trust - http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf)
- **Hereford** - An integrated care organisation based on eight health and social care neighbourhood teams is in development to support the personal health, wellbeing and independence of frail older people and those with chronic illnesses such as diabetes, stroke and lower back pain. Early successes include lower bed utilisation, and reductions in delayed discharges from hospital. (Woodford 2011 - cited in Goodwin, N; Smith, J; The Evidence Base for Integrated Care; King's Fund and Nuffield Trust - http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf)

The aim of increasing people's ability to self-care is in line with national initiatives, e.g. **"The House of Care"** (NHS England), which describes how there is a need to support the potential of both the individual and their network of support to self-care ("Enhancing the quality of life for people living with long term conditions – The House of Care"). This approach is also endorsed by the House of Commons Health Committee.

It is recognised that effective self-management can have benefits for people's attitudes and behaviours, quality of life, their clinical symptoms and use of healthcare resources (Health Foundation – *'Helping people help themselves'*, 2011). With 60-70% of premature deaths caused by detrimental health behaviours, it is vital that people engage more fully with maintaining / improving their own health and to a sharing of responsibility over decision making. The majority of people are themselves best placed to make decisions about their own health and care needs and health behaviour, provided they are motivated and have the capacity to do so and that they are supported and empowered with targeted and easily accessible information, advice, techniques and tools. (Health Foundation – "Helping people to help themselves", 2011). People report that self-management helps them live better lives, and puts them in control of their condition (Avoiding Hospital Admissions - What does the research evidence say? (2010) Sarah Purdy for the Kings Fund).

The diagram below (from "Long Term Conditions in Scotland; final report) illustrates the proportion of people for whom self-care is potentially appropriate:



Research has identified the benefits of investing in health information. A project commissioned by Patient Information Forum found that better health information can have significant impacts on service use and reduce costs including reducing wasted medications, reducing demand for GP consultations, A&E attendances, emergency admissions/ length of stay and re-admissions. (Making the Case for Information The evidence for investing in high quality health information for patients and the public (2013) - Patient Information Forum - http://www.selfcareforum.org/wp-content/uploads/2013/07/PiF-Case-for-Information-Exec-Summ-FINAL-May13.pdf)

The importance of focusing on clear communication and health literacy is highlighted in an article published by the **Royal Society of Medicine**. The article highlights the importance of reducing the use of medical jargon by health care professionals and of using clear and understandable language in supporting patients to be in control of decisions about their health and treatment. (Farrington, 2011; Reconciling managers, doctors, and patients: the role of clear communication - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110963/

The values and approach of this scheme fits with the move to greater personalisation and self-directed support in social care as well as the values of the NHS Constitution on working together with patients and helping people and their communities take responsibility for living healthier lives (NHS Constitution, 2013).

More systematic primary prevention can reduce the overall burden of the disease in the population and so maintain the financial sustainability of the NHS. It is estimated that up to 80% of heart disease, stroke and type 2 diabetes, and up to 40% of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

Investment requirements

£300,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The development of NCTs are expected to deliver the following anticipated outcomes:

- A "silo-free" pattern of service provision will be developed, with co-ordinated multidisciplinary neighbourhood teams reaching out into communities more effectively and working together through effective streamlined and patient and service user-centred processes to support people in their own homes, combat social isolation and improve prevention.
- Acting as an enabler, NCTs will support a number of the key BCF metrics, including for example: potential reduction in delayed transfers of care, in demand for residential care placements, in unnecessary A&E attendances as the existing systems of service delivery

where individuals can "fall through the gaps" in care, or where they currently receive poor care co-ordination, will be replaced with a system where there is a positive impact on care experiences and care outcomes.
- Patients and service users will receive a much more complete and less fragmented service and will report improved experiences of care and support.

The emphasis on self-care and primary prevention is expected to deliver the following anticipated outcomes:

- People will be involved in decision-making about their care and will be supported to look after themselves, make healthier choices and live as independently as possible
- By supporting health improvements earlier people can potentially remain active and prevent illness and falls. In particular there is potential to decrease rates of preventable disease such as coronary heart disease, type 2 diabetes and stroke.
- Patients and service users will report feeling more in control of their treatment through the provision of targeted high quality information and advice and a supportive and empowering environment with shared responsibility and rights over decision making
- Increased take up and benefits from use of combined personal health and social care budgets.
- Increasing self-care and an increase in targeted primary prevention services should result in decreased rates of preventable disease in the local population and therefore reduced unplanned admissions to hospital, fewer visits to GPs etc., so acting as an enabler in supporting some of the key BCF metrics.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

During the development of this scheme, the Project team will undertake ongoing monitoring of progress. As part of implementation, the Project team will determine the process for regular assessment, review and evaluation of the scheme. It is likely to be agreed that, as part of the providing the service, providers working within the NCTs will be required to collect data around:

- the consistent use of co-ordinated risk stratification, assessment of need and personalised care planning
- service user satisfaction (in particular from the perspective of whether the new model of service provision made a difference to those on the receiving end, whether service users report a better experience of care, are being provided with the right information and support to self-care where appropriate and a measure of how active, confident and in control individuals feel about managing their own care and maximising their own health)
- people's health and wellbeing; e.g. – analysing trends in potentially preventable health problems and disease .

Project evaluation will involve both qualitative and quantitative evaluation to ensure that the NCTs are operating effectively and are achieving their objectives. Key objectives will be agreed during development and are likely to include delivering a better experience and better outcomes for patients and service users, that patients are being effectively empowered to self-care and to use strategies to prevent ill health, and the scheme's contribution to the achievement of targets within the Better Care Fund Metrics. It is expected that self-care should have an impact on permanent Admissions of older people to residential and nursing

care homes and on the reduction in avoidable admissions. Evaluation will be undertaken through analysis of data and satisfaction surveys and recorded on the project dashboard.

The results of monitoring and evaluation will be reported to the Wokingham Integration Strategic Partnership and the Primary Care Partnership Board.

What are the key success factors for implementation of this scheme?

Clusters of GP practices and of **community nursing teams** in Berkshire Healthcare Foundation Trust have been established already. To ensure further development, the key success factors are likely to be:

- Effective engagement and co-production with key stakeholders – including patients and service users, health and social care professionals, housing and voluntary sector
- Achieving agreement, support and commitment for the scheme from all key stakeholders, including agreement of project plan. This will include identifying any conflicting organisational priorities / different ways of working between the various professionals, and any perceptions of professional boundaries that may hinder the project and agree action to address these
- The establishment of a framework to support, and set expectations for, practices in cluster working
- Strong leadership to facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and patient-centred care
- Scoping of suitable accommodation within each neighbourhood cluster to provide a team base
- Ensuring that effective IT systems are in place to support delivery of care via NCTs and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Ensuring appropriate governance processes are in place, relevant to the new forms of organisation and service provision
- Identifying and addressing any real and perceived barriers to information and data sharing across the constituent parts of the local health and social care system that might impinge on the development of the project
- Ensuring appropriate governance processes are in place
- Ensuring availability of required resources to deliver new ways of working
- The success of increasing self -care and primary prevention relies on the ability to improve 'patient activation' (Hibbard, J; Gilburt, H (2014): *Supporting people to manage their health - An introduction to patient activation*; Kings Fund). This refers to a person's knowledge, skills, ability and willingness to manage their own health and care. Staff need the necessary skills and training to support people within a model of self-care as this goes beyond the provision of information and understanding of their condition(s) to train and empower patients and carers. There needs to be a focus on building relationships between service users and practitioners and exploring the most effective strategies for encouraging behaviour change (Health Foundation "*Helping people help themselves:*",2011).

Scheme ref no.
Wokingham BCF 09
Scheme name
Access to General Practice
What is the strategic objective of this scheme?
This Scheme aims to create equity of services across General Practice, working to operating as a whole week programme of delivery. This will provide a more positive patient/service user journey and experience of care which is both consistent and efficient. The approach will be complemented through the neighbourhood cluster scheme (BCF08) centred by GP practices, access by all, though a single point of access. Wokingham residents will feel empowered and supported to live well for longer in their own homes, and also support improved communication between the patient their family cares, and health and social care professions responsible for their care. The Scheme will specifically is anticipated to further support admission avoidance, and increase patient satisfaction. In addition, the Scheme will contribute to the a reduction in demand in residential care placements.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model is an expansion of GP service provision beyond core hours 8am -6.30pm, Monday – Friday) to offer access into early morning, evening and at weekends, particularly Saturday morning. This build upon and enhances existing extend hours arrangement than have been commission by NHS England. Practices will offer both routine and urgent appointments during these extended periods, interface with other services to support admissions avoidances, reduce Type 2 A&E attendance and maximise opportunities for discharge back to GPs. During these hours there will be requirement to ring-fence some appointment for patients who have been discharged to access their GP and a requirement to give a priority to patients identified by practices as being at high risk of admission. These will include patients included on the 2% care management registered developed by GPs as part of the national Avoiding unplanned Admission Directly Enhanced Service (DES) (Part I Section 7d). The Scheme will provide more opportunities for patient to access GP Services to help manage their long term conditions in the community, thereby avoiding unnecessary admission and/or attendance to A&E (as demonstrated in Part I, the Case of Change Section 3, Challenge 3). Practices are being commissioning to increase extended hours arrangement during 2014/15 under pilot arrangements which will make more appointment available at times suitable to the patients. The service to be commissioned from April 2015 will be shaped by finding of these pilot and national best practice including emerging results from the Prime Minster Challenge Fund pilot. It will link with the neighbourhood clusters. All patient cohorts are likely to benefit from increased access, but the Scheme is

expected to be particularly effective for patients with complex needs, those identified as being at high risk of admission, those who would otherwise attend A&E for type 3 conditions and those discharged from hospital, including A&E.

Practices will be asked to conduct demand and capacity audits – Practices will be expected to continually review their demand and capacity. Slot availability should be flexible to respond to their patient populations' needs. As part of the service specification practices will be required to report on the following:

- Number of appointment slots offered over the course of the pilot broken down by each week
- Slot utilisation for each week with a total % slot utilisation over the course of the pilot
- DNA rate
- Targeted questionnaire to those attending during extended hours to establish whether patients would likely have presented at Westcall/A&E as an alternative.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

It is anticipated that extended GP hours will be delivered by existing GP providers, working as collaboratively as appropriate, with an interoperable IT solution in place as soon as possible and if appropriate. The service is likely to be commissioned by the CCGs as a **Community Enhanced Service**, potentially linking with NHS England around the existing Extended Hours DES.

GP Providers will commence extended hours working once appropriate plans are in place that ensure there is a sustainable workforce, services are being delivered from an appropriate site, and that the model of delivery is an improvement on existing access arrangements and better meets the needs of patients. It is anticipated that this will be from April 2015.

The scheme will be overseen by the Primary Care Programme Board, with the Primary Care Team within the Berkshire West CCG Federation taking responsibility for setting service specifications and monitoring delivery. The Primary Care Programme Board will in turn feed into the Wokingham Integrated Strategic Partnership. It will be for individual GP providers to implement local practice arrangements.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base around extending GP hours is still emerging and the arrangements will be commissioned as pilots initially with a requirement to collect capacity and utilisation data which will then be triangulated with A&E and Westcall attendance rates and admissions data. What is currently understood is the patient satisfaction rate with opening hours from the **National Patient Survey**. For Wokingham CCG this indicates that the greatest desire is for practices to be open on Saturday and in the evenings.

	% requesting GP access before 8am	% requesting GP access after 6.30pm	% requesting GP access on Saturdays	% requesting GP access on Sundays
Wokingham CCG	37	73	80	42

Ring fenced appointments will help patients who have been discharged from a hospital setting to have easier access to their GP practice. The Scheme will also ensure that GP practices are available outside of core hours to support patients with the management of their long term conditions in the community, thereby avoiding unplanned admissions.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£734,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is envisaged that an increase in access to GP practices will lead to:

- **Reduced (Out of Hours) WestCall activity** – We would anticipate a drop in activity picked up by WestCall. We can track the activity over the length of the pilot and report back the amount of drop. OOH is able to provide us with a baseline.
- **Reducing delayed transfers of care** (BCF Metric, impact to be monitored during pilot period over winter months and reviewed in March 2015 as there is no evidence base).
- **A reduction in demand for residential care placements** (BCF Metric, impact to be monitored during pilot period over winter months and reviewed in March 2015).
- **A reduction in unnecessary A&E attendances** (impact to be monitored during pilot period over winter months and reviewed in March 2015 as there is no evidence base). Anticipated drop in attendances for patients who are redirected into the urgent slots available as part of the Saturday morning and evening provision.
- **Better access for patients who are unable to attend GP surgery during normal working hours** – Baseline data is included within the business case. Follow up local surveys (required in the specification) and the national Ipsos MORI survey should reflect increased satisfaction with opening hours. Targeted advertising within practices to reach patients who could not otherwise attend during normal core hours.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The scheme will be overseen by the Primary Care Programme Board who will report to the Wokingham Integrated Strategic Partnership.

As part of providing the service, providers will be required to collect data around capacity, utilisation and patient satisfaction. A&E and WestCall attendances and

admission rates will be reviewed, with a particular focus on what happens at times close to when the surgery is offering additional access. In addition to practice monitoring of patient satisfaction, GP Patient Survey data (questions relating to satisfaction with opening times) and Friends and Family data will be reviewed.

What are the key success factors for implementation of this scheme?

- Practice engagement will be critical to the success of this scheme. Wokingham CCG practices have been actively discussing the development of the scheme at their Member Council meetings.
- Key Interdependencies: IT connectivity – the project will link with the Connected Care Scheme (BCF 07) to ensure that GPs working through a hub model have access to the necessary clinical information. The Neighbourhood Cluster model will ensure that practices are able to link with other services in the out-of-hours period to meet patient needs.
- The scheme will require robust patient communication.
- Effective co-commissioning arrangements with NHS England to be formalised.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Wokingham
Name of Provider organisation	RBFT
Name of Provider CEO	Jean O'Callaghan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	9556
	2014/15 Plan	9837
	2015/16 Plan	9641
	14/15 Change compared to 13/14 outturn	2.94% Growth
	15/16 Change compared to planned 14/15 outturn	1.99% Reduction
	How many non-elective admissions is the BCF planned to prevent in 14-15?	274 for pump priming BCF although BCF not actually in place in 14/15
	How many non-elective admissions is the BCF planned to prevent in 15-16?	579

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes – the numbers are based on the HWB catchment rather than RBFT as a provider and therefore this does not match our provider plan exactly (Wokingham HWB is around 1/3rd of our total activity). However, we understand and have been involved the calculations arriving at the numbers above and as such recognise the impact of the BCF on the Trust.
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes – the main impact on the Trust is the reduction in non-elective admissions as a result of the Hospital at Home project within the BCF (539 of the 579 above) The Trust is fully engaged with this project and sits on the Project Board. The Trust is actively working with the health and social care system to ensure that there are mechanisms in place to support discharge from the provider into community and home settings with

		associated investment in schemes such as reablement, carers, 7 day working in primary and social care

Health and Wellbeing Board Details
applied for

ROCR approval

Version 3

Wokingham

Please

i
janet.meek@nhs.net

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Wokingham

2015/16 Quarterly

Breakdown of P4P

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	9,768
Change in Non Elective Activity	-194
% Change in Non Elective Activity	-2.0%

	Q4	Q1	Q2	Q3
Cumulative Quarterly Baseline of Non Elective Activity	2,519	4,943	7,302	9,768
Cumulative Change in Non Elective Activity	-50	-98	-145	-194
Cumulative % Change in Non Elective Activity	-0.5%	-1.0%	-1.5%	-2.0%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	448,442
Combined total of Performance and Ringfenced Funds	2,147,0
Shortfall of Contribution to NHS Commissioned Services	

	Q4	Q1	Q2	Q3
Financial Value of Non Elective Saving/ Performance Fund (£)	115,646	111,284	108,300	113,212

Health and Wellbeing Funding Sources

Wokingham		

Please complete white cells

	Gross Contribution (£000)	
Local Authority Social Services	**2014/15**	**2015/16**
Wokingham		**69**
Wokingham	**389**	**425**
Wokingham	**220**	**220**
Wokingham		**216**
Wokingham		**900**
Total Local Authority Contribution	**609**	**1830**
CCG Minimum Contribution		
NHS Wokingham CCG		7,431
-		
Total Minimum CCG Contribution		7,431
Additional CCG Contribution		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution		
Total Contribution		9,261

Summary of Health and Wellbeing Board Schemes
Wokingham

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute					
Mental Health	200	200			
Community Health	285	2158			
Continuing Care					
Primary Care		1034			
Social Care	1630	3879		944	
Other	335	1990			
Total	2450	9251			

Summary of NHS commissioned out of hospital services spend from MINIMUM BCF pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Acute		
Mental Health		
Community Health		2,158
Continuing Care		
Primary Care		1,034
Social Care		278
Other		509
Total		3,979

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric	
	2014/15	2015/16	2015/16	
Reduction in permanent residential admissions	-	-		
Increased effectiveness of reablement	-	-		
Reduction in delayed transfers of care	-	-		
Reduction in non-elective (general + acute only)	-	(1,336)	448	Demographic growth in demand
Other	-	-		
Total	**-**	**(1,336)**	**448**	

Wokingham

Please complete white cells (for as many rows as required):

	Expenditure											
Scheme Name	Area of Spend	Please specify if Other	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)	Validation141	Validation	subcode
BCF01 Health and Social Care Hub	Other	Joint working across the system	Joint			NHS Community Provider	CCG Minimum Contribution		59	-	0	100
										-	0	101
										-	0	102
BCF02 see below												
BCF03 Step Up/Step Down Beds	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		247	-	0	103
										-	639	104
BCF04 Domicilliary Plus	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		528	-	145	105
										-	209	106
BCF05 Hospital at Home Service	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		639	-	300	107
										-	734	108
BCF06 Enhanced Care and Nursing Home Sup	Community Health		CCG			Primary Care	CCG Minimum Contribution		145	-	641	109
										-	278	110
BCF07 Connected Care (NHS number/Interope	Other	Joint working across the system	CCG			NHS Community Provider	CCG Minimum Contribution		209	-	0	111
										-	0	112
BCF08 Neighbourhood Clusters, Primary Preve	Primary Care		CCG			Primary Care	CCG Minimum Contribution		300	-	0	113
BCF09 GP 7 day working	Primary Care		CCG			Primary Care	CCG Minimum Contribution		734	-	0	114
										-	0	115
Existing CCG Reablement spend	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		641	-	0	116
										-	0	117
Existing CCG Carers Fund	Social Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution		278	-	0	118
										-	0	119
Existing Disabled Facilities Grant	Social Care		Local Authority			Private Sector	Local Authority Social Services	389	389	130	130	120
Existing Disabled Facilities Grant (Extra Investm	Social Care		Local Authority			Private Sector	Local Authority Social Services		36	155	155	121
										-	0	122
										-	0	123
										-	0	124
Existing Social Care Capital Grant	Social Care		Local Authority			Local Authority	Local Authority Social Services	220	220	-	0	125
										-	300	126
Existing LA Carers Grant	Social Care		Local Authority			Charity/Voluntary Sector	Local Authority Social Services		216	-	0	127
Existing s256 spend :-										-	448	128
i) Community Equipment and Adaptations	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	236	236	-	0	129
										-	0	130
ii) Telecare	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	30	30	-	0	131
										-	0	132

iii) Integrated crisis and rapid response services	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	155	155	-	0	133		
iv) Reablement Services	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	390	390	-	0	134		
v) Bed based intermediate care services	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	130	130	-	0	135		
vi) Early supported hospital discharge Schemes	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	155	155	-	0	136		
vii) Mental health services	Mental Health		Local Authority			NHS Community Provider	CCG Minimum Contribution	200	200	-	0	137		
viii) Other preventative services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	210	210	-	0	138		
ix) Preparing for the Better Care Fund	Other	<Please specify area of spend>	Local Authority			Local Authority	CCG Minimum Contribution	335	335	-	0	139		
Protecting Social Care spend	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		944	-	0	140		
BCF02 Integrated Short Term Health and Social Care Team	Other	Social and Health care	CCG			NHS Community Provider	CCG Minimum Contribution		300	-	0	141		
BCF02 Integrated Short Term Health and Social Care Team	Other	Social and Health care	Local Authority			Local Authority	Local Authority Social Services		900	-	0	142		
Performance Fund	Community Health		CCG			NHS Acute Provider	CCG Minimum Contribution		448	-	0	143		
Contingency	Other	<Please specify area of spend>	Local Authority			CCG	CCG Minimum Contribution		187	-	0	144		
										-	0	145		
										-	0	146		
										-	0	147		
										-	0	148		
										-	0	149		
										-	0	150		
Total								**2,450**	**9,261**	**285**	**3,979**	**TT1**		

Health and Wellbeing Board Financial Benefits Plan

Wokingham

2014/15

Please complete white cells (for as many rows as required):

Health and Wellbeing Board Financial Benefits Plan

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so. If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

Wokingham

2014/15

Please complete white cells (for as many rows as required):

2014/15

Benefit achieved from	**If other please specify**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Hospital at Home	NHS Commissioner	(108)			Identified via Business Cases	As part of overall performance management system
Reduction in non-elective (general + acute only)		Nursing Home Support	NHS Commissioner	(166)			Identified via Business Cases	As part of overall performance management system
-								
-								
-								
-								
Total				-				

2014/15 Benefit achieved from	If other please specify	Scheme Name	Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
Reduction in non-elective (general + acute only)		BCF05 Hospital at Home	NHS Commissioner	(539)	2,307	(1,243,473)	Identified via Business Cases	As part of overall performance management system
Reduction in non-elective (general + acute only)		BCF06 Nursing Home Support	NHS Commissioner	(40)	2,307	(92,280)	Identified via Business Cases	As part of overall performance management system
Reduction in permanent residential admissions		BCF01 Health and Social Care Hub BCF02 Short Term Integrated TeamBCF03 Step Up / Step Down bedsBCF04 Domicillary Plus	Local Authority				The service outlined for 24/7 support will enable more people to be supported at home with greater need than currently. This will result in a reduction in permanent admissions and a shorter stay once admitted. The financial benefits of this to the LA are being reviewed in line with internal governance arrangements. The process is expected to be completed by the end of December 2014.	As part of overall performance management system
Total						**(1,335,753)**		

Wokingham

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans) Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Pay for performance period Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	1,576	1,517	1,476	1,543	1,530	1,472	1,433	1,498	1,484
	Numerator	2,519	2,424	2,359	2,466	2,469	2,376	2,312	2,417	2,420
	Denominator	159,808	159,808	159,808	159,808	161,375	161,375	161,375	161,375	163,015

Rationale for red/amber ratings

P4P annual change in admissions -194
P4P annual change in admissions (%) -2.0%
P4P annual saving £448,442

Please enter the average cost of a non-elective admission[1]: £2,307
Rationale for change from £1,490: calculated avaerage cost of HRG

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans) Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	% CCG registered population that has resident population in Wokingham	% Wokingham resident population that is in CCG registered population	Contributing CCG activity Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Bracknell and Ascot CCG	2,477	2,205	2,276	2,388	3.3%	2.7%	81	72	74	78
NHS North & West Reading CCG	1,734	1,795	1,739	1,821	0.1%	0.1%	2	3	2	3
NHS Oxfordshire CCG	12,603	12,120	12,501	12,700	0.1%	0.5%	14	14	14	15
NHS South Reading CCG	2,115	2,000	1,944	2,030	10.6%	8.4%	224	212	206	215
NHS Wokingham CCG	2,348	2,269	2,203	2,303	93.6%	86.3%	2,198	2,124	2,062	2,155
Total						100%	2,519	2,424	2,359	2,466

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

s saved.

Wokingham

Please complete all pink cells in tables. Other white cells should be completed/amended as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
	Annual change in admissions		[illegible]	[illegible]
	Annual change in admissions %		[illegible]	[illegible]

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
	Annual change in proportion		[illegible]	[illegible]
	Annual change in proportion %		[illegible]	[illegible]

Delayed transfers of care

[illegible]

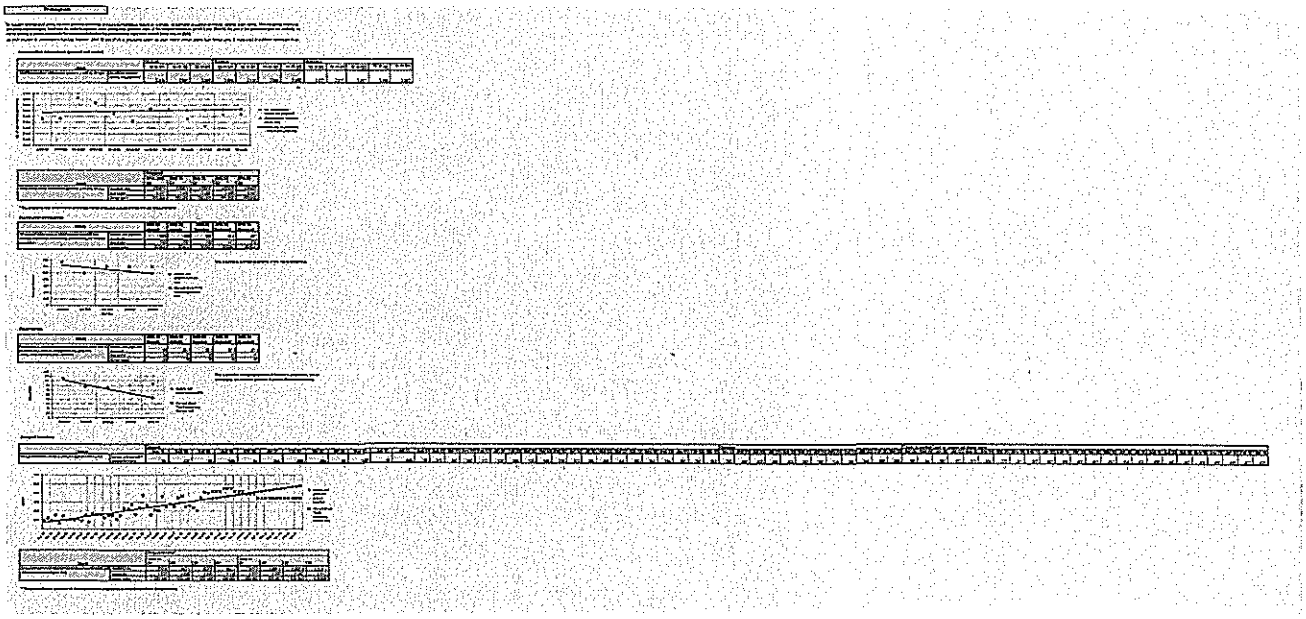
Patient / Service User Experience Metric

[illegible]

Local Metric

[illegible]

[illegible]



HWB Financial Plan

Date	Sheet	Cells	Description
28/07/2014	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/2014	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/2014	HWB ID	J2	Changed to Version 2
28/07/2014	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/2014	a	AP1:AP348	Allocation updated for changes
28/07/2014	All sheets	Columns	Allowed to modify column width if required
30/07/2014	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/2014	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/2014	6. HWB supporting metrics	D19	Comment added
30/07/2014	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/2014	Data	Various	Changed a couple of 'dashes' to zeros
30/07/2014	5. HWB P4P metric	H14	Removed rounding
31/07/2014	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/2014	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/2014	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/2014	5. HWB P4P metric	H13	Apply conditional formatting
01/08/2014	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/2014	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/2014	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/2014	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/2014	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/2014	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/2014	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/2014	a	M8	Add Primary Care to drop down list in column I on sheet *'3. HWB Expenditure Plan'*
13/08/2014	HWB ID	J2	Changed to Version 3
13/08/2014	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions'*
13/08/2014	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/2014	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion'*
13/08/2014	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/2014	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D 18 -C 18)*
13/08/2014	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	E21	Change formula to *= if(E19=0,0,E 18 -D 18)*
13/08/2014	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
13/08/2014	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
13/08/2014	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/2014	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/2014	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/2014	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab