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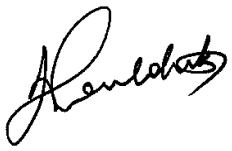
**WOKINGHAM**
**BOROUGH COUNCIL**

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held at the Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 14 APRIL 2016** AT **5.00 PM**



Andy Couldrick
Chief Executive
Published on 6 April 2016

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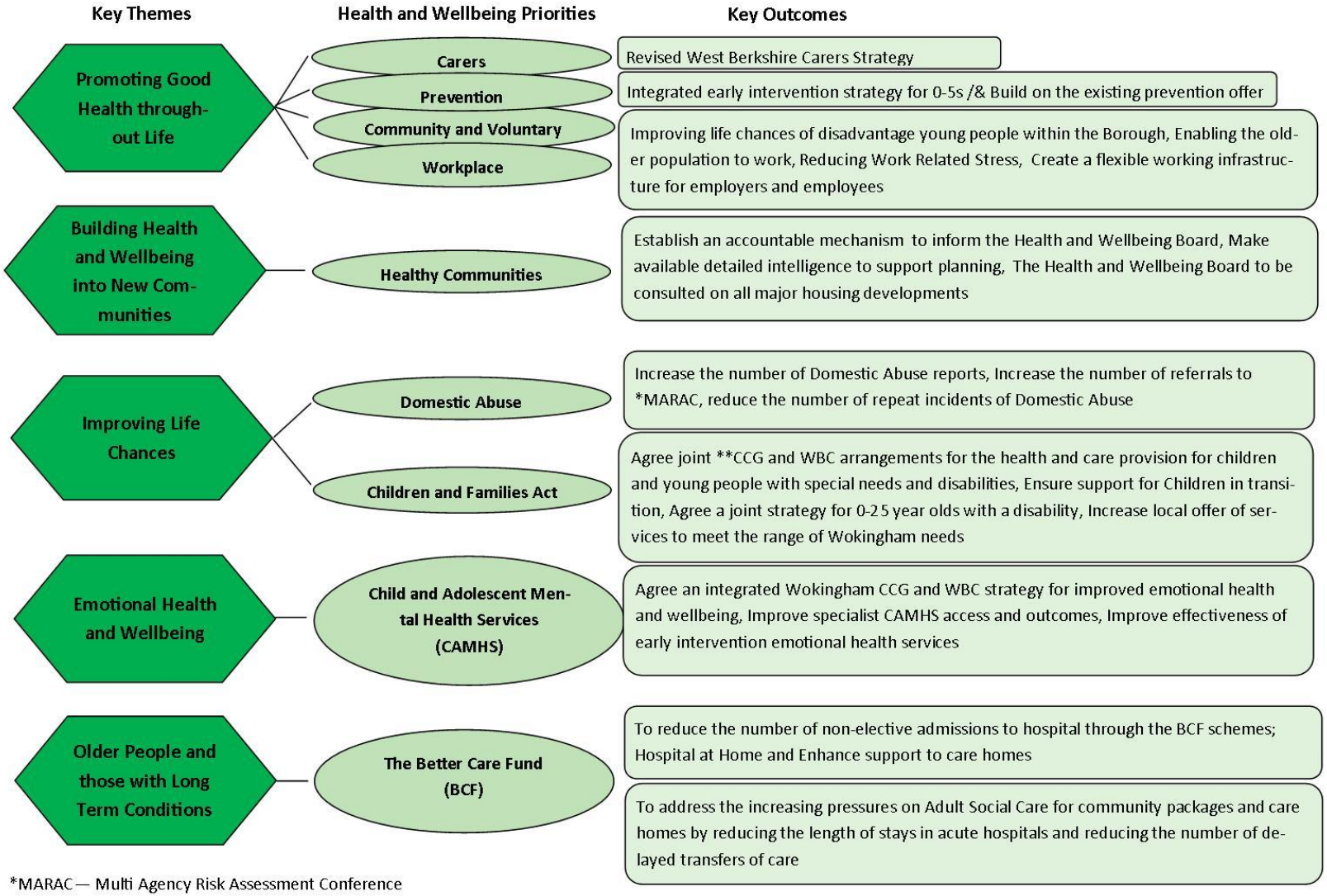
# Wokingham's Health and Wellbeing Strategy 2014-2017




*MARAC— Multi Agency Risk Assessment Conference

**CCG and WBC—Clinical Commissioning Groups and Wokingham Borough Council

## MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

| | |
|---|---|
| Julian McGhee-Sumner | WBC |
| Dr Johan Zylstra | NHS Wokingham CCG |
| Keith Baker | WBC |
| Prue Bray | WBC |
| Charlotte Haitham Taylor | WBC |
| Superintendent Rob France | Community Safety Partnership |
| Beverley Graves | Business Skills and Enterprise Partnership |
| Dr Lise Llewellyn | Director of Public Health |
| Lois Lere | NHS Wokingham CCG |
| Nikki Luffingham | NHS England |
| Judith Ramsden | Director of Children's Services |
| Stuart Rowbotham | Director of Health and Wellbeing |
| Nick Campbell-White | Healthwatch |
| Dr Cathy Winfield | NHS Wokingham CCG |
| Kevin Ward | Place and Community Partnership Representative |
| Clare Rebbeck | Voluntary Sector representative |

**92.** **APOLOGIES**

To receive any apologies for absence

**93.** **MINUTES OF PREVIOUS MEETING** **7 - 14**

To confirm the Minutes of the Meeting held on 11 February 2016.

**94.** **DECLARATION OF INTEREST**

To receive any declarations of interest

**95.** **PUBLIC QUESTION TIME**

To answer any public questions

A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice.

The Council welcomes questions from members of the public about the work of this Board.

Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Board or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions

**96.** **MEMBER QUESTION TIME**

To answer any member questions

**97.** **ORGANISATION AND GOVERNANCE**

| | | | |
|---|---|---|---|
| **98.** | None Specific | **UPDATE FROM BOARD MEMBERS**<br>To receive updates on the work of the following Health and Wellbeing Board members:<br><br>• Business, Skills and Enterprise Partnership<br>• Community Safety Partnership<br>• Place and Community Partnership<br>• Voluntary Sector<br><br>*(15 mins)* | **Verbal Report** |
| **99.** | None Specific | **EMOTIONAL HEALTH AND WELLBEING STRATEGY PERFORMANCE SCORECARD UPDATE**<br>To receive the Emotional Health and Wellbeing Strategy performance scorecard update. *(15 mins)* | **To Follow** |
| **100.** | None Specific | **CCG OPERATING PLAN 2016-17**<br>To receive the CCG Operating Plan 2016-17.<br>*(15 mins)* | **15 - 54** |
| **101.** | None Specific | **CHILDREN'S DISABILITY STRATEGY**<br>To consider the Children's Disability Strategy.<br>*(15 mins)* | **To Follow** |
| **102.** | None Specific | **UPDATE ON PROGRESS MADE AGAINST OFSTED RECOMMENDATIONS RELEVANT TO HEALTH AND WELLBEING BOARD**<br>To receive an update on progress made against Ofsted recommendations relevant to Health and Wellbeing Board. *(15 mins)* | **To Follow** |
| **103.** | None Specific | **WOKINGHAM BOROUGH COUNCIL LOCAL ACCOUNT 2014-15**<br>To receive the Wokingham Borough Council Local Account 2014-15.<br>*(15 mins)* | **55 - 86** |
| **104.** | | **INTEGRATION** | |
| **105.** | None Specific | **BETTER CARE FUND 2016-17**<br>To discuss the Better Care Fund 2016-17. *(15 mins)* | **87 - 156** |
| **106.** | | **PERFORMANCE** | |
| **107.** | None Specific | **PERFORMANCE METRICS**<br>To receive updates on performance against the following:<br><br>• Better Care Fund;<br>• Public Health Outcomes Framework, NHS and | **157 - 158** |

Adult Social Care;
- Health & Wellbeing Strategy 2014-17.

Please note that this will be by exception only. *(15 mins)*

**Any other items which the Chairman decides are urgent**
A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading

## CONTACT OFFICER


| | |
|---|---|
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**MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 11 FEBRUARY 2016 FROM 5.00 PM TO 7.10 PM**

**Present**

| | |
|---|---|
| Dr Johan Zylstra | NHS Wokingham CCG |
| Keith Baker | WBC |
| Prue Bray | WBC |
| Charlotte Haitham Taylor | WBC |
| Superintendent Rob France | Community Safety Partnership |
| Beverley Graves | Business Skills and Enterprise Partnership |
| Dr Lise Llewellyn | Director of Public Health |
| Lois Lere (substituting Katie Summers) | NHS Wokingham CCG |
| Judith Ramsden | Director of Children's Services |
| Stuart Rowbotham | Director of Health and Wellbeing |
| Nick Campbell-White | Healthwatch |
| Kevin Ward | Place and Community Partnership Representative |
| Clare Rebbeck | Voluntary Sector representative |
| Hilary Turner (substituting Nikki Luffingham) | NHS England |

**Also Present:**

| | |
|---|---|
| Madeleine Shopland | Principal Democratic Services Officer |
| Jim Stockley | Healthwatch Wokingham |
| Darrell Gale | Consultant in Public Health |
| Carolyn Lawson | Urgent Care Lead, Berkshire West CCGs |
| Helen Clark | Assistant Chief Officer, Berkshire West CCGs |

## 73. APOLOGIES

Apologies for absence were submitted from Councillor Julian McGhee-Sumner, Nikki Luffingham, Katie Summers and Dr Cathy Winfield.

## 74. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Board held on 10 December 2015 were confirmed as a correct record and signed by the Vice Chairman.

## 75. DECLARATION OF INTEREST

Councillor Haitham Taylor declared a Personal Interest in Agenda Item 86 Urgent & Emergency Care Review – Progress Report and Item 87 Berkshire West Primary Care Strategy on the grounds that her husband's company was contracted to undertake work for NHS 111 services elsewhere in the country.

## 76. PUBLIC QUESTION TIME

There were no public questions received.

## 77. MEMBER QUESTION TIME

There were no Member questions received.

## 78. HEALTH AND WELLBEING

## 79. JOINT STRATEGIC NEEDS ASSESSMENT

The Board was informed that the Joint Strategic Needs Assessment (JSNA) microsite was nearing completion.

During the discussion of this item the following points were made:

- Approximately half of the chapters had been uploaded. Some chapters were still outstanding. Each chapter took some time to upload.
- The JSNA was a live document and would be updated quarterly. Councillor Bray questioned whether this was achievable in light of the length of time it took to upload data. Darrell Gale informed the Board that it would be.
- Darrell Gale demonstrated the new microsite.
- Public Health was looking to launch the new microsite from March. The existing JSNA would be taken down from the Council's website at the same time.
- Superintendent Rob France questioned whether the accessibility guidelines had been met and was assured that they had.
- It was anticipated that going forwards the JSNA would provide 'one version of the truth' which could be referred to by the different commissioners and organisations.
- Judith Ramsden asked whether the microsite included a key words function. Darrell Gale indicated that it did not at this stage.
- Stuart Rowbotham commented that the new microsite was more initiative than the previous document.
- Testing around live situations had taken place.
- Kevin Ward asked whether feedback had been sought from the public. Councillor Baker proposed that for the first 12 months that the microsite was active a popup encouraging users to undertake a survey giving feedback appeared when users clicked on the microsite.

**RESOLVED**: That

1) the new JSNA and the microsite, specifically the navigation, content and structural design be endorsed;

2) the finalisation of the content upload and chapter synthesis be supported;

3) the launch of the JSNA in March 2016 through social media, newsletters etc. be supported.

## 80. DRAFT PUBLIC HEALTH ANNUAL REPORT

Dr Llewellyn presented the Draft Public Health Annual Report.

During the discussion of this item the following points were made:

- The Director of Public Health was required to produce an annual report on the health of the local population.
- Dr Llewellyn commented that much of the Board's focus that year had been on the frail elderly. She had chosen to focus on children's health and some of the inequalities around them in her draft annual report.

- It was noted that 20 years ago mortality in the UK for under 19 years compared favourably with the rest of Europe. However, now the UK had one of the highest rates. The Board noted infant mortality rates for Berkshire.
- Inequalities for children included obesity and there was a link between obesity and deprivation.
- Dr Llewellyn highlighted the impact of education. Those who were better educated tended to be healthier.
- Councillor Haitham Taylor asked that where the report referred to Looked After Children it be amended to read Children in Care. It was noted that Children in Care often had poorer life outcomes.
- Councillor Haitham Taylor highlighted the importance of a good start in life. She expressed concern regarding the speed of the progress made against the CAMHs Strategy for Children in Care.
- The information relating to free school meals had since been updated.
- Judith Ramsden welcomed the report's emphasis on children's health and wellbeing. She referred to the acceleration of the CAMHs agenda and the need to focus on the pre-birth agenda. The Children and Young People's Partnership's continued to work hard regarding CAMHs.
- Judith Ramsden went on to question the role the Health and Wellbeing Board had to play in breaking the cycles of deprivation and narrowing the gap. Dr Zylstra asked how the Board saw its role in meeting challenges. It was agreed that Judith Ramsden and Dr Llewellyn would bring back some options to a future Board meeting.
- Hilary Turner commented that some councils had included children's projects in their Better Care Fund Plans.
- Dr Zylstra commented that similar in depth looks at other areas would be helpful. For example the 40-65 age group were the highest A&E attendees. Dr Zylstra questioned what more could be done to address this.

**RESOLVED:** That the Draft Public Health Annual report be noted.

## 81. PERFORMANCE

## 82. PERFORMANCE METRICS

Stuart Rowbotham, Director of Health and Wellbeing, presented the Performance Metrics.

During the discussion of this item the following points were made:

- It was suggested that the suite of indicators be reviewed after the Health and Wellbeing Strategy was refreshed to ensure that indicators related to more of the Borough's population, children for example.
- Board members agreed that the Key and the Direction of Travel arrows were confusing and could be clearer.
- It was proposed that further context be provided in the commentary section in the future. The Performance Metrics could be simplified.

**RESOLVED:** That the Performance Metrics be noted.

## 83. ORGANISATION AND GOVERNANCE

## 84. URGENT & EMERGENCY CARE REVIEW - PROGRESS REPORT

Carolyn Lawson, Urgent Care Lead, Berkshire West CCGs presented the Urgent & Emergency Care Review Progress Report.

During the discussion of this item the following points were made:

- Urgent and emergency care was one of the new models of care set out in the NHS Five Year Forward View. The Urgent and Emergency Care Review proposed a fundamental shift in the way urgent and emergency care services were provided.
- The patient offer for 2020 would be:
  - A single number – NHS 111 – for all your urgent health needs;
  - Be able to speak to a clinician if needed;
  - That your health records are always available to clinicians treating you wherever you are (111, 999, community, hospital);
  - To be booked into right service for you when convenient to you;
  - Care close to home (at home) unless need a specialist service;
  - Provide specialist decision support and care through a network.
- Carolyn Lawson outlined the vision for future systems. It was a challenging vision and would not be a quick fix.
- NHS England had been working with stakeholders on transformational change.
- NHS England had developed a route map that outlined high-level expectations to support networks and System Resilience Groups in prioritising their delivery of the Review.
- Monitor and NHS England had published "*Urgent and emergency care: a potential new payment model"*, which highlighted potential payment options and provided guidance on how a new payment approach might be implemented in practice.
- With regards to NHS 111, it had been agreed that an integrated NHS 111/Urgent Care Service for Thames Valley would be commissioned. Patients who required it would be offered immediate access to a wide range of clinicians, both experienced generalists and specialists. This model would also offer advice to health professionals locally, such as paramedics and emergency technicians, so that no decision need be taken in isolation.
- Board members were reminded of the role of the Berkshire West Urgent Care Programme Board.
- In response to a question from Dr Llewellyn, Dr Zylstra emphasised that the report set out the basic structure of the system and there was more work to be done. Carolyn Lawson explained that the infrastructure behind the system was under consideration.
- Councillor Haitham Taylor asked whether there was an opportunity to feed in as a Health and Wellbeing Board.
- Clare Rebbeck expressed concern regarding GP capacity, particularly in light of the forthcoming development of the Strategic Development Locations. She indicated that Montague Park residents had been signposted to Wokingham Medical Centre as the nearest surgery. However, many of them had been unable to get appointments or had opted to remain registered at their previous surgery.
- Councillor Bray questioned whether there was likely to be financial consequences for commissioning in Wokingham and was informed that it was not a likely result of the NHS 111/Urgent Care Service procurement.

**RESOLVED:** That

1) the report and the action being taken nationally and locally to deliver the objectives of the "Urgent and Emergency Care Review" be noted.

2) how the local health and social care system currently works in partnership to support good patient flow around the system, which is critical is to the success of our local urgent and emergency care system, be noted.

## 85. BERKSHIRE WEST PRIMARY CARE STRATEGY

Helen Clark, Assistant Chief Officer, Berkshire West CCGs presented the Berkshire West Primary Care Strategy.

During the discussion of this item the following points were made:

- The Primary Care Strategy set out the vision for sustainable, enhanced primary care services which would play a key role in delivering out-of-hospital care for patients as described in the CCG's Strategic Plan. Helen Clark explained that the Strategy was a high level document and more work would be undertaken going forward.
- The Strategy's development had been overseen by the Joint Primary Care Commissioning Committee on which the Health and Wellbeing Board was represented.
- Engagement events had been held and an online consultation carried out.
- Key messages from the public engagement were that there was a desire for Saturday appointments but less so for Sunday appointments. Many practices now offered Saturday appointments. There was a willingness to access primary care in new ways such as using online appointments. Patients wanted continuity and a named GP for long term conditions but were less concerned about seeing a named GP for urgent appointments.
- The CCG had applied to move to a fully delegated co-commissioning arrangement with effect from 1 April 2016. In response to questions from Board members Dr Zylstra commented that should a decision be taken regarding a service which would be commissioned from a GP, that GP would be excluded from voting on the decision. There were strict guidelines in place.
- Helen Clark outlined the five strategic objectives within the Strategy.
    - Addressing current pressures and creating a sustainable primary care sector.
    - Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting;
    - Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home;
    - Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care were met appropriately and appointments were available in the evenings and at weekends;
    - Making effective referrals to other services when patients will most benefit.

- With regards to Strategic Objective 1, work was being carried out to address the workforce challenge. Board members were informed of Physician Associate training offered by the University of Reading.
- With regards to Strategic Objective 3, greater emphasis was being placed on prevention and putting patients in control of their own care planning.
- With regards to Strategic Objective 5, it was noted that an additional 476 appointments a week had been commissioned in Wokingham.
- The Board was informed that the CCG had developed a draft Estates Strategy.
- Kevin Ward asked how the strategy objectives would be achieved and was informed that work around the implementation was ongoing.
- Councillor Bray asked whether the CCG was confident that the Strategy could be delivered. Helen Clark commented that it would not be easy due to the pressure on primary care.
- The Board discussed new ways of working in Primary Care. A move away from a GP focused model was likely.
- Clare Rebbeck asked whose responsibility it was to educate people regarding prevention and self-care.
- Dr Zylstra commented that the same people often attended engagement events and that it was important to also hear the views of other parts of the community.
- Judith Ramsden emphasised that it was vital that there was a line of accountability to the Health and Wellbeing Board.

**RESOLVED:** That the Berkshire West Primary Care Strategy be endorsed.

**86. HEALTH AND WELLBEING BOARD SUB-COMMITTEE - PRIMARY CARE**

The Board considered a report which proposed the dissolution of the Health and Wellbeing Board Sub Committee.

During the discussion of this item the following points were made:

- The Board was informed that the Health and Wellbeing Board Sub-Committee's Terms of Reference were misdirected; the sub-committee had no locus to carry out its purported aims.
- The Department of Health had determined that Clinical Commissioning Groups would be responsible for commissioning Primary Care and a local Joint Primary Care Co-Commissioning Committee had been established for that purpose. A Primary Care Commissioning Strategy had been published which had been presented to the Health and Wellbeing Board.
- The Health and Wellbeing Board was a key consultee for Primary Care commissioning matters, both with regard to the Primary Care Commissioning Strategy and primary care infrastructure planning consent applications. Through these mechanisms the Health and Wellbeing Board would continue to exercise its influence regarding the development of local primary care services.
- It was felt that the continued involvement of the Sub Committee would add bureaucracy and create confusion.

**RESOLVED:** That the Health and Wellbeing Board Sub-Committee –Primary Care be dissolved.

## 87. CHILDREN'S SAFEGUARDING OFSTED REPORT AND THE LOCAL SAFEGUARDING CHILDREN'S BOARD OFSTED REPORT

Judith Ramsden, Director of Children's Services updated the Board on the Children's Safeguarding Ofsted report and the Local Safeguarding Children's Board (LSCB) Ofsted report.

During the discussion of this item the following points were made:

- Ofsted's findings had been published on 5 January. The results of the inspection had validated the self-assessment undertaken by the Council.
- Ofsted had indicated that it would expect to find the Service at 'Good' level in a few months' time.
- The Ofsted report had identified strong leadership and governance. The need for some improvements regarding management had also been identified. This was being addressed.
- Recommendations 3 and 4 of the Ofsted report were particularly relevant to the Health and Wellbeing Board.
- Recommendation 3 - Accelerate the implementation of the joint local authority and clinical commissioning group emotional health strategy to ensure better and quicker access to emotional and mental health support for children and young people.
- The Local Safeguarding Children's Board wanted to bring to the Health and Wellbeing Board's attention the fact that the average length of time spent in the ASD pathway was 2 years. Consideration should be given as to how this could be addressed.
- Recommendations 4 - With partners, ensure that there is an effective integrated service pathway for all children and for young people in transition.
- There were some good transition plans in place and also some examples of poor planning.
- Judith Ramsden noted that an update from the Children and Young People's Partnership on the Early Health and Innovation Project was scheduled for the Board's April meeting. She suggested that alternatively an update on the changes made in response to Recommendation 3 be provided.
- Lines of accountability for progressing the two recommendations needed to be established.
- Dr Zylstra commented that a notice of challenge had been issued to the CAMHs provider. The relevant information requested would be provided to the CCG as commissioners and the Health and Wellbeing Board would be informed of the outcome. Judith Ramsden indicated that she would want to be informed prior to their issue of any future notice of challenge regarding CAMHs. More radical thinking was required to take pressure off of the system.
- Nick Campbell-White commented that Healthwatch Wokingham Borough had concerns regarding workforce levels in CAMHs. He questioned whether greater use could be made of ARC. Dr Zylstra reminded the Board that the CCG was not the primary commissioner of ARC.

**RESOLVED:** That the presentation on the Children's Safeguarding Ofsted report and the Local Safeguarding Children's Board (LSCB) Ofsted report be noted.

## 88. UPDATE FROM BOARD MEMBERS

The Board received updates from several Board members.

During the discussion of this item the following points were made:

*Business, Skills and Enterprise Partnership:*

- Beverley Graves provided an update regarding objective 1d. 'Improving the life chances and wellbeing of disadvantaged young people (Not in Employment, Education and Training) aged 16-25 years) in the Borough' and 1e. 'Enabling the older working population to work in fulfilling, productive employment for longer – including volunteering,' in the current Health and Wellbeing Strategy. Further information would be circulated to Board members.

*Community Safety Partnership:*

- The Ofsted report had commented that joint working regarding missing children was good.
- Superintendent Rob France updated the Board on work being undertaken with regards to domestic abuse.

*Place and Community Partnership:*

- It was noted that the last meeting of the Place and Community Partnership had been cancelled.

*Voluntary Sector*

- Clare Rebbeck informed the Board of partnership development decisions.
- Board members were informed of a community awareness event regarding children's safeguarding which would take place on 22 February.
- It was requested that the item on Updates from Board members be higher up the agenda in future. It was agreed that the most important items should be placed at the start of the agenda to ensure that they were discussed sufficiently.

**RESOLVED:** That the updates from Board members be noted.

**89. FORWARD PROGRAMME**

The Board discussed the Forward Programme for the remainder of the 2015/16 municipal year.

Lois Lere requested that the item on the National Information Board – Local Digital Roadmap scheduled for April be deferred to the next meeting as the project had been delayed.

Board members were asked to inform the Principal Democratic Services Officer of any items that they wished to add or remove from the forward programme.

**RESOLVED:** That the Forward Programme be noted.

NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

# Operational Plan 2016/17 Executive Summary

## Wokingham, Newbury and District, South Reading and North and West Reading Clinical Commissioning Groups

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# 1. Strategic Context and key challenges

This document reflects the Berkshire West CCGs unit of planning and sets out our high level Operational Plan for 2016/17. This plan is supported by a suite of documents including our Financial Strategy, 16/17 Activity plans, Dementia Action plan, Cancer recovery plan, and the Systems resilience plan. This Operational plan sets out our priorities for the coming year in the context of the NHS England planning guidance, forming year one of the emerging Sustainability and Transformation Plan (STP), and which builds on the Berkshire West CCGs strong track record of financial and non-financial performance.

The Berkshire West CCGs are collectively recognised as a high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services.

Nevertheless, like other health and care systems we recognise we are facing increasing operational and financial challenges. Within that context we acknowledge that although individual sectors largely perform well, the overall experience of services for our residents can sometimes be uncoordinated and fragmented, and that the current design of the system and services means that people are often driven into higher and more costly levels of care than their needs determine. This fragmentation of care can impact on both the citizen's experience and outcomes, and is a poor use of public money**.** Health and social care partners in Berkshire West are therefore committed to developing, testing and implementing innovative approaches to new ways of working and in delivering our shared vision for our system as a key foundation on which to build.

By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies.

This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people 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.

# 2. New Models of Care and Sustainability

## 2.1 Berkshire West Accountable Care System (ACS)

The Berkshire West system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which will report back in March 2016, with the findings and actions to be used to inform further pathway redesign and the exploration of new approaches to funding in the current Better Care Fund planning and health provider contracting round.

To meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and to operate as an ACS. The ACS is a collective enterprise that will unite its

members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West.

The key characteristics of our ACS will be:

- We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live
- We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy
- we will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system
- clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system
- finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism
- we will develop and use long term contracts to promote financial stability of the providers
- it will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations.

The three Local authorities in Berkshire West have given their support to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. The implementation of the Five Year Forward View requires the production of Sustainability and Transformation Plan (STP), see below, and the development of an ACS for Berkshire West will be at the heart of the Thames Valley plan (see section 2.2) and will be the vehicle for delivering the service transformation locally that will lead to wider financial sustainability.

The key objectives of our ACS will be to:

1. Improve individual and population health, promoting primary and preventative care and reducing the requirement for more costly care. The ACS will require a strong public health and health promotion component to be effective in this area.
2. Improve people's experience of care by providing transformed, more integrated pathways of care with minimal hand offs between different parts of the system
3. Achieve financial balance at a system level through redesigned pathways and optimal models of delivery, supported by shared cost effective back office mechanisms, providing public confidence in the local NHS

In its first year the ACS will need to achieve two key deliverables: the production of a multiyear Berkshire West Shared Strategy and an underpinning system wide financial model which demonstrates how the transformation strategy will deliver financial sustainability.

The proposal is that social care could be included in the ACS in a subsequent phase of the programme and this has the support of all three Local authorities. This allows time for the three local authorities to pursue the development of a joint commissioning unit on the same Berkshire West footprint.

The ACS Programme will be managed against a clear documented project plan and a risk and issues log maintained. The programme management approach will be underpinned by partnership working and a communications and engagement plan to ensure all stakeholders are kept up to date.

## 2.2 Development of a Thames Valley Footprint STP

The CCGs with colleagues from Buckinghamshire and Oxfordshire (BOB) are working together as requested by NHS England to scope an umbrella Thames Valley Sustainability and Transformation Plan (STP). The proposed footprint presents a number of risks, issues and opportunities which the respective Chief Officers and Chairs will consider over the coming weeks. The key concern is to ensure that such an approach would not have an adverse impact on the local plans for an Accountable Care System.

Once agreement on the footprint has been reached, the organisations concerned will need to undertake considerable work to prepare for and deliver the STP. This will include agreeing governance arrangements as well as undertaking further analysis of current gaps across the domains of health and wellbeing, care and quality and finance and efficiency; identifying key priorities for addressing these before Easter. After Easter the focus will be on the detailed development of a plan which must cover the nine initial 'must-dos' described in the planning guidance as well as setting out a broader platform for transforming local health and care services in accordance with a number of key national parameters.

West Berkshire, Oxford and Buckinghamshire CCGs (BOB) remain committed to our main transformation programmes being at CCG or unit of planning levels, focussed on our key service providers of secondary, community, mental health and primary care as these cover the majority of demand from our local population's health needs. This has led to very different approaches across the wider STP footprint, including one devolution bid and one ACS model.

Whilst we clearly have very different approaches to our transformation programmes, we have identified key areas of our transformation that should be undertaken at BOB STP scale.

In summary, those are:

- Specialised commissioning (note that this is wider than the BOB footprint)
- Workforce
- PLCV and Priorities
- Primary Care provider development
- CSU support
- Urgent & Emergency Care
- Digital Innovation

These have been mapped to the three identified gaps, for clarity and range from transformational work at scale (e.g. digital innovation and interoperability) through to areas where it makes sense to share learning to hasten wider implementation, such as primary care provider development.

**BOB Alliance - Forum for STP Development Oversight**

The BOB AOs and Chairs meet monthly and it is this meeting that will oversee the development of a robust STP. This group will:

- Track progress of STP development, ensuring ongoing alignment with local strategies
- Oversee the aggregation of all local engagement with stakeholders & populations
- Identify further opportunities for BOB scale work to gain maximum efficiencies
- Ongoing monitoring of the work streams above and any further opportunities identified

Draft governance arrangements for this Alliance are in the process of being developed and are going through CCG governance sign-off. These arrangements will ensure effective system governance to oversee both the short and longer term objectives.

# 3. Financial sustainability

## 3.1 Local context

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,047 compared to a national average of £1,221), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The target allocation of the Berkshire West CCG (if it existed) would be £1,067 per person, the second lowest in the South of England area.

Allocations and growth for 2016/17 are as follows:

| | Newbury | N&WR | SR | Wok | BW CCGs total |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| Baseline 16/17 - £m | 131.0 | 125.4 | 135.3 | 172.1 | 563.8 |
| Primary care 16/17 - £m | 14.0 | 13.7 | 18.2 | 18.1 | 64.0 |
| | | | | | |
| Growth in above baseline - £m | 3.8 | 5.6 | 7.2 | 5.0 | 21.6 |
| % growth | 3.05% | 4.78% | 5.75% | 3.05% | 4.07% |

The key financial targets for the BW CCGs in 2016/17 are:

- Achievement of I&E surplus of the greater of 2015/16 surplus less any agreed drawdown or 1%;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2015-2016, and for this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for 2016/17.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;
- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements.

## 3.2 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2015/16 outturn as the starting point for 2016/17 contract negotiations.

The CCG has used the same activity assumptions for the finance and activity components of the plan. In 2016-2017, activity growth will be agreed with each provider based on local circumstances. Initial discussions with the main acute provider (RBFT) and also upon review of the Indicative Hospital Activity Model (IHAM), suggest that overall activity growth will be approximately 2% overall with some areas of emergency activity growing by up to 4%.

The assumptions have been made on a Berkshire West basis rather than at CCG level to account for small number variations and to align to the way the CCG commissions services across Berkshire West. These assumptions still require further work and we still need to understand non-recurrent elements of growth for elective care to reduce waiting list backlogs, especially for cancer services. The CCGs have not modelled in the transformational QIPP changes into the activity models due to further detailed work being required, although this has been done for the

financial plan. Further testing of the growth assumptions is required, especially for non-elective care, compared to what happened in 2015/16 and the CCG has commissioned a specific piece of work to support this.

## 3.3 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2016/17, and amounts to £16m in total, which is 2.8% of allocation.

In order to drive the achievement of QIPPs in 2016/17, a new Planning and Transformation team has been recruited (previously outsourced to the South Central and West CSU) and over the last 3 months the focus has been on developing new processes and governance structures which are now embedded across the organisation. Each QIPP scheme is supported by a full suite of documentation, including PIDs and Quality & Equality Impact Assessments and delivery is overseen through both the new QIPP Operational Delivery Group and strategically through the CCGs QIPP & Finance Committee each month.

Schemes are being developed to meet the QIPP gap and these are shown in the table below. Other schemes are under development to close the financial gap, and currently the schemes yet to be identified amount to £6m.

| Scheme name | Net saving £m |
|---|---|
| Frail Elderly | 1.2 |
| Care homes | 1.2 |
| Business rules | 1.6 |
| MSK | 0.9 |
| Placements | 0.7 |
| Meds management | 0.7 |
| Planned care | 0.8 |
| Better Care Fund | 0.6 |
| Ophthalmology provision | 0.3 |
| Referal variation | 0.5 |
| Urgent care | 0.2 |
| End of life | 0.3 |
| Respiratory | 0.4 |
| Other Long term conditions | 0.6 |
| Innovations in electives | 0.2 |
| Other schemes | 0.6 |
| | 10.8 |

## 3.4 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to endure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation.

The increased investment of up to £2.4m will be utilised in a number of organisations within the health economy including Berkshire Healthcare NHS FT, Royal Berkshire Hospital NHS FT, CCGs and Primary Care.

## 3.5 Moderating demand

Despite a number of initiatives and schemes being put in place during 2015/16 to reduce non-elective activity the system has seen unprecedented activity growth in non-elective activity. Although some of this can be explained by the introduction of a short stay Observation Unit at the RBFT this by no means explains growth of in excess of 10%.

This activity has been in part paid for from the Performance Fund identified in the BCF and if not effectively managed and contained will increase financial unsustainability.

## 3.6 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West. This collaborative approach is exemplified by the Prevention Working Group, part of the BW10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting health organisations.

## 3.7 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care.
In 2015/16 and 2016/17, our system is forecasting an overall deficit:

| | 2015/16 (deficit)/ surplus forecast (£m) | 2015/16 (deficit)/ surplus as a % of turnover | 2016/17 (deficit) forecast (£m) |
|---|---|---|---|
| Royal Berkshire NHS FT | (9) | (2.40) | (11) |
| Berkshire Healthcare NHS FT | (2) | (0.85) | (8) |
| South Central Ambulance Service NHS FT | (4) | (2.10) | TBC |
| Berkshire West CCGs | 5 | 0.90 | (16) QIPP Gap |
| **Total** | **(10)** | | **(36)** |

*NB This is prior to the control totals provided by NHSI to providers*

The local health economy financial baseline shows that the size of the LHE financial challenge is set to grow significantly. Work undertaken across the health authority last year (currently being refreshed) shows the scale of the challenge by FY19.

| | **FY15** | **FY16** | **FY17** | **FY18** | **FY19** |
|---|---|---|---|---|---|
| BHFT CIP cumulative total is **£41.5m** | £8.6m | £12.6m | £6.2m | £6.8m | £7.3m |
| BHFT CIP target as % of income | 3.9 | 5.8 | 2.8 | 3.1 | 3.3 |
| RBFT CIP cumulative total is **£77.9m** | £18.5m | £16.9m | £15.2m | £13.6m | £13.7m |
| RBFT CIP target as % of income | 5.3 | 4.7 | 4.1 | 3.6 | 3.6 |
| Commissioner cumulative net QIPP (RBFT) | £6.1m | £11.9m | £16.8m | £21.1m | **£24.8m** |
| Commissioner cumulative net QIPP (other) | £1.5m | £3.4m | £5.1m | £6.6m | **£8.0m** |
| Combined CIP and QIPP challenge (FY19) | | | | | **£152.2m** |
| Stranded costs at RBFT through alignment of plans | | | | | £4.3m |
| LHE challenge, assuming plans are aligned (FY19) | | | | | **£156.5m** |

*(Source: Berks West Clinical Strategy Programme LHE Financial Baseline, June 2014)*

## 3.8 Primary Care

As CCGs we have already invested £5m in primary care over the last two years in CESs to enhance extended hours provision (see above) and maximise the impact of care planning and ensure we provide proactive support to care homes. We have also developed a plan for the reinvestment of PMS premium monies through a Quality CES which will be developed on an incremental basis over the next five years, reflecting the role that we need primary care to play in the delivery of our strategic objectives. We are exploring the affordability of commissioning such a CES in the CCGs which do not have PMS premium funding.

As we take on fully-delegated responsibility for commissioning primary medical services we will be working to ensure that the delegated budgets we receive are used to maximum effect to commission high quality care for our population. We will also be working with NHS England through the PCTF bidding process and other capital allocation mechanisms to ensure investment in the premises schemes and technological developments which we have identified are a priority for the delivery of our overall strategy for primary care.

## 3.9 Better Care Fund (BCF)

Over £25m has been invested from health monies into the pooled budgets creating the Better Care Funds of the 3 Local Authorities, £15m of which was new investment in 2015/16. Section 75 agreements have been put in place for the management of the overall pooled budgets of £27m.

The CCGs are currently working with local authority partners to evaluate the schemes funded through the BCF during 2015/16 and to agree their plans for the coming year. The requirements set out in the Better Care Fund Planning Requirements for 2016/17 received on 23rd February issued by NHS England will be considered in the development of local plans. Local areas are also expected to maintain the progress made around 2015-16 BCF metrics including admissions to residential and care homes, patient experience, effectiveness of reablement and delayed transfers of care. Details of the final plans will be included in our planning submission on 21st March and in the final plans which will be submitted on 25th April. Approval of the final BCF plans will be via the individual Health and Wellbeing Boards (March for West Berkshire and April for both Reading and Wokingham).

Examples of achievements in 15/16 include:

- Working through the BCF Wokingham has supported the recruitment and training of 12 volunteer navigators to support patients to access the right services and reduce demand on GP appointments, by delivering social prescriptions and guiding patients to voluntary organisations who can support their needs
- In Reading the CCG have funded a Full Intake Model which aims to increase community reablement team capacity offering admission avoidance, reablement and support to the "discharge to assess bed base". The "Discharge to Assess" service has been expanded to 12 beds including for older people with mental health conditions such as dementia
- In West Berkshire the Joint Care Provider Project (incorporating seven day working and direct commissioning by specified health staff) has led to a more cohesive service which will reduce duplication, improve access and increase capacity.

# 4. Primary Care

A strong and effective primary care sector is acknowledged to be a critical aspect of an effective and high performing health care system. The challenges of increasing demand from elderly and frail patients living with multiple and complex chronic diseases is placing an increasing strain on practices and how they respond over the next five years will be crucial to the delivery of our Operational Plan.

Over the last 18 months we have engaged the public, partners and member practices in the development of a detailed Primary Care Strategy. Our Primary Care Strategy clearly defines the following 'asks' of primary care:

- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

The implementation of our Primary Care Strategy is overseen by our Primary Care Commissioning Committee which includes representatives of all four CCGs. A quarterly programme report incorporates progress on both Berkshire-West wide work streams and projects undertaken within individual CCGs. In this way, learning from local projects can be shared across the four CCGs and synergies and further opportunities for joint working can be identified.

Key work streams are described in the following sections.

## 4.1 Sustainability

Across the 4 CCGs we are supporting practices to explore opportunities to work together to create efficiencies and achieve sustainability and are using commissioning levers to align incentives with these models. Below are examples of the CCG specific areas of work we will be focusing on over the coming year.

In South Reading (where there are a large number of smaller practices) our vision for the future of primary care is that we will see a smaller number of providers, working in merged or federated arrangements likely to include hub and spoke models. We envisage that each of these will serve a population of 25,000 - 30,000 patients. Two such provider units are already emerging. We intend to use a proportion of our released PMS premium funding, together with NHSE's vulnerable practice funding to progress this work.

In Wokingham as a CCG we are supporting practices to explore opportunities to work together to create efficiencies and achieve sustainability and are using commissioning levers to align incentives with these models. Our neighbourhood cluster model has created three clusters of practices, each serving a population of 40-60,000 patients, and practices within these clusters are now considering shared posts, pooled back office functions and a joint approach to meeting on-the-day demand.

In North West Reading CCG it is our intention that current procurement exercises will stabilise two practices where there has been a turnover of providers; putting in place contracts that closely reflect our broader primary care strategy.

Newbury and District CCG practices are exploring opportunities to work together to address current pressures particularly around workforce, and are already training a new role called a GP administrative assistant intended to free up GP time and are also piloting clinical pharmacists in practice.

The JPCC will take an oversight role in assessing the impact of these differing approaches and the impact these have on delivery of the Berkshire West Primary Care Strategy.

The Quality Dashboard that we are currently developing for primary care will allow improved comparison with local peers and national figures, thereby enabling a more detailed assessment of variation and inequalities. This will build upon an earlier risk mapping exercise which considered the potential vulnerability of practices based on a range of metrics including CQC visit outcomes, staffing issues, the standard of practice premises and financial status. We are

using this information to support discussions with practices regarding options for future sustainability and in considering priorities for Primary Care Transformation Fund bids and other potential sources of investment.

In addition, where we have had practices rated 'inadequate' by the CQC we are working with NHS England to support these practices to make the necessary improvements and to put in place contingency plans where required.

## 4.2 Workforce

We are currently developing a detailed programme of work to respond to primary care workforce issues, led by a working group reporting to the Primary Care Commissioning Committee. This will consider workforce planning, recruitment and retention of GPs and other staff, innovative approaches to training and CPD and workforce diversification. We will ensure we consider links with the 10 point plan for GP recruitment and retention as part of this. We will also give further consideration to how we can maximise the impact of retainer placements.

We have worked with the University of Reading, BHFT and RBFT to establish a local training programme for Physician Associates. A number of our practices are hosting training placements and will be supporting their first student over the coming weeks. One of the working groups of the Joint Primary Care Co-commissioning committee will be leading on workforce development including workforce planning, recruitment and retention, training and CPD, workforce diversification including scoping the opportunities for expanding the range of professionals offering primary care services such as pharmacists, a specialist GP role for care home patients, and extending the roles of health care assistants and practice nurses supported by appropriate accredited training and development programmes. As part of this we are exploring the potential to collaborate with Health Education England Thames Valley to develop a primary care training hub in Berkshire West.

## 4.3 Managing Demand

We recognise the need to develop a more robust approach to managing demand in primary care and therefore the CCGs are proposing the creation of a joint sub group of the Joint Primary Care Co-commissioning Committee and the Innovation technology and Information systems Programme Board with the purpose of scoping and developing a work plan which aims to address this challenge in Berkshire West. This will include:

- Exploring how we utilise IT to maximum effect to give patients the opportunity to access primary care in new ways thereby enabling practices to better manage demand
- Exploring opportunities for greater self-management by patients, including automating elements of QOF as well as for joint working on urgent access.
- Maximising opportunities around self-care of self-limiting illness, including through the use of symptom-checker and GP triage apps.
- Developing a pilot in Wokingham CCG for NHS111 direct booking into in-hours Primary Care
- Exploring collaborative models which will ensure enhanced access to Primary Care across the week including Sundays and which build on the current CES, and take into account the workforce capacity challenges.

## 4.4 Premises

There will be further development of our Estates Strategy including detailed planning around areas of population growth and maximising CIL/S106 contributions. Our Primary Care Transformation Fund bids reflect additional facilities likely to be required as a result of population growth.

Our priorities for primary care premises investment reflect the need to respond to significant projected population growth, particularly in Wokingham CCG, and to ensure our 'up scaled' providers work from modern, fit-for-purpose premises which support the delivery of an extended range of services in primary care. Our Primary Care Transformation Fund (PCTF bids) will reflect these priorities, focussing on a small number of larger schemes we expect to be required over the next 2-3 years. We have also reviewed the findings of the six-facet premises survey

undertaken by NHS England and assess schemes proposed by practices against this as well as in the light of projected population growth.

As set out above we are currently considering how we can expand extended access provision beyond current commissioned levels and will review premises and technological implications as part of this. As set out in our submission, our Connected Care procurement includes a patient portal which will underpin delivery of self-management and triage approaches. As we pilot NHS 111 direct booking and collaborative working around 7-day routine provision and meeting urgent care demand we will be considering the role of technology within this, including ensuring we maximise the benefit of online access, self-management and remote triage.

## 5. Prevention

Strong public health and health promotion are core components to delivering an effective ACS. The CCGs will continue to work closely with Public Health to place greater emphasis on prevention and putting patients in control of their own health; we will use the individual CCG Public Health profiles (see supporting documents) to inform local priorities in addressing health inequalities. These profiles show that life expectancy for both men and women are significantly better than the national average within 3 of the 4 Berkshire West CCGs. In contrast, South Reading CCG's life expectancy is significantly worse than the national average (2 years less for men, 1.2 years less for women).

Potential Years of Life Lost (PYLL) is an indicator of premature mortality and shows the number of years not lived by an individual from birth to 75. A death is considered amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause could be avoided through good quality healthcare. In 2012-14, the England PYLL rate was 2,032 per 100,000 population. Both Newbury & District CCG and Wokingham CCG's rates were significantly better than the national level and the two Reading CCGs had similar rates. All of the Berkshire West CCGs had similar or better rates of PYLL to their respective CCG comparator groups. The main cause of PYLL in England was ischaemic heart disease. The main cause across all of Berkshire West CCGs was neoplasms, with ischaemic heart disease as the second main cause.

Complimenting existing activity the cross-organisation BW10 Prevention Working Group will develop a comprehensive plan for prevention to support the sustainability of the Berkshire West Health and Social Care system. We will continue to promote healthy lifestyles and target the leading risk factors for ill-health in partnership with Public Health to decrease numbers of smokers and decrease levels of alcohol consumption, increase levels of physical activity, detect people with high blood pressure and cholesterol, and reduce obesity in children and adults by increasing the uptake of the NHS Health Check Programme and referring into local services e.g. Eat 4 Health. Local practices have been tasked with increasing referrals by 25% and are on track to deliver this target with 67 referrals in Q1, health walks, recording alcohol consumption and supporting a reducing alcohol intake through brief interventions and signposting.

Health promoting schemes that we have funded in 15/16 and will continue to fund during 16/17 include the Eat4Health and 'Beat the Streets' programmes. This year 23,992 people took part in Beat the Streets (including 12% of patients with LTCs) and walked 306,599 miles. This is a 63% increase in participants from when the project was first piloted in 2014. At the beginning of the project 40% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the project, this had increased to 48%. 78% of participants said they would try to continue the changes they had made. In 2015/16 North & West Reading CCG commissioned Age UK to deliver a 'Living Well' pilot which provides upstream interventions for older people not requiring medical or nursing care to support improvements in wellbeing and reduce avoidable GP appointments, A&E attendances and 999 contacts. Results from the first 2 quarters of the pilot show that wellbeing has improved by 28% and that there has been a 30% reduction in GP appointments, 50% reduction in A&E attendances and 50% less 999 contacts.

## 5.1 Obesity and being overweight

Berkshire West CCGs have a recorded obesity prevalence rate of 7.0% in the registered population aged 16 and over, which is approximately 29,472 people. This prevalence rate varies between the CCGs, from 6.6% in Wokingham CCG to 7.4% in North & West Reading CCG. However, these are all lower than their respective comparator groups and the national prevalence rare of 9.0%.

Adults with a Body Mass Index over 25 are defined as being overweight. Figures collected through the Active People Survey (2012-2014) estimate that 64.6% of adults living in England are overweight or obese. All of the Berkshire West LAs have a lower level of adults with excess weight and Reading's is significantly lower at 61%.

Key objectives across Reading's Healthy Weight Strategy will be to ensure that people in Berkshire know how to achieve and maintain a healthy weight, are able to choose a healthy diet and can become more physically active in everyday life. In children, there is a significant link between being an overweight or obese child and becoming an obese adult. Establishing a healthy weight and healthy lifestyle habits in early years will help to create the blueprint for life. A focus will be given within the strategy to evidence based interventions and recommendations for the prevention and management of childhood obesity across the CCG area, including schemes to improve facilities for cycling and walking; encouraging active play, minimising sedentary behaviour and the provision of healthy catering in early year's settings and appropriate referral to and endorsement of weight management, physical activity and healthy eating programmes.

We will commission during 2016/17 a Tier 3 weight management intervention service in line with the NICE guidance (CG 189, 2014). Tier 3 services form an important part of the weight management pathway and provide a more specialist intervention delivered by a multidisciplinary team with the aim of reducing mortality rates and levels of co-morbidity associated with clinical obesity. The social and psychological benefits are well known. The objective is to commission an effective and accessible weight management intervention service for patients (with or without co-morbidities) who have already been through an appropriate Tier 1 and Tier 2 weight loss service including nutrition and physical activity advice and psychological approaches to behaviour change.

In addition to obesity services those at risk of developing diabetes will be referred and managed under the National Diabetes Prevention Programme and working with Public Health we will be promoting a cross Berkshire digital campaign which builds on the successful Change for Life programme.

The prevalence of obesity in children as measured though the National Child Measurement Programme (2014/15) show that the prevalence of obesity in Reading is similar to the national average for both ages four to five and ten to eleven, while Wokingham and West Berkshire's are significantly better. The Reading CCGs have committed to working in partnership with the Public Health team to deliver the Beat the Street competition for the third year running, and to explore wider opportunities to collaborate with Primary Care, Maternity services, Health Visiting, School Nurses and Schools to address this issue. We have re-procured programmes to support children who are overweight (Let's Get Going) and within West Berkshire we are piloting an active schools programme from 0-19 years to increase levels of activity. In addition working with Public Health we will review the awaited children strategy and develop an action plan based upon this.

## 5.2 Alcohol

In 2013/14, there were over 333,000 alcohol-related hospital admissions in England, which equates to 645 admissions per 100,000 population. Three of Berkshire West's CCGs had significantly better rates of admission than the national figure, ranging from 366 in Wokingham CCG to 493 in Newbury & District CCG. South Reading CCG's admission rate was similar to England's at 597 per 100,000 population.

Public Health England has estimated the increase on average life expectancy for men and women at a local level if all alcohol-related deaths were prevented. This ranges from 7 to 16 months for men and 3 to 5.5 months for women in the Berkshire West CCGs.

In 2016/17, we will be commissioning a new Alcohol Specialist Nursing Service for people who present and/or are admitted to hospital for alcohol related harm. This will support better management of patients presenting at the ED department at the RBFT with alcohol related problems by ensuring that there are clear pathways into both primary care and specialist drug and alcohol services, and provide a rapid response assessment and triage to avoid delayed discharges and avoidable hospital admission. The service will link with the appropriate community services for on-going community treatment and support to reduce re-attendances at ED. The service will also provide education and training to acute and Primary Care clinicians to enable better manage patients with chronic and acute alcohol problems.

In addition, we will be taking part in the Public Health England led improvement programme reviewing the current pattern of services against best practice. This will support the development of our 5 year action plan to address the impact of alcohol across West Berkshire.

## 5.3 Cholesterol and Blood Pressure

QOF data and Right Care data demonstrate that once detected primary care intervention for high cholesterol and/or blood pressure is effective; however there remains a low level of ascertainment of patients that would benefit from intervention. The national NHS Health Check Programme aims to prevent vascular disease, by inviting eligible people to an assessment of risk of developing a vascular condition. They are then given advice and support to help them manage or reduce any risks identified. GP Practices are the main providers of Health Checks nationally and all of the West of Berkshire LAs have Primary Care Contracts in place with their CCGs to provide this service.

Berkshire West CCG GP Practices completed 22,736 Health Checks from 1st April 2013 to 31st Dec 2015, which equated to 15% of the eligible registered population. The uptake in England over this time was 25%. The local uptake is lower than the national figure and also lower than the apportioned target for this time period (27.5%) and PHE ambition (37%). Working with Public Health we will continue to focus on health checks, including determining alternative ways and venues to find people with high blood pressure in the community.

## 5.4 Tobacco

In 2014 the national smoking prevalence rate for adults was 18.0%. Reading's rate was similar at 17%, while Wokingham and West Berkshire's were significantly better at 9.8% and 15.5% respectively. If we compare this to local smoking prevalence rates from 2010, this would suggest that there are now over 14,000 less smokers in Berkshire West than there were 5 years ago.

Stop Smoking Services operate to offer support to those people finding it difficult to quit. The service in Berkshire 'Smoke Free life Berkshire' is provided by Solutions 4 Health Ltd and jointly commissioned by all 6 Berkshire local authorities. The Stop Smoking Service and Public Health teams have worked closely with Berkshire Healthcare Foundation Trust to address smoking in certain priority groups. This includes people with mental health conditions among whom smoking rates are very high and quit smoking success rates are traditionally poor. The stop smoking service offer quit support on site at mental healthcare settings as well as work with BHFT to promote the service to people with mental health conditions resident in the community. In addition to smoking cessation support, the service has also worked with BHFT to make all community and in-patient mental healthcare settings smoke free. This work was completed in October, meaning that Berkshire is one of the few areas in the country to have totally smoke free mental healthcare facilities, including both indoor areas and grounds.

## 5.5 Screening and Immunisation

Currently screening and immunisation are reviewed and overseen by the health protection community and NHS England area team working across Berkshire. This group has public health and CCG representation ensuring the vital link between primary care development and NHS England in the delivering of screening and immunisation programmes. In a concentrated effort to address the inequalities in immunisation uptake in the 0-5 year cohorts in Berkshire, two Childhood Health Inequalities Nurses have been recruited to work within BHFT on a pilot project (Feb

2016 to April 2017). They will be working with child health records department, primary care, health visitors, local authorities, children's centres and other stakeholder agencies to improve timely childhood immunisation uptake in areas with historically low coverage, follow-up children with delayed or missing immunisation and facilitate access to immunisation services and target hard-to reach families.

Concerted effort is being made to maximise uptake of bowel cancer screening and reduce local variations in uptake. This includes Cancer Research UK's media campaign and screening enhancement kits and North and West Reading CCG quality premium initiative.

# 6. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2016/17. The CCGs have supported our providers to make significant progress in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure ulcers (average of 24 per year reduced to 5 to date in 2015/16), reducing incidents of infection (number of Clostridium Difficile has reduced from 40 in 2013/14 to 29 in 2014/15 and 23 year to date) and reducing falls causing serious harm (22 falls in 2013/14 and in 2014/15 to just 4 in 2015/16 to date). The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fall below what is expected.

The CCGs are in the process of developing the contractual quality schedules which set out clearly our expectations for quality in 2016/17. These are based upon ytd performance in 2015/16, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2016/17. RBFT are developing a process for ensuring all of these patients have a clinical harm review and the CCGs will monitor the outcome of these in 2016/17. In addition, the CCGs will continue to monitor serious incidents that are a result of a failure to meet cancer targets and ensure learning is effectively captured and embedded.

In 2016/17 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections, ensuring any areas requiring improvement are made, with real evidence of change being embedded. The CCGs will continue with its programme of Quality Observational visits to our providers across 2016/17, gaining direct feedback from staff and patients and their families on the care they are receiving.

## 6.1 Primary Care

In 2016/17 the CCGs will continue to improve the quality of primary care provided across all of our practices. The CCGs have developed a quality dashboard for primary care to monitor performance and support continuous improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. In addition, the CCGs will continue to work with NHS England in supporting those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

## 6.2 7 day services

The Berkshire West CCGs have made significant progress on achieving 7 day services access across a range of primary, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national

conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 15/16 (a core part of the 15/16 planning guidance).

In addition to investments made via the BCF, through systems resilience and into MH services all of which directly support 7 day access we have invested in an Enhanced Access CES for Primary Care. This has resulted in over 80% of the CCGs' population now being able to access routine appointments outside of core hours; the vast majority of which are provided by patients' normal practices across the geography of the four CCGs. However, due to workforce constraints in primary care as described previously, as we work to improve coverage and expand availability to all day Saturday and Sundays, we envisage that practices will increasingly need to work together through 'hub' arrangement and/or that we may need to consider alternative provider models. We envisage that this would include provision within each of the four CCG localities; there is no intention for the routine offer to be centred on the walk in centre.

Patients with urgent needs can already access primary care in the evenings and weekends through the Westcall Out of Hours (OOH) service. The Reading walk in centre is also open from 8am-8pm, seven days a week. In addition, the CCGs have worked with NHSE to jointly commission an Enhanced Access CES as an alternative to the Extended Hours DES. This has resulted in 1321 additional routine bookable appointments per week on Saturday mornings and outside of core hours on weekdays (i.e. late evenings or early mornings), covering over 80% of the CCG's population. Some practices are working together to provide these sessions and we intend to increase coverage by promoting this further. A small number of practices continue to offer further extended hours sessions under the DES. We are currently reviewing the potential to expand provision under the CES, recognising however that many practices are affected by workforce constraints. To significantly expand capacity towards full 7 day access we will need to consider alternative provider models such as more systemic collaboration between providers.

Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number for any health or social care referral.

In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met their agreed actions on standards 7 and 9.

We are in the process of finalising the requirements for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the self-assessment tool on 7 days as required by the end of April and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards.

BHFT also had an SDIP which covered the respective elements of standard 7(MH on acute admission, PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning.

## 6.3. Avoidable deaths

The CCGs have a robust Serious Incident process with monthly meetings to scrutinise investigation reports into any incident which has resulted in serious harm or death of a patient. The CCGs will continue to ensure that any lessons learnt from these investigations are fully embedded and will challenge robustly if there are any recurring themes, taking action as necessary if care falls below the quality standards we expect.

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years.

## 6.4 Sepsis

The CCGs acknowledge the risks associated with failure to diagnose and treat sepsis early to reduce mortality. In 2015/16 the CCGs supported a 'Sepsis Improvement Project' delivered by the Berkshire West GP Out of Hours provider WestCall. This project has involved the introduction of a screening and treatment toolkit in the form of a lactate monitor, to support GPs to diagnose potential sepsis and initiate treatment with appropriate antibiotic immediately. Since implementation of the pilot, WestCall have increased their Sepsis diagnosis rates from 5 cases is April 2015 to 32 cases in January 2016. The CCGs plan to roll work with providers to expand this project into primary care and the ambulance service in 2016/17 and are exploring how best to do this, in collaboration with the Academic Health Science Network (AHSN). The CCGs plan to either continue the Sepsis CQUIN for a second year with our acute trust (depending on national CQUIN guidance), or transfer the requirements for screening and treatment within 1 hour to the Trusts quality schedule to ensure practice is embedded as business as usual.

## 6.5 Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC. In 2016/17, we will continue to focus on supporting maternal choice through increasing the percentage of midwifery led deliveries, increasing the number of home births supported and reducing the need for RBFT to divert women in labour. The CCGs have several key performance indicators for maternity in the RBFT quality schedule and in addition monitor a comprehensive Trust maternity dashboard at quarterly Maternity Steering Group meetings, escalating any concerns through to the Berkshire West Quality Committee to agree any action required.

Following the recent publication of the National Maternity Review, a review will be undertaken, led by our CCG Maternity lead and the Maternity Steering Group to ensure its recommendations are fully implemented and progress reported through the Children, Maternity, Mental Health & Voluntary Sector (CMMV) Programme Board and subsequently through the Governing Bodies.

## 6.6 Medicines Management

The CCGs recognise that medicines form a significant part in addressing quality of care in terms of better patient experience, improving health outcomes and reducing patient harm. Optimising the use of medicines aims to ensure that the right drug is received in the right dose in the right place; that the most cost effective choices are made in line with national and local guidance; and that only those medicines that continue to benefit a patient are continued.

Work streams carried out by the CCG Medicines Optimisation Team to support these overarching aims include:

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.

Both schemes above are delivering successfully with over £880k of efficiency savings delivered up to January 2016.

In addition to this, our Medicines Management team were presented with a CCG Prescriber award In November 2015 for cost effective delivery of diabetes care, which took a whole system approach to prescribing.

## 6.7 Antimicrobial stewardship

As part of the Primary Care Prescribing Quality Scheme (PQS) 2015-16, practices were asked to achieve three targets. Two of the targets were based on the national quality premium targets for CCGs which are to have an overall reduction in items (to date 37 of the 52 practices are now meeting this target) and also a reduction of specific broad spectrum antibacterials (to date 50 of the practices are now meeting this target). The last target requires practices to undertake an audit of all patients being prescribed an antibacterial for sore throat. Early results suggest there has been a reduction; however the data is in the process of being reviewed. It is expected that for 16/17, all of these targets will be in the PQS.

We are working with the local health economy to set up an Antimicrobial stewardship (AMS) group which will be looking all aspects of AMS, including having a joint strategy than spans primary, secondary and community care.

In addition, ambitions for reducing prescribing rates in secondary care will be added into the Provider contract in line with the expected Quality Premium.

## 6.8 Learning from cases of violence and abuse

There is an expectation that all providers will deliver domestic abuse awareness training as part of their statutory and mandatory training requirement for staff, ensuring staff know how to identify potential abuse and what support services are available to victims. Compliance with this requirement is monitored through provider quality schedules. Domestic abuse awareness training has been provided to primary care through the IRIS programme and through Berkshire Women's Aid.

The CCGs have a safeguarding children and a safeguarding adult lead to support staff, particularly primary care in understanding their responsibility for safeguarding children and vulnerable adults and this includes victims of abuse. The CCG Designated Nurse Safeguarding chairs the Berkshire West case review group where all cases of abuse are reviewed and lessons learnt are shared across the health economy and formally discussed, ensuring closure of all actions, through the Berkshire West CCG Safeguarding committee, which has a membership of safeguarding leads from all main providers.

## 6.9 CQUINS

Good progress is being made during 15/16, for example the BHFT Transition CQUIN. This CQUIN was designed to ease the journey of the child with mental health need to adult services. This CQUIN has been thoroughly embraced by CAMHS, as was discussed during a quality assurance visit. In order to achieve this CQUIN the Trust has implemented training for staff, questionnaires for the patients, a robust database to ensure all patients are highlighted.

We expect to reflect national guidance on CQUINs in our contract for 2016/17 and as we have done in previous years, secure a mutually acceptable but challenging agreement around CQUIN that reflects national and local clinical commissioning priorities. Our plan is to identify a list of CQUINs via our Transformation Boards and to use contracting levers to accelerate the adoption of best practice and to drive innovation and improvement where this supports better clinical outcomes. In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2016/17 contract, as well as new priorities for CQUIN development for 2016/17. We have actively sought provider input into the development of our proposals for 2016/17, noting that the number of local CQUINs will be relatively limited.

The CCGs have worked with our providers to agree a smaller number of local CQUINs schemes for 2016/17, providing a greater incentive and more intelligently focused on local health needs. The proposed CQUIN schemes are likely to include areas such as End of Life Care, 7 day working focused on weekend discharges, reducing contacts from high care homes users, and suicide prevention

## 6.10 Safeguarding

The CCGs will continue to be active members of the three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. These include early help, child sexual exploitation, domestic violence and vulnerable groups, the child's voice and the continued development of the safeguarding board in its effectiveness. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide

assurance of compliance staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

Our quality assurance reporting framework will monitor progress and contract compliance on the DH and Home Office Prevent strategy against NHS standard contract for all our providers. We will ensure quarterly reporting on training compliance and prevent referrals is submitted to our prevent lead. This training is in accordance with the NHS England prevent and training competencies Framework and as a CCG we have encouraged the use of both Home Office e-learning training and health wrap supported by the regional prevent co-ordinators forum. This is in accordance with the CCGs current status as a non-priority area.

## 6.11 Carers

The CCGs lead a Joint Health and Social Care Carers Commissioning forum which has been instrumental in the procurement of an Advice and Information service which is due to start on 1st April 2016. This forum is leading the development of a Joint Berkshire West Health and Social Care Commissioning Strategy.

We recognise the importance of Carers and the pressures that are often associated with those in a caring role. We have therefore continued our focus on identifying and supporting carers by ensuring that at least 90% of those registered with participating GP practices identified as carers are pro-actively contacted by way of phone or mail and given key information to help them including advice on NHS health checks, benefits, information on respite care and voluntary organisations providing specialist advice and services. We are also encouraging the role out of the use of 'carer champions' in some practices. In addition to expanding the role of Primary Care, the CCGs are also in the process of commissioning Carers Health and Wellbeing reviews with collaborative funding from Public Health West Berkshire. This will involve commissioning Carers Health and Wellbeing reviews being offered through Community Pharmacies, and active signposting by the voluntary sector and other health care professionals. The proposal is to pilot this service from April 2016 with evaluation by Reading University.

We have also engaged our main providers BHFT and the RBFT to ensure that their services are carer friendly.

# 7. Clinical Priorities

The following principles will support our Clinical Priorities for 16/17:

- To put a greater emphasis on prevention and putting patients in control of their own care planning including through the expanded use of technology enabled care, multi-disciplinary care planning led by GPs here (under Anticipatory Care CES), and proactive support for carers and families. This will underpinned through CCG Programme Board led pathway redesign, service line reviews and the development of the CCG QIPP programme for 16/17.
- We will work with providers to explore opportunities to move away from disease specific pathways to care delivery which is person centred and place based, using national and local benchmarking data, best practice, NICE guidance etc to inform priorities (for example, JSNA, SCN, Commissioning for Value, RightCare Programme)
- We will work with providers to implement new models of care which better support better integration which expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care.
- We will work with our providers to ensure that appropriate levels of care and diagnostics are available across the week which enable achievement of improved health outcomes for our populations.
- We would want to work with providers to ensure that contracts are delivered within the agreed financial and activity envelope.
- We would want to explore new payment mechanisms which incentivise the delivery of outcome focused care at the right time in the right place, and which support the future sustainability of our local health and care system.

- We will only purchase treatments and drugs that are evidenced to be cost-effective, either through NICE TAG or evidence reviews that have been specifically accepted and adopted by Commissioners on the recommendation of the Thames Valley Priorities Committee.
- We will seek demonstrable improvements in quality across all services and will expect providers to implement a range of best practice pathways for specific treatments and conditions within the agreed contract value.

# 8. Urgent and Emergency Care

## 8.1 Performance

The CCGs Urgent Care Programme Board will work to deliver a programme of improvements based upon the best practice as set out within the recently published NHSE 'Safer, Faster, Better' document and will take an oversight and scrutiny role in relation to performance; holding individual organisations to account for the role they have to play in an effective Urgent and Emergency Care system.

The Berkshire West health economy will build on its performance during 2015-16 to maintain achievement of the A&E 4 hour standard for each quarter and the full year in 2016-17. The Urgent Care Programme Board takes an oversight and scrutiny role in relation to the A&E 4 hour target and has responsibility for ensuring that the health and social care system provides resilient urgent and emergency care services which consistently meet the A&E target.

Reports generated from the Alamac kitbag will support the Urgent Care Board to understand the drivers and constraints affecting A&E 4 hour performance. The CCGs have recently refreshed the measures collected in the kitbag and are working with Alamac to set what 'good looks like' so that from these standards automated alerts can be sent out to partners to prompt timely escalation.

In 2015/16 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards are at risk of being achieved on an annual basis for the year. During 2015/16, the CCGs served a contract performance notice for this performance and following this a remedial action plan was agreed. This action plan included a trajectory for recovering the standards, all of which should be achieved for the month of March and onwards during 2016/17. This remedial action plan is on track and performance is expected to achieve the March recovery date as agreed. Performance will be challenged during 2016/17 due to the ongoing financial and resource pressures for the ambulance Trust. The contract negotiations are therefore key to ensuring sustainability of performance and achievement in 2016/17.

In 2016/17 the Board work programme will be based on the best practice contained within 'Safer, Faster, Better' with agreed priorities including;

**Acute:**

Achievement of the required clinical standards for 7 day services which will deliver:

- consultant led daily review with consistent "board" rounds leading to early discharge 7 days a week
- Increase in % of patients discharged "same day" and by midday and at weekends
- Focus on expediting straight forward discharges
- Agreement and monitoring of interdepartmental response standards
- 7 day working for therapies and pharmacy
- Focus on ambulatory care and LOS <48 hours

**Community services:**

- Consistent and timely management of frailty in the community

- Integrated health and care teams which are able to respond rapidly 7 days a week, with extended hours access to equipment and social care packages

**Primary Care:**

- A range of options for same day urgent care
- Protected slots for on the day appointments for children
- Development of Urgent Care Metrics for Primary Care
- Explore the opportunities of collaborative approaches for 7 day working in Primary Care
- Continued focus on accountable clinicians, robust care planning and sharing records
- Piloting direct booking into Primary Care for on the day GP appointments via NHS 111

**Ambulance service:**

- Direct access by the ambulance service to a wide range of alternatives to conveyance (physical and mental health)
- Access to a wide range of clinicians via Clinical Hubs, linking into resources already available 'on the ground' (e.g. specialist nurses working in the community)
- A continued focus on increasing 'hear and treat' and 'see and treat' rates
- Increased access to patient transport for discharge 24/7

In addition the Board will continue to focus on a number of general themes along the patient pathway including:

- Increased use of community alternatives pre-admission supporting higher non-conveyance rates for the ambulance service and more rapid response (admission avoidance) in the community
- Ambulatory care as the default pathway in the acute and a greater proportion of patients staying for 2 midnights or less through a relentless focus on straightforward discharges
- Discharge planning for patients in likely need of onward care starting at the point of admission with a fully integrated pathway for discharge reducing duplication/hand offs and delays
- A pull model operating at the back door at the hospital drawing patients out into the community, operating on the principles of Discharge to Assess and Trusted Assessment, moving patients out swiftly, maximising their rehab potential and reducing their long term dependence on care
- Smoothing of patient flow across the days of the week and hours of the day, minimising surges in demand.

Improvements will be incentivised though the investment of resilience monies targeted at delivering desired outcomes, aligned with the CCGs QIPP, and BCF, and their impact on urgent and emergency care performance will be rigorously monitored by the Urgent Care Programme Board.

## 8.2 Integrated NHS 111/Urgent Care Service

In line with "Safer Faster Better" and the recently published Commissioning standards for Integrated Urgent and Emergency Care, the Thames Valley CCGs are working jointly to commission an Integrated NHS 111/Urgent Care service to replace the current NHS111 service which will go live in April 2017. The service will via NHS111 offer a functionally integrated Urgent Care Service with immediate access for assessment and advice to a wide range of clinicians including mental health, pharmacy and dental. The model will also offer advice to health professionals so that no decision needs to be taken in isolation. The new integrated service will have access to a range of dispositions including, but not limited to, red and green ambulances dispositions, 24/7 primary care and direct booking into a wider range of urgent on the day services such as Walk In Centres and Minor injuries units. Clinicians in the Hub will have access to all relevant care records supporting robust clinical decision making.

During 2016-17 the Berkshire West CCGs will work with the incumbent NHS111 and Out of Hours Primary Care Provider to deliver improvements ahead of the establishment of the fully Integrated Service. Improvements will be aimed at delivered aspects of the new Commissioning Standards for Integrated Urgent Care including;

- Providing additional clinical expertise to the current NHS 111 service
- Direct booking from NHS 111 in the OOH service
- Special Patient notes, End of Life and Crisis Care plans to be available at the ideal point in the patient pathway
- Joint management of patient pathways and capacity across NHS 111 and OOH
- Early identification of callers who would benefit from speaking directly to a clinician
- Integrated governance arrangements.

## 8.3 System resilience

System resilience for the urgent & emergency care system operates year round, balancing demand and capacity, planning for expected surges, smoothing patient flow, and early and timely escalation and de-escalation. The Berkshire West system adheres to the Thames Valley Escalation Policy and uses this as a guide and reference point.

Resilience monitoring operates at a number of levels on daily, weekly and monthly basis and is underpinned by robust data and intelligence from the performance dashboard which is the Alamac urgent care kitbag.

In planning for winter 2016/17 the CCGs will build up on the successes of 15/16 and seek to address those opportunities identified for improvement as part of the review of winter 15/16.

| Worked well | Opportunity for improvement |
|---|---|
| • Patient flow was good during the two week holiday period<br>• Conversion rates were high (40-50%) so system working effectively in terms of admission avoidance<br>• Positive response from nursing and care homes<br>• Good liaison between SCAS and RBFT with SCAS activity levels not as high as predicted<br>• Primary Care with extended opening hours offering more capacity and focusing on early visiting<br>• Fit List well maintained with a good flow out to adult social care services | • Capacity in Domiciliary care became constrained by mid-January as the market was saturated (Councils responding by focusing on use of reablement services)<br>• Pressure on the system built through January with RBFT tipping onto internal black by mid-month – different profile of demand compared to 14-15<br>• Difficulties arranging patient transport evenings and week-ends<br>• Westcall extremely busy and challenges getting full shift cover<br>• Lack of pharmacy cover as Oxford Road was the only pharmacy commissioned to open on the Bank Holidays |

Plans for the critical Christmas and New Year period will be scrutinised by the Urgent Care Programme Board. Alamac will be used proactively to predict emerging pressures so that organisations can respond accordingly.

In 2015-16 the CCGs invested recurrent resilience monies into BHFT to support introduction of a 'pull' model from the RBFT acute wards into community services. BHFT established an Integrated Discharge Team with a view to expediting discharges and maintaining flow into community services seven days per week. The team have been hugely successful with a significant reduction in-year for the number of patients on the Medically Fit for Discharge list awaiting community services and patient being pulled out of the acute before they reach the list. The impact of

the scheme is quantified by the number of bed days saved by the team (by comparing the actual and estimated discharge dates) and in the first three quarters of 2015-16 over 2,000 bed days have been saved.

The CCGs also invested in the SCAS) SOS Bus which operates out of Reading Town Centre on week-end evenings. The resilience funding pays for two paramedics to be based on the bus treating patients on scene who would otherwise require conveyance to A&E. In the first three quarters of 2015-16 253 patients have presented at the bus of which 74% have been successfully treated on scene. The patient cohort that can be managed through this service are often under the influence of alcohol and often A&E is the wrong environment for them so it is of significant benefit to both the user and the health economy that they can be treated in this way.

The CCGs are committed to investing resilience monies into the urgent care system where there is a defined case for change and measurable benefits which will contribute to improved system resilience and maintenance of the relevant performance standards throughout the year.

## 9. Hospital Care (Elective care)

Our strategy for Planned Care is to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access specialist assessment and treatment where necessary in a timely way and in line with national performance standards. The CCGs will support local providers to improve their referral to treatment time performance, ensuring they can adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner.

Our vision includes the use of new technologies to enable our patients to interact with services in new ways; reducing attendances at hospital, lengths of stay and the number of follow up outpatient appointments required.

We plan to work with our providers to model the demand and capacity for all specialities including Diagnostics to ensure we are commissioning the appropriate level of services and pathways are delivered efficiently. We will also explore other modalities to deliver follow ups in the hospital and work with primary care to reduce clinical variation in referrals through regular review of data and targeting practices with higher than average level of activity.

The work programme for planned care for 2015/2016 delivered a number of successful outcomes:

- The development of an Integrated Pain Assessment and Spinal Service (IPASS) service for patients with chronic pain enabling them to access the most appropriate level of care to improve their condition and to reduce the outcomes for patients with chronic pain who had previously been accessing multiple services and undergoing multiple procedures without satisfactory resolution of the condition. This service was launched in September 2015 and has recently won an award for Emerging Best Practice by the British Society for Rheumatology.

- Arthritis Care - offers support for patients with hip and knee conditions as an alternative to surgery. The initiative, provided by the voluntary sector organisation Arthritis Care offers four options to patients which includes face to face sessions, online and telephone support. Integrating the Arthritis Care programme and a shared decision making approach into the hip and knee arthritis care pathway has enabled a more patient centred approach to care. The service was launched in June 2014 and feedback from patients and referring GPs has been positive and the programme was extended in 2015/2016.

- We have worked with the RBFT as our main provider to look at efficient methods of delivering elective follow up appointments and the Trust has successfully implemented telephone follow ups for T&O, urology and dermatology where clinically appropriate. The CCGs have also commissioned the Trust to set up a virtual fracture clinic, and see and treat clinics for Dermatology. We are in process of implementing a one stop shop for Urology.

- Best practice pathways are continuing to be developed across several specialities including MSK, and Dermatology for utilisation in Primary Care and accessible via the DXS system with the aim of reducing unwarranted clinical variation.

Our Planned Care Programme work plan for 2016/2017 includes continuing work to redesign services and reduce clinical variation focusing on Orthopaedics and MSK, Ophthalmology, Dermatology, Diagnostics, Gynaecology, Gastroenterology, Urology and Pre-op assessments in primary care.

## 9.1 18 weeks RTT

The RBFT and each of the 4 CCGs are achieving the national incomplete standard for RTT. During 2014/15, there were a number of challenges with RTT reporting at RBFT and as a result the Trust was on a data reporting holiday from July 2014 to January 2015 while the full waiting list was validated. During 2015/16 the Trust has been reporting fully each month, although discussions are continuing with regards to data quality. The CCGs focus during 2015/16 has predominantly been on working with RBFT to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. The CCGs will have a continued focus on RTT performance and the size of the backlog of patients waiting beyond 18 weeks into 2016/17. In aligning our demand and capacity modelling with local Acute Trust we will be factoring in the capacity required to achieve the national performance standard, this will include as referenced previously the capacity for Diagnostics as a critical step in the clinical pathway. The CCG is expecting to agree a Service Development Improvement Plan or quality schedule indicators to build on the improvements in 2015/16.

## 9.2 Cancer

We will continue to focus on delivering the cancer standards especially in Dermatology and Upper and Lower GI pathways. The RBFT's performance against three of the standards require improvement and these are the 2ww from GP referral, the 2ww for symptomatic breast and the 62 day from GP referral standards. The CCGs agreed remedial action plans for all of these standards with RBFT in August 2015. The 2ww standard for symptomatic breast has since recovered performance in line with the agreed trajectory and is expected to continue to achieve in 2016/17. The 2ww from GP referral and the 62 day from GP referral standards are not on plan with the agreed trajectories and the CCGs have been working very closely with RBFT to agree revised remedial action plans and recovery trajectories. The revised remedial action plans are currently being tested with RBFT to ensure that they are robust and achievable. The 2ww from GP referral standard is expected to recover for quarter one of 2016/17. The 62 day from GP referral standard is expected to recover in Q2, although this is subject to the Trust being able to secure additional capacity and this is therefore not finalised at the point of submission.

Revised trajectories and action plans will be included in more detail in the April version of the Operational plan and within the contract for 2016/17. Once agreed the plans will be monitored closely with the provider via a number of meetings already in place, including the RBFT Cancer Taskforce meeting where tumour site clinicians attend to review the factors limiting achievement of the cancer wait time standards.

The CCGs are working with an external organisation and the Trust to understand the demand and capacity required for diagnostics for year 1 and the 5 years forward planning considering the impact of

1. Changes in demographics;
2. Increasing demands for diagnosis from cancer pathways (including current backlogs)from:
    a. Compliance with NICE Guidance on suspected cancers
    b. Diagnosis expected earlier in the pathway (as per the upcoming 28 day standard)
    c. Exploring GP direct access

The CCGs are also engaged in the SCN Diagnostics Demand and Capacity Project which we anticipate to utilise to inform year 1 demand.

The CCGs have set up a Cancer Steering Group which includes all local stakeholders from the provider, Public Health and Voluntary Sector with the aim of developing a joint local Cancer Framework/Strategy to deliver the priorities as set out in the national Cancer Strategy. The main focus is on prevention, earlier and faster diagnosis, improved survivorship and better aftercare. We are working with stakeholders to deliver the following objectives:

- To promote health lifestyle changes to reduce cases of preventable cancer
- To increase uptake of early screening
- Enable direct access tests for GPs including x-ray, ultrasound, brain MRI, CT and gastroscopy including clinical responsibility, the process of managing patients who need further review and who communicates results to patients.
- Increase referrals for suspected cancer ensuring adherence to the NICE Guidance utilising the DXS system,
- Develop a pathway to support and enable GPs to make urgent or 2WW referrals for patients with vague, atypical symptoms and no red flags
- Provide GP/health professional education
- Review and agree local pathways for the four main tumour sties to deliver an efficient flow through the pathway including a review of current waiting times for direct access tests and agreement of when tests will be available within 2 weeks and review which 2 week wait referrals should go straight to test rather than to an outpatient appointment.
- Improve patient experience
- Further develop cancer rehabilitation including risk stratified pathways and the provision of end of treatment summaries
- Ensure the Trust are staging all cancers

Examples of work streams we have in place or are planned which will support delivery of our local Cancer Framework include:

- Working with our Public Health teams and Cancer Research UK to improve prevention and reduce the number of cancer diagnosed following emergency presentation. This service will aim to deliver an educational health promotion intervention to those found to be cancer-free having been referred via the 2ww pathway, using this teachable moment to lead to more sustained health behaviour change.
- Working with Public Health, RBFT and Cancer Research UK we will be piloting a cancer prevention service as part of supporting the development of RBH as a health promoting healthy organisation. This service will aim to deliver an educational health promotion intervention to those found to be cancer-free having been referred via the 2ww pathway, using this teachable moment to lead to more sustained health behaviour change.
- Working with the Macmillan team to improve the aftercare of patients and implementing cancer rehabilitation and to increase the attendance of patients in South Reading CCG for 2 weeks appointments for suspected cancer.

## 9.3 Reducing unwarranted variation in elective care

The CCG is seeking to reduce unwarranted variation in referrals and use of secondary care services by providing practices with their current activity, which can be peer reviewed against the CCG and Federation averages. The aim is for practices to review and utilise this data to learn from and manage clinical variation. By comparing performance, the CCGs will seek to reduce unwarranted variation, underpinned by the use of evidence based clinical pathways.

In signing up to the national RightCare Programme, we will continue to look at the scope across all the CCGs in Berkshire West to provide professional development solutions and data comparisons across the CCGs and help promote services and demonstrate where there are potential opportunities for further cost savings, new services and service re-design.

# 10. Out of Hospital Care

Our Out of Hospital vision is underpinned strategically by the development of our ACS, and more operationally for 16/17 through the work of the CCGs Long Term Conditions (LTC) Programme Board, the BCF and the Frail Elderly Pathway Programme.

Our aim is to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising the opportunities for patient self-management. Within this programme of work are a number of key work streams, supported in many cases by the Strategic Clinical Network and AHSN to help drive transitional change.

We have begun to make good progress in integrating local services – for example, our exemplary community-based multidisciplinary Diabetes service and we are in the process of applying the same principles to designing a community-based respiratory care pathway.

The CCGs will be implementing a project in 2016/17 for patients who have been diagnosed as at End of Life. The objective of the project is to increase the numbers of patients offered and able to achieve their choice of place to be cared for and subsequently die. We will be implementing a 24/7 advice and support service provided by specialist palliative care health professionals which will be available via a single number at the Hub for patients, families, carers, health and social care professionals.

The hub links directly with the appropriate support agency removing the requirement for patients to make multiple phone calls and using the expertise of the specialist palliative care clinical staff will avoid unnecessary admission to and end of life deaths in hospital.

## 10.1 Dementia

The CCGs have commissioned a Memory Clinic service which is now nationally accredited and is already achieving the contractual standard of 6 week waits. Through the AHSN this best practice model of delivery has been shared and is being adopted across Thames Valley. In addition we commission an award winning service for young people with Dementia , which has demonstrated in its first year encouraging outcomes measures for the clients is has served. Although our current models are considered exemplary and "fit for purpose", we are acutely aware that as our population continues to age and numbers of Dementia patients grows, our current model of delivery within the memory clinic services will need to be reviewed in order for us to have sufficient capacity to meet the needs of our population in the future.

During 16/17 our Dementia steering group will work with the AHSN to examine other possible models of delivery and assessment. This may include carrying out more assessments in a community setting e.g. through care home in reach teams , upskilling of the workforce to facilitate simple assessment where it is not appropriate to send the patient to a memory clinic service just for a diagnosis and a screening and triage process for appropriate access to memory clinic services. Using demand and capacity modelling, we will identify and project patient numbers requiring memory clinic service relative to those cohorts of patients who can receive service through different models of service provision. This will include the identification of key performance indicators which will include waiting times and patient numbers by CCG and practice (weighted according to age of population) and numbers of patients engaged with the Dementia care advisors and Admiral Nurse Services.

Outcome measures will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money these services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have identified and costed through a robust business case, as to how the current service may need to adapt to meet the future needs of the population.

We plan to continue delivery of our dementia action plan across Berkshire West to ensure maintenance of the 67% diagnosis of Dementia target in each CCG within Berkshire West. Currently the average across the 4 Berkshire West CCGs at December 2015 is 67.65% however we acknowledge that this varies across the four CCGs ranging from 63.5% to 71.3%. In January 2016 we also saw continued low attainment in Wokingham CCG and a downward trend in diagnosis rates in Newbury & District CCG. Newbury & District CCG have prepared and are implementing a specific 10 point action plan to address these issues. This includes a coding review, further work with individual practices where there is highest variance from predicted prevalence through the practice nurse facilitator as well as raising awareness within practices through a variety of routes at the CCG disposal. Wokingham CCG with the highest proportion of elderly of the four CCGs also has a CCG specific action plan which has been in place since Dec 2015. A number of the elements of this action plan are similar to Newbury but Wokingham are currently piloting the use of the Dementia Care Advisors in Wokingham practices which will help support GP practices identify and provide ongoing support to Dementia patients/carers on the GP registers. This initiative may also help GP practices identify new patients. If successful , this can be rolled out across the other Berkshire West CCGs. Wokingham have also introduced a referral form specifically to facilitate "remote" confirmation of diagnosis of Dementia in existing care home patients who would not be deemed suitable or able to attend a memory clinic, simply to confirm diagnosis. This will it is hoped increase the % diagnosis rates in many of the Wokingham practices in the next few months and could be a technique adopted, if successful , within Newbury CCG also. We aim to have achieved the 67% target in Newbury and Wokingham CCGs by September 2016.

During 2012, the Prime Minister launched the 'Dementia Challenge' which set out an ambitious programme of work to push further and faster in delivering major improvements in dementia care and research by 2015, building on the achievements of the National Dementia Strategy (2009). The local health and social care economy worked in partnership to develop and submit 7 proposals, 5 of which were successful in gaining full funding.

This plan will now be refreshed to allow us to meet the challenges and will be included with the April Operational Plan submission. We will work as a system to develop, own and deliver an agreed affordable implementation plan across Berkshire West. A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6 weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices. Our current variation in primary care project and intelligent health dashboard will be key tools in measuring and addressing unwanted variation in the system. As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision. An essential component for our plan will be to utilise performance benchmarking data to address variation in quality and outcomes for people with Dementia within our population as well as learning from the experiences and models of care elsewhere in the country as shared in the Dementia challenge 2020 publication.

Our current established dementia stakeholders group will meet monthly and by June 2016 will have agreed the Dementia action plan for 2016/17 and beyond. We recognise that as we have come some considerable way so far as a system, much of our anticipated investment in Dementia services planned is likely to be within our baseline expenditure. As part of the 2013-14 QIPP programme the Berkshire West CCGs prioritised increased investment into their Older People's Mental Health services delivered by Berkshire Healthcare Foundation Trust. This investment was in recognition of the costs associated with both the increase in the volume of patients with dementia and the prescribing issues relating to anti-dementia drugs. Capacity in memory clinics was increased in line with demand. Prescribing of anti-dementia drugs has been extended to those with mild dementia in line with NICE guidance. Shared care has been introduced between specialists and GPs, enabling suitable patients to transfer to GP care once stabilised on their medication and agreed by the clinicians involved.

We recognise that increasing demand will mean more people will be cared for by their GP practice and other models of delivery may include looking at the option to further integrate older people's mental health specialists within our practice GP clusters. We have already seen with our young people with dementia service is indicating that savings

can be generated through reduced impact on health and social care spend when patients and their carers are supported and managed appropriately within the community, However, through implementation of the action plan during 2016/17 , should further investment be required in order to deliver the plan, this will need to be clearly articulated and considered by all stakeholders within the resources currently available.

## 10.2 Diabetes

*Prevention*

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading). It is already a strategic priority with a dedicated Federated Clinical lead and CCG locality clinical leads. QOF data indicates a gap between expected prevalence and recorded prevalence and we recognise that more can be done to build on the successful services in many GP practices, especially in identifying people at risk and referring them to risk-reduction services. We currently commission a community enhanced service for pre-Diabetes, which was commissioned in 2013 and further expanded in July 2014 across Berkshire West. Further investment of £51,000 has since been set aside for 2016/17 with agreement to fund the service for a further two years as a minimum. This builds on the pioneering Pre Diabetes Project which has been running within Newbury and District CCG through 2013-14, which has successfully identified Diabetics and Pre Diabetes as well as promoting lifestyle intervention for Diabetics prevention. The GP CES addresses the needs of those already identified with PreDM (coded with IGT, IFG, Resolved DM, h/o Gestational DM, at risk of Diabetes and those with previous HbA1c 42-47), with annual testing for progression, and lifestyle advice etc. As of October 2015, 2509 people had been invited for a review and 910 had taken up the offer.

Berkshire has been selected as a first-wave pilot site and will therefore receive funding for the National Diabetes Prevention programme (all 7 CCGs and 6 LAs). This programme will be locally led by Public Health working closely with the CCGs and will complement the local CES scheme. The lead partners will aim to deliver 3,800 referrals to providers of the Diabetes Prevention Programme across the two year timeframe. If a Diabetes prevention service was available to Berkshire from April 2016 we consider that we could refer at least 1,500 people with pre-diabetes and a further 1,500 with currently undiagnosed diabetes in the first year for risk reduction. Our reasoning is described in our expression of interest but builds upon the early success seen in our local community enhanced service which has been running across Berkshire West since July 2014. This provides us with a sound base to be early adopters within the national programme.

*Diabetes Management*

Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally. A Diabetes steering group has been in place since 2012 and has developed a vision supported by 4 key objectives. Our vision is to enable people with diabetes in Berkshire West to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed , engaged patients , informed motivated Health Care Professionals, collaboration between stakeholders , supported by the of informatics and technology. An action plan is currently in place and we have made major progress since 2012 in achieving our objectives. This has included the commissioning of an innovative interactive database technology “Eclipse”, to which all our practices have access. The Diabetes steering group reports directly to the Long term conditions programme board, a subcommittee of QIPP and finance which has delegated authority from the four Berkshire West CCG Governing Bodies to oversee and implement change.

In order to build on the current action plan, a comprehensive assessment of our performance against NICE Clinical Guideline guidance in type I and type II diabetes. This has enabled us to identify any further gaps in current service provision and forms our refreshed action plan for 2016-2017. A recent Business case presented in Jan 2016 gives an overview of current service provision and any gas that now require to be addressed. Eclipse tells us that we have 1829 type I diabetics and 16,763 type II diabetics currently registered in Berkshire West. With a 100% submission

rate to National Diabetes Audit, we have access to rich data sources on which to base any further actions that may be required locally to improve our Diabetes care.

We have recently invested in a new service for the care of highly complex diabetic patients post discharge, which builds on the success seen in the virtual clinics and will see the implementation of new community based service for this patient cohort, aiming to reduce non-elective admissions and readmissions. The national Diabetic audit also tells us that more work is needed to avoid diabetics locally developing complications and progressing to renal replacement therapy.

Other local initiatives to reduce the numbers of patients with very badly controlled diabetes include the insulin intensification program for patients very badly controlled diabetes on insulin therapy. There is also a focus on managing patients with early diabetic nephropathy. There has been local focus on care of people with diabetes foot problems. This has involved reconfiguration of the diabetic foot clinic with increased vascular and orthopaedic surgical input. HES data and atlas of variation information also indicates we perform well against national benchmarking. Throughout 16/17 we will continue to build on our success and implement further actions where gaps have been identified through data sources and a self-assessment against NICE criteria of service delivery.

South Reading CCG are also one of eight CCGs in England participating in a CQC Diabetes thematic review which aims to identify to challenges in delivery of diabetes services in the community and to share best practice examples across the country To will take this as a golden opportunity to learn from this experience.

## 10.3 Frail Elderly Pathway

Work on the development of a Frail Elderly Pathway first began in recognition of the need to improve the experience of older people in understanding the complex arrangement of services across our system, and the aspiration of being able to use resources more efficiently in the face of growing demand. Our aim is to develop a pathway that is centred on the needs of an individual person and their family, rather than the services themselves, professional boundaries or governance and structural requirements of individual organisations.



In 2014 the Kings Fund worked with the Berkshire West organisations to develop a new pathway for the provision of Frail Elderly Services. This was developed around the needs of a single service user 'Sam'. Work is now underway to assess the progress that has been made since 2014 in implementing the pathway and to model the activity changes and financial impact of its adoption.

In addition in 2015/2016 an evidence base on early prevention activities in older people was produced by Public Health that was shared with each local integration board, this highlighted local strengths and weaknesses and will be used to develop priorities in each locality in 2016/2017. This evidence will inform changes in the way services are commissioned to ensure resources are allocated to those services which make the greatest contribution in supporting the Frail Elderly in Berkshire West.

The governance of the programme is into the Berkshire West 10 Integration Board and Delivery Group and the expected outputs of this programme including identified opportunities for "quick wins" will be used where possible to inform commissioning and contracting decision for 16/17. The final reports including an implementation plan will be produced by the end of March 2016.

## 11. Mental Health - Parity of Esteem

The Mental Health Taskforce has recently published their 'Mental Health Strategy Five Year Forward View'. The CCG's CMMV Programme Board is reviewing this document against our Commissioning ambitions for 16/17. Any changes to these will be reflected in our April submission.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and care system, in partnership with the health arms-length bodies. Berkshire West CCGs is committed to work across the health and social care system in developing a joint mental health strategy to improve the experience of mental health service users and carers.

In Berkshire West we have already made significant investment in mental health services year on year to support the delivery of Parity of Esteem and we will continue to drive change to ensure all our mental health users and carers receive a high quality, outcome focus service to the same level as physical health care. The CCGs have invested in Primary Care education through our Training in Practice event, the latest event in January was specifically focused on Mental health and was adapted for not only to GPs but to practice nursing and reception staff.

We already have a well-established Crisis Care Concordat Steering Group in Berkshire (which will feed into the taskforce) that is hosted and co-ordinated by Berkshire West CCGs Director of Joint Commissioning, involving multi-agencies as part of the CCC Declaration Statement Signatories. A high level plan has been developed and is overseen by this group. As a result this has strengthened partnership working across multi-agencies i.e. Thames Valley Police, Ambulance Service, Local Authorities, CCGs, Mental Health & Acute Provider Trusts, Voluntary Sector Providers, Drug & Alcohol Services, Users/Carers and Public Health.

Berkshire CCGs jointly commission 3 places of safety (POS) with BHFT; these are based at Prospect Park Hospital. One of these is dedicated for Children and Young Person with facilities for parents to stay with their child during assessment period. The POS is managed by BHFT inpatient staff and has support system in place to effectively manage mental health patient with high risk presentation. The POS have significantly reduced mental health patients placed under Section 136 being detained in custody suite.

The Crisis Care Concordat plan includes steps to agree and implement a plan to improve crisis care for all ages, including investing in places of safety. For children and young people under the age of 18 years a CORE 24 compliant service is being piloted for 12 months. This builds on the existing CORE 24 compliant service for YP aged 16+. The pilot has been developed jointly by BHFT, RBFT and CCG commissioners.

In addition work with Public Health on a population wide approach to promoting good mental health and preventing mental illness and has included promoting Five Ways to Wellbeing messages across schools, businesses and local communities, and supporting local groups that work with people experiencing mental illness and social isolation e.g. Friends in Need, Pulling Together and Eight Bells.

### 11.1 Mental Health Standards

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring all its services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver on the Two New National Mental Health Standards as set out in the Planning Guidance.

***IAPT*** – BHFT have been delivering on the IAPT trajectories (of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks).This is being reported quarterly and monitored in our contract monitoring meeting with the provider. The BHFT service has been recognised nationally as a high quality

service with excellent wait times and access rates. This service has received national recognition for its achievements:

- Achieved a **r**ecovery rate of more than 50%
- Wait time of 4 weeks (against a national target of 18 weeks)
- 95% patients reporting a positive experience

Our priority for 16/17 is to ensure that current performance is maintained and that recovery rates are above 50% going the next contractual year. This service will continue to evolve and we are working with BHFT to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading CYP IAPT collaborative and has been for a number of years. (Wokingham CCG is the lead CCG for Berkshire). Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of outcomes framework in Berkshire West

***CAMHS*** –In 15/16 the CCGs invested over £1 million in BHFT to reduce the lengthy waiting list for CAMHS services with a focus on prioritising those children assessed as being high risk, as well as reducing the overall waiting times to provide assessment and offer an appropriate treatment package if required. We will continue to work with the Trust to ensure that we have defined metrics for improvement in 16/17 and that performance is monitored closely through the contract with the Trust (see section on CAMHS transformation and supporting document).

***Early Intervention Psychosis (EIP)*** – In 2015/16 we have an agreed Service Development Plan with our Mental Health Provider BHFT to implement 'A NICE compliant EIP' service that is able to offer and deliver the following NICE recommended treatments to more than 50% of people within 14 days of referral:

- CBT for Psychosis (CBTp)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

We are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria. We are working through our baseline figure with BHFT for 2016/17 and this will be agreed by the EIP Regional Team in the coming month, for reporting to start from April 2016.

BHFT have already started to develop the RTT Pathway for EIP Service for people aged between 14 and 35 and the completion of this pathway is expected by Q1 in 2016. The Referral to Treatment pathways on RiO (the BHFT IT Management System for Health Care Record) will support the reporting of EIP Activity Data from April 2016 using the new NHSE EIP reporting template.

***Crisis Resolution Home Treatment Team (CRHTT)*** – We have increased our investment in this service line to improve workforce capacity to cover week-ends and night shifts to support those experiencing mental health crises out of hours, provide short term interventions and face to face contact. We have also invested in 'Street Triage' one year pilot in Berkshire West to work alongside Police Officers in responding to emergency mental health calls and/or assess individuals picked up by Police on the street to reduce the application of Section 136 under the Mental Health Act 1983. The CRHTT service now operates from Prospect Park Hospital and provides 24hr/7 days a week service in Berkshire West providing rapid response to manage mental health crisis in the community.

***Liaison Psychiatry Service (Psychological Medicine Service)*** – Operating from Royal Berkshire Hospital the Psychological Medicine Service mirrors the 'RAID' (Rapid Assessment Intervention Discharge) model, providing rapid

access to individuals presenting at Emergency Department with mental health problems and working with those admitted into an acute inpatient bed with co-morbid mental health conditions to reduce length of stay. This service is also supported by the Community Crisis Response teams and the Community Psychological Medicine Service working with frequent flyers and those with medically unexplained symptoms.

***Male Mental Health*** - In Berkshire West there were 97 suicide/undetermined/open verdict deaths in 2012-2014 and males have a higher suicide rate compared to women in line with national figures (73% male; 26% female).As part of the Thames Valley network we are supporting the CALM project targeting information and support to men with mental illness to recognise signs of mental illness and access information and services.

***Perinatal Mental Health*** – The Berkshire West Perinatal Service will be launched on the 1st April 2016. The service specification has been agreed including KPIs, Outcome Measures, Information Requirements and expected activity levels. The aim of the service is to provide a comprehensive range of community services for women requiring pre-conceptual counselling or who experience mental health problems or illness during pregnancy or in the first year after birth**.**

In 2016/17 we will continue to prioritise mental health investment, and will be considering recurrent investment in services such as the following:

- **Street Triage Service** – Improve the experience and outcomes for service users in crisis. There will be a professional mental health assessment undertaken by an experience healthcare worker (rather than for example a S136 applied by a police officer) and the person being taken to a Place of Safety, where a full MHA assessment is required. The number of Section 136's in Berkshire West will be reduced as a consequence.
- **Alcohol Specialist Nurse Service** – We have developed a business case to request funding for investment in the Alcohol Specialist Nurse Service to operate from RBH ED and Wards; this service will provide rapid assessment and treatment to all those presenting at ED with alcohol related problems and avoid hospital admission.
- **Recovery College** – We have set up a local project group to develop a recovery college service model to support mental health service users in their recovery journey from mental health problems and access education, training, vocational and paid employment. We also expect this service to support carers in accessing education and training.

***Mental Health and Physical Activity*** – In 2015/2016 we supported Sport in Mind a local charity providing supported sports activity to users of mental health services to obtain a lottery grant for 3 years. Working with BHFT the project will widen participation in 2016/2017 using sport as part of recovery and ongoing health promotion for people experiencing mental health problems. Sport in Mind plan to deliver 1,750 sessions and expect to support 1,500 people in 2016/2017. In addition, working with Public Health, we have promoted the Activity for Health Scheme and Moving Forward; both schemes are designed for people experiencing both physical and mental health problems.

## 11.2 Transforming Care

The Berkshire West Transforming Care plan (see supporting documents) for people with Learning Disabilities is aligned to a regional 'Positive Living Model'. This plan provides the opportunity to develop integrated working, clear lines of accountability and clinical engagement with adult social care to deliver high quality provision in a cost effective way through reducing the need for inappropriate admissions whilst releasing savings into the health and social are system.

Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision through a reduction in beds. The CCG and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

BHFT has signed up to Berkshire West CCGs commissioning intentions to reduce the contracted bed based provision for people with a LD by 2017. The CCG is in the process of completing joint plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans will cover 2016/17, 2017/18 and 2018/19.

The CCG will work with BHFT to review the levels mortality in Berkshire in line with the recommendations of the Mazars report. The CCG will aim to develop a process for ensuring that there is good quality healthcare to achieve outcomes such as admissions avoidance. This process will be developed through understanding the current rate and reasons for mortality amongst people with learning disabilities. In parallel the Transforming Care Programme board will aim to identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

The Berkshire West plan will aim to demonstrate how the national service model will be implemented by March 2019 that requires CCGs and local authorities to work together to reduce the reliance on in-patient beds through intensive intervention services in the community. The Director for Joint Commissioning will be leading this process for Berkshire as the Senior Responsible Officer for transforming care. The aim of this plan is to show where people are placed and how they are funded to provide opportunities for collaborating health and social care to resources to discharge people into community placements. A Pan Berkshire Business plan is also in the process of being finalised, that will show a phased reduction of in-patient beds and mobilisations plans for the intensive intervention service in the community.

Berkshire Healthcare staff, the 3 local authorities, Carers and Commissioners developed new patient care pathways to support phased closure on in-patient beds and utilise the resources to implement a 'Positive Living Model in the community. Time lines for the phased closure will be agreed by a pan Berkshire Transforming Care Board on 3rd February 2016 and further detail will be included in our April submission.

## 11.3 CAMHS Transformation

The CCG has established a multiagency 'Future in Mind' group which includes all key stakeholders (e.g. Schools, Health Visitors, Local Acute and Community Providers and the three local authorities). This group will oversee the joint CAMHs transformation plan for Berkshire West. The focus of which is to improve early intervention and prevention services with the aim of improving outcomes for children and young people and reducing the demand on specialist CAMHS services.

We are putting additional training and support in place across the wider children's workforce (including schools and primary care) so that children and families can access help before problems reach the point where a specialist mental health service is required. We are working with the University of Reading to develop bespoke training for families who have a child with severe conduct disorder where Webster Stratten has been unsuccessful.

We are working with the voluntary sector, our community provider and Local Authorities to ensure appropriate support is provided to families who are awaiting Autism assessment. We are also developing a CAMHs outcomes framework which will be implemented by voluntary and statutory providers in all contracts from 16/17.

Following significant investment by the CCGs additional staff has been appointed into specialist CAMHs services in order to reduce waiting times, mitigate clinical risk and ultimately = minimise the number of children whose needs escalate into crisis. The CCGs are funding a 12 month pilot to improve access to urgent care CAMHs services for children aged less than 18 years, 7 days a week. By having more CAMHs staff available in the Royal Berkshire NHS FT

(RBFT) it is hoped that length of stay will reduce, there will be fewer "frequent fliers" and that children and young people who are in crisis are able to access help more quickly, particularly over weekends.

We will be working with the Police and Crime Commissioner, voluntary sector and Health and Justice commissioning to ensure that the emotional and mental health needs of children who are victims of crime or are involved in the criminal justice system are being met.

We are also working with Berkshire East CCGs and our community provider to develop a community Eating Disorders service that meets the new standards. An enhanced perinatal mental health service has been commissioned. The SHaRON online platform is being expanded to include perinatal, carer and CAMHs support.

### 11.4 Voluntary Sector

The CCG commissions' projects and services from the voluntary sector aligned to the CCG's commissioning priorities and use the Partnership Development fund (PDF) as one of the routes for doing this. This is an annual commissioning cycle and the CCG looks for innovation to support people in the community with Mental Health problems, Children and Young People, Older People and People with Learning Disabilities. Voluntary and community providers play a significant role and these organisations contribute to the wellbeing of people living in Berkshire West; connecting communities, stimulating innovation and flexibility to make a difference to people's lives.

The CCG is in the process of awarding funding to voluntary organisations that submitted PDF applications to support the CCG's strategic priorities. These range from Youth Counselling to support early intervention thus reducing crisis, support for organisations reaching families and children of people with learning disabilities and autism and support for early years. The CCG will also be funding organisations that aim to reach out to support for older people, people with long term conditions, hospital to home services, and community outreach support for people with mental health problems. The CCG will develop generic and specific KPI's to monitor the effectiveness of these services linked to the CCG's commissioning priorities. Successful organisations will be required to submit half yearly written reports to clearly demonstrate achievements against the KPIs.

## 12. Patient Experience and Engagement

### 12.1 Patient Choice

The Berkshire West CCGs support Patient Choice by commissioning a range of accessible physical and mental health services from both the NHS and independent sector. Choice is facilitated by maintaining an extensive and up to date Directory of Services in collaboration with all the local service providers and accessed by the E-referral system.

Clinical pathways around Maternity services, End of Life and Ophthalmology are being investigated to assess feasibility of choice and will be added to the E-referral system where appropriate.

Providers continue to offer access to named consultants on e-referrals system.

### 12.2 Personal Health budgets

Berkshire West CCGs are committed to further rolling out Personal Health Budgets (PHBs) across our area for all patients who would benefit from them and have a programme of work for taking this forward.

Our next step is to take what we have learned from already offering PHBs to those with Continuing Health Care needs (CHC) and apply this in a new offer to people with learning disabilities. In doing so we confidently expect to further develop our processes and practice to facilitate the further roll out of PHBs to other patient groups.

We will develop this work jointly with appropriate local partners in particular the relevant Local Authorities (LAs). The three LAs that cover Berkshire West have already taken part in a public engagement exercise to launch this work and are signed up to being involved in joint delivery and sharing of resources where appropriate and practical.

## 12.3 Patient Engagement

Berkshire West CCGs Patient and Public engagement plans recognise that there are many different ways which people might participate in health depending upon their personal circumstances and interest. In addition to awareness raising, preventative health and system resilience messages throughout the year, topics that were explored in-depth with patients during 2015/16 included;

- Frail elderly pathway redesign
- Alternative Provider Medical Services (APMS) contract procurements
- Primary care strategy
- End of life care planning
- Digital behaviours
- NHS111

We have developed robust methods of listening, engaging and involving patients and the public which have ensured that their insight and experiences have been acted upon at all stages of the commissioning cycle and have influenced our commissioning decisions. We will now make this more systematic and consolidate our engagement and involvement to better empower patients to shape services and the care that they receive.

The engagement strategy for Berkshire West recognises that there are many different ways which people might participate in health depending upon their personal circumstances and interest. Hence CCG engagement ranges from simple awareness building activities for the general public, through to working with patient and community groups to ensure that their concerns and aspirations are understood and considered by commissioners:

- ***Awareness raising*** - Throughout the year a range of messages are shared via CCG and partner communication channels, online, offline and face to face.
- ***Surveys*** - The Berkshire Health Network (BHN) is used to target engagement activities to interested organisations and individuals, and to publish and invite feedback from surveys and discussion documents.
- ***Governing body meetings*** - Members of the public are invited to observe and attend CCG governing body and JPCCC meetings in public.
- ***Public meetings*** - CCG's host regular public meetings themed around a specific area, such as the primary care strategy or the frail elderly pathway. Such meetings create opportunity for group discussion and meeting outputs are documented for commissioners. Public meetings are also used to ensure the widest possible engagement in service change, such as new contract procurement for a GP surgery.
- ***Patient representatives*** - Patient representatives can be found on each programme board. CCG governing bodies are also supported by a lay member with an interest in patient and public participation.
- ***Patient groups*** - The CCGs are currently broadening work in this area to establish dedicated patient groups that engage with and support specific streams of work.

Patient engagement work during 2016/17 will focus on:

- Socialisation of 16/17 CCG plans
- Areas of service change resulting from the implementation of the primary care strategy and QIPP plans
- The move towards the ACS and the introduction of the new Frail Elderly Pathway.
- Development of a digital roadmap by Berkshire West CCGs and support for patients to engage with existing digital services.
- Work with seldom heard and hard to reach groups, encouraging them to become more involved in their local NHS.
- Work to map and engage PPGs directly in communications and engagement work.

- Build on an early trial in West Berkshire to set up and co-ordinate a communications and engagement network; bringing together providers and the unitary authorities, to share intelligence and look at ways in which partners can better engage with the public together.

### 12.4 Patient Activation and self-care

There are a number of measures in place across Berkshire West to support patient activation and self-care, including:

- Development of a self-care strategy to support reduction in urgent care demand
- Development of a self-management protocol enabling patients to enter their own data and remind them to attend appointments
- A social prescribing pilot in South Reading with Reading Voluntary Action group focusing on patients social needs
- Use of a diabetes online tool (ECLIPSE) – including a secure patient portal. In 2015/16 Berkshire West CCGs won first place for the most effective prescribing as a result of using Eclipse widely
- The use of risk stratification and care planning for patients aged 75 and over with input from patients

## 13. Technology

The CCG has been working with partners since 2013 on the innovative and exciting programme called Connected Care to develop a joint vision and strategy for information sharing, and the development of an integrated care record across the 10 Health and Social Care organisations in the Berkshire West community. This will enable delivery of a comprehensive electronic record at the point of care by 2018, including social care partners. Procurement processes for the information integration solution and single electronic care record will be complete by the end of the 2015/16 financial year, allowing the focus to shift to delivery in quarter 3 2016/17.

Delivery of the Local Digital Roadmap will be governed by the Berkshire West CCGs Innovation, Technology and Information Systems Programme Board; this forms part of the overall governance of the Berkshire West 10 Health and Care Integration Programme (BW10). The Connected Care Programme governance feeds in through the BW10 Integration Board and the Delivery Group. This ensures that digital priorities are identified collectively on a system level, and are used as an integral enabler of clinical transformation and organisational priorities across the health economy.

Our system vision for Frail Elderly as described earlier has been used to inform the system requirements based on a local version of the “Sam’s Story” narrative initially created by the Kings Fund. This has enabled us to model our requirements using a patient centred approach to pathway redesign. This work has highlighted how much more efficient and effective care would be by avoiding information silos and having a single integrated record.

Programme benefits are projected at approximately £2.5 million per annum on a Berkshire footprint against a Berkshire system wide investment of circa £10 million over the period of the contract (this includes all health and social care organisations). These benefits are focused on the following:

- Reductions in length of stay
- Reductions in admission
- Reductions in duplicate and unnecessary testing

The benefit values are conservative to avoid double counting against other service transformation programmes which are co-dependent on the delivery of the Connected Care Programme and the broader digital agenda across the Berkshire West 10 organisations.

Key activities outside the Connected Care Programme which will form part of the Digital Roadmap delivery for 2016/17 include:

- working with providers to support their use of electronic prescribing solutions and vital signs monitoring,
- maximising the use of existing clinical systems at the point of care.

In Primary Care, Wokingham CCG will be leading the development of a pilot with their practices and NHS 111 in relation to on the day bookings to commence early in 2016/17. We also envisage expanded access to planned extended hours appointments during 2016/17. A number of practices are already piloting Skype consultations and the use of emails and telephone consultation/triage is widespread amongst our practices. We are still working to further define work streams to expand and build upon these new modes of access and to increase self-care and the use of symptom checker and/or triage apps. Our initial priority will be to maximise the use of existing systems such as EPS2, e-referrals and existing patient online tools accessed through the GP record. Further detail will be set out in our Digital Roadmap.

There are a number of additional clinical systems which support decision support and care planning, and we will work to evaluate and rationalise these, ensuring that any duplicate functionality from any new systems allows the decommissioning of existing systems where appropriate.

As part of the integrated record the CCGs have procured a patient portal which will support projects increasing self-management and prevention. This will allow comprehensive patient access to their records across health and care in future, along with the ability to integrate information from wearable devices and self-monitoring tools. In the interim the CCGs will continue to work with practices to improve the digital services offered to patients through the existing patient online tools accessed through the GP record.

The Digital Roadmap will form an integral part of the STP submission as a key enabler of service transformation.

# 14. Research and Innovation

This statutory responsibility is incorporated into the terms of reference and business cycle of the CCG's Joint Quality committee. The CCGs are committed to and are engaged with the Oxford Academic Health science network, through attendance at the Clinical Innovation Adoption Oversight group and the Strategic Clinical Network (SCN). The AHSN are routinely invited to attend the CCGs Clinical Commissioning committee and the relevant Programme Boards. Innovations are assessed on a case by case basis.

## 14.1 Genomics, precision medicine and diagnostics

As a result of increased molecular knowledge, disease classification will significantly improve over the next five years and will be more precise which will enable us to refine our diagnostic capability and apply a range of different therapeutic interventions. In turn, this will allow the identification of patient populations most likely to benefit from specific interventions and has the potential to improve the effectiveness and efficiency of the entire healthcare system.

In Thames Valley we are fortunate to have a very strong biomedical research centre and university and as well one of the strongest technology 'clusters' in Europe. Through our subscription to the AHSN we will be informed of developments in this field and will engage in opportunities to test new service models.

In the shorter term, we are aware that the capacity and demand gap for diagnostics is growing with the changing NICE guidelines. We are using the SCN support tools to help us quantify the gap and are participating in their programme of work that aims to jointly consider how this gap will be plugged. There are considerable work force issues that will need to be addressed and some consideration will need to be given to ensuring that going forward the work is done by a workforce fit for the future. This will be done in partnership with other health economies in Thames Valley.

## 15. Governance and Assurance

In line with the CCGs constitutions the Operating Plans are required to be signed off by the Council of Member Practices. All 4 plans will be presented at the March meetings which will enable member practices to ratify individual CCG plans in advance of the final April 11th submission date.

Progress against plans will be reported quarterly to Council of Practices and 6 monthly to CCG Governing Bodies. This process is underpinned by monthly reporting on delivery of quality and finance performance standards to the Berkshire West Federation of CCGs standing committees, and quarterly assurance meetings with NHSE area representatives.

The Berkshire West 10 system also has in place a formal governance structure which brings together the senior leadership from all partner organisations at both a strategic (Integration Board chaired by the CCG Federation CO) and operational level (Delivery Group, chaired by the Director of Adult Social Care for Reading Borough Council, and Vice Chair Director of Strategy for the BW CCGs) in support of the achievement of our overarching vision for Berkshire West. There is a direct link from these meetings through the membership to the three Health and Wellbeing Boards, and individual organisational Boards, Committees and Governing Bodies.

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**Supporting documents**

1. Berkshire West CCGs – Public Health Profiles 16/17(to be submitted with 11th April plan)
2. Berkshire West CCGs Commissioning Intentions 2016/17(to be submitted with 11th April plan)
3. Berkshire West CCGs Finance Strategy 2016/17(to be submitted with 11th April plan)
4. Berkshire West CCGs Operating Plans on a Page(to be submitted with 11th April plan)
5. RTT and Cancer Treatment standard recovery plans(to be submitted with 11th April plan)
6. Berkshire West Operational Resilience Capacity Plan(to be submitted with 11th April plan)
7. Berkshire West Primary Care Strategy 2016/17 (attached)
8. Berkshire West CAMHs Transformation Plan (plans produced for each LA – copy of Wokingham plan attached)
9. Crisis Care Concordat Action plan (attached)
10. The Berkshire West Transforming Care plan (attached)
11. Connected Care Programme – Briefing document (to be submitted with 11th April plan)
12. Berkshire West Frail Elderly Pathway final report and implementation plan (to be submitted with 11th April submission)
13. Berkshire West CCG Dementia Action Plan(to be submitted with 11th April plan)
14. Berkshire West CCGs Communications and Engagement Plan (attached)
15. Berkshire West Diabetes Action plan (to be submitted with 11th April plan)
16. Berkshire West ACS PID(to be submitted with 11th April plan)

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| | |
|---|---|
| **TITLE** | **Wokingham Borough Council Local Account 2014-15** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on 14 April 2016 |
| **WARD** | None Specific |
| **DIRECTOR** | Stuart Rowbotham, Director of Health and Wellbeing |

**OUTCOME / BENEFITS TO THE COMMUNITY**

This report tells the residents of Wokingham borough what their adult social care services have been doing.

**RECOMMENDATION**

That the Health and Wellbeing Board note the report.

**SUMMARY OF REPORT**

This report tells residents what we have been doing to make people's lives better, how much we spend on adult social care and what we spend it on and what our plans are for the future.

It will be available to residents on the WBC website.

**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** Jo Jolly | **Service** Strategic Commissioning |
| **Telephone No** | **Email** jo.jolly@wokingham.gov.uk |
| **Date** 29.03.16 | **Version No.** 1 |





# Local Account

# Report for Adult Social Care

# 2014/15

# Local Account 2014-15 – pdf version

# Our local account of services

Each year we produce a local account to tell people what their adult social care services are doing. The report explains:

- What we have been doing to make people's lives better
- How much we spend
- What we spend money on
- What our plans are for the future

To find out more about adult social care services see the WBC web page Care and support for adults.
We have split the local account into seven chapters:

**Contents**



## Our priorities

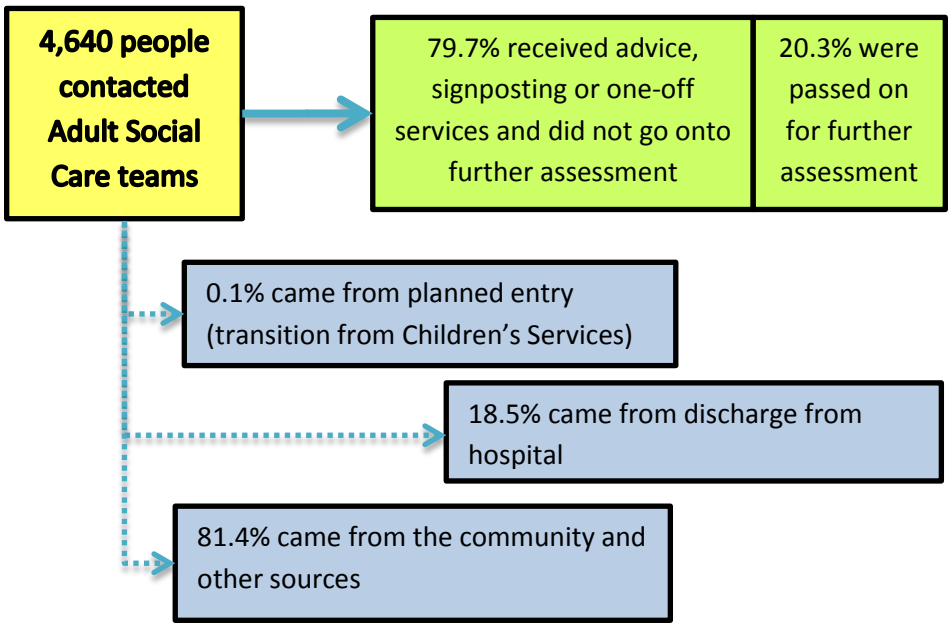
Our **Vision for Adult Social Care** has been co-produced by our staff and customers as well as voluntary and statutory sector partners. It outlines our priorities for adult social care, how we support our customers and how we work with our stakeholders. It is for our customers, carers, Council staff and for the voluntary, private and statutory sector organisations we work with. Ensuring the well-being of our customers, both mental and physical, is at the core of our services. For further details see Adult Social Care Vision.

# What we do for you

We provide Adult Social Care services to thousands of people each year. Our statutory services support vulnerable adults with a wide variety of specific needs. In addition, there are a range of more general prevention services available to help improve the health and wellbeing of all adults in the Borough.

## Who contacted us?

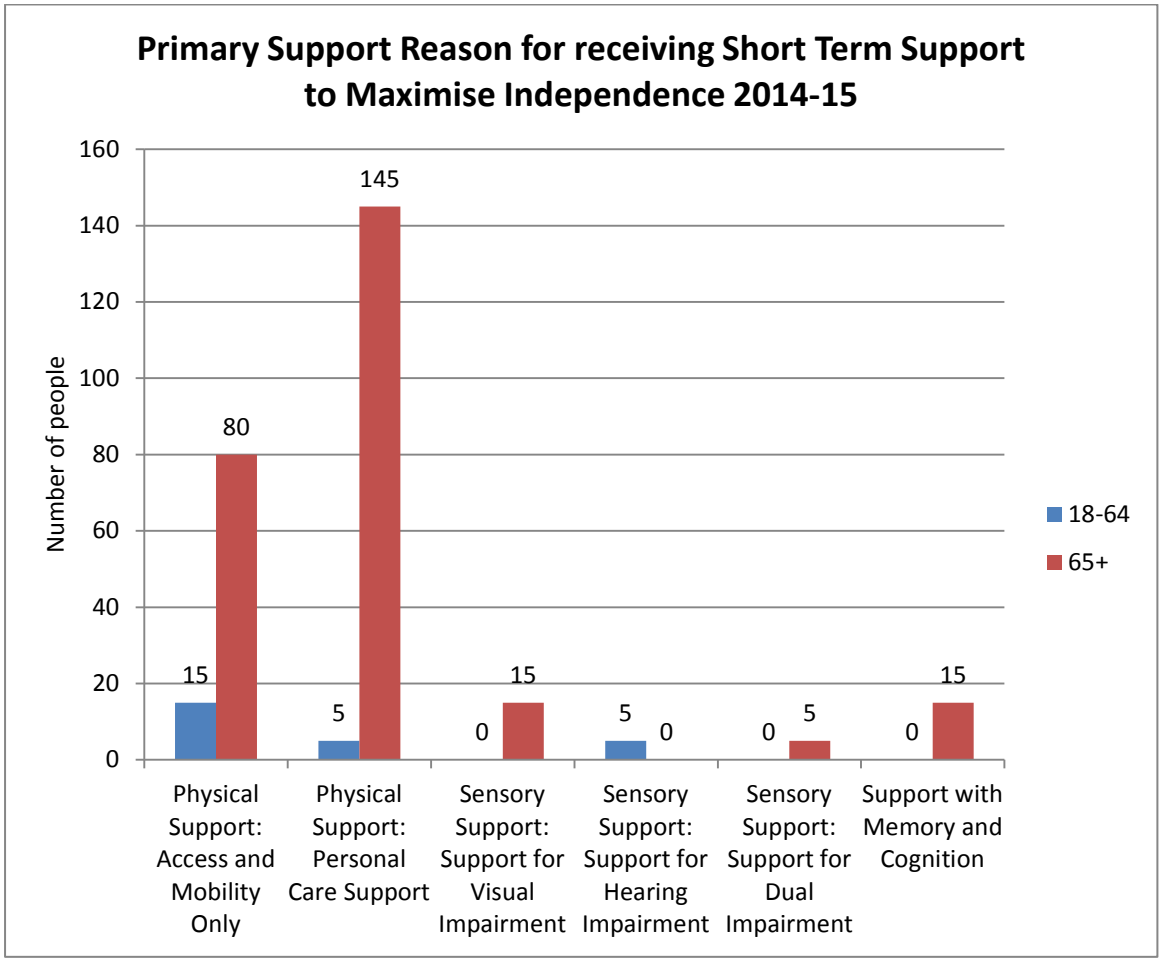
Our Adult Social Care teams were contacted by 4,640 people in 2014-15.

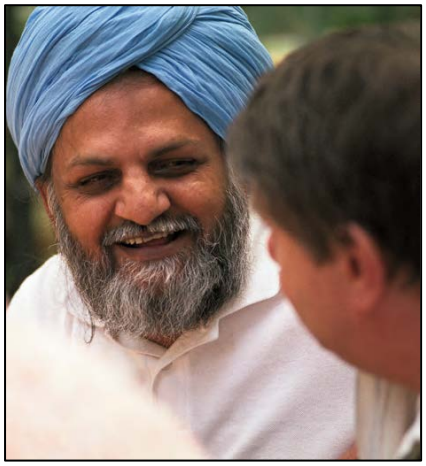


## What happened following requests for support?

### Short Term Support

In total, 285 new clients went on to receive **Short Term Support to Maximise Independence**. 25 of these were aged 18-64 (8.8%) and 260 were aged 65+ (91.2%). The most common reason for receiving this support was 'Physical Support: Personal Care Support' (52.6%) followed by 'Physical Support: Access and Mobility Only' (33.3%).



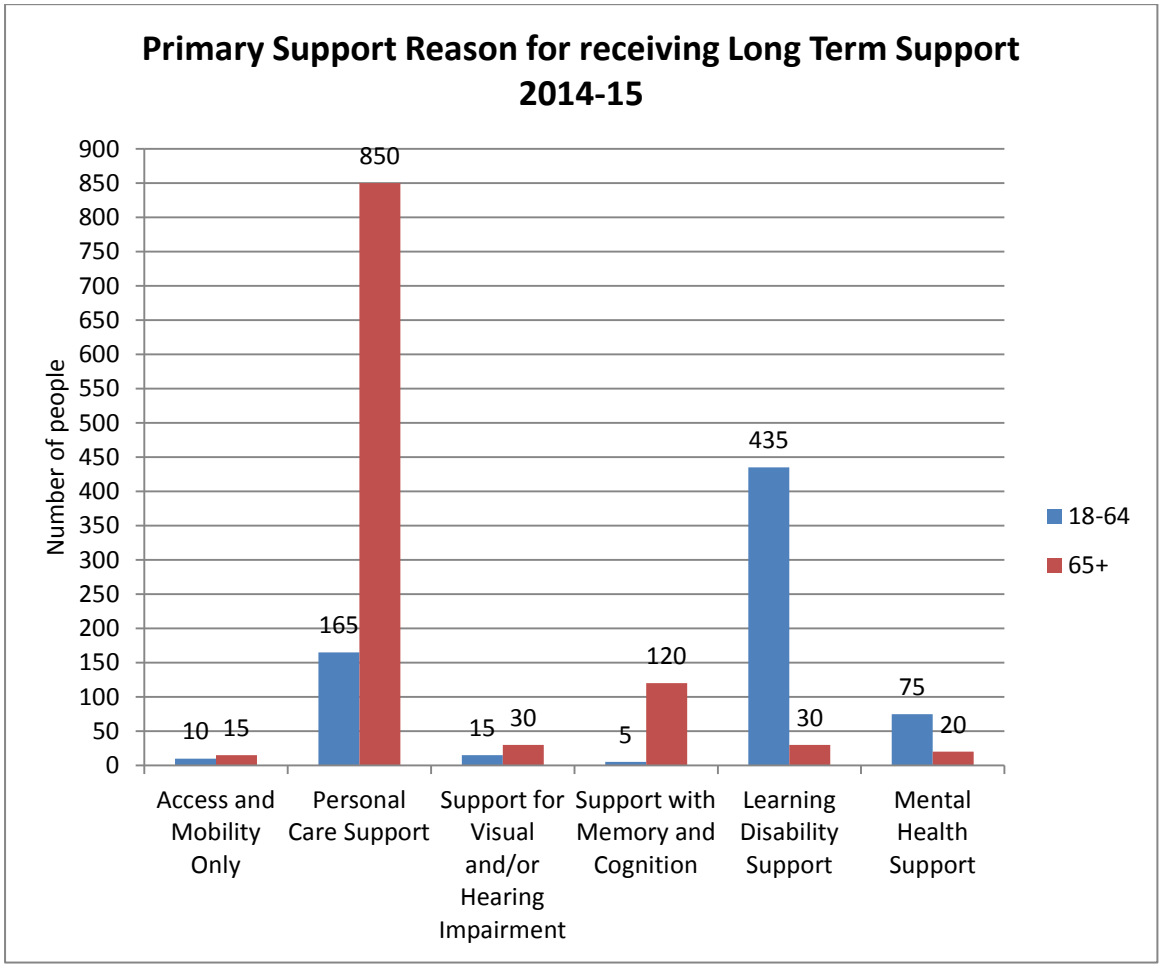



Of these 285 new clients who received **Short Term Support to Maximise Independence**, 50 went onto long term support, 15 ended early, 5 went onto ongoing low level support, 5 had identified needs but were self-funding, 5 declined the support offered, 5 were signposted or went onto universal services, 190 had no services offered because they had no identified needs and 10 went onto other short term support.

## Long Term Support

In total, 1770 clients accessed **Long Term Support** during 2014-15. Of these, 705 clients were aged 18-64 (39.8%) and 1065 were aged 65+ (60.2%). As of 31st March 2015, 650 people aged 18-64 and 720 aged 65+ were still receiving services, making a total of 1370.

The most common reason for receiving this support for clients aged 65+ was 'Physical Support: Personal Care Support'. For those aged 18-64 the most common reason was 'Learning Disability Support'.




## Residential and Nursing Care

Of those clients receiving Long Term Support in 2014-15, 330 people accessed residential care of which 210 were 65+ and 120 were aged 18-64. 260 people accessed nursing care of which 250 were 65+ and 10 were aged 18-64.

The rest of the people receiving long term support were supported in the community.

## Autism and Asperger's Syndrome

In this first SALT (Short and Long Term) data collection, it was mandatory to report on those clients with Autism and Asperger's Syndrome who received Long Term Support at year end. As of 31st March 2015, there were 55 clients with Autism and 45 with Asperger's Syndrome in receipt of long term support. These clients were all aged 18-64. Combined, they accounted for 7.3% of all clients receiving Long Term Support at year end.

## Carers

Carers have a right to receive an assessment of their own needs and may be eligible for services to support them in their caring role. In 2014-15, there were 950 requests for carer support. Of these, 545 had support provided directly to them (57.4%) of which 20 instances (2.1%) related to carers aged under 18. Of the remainder, 225 were helped by respite or other forms of support being given to the person they care for (23.7%) and 180 received no direct support (18.9%). Nationally, 24% of requests for carer support received no direct support.

# What difference have we made?

We provide services to people in a wide range of circumstances. The main aim of these services is to promote and maintain the health and wellbeing of vulnerable adults in the Borough by enabling them to live safely in their own homes. Some people will only need information and advice to do this, others may require short-term support to get them back on their feet and a smaller number will need more intensive, long-term services. Below are some examples of the support we provide.

## Your stories

**Case Study A:** personal budget and becoming an adult

A is a very vulnerable young man who attends a special school and lives at home with his mother. When he reached the age of 17, he was supported by a social worker during his transition from Children's Services to Adult Social Care. The adult assessment highlighted that his mother was responsible for supporting A in all aspects of his life. A Personal Budget was arranged that would allow A to meet new people and develop a sense of independence while giving regular short breaks to his mother allowing her to make plans for herself. A Support Plan was drawn up which detailed how A wanted to spend his budget and how he would be supported safely. He was able to choose his support worker himself and has been able to plan more and more what he would like to do and when he would like to do it. A, with the help of his support worker, fulfilled a long-held dream by travelling to a rock concert to see his favourite band. He made a video of the whole day which he presented to the Learning Disability Partnership Board. This has made a huge difference to his confidence and he is now thinking about going to college next year.

**Case Study B:** how a personal budget allowed a lady to stay in her own home


Mrs B suffers from a number of serious medical conditions. She has been paying privately for full-time, live-in care without which she would have to go into a care home. When her funds depleted, she approached us. After assessment, a Personal Budget was set up to fund her care needs. This is paid in the form of a Direct Payment which is managed by a member of her family. This has enabled Mrs B to have choice and control over her care. All her needs are met by carers with whom she has a close relationship. Mrs B is happy that she can carry on living in her own home with all its fond memories. Her family are happy as they can see that Mrs B is well cared for and safe.

**Case Study C:** how a personal budget helped a resident fulfil their choices


Mr C has a rare degenerative illness and, after an active life, was forced to retire as the illness took its toll upon his physical abilities. He feared being moved out of his beloved home. We first became involved by altering aspects of Mr C's home to allow wheelchair access and to make adaptations designed to help him make the most of his home. For the tasks that Mr C couldn't manage, a Personal Budget was agreed which would pay for support-carers to visit and he made the most of his abilities to remain independent. To do the heavier domestic tasks Mr C had come to rely upon a person he had known for many years. After a period of time, we became involved again when it was suspected that this person had been taking advantage of the relationship for their own financial gain. Our Adult Protection Team worked with Mr C to ensure his safety, and looked again at his Personal Budget. His needs had changed because he could no longer trust this person in his home. Mr C's Personal Budget was therefore increased to pay for his support-carers to undertake all of those domestic tasks that he could not manage, freeing Mr C of his dependency on volunteers/friends and furthering his opportunities to live in his own home safely and to continue to enjoy making his own choices in life.

**Case Study D:** how support allowed a carer to continue in her caring role

D was referred to the assessment team for a Carers Assessment. D is the main carer for her son who has extremely high care needs and is unable to meet any of these needs independently. D provides full support. D's assessment recognised that there are aspects of her day to day living which have been exacerbated due to caring for her son such as the expense of shopping and the amount of laundry she has to do for him. D has said she is happy to continue to support her son despite the impact. However, the washing machine was 'on its last legs' and it would be very difficult for her to take the washing to the launderette. This was causing her stress. A one-off personal budget payment allowed D to buy a new washing machine which meant she could continue her caring role.

## The Step-Up /Step-Down Scheme

The step-up/step-down service is a comprehensive reablement and social care package to prevent people being admitted to hospital unnecessarily, or to enable them to be discharged earlier than would otherwise be possible. Following assessment, trained reablement workers will work with the individual, slowly reducing the level of support they need to carry out the tasks of daily living as they become more independent.

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 so that they may return home safely.

The step-down option will provide a reablement environment for people who are 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 before returning home to a reduced package of care than would otherwise be achieved.

### Where is the service based, and how many beds are available?

Initially there are two flats at Alexandra Place (extra care housing scheme) in Woodley. This number may be increased after the impact of the service has been assessed. The bedroom and bathroom in the flats have been adapted and have a range of equipment. There is a kitchen where meals can be prepared or people can use the cafeteria. The step up/step down service includes placements where a couple can work through reablement needs together.

### What happens afterwards?

Anyone who is assessed as having on-going support needs on leaving the service will have a care and support plan plus a risk management plan. The care and support plan will identify any wider social care or health needs, and will identify any assistive technology which will be used to support the person to live independently in their own home.

### What are we hoping to achieve?

The scheme will encourage individuals to manage their own long-term condition in their own home and will also reduce the amount of ongoing home care a customer will need. It will reduce unplanned admissions to hospital and to care/nursing homes and will contribute to the reduction in the number of delayed discharges.

# End results for people

The **Adult Social Care Outcomes Framework (ASCOF)** is a way of looking at outcomes (or end results) for people who use social care. You can look at any authority in the country and see how outcomes for the key measures compare with other areas.

The Adult Social Care Outcomes Framework (ASCOF) measures are split into four domains:

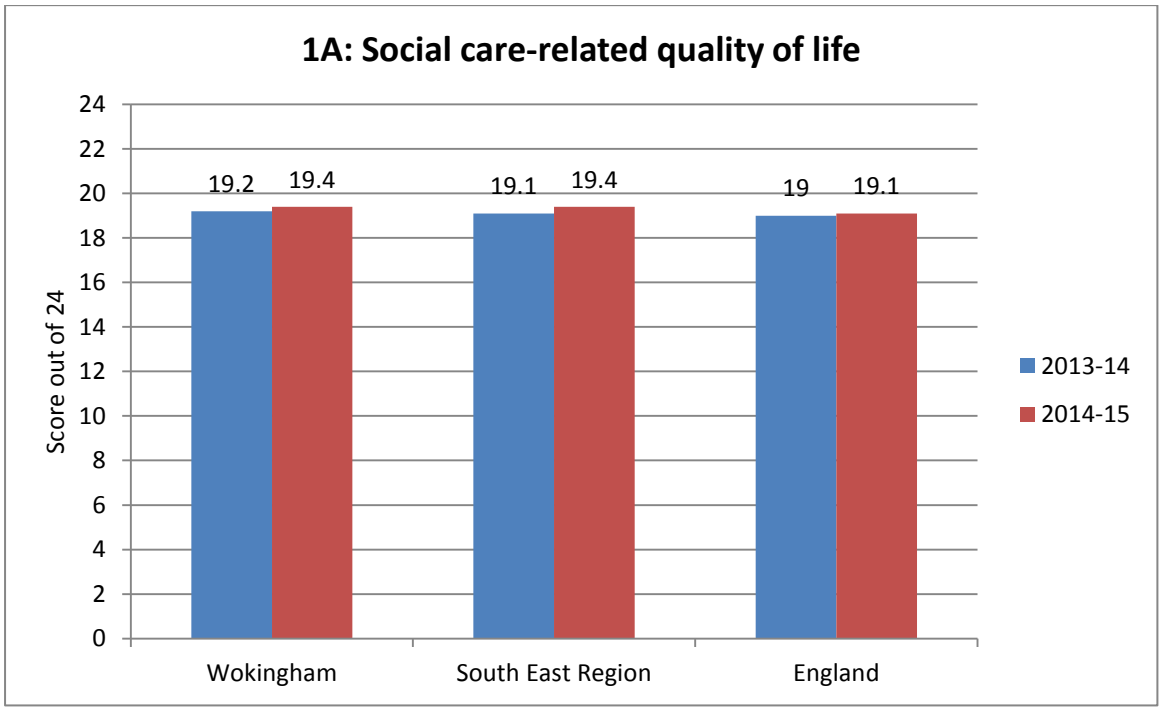
- Domain 1 – Enhancing quality of life for people with care and support needs
- Domain 2 – Delaying and reducing the need for care and support
- Domain 3 – Ensuring that people have a positive experience of care and support
- Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

For further information about the indicators that make up the ASCOF see the GOV.UK web page Adult social care outcomes framework (ASCOF) 2015 to 2016

## Domain 1 – Enhancing quality of life for people with care and support needs

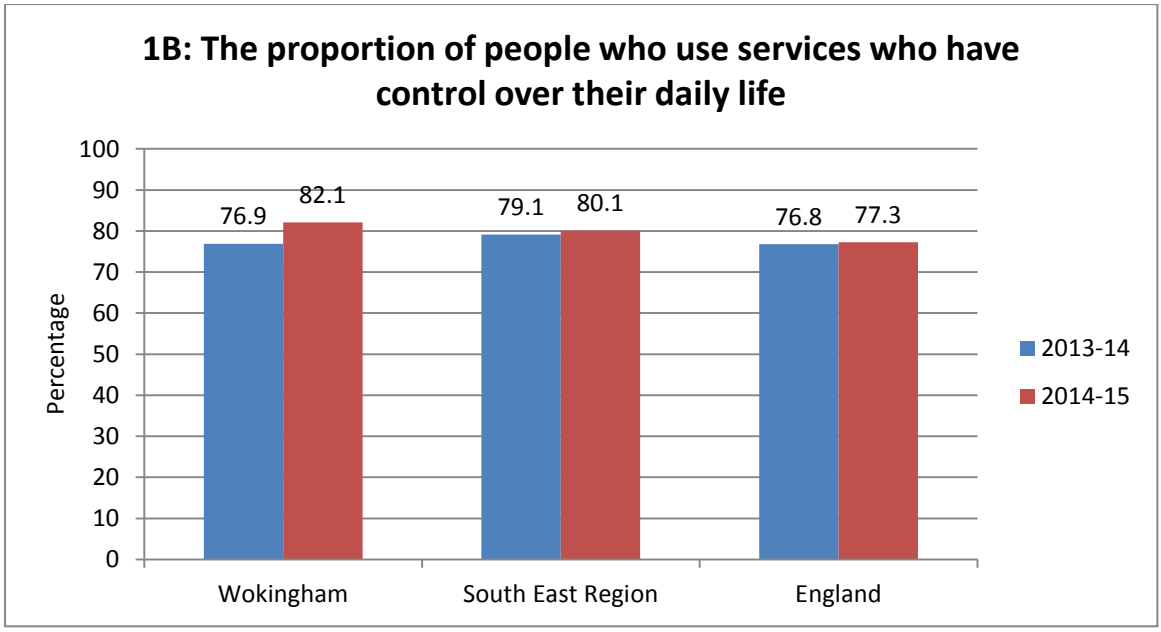
1A: The **social care-related quality of life** measure within the ASCOF gives an overarching view of the quality of life of **users of care and support**. In 2014-15, social care-related quality of life for Wokingham was 19.4 out of a maximum possible score of 24. This is:

- up from 19.2 in 2013-14 ↑
- the same as the average for the South East region ↔
- higher than the average for England as a whole (19.1) ↑

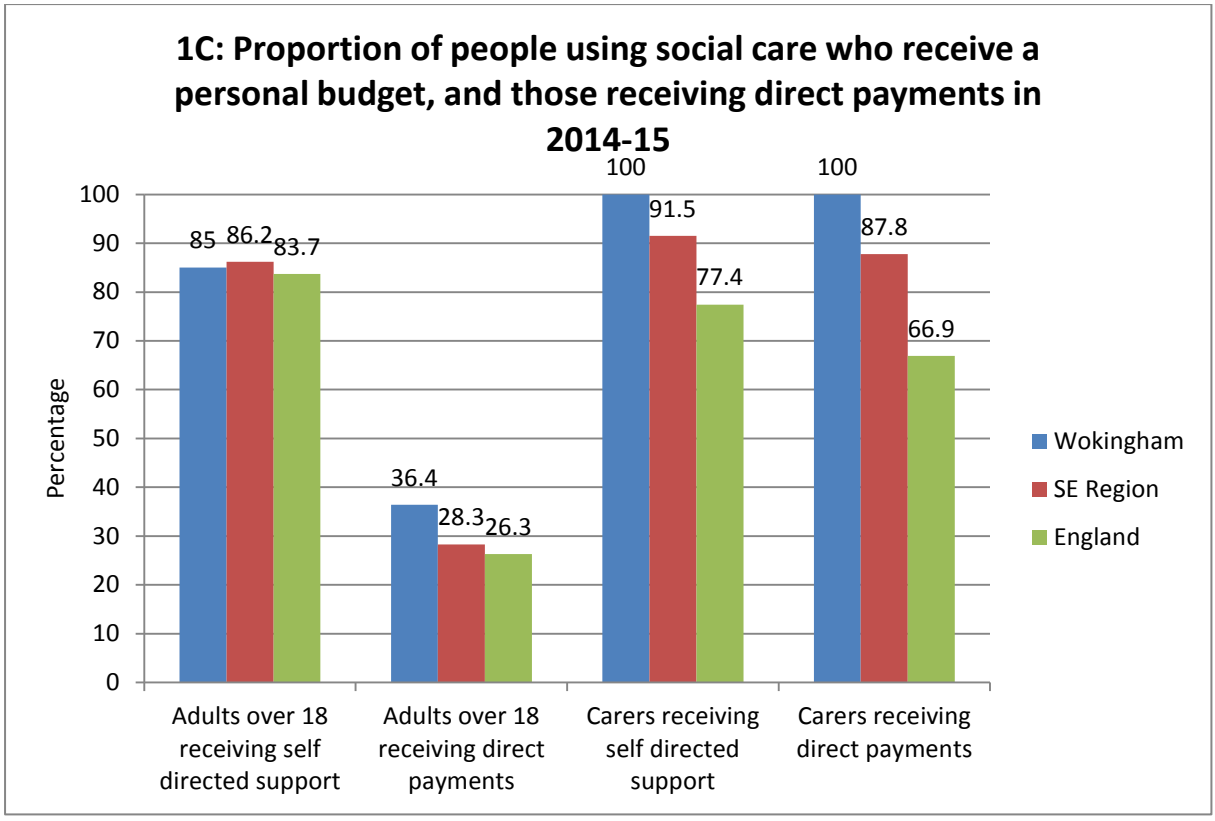



Any decisions about a person's care and support will consider their wellbeing and what is important to them and their family. One measure of this is the proportion of people who use services who have control over their daily life. For Wokingham this was 82.1% in 2014-15 which is:

- up from 76.9% in 2013-14 ↑
- higher than the average for the South East region (80.1%) ↑
- higher than the average for England as a whole (77.3%) ↑




To give people more flexibility and choice about the type of service and provider they want, we have continued to increase the number of people with a personal budget as well as the number receiving all or part of their personal budget through a direct payment.

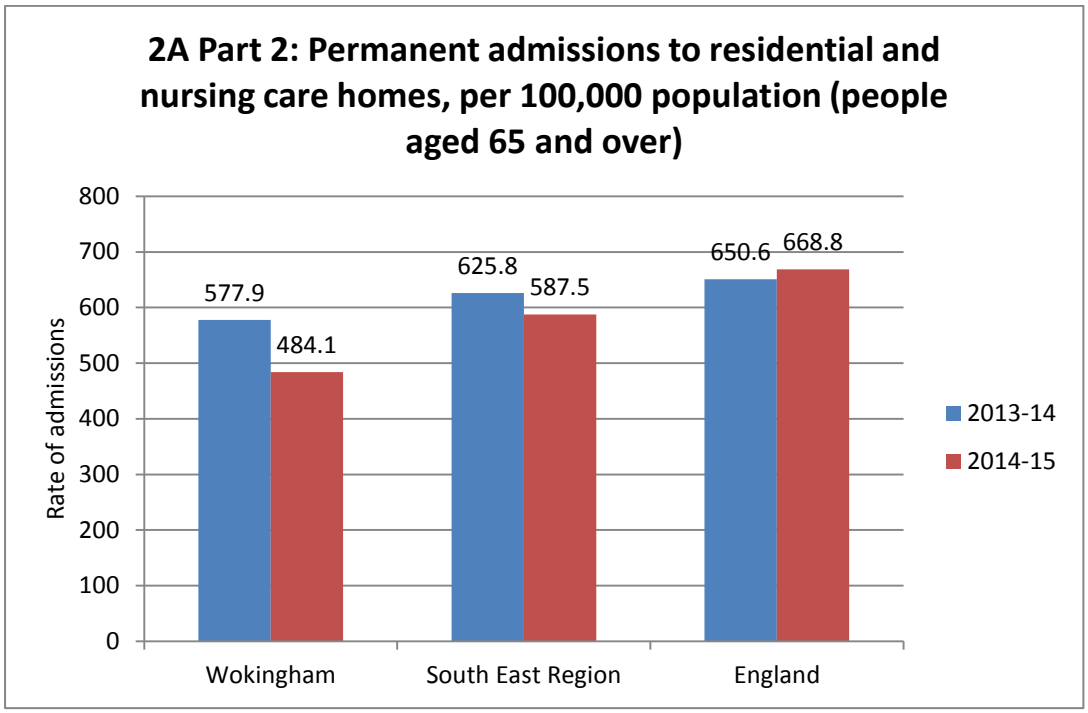


In 2014-15, **carers** reported an average **quality of life** score of 7.8 out of a maximum of 12. This is much the same as the scores for the South East Region (7.7) and for England as a whole (7.9).

## Domain 2: Delaying and reducing the need for care and support

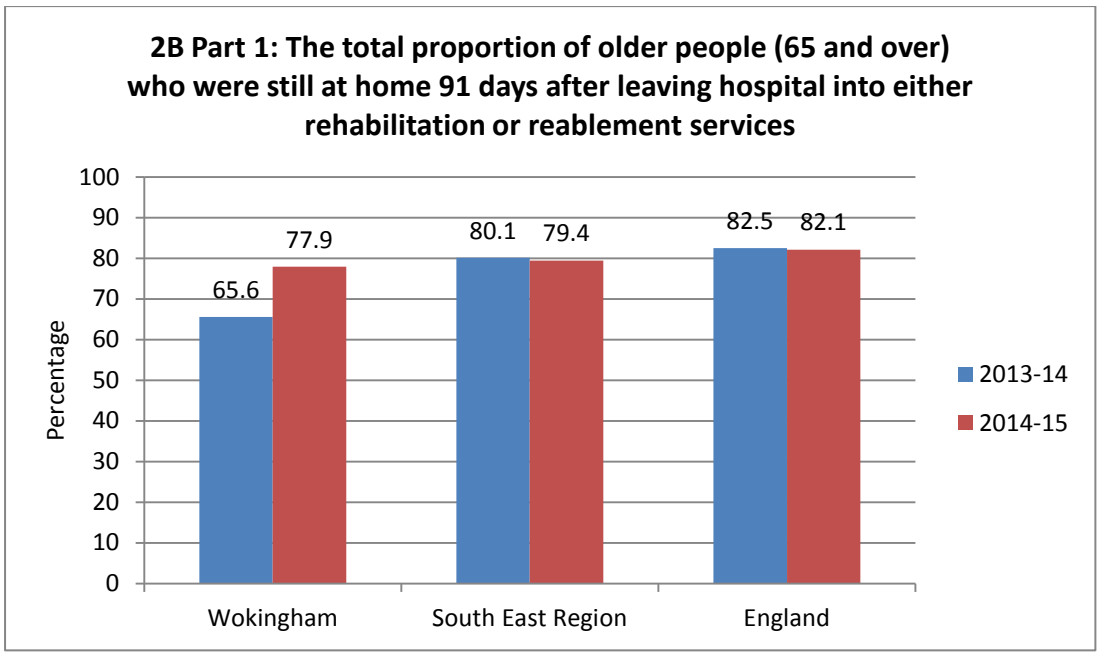
The number of older people admitted to residential and nursing care homes in Wokingham has continued to reduce in line with the Council's policy of enabling people to stay living independently in their own homes. The rate of admissions for 2014-15 was:

- lower than the rate in 2013-14 ⬇
- lower than the average rate for the South East region ⬇
- lower than the average rate for England as a whole ⬇



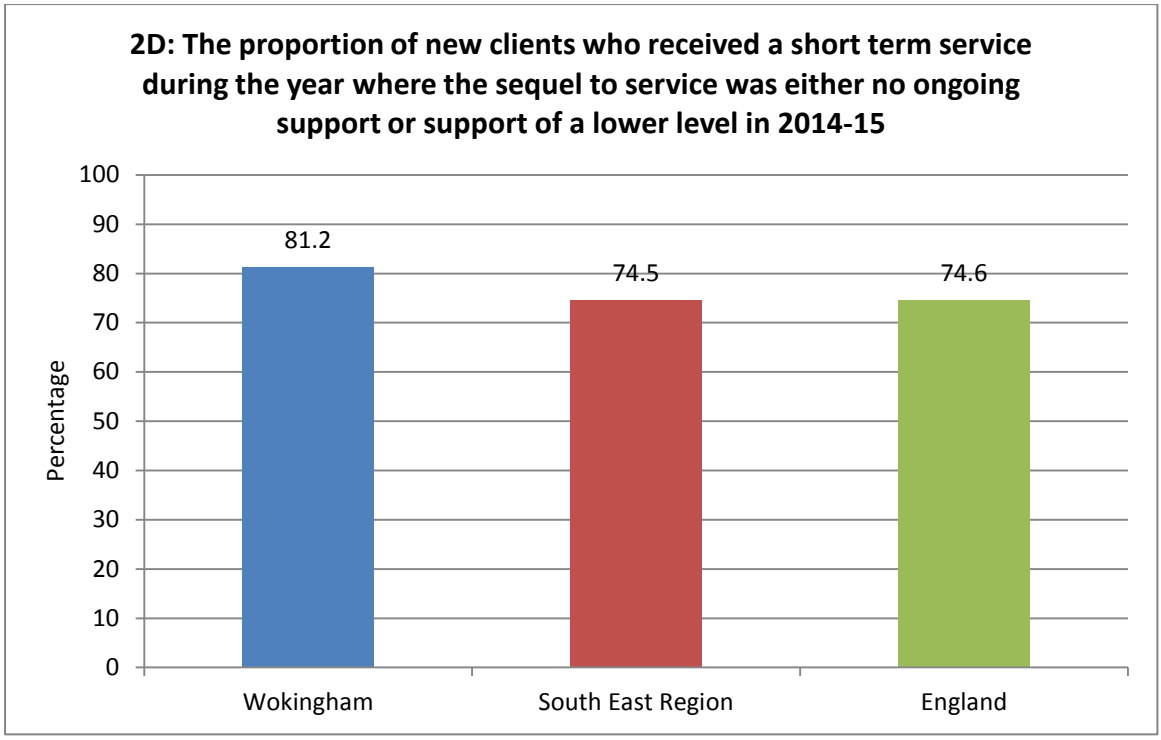
The reablement service aims to support people to relearn lost skills. It promotes independence and enables them to continue with their life. One measure of the effectiveness of this support is to see how many people who have been given reablement services when they leave hospital are still at home 91 days later. For Wokingham, the figure for 2014-15 was 77.9%. This is:

- up from 65.6% in 2013-14 ↑
- lower than the average for the South East region (79.4%) ↓
- lower than the average for Eng land as a whole (82.1%) ↓




Some people who contact the Council for help will only need short-term support to get them back on their feet. We can see how effective this is by measuring what percentage of the people required no further support (or only support of a lower level) after they received short-term support. For Wokingham this was 81.2% in 2014-15. This is:

- higher than the average for the South East region (74.5%) ↑
- higher than the average for England as a whole (74.6%) ↑




## Domain 3: Ensuring people have a positive experience of care and support

See chapter on **What you are telling us**

## Domain 4: Safeguarding

See chapter on **Keeping people safe** below

For a full list of the results see the National Adult Social Care Intelligence Service (NASCIS) ASCOF Comparator Report for Wokingham (pdf).

# Keeping people safe

Everyone has the right to live in safety, free from abuse and neglect. See the WBC web pages about Personal Safety.

**The Safeguarding Adults Board**
The Safeguarding Adults Board is made up of local organisations which work together to protect adults at risk of abuse or neglect and keep them safe.

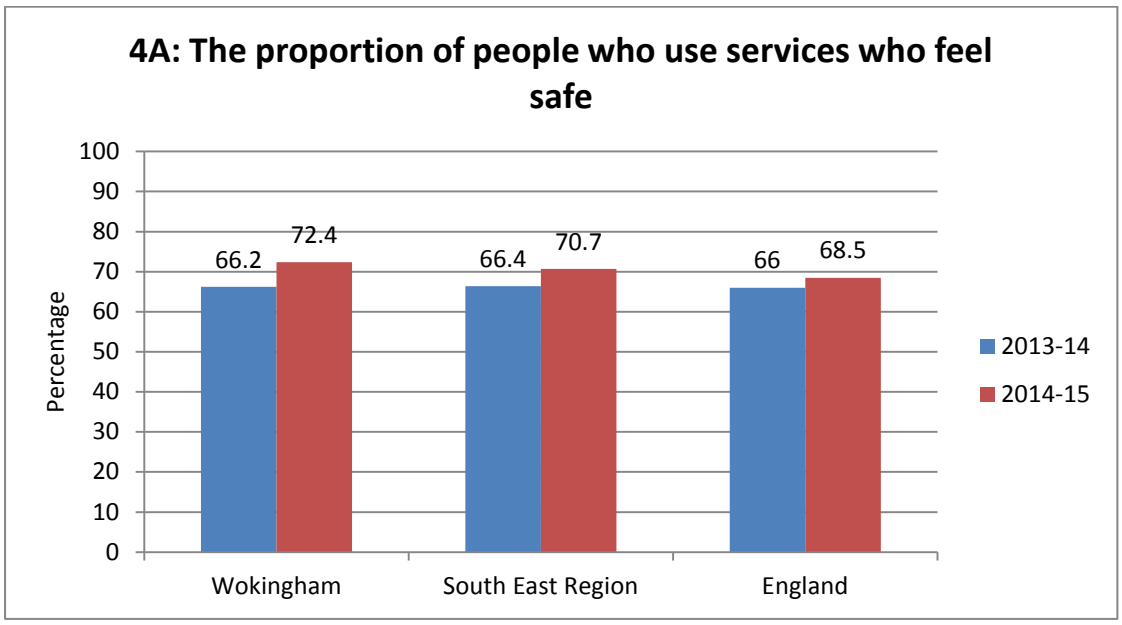
West of Berkshire Safeguarding Adults Board
Reading, West Berkshire & Wokingham

You can find out more on the West of Berkshire Safeguarding Adults Board website.

## How safe do you feel?

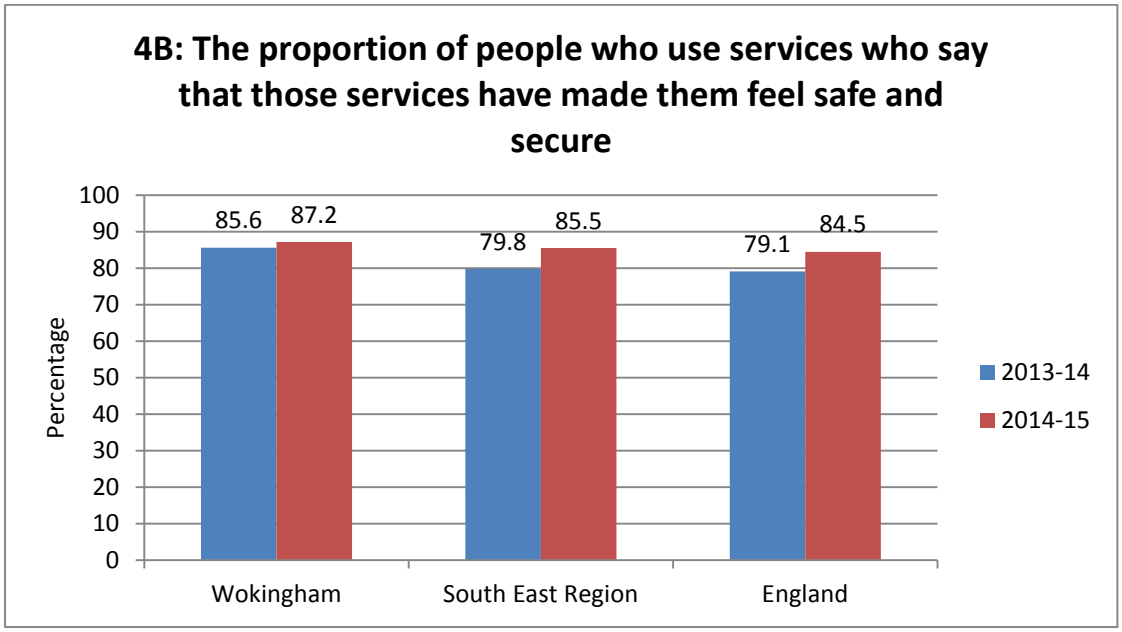
**People who use services** The **proportion of people who use services who feel safe** measure within the Adult Social Care Outcomes Framework shows that, in 2014-15, 72.4% of clients in Wokingham felt safe. This is:

- up from 66.2% in 2013-14 ↑
- higher than the average for the South East region (70.7%) ↑
- higher than the average for England as a whole (68.5%) ↑

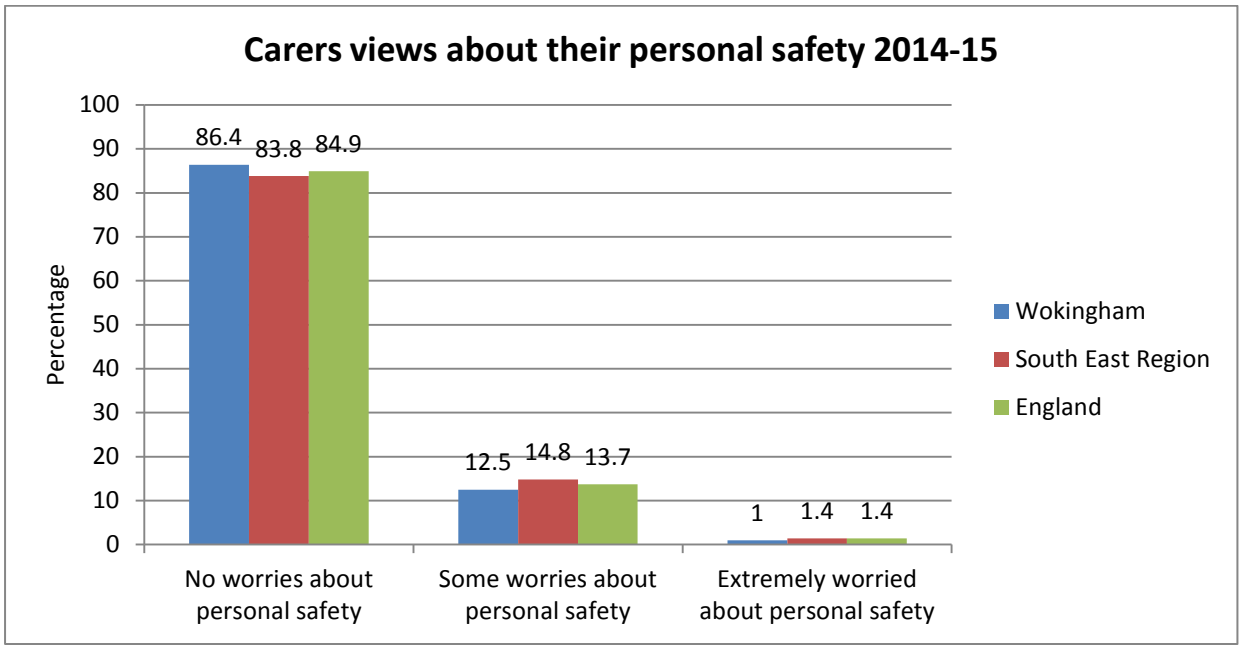


For Wokingham, of the people who use services, 87.2% said that those services have made them feel safe and secure. This is:

- up from 85.6% in 2013-14 ↑
- higher than the average for the South East region (85.5%) ↑
- higher than the average for England as a whole (84.5%) ↑




**Carers** The results from the **Carers survey** show that 86.4% of carers in the Wokingham Borough had no worries about personal safety, 12.5% had some worries about personal safety and 1% were extremely worried. The local results are a very close reflection of the National and Regional figures at 84.9%, 13.7% and 1.4% respectively (SE Region: 83.8%, 14.8%, 1.4%).



## Safeguarding

There were 400 referrals to the safeguarding team during 2014-5, with only 68% of these referrals being for people already known to Wokingham's Adult Social Care service; 60% of these referrals were for females believed to be at risk. The age breakdown of the people referred to the safeguarding service was:

| Age | % |
|---|---|
| 18 – 64 | 28% |
| 65 - 74 | 10% |
| 75 - 84 | 23% |
| 85+ | 39% |
| **Total** | **100%** |

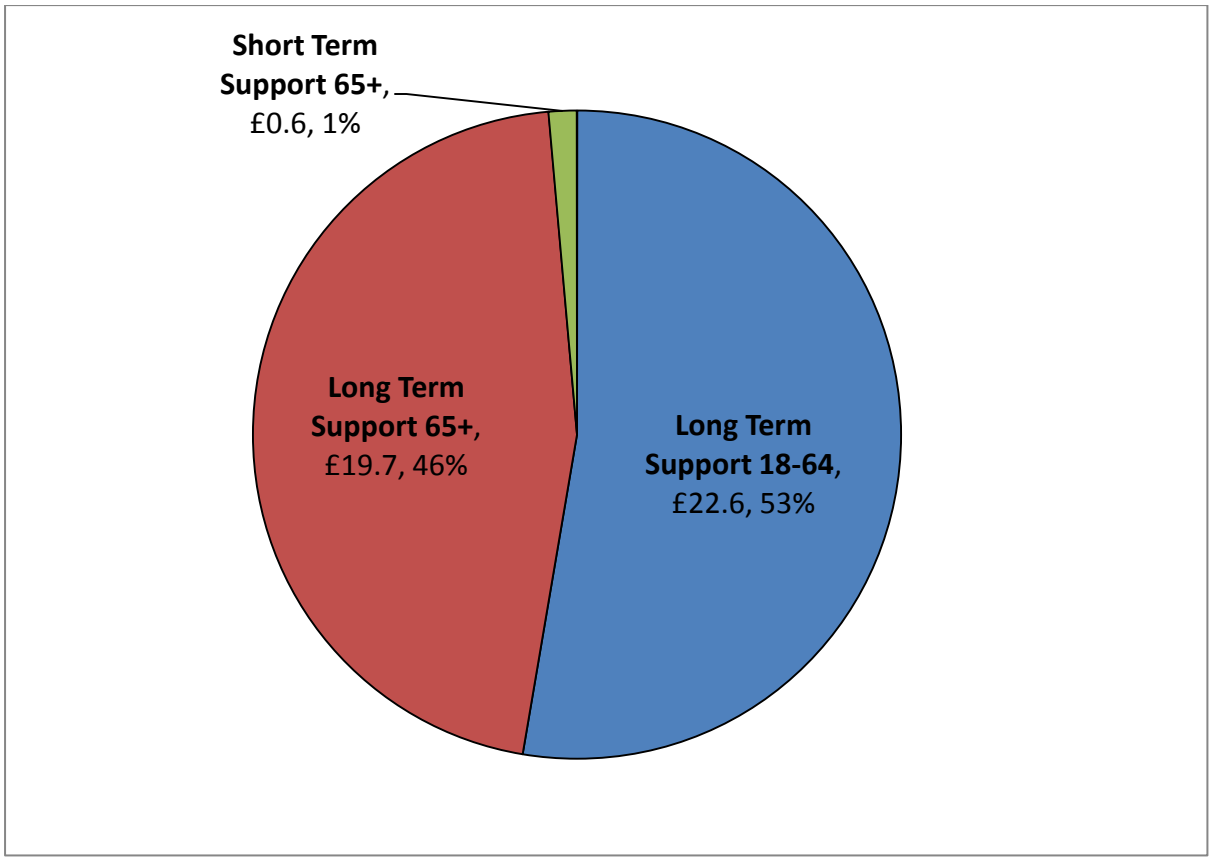
None of these referrals resulted in a serious case review.

# How we spend your money

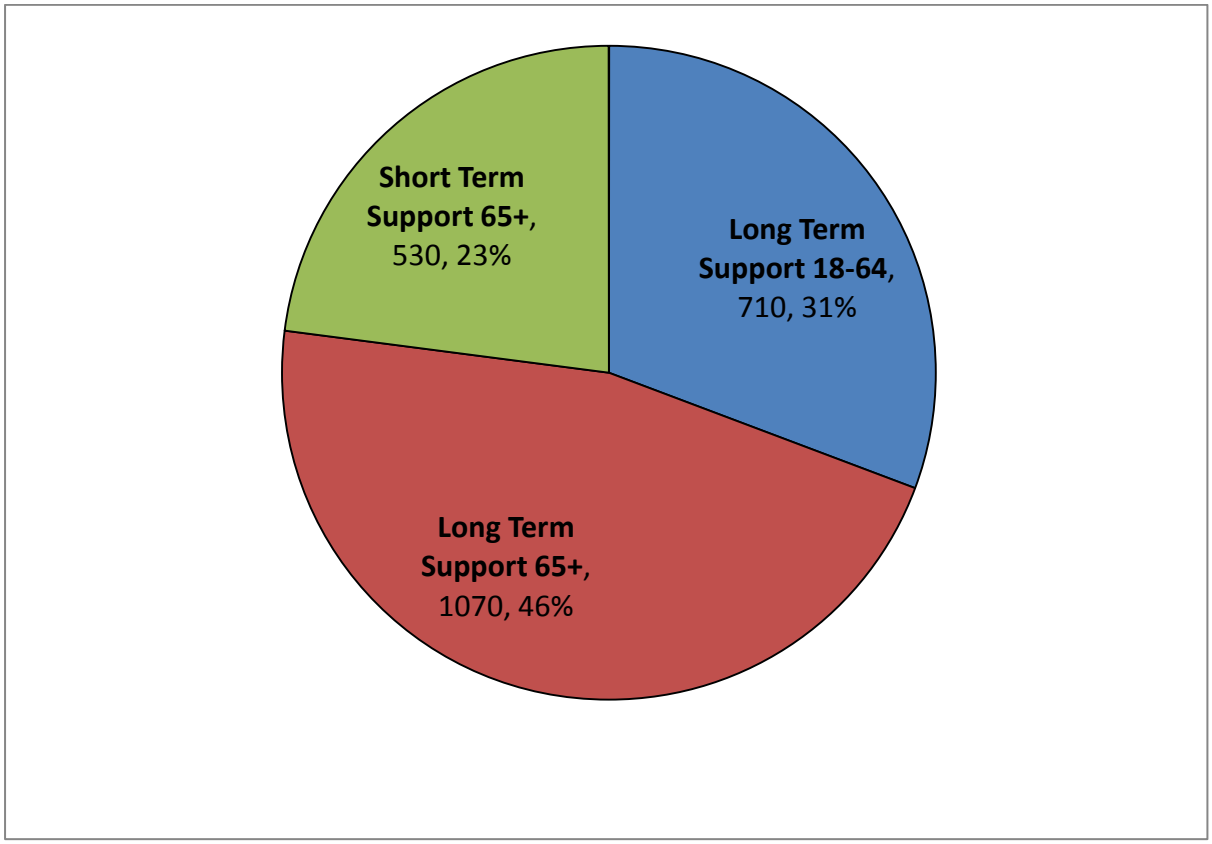
In Wokingham Borough in 2014-15 £42.9 million of gross current expenditure was spent on long and short term support combined; of which

- 47.3 per cent (£20.3 million) was spent on people aged 65 and over
- 52.7 per cent (£22.6 million) on people aged 18 to 64.

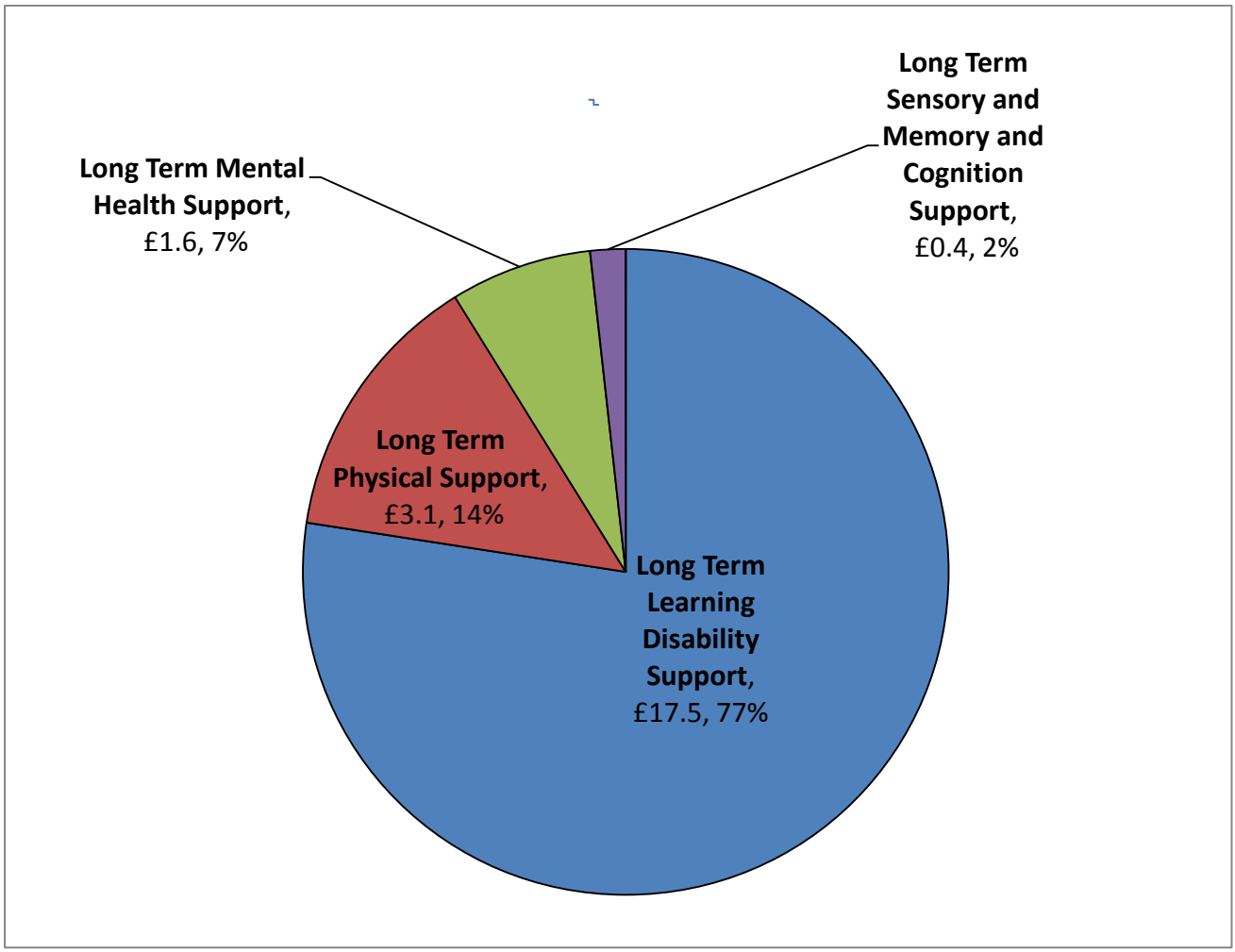
## Total Expenditure in 2014-15 in millions



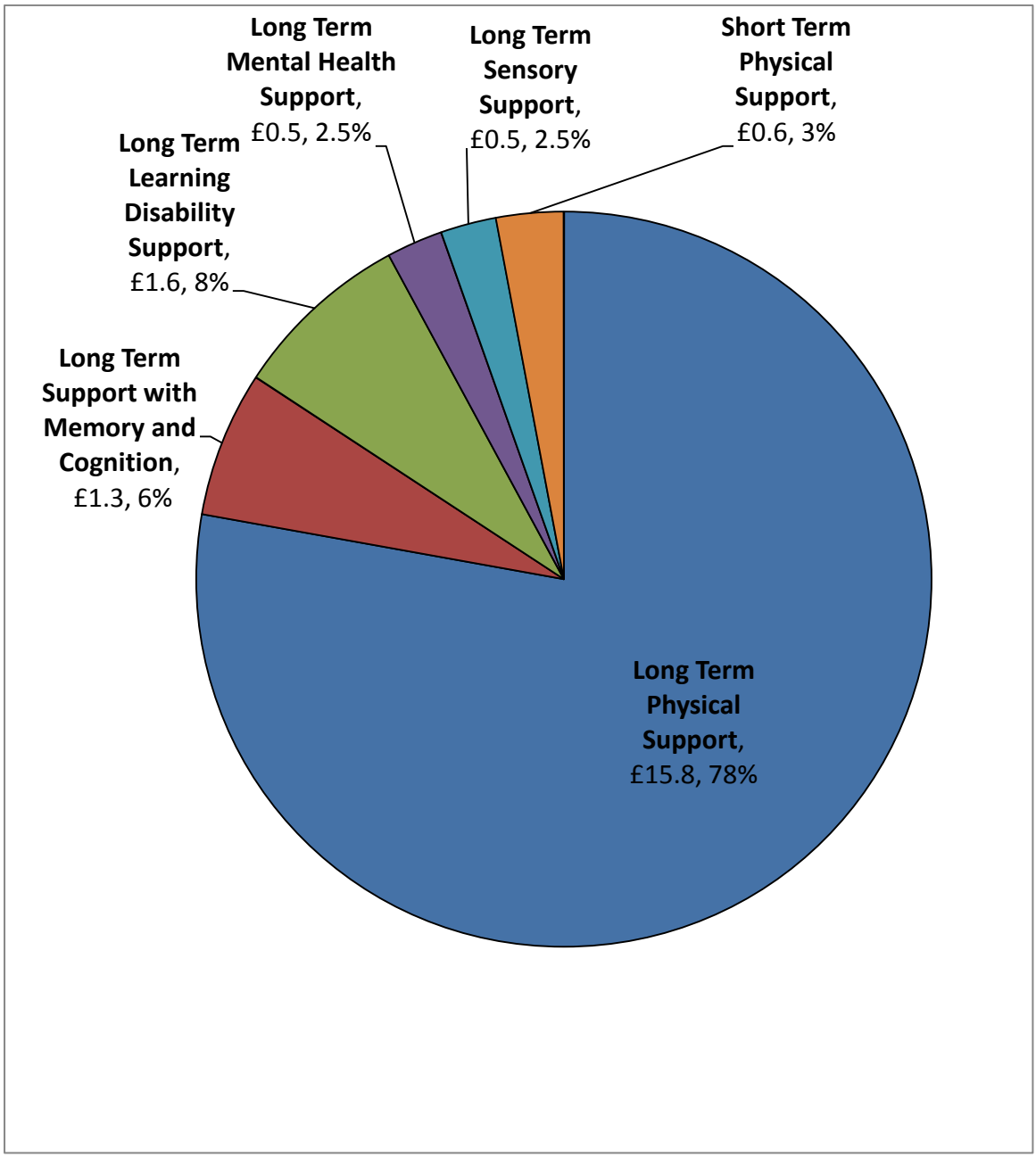

## Total number of people supported in 2014-15



## Expenditure on people aged 18-64 in 2014-15 in millions




## Expenditure on people aged 65+ 2014-15 in millions




## Facts and figures

### Expenditure on long term support

In 2014-15 43.5% (£22.6 million) of gross current expenditure was spent on long term support for people aged **18 to 64**; of which £17.5 million was spent on learning disability support, £3.1 million on physical support, £1.6 million on mental health support, with the remaining £0.4 million split between sensory support and support with memory and cognition.

Of the £22.6 million spent on long term support for adults 18 to 64 year olds, expenditure on residential care amounted to £8.1 million, whilst expenditure for direct payments amounted to £3.8 million and supported living £6.3 million.

For people aged **65 and over**, expenditure on long term support accounted for 38% (£19.7 million) of gross current expenditure; of which £15.8 million was spent on physical support, £1.3 million on support with memory and cognition, £1.6 million on learning disability support, £0.5 million on mental health support and £0.5 million on sensory support.

Of the £19.7 million spent on long term support for adults aged 65 and over, expenditure on residential care amounted to £6.3 million, whilst expenditure on nursing care amounted to £6.4 million and home care amounted to £5.3 million.

### Expenditure on short term support

For people aged **65 and over**, expenditure on short term support accounted for 1.2% (£0.6 million) of gross current expenditure; of which £0.6 million was spent on physical support.

### Other Social Services Expenditure

In 2014-15 17.3% (£9 million) of gross current expenditure was spent on other social care activities including commissioning and service delivery.

For information on key priorities and headline budgets see Wokingham's Medium Term Financial Plan.

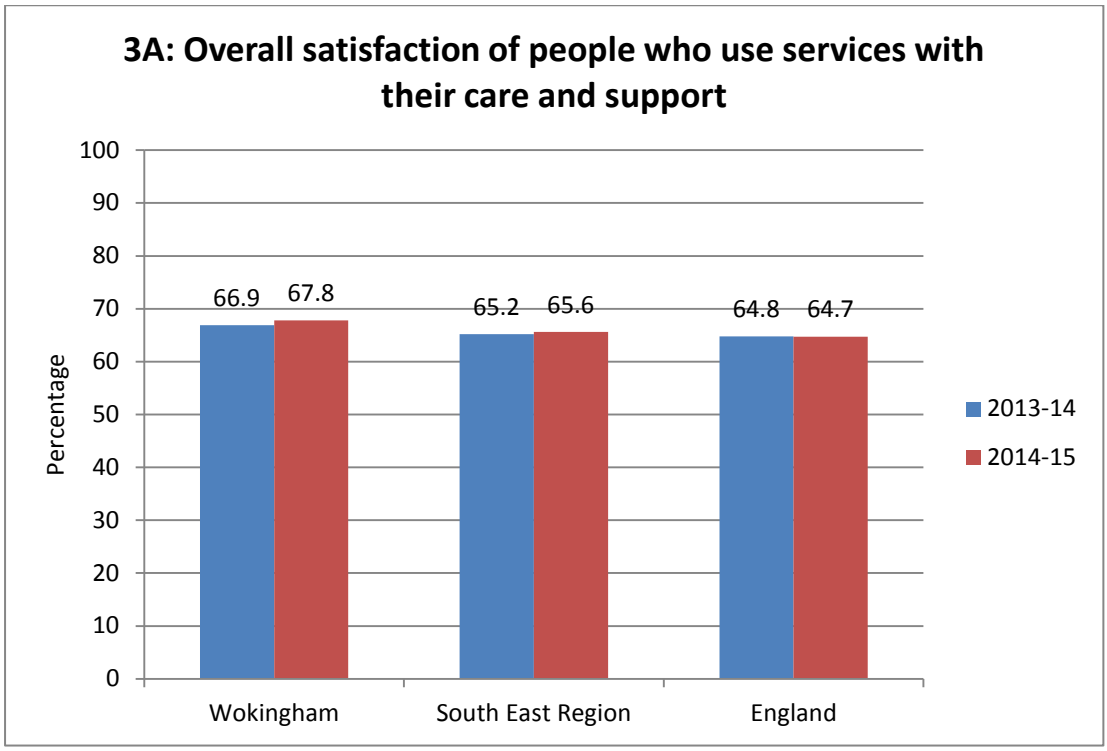
# What you are telling us

## Adult Social Care Survey

Each February, as part of a national survey, we send out a questionnaire to **people over 18 who use social care** to find out what they think about their services. In 2015, 775 surveys were sent out and 303 people responded (39.1%).

Overall, 67.8% of users reported that they were extremely or very satisfied with the care and support services they received in 2014-15. This is:

- up from 66.9% in 2013-14 ↑
- higher than the average for the South East region (64.6%) ↑
- higher than the average for England as a whole (64.7%) ↑



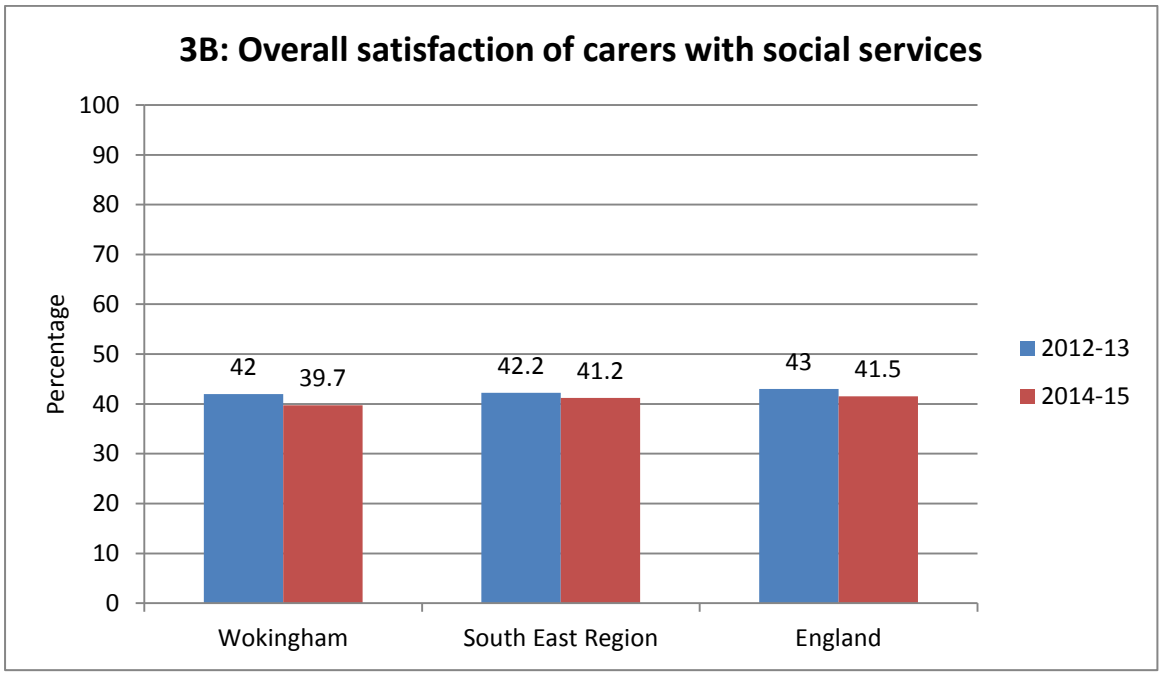
For further information see Personal Social Services Adult Social Care Survey 2014-15 Report (pdf).

## Carers Survey

In addition, every two years a survey is sent out to **carers**. In 2015, 520 surveys were sent out and 277 people responded (53.3%).

Overall, 39.7% of carers reported that they were extremely or very satisfied with the support services they received in 2014-15. This is:

- down from 42% in 2012-13
- lower than the average for the South East region (41.2%)
- lower than the average for England as a whole (41.2%)




For further information see Personal Social Services Survey of Adult Carers 2014-15 Report (pdf).

## Complaints

If you are unhappy about something, it is important to let someone know. Most issues are dealt with straight away by Adult Social Care staff but if the complainant remains unhappy, the complaint will be passed to the Council's Complaints Team. If everything has been done to resolve the complaint and a person is still not satisfied, they can ask the Local Government Ombudsman to review the matter. See web page How do I complain?

In 2014-15 Adult Social Care teams received 13 formal complaints. The reasons for the complaints were:

- Appropriateness of Service 1
- Quality of Food 1
- Delay in Arranging Service 4
- Financial Assessment 2
- Quality of Service 1
- Other 4

12 of the complaints were dealt with at Stage 1 and the other is still with Local Government Ombudsman.

### Learning from complaints

The Assessment Team were made aware of a client who had been moved into residential care funded by us but who had not subsequently had an Annual Review of her care. Unfortunately, the placement wasn't suitable in the longer term but we hadn't made contact with the family to check all was well. As a result of this complaint, which was upheld, we made an unreserved apology to the client and her family and have ensured she is now in suitable accommodation where she is happy and settled and being well cared for. To ensure this will not happen again, changes have been made to our recording processes to electronically transfer this information to our Reviewing Team, and we have also put in place some additional reporting tools so that this can be checked for accuracy on a regular basis.

## Priorities for the next year

### Pre-Paid Cards for Direct Payments

Some people feel that the administration involved in receiving a Direct Payment is not worth the benefit as you need to open a special bank account and send in regular bank statements and receipts.

Work is going on to introduce Pre-paid Cards for Adult Social Care direct payments. The cards are, in effect, a simple electronic bank account that we can monitor online. They will be used in any location or transaction process where a typical credit or debit card can currently be used. This includes shops, banks, ATMs (if allowed), over a telephone or via the internet. You will be able to set up direct debits or standing orders. If you are required to contribute to the costs of your care, you will be able to add your contribution to the card account, keeping all funding in a single place.

We expect to have a contract in place in the final quarter of this financial year. We will then carry out a trial with a small number of current Direct Payment recipients before introducing them to all new and existing customers sometime during the first half of 2016-17.

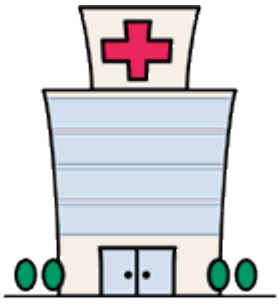
For more information on direct payments see Paying for my support with a direct payment

## The Integrated Hub



We have listened to our residents and customers and, in conjunction with Berkshire Health Foundation Trust during the course of 2016 we plan to have an integrated health and social care hub or Single Point of Access for new referrals for adult social care and NHS services. This will change the current model of two points of contact for WBC and NHS services respectively into a single integrated service. As we develop this towards April 2016 more information will be made available to service users, carers and professionals.

## Joint working across the wider health community – the Frail Elderly Project



A report published by The King's Fund has set out a plan to reduce hospital admission rates, release resources for patients to be cared for at home and stem the growing demand for hospital beds. The plan is based on community services working much more closely with groups of general practices and building multidisciplinary teams to care for people with complex needs.

Across the West of Berkshire the hospitals, GPs, Clinical Commissioning Groups and Local Authorities are working together to deliver on these recommendations. The "Frail Elderly Project" is designed to provide better, more joined-up services to people living in the community as their needs increase with age. Our aim is to develop a health care pathway that responds to the needs of individuals rather than one shaped by the organisational structures, whilst using our combined resources more efficiently to improve the experiences of older people and their families. To take this project forward we are currently:

- mapping services across organisational structures,
- looking at the costs of services provided and desired,
- sharing details on the types of people we currently support.

We are expecting that this analysis will have been finished by spring 2016, so we can make progress towards implementation of the changes during the coming year.

### The King's Fund Report

Radical changes to community services are needed to move more care out of hospital and closer to people's homes, according to a report published by The King's Fund. The report argues that previous policy has failed to achieve this longstanding ambition. It sets out seven interrelated steps:

- reduce any unnecessary complexity in community service provision
- forge much closer relationships with groups of general practices
- build multidisciplinary teams for people with complex needs, including social care, mental health and other services
- support these teams with specialist medical input – particularly for older people and those with chronic conditions
- create services that offer an alternative to a hospital stay
- build the information infrastructure, workforce, and ways of working and commissioning that are required to support this change
- reach out into the wider community to improve prevention, provide support for isolated people, and create healthy communities.

*To see how this might work for an individual, please see Sam's Story at* *http://www.kingsfund.org.uk/audio-video/joined-care-sams-story*

## Service Developments

### Dementia services

- Ensuring we have a range of providers with a skilled workforce which can deliver care with compassion and maintain customers dignity
- Ensuring there is appropriate support for younger people with dementia

### Supported Living options for working age adults

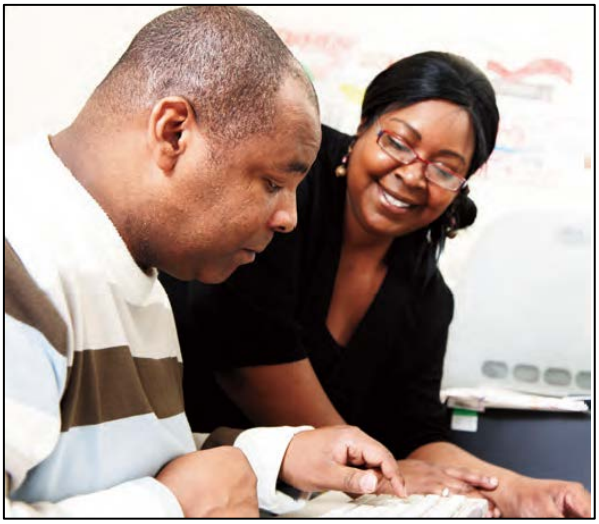
- Continuing our aim to provide care for people in the local community rather than in regulated care homes and outside of the borough
- Working with health partners to meet the needs of those with challenging behaviour

### Older People's Housing – Extra Care (See WBC Housing Strategy 2015-18)

- Making sure we have the right mix of housing and sufficient provision for older people

The redevelopment of the former Fosters Care Home in Woodley as an extra care housing scheme will allow older people to live independently in their own home, with additional facilities and care staff if they need it. There will be 34 self-contained flats, all with a private balcony or ground floor terrace, as well as communal facilities including a lounge and dining room, and a specialist dementia facility.

**Carers** (See Support for Carers)



- Ensuring there is a range of services available to
  - support carers in their caring role
  - support carers to have a life outside caring
  - support carers to maintain their health and wellbeing

  This will include services to provide/offer
  - information and advice
  - emergency support specialist support

Health & Wellbeing
Wokingham Borough Council
PO BOX 154, Shute End
Wokingham, Berkshire
RG40 1WN

| | |
|---|---|
| **TITLE** | **Better Care Fund Plan 2016-17** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on 14th April 2016 |
| **WARD** | None Specific |
| **DIRECTOR** | Stuart Rowbotham, Director of Health and Wellbeing |

**OUTCOME / BENEFITS TO THE COMMUNITY**

The Better Care Fund (BCF) has been created to promote the integration of health and social care services, to provide a better quality of service to users and greater efficiency across the system.

**RECOMMENDATION**

That Health and Well Being Board (HWBB) note and approve the content of Wokingham's Better Care Fund plan 2016-17 subject to the changes being made following NHS England's assurance process and authorise the Chair of the HWBB to give final authorisation for submission of the final plan before the 25th of April 2016.

**SUMMARY OF REPORT**

This report sets out Wokingham's BCF plans for 2016-17 and the assurance process required by NHS England.

**Background**

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fun (BCF). It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England set the following conditions, which local areas will need to meet to access the funding

A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
• A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
• A requirement that plans are approved by NHS England in consultation with DH and DCLG
• A requirement that a proportion of each areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:
• Plans to be jointly agreed ;
• Maintain provision of social care services;
• Agreement for the delivery of 7-day services across health and social care to prevent

unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
• Better data sharing between health and social care, based on the NHS number;
• Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
• Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
• Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
• Agreement on local action plan to reduce delayed transfers of care.

**2016-17 BCF submission**

Our 2016-17 BCF is essentially a continuation of our 2015-16 BCF (previously approved by the HWBB) with the exception that our previous BCF 09 project –Access to General Practice, has been removed from the BCF and is now funded directly by the Clinical Commissioning Group (CCG).

Each BCF scheme has developed a 16-17 business case which have been reviewed and signed off by Wokingham Integration Strategic Partnership (WISP) a sub-group of the HWBB.

The attached template for submission we received from NHS England was completed but does not really allow for a clear easy overview of our BCF, the below allows a summary overview.

## Wokingham's BCF 'On a Page'

1-INTEGRATED FRONT DOOR-
Health and Social Care Hub (BCF01), based at the Old Forge.
Single point of contact, resolving as many issues as possible, triaging enquiries and handover to statutory teams if needed.

ENABLERS
Connected Care (BCF07) - Integrated IT systems

2-INTEGRATED SHORT TERM TEAM (WISH) (BCF02)
Joining Council's Health Liaison team, Optalis' START team and BHFT's Intermediate Care Team.
**Less** Delayed Transfers of Care, **less** avoidable admissions and **less** admissions to residential care homes, **less** handoffs for the public.
Innovative new services- Step Up/Step Down (BCF03) and Night Responder services (BCF04) and more Community Nursing Support to Care Homes (BCF06).

3-NEIGHBOURHOOD CLUSTERS, SELF-CARE AND PREVENTION (BCF08)
Integrating long-term social care and community health services.
Better MDT working with those most at risk of hospital admission.
Community navigators taking social prescriptions from GPs helping people to self-care better.

We were asked to submit a planning return (attached below) by the 2nd March, which outlined the financial contributions from the CCG and the Council, along with our performance metrics.

We were then asked to submit a first draft Narrative plan by 21st March 2016 in which we outlined how our BCF meets NHS England's Key Lines of Enquiries (KLOEs), which is attached below.

**Assurance Process**

NHS England have set out the below assurance process for approving 2016-17 BCF plans:

2 March Local areas to submit only the completed BCF Planning Return template, which includes technical information on funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.

21 March First submission of full narrative plans for Better Care alongside a second submission of the BCF Planning Return template.

25 April Final submission signed off by the Health and Wellbeing Board

After the first submission an NHS England review team give feedback based on where they think 'fully meets, partially meets or does not meet the KLOE criteria.

**Feedback from NHS England**

Wokingham BCF received feedback from NHS England on 1st April 2015 which advised that "the BCF plan was of good quality with supporting evidence on how the National Conditions will be delivered. The plan also demonstrated how performance will be maintained throughout 16/17, and your milestone plan and risk register are exemplars of effective planning and monitoring."

NHS England assessed our BCF plan against 117 separate Key Lines of Enquiries (KLOEs) and Wokingham's plan was deemed to have 'fully met' the criteria in all, except 7 areas that were deemed to have been 'partially met' and 1 area 'not met'. Most of these were with regard to a Delayed Transfer of Care (DToC) plan, which is being developed across Berkshire West.

All the areas of the plan being 'partially met or not met' will be revised to ensure full compliance before the 25th April final submission deadline and a briefing for the Chair of the Health and Well Being Board to explain these changes will be arranged to seek his approval.

**Recommendation**
That the HWBB approves Wokingham's 2016-17 BCF plan, subject to the changes being made following NHS England's assurance process, and authorises the Chair of the HWBB to give final authorisation for submission of the plan before the 25th of April 2016.

| | |
|---|---|
| **Contact** James Burgess | **Service** Health and Wellbeing |
| **Telephone No** 0118 974 6235 | **Email** james.burgess@wokingham.gov.uk |
| **Date** 04.04.16 | **Version No.** 1 |

NHS South of England

# BCF Plan 2016/17 - Cover Sheet

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

# Section 1 – Confirmation of funding contributions

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

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

**BCF Funding Contributions**

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

<table>
<tr><td>CCG Minimum Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>NHS Wokingham CCG</td><td>£7,640,291</td><td>£7,431,000</td><td>2.8%</td></tr>
<tr><td>Total Minimum CCG Contribution</td><td>£7,640,291</td><td>£7,431,000</td><td></td></tr>
</table>

<table>
<tr><td>CCG Additional Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>NHS Wokingham CCG</td><td>£0</td><td>£300,000</td><td></td></tr>
<tr><td>Total Additional CCG Contribution</td><td>£0</td><td>£300,000</td><td></td></tr>
</table>

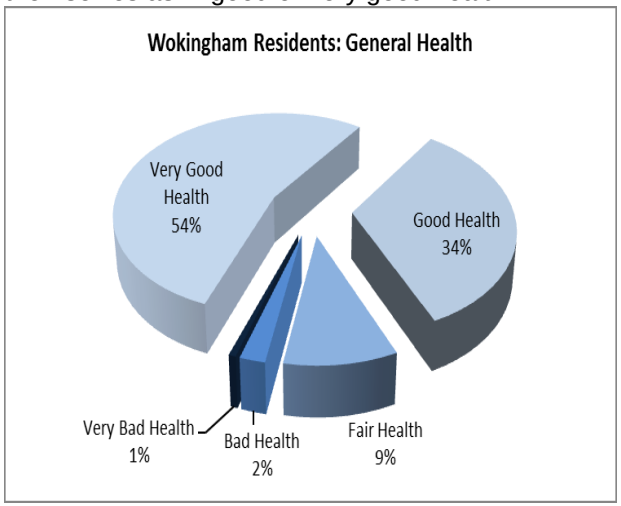
<table>
<tr><td>Total BCF pooled budget</td><td>£9,491,291</td><td>£9,561,000</td><td>-0.7%</td></tr>
</table>

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

# Section 2 – Narrative overview

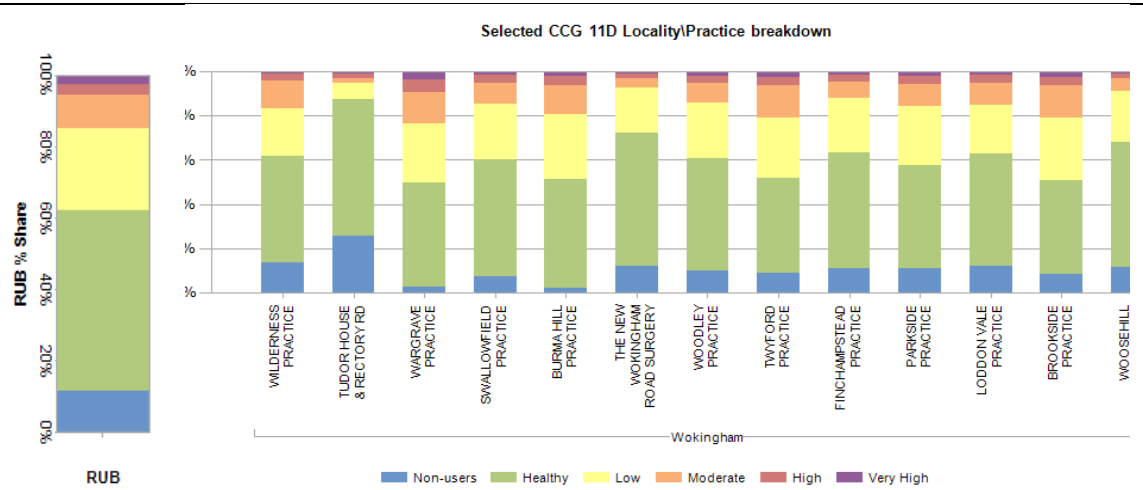
| | |
|---|---|
| Please describe the local vision for health and social care services, including changes to patient and service user experience and outcomes. | We are delivering our BCF both locally and through a wider Berkshire West approach. The Berkshire West system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure (see below structure chart). The Berkshire West system first came together as an agreed footprint back in 2013, and has continued to with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign.<br><br>An overview of Wokingham's 16/17 BCF can be seen in the below document.<br><br>  <br>Wokingham's BCF On a Page UNCLASS]<br><br>Wokingham's vision for integrated health and social care was developed after call to action consultation events and in partnership with all stakeholders in view of the impact of the Care Act 2014, utilising Wokingham's JSNA and Berkshire West CCGs Five year Forward View.<br><br>**Preventing ill health within a growing population and supporting people with more complex needs within the community**<br><br>Wokingham Borough is one of six unitary authorities in Berkshire. It currently has a population of 155,000, but this is projected to increase to 186,000 by 2026. |

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




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

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

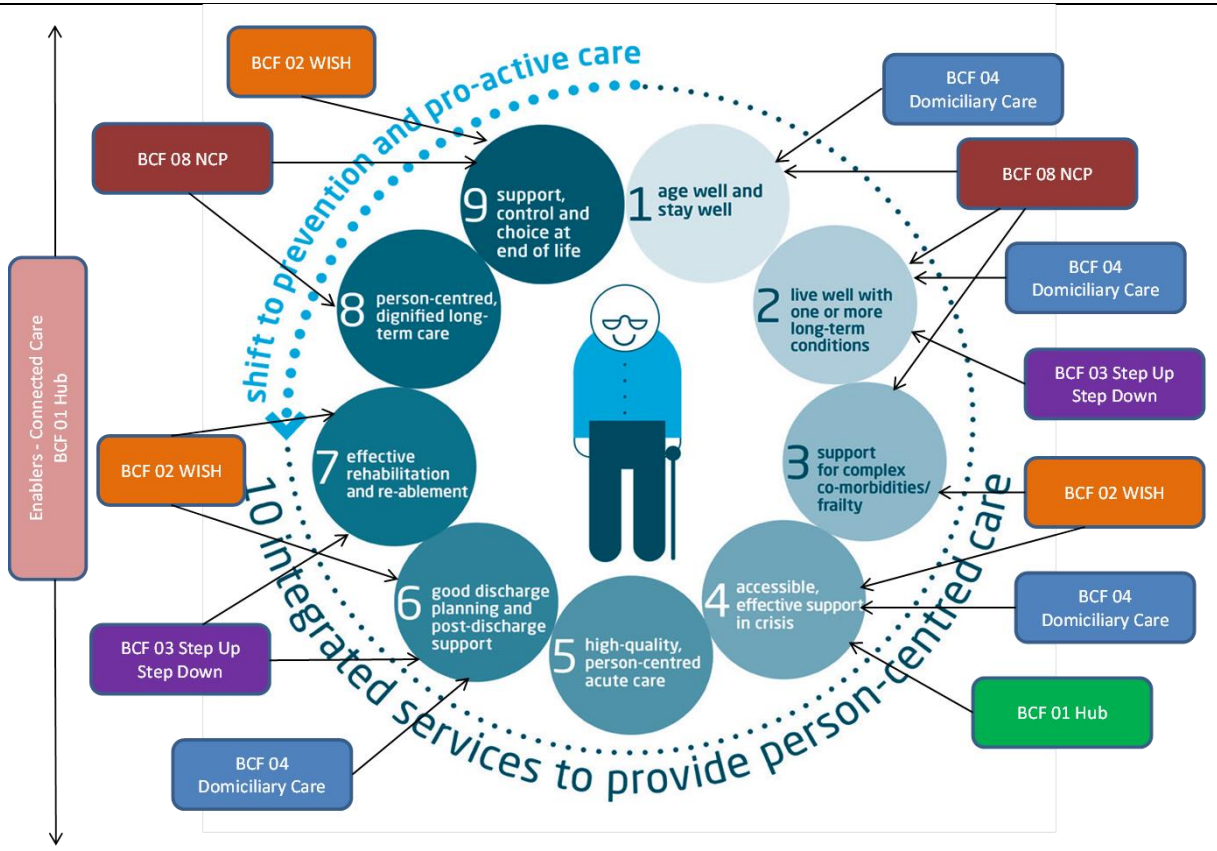



We have increasing rates of people with complex, multiple conditions and a growing frail elderly population. The table below shows current multi-morbidity by age band using our risk stratification tool. At Call to Action events, residents have told us about their difficulties in accessing health and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

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

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

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




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

Frail Elderly Pathway Key Messages Feb 20

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

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

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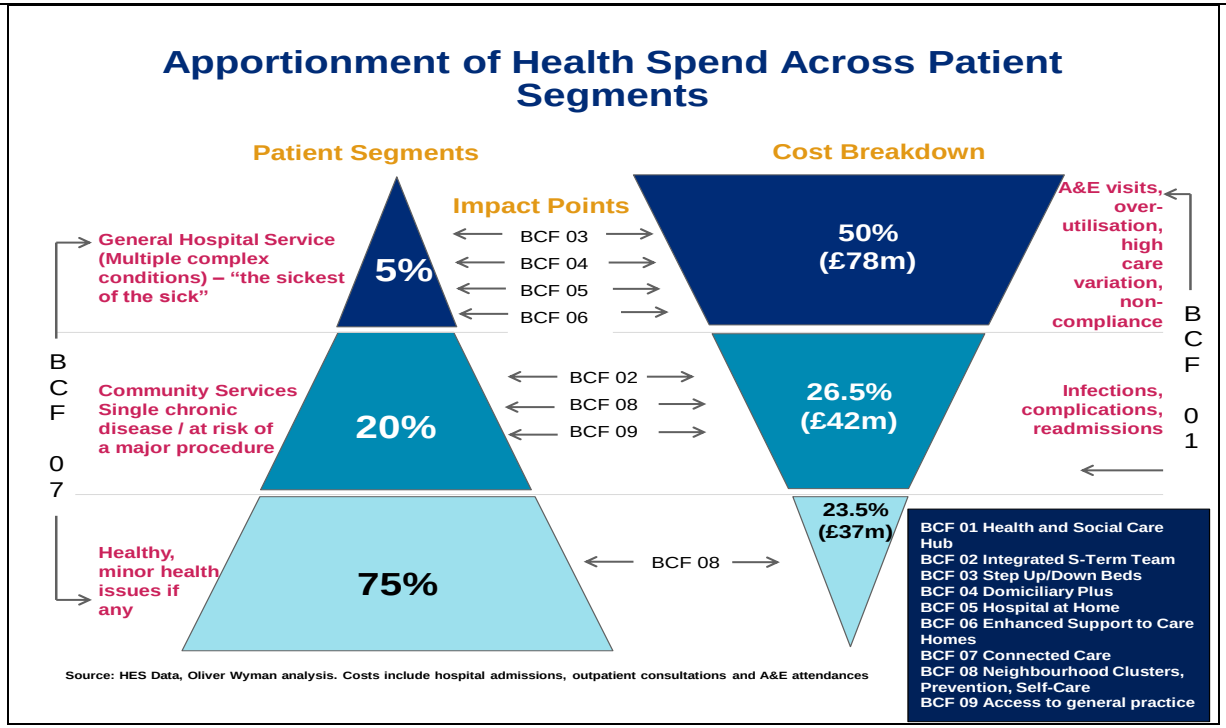
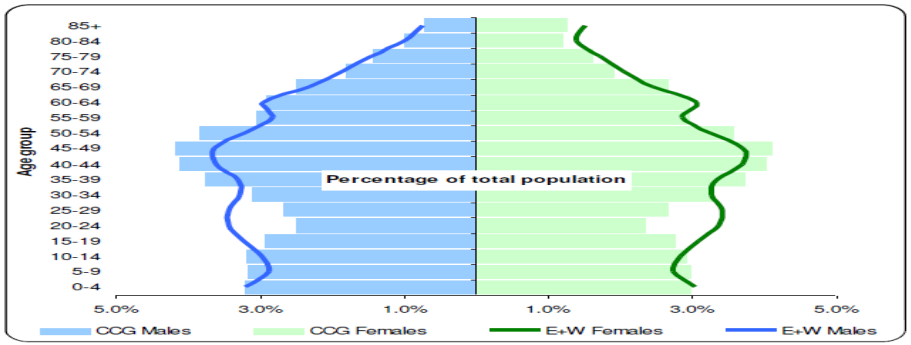
| | • We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live.<br>• We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy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



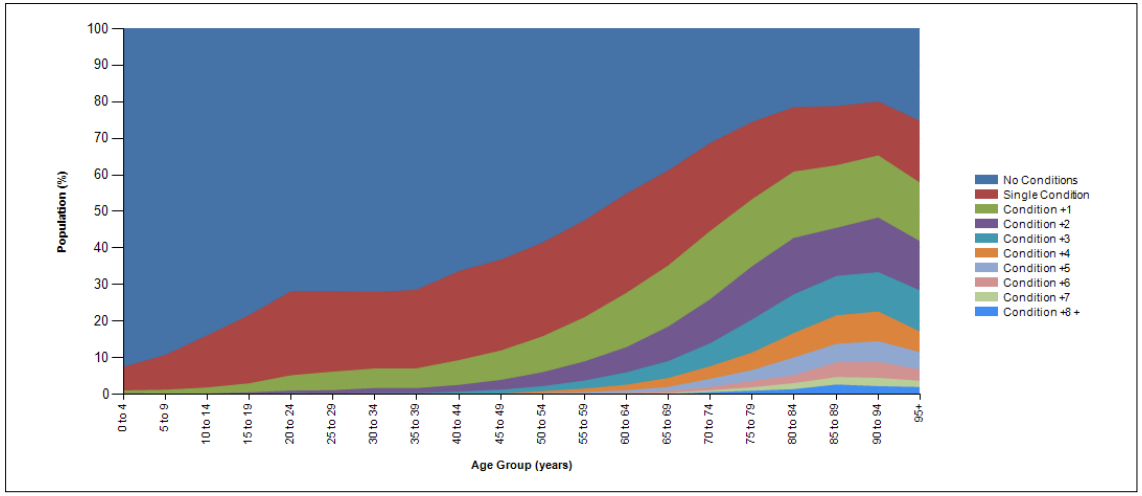

The following section summarises the analysis and risk stratification work we have undertaken, broken down by our key challenges, and how this has informed the development of our integration models.

## Challenge 1: A growing population

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



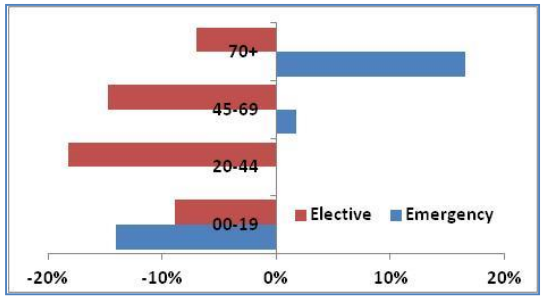

With people in Wokingham living longer, the very elderly will present multiple long term conditions and complex needs. The table below shows current multi-morbidity by age band using the ACG tool.




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

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

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




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

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

**Challenge 2: Non-Elective Admissions**

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

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

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

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| | programme.<br>• Balance the demands of this transformation programme alongside the maintenance of ongoing business operations in each organisation.<br><br>BW10 Integration Governance Map.doc |
| An articulation of the arrangements in place to support joint working?<br><br>• Key milestones associated with the delivery of the plan of action in 2016-17?<br><br>• A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally including:<br>  • A quantified pooled funding amount that is 'at risk'<br>  • Demonstration that this has been calculated using clear analytics and modelling<br>  • An articulation of any other risks associated with not meeting BCF targets in 2016-17<br>  • An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting | Local project resources work across Health and social care reporting to the CCG, Council and other stakeholders through our local implementation board WISP.<br><br>Key Milestones and Progress Plans 2016- Copy of 2016-17 Portal Implementatio Nb. The portal implementation spreadsheet is a very early draft and subject to change and revision.<br><br>Wokingham Risk Register Mar 2016 Of<br><br>Management of the risk share pot will be through monthly monitoring of the individual schemes, identifying the performance against target and assessing progress against plan. Funds will be released from the risk share based on achieving targets. Risks within individual projects will be monitored and manged through the Section 75 agreements, with reports being produced on material variances to seek appropriate action. A contingency fund is held in the first instance to address such risks, however if the schemes are failing, plans to wind up the schemes will be implemented. Consideration is being made from the outset in terms of contracting any longer term commitments.<br><br>The table shows the allocation of risk share across the schemes. Modelling is based on levels of activity from the investment targeted specifically at HRG codes associated with the service and the likely benefit to be realised from avoidance of NELs. A weighting of the saving has been used to allocate the risk to reach the proposed target of £448k equivalent to the performance fund in 15/16 not achieved. |

and payment arrangements

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

# Section 3 - National Conditions

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| **Plans Jointly Agreed** | |
| Does the BCF Plan cover a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, and is it signed off by the HWB itself, and by the constituent Councils and CCGs? | The BCF plan does cover the minimum Fund specified in the Spending Review and has been through the individual governance structures within commissioning organisations for approval and subsequent approval by the HWB. |
| Explain how, in agreeing the plan, have you engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. Please illustrate:<br><br>• There is joint agreement across commissioners and providers as to how the | Health and social Care providers evaluated the Wokingham 15/16 schemes along with other stakeholders and agreed the continuation and varied business cases through our Local integration board. At a more strategic level both main provider trusts have articulated the impact of the BCF in their operating plans and as previously mentioned.<br>Our Better Care Fund projects have been developed and rolled out over a series of meetings of the Wokingham Integrated Strategic Partnership Board involving acute trust, community health providers, social care and primary care.<br><br>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.<br><br>Going forward with our Better Care Fund plans, we expect that the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospitals Trust, local GPs and the Adult Social Care Service will all continue to be part of the integration implementation teams.<br><br>WISP report ref BCF evaluation - DRAFT.dc |

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

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

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

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

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| | there is improved reactive services to clients in crisis alongside the proactive identification and management of clients at risk who need support to reduce the likelihood of needing a hospital admission. |
| **Data Sharing on the NHS Number**<br><br>Please use this section to demonstrate that the right cultures, behaviours and leadership exists locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. In your response please confirm if: | Currently across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different culture, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time. What the Connected Care solution is offering the is ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways:<br><br>• No need for multiple laptops to access health and social care data separately<br>• Access to real time data reducing the need for phone calls to various organisations to collate pieces of information<br>• Reduce the amount of time required to contact the relevant organisations in relation to a person.<br>• More accurate data<br>• The ability to streamline the integrated services better by creating true single assessments<br>• The ability to streamline the transfer of a person from one service to another by developing health and social care pathways |
| • you are using the NHS Number as the consistent identifier for health and care services, and if not, your plan to do so | Wokingham Borough Council have undertaken one batch load to achieve this and have planned following uploads and staff training around this requirement. |
| • you are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls | As part of the procurement there were a number of technical requirements which the preferred bidder has signed up to in relation to Open APIs. The benefit to the use of APIs. The APIs will define what data is shared between the various systems and is what will support the real time access to data. Open APIs will then future proof going forward data exchanges between the multiple systems any changes in technology and legislation. |
| • you have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when you plan for it to be in place | The Connected Care Implementation team consists of an Information Governance Group across Berkshire made up of the Caldicott Guardians, business representatives and technical people to ensure that the appropriate controls are put in place in the new solution. The guiding principles and development of the group were defined around the principles developed by Dame Fiona Caldicott, the Information Governance Oversight Panel and Information Governance Alliance. Copies of the ToR and the Principles have been attached for reference. |

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

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

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

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

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

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

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

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

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

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

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

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

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# Template for BCF submission 2: due on 21 March 2016

## Better Care Fund 2016-17 Planning Template

**Sheet: Guidance**

**Overview**

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

**Timetable**

The submission and assurance process will follow the following timetable:

- NHS Planning Guidance for 2016-17 released – 22 December 2015
- BCF Allocations published following release of CCG allocations – 09 February 2016
- Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
- BCF Planning Return template, released – 24 February 2016
- First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
  - o BCF planning return template

All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)

- First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
- **Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March**
- **Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:**
  - **o High level narrative plan**
  - **o Updated BCF planning return template**
- **Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016**
- BCF plans finalised and signed off by Health and Wellbeing Boards in April, and submitted 2pm on 25 April 2016

This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

**Introduction**

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

| |
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| Data needs inputting in the cell |
| Pre-populated cell |

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

The details of each sheet within the template are outlined below.

**Checklist**

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks

- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.

The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

**1. Cover**

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please **enter the following information:**

- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

**2. Summary and confirmations**

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**

- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

**3. HWB Funding Sources**

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

**4. HWB Expenditure plan**

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

**5. HWB Metrics**

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**
- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

**5b. HWB Metrics Tool**

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

**6. National Conditions**

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

**CCG - HWB Mapping**

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

# Template for BCF submission 2: due on 21 March 2016

## Better Care Fund 2016-17 Planning Template

**Sheet: Checklist**

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

***Complete Template***

**1. Cover**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| Health and Well Being Board | C10 | ☐ | Yes |
| completed by: | C13 | ☐ | Yes |
| e-mail: | C15 | ☐ | Yes |
| contact number: | C17 | ☐ | Yes |
| Who has signed off the report on behalf of the Health and Well Being Board: | C19 | ☐ | Yes |

| | |
|---|---|
| Sheet Completed: | Yes |

**2. Summary and confirmations**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's) | E37 | ☐ | Yes |
| Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance. | F37 | ☐ | Yes |
| Total value of funding held as contingency as part of Icoal risk share to ensure value to the NHS | F47 | ☐ | Yes |

| | |
|---|---|
| Sheet Completed: | Yes |

**3. HWB Funding Sources**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| Local authority Social Services: <Please Select Local Authority> | B16 : B25 | ☐ | Yes |
| Gross Contribution: £000's | C16 : C25 | ☐ | Yes |
| Comments (if required) | E16 : E25 | ☐ | N/A |
| Are any additional CCG Contributions being made? If yes please detail below; | C42 | ☐ | Yes |
| Additional CCG Contribution: <Please Select CCG> | B45 : B54 | ☐ | Yes |
| Gross Contribution: £000's | C45 : C54 | ☐ | Yes |
| Comments (if required) | E45 : E54 | ☐ | N/A |
| Funding Sources Narrative | B61 | ☐ | N/A |
| 1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? | C70 | ☐ | Yes |
| 2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? | C71 | ☐ | Yes |
| 3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? | C72 | ☐ | Yes |
| 4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? | C73 | ☐ | Yes |
| 1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments | D70 | ☐ | Yes |
| 2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments | D71 | ☐ | Yes |
| 3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments | D72 | | Yes |
| 4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments | D73 | ☐ | Yes |

| | |
|---|---|
| Sheet Completed: | Yes |

**4. HWB Expenditure Plan**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| Scheme Name | B17 : B266 | ☐ | Yes |
| Scheme Type (see table below for descriptions) | C17 : C266 | ☐ | Yes |
| Please specify if 'Scheme Type' is 'other' | D17 : D266 | ☐ | Yes |
| Area of Spend | E17 : E266 | ☐ | Yes |
| Please specify if 'Area of Spend' is 'other' | F17 : F266 | ☐ | Yes |
| Commissioner | G17 : G266 | ☐ | Yes |
| if Joint % NHS | H17 : H266 | ☐ | Yes |
| if Joint % LA | I17 : I266 | ☐ | Yes |
| Provider | J17 : J266 | ☐ | Yes |
| Source of Funding | K17 : K266 | ☐ | Yes |
| 2016/17 (£000's) | L17 : L266 | ☐ | Yes |
| New or Existing Scheme | M17 : M266 | ☐ | Yes |
| Total 15-16 Expenditure (£) (if existing scheme) | N17 : N266 | ☐ | Yes |

| | |
|---|---|
| Sheet Completed: | Yes |

**5. HWB Metrics**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| 5.1 - Are you planning on any additional quarterly reductions? | E43 | ☐ | Yes |
| 5.1 - HWB Quarterly Additional Reduction Figure - Q1 | G45 | ☐ | Yes |
| 5.1 - HWB Quarterly Additional Reduction Figure - Q2 | I45 | ☐ | Yes |
| 5.1 - HWB Quarterly Additional Reduction Figure - Q3 | K45 | ☐ | Yes |
| 5.1 - HWB Quarterly Additional Reduction Figure - Q4 | M45 | ☐ | Yes |
| 5.1 - Are you putting in place a local risk sharing agreement on NEA? | E49 | ☐ | Yes |
| 5.1 - Cost of NEA | E54 | ☐ | Yes |
| 5.1 - Comments (if required) | F54 | ☐ | Yes |
| 5.2 - Residential Admissions : Numerator : Forecast 15/16 | G69 | ☐ | Yes |
| 5.2 - Residential Admissions : Numerator : Planned 16/17 | H69 | ☐ | Yes |
| 5.2 - Comments (if required) | I68 | ☐ | N/A |
| 5.3 - Reablement : Numerator : Forecast 15/16 | G82 | ☐ | Yes |
| 5.3 - Reablement : Denominator : Forecast 15/16 | G83 | ☐ | Yes |
| 5.3 - Reablement : Numerator : Planned 16/17 | H82 | ☐ | Yes |
| 5.3 - Reablement : Denominator : Planned 16/17 | H83 | ☐ | Yes |
| 5.3 - Comments (if required) | I81 | ☐ | N/A |
| 5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3 | K94 | ☐ | Yes |
| 5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4 | L94 | ☐ | Yes |
| 5.4 - Delayed Transfers of Care : 16/17 Plans : Q1 | M94 | ☐ | Yes |
| 5.4 - Delayed Transfers of Care : 16/17 Plans : Q2 | N94 | ☐ | Yes |
| 5.4 - Delayed Transfers of Care : 16/17 Plans : Q3 | O94 | ☐ | Yes |
| 5.4 - Delayed Transfers of Care : 16/17 Plans : Q4 | P94 | ☐ | Yes |
| 5.4 - Comments (if required) | Q93 | ☐ | N/A |
| 5.5 - Local Performance Metric | C105 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 15/16 : Metric Value | E105 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 15/16 : Numerator | E106 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 15/16 : Denominator | E107 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 16/17 : Metric Value | F105 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 16/17 : Numerator | F106 | ☐ | Yes |
| 5.5 - Local Performance Metric : Planned 16/17 : Denominator | F107 | ☐ | Yes |
| 5.5 - Comments (if required) | G105 | ☐ | N/A |
| 5.6 - Local defined patient experience metric | C117 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value | E117 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 15/16 : Numerator | E118 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 15/16 : Denominator | E119 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value | F117 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 16/17 : Numerator | F118 | ☐ | Yes |
| 5.6 - Local defined patient experience metric : Planned 16/17 : Denominator | F119 | ☐ | Yes |
| 5.6 - Comments (if required) | G117 | ☐ | N/A |

| | |
|---|---|
| Sheet Completed: | Yes |

**6. National Conditions**

| | Cell Reference | Complete? | Checker |
|---|---|---|---|
| 1) Plans to be jointly agreed | C14 | ☐ | Yes |
| 2) Maintain provision of social care services (not spending) | C15 | ☐ | Yes |
| 3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate | C16 | ☐ | Yes |
| 4) Better data sharing between health and social care, based on the NHS number | C17 | ☐ | Yes |
| 5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional | C18 | ☐ | Yes |
| 6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans | C19 | ☐ | Yes |
| 7) Agreement to invest in NHS commissioned out-of-hospital services | C20 | ☐ | Yes |
| 8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan | C21 | ☐ | Yes |
| 1) Plans to be jointly agreed, Comments | D14 | ☐ | Yes |
| 2) Maintain provision of social care services (not spending), Comments | D15 | ☐ | Yes |
| 3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments | D16 | ☐ | Yes |
| 4) Better data sharing between health and social care, based on the NHS number, Comments | D17 | ☐ | Yes |
| 5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments | D18 | ☐ | Yes |
| 6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments | D19 | ☐ | Yes |
| 7) Agreement to invest in NHS commissioned out-of-hospital services, Comments | D20 | ☐ | Yes |
| 8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments | D21 | ☐ | Yes |

| | |
|---|---|
| Sheet Completed: | Yes |

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# Template for BCF submission 2: due on 21 March 2016

**Submission 2 Template Changes - Updates from Submission 1 template**

| Change | Tabs Impacted | |
|---|---|---|
| Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool' table corrected to show spend from CCG Minimum Contribution **only.** Please review. | 2. Summary and confirmations | |
| We have increased the number of rows available on the "HWB Expenditure" tab to 250 rows. | 4. HWB Expenditure | |
| The NEA activity values have been updated following the second "16/17 Shared NHS Planning" submission. Please review the impact and amend the additional quarterly reduction value if required. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| Q3 15/16 SUS Actual data (mapped from CCG data) is now included. Q1 and Q2 have been updated. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| Actual Q3 15/16 DTOC data is now included. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| The issue around the incorrect assigning of the number of delayed days for the 11 Health and Well-Being Boards effecting the DTOC rates per 100,000 population has been amended. Please review the impact and amend if required. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| Reablement 14/15 actual % has been amended to match published HSCIC data. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| Population figures used for 14/15 changed to match the mid-2014 population estimates used in ASCOF, this impacts on DTOC (Q1 - Q3 14/15) and Residential Admissions rates (14/15). Please review the impact and amend if required. | 5. HWB Metrics | 5b. HWB Metrics Tool |
| Comments fields have had text wrapped to allow for users to easily review comments fields. | 5. HWB Metrics | |

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# Template for BCF submission 2: due on 21 March 2016

## Better Care Fund 2016-17 Planning Template

**Sheet: 1. Cover Sheet**

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net



***You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.***

***Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".***

***Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.***

***It presents a summary of the first BCF submission and a mapped summary of the NEA activity plans received in the second iteration of the "CCG NHS Shared Planning Process".***

| | |
|---|---|
| **Health and Well Being Board** | **Wokingham** |
| **completed by:** | Matt Marsden |
| **E-Mail:** | matthew.marsden@wokingham.gov.uk |
| **Contact Number:** | 07771 843818 |
| **Who has signed off the report on behalf of the Health and Well Being Board:** | Julian McGhee Sumner |

**Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'**

| | No. of questions answered |
|---|---|
| 1. Cover | 5 |
| 2. Summary and confirmations | 3 |
| 3. HWB Funding Sources | 13 |
| 4. HWB Expenditure Plan | 13 |
| 5. HWB Metrics | 34 |
| 6. National Conditions | 16 |

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# Template for BCF submission 2: due on 21 March 2016

**Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

## 2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

## 3. HWB Funding Sources

| | Gross Contribution |
|---|---|
| Total Local Authority Contribution | £1,851,000 |
| Total Minimum CCG Contribution | £7,640,291 |
| Total Additional CCG Contribution | £0 |
| **Total BCF pooled budget for 2016-17** | **£9,491,291** |

| Specific funding requirements for 2016-17 | Select a response to the questions in column B |
|---|---|
| 1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? | Yes |
| 2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? | Yes |
| 3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? | Yes |
| 4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? | Yes |

## 4. HWB Expenditure Plan

**Summary of BCF Expenditure**

| | Expenditure |
|---|---|
| Acute | £448,000 |
| Mental Health | £0 |
| Community Health | £4,915,421 |
| Continuing Care | £0 |
| Primary Care | £0 |
| Social Care | £3,363,639 |
| Other | £764,231 |
| **Total** | **£9,491,291** |

| Please confirm the amount allocated for the protection of adult social care | If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance. |
|---|---|
| **Expenditure** | |
| £944,000 | 15/16 includes DFG funding and S256 funding under the heading of Social care, but this is not being classified as protection of Adult Social Care |

**Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool**

| | Expenditure |
|---|---|
| Mental Health | £0 |
| Community Health | £3,087,711 |
| Continuing Care | £0 |
| Primary Care | £0 |
| Social Care | £0 |
| Other | £530,782 |
| **Total** | **£3,618,493** |

**BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share**

| | Fund |
|---|---|
| Local share of ring-fenced funding | £2,171,154 |
| Total value of NHS commissioned out of hospital services spend from minimum pool | £3,618,493 |
| Total value of funding held as contingency as part of local risk share to ensure value to the NHS | £448,000 |
| **Balance (+/-)** | **£1,895,338** |

## 5. HWB Metrics

**5.1 HWB NEA Activity Plan**

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Total HWB Planned Non-Elective Admissions | 3,171 | 3,219 | 3,383 | 3,357 | 13,129 |
| HWB Quarterly Additional Reduction Figure | 0 | 0 | 0 | 0 | 0 |
| HWB NEA Plan (after reduction) | 3,171 | 3,219 | 3,383 | 3,357 | 13,129 |
| Additional NEA reduction delivered through the BCF | | | | | £0 |

**5.2 Residential Admissions**

| | | Planned 16/17 |
|---|---|---|
| Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual rate | 389.9 |

**5.3 Reablement**

| | | Planned 16/17 |
|---|---|---|
| Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population | Annual % | 78% |

**5.4 Delayed Transfers of Care**

| | | Q1 (Apr 16 - Jun 16) | Q2 (Jul 16 - Sep 16) | Q3 (Oct 16 - Dec 16) | Q4 (Jan 17 - Mar 17) |
|---|---|---|---|---|---|
| Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). | Quarterly rate | 863.8 | 784.2 | 700.6 | 890.9 |

**5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)**

| | Metric Value Planned 16/17 |
|---|---|
| Patients going through Reablement | 79.2 |

**5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)**

| | Metric Value Planned 16/17 |
|---|---|
| Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life? | 88.2 |

## 6. National Conditions

| National Conditions For The Better Care Fund 2016-17 | Please Select (Yes, No or No - plan in place) |
|---|---|
| 1) Plans to be jointly agreed | Yes |
| 2) Maintain provision of social care services (not spending) | Yes |
| 3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate | Yes |
| 4) Better data sharing between health and social care, based on the NHS number | Yes |
| 5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional | Yes |
| 6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans | Yes |
| 7) Agreement to invest in NHS commissioned out-of-hospital services | Yes |
| 8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan | No - in development |

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# Template for BCF submission 2: due on 21 March 2016

**Sheet: 3. Health and Well-Being Board Funding Sources**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**3. HWB Funding Sources**

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

| Local Authority Contribution(s) | Gross Contribution | Comments - please use this box clarify any specific uses or sources of funding |
|---|---|---|
| Wokingham | £1,065,000 | Funding for Health Liaison & Start teams & Carer prevention |
| Wokingham | £733,000 | DFG |
| Wokingham | £53,000 | Carry forward funds |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| <Please Select Local Authority> | | |
| **Total Local Authority Contribution** | **£1,851,000** | |

| CCG Minimum Contribution | Gross Contribution |
|---|---|
| NHS Wokingham CCG | £7,640,291 |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total Minimum CCG Contribution** | **£7,640,291** |

| Are any additional CCG Contributions being made? If yes please detail below; | No |
|---|---|

| Additional CCG Contribution | Gross Contribution | Comments - please use this box clarify any specific uses or sources of funding |
|---|---|---|
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
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| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| **Total Additional CCG Contribution** | **£0** | |

| **Total BCF pooled budget for 2016-17** | **£9,491,291** |
|---|---|

| Funding Contributions Narrative |
|---|
| |

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

| **Specific funding requirements for 2016-17** | **Select a response to the questions in column B** | **Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.** |
|---|---|---|
| 1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? | Yes | |
| 2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? | Yes | |
| 3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? | Yes | |
| 4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? | Yes | |

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# Template for BCF submission 2: due on 21 March 2016

**Sheet: 4. Health and Well-Being Board Expenditure Plan**

**Selected Health and Well Being Board:**
**Wokingham**

**Data Submission Period:**
**2016/17**

**4. HWB Expenditure Plan**

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

| | Expenditure | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheme Name | Scheme Type (see table below for descriptions) | Please specify if 'Scheme Type' is 'other' | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | if Joint % NHS | if Joint % LA | Provider | Source of Funding | 2016/17 Expenditure (£) | New or Existing Scheme | Total 15-16 Expenditure (£) (if existing scheme) |
| Care Homes | Personalised support/ care at home | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £205,700 | Existing | £145,000 |
| Connected Care | Other | Better data sharing | Other | Health and Social Care | CCG | | | Private Sector | CCG Minimum Contribution | £333,333 | Existing | £209,000 |
| Health and Social Care Hub | Other | Integrated single point of access | Community Health | | Joint | 50.0% | 50.0% | NHS Community Provider | CCG Minimum Contribution | £80,421 | Existing | £59,000 |
| Step Up Step Down Beds | Intermediate care services | | Community Health | | Local Authority | | | Private Sector | CCG Minimum Contribution | £282,700 | Existing | £247,000 |
| Domicilliary Plus | Intermediate care services | | Community Health | | Local Authority | | | Private Sector | CCG Minimum Contribution | £76,300 | Existing | £528,000 |
| Neighbourhood Clusters | Integrated care teams | | Community Health | | Local Authority | | | Charity/Voluntary Sector | CCG Minimum Contribution | £88,700 | Existing | £300,000 |
| CCG reablement funds | Reablement services | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £641,000 | Existing | £641,000 |
| Speech and Language Therapy | Personalised support/ care at home | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £53,000 | New | |
| Care Home in-reach | Improving healthcare services to care homes | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £160,000 | New | |
| Community Geriatrician | Personalised support/ care at home | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £139,000 | New | |
| Intermediate Care including integrated discharge, discharge to assess se | Intermediate care services | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £665,000 | New | |
| Health Hub | Integrated care teams | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £304,000 | New | |
| Intemediate Care - night sitting, rapid response, reablement and falls | Intermediate care services | | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | £327,000 | New | |
| CCG Carers Fund | Support for carers | | Community Health | | CCG | | | Charity/Voluntary Sector | CCG Minimum Contribution | £278,000 | Existing | £278,000 |
| LA Carers Fund | Support for carers | | Community Health | | Local Authority | | | Charity/Voluntary Sector | Local Authority Social Services | £124,000 | Existing | £216,000 |
| S256 LA spend | Other | Targeted prevention | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | £1,506,000 | Existing | £1,506,000 |
| Protection of Adult Social Care | Other | Maintaining Provision for Social Care Services | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | £944,000 | Existing | £1,244,000 |
| Integrated short term team | Intermediate care services | | Community Health | | Joint | 50.0% | 50.0% | NHS Community Provider | CCG Minimum Contribution | £549,600 | Existing | £300,000 |
| Integrated short term team existing | Intermediate care services | | Community Health | | Local Authority | | | Local Authority | Local Authority Social Services | £941,000 | Existing | £900,000 |
| BCF BW10 programme office | Other | Supporting Health and social cate Integration Programme | Other | Health and Social Care | CCG | | | CCG | CCG Minimum Contribution | £109,000 | New | |
| BCF Local programme office | Other | Supporting Health and social cate Integration Programme | Other | Health and Social Care | Local Authority | | | Local Authority | CCG Minimum Contribution | £92,000 | New | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Disabled Facilities Grant | Other | Capital | Social Care | | Local Authority | | | Local Authority | Local Authority Social Services | £733,000 | Existing | £645,000 |
| Contingency | Other | Contingency | Other | As required | Joint | 50.0% | 50.0% | CCG | CCG Minimum Contribution | £176,898 | Existing | £187,000 |
| Contingency | Other | Contingency | Other | As required | Joint | 50.0% | 50.0% | CCG | Local Authority Social Services | £53,000 | New | |
| Risk share | Intermediate care services | | Acute | | Joint | 80.0% | 20.0% | NHS Community Provider | CCG Minimum Contribution | £448,000 | New | |
| Care Act | Support for carers | | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | £180,639 | Existing | £335,000 |

# Template for BCF submission 2: due on 21 March 2016

**Sheet: 4. Health and Well-Being Board Expenditure Plan**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**4. HWB Expenditure Plan**

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

# Template for BCF submission 2: due on 21 March 2016

**Sheet: 4. Health and Well-Being Board Expenditure Plan**

**Selected Health and Well Being Board:**
**Wokingham**

**Data Submission Period:**
**2016/17**

**4. HWB Expenditure Plan**

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

# Template for BCF submission 2: due on 21 March 2016

**Sheet: 4. Health and Well-Being Board Expenditure Plan**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**4. HWB Expenditure Plan**

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

| Scheme Type | Description |
|---|---|
| Reablement services | The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages. |
| Personalised support/ care at home | Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance. |
| Intermediate care services | Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge. |
| Integrated care teams | Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions. |
| Improving healthcare services to care homes | Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance. |
| Support for carers | Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance |
| 7 day working | Seven day working across health and/or social care settings. Reablement and avoids admissions |
| Assistive Technologies | Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care |

# Template for BCF submission 2: due on 21 March 2016

**Sheet: 5. Health and Well-Being Board Better Care Fund Metrics**

**Selected Health and Well Being Board:**
**Wokingham**

**Data Submission Period:**
**2016/17**

**5. HWB Metrics**

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

## 5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

| Contributing CCGs | % CCG registered population that has resident population in Wokingham | % Wokingham resident population that is in CCG registered population | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Total (Q1 - Q4) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CCG Total Non-Elective Admission Plan* | HWB Non-Elective Admission Plan** | CCG Total Non-Elective Admission Plan* | HWB Non-Elective Admission Plan** | CCG Total Non-Elective Admission Plan* | HWB Non-Elective Admission Plan** | CCG Total Non-Elective Admission Plan* | HWB Non-Elective Admission Plan** | CCG Total Non-Elective Admission Plan* | HWB Non-Elective Admission Plan** |
| NHS Bracknell and Ascot CCG | 3.2% | 2.7% | 2,221 | 71 | 2,225 | 72 | 2,261 | 73 | 2,214 | 71 | 8,921 | 287 |
| NHS North & West Reading CCG | 0.1% | 0.0% | 2,065 | 3 | 2,094 | 3 | 2,228 | 3 | 2,237 | 3 | 8,624 | 12 |
| NHS Oxfordshire CCG | 0.1% | 0.5% | 14,104 | 15 | 13,911 | 15 | 14,740 | 16 | 13,377 | 15 | 56,132 | 61 |
| NHS South Reading CCG | 11.1% | 9.0% | 2,761 | 306 | 2,793 | 309 | 2,926 | 324 | 2,941 | 326 | 11,421 | 1,265 |
| NHS Wokingham CCG | 93.5% | 87.9% | 2,968 | 2,775 | 3,016 | 2,820 | 3,173 | 2,967 | 3,147 | 2,943 | 12,304 | 11,505 |
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |
| **Totals** | | **100%** | **24,119** | **3,171** | **24,039** | **3,219** | **25,328** | **3,383** | **23,916** | **3,357** | **97,402** | **13,129** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Are you planning on any additional quarterly reductions? | No | | | | | | | |
| If yes, please complete HWB Quarterly Additional Reduction Figures | | | | | | | | |
| HWB Quarterly Additional Reduction Figure | | | | | | | | |
| **HWB NEA Plan (after reduction)** | | | | | | | | |
| HWB Quarterly Plan Reduction % | | | | | | | | |
| | | | | | | | | |
| Are you putting in place a local risk sharing agreement on NEA? | Yes | | | | | | | |
| | | | | | | | | |
| BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share *** | £2,171,154 | | | | | | | |
| | | | | | | | | |
| Cost of NEA as used during 15/16 **** | £2,307 | Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below. | | | | | | |
| Cost of NEA for 16/17 **** | £1,775 | Targeted shorter term stays in hospital for NEL, reducing NEL rate | | | | | | |
| | | | | | | | | |
| **Additional NEA reduction delivered through the BCF** | £0 | | | | | | | £0 |
| HWB Plan Reduction % | 0.00% | | | | | | | |

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 7th March 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

## 5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

| | | Actual 14/15***** | Planned 15/16***** | Forecast 15/16 | Planned 16/17 | Comments |
|---|---|---|---|---|---|---|
| Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual rate | 484.1 | 595.9 | 385.4 | 389.9 | Assumed growth of 130 clients offset by targeted reductions of 18 |
| | Numerator | 131 | 167 | 108 | 112 | |
| | Denominator | 27,060 | 28,024 | 28,024 | 28,724 | |

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data.

## 5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

| | | Actual 14/15***** | Planned 15/16 | Forecast 15/16 | Planned 16/17 | Comments |
|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual % | 77.9% | 72.7% | 76.9% | 77.8% | Estimated numbers for both 16/17 & 15/16 likely to change prior to final submission upon further anlaysis |
| | Numerator | 55 | 80 | 60 | 70 | |
| | Denominator | 70 | 110 | 78 | 90 | |

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

## 5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

| | | 15-16 plans | | | | 15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures | | | | 16-17 plans | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 (Apr 15 - Jun 15) | Q2 (Jul 15 - Sep 15) | Q3 (Oct 15 - Dec 15) | Q4 (Jan 16 - Mar 16) | Q1 (Apr 15 - Jun 15) | Q2 (Jul 15 - Sep 15) | Q3 (Oct 15 - Dec 15) | Q4 (Jan 16 - Mar 16) | Q1 (Apr 16 - Jun 16) | Q2 (Jul 16 - Sep 16) | Q3 (Oct 16 - Dec 16) | Q4 (Jan 17 - Mar 17) | Comments |
| Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). | Quarterly rate | 820.3 | 820.3 | 820.3 | 812.0 | 840.4 | 761.6 | 779.2 | 866.2 | 863.8 | 784.2 | 700.6 | 890.9 | Plan 16/17 is a holding position until further analysis is completed from the DTOC plan, numbers to be updated for the final submission |
| | Numerator | 1,020 | 1,020 | 1,020 | 1,020 | 1,045 | 947 | 969 | 1,088 | 1,085 | 985 | 880 | 1,130 | |
| | Denominator | 124,352 | 124,352 | 124,352 | 125,609 | 124,352 | 124,352 | 124,352 | 125,609 | 125,609 | 125,609 | 125,609 | 126,834 | |

## 5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

| | | Planned 15/16 | Planned 16/17 | Comments |
|---|---|---|---|---|
| Patients going through Reablement | Metric Value | 75.0 | 79.2 | Count of patients going through reablement per month, estimated numbers for 16/17 likely to change before final submission upon further analysis |
| | Numerator | 900.0 | 950.0 | |
| | Denominator | 12.0 | 12.0 | |

## 5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

| | | Planned 15/16 | Planned 16/17 | Comments |
|---|---|---|---|---|
| Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life? | Metric Value | 87.7 | 88.2 | It is not known at present the numbers taregted for 16/17, 15/16 numbers still being counted, both likely to change before final submission upon further analysis |
| | Numerator | 272.0 | 300.0 | |
| | Denominator | 310.0 | 340.0 | |

# Template for BCF submission 2: due on 21 March 2016

**Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**Metrics Tool**



There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

## 5.1 HWB NEA Activity

| Wokingham Data Source Used - 15/16 | SUS | | | | |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Total |
| **Wokingham 14/15 Baseline (outturn)** | 2,698 | 2,669 | 2,910 | 2,796 | 11,073 |
| **Wokingham 15/16 Plan** | 2,742 | 2,699 | 2,977 | 2,917 | 11,335 |
| **Wokingham 15/16 Actual** | 2,828 | 3,044 | | | 5,872 |

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. Actual Q3 and Q4 data is not available at the point of this template being released.

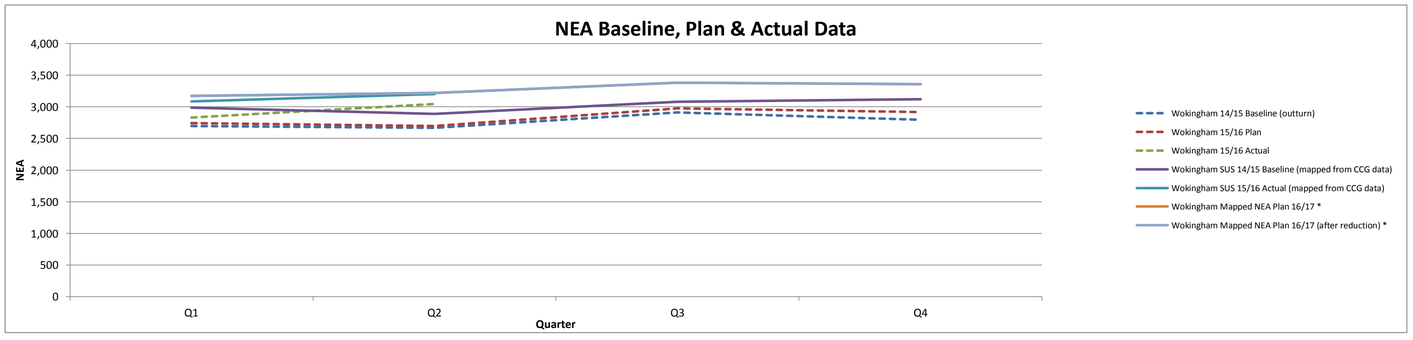
| | | | | | |
|---|---|---|---|---|---|
| **Wokingham SUS 14/15 Baseline (mapped from CCG data)** | **2,986** | **2,887** | **3,079** | **3,121** | **12,072** |
| **Wokingham SUS 15/16 Actual (mapped from CCG data)** | 3,084 | 3,202 | 3,438 | | 9,724 |
| **Wokingham SUS 15/16 FOT (mapped from CCG data)** | | | | | 12,906 |

SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

| | | | | | |
|---|---|---|---|---|---|
| **Wokingham Mapped NEA Plan 16/17 *** | **3,171** | **3,219** | **3,383** | **3,357** | **13,129** |
| **Wokingham Mapped NEA Plan 16/17 (after reduction) *** | **3,171** | **3,219** | **3,383** | **3,357** | **13,129** |

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



# Template for BCF submission 2: due on 21 March 2016

**Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**Metrics Tool**

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

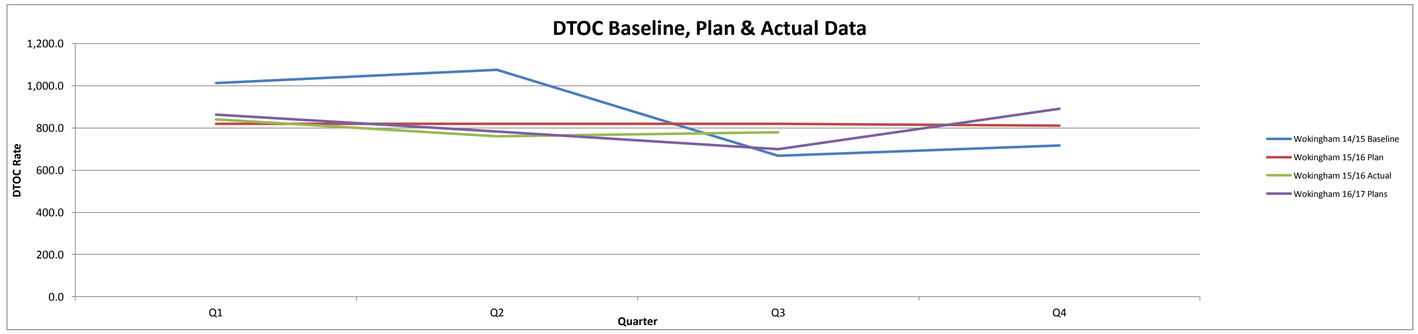
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

## 5.4 Delayed Transfers of Care

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Wokingham 14/15 Baseline** | 1,013.6 | 1,076.6 | 669.2 | 717.3 |
| **Wokingham 15/16 Plan** | 820.3 | 820.3 | 820.3 | 812.0 |
| **Wokingham 15/16 Actual** | 840.4 | 761.6 | 779.2 | |

Delayed Transfers Of Care numerator data for baseline and actual performance has been sourced from the monthly DTOC return found here http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/. Actual Q4 data is not available at the point of this template being released.

| | | | | |
|---|---|---|---|---|
| **Wokingham 16/17 Plans** | **863.8** | **784.2** | **700.6** | **890.9** |



# Template for BCF submission 2: due on 21 March 2016

**Sheet: 6. National Conditions**

**Selected Health and Well Being Board:**

**Wokingham**

**Data Submission Period:**

**2016/17**

**6. National Conditions**

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

| National Conditions For The Better Care Fund 2016-17 | Does your BCF plan for 2016-17 set out a clear plan to meet this condition? | Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information. |
|---|---|---|
| 1) Plans to be jointly agreed | Yes | |
| 2) Maintain provision of social care services (not spending) | Yes | |
| 3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate | Yes | |
| 4) Better data sharing between health and social care, based on the NHS number | Yes | |
| 5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional | Yes | |
| 6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans | Yes | |
| 7) Agreement to invest in NHS commissioned out-of-hospital services | Yes | |
| 8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan | No - in development | DTOC plan in development, sub group formed to review existing DTOC plans and impact from BCF schemes and other initiatives to forumlate a joint approach on DTOC. |

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**CCG to Health and Well-Being Board Mapping**

| HWB Code | LA Name | CCG Code | CCG Name | % CCG in HWB | % HWB in CCG |
|---|---|---|---|---|---|
| E09000002 | Barking and Dagenham | 07L | NHS Barking and Dagenham CCG | 89.7% | 88.4% |
| E09000002 | Barking and Dagenham | 08F | NHS Havering CCG | 6.8% | 8.3% |
| E09000002 | Barking and Dagenham | 08M | NHS Newham CCG | 0.2% | 0.4% |
| E09000002 | Barking and Dagenham | 08N | NHS Redbridge CCG | 2.1% | 2.9% |
| E09000003 | Barnet | 07M | NHS Barnet CCG | 91.1% | 92.9% |
| E09000003 | Barnet | 07P | NHS Brent CCG | 2.0% | 1.8% |
| E09000003 | Barnet | 07R | NHS Camden CCG | 0.8% | 0.5% |
| E09000003 | Barnet | 09A | NHS Central London (Westminster) CCG | 0.1% | 0.0% |
| E09000003 | Barnet | 07X | NHS Enfield CCG | 2.9% | 2.4% |
| E09000003 | Barnet | 08D | NHS Haringey CCG | 2.1% | 1.6% |
| E09000003 | Barnet | 08E | NHS Harrow CCG | 1.2% | 0.8% |
| E09000003 | Barnet | 08H | NHS Islington CCG | 0.1% | 0.0% |
| E09000003 | Barnet | 08Y | NHS West London (K&C & QPP) CCG | 0.1% | 0.0% |
| E08000016 | Barnsley | 02P | NHS Barnsley CCG | 94.4% | 98.2% |
| E08000016 | Barnsley | 02X | NHS Doncaster CCG | 0.3% | 0.3% |
| E08000016 | Barnsley | 03A | NHS Greater Huddersfield CCG | 0.2% | 0.2% |
| E08000016 | Barnsley | 03L | NHS Rotherham CCG | 0.3% | 0.3% |
| E08000016 | Barnsley | 03N | NHS Sheffield CCG | 0.2% | 0.4% |
| E08000016 | Barnsley | 03R | NHS Wakefield CCG | 0.4% | 0.6% |
| E06000022 | Bath and North East Somerset | 11E | NHS Bath and North East Somerset CCG | 94.0% | 98.3% |
| E06000022 | Bath and North East Somerset | 11H | NHS Bristol CCG | 0.3% | 0.8% |
| E06000022 | Bath and North East Somerset | 11X | NHS Somerset CCG | 0.2% | 0.5% |
| E06000022 | Bath and North East Somerset | 12A | NHS South Gloucestershire CCG | 0.0% | 0.1% |
| E06000022 | Bath and North East Somerset | 99N | NHS Wiltshire CCG | 0.1% | 0.3% |
| E06000055 | Bedford | 06F | NHS Bedfordshire CCG | 37.5% | 97.4% |
| E06000055 | Bedford | 06H | NHS Cambridgeshire and Peterborough CCG | 0.4% | 1.9% |
| E06000055 | Bedford | 04G | NHS Nene CCG | 0.2% | 0.7% |
| E09000004 | Bexley | 07N | NHS Bexley CCG | 93.6% | 89.4% |
| E09000004 | Bexley | 07Q | NHS Bromley CCG | 0.0% | 0.1% |
| E09000004 | Bexley | 09J | NHS Dartford, Gravesham and Swanley CCG | 1.5% | 1.6% |
| E09000004 | Bexley | 08A | NHS Greenwich CCG | 7.7% | 8.9% |
| E08000025 | Birmingham | 13P | NHS Birmingham Crosscity CCG | 92.0% | 57.3% |
| E08000025 | Birmingham | 04X | NHS Birmingham South and Central CCG | 96.9% | 20.5% |
| E08000025 | Birmingham | 05C | NHS Dudley CCG | 0.2% | 0.0% |
| E08000025 | Birmingham | 05J | NHS Redditch and Bromsgrove CCG | 2.9% | 0.4% |
| E08000025 | Birmingham | 05L | NHS Sandwell and West Birmingham CCG | 40.1% | 18.6% |
| E08000025 | Birmingham | 05P | NHS Solihull CCG | 15.0% | 3.0% |
| E08000025 | Birmingham | 05Y | NHS Walsall CCG | 0.5% | 0.1% |
| E06000008 | Blackburn with Darwen | 00Q | NHS Blackburn with Darwen CCG | 89.0% | 95.8% |
| E06000008 | Blackburn with Darwen | 00T | NHS Bolton CCG | 1.2% | 2.3% |
| E06000008 | Blackburn with Darwen | 00V | NHS Bury CCG | 0.2% | 0.2% |
| E06000008 | Blackburn with Darwen | 01A | NHS East Lancashire CCG | 0.7% | 1.6% |
| E06000009 | Blackpool | 00R | NHS Blackpool CCG | 87.0% | 97.5% |
| E06000009 | Blackpool | 02M | NHS Fylde & Wyre CCG | 2.6% | 2.5% |
| E08000001 | Bolton | 00T | NHS Bolton CCG | 97.3% | 97.6% |
| E08000001 | Bolton | 00V | NHS Bury CCG | 1.3% | 0.9% |
| E08000001 | Bolton | 00X | NHS Chorley and South Ribble CCG | 0.2% | 0.1% |
| E08000001 | Bolton | 01G | NHS Salford CCG | 0.6% | 0.5% |
| E08000001 | Bolton | 02H | NHS Wigan Borough CCG | 0.8% | 0.9% |
| E06000028 & E06000029 | Bournemouth & Poole | 11J | NHS Dorset CCG | 45.7% | 100.0% |
| E06000036 | Bracknell Forest | 10G | NHS Bracknell and Ascot CCG | 82.1% | 94.8% |
| E06000036 | Bracknell Forest | 99M | NHS North East Hampshire and Farnham CCG | 0.6% | 1.1% |
| E06000036 | Bracknell Forest | 10C | NHS Surrey Heath CCG | 0.1% | 0.1% |
| E06000036 | Bracknell Forest | 11C | NHS Windsor, Ascot and Maidenhead CCG | 1.8% | 2.2% |
| E06000036 | Bracknell Forest | 11D | NHS Wokingham CCG | 1.4% | 1.8% |
| E08000032 | Bradford | 02N | NHS Airedale, Wharfdale and Craven CCG | 67.4% | 18.7% |
| E08000032 | Bradford | 02W | NHS Bradford City CCG | 99.4% | 21.5% |
| E08000032 | Bradford | 02R | NHS Bradford Districts CCG | 97.8% | 58.4% |
| E08000032 | Bradford | 02T | NHS Calderdale CCG | 0.1% | 0.0% |
| E08000032 | Bradford | 02V | NHS Leeds North CCG | 0.6% | 0.2% |
| E08000032 | Bradford | 03C | NHS Leeds West CCG | 1.7% | 1.1% |
| E08000032 | Bradford | 03J | NHS North Kirklees CCG | 0.1% | 0.0% |
| E09000005 | Brent | 07M | NHS Barnet CCG | 2.0% | 2.1% |
| E09000005 | Brent | 07P | NHS Brent CCG | 89.6% | 87.2% |
| E09000005 | Brent | 07R | NHS Camden CCG | 4.0% | 2.7% |
| E09000005 | Brent | 09A | NHS Central London (Westminster) CCG | 1.2% | 0.6% |
| E09000005 | Brent | 07W | NHS Ealing CCG | 0.5% | 0.6% |
| E09000005 | Brent | 08C | NHS Hammersmith and Fulham CCG | 0.2% | 0.1% |
| E09000005 | Brent | 08E | NHS Harrow CCG | 5.7% | 3.9% |
| E09000005 | Brent | 08Y | NHS West London (K&C & QPP) CCG | 4.4% | 2.8% |
| E06000043 | Brighton and Hove | 09D | NHS Brighton and Hove CCG | 97.8% | 99.7% |
| E06000043 | Brighton and Hove | 09G | NHS Coastal West Sussex CCG | 0.1% | 0.2% |
| E06000043 | Brighton and Hove | 99K | NHS High Weald Lewes Havens CCG | 0.3% | 0.2% |
| E06000023 | Bristol, City of | 11H | NHS Bristol CCG | 94.7% | 97.9% |
| E06000023 | Bristol, City of | 12A | NHS South Gloucestershire CCG | 3.8% | 2.1% |
| E09000006 | Bromley | 07N | NHS Bexley CCG | 0.2% | 0.1% |
| E09000006 | Bromley | 07Q | NHS Bromley CCG | 94.9% | 95.3% |
| E09000006 | Bromley | 07V | NHS Croydon CCG | 1.1% | 1.3% |
| E09000006 | Bromley | 08A | NHS Greenwich CCG | 1.5% | 1.2% |
| E09000006 | Bromley | 08K | NHS Lambeth CCG | 0.0% | 0.1% |
| E09000006 | Bromley | 08L | NHS Lewisham CCG | 2.0% | 1.8% |
| E09000006 | Bromley | 99J | NHS West Kent CCG | 0.1% | 0.2% |
| E10000002 | Buckinghamshire | 10Y | NHS Aylesbury Vale CCG | 91.2% | 35.0% |
| E10000002 | Buckinghamshire | 06F | NHS Bedfordshire CCG | 0.6% | 0.5% |
| E10000002 | Buckinghamshire | 10H | NHS Chiltern CCG | 96.1% | 59.9% |
| E10000002 | Buckinghamshire | 06N | NHS Herts Valleys CCG | 1.2% | 1.4% |
| E10000002 | Buckinghamshire | 08G | NHS Hillingdon CCG | 0.8% | 0.5% |
| E10000002 | Buckinghamshire | 04F | NHS Milton Keynes CCG | 1.2% | 0.6% |
| E10000002 | Buckinghamshire | 04G | NHS Nene CCG | 0.1% | 0.2% |
| E10000002 | Buckinghamshire | 10Q | NHS Oxfordshire CCG | 0.6% | 0.8% |
| E10000002 | Buckinghamshire | 10T | NHS Slough CCG | 2.8% | 0.8% |
| E10000002 | Buckinghamshire | 11C | NHS Windsor, Ascot and Maidenhead CCG | 1.3% | 0.4% |
| E08000002 | Bury | 00T | NHS Bolton CCG | 0.8% | 1.2% |

| | | | | | |
|---|---|---|---|---|---|
| E08000002 | Bury | 00V | NHS Bury CCG | 94.3% | 94.3% |
| E08000002 | Bury | 01A | NHS East Lancashire CCG | 0.1% | 0.2% |
| E08000002 | Bury | 01D | NHS Heywood, Middleton and Rochdale CCG | 0.4% | 0.5% |
| E08000002 | Bury | 01M | NHS North Manchester CCG | 2.0% | 2.0% |
| E08000002 | Bury | 01G | NHS Salford CCG | 1.4% | 1.8% |
| E08000033 | Calderdale | 02R | NHS Bradford Districts CCG | 0.4% | 0.7% |
| E08000033 | Calderdale | 02T | NHS Calderdale CCG | 98.6% | 98.8% |
| E08000033 | Calderdale | 03A | NHS Greater Huddersfield CCG | 0.4% | 0.4% |
| E08000033 | Calderdale | 01D | NHS Heywood, Middleton and Rochdale CCG | 0.1% | 0.1% |
| E10000003 | Cambridgeshire | 06F | NHS Bedfordshire CCG | 1.1% | 0.8% |
| E10000003 | Cambridgeshire | 06H | NHS Cambridgeshire and Peterborough CCG | 72.1% | 96.6% |
| E10000003 | Cambridgeshire | 06K | NHS East and North Hertfordshire CCG | 0.9% | 0.7% |
| E10000003 | Cambridgeshire | 99D | NHS South Lincolnshire CCG | 0.4% | 0.0% |
| E10000003 | Cambridgeshire | 07H | NHS West Essex CCG | 0.2% | 0.1% |
| E10000003 | Cambridgeshire | 07J | NHS West Norfolk CCG | 1.5% | 0.4% |
| E10000003 | Cambridgeshire | 07K | NHS West Suffolk CCG | 4.0% | 1.4% |
| E09000007 | Camden | 07M | NHS Barnet CCG | 0.1% | 0.2% |
| E09000007 | Camden | 07P | NHS Brent CCG | 1.5% | 2.2% |
| E09000007 | Camden | 07R | NHS Camden CCG | 84.6% | 88.4% |
| E09000007 | Camden | 09A | NHS Central London (Westminster) CCG | 6.0% | 5.1% |
| E09000007 | Camden | 08D | NHS Haringey CCG | 0.5% | 0.6% |
| E09000007 | Camden | 08H | NHS Islington CCG | 3.4% | 3.2% |
| E09000007 | Camden | 08Y | NHS West London (K&C & QPP) CCG | 0.2% | 0.2% |
| E06000056 | Central Bedfordshire | 10Y | NHS Aylesbury Vale CCG | 2.1% | 1.5% |
| E06000056 | Central Bedfordshire | 06F | NHS Bedfordshire CCG | 56.8% | 95.1% |
| E06000056 | Central Bedfordshire | 06K | NHS East and North Hertfordshire CCG | 0.2% | 0.5% |
| E06000056 | Central Bedfordshire | 06N | NHS Herts Valleys CCG | 0.4% | 0.8% |
| E06000056 | Central Bedfordshire | 06P | NHS Luton CCG | 2.4% | 2.0% |
| E06000049 | Cheshire East | 01C | NHS Eastern Cheshire CCG | 96.3% | 50.6% |
| E06000049 | Cheshire East | 04J | NHS North Derbyshire CCG | 0.4% | 0.3% |
| E06000049 | Cheshire East | 05G | NHS North Staffordshire CCG | 1.1% | 0.6% |
| E06000049 | Cheshire East | 05N | NHS Shropshire CCG | 0.1% | 0.0% |
| E06000049 | Cheshire East | 01R | NHS South Cheshire CCG | 98.6% | 45.3% |
| E06000049 | Cheshire East | 01W | NHS Stockport CCG | 1.6% | 1.3% |
| E06000049 | Cheshire East | 02A | NHS Trafford CCG | 0.2% | 0.1% |
| E06000049 | Cheshire East | 02D | NHS Vale Royal CCG | 0.7% | 0.2% |
| E06000049 | Cheshire East | 02E | NHS Warrington CCG | 0.7% | 0.4% |
| E06000049 | Cheshire East | 02F | NHS West Cheshire CCG | 2.0% | 1.3% |
| E06000050 | Cheshire West and Chester | 01C | NHS Eastern Cheshire CCG | 1.1% | 0.7% |
| E06000050 | Cheshire West and Chester | 01F | NHS Halton CCG | 0.2% | 0.0% |
| E06000050 | Cheshire West and Chester | 01R | NHS South Cheshire CCG | 0.5% | 0.2% |
| E06000050 | Cheshire West and Chester | 02D | NHS Vale Royal CCG | 99.3% | 29.3% |
| E06000050 | Cheshire West and Chester | 02E | NHS Warrington CCG | 0.4% | 0.3% |
| E06000050 | Cheshire West and Chester | 02F | NHS West Cheshire CCG | 96.8% | 69.4% |
| E06000050 | Cheshire West and Chester | 12F | NHS Wirral CCG | 0.3% | 0.2% |
| E09000001 | City of London | 07R | NHS Camden CCG | 0.2% | 6.0% |
| E09000001 | City of London | 09A | NHS Central London (Westminster) CCG | 0.0% | 0.8% |
| E09000001 | City of London | 07T | NHS City and Hackney CCG | 1.9% | 74.1% |
| E09000001 | City of London | 08H | NHS Islington CCG | 0.1% | 3.1% |
| E09000001 | City of London | 08Q | NHS Southwark CCG | 0.0% | 0.1% |
| E09000001 | City of London | 08V | NHS Tower Hamlets CCG | 0.4% | 15.8% |
| E06000052 | Cornwall & Scilly | 11N | NHS Kernow CCG | 99.7% | 99.4% |
| E06000052 | Cornwall & Scilly | 99P | NHS North, East, West Devon CCG | 0.4% | 0.6% |
| E06000047 | County Durham | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 97.4% | 53.0% |
| E06000047 | County Durham | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 0.1% | 0.0% |
| E06000047 | County Durham | 13T | NHS Newcastle Gateshead CCG | 0.7% | 0.7% |
| E06000047 | County Durham | 00J | NHS North Durham CCG | 96.6% | 45.7% |
| E06000047 | County Durham | 00P | NHS Sunderland CCG | 1.2% | 0.6% |
| E08000026 | Coventry | 05A | NHS Coventry and Rugby CCG | 74.0% | 99.9% |
| E08000026 | Coventry | 05H | NHS Warwickshire North CCG | 0.3% | 0.1% |
| E09000008 | Croydon | 07Q | NHS Bromley CCG | 1.5% | 1.3% |
| E09000008 | Croydon | 07V | NHS Croydon CCG | 95.6% | 93.7% |
| E09000008 | Croydon | 09L | NHS East Surrey CCG | 3.0% | 1.3% |
| E09000008 | Croydon | 08K | NHS Lambeth CCG | 2.7% | 2.6% |
| E09000008 | Croydon | 08R | NHS Merton CCG | 0.8% | 0.4% |
| E09000008 | Croydon | 08T | NHS Sutton CCG | 0.8% | 0.4% |
| E09000008 | Croydon | 08X | NHS Wandsworth CCG | 0.4% | 0.4% |
| E10000006 | Cumbria | 01H | NHS Cumbria CCG | 97.4% | 100.0% |
| E10000006 | Cumbria | 01K | NHS Lancashire North CCG | 0.2% | 0.0% |
| E06000005 | Darlington | 00C | NHS Darlington CCG | 98.2% | 96.3% |
| E06000005 | Darlington | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 1.2% | 3.1% |
| E06000005 | Darlington | 03D | NHS Hambleton, Richmondshire and Whitby CCG | 0.0% | 0.1% |
| E06000005 | Darlington | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 0.2% | 0.5% |
| E06000015 | Derby | 04R | NHS Southern Derbyshire CCG | 50.1% | 100.0% |
| E10000007 | Derbyshire | 02Q | NHS Bassetlaw CCG | 0.2% | 0.0% |
| E10000007 | Derbyshire | 05D | NHS East Staffordshire CCG | 8.1% | 1.4% |
| E10000007 | Derbyshire | 01C | NHS Eastern Cheshire CCG | 0.3% | 0.0% |
| E10000007 | Derbyshire | 03X | NHS Erewash CCG | 92.2% | 11.3% |
| E10000007 | Derbyshire | 03Y | NHS Hardwick CCG | 94.6% | 12.2% |
| E10000007 | Derbyshire | 04E | NHS Mansfield and Ashfield CCG | 1.9% | 0.5% |
| E10000007 | Derbyshire | 04J | NHS North Derbyshire CCG | 98.3% | 36.0% |
| E10000007 | Derbyshire | 04L | NHS Nottingham North and East CCG | 0.2% | 0.0% |
| E10000007 | Derbyshire | 04M | NHS Nottingham West CCG | 5.0% | 0.6% |
| E10000007 | Derbyshire | 03N | NHS Sheffield CCG | 0.5% | 0.4% |
| E10000007 | Derbyshire | 04R | NHS Southern Derbyshire CCG | 48.2% | 33.0% |
| E10000007 | Derbyshire | 01W | NHS Stockport CCG | 0.1% | 0.0% |
| E10000007 | Derbyshire | 01Y | NHS Tameside and Glossop CCG | 14.1% | 4.3% |
| E10000007 | Derbyshire | 04V | NHS West Leicestershire CCG | 0.5% | 0.2% |
| E10000008 | Devon | 11J | NHS Dorset CCG | 0.3% | 0.3% |
| E10000008 | Devon | 11N | NHS Kernow CCG | 0.3% | 0.2% |
| E10000008 | Devon | 99P | NHS North, East, West Devon CCG | 70.0% | 80.5% |
| E10000008 | Devon | 11X | NHS Somerset CCG | 0.4% | 0.3% |
| E10000008 | Devon | 99Q | NHS South Devon and Torbay CCG | 51.1% | 18.7% |
| E08000017 | Doncaster | 02P | NHS Barnsley CCG | 0.4% | 0.3% |
| E08000017 | Doncaster | 02Q | NHS Bassetlaw CCG | 1.2% | 0.5% |
| E08000017 | Doncaster | 02X | NHS Doncaster CCG | 96.7% | 97.8% |
| E08000017 | Doncaster | 03L | NHS Rotherham CCG | 1.5% | 1.3% |

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| E08000017 | Doncaster | 03R | NHS Wakefield CCG | 0.1% | 0.1% |
| E10000009 | Dorset | 11J | NHS Dorset CCG | 52.7% | 95.9% |
| E10000009 | Dorset | 11X | NHS Somerset CCG | 0.6% | 0.7% |
| E10000009 | Dorset | 11A | NHS West Hampshire CCG | 2.0% | 2.5% |
| E10000009 | Dorset | 99N | NHS Wiltshire CCG | 0.8% | 0.9% |
| E08000027 | Dudley | 13P | NHS Birmingham Crosscity CCG | 0.2% | 0.5% |
| E08000027 | Dudley | 05C | NHS Dudley CCG | 93.2% | 90.9% |
| E08000027 | Dudley | 05L | NHS Sandwell and West Birmingham CCG | 4.0% | 6.9% |
| E08000027 | Dudley | 06A | NHS Wolverhampton CCG | 1.8% | 1.5% |
| E08000027 | Dudley | 06D | NHS Wyre Forest CCG | 0.6% | 0.2% |
| E09000009 | Ealing | 07P | NHS Brent CCG | 1.7% | 1.5% |
| E09000009 | Ealing | 09A | NHS Central London (Westminster) CCG | 0.1% | 0.0% |
| E09000009 | Ealing | 07W | NHS Ealing CCG | 86.7% | 90.8% |
| E09000009 | Ealing | 08C | NHS Hammersmith and Fulham CCG | 5.7% | 2.9% |
| E09000009 | Ealing | 08E | NHS Harrow CCG | 0.3% | 0.2% |
| E09000009 | Ealing | 08G | NHS Hillingdon CCG | 0.6% | 0.5% |
| E09000009 | Ealing | 07Y | NHS Hounslow CCG | 5.0% | 3.7% |
| E09000009 | Ealing | 08Y | NHS West London (K&C & QPP) CCG | 0.6% | 0.4% |
| E06000011 | East Riding of Yorkshire | 02Y | NHS East Riding of Yorkshire CCG | 97.4% | 85.2% |
| E06000011 | East Riding of Yorkshire | 03F | NHS Hull CCG | 9.4% | 8.0% |
| E06000011 | East Riding of Yorkshire | 03M | NHS Scarborough and Ryedale CCG | 0.7% | 0.2% |
| E06000011 | East Riding of Yorkshire | 03Q | NHS Vale of York CCG | 6.4% | 6.6% |
| E10000011 | East Sussex | 09D | NHS Brighton and Hove CCG | 1.0% | 0.6% |
| E10000011 | East Sussex | 09F | NHS Eastbourne, Hailsham and Seaford CCG | 100.0% | 34.5% |
| E10000011 | East Sussex | 09P | NHS Hastings and Rother CCG | 99.7% | 33.3% |
| E10000011 | East Sussex | 99K | NHS High Weald Lewes Havens CCG | 98.1% | 29.7% |
| E10000011 | East Sussex | 09X | NHS Horsham and Mid Sussex CCG | 2.9% | 1.2% |
| E10000011 | East Sussex | 99J | NHS West Kent CCG | 0.8% | 0.7% |
| E09000010 | Enfield | 07M | NHS Barnet CCG | 1.1% | 1.3% |
| E09000010 | Enfield | 07T | NHS City and Hackney CCG | 0.1% | 0.1% |
| E09000010 | Enfield | 06K | NHS East and North Hertfordshire CCG | 0.3% | 0.6% |
| E09000010 | Enfield | 07X | NHS Enfield CCG | 95.5% | 90.7% |
| E09000010 | Enfield | 08D | NHS Haringey CCG | 7.8% | 6.9% |
| E09000010 | Enfield | 06N | NHS Herts Valleys CCG | 0.1% | 0.2% |
| E09000010 | Enfield | 08H | NHS Islington CCG | 0.2% | 0.1% |
| E10000012 | Essex | 07L | NHS Barking and Dagenham CCG | 0.1% | 0.0% |
| E10000012 | Essex | 99E | NHS Basildon and Brentwood CCG | 99.8% | 18.3% |
| E10000012 | Essex | 06H | NHS Cambridgeshire and Peterborough CCG | 0.1% | 0.0% |
| E10000012 | Essex | 99F | NHS Castle Point and Rochford CCG | 95.4% | 11.7% |
| E10000012 | Essex | 06K | NHS East and North Hertfordshire CCG | 1.8% | 0.7% |
| E10000012 | Essex | 08F | NHS Havering CCG | 0.2% | 0.0% |
| E10000012 | Essex | 06L | NHS Ipswich and East Suffolk CCG | 0.2% | 0.0% |
| E10000012 | Essex | 06Q | NHS Mid Essex CCG | 100.0% | 25.4% |
| E10000012 | Essex | 06T | NHS North East Essex CCG | 98.7% | 22.4% |
| E10000012 | Essex | 08N | NHS Redbridge CCG | 3.2% | 0.6% |
| E10000012 | Essex | 99G | NHS Southend CCG | 3.4% | 0.4% |
| E10000012 | Essex | 07G | NHS Thurrock CCG | 1.5% | 0.2% |
| E10000012 | Essex | 08W | NHS Waltham Forest CCG | 0.5% | 0.1% |
| E10000012 | Essex | 07H | NHS West Essex CCG | 97.3% | 19.7% |
| E10000012 | Essex | 07K | NHS West Suffolk CCG | 2.3% | 0.4% |
| E08000037 | Gateshead | 13T | NHS Newcastle Gateshead CCG | 39.6% | 98.0% |
| E08000037 | Gateshead | 00J | NHS North Durham CCG | 0.9% | 1.1% |
| E08000037 | Gateshead | 00L | NHS Northumberland CCG | 0.5% | 0.7% |
| E08000037 | Gateshead | 00N | NHS South Tyneside CCG | 0.3% | 0.2% |
| E10000013 | Gloucestershire | 11M | NHS Gloucestershire CCG | 97.6% | 98.6% |
| E10000013 | Gloucestershire | 05F | NHS Herefordshire CCG | 0.5% | 0.1% |
| E10000013 | Gloucestershire | 10Q | NHS Oxfordshire CCG | 0.2% | 0.2% |
| E10000013 | Gloucestershire | 12A | NHS South Gloucestershire CCG | 0.3% | 0.1% |
| E10000013 | Gloucestershire | 05R | NHS South Warwickshire CCG | 0.5% | 0.2% |
| E10000013 | Gloucestershire | 05T | NHS South Worcestershire CCG | 1.1% | 0.5% |
| E10000013 | Gloucestershire | 99N | NHS Wiltshire CCG | 0.2% | 0.2% |
| E09000011 | Greenwich | 07N | NHS Bexley CCG | 5.2% | 4.3% |
| E09000011 | Greenwich | 07Q | NHS Bromley CCG | 1.1% | 1.3% |
| E09000011 | Greenwich | 08A | NHS Greenwich CCG | 88.6% | 89.9% |
| E09000011 | Greenwich | 08L | NHS Lewisham CCG | 4.1% | 4.5% |
| E09000012 | Hackney | 07R | NHS Camden CCG | 0.8% | 0.7% |
| E09000012 | Hackney | 09A | NHS Central London (Westminster) CCG | 0.1% | 0.1% |
| E09000012 | Hackney | 07T | NHS City and Hackney CCG | 90.6% | 94.6% |
| E09000012 | Hackney | 08D | NHS Haringey CCG | 0.6% | 0.7% |
| E09000012 | Hackney | 08H | NHS Islington CCG | 4.1% | 3.4% |
| E09000012 | Hackney | 08V | NHS Tower Hamlets CCG | 0.5% | 0.5% |
| E06000006 | Halton | 01F | NHS Halton CCG | 98.2% | 96.7% |
| E06000006 | Halton | 01J | NHS Knowsley CCG | 0.1% | 0.2% |
| E06000006 | Halton | 99A | NHS Liverpool CCG | 0.3% | 1.1% |
| E06000006 | Halton | 02E | NHS Warrington CCG | 0.6% | 0.9% |
| E06000006 | Halton | 02F | NHS West Cheshire CCG | 0.6% | 1.2% |
| E09000013 | Hammersmith and Fulham | 07P | NHS Brent CCG | 0.3% | 0.5% |
| E09000013 | Hammersmith and Fulham | 07R | NHS Camden CCG | 0.0% | 0.1% |
| E09000013 | Hammersmith and Fulham | 09A | NHS Central London (Westminster) CCG | 2.4% | 2.3% |
| E09000013 | Hammersmith and Fulham | 07W | NHS Ealing CCG | 0.6% | 1.2% |
| E09000013 | Hammersmith and Fulham | 08C | NHS Hammersmith and Fulham CCG | 90.9% | 88.0% |
| E09000013 | Hammersmith and Fulham | 07Y | NHS Hounslow CCG | 0.5% | 0.8% |
| E09000013 | Hammersmith and Fulham | 08Y | NHS West London (K&C & QPP) CCG | 6.4% | 7.2% |
| E10000014 | Hampshire | 10G | NHS Bracknell and Ascot CCG | 0.6% | 0.0% |
| E10000014 | Hampshire | 09G | NHS Coastal West Sussex CCG | 0.2% | 0.0% |
| E10000014 | Hampshire | 11J | NHS Dorset CCG | 0.5% | 0.3% |
| E10000014 | Hampshire | 10K | NHS Fareham and Gosport CCG | 98.6% | 14.5% |
| E10000014 | Hampshire | 09N | NHS Guildford and Waverley CCG | 2.9% | 0.5% |
| E10000014 | Hampshire | 10M | NHS Newbury and District CCG | 5.9% | 0.5% |
| E10000014 | Hampshire | 10N | NHS North & West Reading CCG | 0.9% | 0.0% |
| E10000014 | Hampshire | 99M | NHS North East Hampshire and Farnham CCG | 76.4% | 12.4% |
| E10000014 | Hampshire | 10J | NHS North Hampshire CCG | 99.2% | 15.9% |
| E10000014 | Hampshire | 10R | NHS Portsmouth CCG | 4.5% | 0.7% |
| E10000014 | Hampshire | 10V | NHS South Eastern Hampshire CCG | 95.4% | 14.6% |
| E10000014 | Hampshire | 10X | NHS Southampton CCG | 5.5% | 1.1% |
| E10000014 | Hampshire | 10C | NHS Surrey Heath CCG | 0.7% | 0.0% |
| E10000014 | Hampshire | 11A | NHS West Hampshire CCG | 97.7% | 39.0% |

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| E10000014 | Hampshire | 99N | NHS Wiltshire CCG | 1.3% | 0.5% |
| E10000014 | Hampshire | 11D | NHS Wokingham CCG | 0.6% | 0.0% |
| E09000014 | Haringey | 07M | NHS Barnet CCG | 1.1% | 1.6% |
| E09000014 | Haringey | 07R | NHS Camden CCG | 0.5% | 0.5% |
| E09000014 | Haringey | 07T | NHS City and Hackney CCG | 3.0% | 3.1% |
| E09000014 | Haringey | 07X | NHS Enfield CCG | 1.3% | 1.4% |
| E09000014 | Haringey | 08D | NHS Haringey CCG | 87.7% | 91.6% |
| E09000014 | Haringey | 08H | NHS Islington CCG | 2.3% | 1.9% |
| E09000015 | Harrow | 07M | NHS Barnet CCG | 4.3% | 6.3% |
| E09000015 | Harrow | 07P | NHS Brent CCG | 3.7% | 5.0% |
| E09000015 | Harrow | 07W | NHS Ealing CCG | 1.3% | 1.9% |
| E09000015 | Harrow | 08E | NHS Harrow CCG | 90.0% | 84.3% |
| E09000015 | Harrow | 06N | NHS Herts Valleys CCG | 0.2% | 0.4% |
| E09000015 | Harrow | 08G | NHS Hillingdon CCG | 1.7% | 1.9% |
| E09000015 | Harrow | 08Y | NHS West London (K&C & QPP) CCG | 0.1% | 0.1% |
| E06000001 | Hartlepool | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 0.1% | 0.4% |
| E06000001 | Hartlepool | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 32.6% | 99.6% |
| E09000016 | Havering | 07L | NHS Barking and Dagenham CCG | 4.0% | 3.3% |
| E09000016 | Havering | 08F | NHS Havering CCG | 92.0% | 95.9% |
| E09000016 | Havering | 08M | NHS Newham CCG | 0.0% | 0.1% |
| E09000016 | Havering | 08N | NHS Redbridge CCG | 0.5% | 0.6% |
| E09000016 | Havering | 07G | NHS Thurrock CCG | 0.1% | 0.1% |
| E06000019 | Herefordshire, County of | 11M | NHS Gloucestershire CCG | 0.3% | 0.9% |
| E06000019 | Herefordshire, County of | 05F | NHS Herefordshire CCG | 98.1% | 97.3% |
| E06000019 | Herefordshire, County of | 05N | NHS Shropshire CCG | 0.3% | 0.5% |
| E06000019 | Herefordshire, County of | 05T | NHS South Worcestershire CCG | 0.8% | 1.3% |
| E10000015 | Hertfordshire | 10Y | NHS Aylesbury Vale CCG | 0.4% | 0.0% |
| E10000015 | Hertfordshire | 07M | NHS Barnet CCG | 0.2% | 0.0% |
| E10000015 | Hertfordshire | 06F | NHS Bedfordshire CCG | 0.1% | 0.0% |
| E10000015 | Hertfordshire | 06H | NHS Cambridgeshire and Peterborough CCG | 2.1% | 1.6% |
| E10000015 | Hertfordshire | 10H | NHS Chiltern CCG | 0.1% | 0.0% |
| E10000015 | Hertfordshire | 06K | NHS East and North Hertfordshire CCG | 96.8% | 46.6% |
| E10000015 | Hertfordshire | 07X | NHS Enfield CCG | 0.3% | 0.0% |
| E10000015 | Hertfordshire | 08E | NHS Harrow CCG | 0.5% | 0.1% |
| E10000015 | Hertfordshire | 06N | NHS Herts Valleys CCG | 98.1% | 50.9% |
| E10000015 | Hertfordshire | 08G | NHS Hillingdon CCG | 2.3% | 0.6% |
| E10000015 | Hertfordshire | 06P | NHS Luton CCG | 0.4% | 0.0% |
| E10000015 | Hertfordshire | 07H | NHS West Essex CCG | 0.7% | 0.2% |
| E09000017 | Hillingdon | 10H | NHS Chiltern CCG | 0.1% | 0.1% |
| E09000017 | Hillingdon | 07W | NHS Ealing CCG | 5.2% | 6.9% |
| E09000017 | Hillingdon | 08C | NHS Hammersmith and Fulham CCG | 0.5% | 0.3% |
| E09000017 | Hillingdon | 08E | NHS Harrow CCG | 2.2% | 1.8% |
| E09000017 | Hillingdon | 08G | NHS Hillingdon CCG | 94.3% | 90.0% |
| E09000017 | Hillingdon | 07Y | NHS Hounslow CCG | 1.0% | 0.9% |
| E09000018 | Hounslow | 07W | NHS Ealing CCG | 5.8% | 8.0% |
| E09000018 | Hounslow | 08C | NHS Hammersmith and Fulham CCG | 1.0% | 0.6% |
| E09000018 | Hounslow | 08G | NHS Hillingdon CCG | 0.2% | 0.2% |
| E09000018 | Hounslow | 07Y | NHS Hounslow CCG | 88.0% | 87.1% |
| E09000018 | Hounslow | 09Y | NHS North West Surrey CCG | 0.3% | 0.4% |
| E09000018 | Hounslow | 08P | NHS Richmond CCG | 5.3% | 3.6% |
| E09000018 | Hounslow | 08Y | NHS West London (K&C & QPP) CCG | 0.1% | 0.1% |
| E06000046 | Isle of Wight | 10L | NHS Isle of Wight CCG | 100.0% | 100.0% |
| E09000019 | Islington | 07R | NHS Camden CCG | 4.4% | 4.9% |
| E09000019 | Islington | 09A | NHS Central London (Westminster) CCG | 0.4% | 0.4% |
| E09000019 | Islington | 07T | NHS City and Hackney CCG | 3.2% | 4.1% |
| E09000019 | Islington | 08D | NHS Haringey CCG | 1.3% | 1.7% |
| E09000019 | Islington | 08H | NHS Islington CCG | 89.8% | 89.0% |
| E09000020 | Kensington and Chelsea | 07P | NHS Brent CCG | 0.0% | 0.1% |
| E09000020 | Kensington and Chelsea | 07R | NHS Camden CCG | 0.2% | 0.4% |
| E09000020 | Kensington and Chelsea | 09A | NHS Central London (Westminster) CCG | 4.1% | 5.1% |
| E09000020 | Kensington and Chelsea | 08C | NHS Hammersmith and Fulham CCG | 0.9% | 1.2% |
| E09000020 | Kensington and Chelsea | 08Y | NHS West London (K&C & QPP) CCG | 64.1% | 93.2% |
| E10000016 | Kent | 09C | NHS Ashford CCG | 100.0% | 8.3% |
| E10000016 | Kent | 07N | NHS Bexley CCG | 1.1% | 0.2% |
| E10000016 | Kent | 07Q | NHS Bromley CCG | 0.8% | 0.2% |
| E10000016 | Kent | 09E | NHS Canterbury and Coastal CCG | 100.0% | 14.1% |
| E10000016 | Kent | 09J | NHS Dartford, Gravesham and Swanley CCG | 98.3% | 16.5% |
| E10000016 | Kent | 09L | NHS East Surrey CCG | 0.1% | 0.0% |
| E10000016 | Kent | 08A | NHS Greenwich CCG | 0.1% | 0.0% |
| E10000016 | Kent | 09P | NHS Hastings and Rother CCG | 0.3% | 0.0% |
| E10000016 | Kent | 99K | NHS High Weald Lewes Havens CCG | 0.6% | 0.0% |
| E10000016 | Kent | 09W | NHS Medway CCG | 6.0% | 1.1% |
| E10000016 | Kent | 10A | NHS South Kent Coast CCG | 100.0% | 13.0% |
| E10000016 | Kent | 10D | NHS Swale CCG | 99.9% | 7.1% |
| E10000016 | Kent | 10E | NHS Thanet CCG | 100.0% | 9.3% |
| E10000016 | Kent | 99J | NHS West Kent CCG | 98.7% | 30.4% |
| E06000010 | Kingston upon Hull, City of | 02Y | NHS East Riding of Yorkshire CCG | 1.3% | 1.5% |
| E06000010 | Kingston upon Hull, City of | 03F | NHS Hull CCG | 90.6% | 98.5% |
| E09000021 | Kingston upon Thames | 08J | NHS Kingston CCG | 87.1% | 95.8% |
| E09000021 | Kingston upon Thames | 08R | NHS Merton CCG | 1.0% | 1.2% |
| E09000021 | Kingston upon Thames | 08P | NHS Richmond CCG | 0.7% | 0.8% |
| E09000021 | Kingston upon Thames | 99H | NHS Surrey Downs CCG | 0.9% | 1.5% |
| E09000021 | Kingston upon Thames | 08T | NHS Sutton CCG | 0.1% | 0.1% |
| E09000021 | Kingston upon Thames | 08X | NHS Wandsworth CCG | 0.3% | 0.5% |
| E08000034 | Kirklees | 02P | NHS Barnsley CCG | 0.1% | 0.0% |
| E08000034 | Kirklees | 02R | NHS Bradford Districts CCG | 1.0% | 0.8% |
| E08000034 | Kirklees | 02T | NHS Calderdale CCG | 1.3% | 0.6% |
| E08000034 | Kirklees | 03A | NHS Greater Huddersfield CCG | 99.5% | 54.8% |
| E08000034 | Kirklees | 03C | NHS Leeds West CCG | 0.3% | 0.2% |
| E08000034 | Kirklees | 03J | NHS North Kirklees CCG | 99.0% | 42.4% |
| E08000034 | Kirklees | 03R | NHS Wakefield CCG | 1.5% | 1.2% |
| E08000011 | Knowsley | 01F | NHS Halton CCG | 1.1% | 0.9% |
| E08000011 | Knowsley | 01J | NHS Knowsley CCG | 86.9% | 88.2% |
| E08000011 | Knowsley | 99A | NHS Liverpool CCG | 2.5% | 8.0% |
| E08000011 | Knowsley | 01T | NHS South Sefton CCG | 0.2% | 0.1% |
| E08000011 | Knowsley | 01X | NHS St Helens CCG | 2.3% | 2.9% |
| E09000022 | Lambeth | 09A | NHS Central London (Westminster) CCG | 0.7% | 0.4% |

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| E09000022 | Lambeth | 07V | NHS Croydon CCG | 0.7% | 0.8% |
| E09000022 | Lambeth | 08K | NHS Lambeth CCG | 86.8% | 92.7% |
| E09000022 | Lambeth | 08R | NHS Merton CCG | 1.2% | 0.7% |
| E09000022 | Lambeth | 08Q | NHS Southwark CCG | 1.8% | 1.6% |
| E09000022 | Lambeth | 08X | NHS Wandsworth CCG | 3.6% | 3.8% |
| E10000017 | Lancashire | 02N | NHS Airedale, Wharfdale and Craven CCG | 0.2% | 0.0% |
| E10000017 | Lancashire | 00Q | NHS Blackburn with Darwen CCG | 11.0% | 1.5% |
| E10000017 | Lancashire | 00R | NHS Blackpool CCG | 13.0% | 1.8% |
| E10000017 | Lancashire | 00T | NHS Bolton CCG | 0.3% | 0.0% |
| E10000017 | Lancashire | 00V | NHS Bury CCG | 1.4% | 0.2% |
| E10000017 | Lancashire | 00X | NHS Chorley and South Ribble CCG | 99.8% | 14.5% |
| E10000017 | Lancashire | 01H | NHS Cumbria CCG | 1.4% | 0.6% |
| E10000017 | Lancashire | 01A | NHS East Lancashire CCG | 98.9% | 30.0% |
| E10000017 | Lancashire | 02M | NHS Fylde & Wyre CCG | 97.4% | 11.9% |
| E10000017 | Lancashire | 01E | NHS Greater Preston CCG | 100.0% | 17.1% |
| E10000017 | Lancashire | 01D | NHS Heywood, Middleton and Rochdale CCG | 0.9% | 0.2% |
| E10000017 | Lancashire | 01J | NHS Knowsley CCG | 0.1% | 0.0% |
| E10000017 | Lancashire | 01K | NHS Lancashire North CCG | 99.8% | 12.8% |
| E10000017 | Lancashire | 01T | NHS South Sefton CCG | 0.5% | 0.0% |
| E10000017 | Lancashire | 01V | NHS Southport and Formby CCG | 3.0% | 0.3% |
| E10000017 | Lancashire | 01X | NHS St Helens CCG | 0.5% | 0.0% |
| E10000017 | Lancashire | 02G | NHS West Lancashire CCG | 97.1% | 8.8% |
| E10000017 | Lancashire | 02H | NHS Wigan Borough CCG | 0.8% | 0.2% |
| E08000035 | Leeds | 02W | NHS Bradford City CCG | 0.6% | 0.0% |
| E08000035 | Leeds | 02R | NHS Bradford Districts CCG | 0.7% | 0.3% |
| E08000035 | Leeds | 02V | NHS Leeds North CCG | 96.4% | 24.3% |
| E08000035 | Leeds | 03G | NHS Leeds South and East CCG | 98.5% | 31.9% |
| E08000035 | Leeds | 03C | NHS Leeds West CCG | 97.9% | 42.7% |
| E08000035 | Leeds | 03J | NHS North Kirklees CCG | 0.3% | 0.0% |
| E08000035 | Leeds | 03Q | NHS Vale of York CCG | 0.6% | 0.2% |
| E08000035 | Leeds | 03R | NHS Wakefield CCG | 1.5% | 0.6% |
| E06000016 | Leicester | 03W | NHS East Leicestershire and Rutland CCG | 2.5% | 2.2% |
| E06000016 | Leicester | 04C | NHS Leicester City CCG | 92.5% | 95.2% |
| E06000016 | Leicester | 04V | NHS West Leicestershire CCG | 2.6% | 2.6% |
| E10000018 | Leicestershire | 03V | NHS Corby CCG | 0.6% | 0.0% |
| E10000018 | Leicestershire | 03W | NHS East Leicestershire and Rutland CCG | 85.3% | 40.1% |
| E10000018 | Leicestershire | 04C | NHS Leicester City CCG | 7.5% | 4.2% |
| E10000018 | Leicestershire | 04N | NHS Rushcliffe CCG | 5.4% | 1.0% |
| E10000018 | Leicestershire | 04Q | NHS South West Lincolnshire CCG | 5.7% | 1.1% |
| E10000018 | Leicestershire | 04R | NHS Southern Derbyshire CCG | 0.6% | 0.5% |
| E10000018 | Leicestershire | 05H | NHS Warwickshire North CCG | 1.6% | 0.4% |
| E10000018 | Leicestershire | 04V | NHS West Leicestershire CCG | 96.2% | 52.7% |
| E09000023 | Lewisham | 07Q | NHS Bromley CCG | 1.3% | 1.5% |
| E09000023 | Lewisham | 09A | NHS Central London (Westminster) CCG | 0.1% | 0.1% |
| E09000023 | Lewisham | 08A | NHS Greenwich CCG | 2.2% | 2.0% |
| E09000023 | Lewisham | 08K | NHS Lambeth CCG | 0.2% | 0.3% |
| E09000023 | Lewisham | 08L | NHS Lewisham CCG | 92.1% | 92.5% |
| E09000023 | Lewisham | 08Q | NHS Southwark CCG | 3.7% | 3.7% |
| E10000019 | Lincolnshire | 06H | NHS Cambridgeshire and Peterborough CCG | 0.2% | 0.2% |
| E10000019 | Lincolnshire | 03W | NHS East Leicestershire and Rutland CCG | 0.2% | 0.0% |
| E10000019 | Lincolnshire | 03T | NHS Lincolnshire East CCG | 99.2% | 32.1% |
| E10000019 | Lincolnshire | 04D | NHS Lincolnshire West CCG | 98.5% | 30.4% |
| E10000019 | Lincolnshire | 04H | NHS Newark & Sherwood CCG | 2.4% | 0.4% |
| E10000019 | Lincolnshire | 03H | NHS North East Lincolnshire CCG | 2.7% | 0.6% |
| E10000019 | Lincolnshire | 03K | NHS North Lincolnshire CCG | 2.6% | 0.6% |
| E10000019 | Lincolnshire | 99D | NHS South Lincolnshire CCG | 90.6% | 19.5% |
| E10000019 | Lincolnshire | 04Q | NHS South West Lincolnshire CCG | 93.2% | 16.2% |
| E08000012 | Liverpool | 01J | NHS Knowsley CCG | 8.5% | 2.8% |
| E08000012 | Liverpool | 99A | NHS Liverpool CCG | 94.3% | 96.2% |
| E08000012 | Liverpool | 01T | NHS South Sefton CCG | 3.3% | 1.0% |
| E06000032 | Luton | 06F | NHS Bedfordshire CCG | 2.3% | 4.5% |
| E06000032 | Luton | 06P | NHS Luton CCG | 97.2% | 95.5% |
| E08000003 | Manchester | 00V | NHS Bury CCG | 0.3% | 0.1% |
| E08000003 | Manchester | 00W | NHS Central Manchester CCG | 93.7% | 36.9% |
| E08000003 | Manchester | 01D | NHS Heywood, Middleton and Rochdale CCG | 0.5% | 0.2% |
| E08000003 | Manchester | 01M | NHS North Manchester CCG | 85.1% | 30.3% |
| E08000003 | Manchester | 00Y | NHS Oldham CCG | 0.9% | 0.4% |
| E08000003 | Manchester | 01G | NHS Salford CCG | 2.5% | 1.1% |
| E08000003 | Manchester | 01N | NHS South Manchester CCG | 93.9% | 28.2% |
| E08000003 | Manchester | 01W | NHS Stockport CCG | 1.5% | 0.8% |
| E08000003 | Manchester | 01Y | NHS Tameside and Glossop CCG | 0.4% | 0.2% |
| E08000003 | Manchester | 02A | NHS Trafford CCG | 4.3% | 1.8% |
| E06000035 | Medway | 09J | NHS Dartford, Gravesham and Swanley CCG | 0.2% | 0.2% |
| E06000035 | Medway | 09W | NHS Medway CCG | 94.0% | 99.5% |
| E06000035 | Medway | 10D | NHS Swale CCG | 0.1% | 0.0% |
| E06000035 | Medway | 99J | NHS West Kent CCG | 0.2% | 0.3% |
| E09000024 | Merton | 07V | NHS Croydon CCG | 0.5% | 0.8% |
| E09000024 | Merton | 08J | NHS Kingston CCG | 3.5% | 3.0% |
| E09000024 | Merton | 08K | NHS Lambeth CCG | 0.9% | 1.4% |
| E09000024 | Merton | 08R | NHS Merton CCG | 87.7% | 81.5% |
| E09000024 | Merton | 08T | NHS Sutton CCG | 3.4% | 2.7% |
| E09000024 | Merton | 08X | NHS Wandsworth CCG | 6.5% | 10.5% |
| E06000002 | Middlesbrough | 03D | NHS Hambleton, Richmondshire and Whitby CCG | 0.2% | 0.2% |
| E06000002 | Middlesbrough | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 0.2% | 0.3% |
| E06000002 | Middlesbrough | 00M | NHS South Tees CCG | 52.0% | 99.5% |
| E06000042 | Milton Keynes | 06F | NHS Bedfordshire CCG | 1.5% | 2.5% |
| E06000042 | Milton Keynes | 04F | NHS Milton Keynes CCG | 95.5% | 96.1% |
| E06000042 | Milton Keynes | 04G | NHS Nene CCG | 0.6% | 1.4% |
| E08000021 | Newcastle upon Tyne | 13T | NHS Newcastle Gateshead CCG | 58.0% | 95.0% |
| E08000021 | Newcastle upon Tyne | 99C | NHS North Tyneside CCG | 6.0% | 4.2% |
| E08000021 | Newcastle upon Tyne | 00L | NHS Northumberland CCG | 0.8% | 0.8% |
| E09000025 | Newham | 07L | NHS Barking and Dagenham CCG | 0.5% | 0.3% |
| E09000025 | Newham | 09A | NHS Central London (Westminster) CCG | 0.1% | 0.0% |
| E09000025 | Newham | 07T | NHS City and Hackney CCG | 0.1% | 0.0% |
| E09000025 | Newham | 08M | NHS Newham CCG | 96.9% | 97.9% |
| E09000025 | Newham | 08N | NHS Redbridge CCG | 0.2% | 0.2% |
| E09000025 | Newham | 08V | NHS Tower Hamlets CCG | 0.2% | 0.2% |

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| E09000025 | Newham | 08W | NHS Waltham Forest CCG | 1.7% | 1.4% |
| E10000020 | Norfolk | 06H | NHS Cambridgeshire and Peterborough CCG | 0.7% | 0.7% |
| E10000020 | Norfolk | 06M | NHS Great Yarmouth and Waveney CCG | 47.5% | 12.3% |
| E10000020 | Norfolk | 06L | NHS Ipswich and East Suffolk CCG | 0.1% | 0.0% |
| E10000020 | Norfolk | 06V | NHS North Norfolk CCG | 100.0% | 18.8% |
| E10000020 | Norfolk | 06W | NHS Norwich CCG | 100.0% | 23.7% |
| E10000020 | Norfolk | 99D | NHS South Lincolnshire CCG | 0.2% | 0.0% |
| E10000020 | Norfolk | 06Y | NHS South Norfolk CCG | 98.8% | 25.3% |
| E10000020 | Norfolk | 07J | NHS West Norfolk CCG | 98.5% | 18.5% |
| E10000020 | Norfolk | 07K | NHS West Suffolk CCG | 2.6% | 0.7% |
| E06000012 | North East Lincolnshire | 03T | NHS Lincolnshire East CCG | 0.8% | 1.2% |
| E06000012 | North East Lincolnshire | 03H | NHS North East Lincolnshire CCG | 95.9% | 98.7% |
| E06000012 | North East Lincolnshire | 03K | NHS North Lincolnshire CCG | 0.1% | 0.2% |
| E06000013 | North Lincolnshire | 02Q | NHS Bassetlaw CCG | 0.2% | 0.1% |
| E06000013 | North Lincolnshire | 02X | NHS Doncaster CCG | 0.0% | 0.1% |
| E06000013 | North Lincolnshire | 02Y | NHS East Riding of Yorkshire CCG | 0.0% | 0.1% |
| E06000013 | North Lincolnshire | 04D | NHS Lincolnshire West CCG | 1.0% | 1.4% |
| E06000013 | North Lincolnshire | 03H | NHS North East Lincolnshire CCG | 1.4% | 1.4% |
| E06000013 | North Lincolnshire | 03K | NHS North Lincolnshire CCG | 97.2% | 96.8% |
| E06000024 | North Somerset | 11E | NHS Bath and North East Somerset CCG | 1.7% | 1.6% |
| E06000024 | North Somerset | 11H | NHS Bristol CCG | 0.3% | 0.6% |
| E06000024 | North Somerset | 11T | NHS North Somerset CCG | 99.1% | 97.7% |
| E06000024 | North Somerset | 11X | NHS Somerset CCG | 0.0% | 0.2% |
| E08000022 | North Tyneside | 13T | NHS Newcastle Gateshead CCG | 1.0% | 2.5% |
| E08000022 | North Tyneside | 99C | NHS North Tyneside CCG | 93.1% | 96.4% |
| E08000022 | North Tyneside | 00L | NHS Northumberland CCG | 0.7% | 1.1% |
| E10000023 | North Yorkshire | 02N | NHS Airedale, Wharfdale and Craven CCG | 32.4% | 8.3% |
| E10000023 | North Yorkshire | 01H | NHS Cumbria CCG | 1.2% | 1.0% |
| E10000023 | North Yorkshire | 00C | NHS Darlington CCG | 1.3% | 0.2% |
| E10000023 | North Yorkshire | 02X | NHS Doncaster CCG | 0.2% | 0.1% |
| E10000023 | North Yorkshire | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 0.2% | 0.1% |
| E10000023 | North Yorkshire | 01A | NHS East Lancashire CCG | 0.1% | 0.0% |
| E10000023 | North Yorkshire | 02Y | NHS East Riding of Yorkshire CCG | 1.3% | 0.7% |
| E10000023 | North Yorkshire | 03D | NHS Hambleton, Richmondshire and Whitby CCG | 98.7% | 22.9% |
| E10000023 | North Yorkshire | 03E | NHS Harrogate and Rural District CCG | 99.9% | 26.3% |
| E10000023 | North Yorkshire | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 0.2% | 0.0% |
| E10000023 | North Yorkshire | 02V | NHS Leeds North CCG | 3.0% | 1.0% |
| E10000023 | North Yorkshire | 03G | NHS Leeds South and East CCG | 0.5% | 0.2% |
| E10000023 | North Yorkshire | 03M | NHS Scarborough and Ryedale CCG | 99.3% | 19.2% |
| E10000023 | North Yorkshire | 03Q | NHS Vale of York CCG | 32.6% | 18.7% |
| E10000023 | North Yorkshire | 03R | NHS Wakefield CCG | 2.0% | 1.2% |
| E10000021 | Northamptonshire | 10Y | NHS Aylesbury Vale CCG | 0.1% | 0.0% |
| E10000021 | Northamptonshire | 06F | NHS Bedfordshire CCG | 0.1% | 0.0% |
| E10000021 | Northamptonshire | 06H | NHS Cambridgeshire and Peterborough CCG | 1.6% | 1.9% |
| E10000021 | Northamptonshire | 03V | NHS Corby CCG | 99.1% | 9.6% |
| E10000021 | Northamptonshire | 05A | NHS Coventry and Rugby CCG | 0.3% | 0.2% |
| E10000021 | Northamptonshire | 03W | NHS East Leicestershire and Rutland CCG | 1.9% | 0.8% |
| E10000021 | Northamptonshire | 04F | NHS Milton Keynes CCG | 3.2% | 1.2% |
| E10000021 | Northamptonshire | 04G | NHS Nene CCG | 98.8% | 85.0% |
| E10000021 | Northamptonshire | 10Q | NHS Oxfordshire CCG | 1.2% | 1.1% |
| E10000021 | Northamptonshire | 99D | NHS South Lincolnshire CCG | 0.9% | 0.2% |
| E06000057 | Northumberland | 01H | NHS Cumbria CCG | 0.0% | 0.1% |
| E06000057 | Northumberland | 13T | NHS Newcastle Gateshead CCG | 0.3% | 0.4% |
| E06000057 | Northumberland | 00J | NHS North Durham CCG | 0.2% | 0.2% |
| E06000057 | Northumberland | 99C | NHS North Tyneside CCG | 0.9% | 0.6% |
| E06000057 | Northumberland | 00L | NHS Northumberland CCG | 98.0% | 98.7% |
| E06000018 | Nottingham | 04K | NHS Nottingham City CCG | 89.7% | 94.8% |
| E06000018 | Nottingham | 04L | NHS Nottingham North and East CCG | 4.7% | 2.1% |
| E06000018 | Nottingham | 04M | NHS Nottingham West CCG | 5.7% | 1.6% |
| E06000018 | Nottingham | 04N | NHS Rushcliffe CCG | 4.1% | 1.5% |
| E10000024 | Nottinghamshire | 02Q | NHS Bassetlaw CCG | 97.5% | 13.5% |
| E10000024 | Nottinghamshire | 02X | NHS Doncaster CCG | 1.7% | 0.6% |
| E10000024 | Nottinghamshire | 03W | NHS East Leicestershire and Rutland CCG | 0.3% | 0.1% |
| E10000024 | Nottinghamshire | 03X | NHS Erewash CCG | 7.8% | 0.9% |
| E10000024 | Nottinghamshire | 03Y | NHS Hardwick CCG | 5.1% | 0.6% |
| E10000024 | Nottinghamshire | 04D | NHS Lincolnshire West CCG | 0.4% | 0.1% |
| E10000024 | Nottinghamshire | 04E | NHS Mansfield and Ashfield CCG | 98.1% | 22.5% |
| E10000024 | Nottinghamshire | 04H | NHS Newark & Sherwood CCG | 97.6% | 15.5% |
| E10000024 | Nottinghamshire | 04K | NHS Nottingham City CCG | 10.3% | 4.4% |
| E10000024 | Nottinghamshire | 04L | NHS Nottingham North and East CCG | 95.0% | 17.3% |
| E10000024 | Nottinghamshire | 04M | NHS Nottingham West CCG | 89.3% | 10.2% |
| E10000024 | Nottinghamshire | 04N | NHS Rushcliffe CCG | 90.5% | 13.6% |
| E10000024 | Nottinghamshire | 04Q | NHS South West Lincolnshire CCG | 0.7% | 0.1% |
| E10000024 | Nottinghamshire | 04R | NHS Southern Derbyshire CCG | 0.6% | 0.4% |
| E10000024 | Nottinghamshire | 04V | NHS West Leicestershire CCG | 0.1% | 0.0% |
| E08000004 | Oldham | 01D | NHS Heywood, Middleton and Rochdale CCG | 1.4% | 1.3% |
| E08000004 | Oldham | 01M | NHS North Manchester CCG | 2.6% | 2.1% |
| E08000004 | Oldham | 00Y | NHS Oldham CCG | 94.7% | 96.3% |
| E08000004 | Oldham | 01Y | NHS Tameside and Glossop CCG | 0.2% | 0.2% |
| E10000025 | Oxfordshire | 10Y | NHS Aylesbury Vale CCG | 6.2% | 1.8% |
| E10000025 | Oxfordshire | 11M | NHS Gloucestershire CCG | 0.2% | 0.2% |
| E10000025 | Oxfordshire | 04G | NHS Nene CCG | 0.1% | 0.1% |
| E10000025 | Oxfordshire | 10M | NHS Newbury and District CCG | 0.1% | 0.0% |
| E10000025 | Oxfordshire | 10N | NHS North & West Reading CCG | 2.0% | 0.3% |
| E10000025 | Oxfordshire | 10Q | NHS Oxfordshire CCG | 97.3% | 96.6% |
| E10000025 | Oxfordshire | 05R | NHS South Warwickshire CCG | 0.7% | 0.3% |
| E10000025 | Oxfordshire | 12D | NHS Swindon CCG | 2.6% | 0.8% |
| E06000031 | Peterborough | 06H | NHS Cambridgeshire and Peterborough CCG | 22.6% | 96.1% |
| E06000031 | Peterborough | 99D | NHS South Lincolnshire CCG | 5.2% | 3.9% |
| E06000026 | Plymouth | 99P | NHS North, East, West Devon CCG | 29.3% | 100.0% |
| E06000044 | Portsmouth | 10K | NHS Fareham and Gosport CCG | 1.4% | 1.3% |
| E06000044 | Portsmouth | 10R | NHS Portsmouth CCG | 95.5% | 98.4% |
| E06000044 | Portsmouth | 10V | NHS South Eastern Hampshire CCG | 0.3% | 0.3% |
| E06000038 | Reading | 10N | NHS North & West Reading CCG | 61.2% | 36.6% |
| E06000038 | Reading | 10Q | NHS Oxfordshire CCG | 0.2% | 0.6% |
| E06000038 | Reading | 10W | NHS South Reading CCG | 79.9% | 60.1% |
| E06000038 | Reading | 11D | NHS Wokingham CCG | 3.1% | 2.7% |

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| E09000026 | Redbridge | 07L | NHS Barking and Dagenham CCG | 5.6% | 3.8% |
| E09000026 | Redbridge | 08F | NHS Havering CCG | 0.9% | 0.8% |
| E09000026 | Redbridge | 08M | NHS Newham CCG | 1.5% | 1.8% |
| E09000026 | Redbridge | 08N | NHS Redbridge CCG | 92.6% | 88.7% |
| E09000026 | Redbridge | 08W | NHS Waltham Forest CCG | 3.4% | 3.2% |
| E09000026 | Redbridge | 07H | NHS West Essex CCG | 1.8% | 1.7% |
| E06000003 | Redcar and Cleveland | 03D | NHS Hambleton, Richmondshire and Whitby CCG | 1.0% | 1.0% |
| E06000003 | Redcar and Cleveland | 00M | NHS South Tees CCG | 47.7% | 99.0% |
| E09000027 | Richmond upon Thames | 08C | NHS Hammersmith and Fulham CCG | 0.4% | 0.4% |
| E09000027 | Richmond upon Thames | 07Y | NHS Hounslow CCG | 5.0% | 7.1% |
| E09000027 | Richmond upon Thames | 08J | NHS Kingston CCG | 1.6% | 1.5% |
| E09000027 | Richmond upon Thames | 08P | NHS Richmond CCG | 92.2% | 90.3% |
| E09000027 | Richmond upon Thames | 99H | NHS Surrey Downs CCG | 0.0% | 0.1% |
| E09000027 | Richmond upon Thames | 08X | NHS Wandsworth CCG | 0.3% | 0.6% |
| E08000005 | Rochdale | 00V | NHS Bury CCG | 0.6% | 0.5% |
| E08000005 | Rochdale | 01A | NHS East Lancashire CCG | 0.2% | 0.3% |
| E08000005 | Rochdale | 01D | NHS Heywood, Middleton and Rochdale CCG | 96.6% | 96.6% |
| E08000005 | Rochdale | 01M | NHS North Manchester CCG | 1.8% | 1.6% |
| E08000005 | Rochdale | 00Y | NHS Oldham CCG | 0.8% | 0.9% |
| E08000018 | Rotherham | 02P | NHS Barnsley CCG | 3.4% | 3.2% |
| E08000018 | Rotherham | 02Q | NHS Bassetlaw CCG | 0.9% | 0.4% |
| E08000018 | Rotherham | 02X | NHS Doncaster CCG | 1.1% | 1.3% |
| E08000018 | Rotherham | 03L | NHS Rotherham CCG | 97.9% | 93.5% |
| E08000018 | Rotherham | 03N | NHS Sheffield CCG | 0.7% | 1.6% |
| E06000017 | Rutland | 06H | NHS Cambridgeshire and Peterborough CCG | 0.0% | 0.3% |
| E06000017 | Rutland | 03V | NHS Corby CCG | 0.3% | 0.6% |
| E06000017 | Rutland | 03W | NHS East Leicestershire and Rutland CCG | 9.8% | 85.6% |
| E06000017 | Rutland | 99D | NHS South Lincolnshire CCG | 2.7% | 12.0% |
| E06000017 | Rutland | 04Q | NHS South West Lincolnshire CCG | 0.4% | 1.5% |
| E08000006 | Salford | 00T | NHS Bolton CCG | 0.2% | 0.3% |
| E08000006 | Salford | 00V | NHS Bury CCG | 1.8% | 1.4% |
| E08000006 | Salford | 00W | NHS Central Manchester CCG | 0.3% | 0.3% |
| E08000006 | Salford | 01M | NHS North Manchester CCG | 2.1% | 1.7% |
| E08000006 | Salford | 01G | NHS Salford CCG | 93.9% | 95.1% |
| E08000006 | Salford | 02A | NHS Trafford CCG | 0.2% | 0.1% |
| E08000006 | Salford | 02H | NHS Wigan Borough CCG | 0.9% | 1.2% |
| E08000028 | Sandwell | 13P | NHS Birmingham Crosscity CCG | 2.8% | 6.2% |
| E08000028 | Sandwell | 04X | NHS Birmingham South and Central CCG | 0.2% | 0.2% |
| E08000028 | Sandwell | 05C | NHS Dudley CCG | 3.0% | 2.8% |
| E08000028 | Sandwell | 05L | NHS Sandwell and West Birmingham CCG | 54.3% | 89.2% |
| E08000028 | Sandwell | 05Y | NHS Walsall CCG | 1.6% | 1.3% |
| E08000028 | Sandwell | 06A | NHS Wolverhampton CCG | 0.3% | 0.3% |
| E08000014 | Sefton | 01J | NHS Knowsley CCG | 1.8% | 1.0% |
| E08000014 | Sefton | 99A | NHS Liverpool CCG | 2.9% | 5.2% |
| E08000014 | Sefton | 01T | NHS South Sefton CCG | 96.1% | 51.9% |
| E08000014 | Sefton | 01V | NHS Southport and Formby CCG | 97.0% | 41.9% |
| E08000014 | Sefton | 02G | NHS West Lancashire CCG | 0.3% | 0.1% |
| E08000019 | Sheffield | 02P | NHS Barnsley CCG | 0.8% | 0.4% |
| E08000019 | Sheffield | 03Y | NHS Hardwick CCG | 0.4% | 0.0% |
| E08000019 | Sheffield | 04J | NHS North Derbyshire CCG | 0.7% | 0.3% |
| E08000019 | Sheffield | 03L | NHS Rotherham CCG | 0.3% | 0.1% |
| E08000019 | Sheffield | 03N | NHS Sheffield CCG | 98.6% | 99.2% |
| E06000051 | Shropshire | 05F | NHS Herefordshire CCG | 0.5% | 0.3% |
| E06000051 | Shropshire | 05G | NHS North Staffordshire CCG | 0.4% | 0.3% |
| E06000051 | Shropshire | 05N | NHS Shropshire CCG | 96.5% | 95.4% |
| E06000051 | Shropshire | 01R | NHS South Cheshire CCG | 0.5% | 0.3% |
| E06000051 | Shropshire | 05Q | NHS South East Staffs and Seisdon Peninsular CCG | 1.2% | 0.9% |
| E06000051 | Shropshire | 05T | NHS South Worcestershire CCG | 1.0% | 1.0% |
| E06000051 | Shropshire | 05X | NHS Telford and Wrekin CCG | 2.4% | 1.4% |
| E06000051 | Shropshire | 02F | NHS West Cheshire CCG | 0.2% | 0.1% |
| E06000051 | Shropshire | 06D | NHS Wyre Forest CCG | 0.7% | 0.3% |
| E06000039 | Slough | 10H | NHS Chiltern CCG | 3.2% | 6.7% |
| E06000039 | Slough | 10T | NHS Slough CCG | 96.6% | 92.9% |
| E06000039 | Slough | 11C | NHS Windsor, Ascot and Maidenhead CCG | 0.4% | 0.4% |
| E08000029 | Solihull | 13P | NHS Birmingham Crosscity CCG | 2.0% | 6.8% |
| E08000029 | Solihull | 04X | NHS Birmingham South and Central CCG | 0.3% | 0.3% |
| E08000029 | Solihull | 05A | NHS Coventry and Rugby CCG | 0.0% | 0.1% |
| E08000029 | Solihull | 05J | NHS Redditch and Bromsgrove CCG | 0.4% | 0.3% |
| E08000029 | Solihull | 05P | NHS Solihull CCG | 83.8% | 91.7% |
| E08000029 | Solihull | 05R | NHS South Warwickshire CCG | 0.4% | 0.5% |
| E08000029 | Solihull | 05H | NHS Warwickshire North CCG | 0.2% | 0.2% |
| E10000027 | Somerset | 11E | NHS Bath and North East Somerset CCG | 3.1% | 1.1% |
| E10000027 | Somerset | 11J | NHS Dorset CCG | 0.5% | 0.7% |
| E10000027 | Somerset | 11T | NHS North Somerset CCG | 0.9% | 0.3% |
| E10000027 | Somerset | 99P | NHS North, East, West Devon CCG | 0.3% | 0.5% |
| E10000027 | Somerset | 11X | NHS Somerset CCG | 98.5% | 97.3% |
| E10000027 | Somerset | 99N | NHS Wiltshire CCG | 0.1% | 0.0% |
| E06000025 | South Gloucestershire | 11E | NHS Bath and North East Somerset CCG | 0.6% | 0.4% |
| E06000025 | South Gloucestershire | 11H | NHS Bristol CCG | 4.7% | 8.2% |
| E06000025 | South Gloucestershire | 11M | NHS Gloucestershire CCG | 0.8% | 1.8% |
| E06000025 | South Gloucestershire | 12A | NHS South Gloucestershire CCG | 95.0% | 89.4% |
| E06000025 | South Gloucestershire | 99N | NHS Wiltshire CCG | 0.0% | 0.1% |
| E08000023 | South Tyneside | 13T | NHS Newcastle Gateshead CCG | 0.0% | 0.1% |
| E08000023 | South Tyneside | 00N | NHS South Tyneside CCG | 99.3% | 99.2% |
| E08000023 | South Tyneside | 00P | NHS Sunderland CCG | 0.3% | 0.6% |
| E06000045 | Southampton | 10X | NHS Southampton CCG | 94.5% | 99.6% |
| E06000045 | Southampton | 11A | NHS West Hampshire CCG | 0.2% | 0.4% |
| E06000033 | Southend-on-Sea | 99F | NHS Castle Point and Rochford CCG | 4.6% | 4.5% |
| E06000033 | Southend-on-Sea | 99G | NHS Southend CCG | 96.6% | 95.5% |
| E09000028 | Southwark | 07R | NHS Camden CCG | 0.5% | 0.4% |
| E09000028 | Southwark | 09A | NHS Central London (Westminster) CCG | 2.0% | 1.3% |
| E09000028 | Southwark | 08K | NHS Lambeth CCG | 6.6% | 7.6% |
| E09000028 | Southwark | 08L | NHS Lewisham CCG | 1.9% | 1.8% |
| E09000028 | Southwark | 08Q | NHS Southwark CCG | 94.5% | 88.9% |
| E09000028 | Southwark | 08X | NHS Wandsworth CCG | 0.0% | 0.1% |
| E08000013 | St. Helens | 01F | NHS Halton CCG | 0.2% | 0.1% |
| E08000013 | St. Helens | 01J | NHS Knowsley CCG | 2.6% | 2.3% |

| | | | | | |
|---|---|---|---|---|---|
| E08000013 | St. Helens | 01X | NHS St Helens CCG | 91.1% | 96.5% |
| E08000013 | St. Helens | 02H | NHS Wigan Borough CCG | 0.6% | 1.1% |
| E10000028 | Staffordshire | 13P | NHS Birmingham Crosscity CCG | 0.5% | 0.4% |
| E10000028 | Staffordshire | 04Y | NHS Cannock Chase CCG | 99.3% | 14.9% |
| E10000028 | Staffordshire | 05C | NHS Dudley CCG | 1.4% | 0.5% |
| E10000028 | Staffordshire | 05D | NHS East Staffordshire CCG | 91.9% | 14.5% |
| E10000028 | Staffordshire | 01C | NHS Eastern Cheshire CCG | 0.6% | 0.1% |
| E10000028 | Staffordshire | 04J | NHS North Derbyshire CCG | 0.7% | 0.2% |
| E10000028 | Staffordshire | 05G | NHS North Staffordshire CCG | 95.1% | 23.5% |
| E10000028 | Staffordshire | 05N | NHS Shropshire CCG | 1.1% | 0.4% |
| E10000028 | Staffordshire | 01R | NHS South Cheshire CCG | 0.5% | 0.1% |
| E10000028 | Staffordshire | 05Q | NHS South East Staffs and Seisdon Peninsular CCG | 96.2% | 23.7% |
| E10000028 | Staffordshire | 04R | NHS Southern Derbyshire CCG | 0.5% | 0.3% |
| E10000028 | Staffordshire | 05V | NHS Stafford and Surrounds CCG | 99.5% | 16.6% |
| E10000028 | Staffordshire | 05W | NHS Stoke on Trent CCG | 8.9% | 2.9% |
| E10000028 | Staffordshire | 05X | NHS Telford and Wrekin CCG | 1.0% | 0.2% |
| E10000028 | Staffordshire | 05Y | NHS Walsall CCG | 1.6% | 0.5% |
| E10000028 | Staffordshire | 05H | NHS Warwickshire North CCG | 1.2% | 0.2% |
| E10000028 | Staffordshire | 06A | NHS Wolverhampton CCG | 2.8% | 0.9% |
| E10000028 | Staffordshire | 06D | NHS Wyre Forest CCG | 0.2% | 0.0% |
| E08000007 | Stockport | 00W | NHS Central Manchester CCG | 0.7% | 0.6% |
| E08000007 | Stockport | 01C | NHS Eastern Cheshire CCG | 1.6% | 1.1% |
| E08000007 | Stockport | 01N | NHS South Manchester CCG | 2.9% | 1.7% |
| E08000007 | Stockport | 01W | NHS Stockport CCG | 95.2% | 96.5% |
| E08000007 | Stockport | 01Y | NHS Tameside and Glossop CCG | 0.2% | 0.2% |
| E06000004 | Stockton-on-Tees | 00C | NHS Darlington CCG | 0.4% | 0.2% |
| E06000004 | Stockton-on-Tees | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 0.3% | 0.5% |
| E06000004 | Stockton-on-Tees | 03D | NHS Hambleton, Richmondshire and Whitby CCG | 0.1% | 0.1% |
| E06000004 | Stockton-on-Tees | 00K | NHS Hartlepool and Stockton-On-Tees CCG | 66.8% | 98.7% |
| E06000004 | Stockton-on-Tees | 00M | NHS South Tees CCG | 0.3% | 0.5% |
| E06000021 | Stoke-on-Trent | 05G | NHS North Staffordshire CCG | 3.4% | 2.7% |
| E06000021 | Stoke-on-Trent | 05V | NHS Stafford and Surrounds CCG | 0.5% | 0.3% |
| E06000021 | Stoke-on-Trent | 05W | NHS Stoke on Trent CCG | 91.1% | 97.0% |
| E10000029 | Suffolk | 06H | NHS Cambridgeshire and Peterborough CCG | 0.1% | 0.2% |
| E10000029 | Suffolk | 06M | NHS Great Yarmouth and Waveney CCG | 52.5% | 16.5% |
| E10000029 | Suffolk | 06L | NHS Ipswich and East Suffolk CCG | 99.6% | 52.8% |
| E10000029 | Suffolk | 06T | NHS North East Essex CCG | 1.3% | 0.6% |
| E10000029 | Suffolk | 06Y | NHS South Norfolk CCG | 1.2% | 0.4% |
| E10000029 | Suffolk | 07K | NHS West Suffolk CCG | 91.0% | 29.6% |
| E08000024 | Sunderland | 00D | NHS Durham Dales, Easington and Sedgefield CCG | 0.7% | 0.7% |
| E08000024 | Sunderland | 13T | NHS Newcastle Gateshead CCG | 0.5% | 0.8% |
| E08000024 | Sunderland | 00J | NHS North Durham CCG | 2.3% | 2.0% |
| E08000024 | Sunderland | 00N | NHS South Tyneside CCG | 0.4% | 0.2% |
| E08000024 | Sunderland | 00P | NHS Sunderland CCG | 98.5% | 96.2% |
| E10000030 | Surrey | 10G | NHS Bracknell and Ascot CCG | 1.7% | 0.2% |
| E10000030 | Surrey | 07Q | NHS Bromley CCG | 0.4% | 0.1% |
| E10000030 | Surrey | 09G | NHS Coastal West Sussex CCG | 0.2% | 0.0% |
| E10000030 | Surrey | 09H | NHS Crawley CCG | 6.6% | 0.7% |
| E10000030 | Surrey | 07V | NHS Croydon CCG | 1.2% | 0.4% |
| E10000030 | Surrey | 09L | NHS East Surrey CCG | 96.6% | 14.1% |
| E10000030 | Surrey | 09N | NHS Guildford and Waverley CCG | 94.0% | 16.9% |
| E10000030 | Surrey | 09X | NHS Horsham and Mid Sussex CCG | 1.6% | 0.3% |
| E10000030 | Surrey | 07Y | NHS Hounslow CCG | 0.5% | 0.1% |
| E10000030 | Surrey | 08J | NHS Kingston CCG | 4.4% | 0.7% |
| E10000030 | Surrey | 08R | NHS Merton CCG | 0.2% | 0.0% |
| E10000030 | Surrey | 99M | NHS North East Hampshire and Farnham CCG | 23.0% | 4.2% |
| E10000030 | Surrey | 10J | NHS North Hampshire CCG | 0.1% | 0.0% |
| E10000030 | Surrey | 09Y | NHS North West Surrey CCG | 99.5% | 29.6% |
| E10000030 | Surrey | 08P | NHS Richmond CCG | 0.5% | 0.0% |
| E10000030 | Surrey | 10V | NHS South Eastern Hampshire CCG | 0.1% | 0.0% |
| E10000030 | Surrey | 99H | NHS Surrey Downs CCG | 97.1% | 23.9% |
| E10000030 | Surrey | 10C | NHS Surrey Heath CCG | 99.0% | 7.6% |
| E10000030 | Surrey | 08T | NHS Sutton CCG | 1.2% | 0.2% |
| E10000030 | Surrey | 99J | NHS West Kent CCG | 0.2% | 0.0% |
| E10000030 | Surrey | 11C | NHS Windsor, Ascot and Maidenhead CCG | 7.7% | 1.0% |
| E09000029 | Sutton | 07V | NHS Croydon CCG | 1.0% | 1.9% |
| E09000029 | Sutton | 08J | NHS Kingston CCG | 3.3% | 3.2% |
| E09000029 | Sutton | 08K | NHS Lambeth CCG | 0.1% | 0.2% |
| E09000029 | Sutton | 08R | NHS Merton CCG | 6.2% | 6.5% |
| E09000029 | Sutton | 99H | NHS Surrey Downs CCG | 1.4% | 2.0% |
| E09000029 | Sutton | 08T | NHS Sutton CCG | 94.5% | 86.0% |
| E09000029 | Sutton | 08X | NHS Wandsworth CCG | 0.1% | 0.2% |
| E06000030 | Swindon | 11M | NHS Gloucestershire CCG | 0.0% | 0.2% |
| E06000030 | Swindon | 12D | NHS Swindon CCG | 96.3% | 98.4% |
| E06000030 | Swindon | 99N | NHS Wiltshire CCG | 0.6% | 1.4% |
| E08000008 | Tameside | 00W | NHS Central Manchester CCG | 0.5% | 0.5% |
| E08000008 | Tameside | 01M | NHS North Manchester CCG | 6.4% | 5.5% |
| E08000008 | Tameside | 00Y | NHS Oldham CCG | 3.6% | 3.8% |
| E08000008 | Tameside | 01W | NHS Stockport CCG | 1.6% | 2.1% |
| E08000008 | Tameside | 01Y | NHS Tameside and Glossop CCG | 85.1% | 88.1% |
| E06000020 | Telford and Wrekin | 05N | NHS Shropshire CCG | 1.8% | 3.0% |
| E06000020 | Telford and Wrekin | 05X | NHS Telford and Wrekin CCG | 96.7% | 97.0% |
| E06000034 | Thurrock | 07L | NHS Barking and Dagenham CCG | 0.2% | 0.2% |
| E06000034 | Thurrock | 99E | NHS Basildon and Brentwood CCG | 0.2% | 0.2% |
| E06000034 | Thurrock | 08F | NHS Havering CCG | 0.1% | 0.2% |
| E06000034 | Thurrock | 07G | NHS Thurrock CCG | 98.4% | 99.3% |
| E06000027 | Torbay | 99Q | NHS South Devon and Torbay CCG | 48.9% | 100.0% |
| E09000030 | Tower Hamlets | 07R | NHS Camden CCG | 1.1% | 0.9% |
| E09000030 | Tower Hamlets | 09A | NHS Central London (Westminster) CCG | 0.3% | 0.2% |
| E09000030 | Tower Hamlets | 07T | NHS City and Hackney CCG | 0.8% | 0.8% |
| E09000030 | Tower Hamlets | 08M | NHS Newham CCG | 0.2% | 0.3% |
| E09000030 | Tower Hamlets | 08V | NHS Tower Hamlets CCG | 98.9% | 97.7% |
| E08000009 | Trafford | 00W | NHS Central Manchester CCG | 4.7% | 4.3% |
| E08000009 | Trafford | 01G | NHS Salford CCG | 0.1% | 0.1% |
| E08000009 | Trafford | 01N | NHS South Manchester CCG | 3.2% | 2.2% |
| E08000009 | Trafford | 02A | NHS Trafford CCG | 95.3% | 93.2% |
| E08000009 | Trafford | 02E | NHS Warrington CCG | 0.1% | 0.1% |

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|---|---|---|---|---|---|
| E08000036 | Wakefield | 02P | NHS Barnsley CCG | 0.8% | 0.6% |
| E08000036 | Wakefield | 03G | NHS Leeds South and East CCG | 1.0% | 0.8% |
| E08000036 | Wakefield | 03C | NHS Leeds West CCG | 0.1% | 0.2% |
| E08000036 | Wakefield | 03J | NHS North Kirklees CCG | 0.6% | 0.3% |
| E08000036 | Wakefield | 03R | NHS Wakefield CCG | 94.6% | 98.1% |
| E08000030 | Walsall | 13P | NHS Birmingham Crosscity CCG | 1.8% | 4.7% |
| E08000030 | Walsall | 04Y | NHS Cannock Chase CCG | 0.7% | 0.3% |
| E08000030 | Walsall | 05L | NHS Sandwell and West Birmingham CCG | 1.6% | 3.1% |
| E08000030 | Walsall | 05Y | NHS Walsall CCG | 92.4% | 90.7% |
| E08000030 | Walsall | 06A | NHS Wolverhampton CCG | 1.3% | 1.2% |
| E09000031 | Waltham Forest | 07T | NHS City and Hackney CCG | 0.3% | 0.3% |
| E09000031 | Waltham Forest | 08M | NHS Newham CCG | 1.1% | 1.5% |
| E09000031 | Waltham Forest | 08N | NHS Redbridge CCG | 1.4% | 1.4% |
| E09000031 | Waltham Forest | 08W | NHS Waltham Forest CCG | 94.3% | 96.8% |

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|---|---|---|---|---|---|
| E09000032 | Wandsworth | 09A | NHS Central London (Westminster) CCG | 0.7% | 0.4% |
| E09000032 | Wandsworth | 08C | NHS Hammersmith and Fulham CCG | 0.3% | 0.2% |
| E09000032 | Wandsworth | 08J | NHS Kingston CCG | 0.1% | 0.0% |
| E09000032 | Wandsworth | 08K | NHS Lambeth CCG | 2.7% | 2.9% |
| E09000032 | Wandsworth | 08R | NHS Merton CCG | 3.0% | 1.8% |
| E09000032 | Wandsworth | 08P | NHS Richmond CCG | 1.3% | 0.7% |
| E09000032 | Wandsworth | 08X | NHS Wandsworth CCG | 88.8% | 93.6% |
| E09000032 | Wandsworth | 08Y | NHS West London (K&C & QPP) CCG | 0.5% | 0.3% |
| E06000007 | Warrington | 01F | NHS Halton CCG | 0.3% | 0.2% |
| E06000007 | Warrington | 01G | NHS Salford CCG | 0.5% | 0.6% |
| E06000007 | Warrington | 01X | NHS St Helens CCG | 2.2% | 2.0% |
| E06000007 | Warrington | 02E | NHS Warrington CCG | 97.8% | 97.0% |
| E06000007 | Warrington | 02H | NHS Wigan Borough CCG | 0.2% | 0.2% |
| E10000031 | Warwickshire | 13P | NHS Birmingham Crosscity CCG | 0.1% | 0.2% |
| E10000031 | Warwickshire | 05A | NHS Coventry and Rugby CCG | 25.6% | 21.4% |
| E10000031 | Warwickshire | 11M | NHS Gloucestershire CCG | 0.2% | 0.2% |
| E10000031 | Warwickshire | 04G | NHS Nene CCG | 0.2% | 0.2% |
| E10000031 | Warwickshire | 10Q | NHS Oxfordshire CCG | 0.3% | 0.3% |
| E10000031 | Warwickshire | 05J | NHS Redditch and Bromsgrove CCG | 0.8% | 0.2% |
| E10000031 | Warwickshire | 05P | NHS Solihull CCG | 0.6% | 0.3% |
| E10000031 | Warwickshire | 05Q | NHS South East Staffs and Seisdon Peninsular CCG | 0.8% | 0.3% |
| E10000031 | Warwickshire | 05R | NHS South Warwickshire CCG | 96.1% | 45.6% |
| E10000031 | Warwickshire | 05H | NHS Warwickshire North CCG | 96.8% | 30.9% |
| E10000031 | Warwickshire | 04V | NHS West Leicestershire CCG | 0.5% | 0.3% |
| E06000037 | West Berkshire | 10M | NHS Newbury and District CCG | 93.1% | 66.2% |
| E06000037 | West Berkshire | 10N | NHS North & West Reading CCG | 35.7% | 23.7% |
| E06000037 | West Berkshire | 10J | NHS North Hampshire CCG | 0.7% | 0.9% |
| E06000037 | West Berkshire | 10Q | NHS Oxfordshire CCG | 0.2% | 1.1% |
| E06000037 | West Berkshire | 10W | NHS South Reading CCG | 9.1% | 7.6% |
| E06000037 | West Berkshire | 99N | NHS Wiltshire CCG | 0.1% | 0.4% |
| E06000037 | West Berkshire | 11D | NHS Wokingham CCG | 0.1% | 0.1% |
| E10000032 | West Sussex | 09D | NHS Brighton and Hove CCG | 1.2% | 0.4% |
| E10000032 | West Sussex | 09G | NHS Coastal West Sussex CCG | 99.5% | 57.7% |
| E10000032 | West Sussex | 09H | NHS Crawley CCG | 93.4% | 13.9% |
| E10000032 | West Sussex | 09L | NHS East Surrey CCG | 0.3% | 0.0% |
| E10000032 | West Sussex | 09N | NHS Guildford and Waverley CCG | 3.1% | 0.8% |
| E10000032 | West Sussex | 99K | NHS High Weald Lewes Havens CCG | 1.0% | 0.2% |
| E10000032 | West Sussex | 09X | NHS Horsham and Mid Sussex CCG | 95.6% | 25.8% |
| E10000032 | West Sussex | 10V | NHS South Eastern Hampshire CCG | 4.2% | 1.0% |
| E10000032 | West Sussex | 99H | NHS Surrey Downs CCG | 0.5% | 0.2% |
| E09000033 | Westminster | 07P | NHS Brent CCG | 1.3% | 2.0% |
| E09000033 | Westminster | 07R | NHS Camden CCG | 2.9% | 3.1% |
| E09000033 | Westminster | 09A | NHS Central London (Westminster) CCG | 81.6% | 71.1% |
| E09000033 | Westminster | 08C | NHS Hammersmith and Fulham CCG | 0.1% | 0.0% |
| E09000033 | Westminster | 08Y | NHS West London (K&C & QPP) CCG | 23.5% | 23.7% |
| E08000010 | Wigan | 00T | NHS Bolton CCG | 0.1% | 0.1% |
| E08000010 | Wigan | 01G | NHS Salford CCG | 1.1% | 0.8% |
| E08000010 | Wigan | 01X | NHS St Helens CCG | 3.9% | 2.3% |
| E08000010 | Wigan | 02E | NHS Warrington CCG | 0.4% | 0.2% |
| E08000010 | Wigan | 02G | NHS West Lancashire CCG | 2.7% | 0.9% |
| E08000010 | Wigan | 02H | NHS Wigan Borough CCG | 96.7% | 95.6% |
| E06000054 | Wiltshire | 11E | NHS Bath and North East Somerset CCG | 0.7% | 0.3% |
| E06000054 | Wiltshire | 11J | NHS Dorset CCG | 0.3% | 0.5% |
| E06000054 | Wiltshire | 11M | NHS Gloucestershire CCG | 0.4% | 0.6% |
| E06000054 | Wiltshire | 10M | NHS Newbury and District CCG | 0.9% | 0.2% |
| E06000054 | Wiltshire | 11X | NHS Somerset CCG | 0.3% | 0.4% |
| E06000054 | Wiltshire | 12A | NHS South Gloucestershire CCG | 0.9% | 0.5% |
| E06000054 | Wiltshire | 12D | NHS Swindon CCG | 1.0% | 0.5% |
| E06000054 | Wiltshire | 11A | NHS West Hampshire CCG | 0.1% | 0.1% |
| E06000054 | Wiltshire | 99N | NHS Wiltshire CCG | 96.7% | 97.0% |
| E06000040 | Windsor and Maidenhead | 10G | NHS Bracknell and Ascot CCG | 12.3% | 10.9% |
| E06000040 | Windsor and Maidenhead | 10H | NHS Chiltern CCG | 0.6% | 1.2% |
| E06000040 | Windsor and Maidenhead | 09Y | NHS North West Surrey CCG | 0.2% | 0.5% |
| E06000040 | Windsor and Maidenhead | 10Q | NHS Oxfordshire CCG | 0.0% | 0.2% |
| E06000040 | Windsor and Maidenhead | 10T | NHS Slough CCG | 0.6% | 0.5% |
| E06000040 | Windsor and Maidenhead | 10C | NHS Surrey Heath CCG | 0.1% | 0.0% |
| E06000040 | Windsor and Maidenhead | 11C | NHS Windsor, Ascot and Maidenhead CCG | 88.9% | 85.5% |
| E06000040 | Windsor and Maidenhead | 11D | NHS Wokingham CCG | 1.2% | 1.2% |
| E08000015 | Wirral | 02F | NHS West Cheshire CCG | 0.4% | 0.3% |
| E08000015 | Wirral | 12F | NHS Wirral CCG | 99.7% | 99.7% |
| E06000041 | Wokingham | 10G | NHS Bracknell and Ascot CCG | 3.2% | 2.7% |
| E06000041 | Wokingham | 10N | NHS North & West Reading CCG | 0.1% | 0.0% |
| E06000041 | Wokingham | 10Q | NHS Oxfordshire CCG | 0.1% | 0.5% |
| E06000041 | Wokingham | 10W | NHS South Reading CCG | 11.1% | 9.0% |
| E06000041 | Wokingham | 11D | NHS Wokingham CCG | 93.5% | 87.9% |
| E08000031 | Wolverhampton | 05C | NHS Dudley CCG | 1.4% | 1.7% |
| E08000031 | Wolverhampton | 05L | NHS Sandwell and West Birmingham CCG | 0.1% | 0.3% |
| E08000031 | Wolverhampton | 05Q | NHS South East Staffs and Seisdon Peninsular CCG | 1.7% | 1.4% |
| E08000031 | Wolverhampton | 05Y | NHS Walsall CCG | 3.9% | 4.0% |
| E08000031 | Wolverhampton | 06A | NHS Wolverhampton CCG | 93.7% | 92.7% |
| E10000034 | Worcestershire | 13P | NHS Birmingham Crosscity CCG | 0.5% | 0.6% |
| E10000034 | Worcestershire | 04X | NHS Birmingham South and Central CCG | 2.6% | 1.1% |
| E10000034 | Worcestershire | 05C | NHS Dudley CCG | 0.8% | 0.4% |
| E10000034 | Worcestershire | 11M | NHS Gloucestershire CCG | 0.5% | 0.6% |
| E10000034 | Worcestershire | 05F | NHS Herefordshire CCG | 1.0% | 0.3% |
| E10000034 | Worcestershire | 05J | NHS Redditch and Bromsgrove CCG | 95.9% | 27.9% |
| E10000034 | Worcestershire | 05N | NHS Shropshire CCG | 0.3% | 0.1% |
| E10000034 | Worcestershire | 05P | NHS Solihull CCG | 0.5% | 0.2% |
| E10000034 | Worcestershire | 05R | NHS South Warwickshire CCG | 2.3% | 1.1% |
| E10000034 | Worcestershire | 05T | NHS South Worcestershire CCG | 97.1% | 48.8% |
| E10000034 | Worcestershire | 06D | NHS Wyre Forest CCG | 98.5% | 18.8% |
| E06000014 | York | 03E | NHS Harrogate and Rural District CCG | 0.1% | 0.1% |
| E06000014 | York | 03Q | NHS Vale of York CCG | 60.4% | 99.9% |

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# Health and Wellbeing Board Performance Report

**Reporting Period**: April to December 2015

| Key: | ⇧ | Performance Improving compared to previous period |
|---|---|---|
| | ⇩ | Performance Deteriorating compared to previous period |

| HWB Priority | HWB Strategy Objective | Performance Indicator (Better Care Fund Indicator are in BOLD) | Year End Target 2015-16 | Benchmark | Provenance of Benchmark | Reporting Frequency | Period | Expected Performance this Period | Actual Performance this Period | RAG this Period | Direction of Performance (see key) | Expected Performance to Date | Actual Performance to Date | RAG to Date | Projected Year End Performance | Commentary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BCF | 5a | **Total non-elective admissions in to hospital (general & acute), all-age** | Q4<br>3,148 | 1,695 | Berkshire West CCG Average per 1,000 population.<br>Wok is 1,650 per 1,000 population | Quarterly | Quarter 3 | 2,977 | 2,879 | Green | ⇧ | 2,977 | 2,879 | Green | 3,148 | Mar 16<br>Updated to include January 2016, Q4 incomplete. 17% more activity compared to January 2015 - RBFT had a partial submission of non elective data in November which has yet to be corrected. |
| BCF | 5a | **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes** | 167<br>(619 per 100,000) | 588 per 10,000 population | National Data published by HSCIC for the Adult Social Care Outcomes Framework. 588 per 100,000 is the 2014/15 average for SE Region and 669 nationally | Monthly | Feb-16 | 14 | 2 | Green | ⇧ | 153 | 98 | Green | 107 | **March 16:** YTD Jan - 27 less permanent admissions compared to 2014-15 |
| BCF | 5a | **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** | 70%<br>(2013/4 outturn was 65.6%) | SE Region 80.1% in 2013/4 | SE Region 80.1%, English average 82.5% in 2013/4. Collected in the annual SALT return, published by HSCIC | Annual | January to March 15 | 70% | 77.9% | Green | ⇧ | 70% | 77.9% | Green | NA | From December 1st this has been recorded in FWi. The performance team has monitored the data quality and found issues which have been fed back to the team. NH to work with Ros Edwards to ensure this is captured accurately |
| BCF | 5a | **Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).** | 4,080 | 269 | NHS Statistics website: Monthly average for Berkshire Unitary Authorities for September 2015. (Monthly average for SE region 1,536) | Monthly | Jan-16 | 255 | 389 | Green | ⇩ | 3,400 | 3,350 | Green | 4,020 | **March 16**: January by sector: NHS 256, Social Care 59, Both 74, YTD 334, fewer days compared to 2014-15 |
| BCF | 5b | **Number of patients going through reablement** | 900 | 105 | National Data published by HSCIC for Short & Long Term Services 2014/15. Berkshire Unitary Authorities average figure for end of year snapshot for those receiving short term rehabilitation | Monthly | Feb-16 | 75 | 83 | Green | ⇩ | 825 | 908 | Green | 1,211 | Whilst START's capacity is below where it should be, START is actually delivering in excess of the block contract.<br>There is an on-going recruitment programme to build capacity. |
| BCF | 5b | **Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life?** | 87.2% | 89.1% | National data published by HSCIC of the Adult Social Care Survey 2014/15. South East Region average | Annual | 2014-15 | 87.2% | 89.0% | Green | ⇧ | 87.2% | 89.0% | Green | | Because of changes to the cohort and methodology it is not possible to make direct comparisons between data for 2014-15 and previous years. The survey for 2015/16 is underway and will be submitted by 11th May 2016 |
| | | **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.** | Not set | 64% | England | Annual | 2014-15 | 66% | Survey currently being undertaken | NA | NA | 66% | Survey currently being undertaken | NA | Not set | Data is based on collection during July-September 2014 and January-March 2015. Current performance is 66% which consists of fieldwork from January-March 2014 and July-September 2014. |
| | | Adult Social Care User Experience Survey: Question 2. Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole? | 89.9% | 92.4% | National data published by HSCIC of the Adult Social Care Survey 2014/15. South East Region average | Annual | 2014-15 | 88% | 91.5% | Green | ⇧ | 88% | 91.5% | Green | | This indicator is a percentage of all respondents to the survey who said their quality of life was 'So good, it could not be better', 'Very good', 'Good' or 'Alright'. The 2015/16 survey is in progress and is due to be submitted to HSCIC in May 2016. |
| | | Number of Adult Safeguarding Enquiries (previously called Referrals) | Not set | 257 Berkshire average for individuals | In 2013/4 the English average was 246 per 100,000 population) . Taken from the Annual Safeguarding Adults Return, published by HSCIC | Monthly | Feb-16 | 43 | 30 | NA | ⇧ | 473 | 506 | NA | 552 | This is an area of significant concern and impact nationally and is something we need to monitor closely as a Board. |
| CCG - Local quality priority | | Increase the number of referrals to the BHFT memory clinic | 612 | None | This is a local measure based on the capacity of the local service to see more patients | Quarterly | Quarter 2 | 153 | 129 | Red | ⇧ | 306 | 238 | Red | 476 | Local target, to support increase in diagnosis of Dementia - 10% increase of referrals.<br><br>Quarter 3 15-16 data is not yet available. |
| CCG - Local quality priority | | Dementia Diagnosis Rate: Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence | 67.0% | 66.7% | Based on the Prime Ministers Dementia Challenge | Annual | Dec-15 | 67.0% | 65.4% | Red | ⇧ | 67.0% | 65.4% | Red | NA | Figures relate to 14/15. methodology changed in 15/16. Expectation to achieve 67% for March 2016. Data will be published in October by National Team |
| CCG national quality priority | | IAPT Access: The proportion of people with depression /anxiety that have entered psychological therapies | 15.9% | 15.0% | Based upon National standard | Quarterly | Quarter 1 | 3.8% | 4.2% | Green | ⇩ | 3.8% | 4.2% | Green | 15.9% | Increased investment from the CCG to the IAPT service in 2014-15. Awaiting Q2 data. |
| CCG national quality priority | | IAPT recovery rate | 50% | 50.0% | Based upon National standard | Quarterly | Quarter 1 | 50% | 54% | Green | ⇩ | 50% | 54% | Green | 50% | Increased investment from the CCG to the IAPT service in 2014-15. |

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