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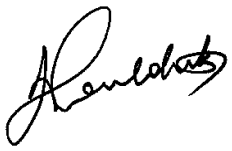
WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held at the Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 15 JUNE 2017** AT **5.00 PM**



Andy Couldrick
Chief Executive
Published on 7 June 2017

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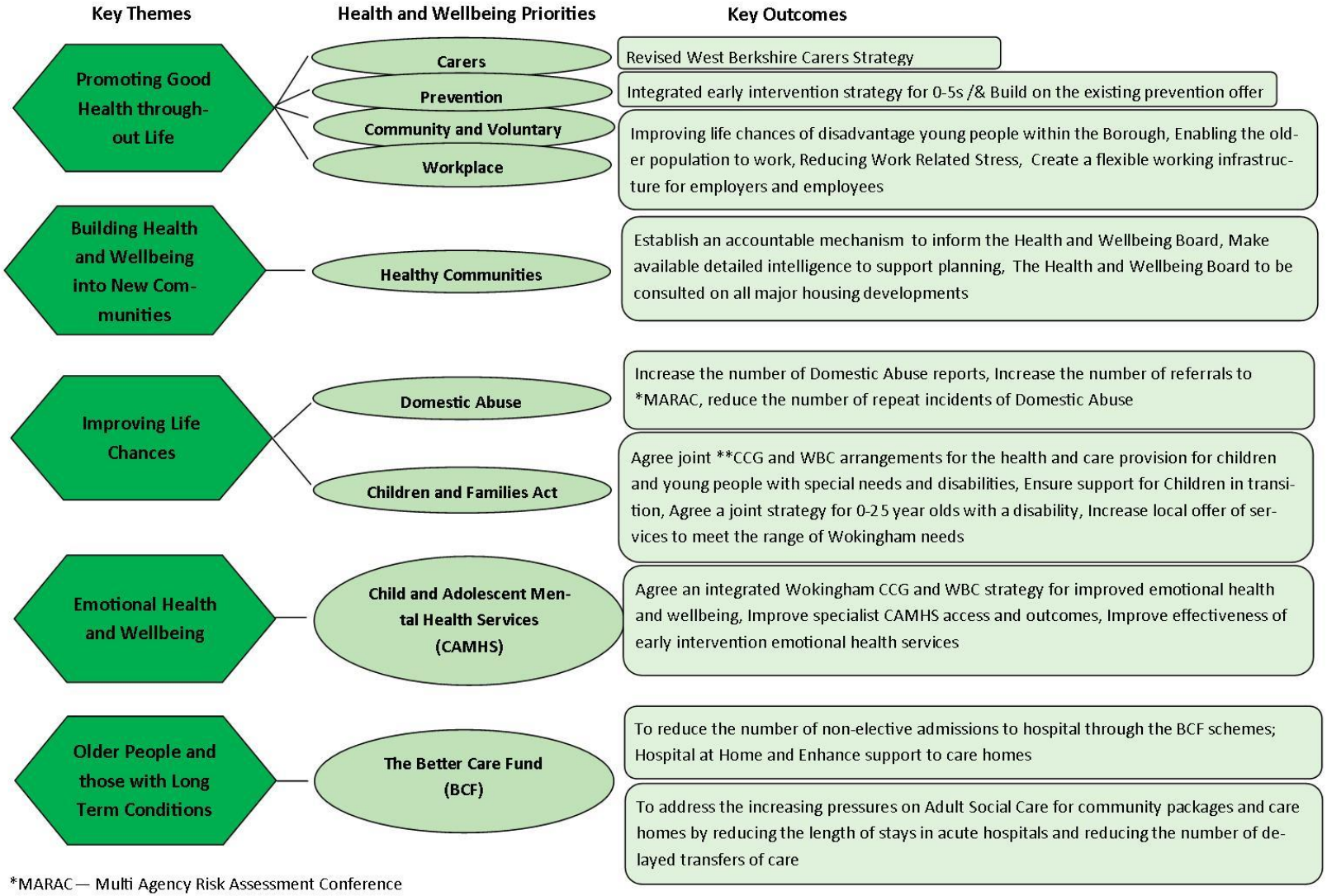
Wokingham's Health and Wellbeing Strategy 2014-2017



*MARAC— Multi Agency Risk Assessment Conference

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

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Mark Ashwell	WBC
Nick Campbell-White	Healthwatch
Superintendent Rob France	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Charlotte Haitham Taylor	WBC
Dr Lise Llewellyn	Director of Public Health
Nikki Luffingham	NHS England
Julian McGhee-Sumner	WBC
Ian Pittock	WBC
Judith Ramsden	Director of People Services
Clare Rebbeck	Voluntary Sector representative
Katie Summers	Director of Operations, Wokingham CCG
Kevin Ward	Place and Community Partnership Representative
Dr Cathy Winfield	NHS Wokingham CCG
Dr Johan Zylstra	NHS Wokingham CCG

1. None Specific

ELECTION OF CHAIRMAN
To elect a Chairman for the 2017/18 municipal year.

2. None Specific

APPOINTMENT OF VICE CHAIRMAN
To appoint a Vice Chairman for the 2017/18 municipal year.

3.

APOLOGIES
To receive any apologies for absence

4.

MINUTES OF PREVIOUS MEETING **7 - 14**
To confirm the Minutes of the Meeting held on 6 April 2017.

5.

DECLARATION OF INTEREST
To receive any declarations of interest

6.

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

7.		**MEMBER QUESTION TIME** To answer any member questions	
8.	None Specific	**HEALTH AND WELLBEING STRATEGY STRATEGIC DELIVERY PLAN** To consider the Health and Wellbeing Strategy Strategic Delivery Plan and KPI's within the Delivery Plan. *(30 mins)*	**To Follow**
9.	None Specific	**WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015-2016** To receive the West of Berkshire Safeguarding Adults Board Annual Report 2015-2016. *(15 mins)*	**15 - 22**
10.	None Specific	**UPDATE ON COMMUNITY NAVIGATORS/ CHASC** To receive an update on the Community Navigators/ CHASC. *(20 mins)*	**23 - 94**
11.	None Specific	**HEALTHWATCH WOKINGHAM BOROUGH - EXTRA CARE** To consider the report from Healthwatch Wokingham Borough on Extra Care. *(15 mins)*	**95 - 114**
12.	None Specific	**COMMUNITY SAFETY PARTNERSHIP STRATEGY** To receive an update regarding the Community Safety Partnership Strategy. *(15 mins)*	**Verbal Report**
13.	None Specific	**INDEPENDENT ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH** To receive the Independent Annual Report of the Director of Public Health. *(15 mins)*	**115 - 142**
14.	None Specific	**PHARMACEUTICAL NEEDS ASSESSMENT DELIVERY PLAN** To consider the Pharmaceutical Needs Assessment Delivery Plan. *(5 mins)*	**143 - 146**
15.	None Specific	**UPDATES FROM BOARD MEMBERS** To be updated on the work of the following Health and Wellbeing Board members: • Business, Skills and Enterprise Partnership • Community Safety Partnership • Place and Community Partnership • Healthwatch Wokingham Borough • Voluntary Sector *(15 mins)*	**147 - 148**
16.		**FORWARD PROGRAMME** To consider the Board's work programme for the remainder of the municipal year. *(5 mins)*	**149 - 152**

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

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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 6 APRIL 2017 FROM 5.00 PM TO 6.50 PM

Present

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Keith Baker	WBC
Prue Bray	WBC
Nick Campbell-White	Healthwatch
Charlotte Haitham Taylor	WBC
Superintendent Rob France	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Judith Ramsden	Director of People Services
Katie Summers	Director of Operations, Wokingham CCG
Dr Cathy Winfield	NHS Wokingham CCG

Also Present:

Madeleine Shopland	Principal Democratic Services Officer
Sonia Khoury	Public Health Project Officer
Julie Stevens	Better Care Fund Programme Manager
Carol-Anne Bidwell	Public Health Project Officer

61. APOLOGIES

Apologies for absence were submitted from Andy Couldrick, Darrell Gale, Dr Lise Llewellyn, Nikki Luffingham, Clare Rebbeck and Kevin Ward.

The Chairman commented that the Board's terms of reference stated that in order for a meeting of the Board to be quorate either the Chairman or Vice Chairman needed to be present. It was proposed that this be removed from the terms of reference. The Principal Democratic Services Officer was asked to provide wording which would clarify how a Chairman would be elected for a meeting should neither the Chairman nor Vice Chairman be present, and circulate it to the Board for agreement.

62. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Board held on 9 February 2017 were confirmed as a correct record and signed by the Chairman.

63. DECLARATION OF INTEREST

There were no declarations of interest made.

64. PUBLIC QUESTION TIME

There were no public questions.

65. MEMBER QUESTION TIME

There were no Member questions.

66. HEALTH AND WELLBEING STRATEGY

The Board received the Health and Wellbeing Strategy.

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

- A new Health and Wellbeing Strategy for the period 2017-2020 had been designed around four newly articulated priorities:
    - Enabling and empowering resilient communities;
    - Promoting and supporting good mental health;
    - Reducing health inequalities in our Borough;
    - Delivering person-centred integrated services.
- Judith Ramsden emphasised that the Strategy presented was high level and that a more detailed action plan to support it would be developed. The Consultant in Public Health would be setting up meetings in order to discuss and produce this action plan. This would be presented to the Board at its meeting in June.
- Dr Zylstra commented that Health and Wellbeing Board agendas currently included a summary of the Health and Wellbeing Strategy 2014-17. He questioned whether this would also be updated. Judith Ramsden indicated that this would be undertaken as part of the refresh. The Health and Wellbeing dashboard would also be reviewed in order to ensure a coherent approach was being taken.
- Councillor Bray commented that the Strategy included a number of acronyms and proposed that a glossary explaining the terms be included as an appendix to the Strategy.
- Katie Summers questioned whether engagement would take place with residents. Judith Ramsden commented that this would sit behind the Strategy and that there would be opportunities for conversations as to whether the Strategy priorities resonated.
- Nick Campbell-White indicated that Healthwatch Wokingham Borough had a number of champions who could be used as sounding boards.

RESOLVED: That the Health and Wellbeing Strategy priorities be approved and recommended to Council.

67. BERKSHIRE SUICIDE PREVENTION STRATEGY AND WOKINGHAM SUICIDE PREVENTION ACTION PLAN

Carol-Anne Bidwell, Public Health Project Officer, presented the Berkshire Suicide Prevention Strategy and Wokingham Suicide Prevention Action Plan.

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

- The Berkshire councils had not published a suicide prevention action plan at the time of the 2015 all Party Parliamentary Group inquiry into local suicide prevention plans in England. Action plans had been a recommendation of the suicide prevention strategy published in 2012. Since 2015, a high-level multi-agency Berkshire steering group had met to plan a local audit of suicides and to work on a strategy and action plans for the councils.
- The Strategy was being presented to all of the Berkshire Health and Wellbeing Board for endorsement.
- The Strategy set out a target of reducing suicide by at least 25% from 2014 levels, by 2020. Royal Berkshire NHS Foundation Trust and Berkshire NHS Foundation Trust had a zero suicide ambition. West Berkshire Council had also indicated that they wished to have a zero suicide target.
- The Board supported the target of a 25% reduction rate in suicides and the aspiration to go beyond this.
- There had been an increase in the number of suicides across Berkshire as a whole.

- For the year to date there had been 3 recorded suicides, although this number may increase. There had been no child suicides for Berkshire.
- The Strategy detailed ways in which access to suicide could be reduced and removed.
- Councillor Bray questioned the inclusion of the wording 'We recognise that a Berkshire without suicide is the true aim we work towards' within the Strategy.
- Carol-Anne Bidwell took the Board through the Wokingham Action Plan. Councillor Haitham Taylor suggested that reference be made to the possible impact of social media and cyber bullying and also post-natal depression. Superintendent Rob France suggested that reference be made to those accused of child sex offences. Carol-Anne Bidwell stated that the Wokingham Action Plan was high level but that these could be referenced.
- The Board questioned who the champion for Wokingham would be and was informed that it would be Darrell Gale, Consultant in Public Health.
- It was hoped that the Strategy would be launched at a multi-agency suicide prevention summit in October 2017 or by Suicide Awareness Day in September 2017.
- The Berkshire wide suicide audit would be refreshed and reported on.

RESOLVED: That

1) the strategy be noted and endorsed.
2) the action plan for Wokingham Borough contained within the strategy be agreed.

68. BETTER CARE FUND BRIEFING FROM THE BETTER CARE FUND - QUARTER 3

The Board received a Better Care Fund Briefing from the Better Care Fund – Quarter 3.

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

- Non electives (NELs) in the third quarter had performed 0.4% better than planned. It was noted that the Nurse led Rapid Response Service had commenced in September 2016 and that this had supported the strong performance in NEL avoidance.
- Permanent placements in residential care had fallen by 25 placements compared with the figures for April 2016.
- Cumulative Delayed Transfers of Care (DTOC) had saved more nights than the 130 nights planned.
- Due to there not being access to sufficient nursing staff and facilities, the Step Up scheme had not contributed as had been expected to the NEL avoidance. Plans were being considered for six Step Up beds at Wokingham Hospital, which would ensure that the right support could be offered for a Step Up service. The Chairman questioned whether people were asked if they felt that reablement was a better outcome than being admitted to the Royal Berkshire Hospital.
- The Board was advised that reablement had underspent as a result of recruitment issues in Optalis START. As a result the Council's homecare spend was forecast to overspend. Some of this underspend had been returned to the Council to offset the homecare spend.
- Councillor Bray asked whether recruitment problems were ongoing and what was being done to resolve this issue. Judith Ramsden commented that a new manager was in place and that she was confident that improvements would be seen.

- The Night Responder scheme was not delivering as anticipated as the number of customers accessing the service had been low. In addition some access was not considered appropriate.
- The Step Down scheme was under review as it had not delivered above an average of 58% of the capacity. Katie Summers commented that there were a number of patients who had used the facility longer than anticipated which had had an impact on the functionality of the facility. There was currently no charge for reablement.
- The Community Health and Social Care programme (CHASC) was moving forward and the PID would be brought to the Health and Wellbeing Board for approval. The Community Navigator programme was in the final stages of development.
- In response to a question from Nick Campbell-White as to when the Community Navigators would be rolled out to all GP practices, Katie Summers commented that they had been piloted in several practices to varying success. They had been particularly successful at Wargrave Surgery and also worked well with the Community Nurses in Berkshire Healthcare NHS Foundation Trust. However, they would not be rolled out to all practices until learning points from the pilot had been incorporated.
- Nick Campbell-White commented that Healthwatch had received comments regarding some Community Navigators, such as they were not available when patients wished to access them. Katie Summers indicated that these comments should be fed back to Involve. Involve had had some issues regarding the recruitment of volunteers but two new volunteers were due to start shortly.
- The Board requested information on where the Community Navigators were operating and where they were working well.
- Councillor Haitham Taylor questioned whether all the Step Up funding had been used. Julie Stevens, Better Care Fund Programme Manager stated that it had been a block contract and that rent had been payable regardless of the take up of the facility.
- Judith Ramsden reminded the Board that many of the schemes had been pilot schemes and that whilst some would be successful some would be less so.
- Wokingham was still performing well against its plan.

RESOLVED: That the report be noted.

69. BETTER CARE FUND ANNUAL RETURN TO DEPARTMENT OF HEALTH 2016/17

The Board considered the Better Care Fund Annual Return to the Department of Health 2016/17.

An annual return was required for the Better Care Fund Programme in order to provide a high level overview of performance against the budget of the Better Care Fund for 2015/16 in accordance with the Section 75 agreement. However, the Department of Health timetable for the returns did not fit with Wokingham Health and Wellbeing Board meeting dates. It was therefore proposed that the Chairman of the Health and Wellbeing Board sign off the annual return on behalf of the Board.

RESOLVED: That the sign off of the Better Care Fund Annual Return to the Department of Health 2016/17, be delegated to the Chairman of the Health and Wellbeing Board following consultation with the Director of People Services, in order to meet the date of the annual plan return within the timescales set by the NHS.

70. UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN

Dr Winfield updated the Board on the Sustainability and Transformation Plan.

The Board was informed that the Berkshire West system had been identified as one of nine systems in the country to be Accountable Care Systems (ACS). The ACS was comprised of the four Berkshire West CCGs, Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust. There was an ambition also to eventually involve social care across Berkshire West. Wokingham Borough Council had been invited to participate in the ACS and the Chief Executive was part of the ACS Leadership Group. The purpose of the ACS was to bring together the relevant partners to apply a single capitated budget to meet the health and care needs of the local population.

RESOLVED: That the update on the Sustainability and Transformation Plan be noted.

71. UPDATES FROM BOARD MEMBERS

The Board was updated on the work of the following partnership Board members:

Business, Skills and Enterprise Partnership:

- With regards to the targets from the Elevate City Deal, there would be differences to the way the service would be delivered in future.
- Work was being undertaken with regards to promoting apprenticeship starts particularly in Science, Technology, Engineering and Maths.
- Funding had been received from the European Social Fund for targeted activities for those aged 15 and over.
- In response to a question from Dr Zylstra regarding the apprenticeship levy, Beverley Graves commented that Thames Valley Berkshire Local Enterprise Partnership (LEP) had surveyed local companies on the apprenticeship levy. There had been significant interest in taking on apprentices; however, there was still much to be done around perceived 'red tape.'
- Beverley Graves commented that there was still a lack of understanding regarding apprenticeships and what they could offer.
- Councillor Bray noted that the levels of unemployment in the over 50's appeared to be increasing, and questioned why that was. Beverley Graves indicated that she was unaware of a particular reason for this.
- Board members asked about Elevate funding. Judith Ramsden indicated that the Council had applied for additional funding from the EU.
- Katie Summers asked if apprenticeship opportunities in health and social care were being promoted.
- Board members were informed of the Worlds of Opportunity initiative.

Community Safety Partnership:

- The Community Safety Strategy had been refreshed. It was requested that this be brought to the next Board meeting.

Healthwatch Wokingham Borough:

- Healthwatch Wokingham Borough's report on extra care had been completed and comments were awaited from the commissioners and suppliers. Healthwatch had visited four extra care facilities and interviewed a number of people. There was still a lot of confusion around what extra care was.

- The Healthwatch Wokingham Borough quarterly report had been streamlined.
- Healthwatch Wokingham Borough had launched a new website – Youthwatch, about young people's concerns. Board members were encouraged to look at the website.
- Four more reports had been produced by small groups that Healthwatch had provided funding to, to help get their messages out.
- There had been a number of enquiries relating to Wokingham Medical Centre during the quarter and Healthwatch Wokingham Borough would be meeting with the Practice Manager. Dr Zylstra asked whether these enquiries related to clinical competence and was informed that they did not and that they related largely to people not being able to get an appointment. Katie Summers asked that Healthwatch Wokingham Borough share the outcomes of the conversations with the CCG.
- Nick Campbell-White informed the Board that Healthwatch Wokingham Borough was currently producing its annual report and a list of projects that would be undertaken in the new financial year.
- Two Enter and Views were due to take place, including a joint visit with Reading Healthwatch.

RESOLVED: That the updates from Board members be noted.

72. HEALTH AND WELLBEING DASHBOARD

The Board received the Health and Wellbeing dashboard.

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

- The Board discussed the indicator relating to the number of affordable dwellings completed. Councillor McGhee-Sumner commented that one development had been delayed due to poor weather.
- Board members questioned if the Narrowing the Gap indicator needed to be monitored by the Board. Judith Ramsden indicated that the dashboard and its key performance indicators would be reviewed in light of the new Health and Wellbeing Strategy and supporting action plan. It was agreed that there was a need for a more outcomes based approach.
- The Board discussed recruitment and retention at the Royal Berkshire Hospital and Berkshire Healthcare NHS Foundation Trust and General Practice Workforce vacancy rate for General Practitioners. Dr Zylstra commented that there had been no take up locally of the NHS England scheme to recruit foreign doctors.
- Dr Winfield suggested that the Board needed to focus in particular on the outcomes and whether these were being met.
- Councillor Bray emphasised that the Health Overview and Scrutiny Committee should hold organisations to account.
- Nick Campbell-White commented that it would be helpful to receive further information on CAMHS waiting times. Judith Ramsden emphasised that there had been real improvements made.
- Dr Zylstra suggested that the Tier 2 CAMHS wait time indicator be divided into those who were waiting for ADHD and ASD pathways and those who were not. Those on the ADHD and ASD pathways tended to wait longer.
- With regards to accountability Dr Zylstra emphasised that the Board, in addition to monitoring what had already occurred, needed to look forwards.

- Judith Ramsden commented that updated priorities would be produced for the next Board meeting.
- It was noted that it was Sonia Khoury's last Health and Wellbeing Board meeting. Board members thanked her for her involvement with the Board.

RESOLVED: That the Health and Wellbeing dashboard be noted.

73. FORWARD PROGRAMME

The Board discussed the forward programme for the forthcoming municipal year.

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

- Judith Ramsden asked that the following be added to the agenda for the June meeting:
    - Local Account 2016/17;
    - Healthwatch Annual Report;
    - Update on the Community Navigator Scheme;
    - Community Safety Partnership Strategy.

RESOLVED: That the forward programme be noted.

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West of Berkshire Safeguarding Adults Board

Annual Report 2015-16

If you would like this document in a different format or require any of the appendices as a word document, contact natalie.madden@reading.gov.uk

West of Berkshire Safeguarding Adults Board **Annual Report 2015-16**

1. Message from the Independent Chair

I have welcomed the opportunity to take over as interim Independent Chair for the Board and have enjoyed working across three Councils and partner organisations to ensure that safeguarding adults is embedded across the West of Berkshire. I have been impressed by the excellent attendance of Partners and the full participation at Board meetings. The agenda items have been varied and challenging, including learning from Safeguarding Adults Reviews and ensuring that such learning is embedded into practice and not "one off events," as well as taking a more thematic approach to Board agendas to reflect the four strategic priorities that underpin the work of the Board.

The Board is very mindful that all efforts going into making adults safe need to reflect on the experience of adults who may be subject of a safeguarding enquiry. Making Safeguarding Personal, an initiative led by the Directors of Adults Social Services, has proven to be a helpful reminder to us all to take stock of all documents, literature and services available to the public to highlight the importance of adult safeguarding and where to go to seek further information.

Closer links with the Local Safeguarding Children's Boards remain a priority, recognising that adult safeguarding will often involve working with families and we need to ensure that, given the challenges all organisations face in respect of finance, we learn from each other, share good practice and avoid duplication.

The Board is working well but we are not complacent and know there is much more to do. We have streamlined the Annual Report in an attempt to explain more simply what the Board has been set up to achieve as well as progress made over the last year. I would welcome your views as to whether we have managed to achieve this aim. The Partner organisations will be seeking to appoint a permanent Chair over the forthcoming year and I welcome the opportunity to work with the new Chair to ensure that a smooth and effective handover of responsibilities takes place.

I would like to extend my thanks to all Partners who have attended Board meetings and have invested time, energy, and professional commitment to adult safeguarding across the West of Berkshire and look forward to a continued excellent working relationship.

Brian M Walsh

Interim Independent Chair West of Berkshire Safeguarding Adults Board

1. Our vision for safeguarding adults

People are able to live independently and are able to manage risks and protect themselves; they are treated with dignity and respect and are properly supported when they need protection.

2. Who we are

The West of Berkshire Safeguarding Adults Board covers the Local Authority areas of Reading, West Berkshire and Wokingham. The Board is made up of local organisations which work together to protect adults at risk of abuse or neglect. From April 2015 mandatory partners on the Board are the Local Authority, Clinical Commissioning Groups and Police. Other organisations are represented on the Board, such has health, fire and rescue, ambulance service, HealthWatch, probation and the voluntary sector.

A full list of Partners is given in Appendix A.

3. Who we help

Any person 18 or over at risk of abuse or neglect because of their needs for care and support and as a result of those care and support needs is unable to protect themselves.

4. What we do

Safeguarding means looking out for and trying to protect others in our community who are vulnerable, or may be at risk of harm. We work together to ensure there are systems in place to keep vulnerable people in the West of Berkshire safe; we hold partner agencies to account to ensure they are safeguarding vulnerable people; we work to ensure agencies and organisations are focused on outcomes, performance, learning and engagement. There are many different forms of abuse:

Physical
Domestic
Sexual
Psychological
Financial / material
Modern slavery
Discriminatory
Organisational
Neglect or acts of omission
Self-neglect

For more information, go to the Board's website: http://www.sabberkshirewest.co.uk/
or click on the links: What is abuse? Signs of abuse Concerned about an adult?

How to get help and advice:

In an emergency situation call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101.

If you are concerned about yourself or another adult who may be being abused or neglected, contact Adult Social Care in the area in which the person lives, on the numbers below:

Reading 0118 937 3747

West Berkshire 01635 519056

Wokingham 0118 974 6800

Out of normal working hours, contact the Emergency Duty Team 01344 786 543

5. Trends across the area

The number of safeguarding concerns continues to increase year on year.

Over half the concerns are raised by social care and health staff.

As in previous years, the majority of enquiries relate to older people over 65 years.

More women were the subject of a safeguarding enquiry than males, as in previous years,

Individuals with a White ethnicity are more likely to be referred to safeguarding and the proportion is higher than for the whole population.

The most common types of abuse were for Neglect and Acts of Omission followed by Physical Abuse and Psychological Abuse.

For the majority of cases the primary support reason was physical support.

The most common locations where the alleged abuse took place were a person's own home and a care home.

The majority of concluded enquiries involved a source of risk known to the individual in Reading and West Berkshire but the source of risk in Wokingham was social care support.

Further details are presented in the Safeguarding Performance Annual Reports by partner agencies, Appendix E.

6. How we have made a difference by working together

The *Berkshire Multi-Agency Safeguarding Adults Policy and Procedures 2016* were launched and support staff to respond appropriately to all concerns of abuse or neglect they may encounter, providing a consistent response across the county.

The annual joint conference was held on 9 October 2015, based on the theme of *Challenging Cultural Assumptions in Safeguarding*. Topics included: cultural sensitivity in safeguarding, radicalisation, forced marriage, working with interpreters, witchcraft and possession, supporting traveller communities, anti-trafficking, and providing culturally sensitive care.

Stronger links between health, adult safeguarding teams and local authority Care Governance teams has enabled the timely access to information and expertise, such as the Berkshire West Federation of CCGs pharmacy and infection control involvement in section 42 enquires.

Partnership working through the Integrated Care Home Project Board promotes integration in the commissioning of care homes, best practice and the recognition of patients' rights, choices, needs and safety.

A joint health and social care conference, *Embedding the MCA in Practice*, was held in September 2015; positive feedback included carers' perspectives and evidenced direct impact on front line practice.

A joint Training in Practice (TIPS) event for primary care included LA and voluntary sector representatives as speakers or stall holders.

Peer review of safeguarding services in local authorities, to which all partner agencies contributed.

Development of a Care Governance Framework to promote Care Act accountabilities and joint responses to organisational safeguarding concerns. Health agencies supported LAs and CCGs with the management of concerns in care homes.

Raising awareness of adult safeguarding by community groups and people who use services by means of *experts by experience* delivering talks and designing easy read literature.

Engagement in the development of female genital mutilation (FGM) multiagency protocol and pathway; raised awareness of FGM through a new RBH intranet webpage; an RBH midwife who had undergone FGM supports victims.

Through the Independent Trauma Adviser Steering Group, partners work with Rahab to support victims of modern day slavery, particularly in relation to Brothel warrants. This gives specialist support to the victims who are potentially trafficked, and support officers with addressing the welfare needs.

Partnership working between Police and Mental Health Nurse in response to mental health calls has led to a reduction in detentions and provision of more appropriate mental health support for the individual.

Multi-agency partnerships (Sex Workers Action Group and Street Population) identify health, housing and financial support to meet the needs of vulnerable people.

World Cafe Planning with partners to obtain community views and ideas in relation to vulnerable and exploited individuals.

Joined Up Front Line Action (JUFA) initiated in March 2016 and piloted in Whitley, is a partnership between Police, Fire Service, Health, Voluntary Sector agencies and others to make better use of visits by professionals. Other partners are informed of an individual's needs, for example a Police visit may identify the need for a smoke alarm.

Problems in Practice meetings are held monthly to discuss issues in relation to partnership working across health, mental health and the Police. Discussions enhance knowledge of other organisations' processes and procedures and allow a platform to improve practice.

How we have embedded Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. Locally, steps have been taken to develop person centred, outcome-focused practice, including:

- Partners implemented a standard audit template reflective of MSP requirements, with an aim to provide consistent measures of safeguarding quality assurance reporting to the Board.
- Promotion of MSP in safeguarding training; training has been reviewed to ensure that obtaining consent and desired outcome is central to safeguarding practice; joint commissioning of specific MSP training for frontline workers and managers.
- Safeguarding newsletters promoted MSP and the importance of asking service users what their desired outcomes are.
- Computer systems, templates and practice guidance for staff and service users have been amended to reflect MSP; safeguarding forms have a requirement to include service users' desired outcomes and whether they were achieved.
- Quality Assurance measures incorporate MSP.
- MSP is promoted through coaching and conversations with the workforce and wider stakeholders.
- Incident reporting processes have been refocused to give prominence to the adult's voice.

Case study 1: The Involvement of the individual at a safeguarding meeting with her family and staff from the police, mental health, social care, her GP

and an external provider was a positive way of getting everyone to appreciate each other's involvement and identify a plan to support the individual. The meeting provided a forum for open discussion and prevented any miscommunication between both professionals and the services user. Early multi–agency planning and discussion between the safeguarding leads from both health and adult social care provided the leadership and direction to move the case forward.

Case study 2: Multi-agency approach to a significant safeguarding situation led to client being supported to continue leisure pursuits that had previously been a source of high risk.

Further achievements by partner agencies are presented in Appendix B.

7. Safeguarding Adults Reviews

The Board has a legal duty to carry out a Safeguarding Adults Review when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died and abuse or neglect is suspected to be a factor in their death. The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The West of Berkshire Safeguarding Adults Board has a Safeguarding Adults Review Panel that oversees this work.

During the reporting year, the Board commissioned two Safeguarding Adults Reviews both of which involved practitioners. We cannot publish information about one of the cases as there is a criminal investigation underway. An executive summary about the second case and the full report can be found on the Board's website at http://www.sabberkshirewest.co.uk/board-members/safeguarding-adults-reviews/

8. Key priorities for next year

Develop our oversight of the quality of safeguarding performance through the Board's Quality Assurance Framework and the annual self-assessment audit completed by partner agencies.

Develop a Performance and Quality Assurance framework to support and promote Making Safeguarding Personal.

Promote the new Berkshire Multi-agency Safeguarding Adults Policy and Procedures, ensuring agencies are compliant through case audits and multi-agency thematic reviews.

Continue to learn from Serious Adults reviews and embed lessons learnt across all organisations which can be monitored and reviewed at regular intervals.

Raise awareness of the Board's function and of local safeguarding processes.

Continue to ensure staff receive an appropriate level of safeguarding adults training.

Develop mechanisms to measure outcomes for individuals who have been through the safeguarding process and ensure service user feedback is collected and understood.

Ensure person centred responses are promoted through the involvement of advocates and Independent Mental Capacity Assessors.

Ensure successful recruitment to permanent Chair and effective handover of responsibilities.

Continue closer working with three Local Children's Safeguarding Boards to identify joint priorities, learning and effective communication.

Review the infrastructure that supports the Board, streamline subgroups where possible to avoid duplication and utilise more effectively the use of Partners' time.

Learn from other Safeguarding Adults Boards and share, more widely, examples of good practice from the West of Berkshire Board on a local, regional and national level.

Appendices

Appendix A Board member organisations

Appendix B Achievements by partner agencies

Appendix C Completed Business Plan 2015-16

Appendix D Business Plan 2016-17.

Appendix E Safeguarding Performance Annual Reports from partners agencies:

Berkshire Healthcare Foundation Trust,
Reading Borough Council,
Royal Berkshire Foundation Trust,
West Berkshire Council,
Wokingham Borough Council

Appendix F Training activity

Community Navigator Service (CNS)
Year 1
April 2016- March 2017

16th May 2017

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service

Helping you find support in your community

Aim/Purpose of CNS

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

To promote and improve access to local voluntary and community resources by providing targeted, up to date information to service users and their families, and support local people to self-care and maximise their wellbeing.

Benefits

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

GP Practice	Patients
Reduction in appointments	Improved wellbeing
More appropriate use of time	Improved mental & physical health
Decrease in demand	Healthier lifestyles
Simple system	Empowerment
Enhanced Partnerships	Builds self confidence

How navigators operate

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

- Service is run by Involve
- Navigators are volunteers who are managed by a co-ordinator
- As of the 1st April 2017:
  - 7 active volunteers (2 are office based)
  - 2 new volunteers to come on line in April
  - 4 interviews in April

Very helpful indeed. However, family issues have delayed my being able to action information at the moment. Just talking with Navigator helped a great deal. Thank you

Client stated her situation has improved enormously since seeing Navigator. Client is now extremely happy and has arranged a move to new sheltered accommodation. Very positive response about the service. Reports that she is so much better now than before

How navigators operate

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service

Helping you find support in your community

COMMUNITY NAVIGATORS PRESCRIPTION

Please contact **Community Navigators** and tell them you have discussed the following problems with your GP or Health/Social Care practitioner:

- Physical Health ☐
- Mental Health ☐
- Emotional ☐
- Independence ☐
- Self-help ☐
- Social Care ☐
- Carer support ☐
- Loneliness ☐
- Safety ☐
- Housing ☐
- Financial ☐
- Legal ☐
- Other (please specify) ☐

HELP IS AVAILABLE!
PLEASE FOLLOW THE INSTRUCTIONS OVERLEAF.

FUNDED BY AND WORKING IN PARTNERSHIP WITH

Wokingham Borough Council · involve · NHS Wokingham Clinical Commissioning Group

Community Navigator Service is co-ordinated by Involve.
Involve Community Services is a registered charity (1061373) and company limited by guarantee (3332555)

- Following a referral to the scheme, which could be made by the person, a family member or friend or a professional, an appointment with a Volunteer Community Navigator will be made.
- Trained volunteer Community Navigators will meet the person within their GP surgery (or possibly another community venue) to identify their community support needs.
- The Community Navigator will explore local charities, community groups and services that may be of interest or benefit and will give all relevant information and details to make contact. They will signpost the person to appropriate sources of social support and other non-medical services within their community.
- The person will receive a follow up call or communication 4-6 weeks after their appointment to find out how they got on, what difference has been made and whether any further assistance is required.

Navigator Locations

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

Live

Wargrave, Wokingham Medical Centre, Swallowfield, Brookside and Woodley Centre

Used a decorator from buy with confidence and is very pleased with results

Planned

May 2017 – New Wokingham Road

July 2017 - Woosehill Finchampstead and Parkside

October 2017 - Burma Hills, Loddon Vale, Twyford and Wilderness Road

Services in Wokingham supported

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

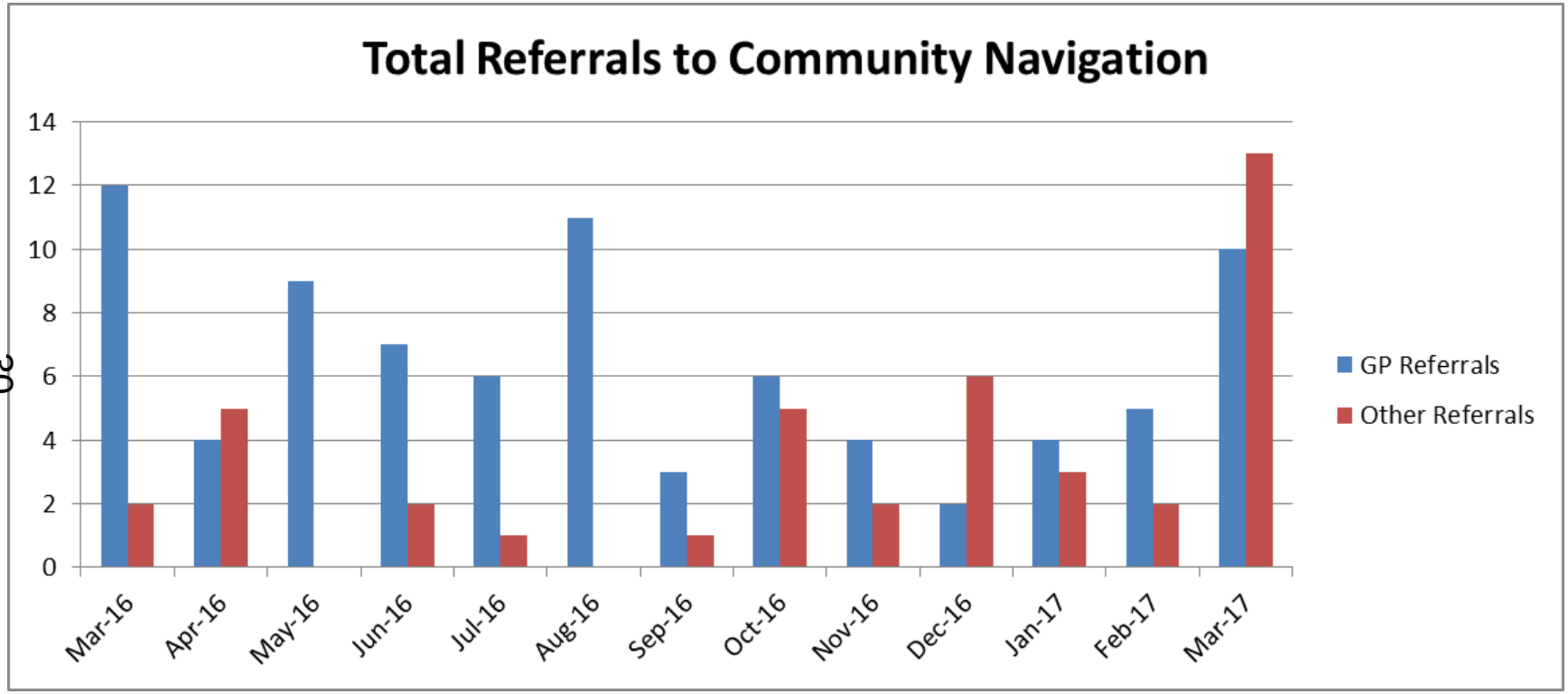
- GP Practices
- Community Nurses
- Social care – WBC & Optalis
- RBFT
- Health & Social Care Hub
- WISH

- All BHFT Specialist Services e.g. IAPT, CBNRT, Continence
- SCAS
- Police
- Fire Service

Fantastic service from Navigator, lovely guy he encouraged me to try to find information on my own. Opened my eyes to what's available

Residents accessing Navigation

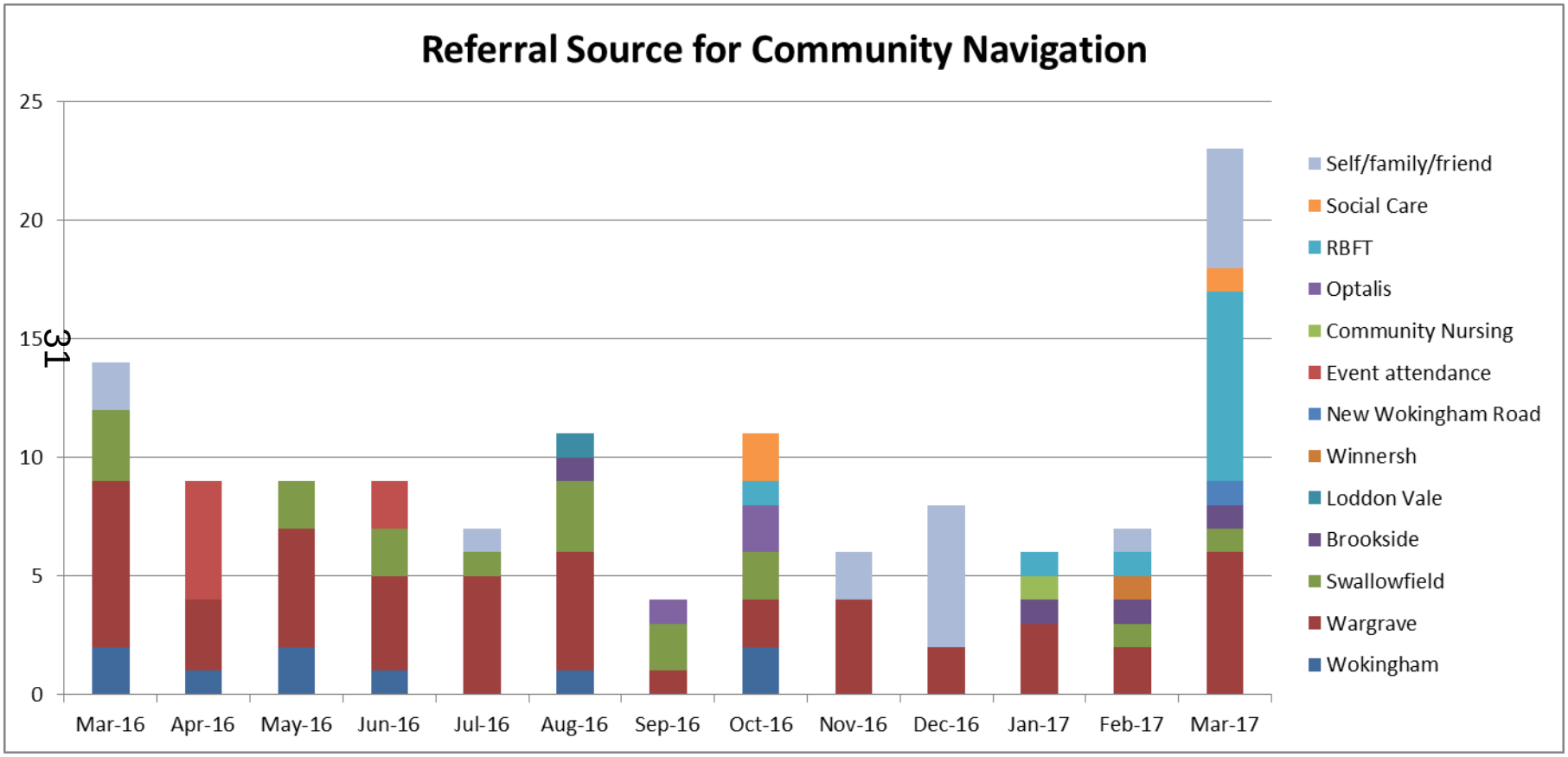
COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community



Total referrals for 2016/17 = 126

Residents accessing Navigation

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community



Financials 16/17

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

Budget 2016/17	Actual 2016/17	Variance
£47,386	£26,907	£20,479

The costs of the service include:

- Navigator Co-ordinator (25hrs per week)
- Navigator Training
- Navigator travel costs
- Marketing design and printing

The underspend in 16/17 was due to an additional navigator co-ordinator post being budgeted for the last 2 quarters of 16/17

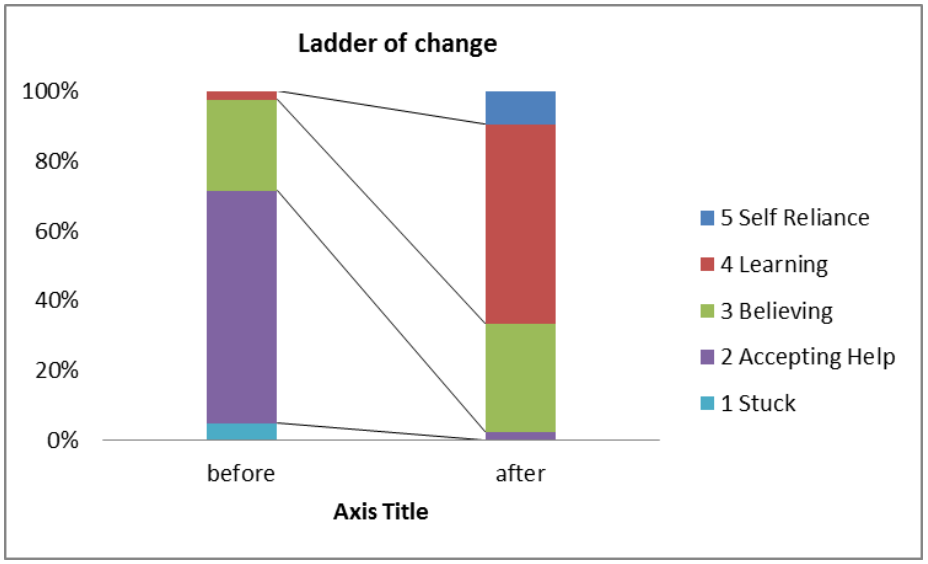
Services Referred To

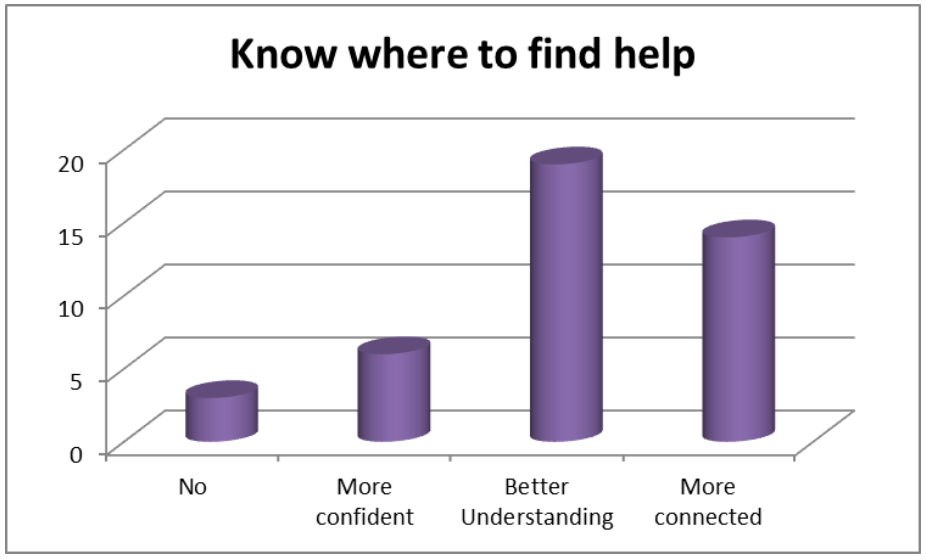
COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

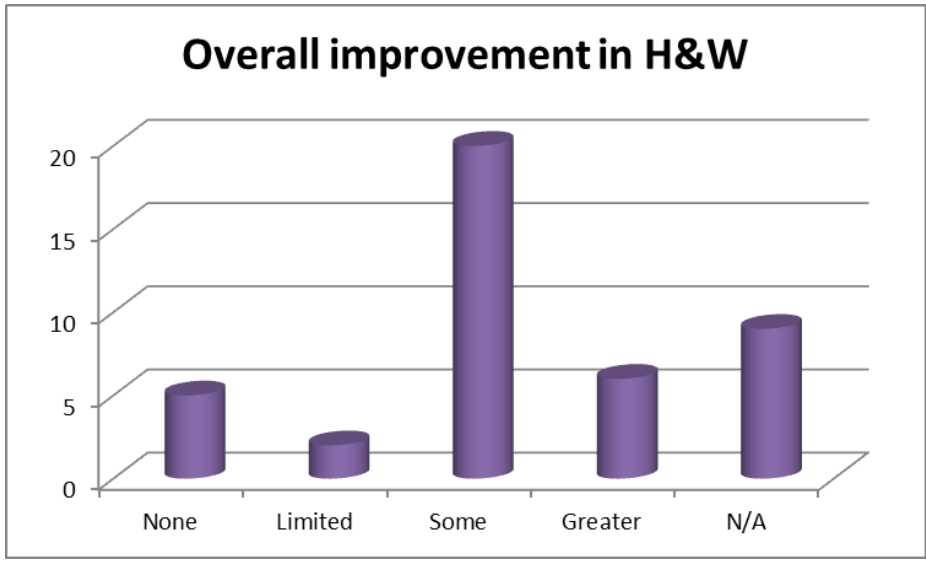
Muscular Dystrophy UK	Sportsable.co.uk	ABLEize Disability and Mobility Directory
East Berks Ramblers	Oakwood Centre	Reading Cycle Club
Cruse Bereavement	Sonning Club	Sonning Art Club
Wokingham Walks	California Park	Pure Gym
Number One Club	MENCAP	Cruse Bereavement
Support With Confidence	SCIP West Berks	Paying For Care
Chiropody Age UK	Cruse Bereavement	Linking Scheme
Cruse Bereavement	ARC Counselling Wokingham	Reading Rockets Basketball Loddon Valley Centre For Son
Optalis	Link Visiting Scheme	Adult Social Care
CAB Crowthorne	wbda.org	St Thomas 50+ Forum
Age UK	Wargrave Pop In Clubs	

Service User Reported Outcomes (1)

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

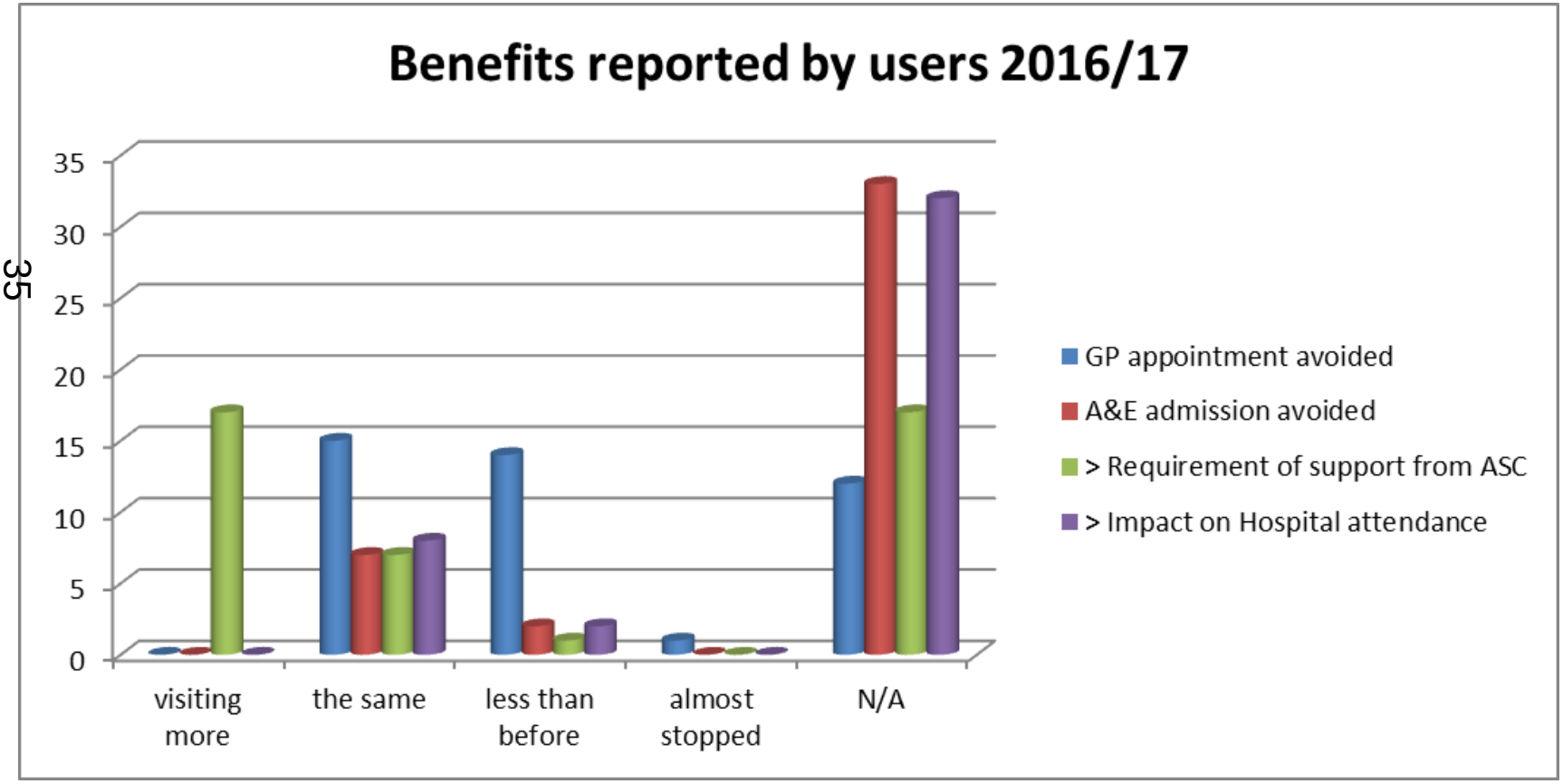






Service User Reported Outcomes (2)

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community



Case Studies

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service

Helping you find support in your community

Mrs Jones has been struggling with caring for her husband. Following referral to the Community Navigator they assisted Mrs Jones locating various support groups. Mrs Jones was given details about Respite care, Age Concern and a Day Centre that her husband now attends

Mrs Shell visited her GP about her mother who has memory issues. Community Navigator was able to find information about support groups for her mother and respite care

Mr Plain referred to Community Navigator with worries about finances. Community Navigator put Mr P in touch with Front line debt advice that helped him with his finances

Mr Ken visited his GP about his Macular degeneration and asked about transport to get to Hospital appointments. Referred to Community Navigator who found out about Transport scheme and Macular support group in Wokingham

Service User Feedback

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

Navigator was extremely helpful in assisting with the form filling and gave me a greater understanding of how I need to explain my challenges. I have since been able to assist my mother with attendance allowance claim which was successful

Timothy's father felt the CN intervention was very positive but no new information identified. However, would definitely contact CN in future if required

Thank you for all of the information and for taking the time to meet me and my mother. I haven't had the chance yet but will call the contacts you gave for further information. Many thanks for your help

GP Feedback

COMMUNITY NAVIGATORS | Wokingham Borough Community Navigator Service
Helping you find support in your community

GP at Wargrave Surgery

“We have found the CN scheme to be of great help. Patients, especially elderly patients, often suffer from social problems, loneliness, difficulty accessing services, and confusion about available sources of support.

The CNs have the time and resources to address these problems, which unfortunately often end up at the 'door' of the GPs. GPs are not necessarily the best professionals to deal with some of these non-health issues, that nevertheless impact on patients' health.

The scheme has significantly helped to reduce pressure on our ever-decreasing time resources, as well as, in the long-run, potentially helping to work to reduce acute hospital admissions through 'social crisis' avoidance.”

BW10 INTEGRATION PROGRAMME

Wokingham Community Health & Social Care (CHASC) – (Neighbourhood Clusters, Self-Care and Prevention) BCF Project

Project Initiation Document

DATE & VERSION NO.
1ST JUNE 2017 VS. 1.7
BETTER CARE FUND REF:
BCF 08

PROJECT/ SCHEME NAME AND BRIEF DESCRIPTION

This paper sets out the business case for continued Better Care Funding (BCF) funding from 2016/17 to 2020/21for the Community Health and Social care project.

The Community Health and Social Care projects overarching aim is:

'to keep the residents of Wokingham fit, well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention and ***ultimately makes the most effective use of all resources in the system'***

Community Health and Social Care (CHASC) is about integration. As a person or a clinician, you would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services. The boundaries make it harder to provide joined-up care that is preventative, high quality and efficient. CHASC aims to dissolve the divides. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model.

CHASC enables alignment of health and social care's objectives for the next 5 years, as seen in the Five Year Forward View, Wokingham Boroughs 21st Century Programme and the CCG Objectives.

1. Health and Social Care Integration – commissioning appropriate health and social care within available resources
2. Smart working - Locality working and dissolving organisational boundaries
3. Assets – making the best use of all public assets
4. Enabling Partnership working

The underlying logic of CHASC is that by focusing on prevention and redesigning care, it is possible to improve health and wellbeing, achieve better quality, reduce avoidable hospital admissions and elective activity, and unlock more efficient ways of delivering care. The model of integrated health and social care will have a much stronger emphasis on empowering clients to take more control over their lives through promoting their independence. The plan is to bring disparate services together and align these services. CHASC will enable the following:

- Pro-active care
- People will only need to tell their story once

- Everyone will have a single care plan
- People will have an accountable key worker
- Reduce duplication of effort by providers

The benefits the project plans to deliver are:

- Reduced Non-Elective (NEL) admissions
- Reduced Accident and Emergency (A&E) attendances
- Reduced/delayed cost of social care packages
- Reduced/delayed care home placements in the long term
- Improved satisfaction of care
- Care and support are centred on the person's needs
- People have a high quality of life, and enjoy their improved health status
- People feel empowered, capable of and engage in self-management
- Care is of high quality and safe
- People experience pro-active, coordinated care and support
- Reduction in use of GP appointments for non-medical problems

Community Health and Social Care system will provide joined up, long-term, health and social care support which will **deliver**:

1. Risk stratification or predictive modelling
2. Care co-ordination
3. Care delivery/Case management
4. Management of ambulatory care-sensitive conditions
5. Primary prevention
6. Self-care

The **impacts** of the project will be:

- Better health for the whole population
- Reduced inequalities in access to health and social care, including improved access to the right service at the right time.
- Reduced variation in outcomes
- Increased quality of care and safety for all residents
- Better value for the taxpayer
- Supporting people to live well in their own homes for as long as they wish and are able to
- Improve residents experience of health and social care
- Contribute to a more sustainable system for the future by reducing demand

The proposal requires gross investment of £691,620 up to 20/21 and will deliver gross savings of £1,809,267 at the end of year 20/21 ROI of 162%. The project is expected to return a net saving in 2018/19 and with savings expected to continue. The funding source is the BCF.

SENIOR RESPONSIBLE PERSON (SRO)	PROJECT / SCHEME MANAGER
Judith Ramsden, Director of People Services Wokingham Borough Council **Katie Summers, Director of Operations, NHS Wokingham CCG**	**Rhian Warner, Project Manager**

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Purpose of Document

The purpose of this document is to define the project, to form the basis for its ongoing management and the assessment of overall success. It also provides a statement of how and when the project's objectives are to be achieved, by showing the major products, activities and resources required on the project.

Specifically the paper aims:

- To explain the rationale behind the Community Health and Social Care Project
- To demonstrate what the programme will deliver in 2016/17 and in the medium term
- To show how the programme might achieve its objectives

Though the PID describes the full breadth of this programme the focus for the rest of 2016/17 will be delivery of the phase 1 objectives.

Recommendations

That Wokingham Integrated Strategic Partnership (WISP) and the Health and Well-being Board agree:

- To proceed with the project as outlined (subject to BCF funding)
- To proceed with BHFT managing the services across the system and the appointment of the Head of Community Health and Social Care as soon as is practicable. BHFT would manage the services on behalf of the partnership, with clear accountability to the local authority for its statutory social care duties.

Section 1 – Project Definition, Description & Purpose

Strategic Case – Project Description and Aims

1.1 Background

This business case builds on the original Neighbourhood Clusters, Self-Care and Prevention business cases which were submitted to WISP in August 2015 and March 2016. The main aim of the Neighbourhood Clusters, Self-Care and Prevention project was:

To strengthen community capacity and improve the health literacy, service quality and outcomes of care for people such that fewer people will require hospital admission and consequently reduce demand on the current health and social care system.

Nationally the NHS England "Five Year Forward View" recognises the financial challenges which face the NHS over the coming years and indicates a drive towards closer integration and joint commissioning between health and social care services, the development of different models of provision including multispecialty community providers, primary and acute care systems and the transformation of primary care. The plan also describes a stronger role for the voluntary sector (which the project will provide core financial support for delivery) with more emphasis on putting patients in control of their own care. It also emphasises the need to exploit the use of technology and the role of public health in achieving better outcomes for communities.

It sets out how organisations might work together to implement new models of care through, for example, "multispecialty community providers (MCPs)", which may include variants aligned to plans for locality development. Establishing an MCP requires local leadership, strong relationships and trust. No system of accountable care will get off the ground and be viable without the inclusion and active support of general practice, working with local partners. As expert generalists, with their registered lists of patients, general practitioners will always be the cornerstone of any system of accountable care provision. The Five Year Forward View also invites organisations to "Get serious about prevention".

The Care Act, 2014 outlines the responsibilities Local Authorities have towards residents as commissioners and their statutory duties to safeguard residents and ensure their wellbeing. The key within this is to emphasise the importance of 'people maintaining their independence as much as possible and for as long as possible'. Over the next few years there will need to be fundamental changes to the way care is delivered and paid for. These changes will mean that users of the service and their carers are in control of their own care and support as part of the Act.

The Adult Social Care Outcomes Framework (ASCOF) is the tool used to measure performance against this ambition and the four domains link into the overall work described in this PID and associated guidance:

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

The Better Care Fund (BCF) programme has added further momentum to our local integration programme, and offers a vehicle to lever the transformation of health and social care services in the provision of integrated care and support. Integrated commissioning and provision through the use of the BCF also offers an opportunity to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life. The on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services

Wokingham Borough Council has responded effectively to financial austerity and funding reductions since 2010. The point has been reached where a radical, whole-council approach to transformation is required to achieve the efficiencies required over the next three years. A sound, three-year plan has been developed to deliver the necessary savings up to 2019-20. The 21st Century Council programme makes a substantial contribution to that plan. The figure below shows all elements of the programme.

Figure 1 – Wokingham Borough Council, 21st Century Programme

1.1.1 What are the health and social care problems/issues that need to be addressed?

In Wokingham the following have been identified as drivers that need to be urgently addressed:

- The continuing financial pressures, both Health and Social care budgets need to be made financially viable for now and the future, eliminating inefficient duplication of work and hand offs between parties.
- Primary care is under pressure and is at risk of falling over due to workforce issues, the development of Wokingham as an SDL (strategic development location) and single handed practices no longer being viable models of delivery.
- The 2015 Autumn Position Statement and Comprehensive Spending Review mandated Upper Tier Local Authorities and the NHS to deliver health and social care integration plans by April 2017 and full implementation by April 2020. Integration planning is consequently a condition of the 2016/17 Better Care Fund.
- Increasing demands on services - Complex patients in Wokingham Clinical Commissioning Group (CCG) account for 2% of the user population and they form 14.9% of Wokingham CCGs spend on acute hospital care (out-patient appointments, A&E attendances and inpatient admissions), nationally this patient cohort spend is 15%. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system.
- In 2013/14[1] (Full data on the population and demographics for Wokingham Borough and Wokingham CCG can be found in **Appendix 1** of this paper):
    - 30 patients had a total of 308 A&E attendances between them
    - 309 patients had a total of 2,649 outpatient appointments in an acute hospital setting
    - Wokingham's average complex patient has 5 inpatient admissions per year across 3 different conditions.
    - Wokingham's CCG spends most on Circulation, Cancer and Musculo-skeletal
    - 60% of these complex patients are aged 65 or over
    - 34% of these complex patients are aged 75 or over
    - 10% of these complex patients are aged 85 or over
- Feedback from service users – they feel that health and social care staff work in silos and that care is not joined up, the voluntary sector will become overwhelmed, services are not always accessible in an easy or timely manner.
- Not intervening early enough in a resident's disease journey, which creates bigger demands and greater need

[1] Commissioning for Value: Where to Look, January 2016, NHS Wokingham CCG, Gateway Ref:04599

- The population is getting older which will lead to greater care demands
- The prevalence of long term conditions is increasing as the population get older
- Traditional care services will not meet the demand for, and expectations of, care across the Borough's population possibly contributing to inequalities of health and wellbeing in Wokingham.

These drivers have led to:

- Variability in health outcomes
- Inequitable resource allocation
- Increasing inequalities
- Increased costs

It is recognised that as a system we need to do things differently in order to manage and reduce the impact of these drivers to deliver the best possible care in the most effective way. As the population ages and long term conditions (LTCs) increase in prevalence, providers and commissioners are being asked to do more with less. In this context, the current approach to care is unsustainable as it is both unaffordable and does not provide people with the person-centred, pro-active, integrated and quality of care they tell us they need.

The current situation is not financially viable and we need to shine an honest light on what we are doing. The BCF, NHS England's Right Care Programme and The Frail Elderly Pathway support the vision set out in the Five Year Forward View with its focus on the transformation of health and social care services to drive improvements in quality and efficiency, to be able to continue to care for our local population in the manner it expects.

1.1.2 Pyramid of Need - The projects target cohort

The target groups that Community Health and Social Care working will focus on, at least initially, are:

- Case Management- Very high intensity services users (and their carers) with complex co-morbidities, the top 2% of users (315 residents). They require multi-disciplinary teams focussing interventions to avoid, anticipate and manage crisis to avoid admission.
- Disease Management – High risk service users often with complex needs, top 3-10% of service users (1261 residents). They require responsive teams focused on managing disease and preventing further ill-health
- Supported Self-Care – Moderate risk service users (70-80% of LTC population). They require supported self-care to maximise independence involving third sector and voluntary organisations
- Prevention & Promotion of Wellbeing – Low risk service users, their carers and the general population. This group need to maintain health and well-being through healthy lifestyles within a cohesive community and might benefit from local information and support to self-care and enhance their health & wellbeing. This group would be predominantly supported by the Public Health services.

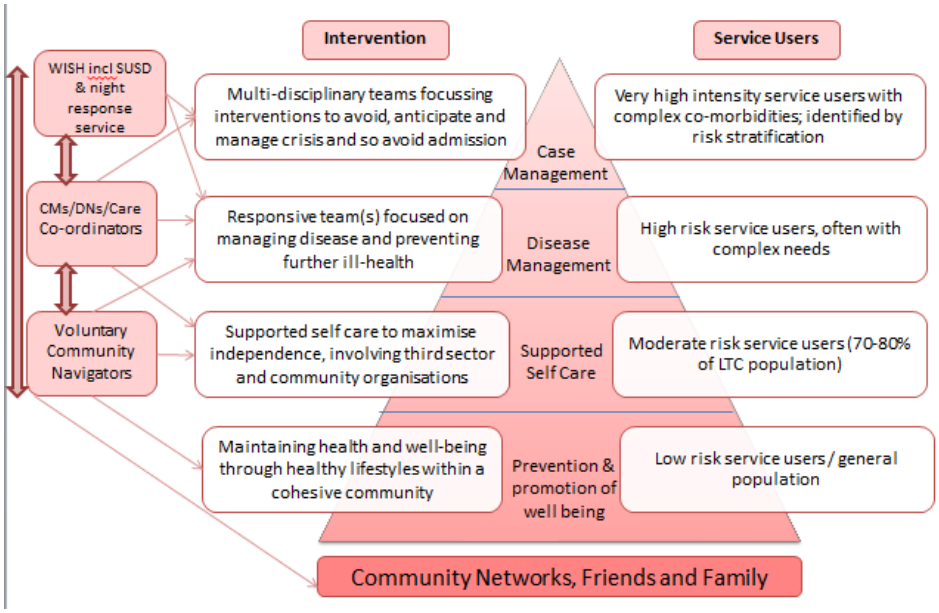


Figure 2 – Pyramid of Need

Clearly, a significant proportion of the care provided will be common to all tiers. However, health and social care needs of the tiers also differ in crucial ways, meaning each tier requires a set of targeted interventions to support people to keep them well. It is important to note that these tiers are fluid. People can and will move between the different levels of care as they experience periods of instability and recover from them. The system response designed will need to be proportionate to the individual's requirements i.e. resources in the right place at the right time and it will not be a one size fits all solution.

1.2 Strategic Fit

This proposal is set in the wider context of increasing health and social care demand, primarily due to demography, and the need for the local authority and Berkshire Healthcare NHS Foundation Trust (BHFT) to achieve challenging savings targets while maintaining/improving the quality/safety of care.

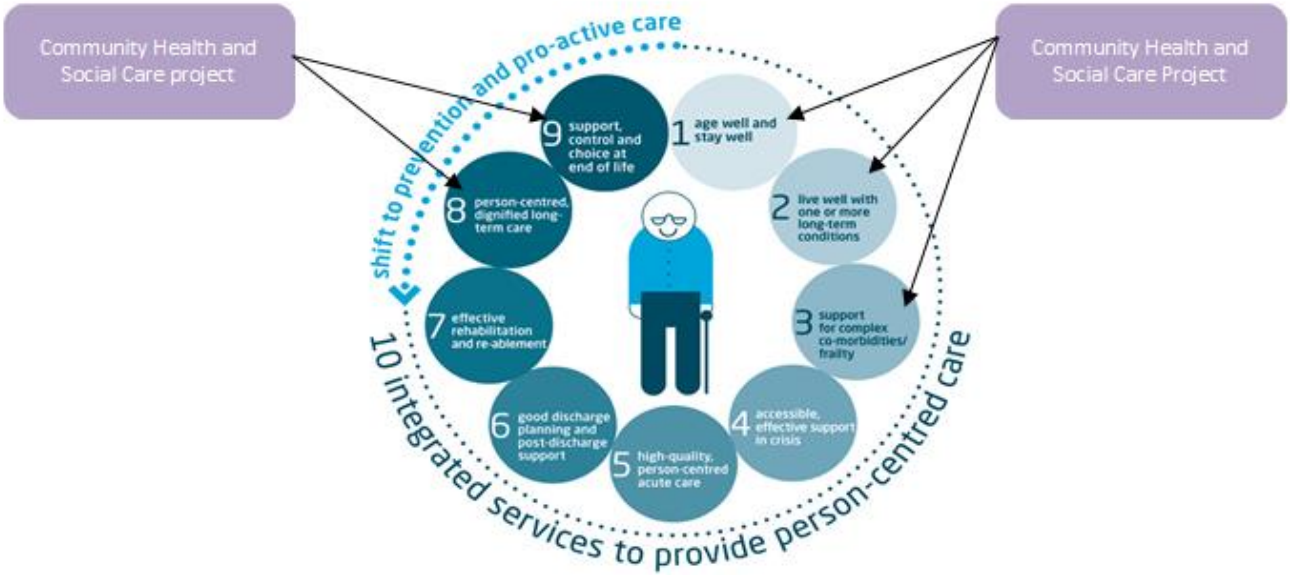


Figure 3 - Sam's Story – BCF 08

The objective of this BCF scheme is to deliver better outcomes for Wokingham clients through an integrated pathway between Health and Social Care. This will support the need to deliver services in a much more cost effective way and deliver savings.

General practice is experiencing unprecedented workload and workforce challenges. When general practice fails, the NHS fails[2]. A big reason to develop CHASC is to provide practical help to sustain general practice right now. CHASC will support practices to work at scale and also to benefit from working with larger community based teams. CHASC opens up new options for partners, clinicians and managers. Over time it should also help with managing demand for general practice, by building community networks, connecting with the voluntary sector, and supporting patient activation and self-care.

This will be achieved through ensuring timely and effective responses to meeting needs of clients based in the community. This scheme sits within the overall BCF programme and will support a renewed focus on decreasing dependency and promoting independence. The need for long term care will be reduced. Doing things once with the right resources identified from the outset, responding quickly and having well trained staff available to meet the needs.

The project is underpinned by health and social care professionals working alongside one another, and with family and carers as expert partners in care, to:

- Provide the right care, by the right people, at the right time and in the right place with more people

[2] The multispecialty community provider (MCP) emerging care model and contract framework, July 2016, Gateway ref: 05637

supported within their community, and the development of 7-day working across Health and Social Care
- Keep the individual at the centre of a co-ordinated health and care system with a single point of contact via a 'hub'
- Develop and earn trust, from patients/service users and across organisational boundaries
- Keep improving health and care systems with the people who use them increasingly involved in the design, delivery and evaluation of services
- Protect community (including family) connections for those with care and support needs, in recognition of the positive impacts these have on emotional and physical wellbeing
- Make the experience of care a more positive one, in which the individual retains as much choice and control as possible.

It provides an opportunity for Health and Social Care, working together to meet the requirements within:
- Care Act, 2014
- The NHS England Five Year Forward View, October 2014.
- The Berkshire West 10 Frail Elderly Programme (FEP) recommendations and implementation plan

Alignment with 16-17 BCF Priorities
- People's experiences of care
- Care outcomes in terms of changes to people's health and wellbeing
- Better use of resources.

Alignment to Wokingham Borough Council Health and Wellbeing Strategy 2014-2017
- Promoting good health throughout life
- Building health and wellbeing into new communities
- Improving life chances
- Older people and those with long term conditions

Alignment to CCG objectives
- To achieve good health outcomes across the patch - benchmarked within the top quartile in UK
- To commission appropriate healthcare within available resources ensuring value for money
- To commission safe, high-quality services which meet the health needs of the Wokingham population through optimum use of the latest technology, with all health and social care professionals working together across the health economy, to ensure that Wokingham residents get the care they need in the most appropriate place
- To optimise patient and public engagement/ involvement to ensure a broad, representative patient/ public voice is heard.

Alignment to Wokingham Borough Councils 21st Century Programme
- Health and Social Care Integration: working with the NHS to deliver better connected care at home, promoting independence and avoiding unnecessary hospital admissions. The Council has to respond to growing demand that is not matched by funding increases
- Smart Working Phase 2: the Council already works smart, and has saved significant sums through reducing its office footprint, including considering the potential future use of Shute End, locality working
- Assets: The Council owns substantial assets in the borough and is working to ensure these are put to best use, and where possible delivering revenue or capital receipts. Linked to this the Council is leading a programme with all public sector partners across Berkshire including police, health and the fire service, to make best possible use of publicly-owned assets and buildings to save public money

Fit with CCG 16-17 Operational Priorities
- Piloting new technology – enabling care
- Innovative approaches to transform clinical pathways building on the Hospital without walls
- Highly responsive urgent and crisis care services outside of hospital
- Successful delivery of QIPP

1.3 Community Health and Social Care Overview

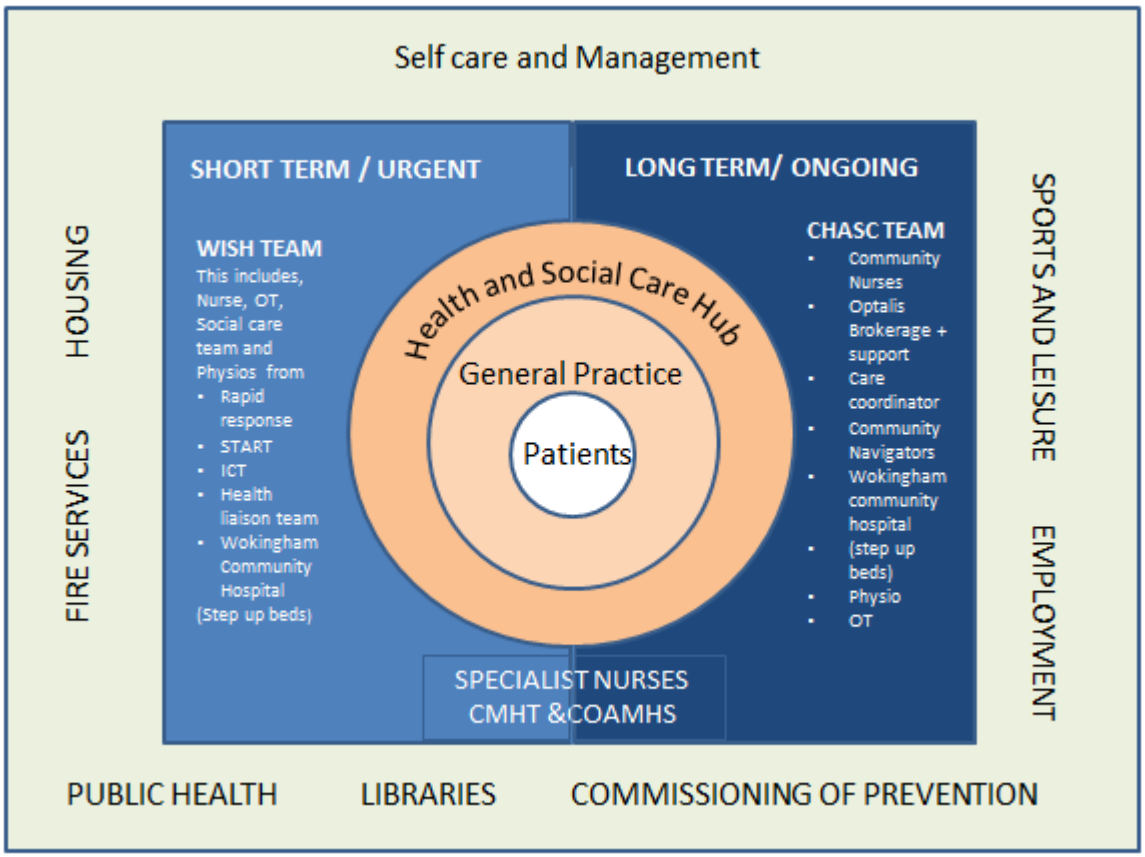
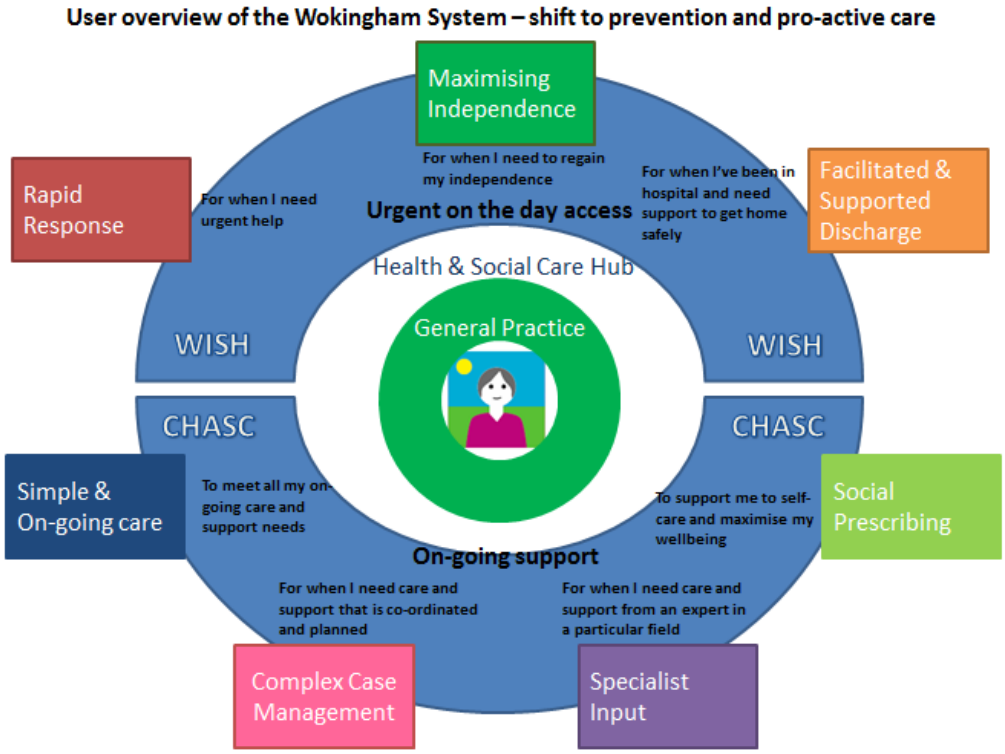


Figure 4 – The proposed system Model

The model shows how the new services created by the BCF programme all fit together and are able to deliver the right care at the right time for all of Wokingham's residents.

For CHASC a simple pattern of services needs to be developed, based around primary care and natural geographies and with a multidisciplinary team. These teams need to work in new ways with specialist services – both community and hospital based, to offer residents a much more complete and less fragmented service.



As the new model is developed there is a need to include both mental health and social care, including the management of the health and social care budget for the care of their service users. Community services also need to reach out into communities more effectively. The opportunity to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention is not being fully exploited.

We therefore need to design and deliver a service that:

- provides pro-active rather than reactive management, 'doing it better earlier on'
- improves the value and utilisation of resources by streamlining process and procedures and through economies of scale
- reduces/removes barriers by linking services and teams to provide consistency which builds trust
- drives accountability from staff and users
- addresses needs in a timely manner

This case proposes locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services[3]. The localities proposed are below.

Figure 5 – Proposed Localities
(Practices and changes in population from now to 2022 – taking into account new housing developments)

The idea of localities has emerged within the context of:

- The MCP vanguard results to date.
    - The building blocks of an MCP are the 'care hubs' of integrated teams. Each typically serves a community of around 30-50,000 people. These hubs are the practical, operational level of any model of accountable care provision. The wider the scope of services included in the MCP, the more hubs you may need to connect together to create sufficient scale.
    - An MCP model is a place-based model of care. It serves the whole population, not just an important subset (such as people over the age of 65).
- Under-developed relationships between health and social care, housing and the voluntary sector, a particular issue given that some people receive care from all or many of these services
- Unwarranted variations in practice

[3] Nigel Edwards, Community Services – How they can transform care. The Kings Fund February 2014

- Local people telling us that they want better access to services and more joined up services
- Financial and demand pressures on the health and social care system, and the need to address these through new ways of working

The Community Health and Social Care project has 2 elements:

1. *Integration of long term health and social care* - Localities are being developed to focus service planning and delivery around local communities with the aim of more effectively coordinating care and support for people with complex needs and emphasising self-care and early, targeted prevention. Within each Locality, 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 to self-care and prevent further ill health.

The initial phase of this will integrate Wokingham Borough Council's (WBC) long-term social work functions, currently provided by Optalis brokerage and support, with BHFT's community nurse teams. Other organisations' services that may be better delivered on a locality basis may also join the Locality at a later date.

2. *Promoting Self-Care and Prevention* of health and social care issues and conditions, this is being undertaken in partnership with the voluntary sector through Involve who have developed a Volunteer Community Navigator scheme to improve access to local voluntary and community resources by providing targeted, up to date information to service users and their families, and support local people to self-care and maximise their wellbeing.

In February 2015 Jeremy Hunt reported that a fifth of GPs time is spent dealing with patients' social problems, such as debt, isolation, housing, and employment. We do not have data specific for Wokingham and as Wokingham is not described as socio-economically deprived the percentage may be lower. The Low Commission inquiry into social welfare advice provision chaired by Lord Colin Low, reported services located in primary care settings could cut time spent by GPs on benefits issues by 15% and reduce repeat appointments and prescriptions. The report called on NHS commissioners to use welfare advice services to address the social determinants of ill health, improving health outcomes, addressing health inequalities and reducing demand on the NHS.

Social prescribing has been shown to:

- Reduce the use of GP appointments for social problems
- Reduce the level of care required for care packages
- Improve general health
- Improve well-being
- Reduce feelings of isolation
- Help people meet others who have the same diagnosis

These 2 elements form one of the three key parts of Wokingham's Integration plan set out below, which shows how the long-term integrated teams fit with other integrated services such as the Hub and the short-term (WISH) team. This is the final piece of the jigsaw for Wokingham's integrated system.

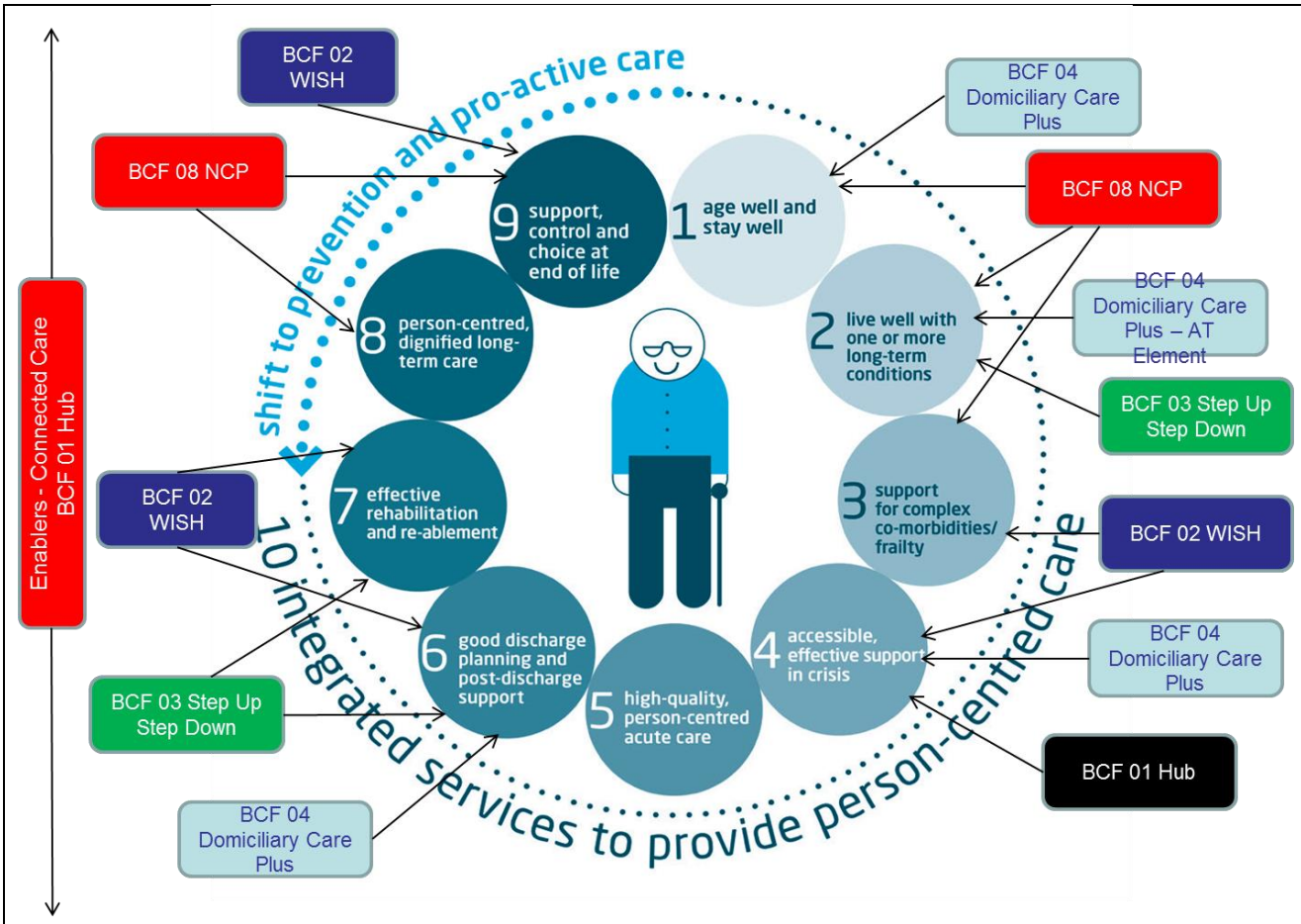


Figure 6 – Sam's story – Wokingham's BCF Programme overview

1.4 CHASC Aims and Impacts

The projects overarching aim is:

'to keep the residents of Wokingham fit, well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention and **ultimately makes the most effective use of all resources in the system'**

The objectives of the project are:

- Reducing the complexity of services – removing organisational boundaries, single care plan, accountable key workers
- Wrapping services around primary care – delivered with and alongside GPs
- Aligning teams/services and geographical localities to provide most effective coverage that meets the population needs throughout the year
- Building multidisciplinary teams for people with complex needs, including social care, mental health and other services
- Supporting these teams with specialist medical input – particularly for older people and those with long-term conditions
- Building an infrastructure to support the model based on these components including much better ways to measure and pay for services, use of technology, using data to inform care co-ordination and delivery
- Developing the capability to harness the power of the wider community e.g. voluntary sector, fire service
- Ensuring that the response is proportionate to the individuals needs in all aspects of care and safeguarding

Community Health and Social Care system will be responsible for delivering integrated care through smart working, as opposed to isolated care. This will provide person centred care delivered by an appropriate professional from the integrated team. It will be collective, joined up, long-term, health and social care support and will deliver:

- Primary prevention - Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system. The King's Fund has recently published a resource for local authorities that outline the key priorities for prevention and improving the public's health (Buck and Gregory 2013). The paper highlights partnership working and systematic use of health impact assessments as key and highlights key areas that can improve public health and reduce inequalities.
- Self-care - People with long-term conditions account for 70 per cent of all inpatient bed days (Naylor et al 2013). Self-management programmes, which aim to support patients/service users to manage their own condition, have been shown to reduce unplanned hospital admissions for some conditions such as chronic obstructive pulmonary disease (COPD) and asthma (Purdy 2010).
- Managing ambulatory care-sensitive conditions - Conditions where the need for hospital admissions can be reduced through active management (known as ambulatory care-sensitive (ACS) conditions) accounted for 15.9 per cent of all emergency hospital admissions in England in 2009/10, with an estimated cost of £1.42 billion (Tian et al 2012). The annual Care Quality Commission (CQC) 'state of care' report (2013) found that 'older people are increasingly arriving in A&E with avoidable conditions' such as diabetes or respiratory diseases. The report found that some areas were more able to avoid these admissions and it highlights interaction between primary health care, secondary health care and social care as key (CQC 2013). An emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care. Conditions (such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure) where optimum management can be achieved in the community.
- Risk stratification or predictive modelling - Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions. In an evaluation of predictive modelling options, Billings et al (2013) suggest:
  - choosing which predictive model should be based on a number of factors, including the intervention design and the data that it will analyse
  - including GP data in predictive modelling is particularly important, and including all patients in an area rather than just those with prior hospital use was found to improve case-finding.

  We will need to consider what data is available to us and it will be a key enabler of the project. One example of a service model that uses risk stratification is 'virtual wards', which provide multidisciplinary case management to people in their own homes identified as high risk, as would be available in a hospital ward, in order to prevent emergency admissions.
- Care co-ordination - Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual's needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in recent changes to the GP contract. Using the GPs anticipatory care plan so that people have one single health and social care plan.
- Care Delivery/ Case management - Co-ordinated and integrated services for people with long-term conditions have potential to deliver better and more cost-effective care if they are well designed, involve professionally trained case managers and care teams, and are embedded in a wider system that supports co-ordinated care (Ross et al 2011). Evidence suggests that a significant proportion of admissions could be avoided if alternative forms of care were available (Health Foundation 2013).

The impacts of the project will be:

- better health for the whole population
- reduced inequalities in access to health and social care, including improved access to the right service at the right time
- reduced variation in outcomes
- increased quality of care and safety for all residents
- better value for the taxpayer
- supporting people to live well in their own homes for as long as they wish and are able to
- improve residents experience of health and social care

- contribute to a more sustainable system for the future by reducing demand

1.5 CHASC - How are we going to do it?

CHASC cannot simply be willed into being through a transactional contracting process. Merely rewiring institutional forms, contracts and financial flows changes nothing. By far the most critical task in developing CHASC is to get going on care redesign, locality by locality. However, to be sustainable and fulfil its potential, CHASC will ultimately need to be commissioned rather than continue to rely on a shared vision and goodwill. In this way money flows and contracts and organisational structures all actively help rather than hinder staff to do the right thing. CHASC may start off as a loose coalition, but sooner or later it has to be established on a sound legal footing under contract.

The proposed changes in service delivery are ambitious and reflect the 5 year vision for health & social care for people in Wokingham. Therefore we need to phase and prioritise the implementation of the model of care, recognising that immediate changes do need to be made. The project will need to be phased into 4 phases to ensure successful delivery.

1. Phase 1 - Volunteer Community Navigators – implementation started March 2016 for completion January 2017
2. Phase 2a – Developing CHASC Model of Care (delivery in year 16/17) and Phase 2b - Implementing CHASC Model of Care (delivery Q1 & Q2 of 17/18)
3. Phase 3a – Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC – Now to May 2017) and Phase 3b Testing Phase with a single locality (September 2017 to December 2017)
4. Phase 4 – Development of future plans with wider partners, to work up as a model in 17/18

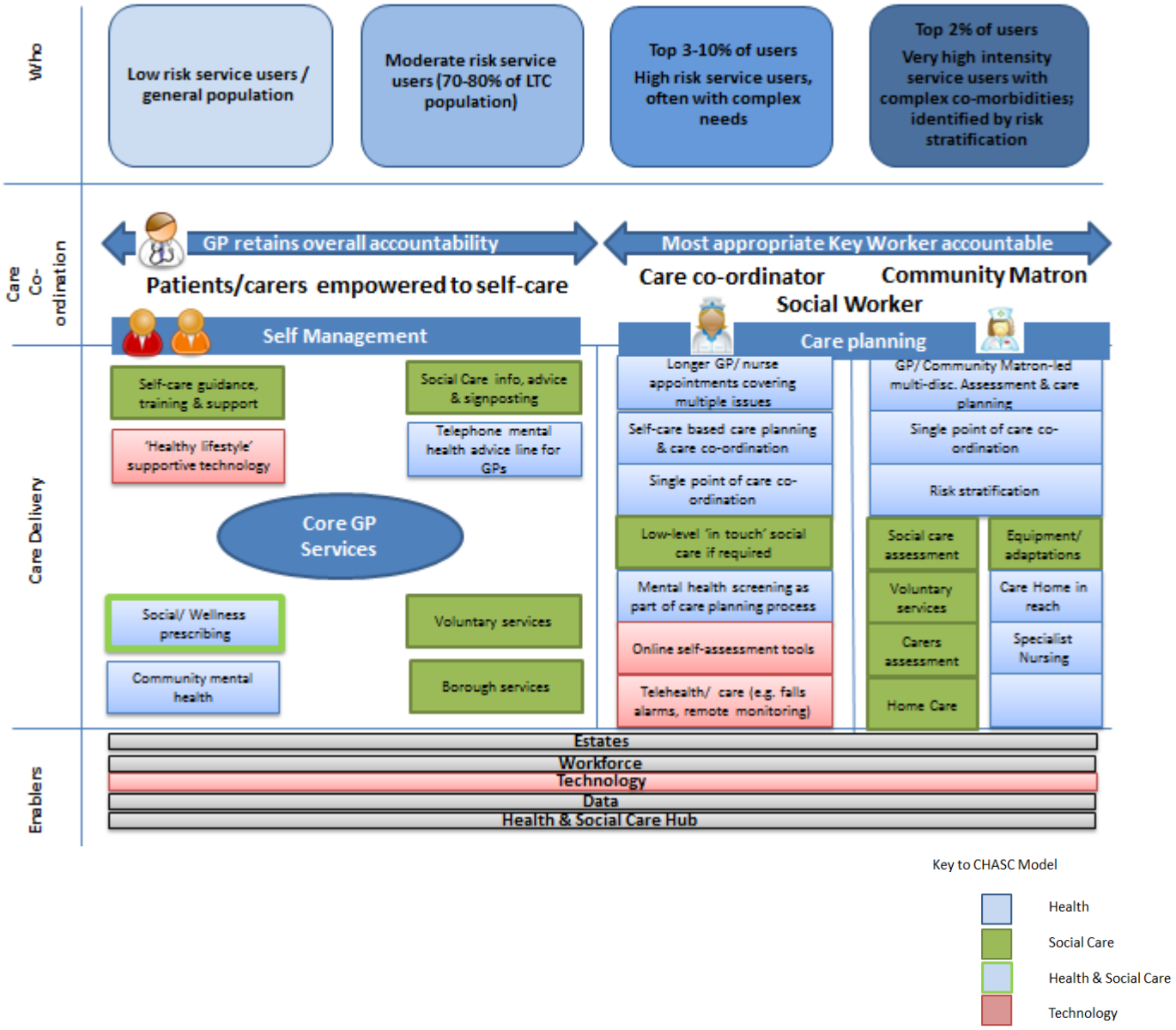
This Business Case lays the foundations for whole systems integration. Achieving the initial savings through the reduction in NELs is critical to enabling further investment in pro-active and preventative services, however through better co-ordination of existing services we can ensure that the benefits can start to be realised.

Key objective deliverables:

- One service offer across Wokingham Borough to be delivered with and alongside General Practice
- Aligning teams/services and geographical localities to provide most effective coverage that meets the population needs
- Reviewing and agreeing the role and responsibility of all staff groups e.g. community navigators, care coordinators, social workers, GPs and community matrons
- Reviewing and updating all processes to provide efficiency and consistency
- Investigating and implementing technology where needed
- Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people. The new model is reliant on using high quality business intelligence systems, with data that is as real time as possible. Without these, CHASC is ‘flying blind’. Core aspects of ‘commissioning support’ such as business intelligence will increasingly become ‘population health management support’, and CHASC will need to use these services as a key customer
- Developing partnership working with the 3rd sector
- Delivering services around Primary Care
- Ensuring delivery of statutory local authority duties

1.5.1 Proposed Care Delivery Model – LONG TERM CARE

Figure 7 – Proposed Care Delivery Model



The model will require further refinement during the planning phase. The model builds on the view that at risk people benefit most from high quality, integrated multi-disciplinary care and support which is provided as close to their home environment as possible. To deliver a genuine person-centred approach to care, it is necessary for partners in Wokingham to think across organisational boundaries to create joined-up services operating under a 'one team' ethos. Working with lay partners, clinicians, and health and social care practitioners, the new, long term model of care has been designed based on the pyramid of need defined (Figure 1 page 7).

The transformation of care involves major shifts:

- In the boundary between formal and informal care
- In the use of technology - not only to provide fully interoperable electronic records and real time data, but also to redesign the process of care delivery, for example through phone and Skype consultations, diagnostics, the use of apps and early adoption of innovative drugs and devices.
- In the workforce - it empowers and engages staff to work in different ways by creating new multi-disciplinary teams; by redesigning jobs so that they are more rewarding, sustainable and efficient; and by implementing newer professional roles.

The opportunity for CHASC is across all three. An effective model engages and activates service users, their carers, families and communities in helping to take control of their own care – rather than assuming

that the main source of value is clinicians doing things to people.

The model shows that everyone will receive a level of pro-active care. Care will then 'ramp up' as level of need increases. People will have easy access to health, care, social care, mental health and well-being services. Crucially both physical and mental health needs have equal status and are accounted for under 'health' in the diagram.

- Self-Management - The model focusses on providing high quality through pro-active and preventative action to stop at risk people becoming unwell in the first place.
- General Practice - will remain fundamental to the delivery of care for all tiers, but there will be a greater role for GPs across all settings of care.
- Social Prescribing -It recommends that well-being prescription should be seen as on par with medical prescription. As such, referral to local voluntary and faith organisations that provide well-being activities will be increased.
- Care Co-ordination - The model of care will be underpinned by care co-ordination that will ensure agencies are able to work more effectively together, as opposed to delivering specific elements of care independently.
    - A person's GP will retain overall clinical accountability for that person throughout their care pathway and for those individuals on the community hub caseload, their assigned Locality MDT Co-ordinator will retain overall accountability for the co-ordination of their care throughout their journey including if they require CHASC services. Even though an attitude of co-ordination will be expressed by all professionals, the locality MDT Co-ordinator explicitly functions as the 'glue' between the different services.
    - This will involve ensuring that the persons care plan is up-to-date and acted upon, working with people and other professionals to co-ordinate care more effectively, as opposed to delivering specific elements of care independently and ensuring that everyone involved in the person's care is kept up to date as to where they are on their care journey.
    - The Locality MDT Co-ordinators will organise support to ensure that people receive co-ordinated multi-disciplinary care and will maintain regular contact with people and those providing their care. They will ensure that any change in condition is identified early and escalated to the appropriate professional in a timely manner. The Locality MDT Co-ordinator is the primary point of contact for the person receiving the service.

It will also begin to bring about the whole-system change we know the area needs by:

- Creating a single, integrated, multi-disciplinary team operating under the 'Community Health and Social Care' banner
- Improving the way in which professionals share information within and between organisations, such that a person only needs to tell their story once and has confidence that everyone involved in their care will have access to the medical history
- Placing and increased emphasis on pro-active care and moving as much care as possible out of the hospital and into homes and communities
- Developing step up beds at Wokingham Community Hospital to manage users within their community and prevent acute NEL admissions
- Delivering improvements in access to general practice as described in the General Practice Forward View. E.g. delivering enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access.
- Improve the care co-ordination and delivery of care to not only the top 2% but also the top 10% of users of health and social care

Under the new model of care people will receive:

- Care that is centred around the person's needs, wishes and aspirations e.g. a single point of access to services
- Care that emphasises self-management and the pro-active involvement of individuals in their own care
- Timely health and social care assessments and preventative intervention
- Care planning & co-ordination for integrated health and social care packages
- Access to community assets in parallel with health and social care interventions to improve wellbeing, reduce social isolation and encourage healthier lifestyles

1.5.2 Phase 1 – Volunteer Community Navigator Scheme – delivery 16/17 and 17/18

In order to keep users fit and well early intervention is required as shown in the proposed model. It is aimed at people who might benefit from local 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. The overall aim being to promote integrated health and social care, partnered with the voluntary and community sector by improving access to local voluntary and community resources by providing targeted, up to date information to service users and their families.

The scheme provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. It can also be accessed by all health and social care professionals and well as self-referrals from users. The scheme is currently on a phased roll-out, starting in April 2016 to be able to provide a service to all 13 GP practices in Wokingham by December 2017.

Involve is running the scheme and it requires a part-time employed community navigator coordinator who is responsible for:

- Recruitment of volunteers
- Training of volunteers
- Liaison with GP surgeries for roll-out
- Day to day operational management of the volunteers and the scheme
- Comms and service profile development

Service Description

Referrals can be made on-line, by telephone, by email or on a referral form and mailed to the team.

Once the referral is received the trained volunteer Community Navigators will arrange to meet users at their GP surgery or another community venue to identify their community support needs.

Community Navigators signpost users to appropriate sources of social support and other non-medical services within the community, neighbourhood and beyond.

Community Navigators will assist users by:

- Finding out what they would like to do, their availability, and when.
- Searching for local charities, community groups and organisations that can meet their needs.
- Making the first contact with the organisation on their behalf, if they choose.

Community navigators will follow-up users 4-6 weeks after their appointment to see what services the user took up and what other assistance they may require.

1.5.3 Phase 2a – Developing CHASC Model of Care (delivery Q1, Q2 and Q3) and Phase 2b - Implementing CHASC Model of Care (delivery Q3 & Q4 of 17/18 and Q1, Q2 & Q3 18/19)

Phase 2a - Developing CHASC Model of Care

The proposal requires significant organisational change and coordination across multiple organisations – GPs, BHFT, WBC, Optalis and Involve (voluntary sector). The current services are fragmented with many separate teams. The proposal is to form a single MDT team of social workers, nurses, MDT coordinators and volunteer community navigators to lead on assessment, care planning and coordination to improve the efficiency of the service. Joint commissioning by Wokingham CCG and WBC has been discussed and will be agreed prior to the approval of this business case. A proposal for Wokingham Adults Integrated Health and Social Care Governance will be prepared for agreement by the commissioners and the Health and Wellbeing Board

The services in the system are commissioned currently by WBC and Wokingham CCG and this will continue to be the case. It is proposed in phase 2 that BHFT, WBC and Wokingham GP Alliance will be the organisations that will partner in order to manage and deliver the services provided in the system. In the medium term they will sub-contract services e.g. Optalis and Involve, in order that one board has the management and oversight of the whole system.

It is also proposed that a Head Of Community Health and Social Care is employed, as soon as is

practicable. This would provide the level of oversight required for the planning and development of the model and system. This post will initially require a simple service level agreement (SLA) between WBC and BHFT in the first instance. The SLA will need to include:

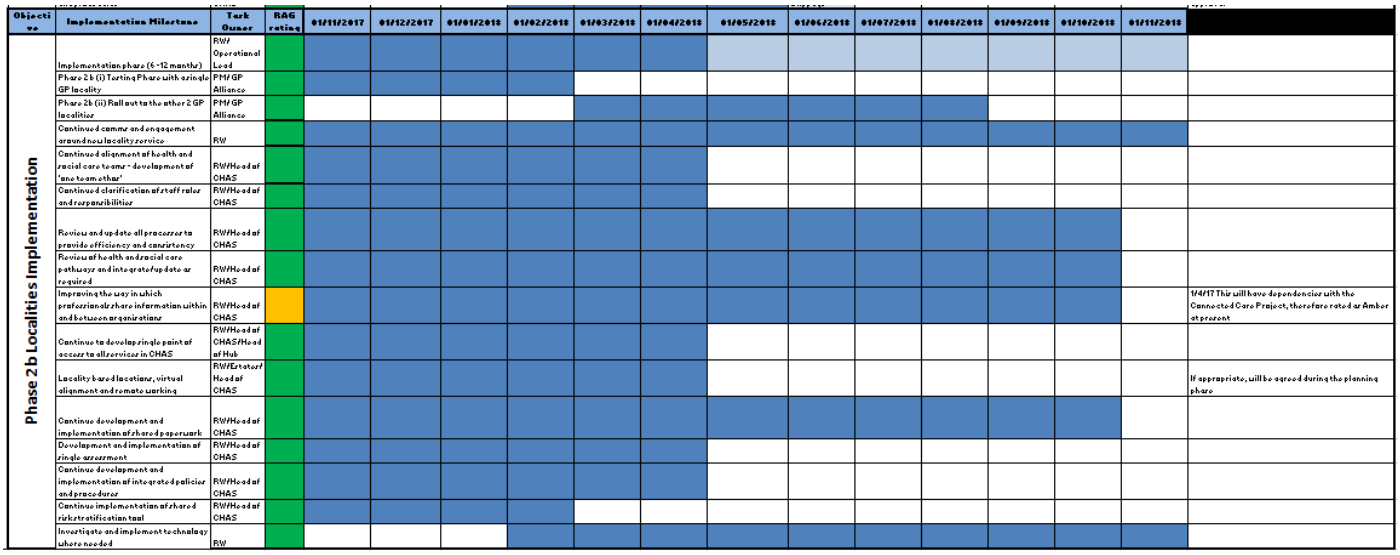
- This will be a jointly managed post by WBC and BHFT and the council will empower the manager to direct resource usage and will enable the council to build trust and confidence in the management of the social work function.
- BHFT have agreed that no additional funding is required for this post as it will use existing resources
- There will be matrix accountability to WBC as this post will have equivalent authority of a Head of Adult Social Care and Safeguarding post and will need to comply with WBC's governance and constitution in carrying out the management of social care and the social care function.
- The arrangement can be withdrawn at short notice if there are performance issues in adult social care

During the planning phase we will need to consider/include:

- 'One Team Ethos' - Whilst the Community Nursing and the Brokerage and Support team will be employed by separate partner organisations initially, both services will be providing care for the same cohort of people, but meeting different levels of need, therefore operationally they will need to work together as complementary teams with shared outcomes that have been agreed with the person and their carer. As such all people providing the core services outlined in this Business Case will identify themselves not through their organisational employment but as a member of the 'Community Health and Social Care'. This will be reinforced through visual signs such as uniform and identification lanyards and through shared documentation and processes.
- Different ways of working – what is the purpose of the persons role and how can it be delivered
- The delivery of Wokingham Borough Council statutory duties will require regular reporting to Wokingham's Director of People Services and lead member for Social Care
- A different way of communing, social interaction
- What motivates staff to come to work?
- The move to remote working – need to think differently about how we do it
- Investment in technology to enable such working practices (aligned with the Connected Care project and milestones)
- Voluntary Sector support – provision will need to be made to ensure that the voluntary sector is appropriately supported
- Co-design across the system – commissioners, providers and users will all be involved in the design of the model and the processes required delivering the model
- Review and revision of all SLAs for providers
- Agreement and design of a single care plan

Given the complexity of the project at its dependencies slippage has been built into the implementation plans. At the monthly steering group meeting an update will be given on progress against the plan and any timescale updates that are required.

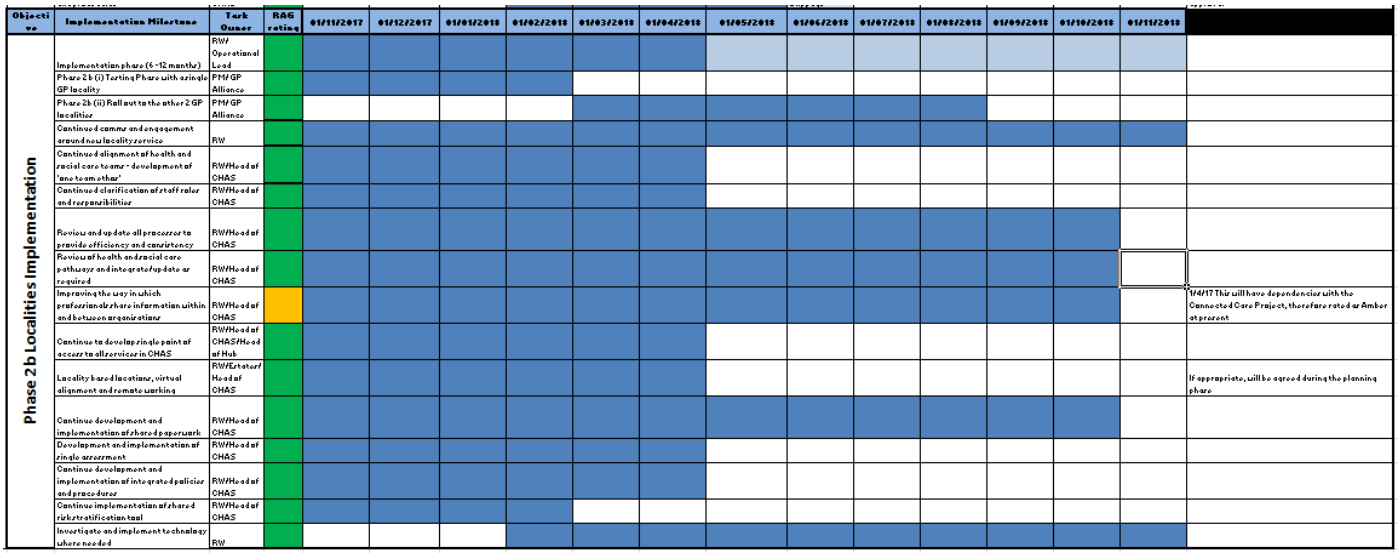
Figure 8 - High Level Project Plan for Development of CHASC Phase 2a



Phase 2b Implementing CHASC Model of Care

Implementation of the model will start in April 2017. Phase 2b implementation will focus on the integration of the BHFT community nursing, Optalis and Community Navigators services.

Figure 9 – High Level Project Plan for Implementation of CHASC Phase 2b



N.B. Larger formats of the implementation plans can be found in Appendix 2.

1.5.4. Phase 2a(i) – Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC – Q1, Q2 & Q3 17/18) and Phase 2b(i) Testing Phase with a single locality (Q3 &Q4 17/18)

Primary care is now in a position to proceed with an integrated model with community health and social care.

The benefits to primary care will be:

- A reduction in the number of GP appointments for social problems, through the use of Volunteer community navigators and enhanced signposting. West Wakefield Health and Wellbeing Ltd MCP vanguard has increased the number of its patients signposted by care navigators by forty per cent over three months. A care navigation framework (directory of services) is embedded across practices and

receptionists use this to signpost patients to cost effective and appropriate services to meet their needs in a timely manner.

- Provide accessible and responsive urgent and emergency care by delivering enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access. Integrated access means that the CHASC is able to appropriately divert a proportion of potential urgent and emergency care patients away from secondary care but ensure the patient has access to the right point in the system. Better Local Care (Southern Hampshire) MCP vanguard has created a 'same-day access service', which pools together the urgent workload for the participating GP practices into a single service that is operated from a central location and is resourced by the practices. In the six weeks from opening in December 2015, the service handled 5,500 patients - almost two thirds of whom had their needs met over the telephone.

Phase 2a (i)- GP alignment in localities and formal agreement on working arrangement – between practices and CHASC

Considerations for this phase need to include:

- The Wokingham CCG GP practices will need to agree locality alignments and will need some form of alliance federation within the localities
- GPs will want to agree within each locality which will be the host GP site for the locality CHASC team and how the CHASC team will support the sister sites within each locality
- Clarity will be needed around the practice nurse and community nurses roles, this can be addressed in the updated service level agreements with BHFT for Community Nursing
- Exploration around collective GP and CHASC working, including how GPs would support access and deployment of the CHASC services
- Design and agreement of a single, shared care plan for all providers

Phase 2b (ii)– Testing phase with 1 locality

It is proposed that one geographical locality is developed in order to explore and develop the model with the outcomes will helping to shape the other 2 localities. This would include developing a location in Wokingham to provide all the urgent on the day GP appointments, including near patient testing diagnostics. This would enable the GP surgeries to focus and have more time to manage the users with long-term conditions who are high risk or high intensity users.

1.5.5 Phase 3 – Development of future plans with wider partners, to work up as a model in 18/19

There are a wider range of services that could be included in this model. In order to ensure that the new model of care becomes embedded and successful it was decided that in the early phases that these would not be included but would be looked at as a future development for 18/19.

1.6 Outcomes

Avoiding unnecessary emergency hospital admission and / or readmissions is one of the priority outcomes of the programme because of the high and rising unit costs of emergency admission compared with other forms of care. For service users it is crucial to help them to manage the disruption to their lives and to support them to manage their own care in their own homes or care home.

The **outcomes** will be:

- Better health for the whole population – by providing targeted, pro-active care and intervening early in a person's illness pathway. Analysing and using health and social care data collected to target interventions where needed.
- Reduced inequalities in access to health and social care – the system is currently provided by multiple organisations working separately, making navigation of the system difficult for people and users. GPs are the first point of access for many people and they will use the health and social care hub as a single point of access to services.
- Improving access to the right service at the right time – by wrapping services around primary care and developing social prescribing services and use of the voluntary sector.
- Reduced variation in outcomes - by removing the complexity that has resulted from different policy

initiatives over the years; ensuring clear lines of accountability and responsibility for staff

- Increased quality of care and safety for all residents – through timely, targeted care co-ordination provided by one responsible organisation
- Better value for the taxpayer – by ensuring the response is proportionate to the person's needs; that resource utilisation is streamlined and economies of scale are utilised; targeting the top 10% of users of services (1,576 people) and not just the top 2% of service users (315 people). Robust mechanisms for the review of long term packages of care.
- Supporting people to live well in their own homes for as long as they wish and are able to
- Improve residents experience of health and social care- by reducing/removing barriers between services and professionals; aligning teams to localities to meet the populations needs
- Contribute to a more sustainable system for the future demand - More efficient working by reducing hand-offs, duplication of effort, organisational boundaries and wasted time and reviewing all processes, allows for more and better quality interventions. Implementing appropriate technology where required. Introduction of enhanced urgent care services to reduce pressure on GPs

1.7 Benefits

The **financial** benefits will be:

- Reduced NELs
- Reduced A&E attendances
- Reduced/delayed cost of social care packages
- Reduced/delayed care home placements in the long term

The **people** benefits will be:

- *People have a higher quality of life, and enjoy their improved health status.* The impact of their conditions on daily life has been lowered considerably. Evidenced by a reduction in NEL & A&E attendance, LOS and readmission within 91 days of those over 65.
- *Improved satisfaction of care.* Care will be better organised and of high quality. The proportion of people satisfied with the care and support services they receive should increase. There should be less fragmentation and duplication.
- *Care and support are centred on the person's needs.* People appreciate that care follows their needs and preferences. Their needs and preferences are incorporated in the care plan.
- *People experience pro-active, co-ordinated care and support.* Care focuses on improving health status and preventing exacerbations. Multi-disciplinary care is co-ordinated by the Care Co-ordinator. People experience a seamless service.
- *Care is of high quality and safe.* Care is provided according to best practice and meets NHS and Care Act standards. Continuous learning framework and monitoring of incidents are in place.
- *People feel empowered, capable of and engage in self-management.* People are actively involved in care planning and have access to support for self-management.

The **Professionals** benefits will be:

- *The person is central to how professionals work together in the multi-disciplinary teams.* The person's needs and preferences shape what care is delivered and how the MDT delivers this.
- *Professionals enjoy their work as together they ensure people get the care they need***.** They provide this care themselves or this is provided by a colleague of the multi-disciplinary team.
- *Professionals will no longer work together across organisations through multi-disciplinary teams.* Instead, organisational barriers removed and there will be investment in integration where needed.
- *Professionals work with clear and well-known paths for referral.* There is a Single Point of Access and the GP and Care Co-ordinator are the key contact points for further information.
- *Increasing mutual respect and trust between different professionals, within and between organisations.*

The **whole system** benefits will be:

- *The system is flexible to meet people's changing needs over time***.** People's needs will vary over time with periods with more or less intensive care. The system supports people through these in a seamless way.

- *Reduction in use of GP appointments for non-medical problems*
- *On-going co-ordination and integration between health and social care partners.* Establish integrated services that provide co-ordinated and multi-disciplinary care & support with a Single Point of Access.
- *The relations between local providers have strengthened and matured.*
- *Financial pressures on local health and social care providers are reducing and stabilising.* The current resources are able to meet people's need in the community cost effectively.

1.8 Project Outputs

As the services will become integrated there will be a range of new products it will be delivering:

- Shared Paperwork
- Single Assessment
- Integrated Policies and Procedures for the Service
- Shared Risk Stratification tool – to include data sharing from providers to direct care to frequent users of health and/or social care
- Revised MDT structure and delivery
- True single point of access to long-term health and social care
- Review of health and social care pathways and integrate/update as required
- Develop audit tool to measure the quality benefits of the integrated system

The purpose of the following section is to clearly define the benefits to be delivered by the project, how these benefits fit in with local and national strategy to deliver person centred coordinated care, and the metrics to be used to measure progress and asses long term impact. For more information and to assist with completing this section please see the NHS England BCF How to Guide – How to understand and Measure impact https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-user-guide-04.pdf.pdf

Impacts & Outcomes

	Expected Long Term Impact	Project Benefit/s	Metric / Measure*
Scheme/Project 29	**Improving people's experience of health, care and support**	Improved satisfaction of care.	The proportion of people satisfied with the care and support services they receive should increase. Friends and Family Test or locally devised patient/service user questionnaire
		Care and support are centred on the person's needs.	Audit of patient/service user care plans
	Better Outcomes for patients and service users	People have a higher quality of life, and enjoy their improved health status.	Reduction in NELs, A&E attendances, LOS and readmission rates
		People feel empowered, capable of and engage in self-management	Involve devised outcome measure – Ladder of Change
		Care is of high quality and safe	Reduction in safeguarding reports, complaints, etc.
		People experience pro-active, co-ordinated care and support.	Audit of notes and locally devised patient/service user questionnaire
	Better Use of Resources	Reduction in NEL admissions (BCF metric)	Reduction of 331 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduction in A&E attendances	Reduction of 499 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduced/delayed cost of social care packages	Social Care packages - Will be monitored in first instance to form a baseline. Will monitor on a monthly basis, total spend of cost of long term care packages, number of social care packages, and average cost of social care packages. Referrals through to the volunteer community navigator scheme and the impact this has on the numbers entering

			long term care. Reduced numbers on waiting lists as redirected to the volunteer scheme.
		Reduced/delayed in permanent care home placements (BCF metric)	Permanent care home placements - Will be monitored in the first instance to form a baseline. Will monitor the number of users of social care packages that become care home admissions each month. Also should monitor local authority monthly care home placements and total spend
		Reduction in use of GP appointments for non-medical problems	At present GP activity is not available so unable to measure this benefit, but will need to explore how this can be measured

Performance Metrics

		Metric	Data Source	Baseline	Target / Impact
Project/Scheme 63	Performance	Social care packages - Will monitor on a monthly basis, total spend on long term care packages, total number of social care packages provided , average cost of social care packages provided	Wokingham Borough Council/Optalis data	This will provide a baseline	No increase/reduction/ delay in total costs of care packages in Wokingham in 16/17
		Permanent care home placements - Will monitor the number of users of social care packages that become permanent care home admissions each month. Also should monitor local authority monthly care home placements and total spend	Wokingham Borough Council/Optalis data	This will provide a baseline	No increase/reduction/ delay in local authority spend on care home placements in 16/17
		Reduction in use of GP appointments for non-medical problems – will work with the GPs/CNS to see if can devise a recording mechanism to be able measure any reductions	GP/CCG data	This will provide a baseline	Increase in GP time to spend with high intensity and high risk users
		Whole Systems Working – Do Multi-Disciplinary Care Meetings take place? Are staff satisfied with whole systems working? Are demand and supply balanced across the system?	BHFT Audit - Review MDT meetings and discuss staff experience At the bi-weekly MDT and reported quarterly at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved whole system working
		Care Co-ordination - Care and support are centred on the person's needs Has a care plan been established? Is there is an appointed co-ordinator of care (self, carer or professional care co-ordinator)?	BHFT/Optalis Audit - Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved patient/service user centred care
	a l .	Quality of life and improved health status –	BHFT /Optalis Audit - Analyse the care	No baseline	Increase in quality of life

64		Can the person fulfil their desired activities of daily living (with support)? Is their mental wellbeing is good? Is their physical wellbeing is good? Has there been an admission into acute care?	documentation of a random sample of people that has been cared for and ask feedback from a number of service users. Quarterly - at the monthly steering group meeting	required and will provide a baseline moving forwards	and health status
		People's experience and satisfaction of care – Is care centred on the person? Does the person feel listened to? Does the person understand their care and do they feel involved? Is care consistent and co-ordinated? Is quality of care good? Does the person feel safe?	BHFT/Optalis- Use the outcomes of the Friends and Family test (will need to consider use for social care). In addition get feedback from a number of service users. Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved patient/service user experience
		Pro-active Care – People experience pro-active, co-ordinated care and support. Have the appropriate assessments been conducted? Has a care plan been established? Is the care plan being implemented?	BHFT/Optalis Audit - Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved pro-active care
		Quality and Safety – Does care meet NHS and ASC standards? CQC, Monitor and local Wokingham Policy and Procedures Are evaluation processes on-going? Have there been incidents related to whole systems approach?	BHFT/Optalis - Review quality, incidents, safeguarding and evaluation Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved quality and safety
		Person Centred Care - Care and support are centred on the person's needs Has the person been engaged with? Is shared decision making taking place? Has the person contributed to their care plan? Does the person self-manage? Is the person's carer involved when applicable?	Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved person centred care
	Financial	Reduction of 331 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 331 NELs
		Reduction of 499 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 499 A&E attendances

Options

Two options were considered:

Option 1: Do nothing – Health and social care services for Wokingham will continue unchanged in from 2016/17 to 2020/21.

This option should be discounted because it does not improve care for people, align with Wokingham's strategic direction nor deliver financial benefits.

Option 2: Integrate the long term health and social care teams to provide people with a single health and social care system

Recommendation

The options have been evaluated against the implications they would have on: the financial resources available in the Wokingham health and care economy, co-location of staff, people's experience of care; realising the Integration strategy, clinical quality and staff satisfaction. (Poor – 1, Satisfactory – 2, Good – 3).

	Financial Affordability	Co-location of staff	People's experience of care	Realisation of integration strategy	Care quality	Staff satisfaction	Total
Option 1	**1**	**1**	**2**	**2**	**2**	**2**	**10**
Option 2	**3**	**3**	**3**	**3**	**3**	**3**	**18**

Option 2 is the preferred option as it balances the need to make rapid progress towards an integrated, multi-disciplinary approach to care, while being able to work within the current financial constraints.

Assumptions and Constraints

Assumptions

- That all Wokingham health and social care organisations will agree to the project and the integration of their services to work in the best possible way for residents. To date there has been no feedback from any of the Wokingham organisations that they are opposed to the project.
- There will be a framework to support, and set expectations for, locality working
- Strong leadership to facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and resident-centred care
- Effective IT systems in place to support delivery of care via localities and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Suitable accommodation is available within each locality or centrally to provide a team base. This will require review of community asset mapping work previously undertaken, discussion with the Core Strategy group and planners, and approaches to local businesses to enquire about possible assets.
- Residents are open to the concept of "patient activation" (Hibbard, J; Gilburt, H; 2014). This refers to a person's knowledge, skills, ability and willingness to manage their health and care. Staff need the necessary skills and training to support people within a model of self-care, as this goes beyond the provision of information and understanding of their condition(s) to train and empower patients/service users and carers.
- There will need to be discussion and agreement across the Wokingham BCF schemes at WISP to ensure that KPI measurement across all schemes to ensure that there are no benefits overlaps or double counting. The solution may be to have a single target across schemes e.g. combining NEL benefits from WISH and CHASC (circa 370 NELs for WISH and 331 NELs for CHASC would become a

target of 701 NEL reduction)
- BHFT will be the main provider of the Community Health and Social Care Project and will sub-contract the services required to deliver the project. This assumption has been made as for the following reasons:
    - It enables the project to be delivered at speed as it will be the least disruptive
    - Optalis has no experience of managing health services but BHFT have experience of managing social care services
    - As part of the 21st century council plans, WBC plans to be a commissioner and not a provider so this meets the council's strategic needs.

Constraints
- Ensure that in the modelling of the service that local authority statutory duties are able to be carried out according to legislation
- The role out of the Connected Care project as the sharing of patient/service user information is essential for the pathway
- Culture change is a key component in the delivery of new ways of working and may have an impact on the speed of delivery of the programme

Scope and Exclusions

Scope

The following 'core' services are proposed to be included in the first phase of CHASC development:
- Community matrons and District nurses
- Adult long term care - Brokerage & long term support
- CMHT (18-65 yrs.) and COAMHS (65 yrs. +) – in scope but in a longer term approach
- Volunteer Community Navigators
- Commissioning of prevention services and Carer's services that support long-term care
- Primary Care - GP Surgery staff
- Public Health

NOT in scope, as least initially, although the ambition would be to coordinate development of future plans in association with these partners:
- Services where there are a limited number of professional resources (e.g. Specialist nursing teams)
- Community development
- Libraries
- Sport & leisure
- Employment support
- Housing support
- Children's services – transition services
- Acute services

Exclusions

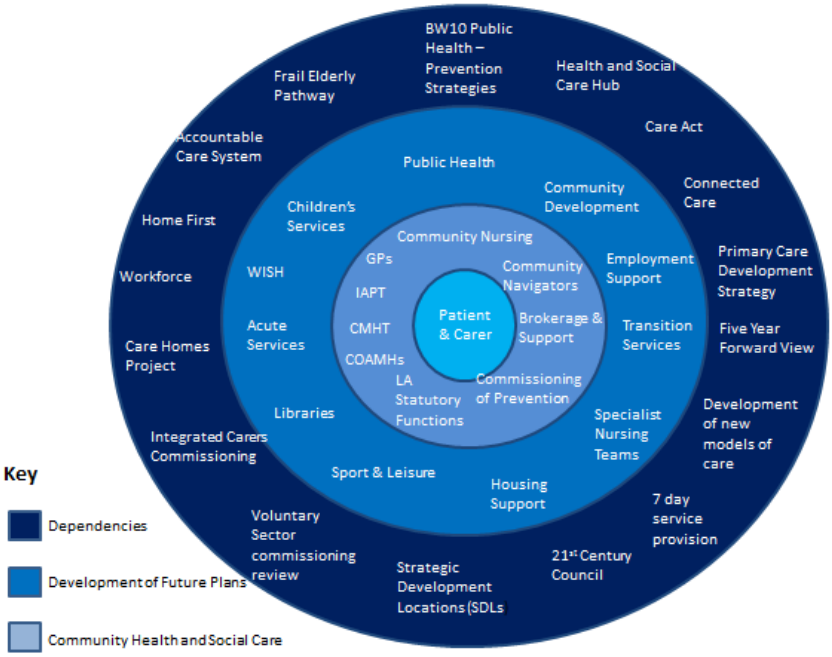
Health and social care services for the following groups will be excluded from the project at this stage but may be considered appropriate at some point in the future:
- Children's services

GPs

Determination of the ownership of GP practices is excluded from the project.

Shinfield Medical Practice is included in this model, although it is within South Reading CCG, as a large proportion of the patients registered at this surgery live in Wokingham borough.

Dependencies



As shown above it is clear that CHASC is connected to a whole community strategy. It naturally focusses on health and social care, but both of those things exist within a wider social construct. CHASC is a leading component of sustainable communities that includes public health, housing, leisure, community safety, wider prevention etc. Since January 2017 additional dependencies have been recognised including the Wokingham GP Alliance and the Long Term Conditions Programme Board.

Development of this project will need to align with the following programmes:

- Care Act implementation – especially regarding provision of co-ordinated care and enhancing the provision of comprehensive information and advice about care and support services in the local area;
- Frail Elderly pathway;
- Public Health outcomes framework and development of the Public Health prevention strategy;
- Structures will dovetail with those established for the accountable named GPs and the unplanned admissions DES/CES;
- The development of new provider models;
- Primary Care Development Strategy; and
- The implementation of the GP DxS (clinical information tool) system.

Specifically within the Better Care Fund Programme:

- Integrated Health & Social Care Hub (BCF 01), in particular avoiding duplication in approach to information provision for self-care and prevention;
- Enhancement of the quality of medical cover for all adult residents of registered Care Homes in Berkshire West (BCF06)
- The implementation of the Berkshire West Connected Care scheme (BCF 07), including the electronic sharing of demographic information using the NHS number as the unique identifier, will significantly enhance the efficiency and effectiveness of the NCTs; and
- WISH (BCF 09), in particular ensuring processes for moving between WISH and CHASC are joined up

Many of these dependencies are programmes and projects being run at a Berkshire West level. For locality working within Wokingham borough to reflect local needs, Berkshire West initiatives will need to allow for a local dimension where appropriate.

Section 2 - Economic and Affordability Case

Budget / Cost Summary

Costs of operation & implementation	16/17	17/18	18/19	19/20	20/21
Localities					
One off costs for implementation	60,803	82,100	0	0	0
On-going costs for running operations	48,896	46,841	150,993	150,993	150,993
Total costs	**109,700**	**128,941**	**150,993**	**150,993**	**150,993**

A breakdown of the cost calculations can be seen in **Appendix 3.**

Source of Funding:

The Community Health and Social Care project is BCF Funded, with additional funding coming from Wokingham's BCF funds. For The Project Manager post is hosted by Wokingham Borough Council and Wokingham CCG.

One-off costs for implementation

At this stage of the project we have identified the following one-off costs:

1. Project Manager Costs

In order to be able to scope, plan and implement the significant change require a project manager is required. Indicative costs of the resourcing are:

- Interim post £450 per day

2. Local programme office support

All BCF projects in Wokingham have access to local programme office support provided by the BCF programme manager, finance manager and support officer. These costs are split between all the Wokingham BCF projects. These costs are pending budget confirmation from 17/18 onwards and are therefore excluded at present (indicative cost circa £20,000).

On-going costs for running operations

At this stage of the project we have identified the following costs. Within this there are also some one off costs:

1. Restructure of the MDT Care coordinators (16/17)

There is funding for 2 WTE MDT administrators, at a higher banding, within BHFT current budgets. The roles were reviewed as part of this project and were down banded and changed to coordinator roles. In order to deliver the locality model an additional MDT co-ordinator is required. The surplus funds generated by the change in banding nearly allows for the additional post. An additional £1,000 is required for BHFT to fund this final post.

2. Voluntary Sector Sustainability (18/19 and 19/20)

A placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20 as it is expected that increased numbers of users will be directed towards the voluntary and community sector. The aim of this funding is to be able to provide one-off support to the sector to become more sustainable, e.g. volunteer recruitment, long-term fundraising initiatives. We will carry out a review in 17/18 to assess the impact and whether we would need to provide the additional funding for this sector.

3. Training for new virtual model of delivery (17/18)

The project plans to deliver a new model of working and there may be training needs for the different staff groups and this has been built in to recognise this.

4. IT infrastructure costs(17/18)

BHFT and WBC have differing IT systems, governance of those systems and hardware available to staff. We have already identified that working in a different way may have implications on IT costs e.g. Firewall issues, hardware suitable for remote working.

5. Property costs (17/18)

There may be moving costs and impacts on rents. It is unlikely that additional assets or equipment will be required in year as each team will have those and it should be a case of moving these if required. The project is proposing to co-locate and integrate the services that are involved in long term health and social care, there may be some costs to make existing premises fit for purpose or finding new premises, but as

yet this is an unknown at present. The current rental cost of the space used by the teams is circa £160,000 which is the current market rate for the equivalent space.

The on-going costs that will be incurred year on year are:
1. Volunteer Community Navigator Scheme, including travel and training costs (from 16/17)
The volunteer community navigator scheme will be staffed by volunteers but a part-time service lead is needed to manage, recruit and train the volunteers. This role will also lead the development and implementation of the scheme in practices and across the borough as the service rolls out. Volunteers will require training and there are costs associated with this and volunteers will need to be offered travel expenses incurred whilst performing the role.
2. Investment in MDT (from 17/18)
MDTs will be the central tool for care coordination and ensuring care delivery. We have recognised that there may be additional support requirements for the MDT process to be able to manage the top 10% of users and have built in some investment here for review in 17/18.
3. Marketing and promotion (from 16/17)
The programme will require a robust communications plan and may require some professionally produced information for service users and staff. At this stage of the programme there are no confirmed requirements.

It is not anticipated that there will be any increased costs in staffing in the health and social care teams as there are no new posts required. The current health and social care team staffing cost is circa £3,762,000, this includes on costs but not overheads.

Planned Savings/Efficiencies

Benefits	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**
A&E admissions avoidance	0	-42,415	-84,830	-84,830	-84,830
NEL's avoidance	0	-177,742	-355,484	-355,484	-355,484
Care Home avoidance	0	0	-10,068	-10,068	-10,068
Early intervention opportunities	0	-17,051	-73,637	-73,637	-73,637
Total Benefits	**0**	**-237,208**	**-524,019**	**-524,019**	**-524,019**
Net cost / (Benefit)	**109,700**	**-108,267**	**-373,026**	**-373,026**	**-373,026**
Cumulative Net Cost / (Benefit)	**109,700**	**1,432**	**-371,594**	**-744,620**	**-1,117,647**

Net present value **-£951,703**
Payback **18/19**
ROI **162%**
A breakdown of the savings calculations can be seen in Appendix 3
The business case uses SUS data for non-elective admissions (NELs) during 2015/16 within the Wokingham locality as the basis for determining savings to the programme. There are 2 elements of the service that have a direct contribution the overall total savings – Community Navigators and Community Health and Social Care

Efficiency/Savings
An indication from other similar schemes is that there is a potential for savings and these will come predominantly from:
- Reduced NELs
- Reduced A&E attendances

We recognise that this project also has the potential for savings from:
- Reduction in care home placement
- Reduction in care package funding

Assumptions
We have had to build in assumptions for the targets, based on estimates of the impact of an evolving project over its first few years. More ambitious targets will undoubtedly be achieved from year 2 onwards, as locality based working becomes 'business as usual' and as more volunteer Community Navigators are recruited and confidence in their effectiveness increases and as improved provision of targeted information to enable people to self-care and prevent further ill health further delays or prevents people's dependence on health and social care services.

1. Reduced NELs
In order to be able calculate the number of NELs the project can reduce a year the following information was reviewed.
Wokingham 15/16 NEL activity

- 9013 NEL admissions 19+ years and above
- 315 people (19+ years and above) in Wokingham have been identified as the top 2% of health and social care users and accounted for **1567** NELs, an average of 5 NELs, per person
- 473 people (19+ years and above) in Wokingham have been identified as the top 3-5% of health and social care users and accounted for **1286** NELs, an average of 3 NELs per person
- 788 people (19+ years and above) in Wokingham have been identified as the top 5-10% of health and social care users and accounted for **1576** NELs, an average of 2 NELs per person

The activity above demonstrates the use of health by very high intensity service users (top 2%) and the high risk service users (top 3-10%). By changing the model of care it will be possible to better support these users and reduce the NELs activity.

Wokingham's NEL growth was reported as 5% for 15/16 and YTD 16/17 (year to date) NEL growth is 2.99% (N.B. the percentage growth includes the 0 – 19 age group). By integrating services and taking a system approach the project aims to reduce NELs in this group by **7.5%.** This percentage target was agreed as it will not only halt the annual NEL growth seen in 15/16 (5%) that has been experienced year on year, but aims for a small, but realistic downward trajectory (2.5%).

Therefore we propose the following NEL reductions:

- Top 2% - 1567/100 x 7.5 = 117 NEL reduced
- Top 3-5% - 1286/100 x 7.5 = 96 NELs reduced
- Top 5-10% - 1576/100 x 7.5 = 118 NELs reduced

TOTAL NEL reduction – 331 per year.

Assumes relatively low end needs on entry, therefore tariff rates reflected accordingly based on 5 day rate as per SUSD £1,073.97

2. Reduced A&E Attendances
In order to be able calculate the reduction in A&E Attendances the project can reduce a year the following information was reviewed.
Wokingham 15/16 A&E Attendance activity
o 29,649 A&E Attendances in 19+ years and above
o 315 people (19+ years and above) in Wokingham have been identified as the top 2% of health and social care users and accounted for 2315 A&E attendances, an average of 7.3 A&E Attendances, per person
o 473 people (19+ years and above) in Wokingham have been identified as the top 3-5% of health and social care users and accounted for 1981 A&E Attendances, an average of 4.2 A&E Attendances per person
o 788 people (19+ years and above) in Wokingham have been identified as the top 6-10% of health and social care users and accounted for 2383 A&E Attendances, an average of 3 A&E Attendances per person
The activity above demonstrates the use of health by very high intensity service users (top 2%) and the high risk service users (top 3-10%). By changing the model of care it will be possible to better support these users and reduce the A&E Attendance activity.

By integrating services and taking a system approach the project aims to reduce A&E Attendance in this group by 7.5%. This percentage target was agreed as it will not only halt the annual A&E attendance that has been experienced year on year, but aims for a small, but realistic downward trajectory.

Therefore we propose the following NEL reductions:
- Top 2% - 2315/100 x 7.5 = 173 A&E attendances reduced
- Top 3-5% - 1981/100 x 7.5 = 148 A&E attendances reduced
- Top 5-10% - 2383/100 x 7.5 = 178 A&E attendances reduced

TOTAL A&E attendance reduction – 499 per year.

Calculated at £170 per admission

3. Reduction in funding of social care packages

Expectation is the navigator scheme will still achieve reductions in this area as users that may have required packages of care or higher levels of packages of care could be supported by voluntary/charity sector services. We have assumed that 24% of referrals will lead to benefits from reduced social care packages and have calculated a cost benefit of £175 per month (represents 15% reduction on cost of average social care package).

4. Reduction in care home placements

On the basis the above is successful this will naturally lead to reductions in home care placements (suggest this could be year 3 before an effect is seen) This has been calculated based on those for whom the provision of adequate support in the community results in delay in care home admission, assumes delayed entry of 24 months, therefore generates 24 months of cumulative benefit – balanced by the assumption that those kept from care home placements require a home care package, therefore applying same rate as WISH assumptions.

We have assumed that of the 24% of navigator referrals that result in a reduction in funding of social care, 25% of those will benefit from a delay in care home placement which is calculated at differential between £681 per week which is the care home cost versus £267 per week which is the cost of a social care package when the user remains in their own home, which is £414 per week.

Phasing Assumptions

- There will be a slower uptake in year 1 and 2 as the scheme develops and is implemented
- There will be greater impact in year 2 and subsequent years, as more volunteer Community Navigators are recruited and the Community Health and Social care system integrates, there is greater awareness of their presence and increased confidence in their effectiveness
- For community navigators implemented a year 1 & 2 uptake to reduce levels of activity as scheme is embedded into GP's practices (referrals roughly aligned with current activity)
- Benefits realised from home care is 1 year post referral
- The percentage of those benefiting from community care and avoidance of home care will result in a longer term saving to Res care.
- In the longer term, more admissions and more A&E attendances will be prevented through the impact of targeted early self-care / prevention

Impact of Non-Financial Outcomes

An important consideration for investment is the impact on non-financial outcomes:

- The programme will support the Wokingham health and social care economy to achieve its strategic aims.
- The programme is expected to make a significant impact on people's experience of care and their health outcomes.
- The programme supports commissioners and providers to develop a sustainable health and care economy.
    - Reduced cost of social care packages
    - Reduced care home placements
    - Reduced non-medical GP appointments
- In addition, the programme also aims to transform the way organisations work together and as such contribute positively to the work satisfaction of local health and care professionals.

'Dis-benefits'

- There may be a reduction in income for the Royal Berkshire NHS Foundation Trust as project aims to reduce NEL and A&E activity
- BHFT currently rent rooms from GP surgeries at varying costs; this could be a loss of income for the GPs if the community nurses were to vacate.
- Optalis currently rents its office space from WBC for is Brokerage and Support team, this would be a loss of income for WBC, but they may want to re-negotiate with Optalis on the overall contract if this was built into existing contractual arrangements with Optalis.

Payback period

The project is expected to return a net saving in 2018/19.

Section 3 - Project Approach & Governance

Key Project Milestones (to include initial start date, main delivery points and Go Live date)			
Milestone	**Milestone Description**	**Date**	**Owner/Lead**
1	Present draft business case to the Steering Group	13/9/16	Project Manager
2	Present final business case to WISP for approval	14/11/16	Project Manager/WISP
3	Present final business case to relevant CCG, BHFT and WBC boards for approval	October/ November/ December 2016	SROs and DC
4	Plan and present Commissioning and Governance process and proposal for Wokingham Integrated Health & Social Care system for commissioning Exec Boards and HWBB approval	June 2017	SROs
5	Present final business case to Health and Well-being board for approval	June 2017	Project Manager/HWB
6	On-going roll-out of the community navigator service	On-going to December 2017	Involve
7	Prepare detailed project plan	November 2016 & January 2017	Project Manager
8	Phase 2a Design and Engagement Phase – including the recruitment of the Head of CHASC Phase 2a (i) Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC)	March 2017 to October 2017	Project Manager/ Providers/ Service Users
9	Phase 2b Implementation of CHASC Phase 2b (i) Testing Phase with a single GP locality Phase 2b (ii) Roll out to the other 2 GP localities	November 2017 to November 2018	Project Manager & Providers
10	Phase 3 Development of future plans with wider partners, to work up as a model in 17/18	February 2018 to May 2018	Project Manager & Head of CHASC

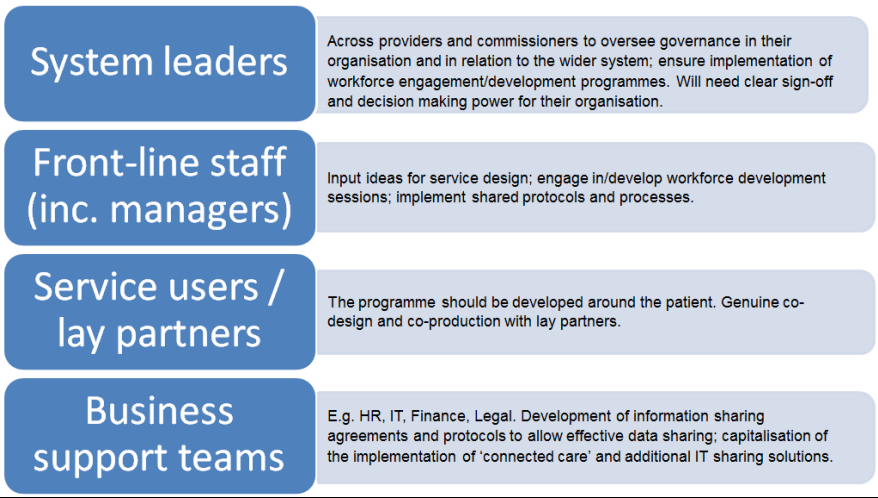
Delivery Chain

The provision of coordinated services though the Community Health and Social Care project is likely to be commissioned by Wokingham CCG in conjunction with Wokingham Borough Council and provided through integrated teams of multi-disciplinary professionals within the Wokingham borough area. Responsibilities and governance will need to be established. Providers of services will include:

- General practice
- Berkshire Healthcare NHS Foundation Trust
- Wokingham Borough Council
- Optalis
- Voluntary sector organisations

The resources for delivery by partners, where applicable, been fully considered. At present only some GPs are engaged in the project as primary care has yet to decide it long term strategy and plans at present. All other partners are fully engaged and part of the project planning.

The roles, responsibilities & accountability of the stakeholders in this programme are summarised below.



Project Organisation, Governance and Controls

Project implementation

Draft refreshed PID to be presented to WISP in September 2016. This will be following consultation through the Steering Group and with key stakeholders.

A project Steering Group is in place to lead on the strategic development and implementation the on-going review and monitoring to ensure success of the project post initial implementation of the Community Health and Social Care Project. A key focus will be ensuring that all enabling work areas critical to the success of the project are engaged and involved in delivery, from development through to implementation and that there is a co-ordinated, coherent set of plans in place to achieve the agreed changes and that these are well communicated across all organisations involved. The Community Health & Social Care steering group membership and meeting frequency has been reviewed and refreshed and is meeting monthly on the 1st Tuesday of the month.

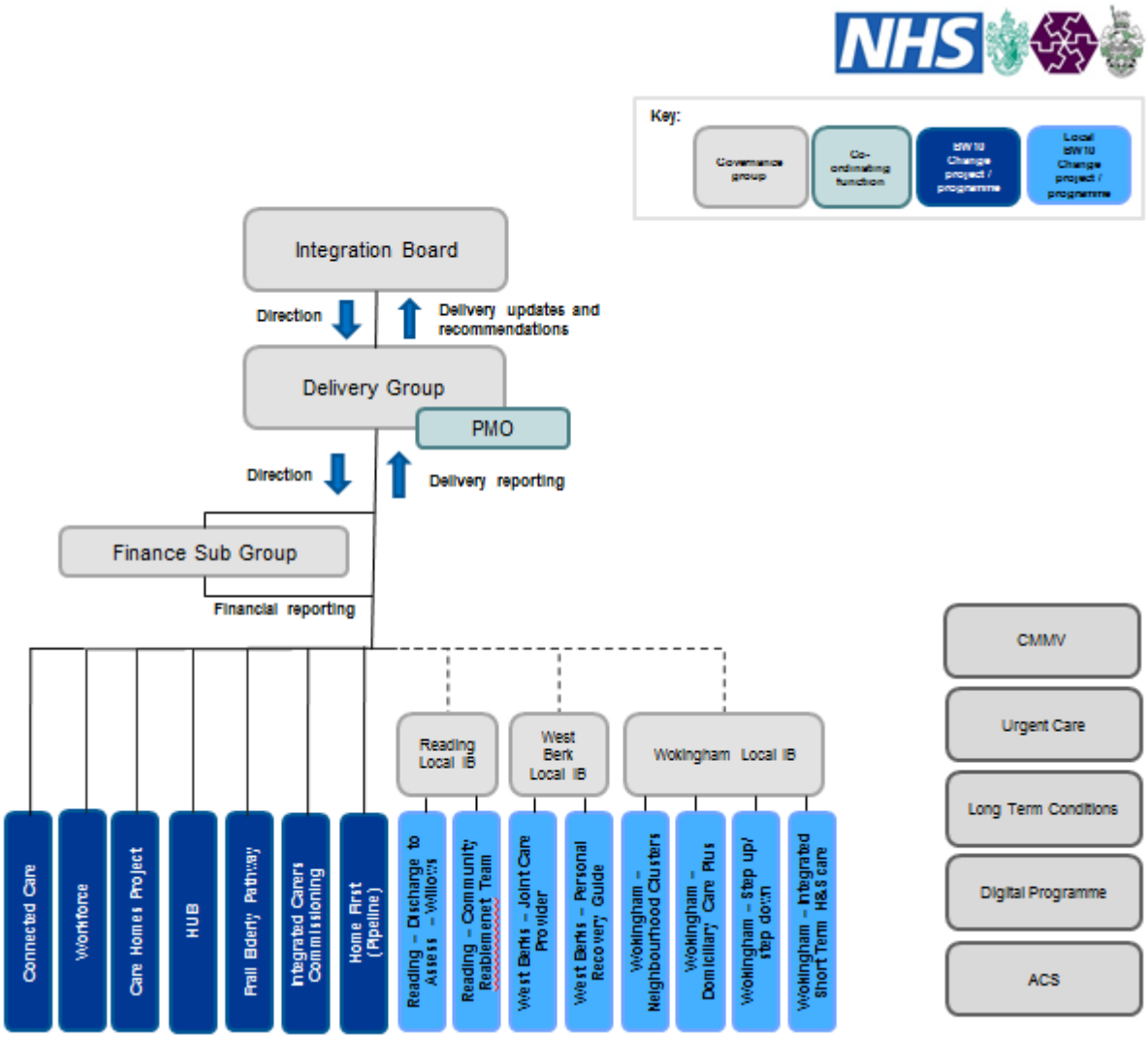
The Steering Group will report into WISP via Highlight reports and where necessary exception report to the SRO outside of these meetings. The steering group will work within the scope of the project as identified within the PID.

At present there is a project manager in post 3 days a week to deliver this project. The project manager will develop a robust implementation plan once the PID is approved to identify what is required to deliver the change. The Project manager will develop appropriate work streams and will develop working groups to deliver the work of the work streams.

Project Structure

Health and Wellbeing Board
↕
WISP
↕
Steering Group ↔ Task and Finish Groups
↕
(may require Locality Working Groups x 3)

Governance Structure



Governance Group and Roles

A dedicated steering group has been established to oversee the development and implementation of the project. The accountability for the delivery of this programme will be to WISP. Local assurance, troubleshooting and escalation will be via the Steering Group.

Steering group reporting bi-monthly to Wokingham Integration Strategic Partnership, and through them, into the Wokingham Borough Health and Wellbeing Board. The Health and Wellbeing Board (HWB) has strategic oversight and governance for related projects within the Better Care Fund.

Monthly written update reports will contain details of progress to date, achievements in the current period and achievements expected in the next period, details of actual or potential problems and suggestions for

their resolution. Exception reports will be produced when any stage of the project plan deviates outside tolerance limits. Exception reports will detail the problem, outline the available options and identify the recommended option;

The steering group will also feed into the Frail Elderly Programme and the Berkshire West 10 Integration Programme.

There are joint SRO arrangements for the programme, having a SRO from both Health and Social care. The project manager will report to joint SROs and day to day operational support is provided by the Wokingham BCF Programme Manager.

Membership

Joint SROs:

- Katie Summers, Director of Operations, Wokingham CCG
- Stuart Rowbotham, Director Health and Wellbeing Wokingham Borough Council

Scheme Project Manager: Rhian Warner

Steering Group Members

Name	Role
Katie Summers	Director of Operations, NHS Wokingham CCG; Joint SRO for this scheme
Judith Ramsden	Director of People Services; Wokingham Borough Council; Joint SRO for this scheme
Johan Zylstra & Matt Shaw	GP, Finchampstead; Clinical Lead for East Cluster GP, Brookside: ACS GP Provider Lead
David Cahill	Director- Wokingham Locality, Berkshire Healthcare Foundation Trust
Julie Stevens	Wokingham BCF Programme Manager
Mette Jakobsen	Optalis
Philip Cook	General Manager; Involve – Wokingham
Darrell Gale	Consultant In Public Health, Wokingham Borough Council
Nicola Strudley/Jim Stockley	Healthwatch Wokingham
Mike Chow	Finance Lead Wokingham BCF, Wokingham Borough Council
Rhian Warner	Community Health and Social Care Project Manager

As required additional staff will be invited to the steering group as and when required and may include the following:

- CCG Manager
- WBC representative with strategic/policy/development perspective
- GP from each cluster
- Practice Manager
- Practice Nurse
- MH Lead
- WBC – Community Development Worker link
- Voluntary / community organisation(s)
- Residents/service users (e.g. from PPG Forum; social care user, co-production network),
- Health and Well-being Board member and/or one of the local ward members.

As this programme is proposed as a BW10 Integration project it will develop and maintain the following key control documents for monthly submission to WISP, the Health & Well-being Board and the BW10 Project Management Office (for BWPB / FEP):

- Monthly Highlight/Status report
- Programme Initiation Document and Business Cases
- Delivery Milestone plans
- Risks & Issues and Dependency logs
- Monthly Financial forecast and spend to date statements

The project will have a 6 month post project completion evaluation against the projects objectives and key outputs and include:

- Implementation review
- Finance review
- Activity review
- Benefit realisation
- Risks review
- Lesson learnt

Information Governance

Once operational, the multi-disciplinary teams of staff working within the localities will comply with all requirements regarding data protection and confidentiality.

This project will involve the use of personal data across multiple organisations within the Berkshire West 10 Partnership. In order to ensure the safe governance of information the following will need to be delivered:

- Development of information sharing agreements and protocols to allow effective data sharing
- Capitalisation of the implementation of ‘connected care’ and additional IT sharing solutions
- Shared documentation
- Raise awareness of information governance requirements with staff
- Clarity re: information requirements and who needs access to information
- Connected Care BCF project to progress integrated information system

The Adjusted Clinical Groups® (ACG) System is used to help identify health needs and commissioning issues, this data is anonymised.

Risks Management and Contingency Plans

The project has already identified potential risks as well as mitigations to the delivery of the project; these can be seen in the table below with a brief summary of the proposed controls and mitigating actions.

The project is already has a Project Risk log and the project manager is responsible for managing the risk register and escalating risk as required. The Risk Log is attached as an appendix.

The review of the risk log will be a standing item on the Steering Group agenda, to ensure regular, monthly, review of risks and appropriate escalation. Any high risks will be escalated to the Wokingham BCF Programme Risk Register, which is reviewed at the monthly WISP board meeting.

Risk Description	RR	Required controls and actions to reduce/mitigate risk
Stakeholder commitment to the locality model - Risk that not all key stakeholders will be committed to the development and implementation of a locality model (also potential barriers due to conflicting organisational priorities / different internal processes and sign-offs for decision making); also inability to agree what should be included in localities and how they are designed and governed	12	Full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the scheme from all key stakeholders, the identification and resolution of any conflicting organisational priorities / different ways of working between the various professionals and any perceptions of professional boundaries that may hinder the project. Will need to consider and develop an appropriate contracting and governance mechanism between all partners. 11/1/17 The CCG is now very much engaged with proposals to take this forward & it was considered that partner organisations also support this. Work is now needed for next steps, engaging with staff and the public to promote the service. To be rolled out once HWBB (Health and Well Being Board) sign off the PID. Healthwatch volunteers/ resources can be utilised if requested – this is a growing base of information and interested participants.
Critical Mass of staff for locality modelling - Some services are currently provided at Berks West level and it may not be easy, nor sensible, to cluster -base. Social Care services also need a critical mass of staff for viability and this needs to be considered	6	Must have a phased approach - identify those services / resources that are 'locality-able' for 1st phase and aspiration list of those services / resources to include later when/if possible. Also need to work closely with all providers to ensure that services are viable
CNS, Patient Information Sharing - Risk of resistance to information sharing across the constituent parts of the local health and social care system that might impinge on the ability of the voluntary Community Navigators to provide accurate and up to date accessible information and signposting	6	to be managed through co-production - full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the project from all key stakeholders; to include the identification and resolution of any conflicting priorities within / between relevant professionals and organisations 14/12/16 Currently trying to secure an nhs.net account for Community Navigators to ensure easy information sharing moving forwards
CNS, Insufficient Volunteers - Risk of insufficient volunteers being recruited in each locality to provide the focused support and information required for identified service users	12	To be managed through effective recruitment – i.e. innovative advertising and wide-ranging publicity and the assurance of comprehensive training and support to carry out the role. Also need to ensure retention once recruited. Involve is responsible for ensuring this. 11/1/17 To be discussed at the next meeting – PC to confirm if volunteer numbers are adequate, the status of recruitment and plans to move forward. Community Navigators struggled to get volunteers last year.

CNS, Low referral numbers - Risk of under-utilisation of the service due to reluctance of professionals and organisations to use social prescribing to refer people to the volunteer Community Navigators / no agreement regarding accountability and liability for 'referred' patients.	12	to be managed through development of the project by co-production so all key stakeholders are engaged; accurate and clear communication about social prescribing, the role of this project and its aims and objectives; volunteer Community navigator induction will include personal meetings with key personnel in the relevant locality; and the volunteer Forum will act as an additional opportunity to engage with relevant professionals and organisations. 14/12/16 Service specification needs to be developed and Involve now have a clear action plan in order to ensure engagement with all relevant referrers
Information governance - Risk of Information governance and sharing issues due to multiple providers delivering the service.	8	Training, support and supervision of volunteers Raise awareness of information governance requirements with staff as rqd. 14/12 /16 Connected Care project will act as an enabler in this area, but the information governance issues will only be resolved when Connected Care becomes available and there may need to be work arounds in the interim period.
CNS, Voluntary sector sustainability - Risk of overwhelming local voluntary and community organisations with referrals from Volunteer Community Navigator scheme	9	Regular contact with VCOs through Involve; and monitoring through CHASC Steering group 14/12/16 In refreshed Business Case (November 2016) have built in financial support for the voluntary sector and in service specification for navigators have added that they will monitor this
Delays around the PID/Business Case - The complexity of the refreshed business case (November 2016) approval process could add delays into the proposed implementation plan for the project	12	Implementation plan is fluid and can be updated to reflect this. Implementation plan needs to be a regular item on the steering Group Agenda. Need to ensure that slippage is built into the implementation plan. 11;/1/17 Looking to progress this item to the implementation delivery plan in the next few months, dependent on approval at January (informal) and February 2017 (formal) HWBB meetings.
Culture change - Culture, physical and structural change within and between organisations is a critical to the success of the CHASC project/service. Culture change is always challenging and can take long periods of time to embed	12	Ensure that there is a robust plan for culture change which must include staff engagement and resident engagement at the earliest stage. Make use of available evidence and methods for achieving culture change.

Section 4 – Co-production, Engagement and Communications

Patient/Service User Engagement and Co-production plan outline

The intention is to fully engage with all key stakeholders during the process of developing the Community Health and Social Care Service, with the scoping, planning and delivery being co-produced through health and social care professionals working closely together to design the most effective model for the service.

Local patients/social care clients, their families/carers, and all relevant support organisations and communities will also be involved and engaged with the design, planning, implementation and delivery of the service, with specific input into the detail around focusing on self-care and primary prevention.

Engagement will be co-designed between the CCG and the unitary authority.

Key stakeholders to be engaged with are:

- Service users (including patients and carers) and / or their representatives, including local voluntary organisations
- Borough and parish councillors
- Service providers: general practice; community nursing teams; local authority teams; mental health

staff, voluntary sector organisations; acute and community trusts
- Public health team regarding prevention and self-care in particular

In order to ensure co-production and engagement of users/patients a plan will be devised which would include:
- A patient/user representative on the steering group - COMPLETED
- Regular workshops/engagement sessions with staff and service users
- Regular feedback to Integration board, Health and Well-being Board and Healthwatch

Equality Impact Assessment

As part of the development of this BC, we have conducted an Equalities Impact Assessment Screening process. This has been informed by the previous cases and the stakeholder engagement activity. We have come to the conclusion that the proposed programme will not negatively impact any of the protected Equality groups. The programme aim is to have a positive impact upon the provision of health and care services on all people over the age of 18 in Wokingham. This will indirectly also benefit their carers and families.

None of the aspects has scored over the threshold of 8 and therefore does not require sign off by the quality team. See **Appendix 4.**

Key Stakeholders/ Clinical Engagement and communications plan outline

Key Stakeholders
- Director of People Services, Wokingham Borough Council
- Director of Operations, Wokingham CCG
- Berkshire Healthcare Foundation Trust (Community Nursing, Adult Mental Health Services and specialist services)
- Optalis
- Involve and volunteer community navigators
- Public Health
- Public/Patient representatives (Service users/lay partners)
- Healthwatch
- Front-line staff (inc. managers)
- Service development staff
- WBC Commissioners
- WISP
- Wokingham Health and Well-being board
- Voluntary sector
- Estates services, WBC and BHFT
- Adult Safeguarding, WBC
- Housing support, WBC
- BW10 Project Management Office
- Community development
- Libraries, WBC
- Sport & leisure, WBC
- Employment support, WBC
- Children's services – transition services

Details of partner engagement already undertaken
Clusters:
- Stakeholder (GP / WBC) workshop (December 2014)

- Stakeholder (GP) workshop (January 2015)
- WISP (January 2015)
- Practice Managers (January 2015)
- Council Executive members (January 2015)
- Have Your Say events (March 15)
- Patient Participation Group Forum (March 2015)
- Health and Wellbeing Board (May 2015)

Overall, these stakeholders indicated their general support for the concept and proposals for neighbour cluster teams. There was a view that, given the complexity of the project, it is important that timescales are realistic. The need for suitable transport and access was an issue that was raised by many stakeholders.

Prevention:

- Patient Participation Group Forum (January 2015)
- Place & Community Partnership / Co-production Network (January 15);
- Survey regarding maximising independence through prevention and self-care (February 15)

Partner Engagement Planned

At present there are no planned partner engagement events until the PID has been agreed. Once the PID has been agreed the project manager will work with WBC Community engagement team to plan what is required.

Clinical Input Requirements

The project require will require clinical input and this will this be sought through the following:

- Engagement sessions with front-line staff
- Programme planning; programme design forums and establishment of programme design teams
- Knowledge sharing and 'up-skilling' of workforce
- Implementing new staffing models based on the new model of care

Communications Plan

A communication plan needs to be developed. Consultation and engagement with professionals and service users will continue throughout the trial period and during the evaluation phase. Recognising the potential challenges involved with meeting the needs of all sectors of the local population, the feasibility of seeking the views of those "seldom heard" within the population will be considered.

Section 5 - Document Information

Document Title	Wokingham Community Health & Social Care (CHASCC) – (Neighbourhood Clusters, Self-Care and Prevention) BCF Project

File path\Filename	Format	Comments
BW10 PID and Business case Wokingham Community Health and Social Care Sept 2016 vs. 1.6	MS Word	Main Document

Supporting Documents	Format	Location/ Comments
1. *Project/Programme Plan*	Excel	Will be submitted as an additional document
2. *Equalities Impact Assessment*	N/A	Appendix 4 in this document
3. *Wokingham Neighbourhood Clusters, Self-Care and Primary Prevention Initiation Document and Business Case (Draft v 8.1) 14th August 2015*	MS Word	Author: Jane Brooks Will be submitted as an additional document
4. *BCF BUSINESS CASE 2016/17 Prepared for WISP Feb 2016; updated 05-5-16 (draft v 8) Neighbourhood Clusters, Self-Care and Prevention*	MS Word	Author: Jane Brooks and James Burgess Will be submitted as an additional document
5. *DISCUSSION PAPER Wokingham Neighbourhood Clusters – structure and organisation Feb 16 (draft v 2.0)*	MS Word	Author: Jane Brooks Will be submitted as an additional document

Responsibilities

Distribution	Project Manager
Ownership	Project Steering Group and WISP
Maintenance	Project Manager

Distribution of Final Version

Copy	Keeper	Area	Purpose	Media
1	Programme Manager	Programme Office	Reference	Paper & Electronic
2	Knowledge Library	Programme Office	Master	Electronic

Version History

Version No./ Status	Issue Date	Author	Quality Review/ Change Date	Reviewed By	Brief Description of Action/Changes
1.1 Draft	August 2016	Rhian Warner	13th September 2016	Steering Group & Rhian Warner	Addition of Financials, proposed model of care and further detail in Background section
1.2 Final	September 2016	Rhian Warner	29th September 2016	Steering Group & Rhian Warner	Removal of structure options and minor amendments in Background section

1.3 Final	October 2016	Rhian Warner	17th October 2016	SROs	Adding in GPs into the model, minor changes to steering group board members
1.4 Final	November 2016	Rhian Warner	3rd November	Steering Group	Final review and changes to the order of the narrative in the PID. Update of the project phasing
1.5 Final	November 2016	Rhian Warner	16th November	SROs	Addition of commissioning and improved wording to percentage growth
1.6 Final	January 2017	Rhian Warner	24th January	SROs	Addition of LA information, updated implementation plan, updated financials
1.7 Final	June 2017	Rhian Warner	1st June 2017	SROs	Updated financials to match 17/19 BCF planning and review of project milestones to reflect the pause whilst governance arrangements agreed.

Sign Off & Approval (of finances, proposed development)	
Name & Lead function (e.g. Finance, CCG lead, LA Lead):	Authorisation signature:
Wokingham Integrated Strategic Partnership – Stuart Rowbotham/Katie Summers	16/11/16
BHFT David Cahill	1/12/16
Wokingham Borough Council Stuart Rowbotham	19/12/16
Wokingham Clinical Commissioning Group Katie Summers	1/12/16
Wokingham Health and Wellbeing Board	

Appendix 1 – Wokingham CCG and Local Authority Population Demographics

This data has been taken from:

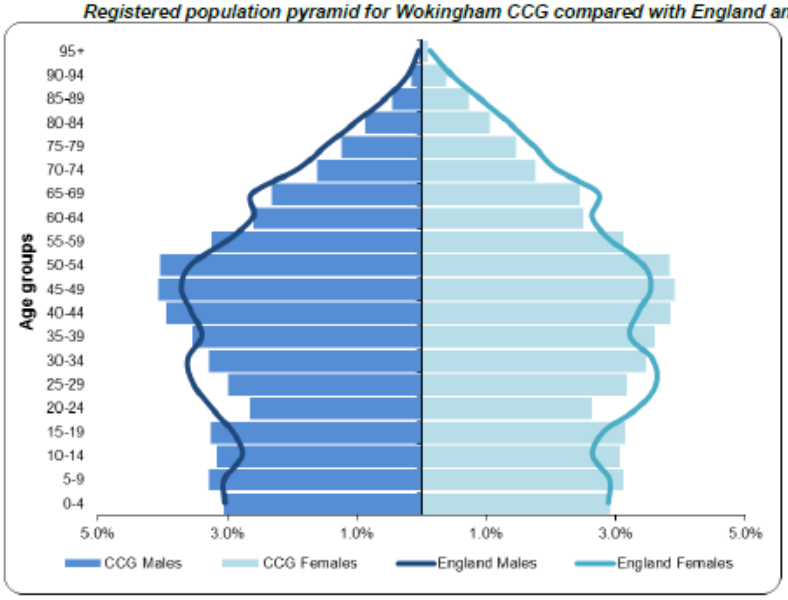
- Wokingham Clinical Commissioning Group: Locality Profile 2015, Public Health Services for Berkshire, November 2015
- Commissioning for Value: Where to Look, January 2016, Right Care Profile, Gateway ref: 04599

Wokingham's population is approximately 159,097 at the 30th June 2015 and with 99.9% registered with one of the 13 GP practices who belong to the Wokingham CCG group

Brookside Group Practice	Burma Hills Surgery	Finchampstead Surgery
Loddon Vale Practice	New Wokingham Road Surgery	Parkside Family Practice
Swallowfield Medical Practice	Twyford Surgery	Wargrave Surgery
Wilderness Road Surgery	Wokingham Medical Centre	Woodley Centre Surgery
Woosehill Surgery		

Population Profile

Registered population pyramid for Wokingham CCG compared with England and Wales at 30-Jun-15

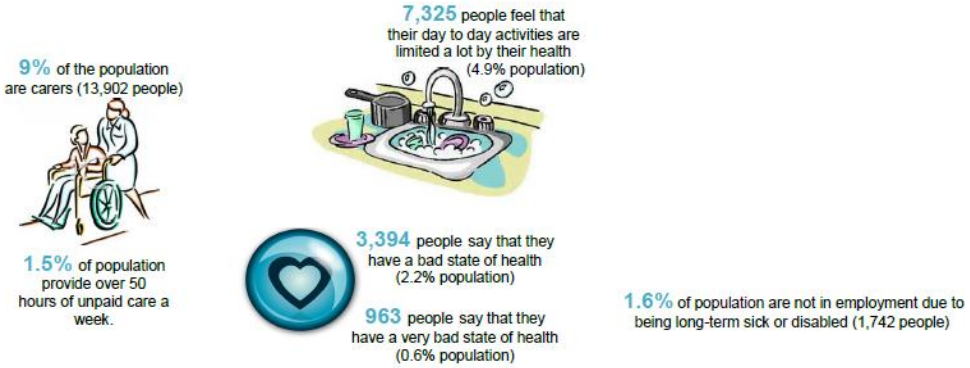


Age Group	Male	Female	People
0-4	4,885	4,603	9,488
5-9	5,255	4,996	10,251
10-14	5,058	4,663	9,721
15-19	4,593	4,276	8,869
20-24	3,757	3,653	7,410
25-29	4,361	4,369	8,730
30-34	4,596	5,005	9,601
35-39	5,673	5,826	11,499
40-44	6,342	6,181	12,523
45-49	6,466	6,209	12,675
50-54	6,191	6,129	12,320
55-59	5,287	4,925	10,212
60-64	4,183	4,223	8,406
65-69	4,135	4,535	8,670
70-74	3,109	3,370	6,479
75-79	2,382	2,711	5,093
80-84	1,673	2,071	3,744
85-89	836	1,272	2,108
90-94	306	646	952
95+	63	191	254
Total	79,151	79,854	159,005

Source: Health and Social Care Information Centre (July 2015)

Demography

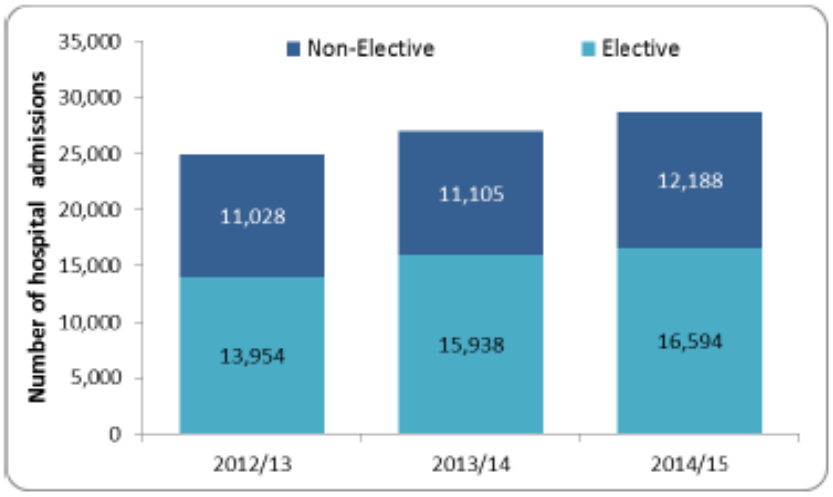
Key demographics from the 2011 census show the following:



Hospital Activity

Wokingham CCG had 80,807 hospital admissions for people aged 18 and over from April 2012 to March 2015. The majority (72%) of these admissions were at Royal Berkshire Foundation Trust.

Wokingham CCG's hospital admissions for people aged 18 and over (2012/13 to 2014/15)



Source: Dr Foster (2015)

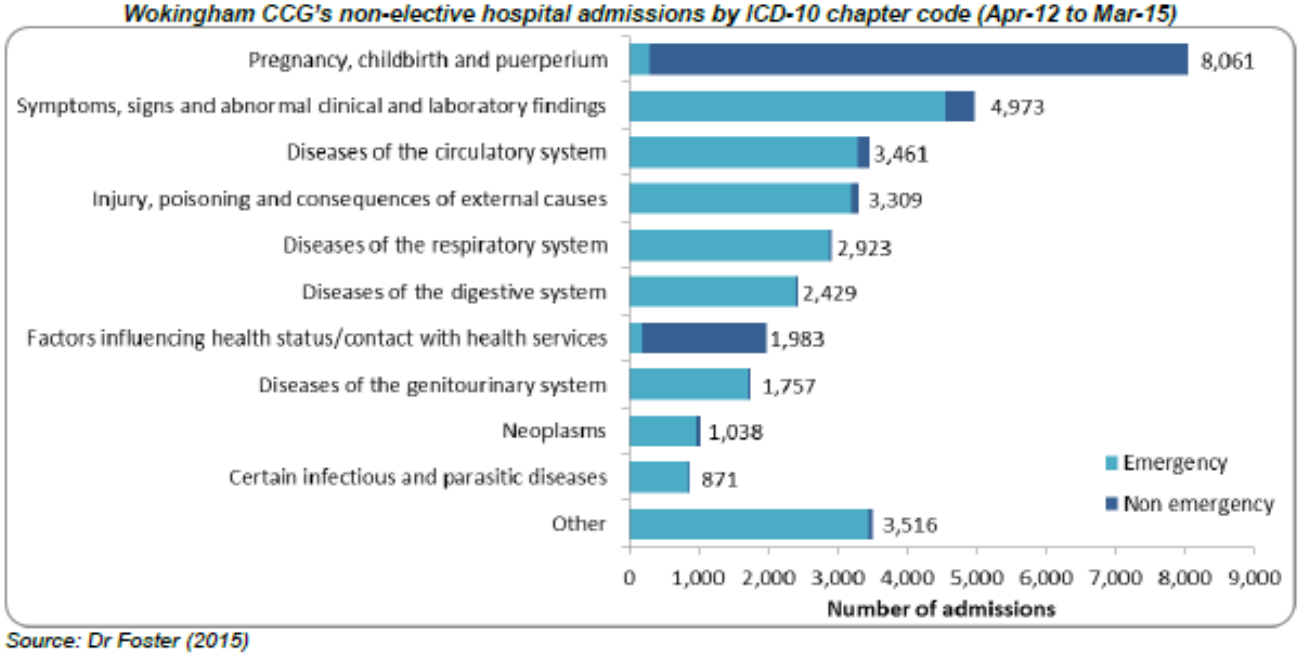
42.5% of hospital admissions for Wokingham CCG residents (aged 18 and over) were non-elective and these made up 82% of bed days from April 2012 to March 2015.

	Elective hospital admissions	Non-elective hospital admissions
Number of admissions:	46,486 elective admissions (57.5% of all admissions)	34,321 admissions (42.5% of all admissions)
Bed days:	39,736 bed days (18.0% of all bed days)	171,788 bed days (82.0% of all bed days)
Average length of stay:	0.9 days	5.0 days

Source: Dr Foster (2015)

The table below summarises Wokingham CCG's non-elective hospital admissions for April 2012 to March 2015 showing the ten most common reasons for admission.

Wokingham CCG's non-elective hospital admissions by ICD-10 chapter code (Apr-12 to Mar-15)



Source: Dr Foster (2015)

Further analysis of the data has shown that there are opportunities to reduce admissions to hospital.

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (ACSCs) include admissions for long-term conditions such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure. These are admissions which could be prevented by effective community care and case-management.

  In 2014/15, Wokingham CCG had 825 unplanned admissions for ACSCs. This is 546 admissions per 100,000 population. The rate of admissions in the CCG continues to be significantly lower than the national rate.
- Emergency admissions for acute conditions that should not usually require hospital admission include disease such as influenza, pneumonia, urinary tract infections and cellulitis. These should be managed without the patient needing to be admitted to hospital.

  In 2014/15, Wokingham CCG had 1,320 emergency admissions for acute conditions that should not require admission. This is 882 admissions per 100,000 population. The rate of admissions in the CCG continues to be significantly lower than the national rate and CCG Comparator group.

Complex Patients

The following data include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that the CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2013/14. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system

2% Most Complex Patients (14.9% of CCG Spend)					
Age	Number of complex patients	Mean Number of Admissions	Mean Number of Different Conditions	Total Spend (£000s)	
0	16	5.4	3.19	£	505
1-4	*	9.0	3.20	£	117
5-9	6	2.8	1.83	£	186
10-14	8	6.0	2.25	£	267
15-19	*	2.4	1.60	£	115
20-24	*	12.7	2.33	£	49
25-29	*	4.0	1.33	£	68
30-34	7	8.9	2.71	£	145
35-39	6	14.5	2.50	£	193
40-44	12	15.2	2.92	£	211
45-49	10	7.4	2.70	£	197
50-54	12	5.3	2.08	£	218
55-59	16	6.9	2.56	£	333
60-64	25	6.5	2.44	£	556
65-69	38	9.6	2.71	£	774
70-74	50	6.4	2.52	£	932
75-79	46	5.7	2.46	£	865
80-84	38	7.4	2.63	£	758
85-89	24	4.1	2.67	£	419
90+	10	3.8	2.60	£	188
TOTAL	345	6.8	2.52	£	7,096

* Represents low number and the total number of complex patients have been adjusted due to suppressed numbers

Public Health England RightCare NHS England

- Your average complex patient has 7 inpatient admissions per year across 3 different conditions(based on programme budgeting categories)
  - Your CCG spends most on Circulation, Cancer and Musculo skeletal
  - 60% of these complex patients are aged 65 or over
  - 34% of these complex patients are aged 75 or over
  - 10% of these complex patients are aged 85 or over
- 91% of the complex patients also had an outpatient attendance during the year
  - 56% of those patients had more than 5 attendances
  - 15% had more than 15 attendances
  - The average patient had 9 attendances a year

- 80% of the complex patients also had an A & E attendance during the year
    - 9% of those patients had more than 5 attendances
    - The average patient had 3 attendances a year

Appendix 2 - Phase 2a and 2b Implementation plans

Phase 2a

Objective	Implementation Milestone	Task Owner		01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017	01/10/2017	01/11/2017	01/12/2017	01/01/2018	01/02/2018	01/03/2018	01/04/2018	
Phase 2a Localities Development	Development of new system/services, including service specification	RW			Draft to CHASC												Draft specification developed with BHFT and Optalis in Feb, March & April 2017. 1st Draft shared for comment at CHASC May 17. At present no sign off or comments until agreement of governance
	Phase 2a (i) Delivery around Primary Care	RW/GP Alliance									Slippage						
	Continued comms and engagement around new locality service	RW															1/4/17 Paused until HWBB approval. Realigned to Jul 17 start. Remains amber due to realignment
	Governance & Contracting arrangements to be agreed	RW/SROs				Slippage	Slippage										1/5/17 Proposal paper completed April 17. SROs taking to relevant boards for approval in May17 with plans for Jun 17 HWBB
	Appointment of Head of CHASC	RW/SROs				Consult			Slippage	Slippage	Slippage						1/4/17 on hold at present as CHASC PID not approved. Realigned to Jul 17 start. Remains amber due to realignment
	CHASC Engagement and design sessions with staff	RW/Staff									Slippage						Planned to start March 17 but on hold until governance and PID approved 1/5/17 Work streams agreed and senior staff allocated. Realigned to start Jul 17
	CHASC Engagement and design sessions with public/users	RW/Citizens									Slippage						Planned to start March 17 but on hold until governance and PID approved 1/5/17. Realigned to start Jul 18
	KPIs - ensure all baseline measures and audit tools developed and agreed	RW/Head of CHAS			Final to CHASC		Slippage	Slippage									KPIs for approval May 17 CHASC. JR would like BCF umbrella KPIs and then CHASC KPIs. Meeting booked for 17/5/17
	Appoint 3rd Locality MDT coordinator	BHFT Head of Adults															Appointed and due to start June 17
	Agree design of system/model of care	Steering Group							Slippage	Slippage							Realigned as paused until CHASC PID sign off planned for Jun 17
	Development of single shared risk stratification tool- Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people	RW/Head of CHAS							Slippage	Slippage							1/4/17 this should be achieved with the Risk Stratification tool which the CSU are redeveloping for a Sept 17 launch, so timelines realigned.
	Delivery of statutory duties	RW/SROs							Slippage								1/4/17 Made contact with WBC Head of Safeguarding and will also need to be addressed by the governance agreements.
	Revised MDT structure and delivery across localities	RW/Head of CHAS							Slippage								Review of MDTs in
	Single point of access to all services in CHAS	RW/Head of CHAS/Head of Hub									Slippage						Realigned to Jul 17 start due to governance proposal approval
	A locality based locations, virtual alignment and remote working	RW/Estates/ Head of CHAS									Slippage						Realigned to Jul 17 start due to governance proposal approval
	Alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS															Realigned to Jul 17 start due to governance proposal approval
	Development of integrated policies and procedures	RW/Head of CHAS									Slippage						Realigned to Jul 17 start due to governance proposal approval

Phase 2b

Objective	Implementation Milestone	Task Owner	RAG rating	01/11/2017	01/12/2017	01/01/2018	01/02/2018	01/03/2018	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	
Phase 2b Localities Implementation	Implementation phase (6 -12 months)	RW/ Operational Lead															
	Phase 2 b (i) Testing Phase with a single GP locality	PM/ GP Alliance															
	Phase 2b (ii) Roll out to the other 2 GP localities	PM/ GP Alliance															
	Continued comms and engagement around new locality service	RW															
	Continued alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS															
	Continued clarification of staff roles and responsibilities	RW/Head of CHAS															
	Review and update all processes to provide efficiency and consistency	RW/Head of CHAS															
	Review of health and social care pathways and integrate/update as required	RW/Head of CHAS															
	Improving the way in which professionals share information within and between organisations	RW/Head of CHAS															1/4/17 This will have dependencies with the Connected Care Project, therefore rated as Amber at present
	Continue to develop single point of access to all services in CHAS	RW/Head of CHAS/Head of Hub															
	Locality based locations, virtual alignment and remote working	RW/Estates/ Head of CHAS															If appropriate, will be agreed during the planning phase
	Continue development and implementation of shared paperwork	RW/Head of CHAS															
	Development and implementation of single assessment	RW/Head of CHAS															
	Continue development and implementation of integrated policies and procedures	RW/Head of CHAS															
	Continue implementation of shared risk stratification tool	RW/Head of CHAS															
	Investigate and implement technology where needed	RW															

Appendix 3 – Finance Detail

Cost profiles

Cost base 16/17		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**62,100**
Local programme office support		1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	**20,900**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	**19,848**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	92	92	92	92	92	92	114	114	114	137	137	137	**1,304**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19													**0**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery														**0**
IT infrastructure costs	Firewall issues etc													**0**
Property costs	Moving costs and impacts on rents													**0**
Total Costs		**9,196**	**8,946**	**8,946**	**9,196**	**8,946**	**8,946**	**9,218**	**8,968**	**8,968**	**9,241**	**8,991**	**8,991**	**108,552**

Cost base 17/18		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**62,100**
Local programme office support														**0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**39,696**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	229	229	229	229	229	229	229	229	229	229	229	229	**2,748**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery		5,000												**5,000**
IT infrastructure costs	Firewall issues etc	10,000												**10,000**
Property costs	Moving costs and impacts on rents	5,000												**5,000**
Total Costs		**29,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**128,944**

Cost base 18/19		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
CHASC and CNS														
Project Management agency consultant	No requirement from 18/19													**0**
Local programme office support														**0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**39,696**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	381	381	381	381	381	381	477	477	477	477	477	477	**5,147**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	**51,750**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	**50,000**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery														**0**
IT infrastructure costs	Firewall issues etc													**0**
Property costs	Moving costs and impacts on rents													**0**
Total Costs		**12,702**	**12,452**	**12,452**	**12,702**	**12,452**	**12,452**	**12,797**	**12,547**	**12,547**	**12,797**	**12,547**	**12,547**	**150,993**

Saving Profiles

Totals	2016/17	2017/18	2018/19	2018/20	2018/21
Levels of activity					
A&E admissions avoidance	0	250	499	499	499
NEL's avoidance	0	166	331	331	331
GP Appointments avoided	19	39	74	99	99
Care Home avoidance	0	0	4	9	16
Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ 42,415	£ 84,830	£ 84,830	£ 84,830
NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits	**£ -**	**£240,697**	**£524,019**	**£643,365**	**£801,619**

Volunteer Navigators					
Levels of activity	**2016/17**	**2017/18**	**2018/19**	**2018/20**	**2018/21**
A&E admissions avoidance	0	0	0	0	0
NEL's avoidance	0	0	0	0	0
GP Appointments avoided	19	39	74	99	99
Care Home avoidance	0	0	4	9	16
Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ -	£ -	£ -	£ -
GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits from volunteer Navigators	**£ -**	**£ 20,540**	**£ 83,705**	**£203,051**	**£361,304**

Locality MDT coordinator	2016/17	2017/18	2018/19	2018/20	2018/21
Levels of activity					
A&E admissions avoidance	0	250	499	499	499
NEL's avoidance	0	166	331	331	331

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ 42,415	£ 84,830	£ 84,830	£ 84,830
NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
Total benefits from Locality MDT coordinator	**£ -**	**£220,157**	**£440,314**	**£440,314**	**£440,314**

Appendix 4 - Integrated Impact Assessment Tool - Stage 1 Proforma

Area of Quality	Impact Question	Impact	Likeli-hood	Score	Stage 2 req?	Rationale for scoring
Duty of Quality - Could the proposal impact negatively on:	Compliance with the NHS Constitution?	1	1	1	No	This is compliant with the NHS constitution.
	Partnerships?	1	3	3	No	There should be an improvement in partnership working between all partners involved as this project aim is integration. There is a possibility that if there is an adverse event with a service user, partnerships could be affected.
	Safeguarding children or adults?	1	1	1	No	Should improve safeguarding of adults as improving/enhancing quality and safety by removing duplication and provision of services by multiple organisations. N/A for children.
NHS Outcomes Framework – Could the proposal impact negatively on:	Preventing people from dying prematurely?	2	1	2	No	The aim of the project is to reduce the risk of dying prematurely and by bringing services under one organisation and working towards prevention there should be an improvement
	Enhancing quality of life?	1	1	1	No	The project will enhance quality of life as the aim is to provide pro-active, co-ordinated care and support in the most appropriate environment for the service user as opposed to the reducing the risk of admissions to acute care.
	Helping people recover from episodes of ill health or following injury?	1	1	1	No	The project aims to make people feel empowered, capable of and engage in self-management of their health and social care so works to improve recovery
	Ensuring people have a positive experience of care?	1	1	1	No	The project is focussing on delivering care centred on the person, ensuring they feel listened to, understand their care and that they feel involved. The other key delivery of the project is that care is consistent and co-ordinated.
	Treating & caring for people in a safe environment & protecting them from avoidable harm?	5	1	5	No	The project aims to keep people as fit and healthy as they can be in their own homes. There therefore is a small risk that patient safety could be breeched.
Access	Could the proposal impact negatively on patient choice?	2	2	4	No	With one organisation leading the system the offering will be equal across Wokingham. There are service users who wish to be treated in the setting of their choice and they could still choose that option. Service users and or carers could complain if their needs are not met
	Could the proposal impact negatively on access?	1	1	1	No	There is an increase in access as this aims to streamline and join up pathways and organisations.
	Could the proposal impact negatively on integration?	1	3	3	No	The project is based around integration of services and providers so should improve integration. There is a possibility that an adverse event could affect integration.

Duty of Equality **Could the proposal impact negatively on:**	Age?	1	4	4	No	The services are for over 18 year olds, therefore there is no access for service users under the age of 18, but there are already equivalent non-integrated services in place for children.
	Disability?	1	1	1	No	There are no restrictions on disability
	Race?	1	1	1	No	There are no race restrictions
	Religion or belief?	1	1	1	No	There are no religious or belief restrictions
	Sex?	1	1	1	No	There are no restrictions based on a service users sex
	Sexual orientation?	1	1	1	No	There are no restrictions based on a service users sexual orientation
	Gender re-assignment?	1	1	1	No	There are no restrictions based on a service users gender re-assignment
	Pregnancy or maternity?	1	5	5	No	The services do not deliver pregnancy or maternity services as these are provided by other services. Pregnant or new mothers would not be excluded from accessing these services if they required them.
	Marriage & civil partnership?	1	1	1	No	There are no restrictions based on a service user marriage or civil partnership

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Name of person completing assessment: Rhian Warner	Date of assessment: 27th September 2016

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healthwatch Wokingham Borough

Healthwatch Wokingham Borough

Review of Extra Care Services

May 2017

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About Healthwatch Wokingham Borough

Healthwatch Wokingham Borough is the independent health and social care champion for local people. We work to ensure your voice counts when it comes to shaping and improving services. We address inequalities in health and care, to help ensure everyone gets the services they need. There are local Healthwatch across the country as well as a national body, Healthwatch England.

Executive Summary

Healthwatch Wokingham Borough interviewed residents and staff in the Borough's 3 existing Extra Care Schemes. Healthwatch were interested in how living in Extra Care schemes enabled people to have a good quality of life, improved independence and decreased isolation and loneliness.

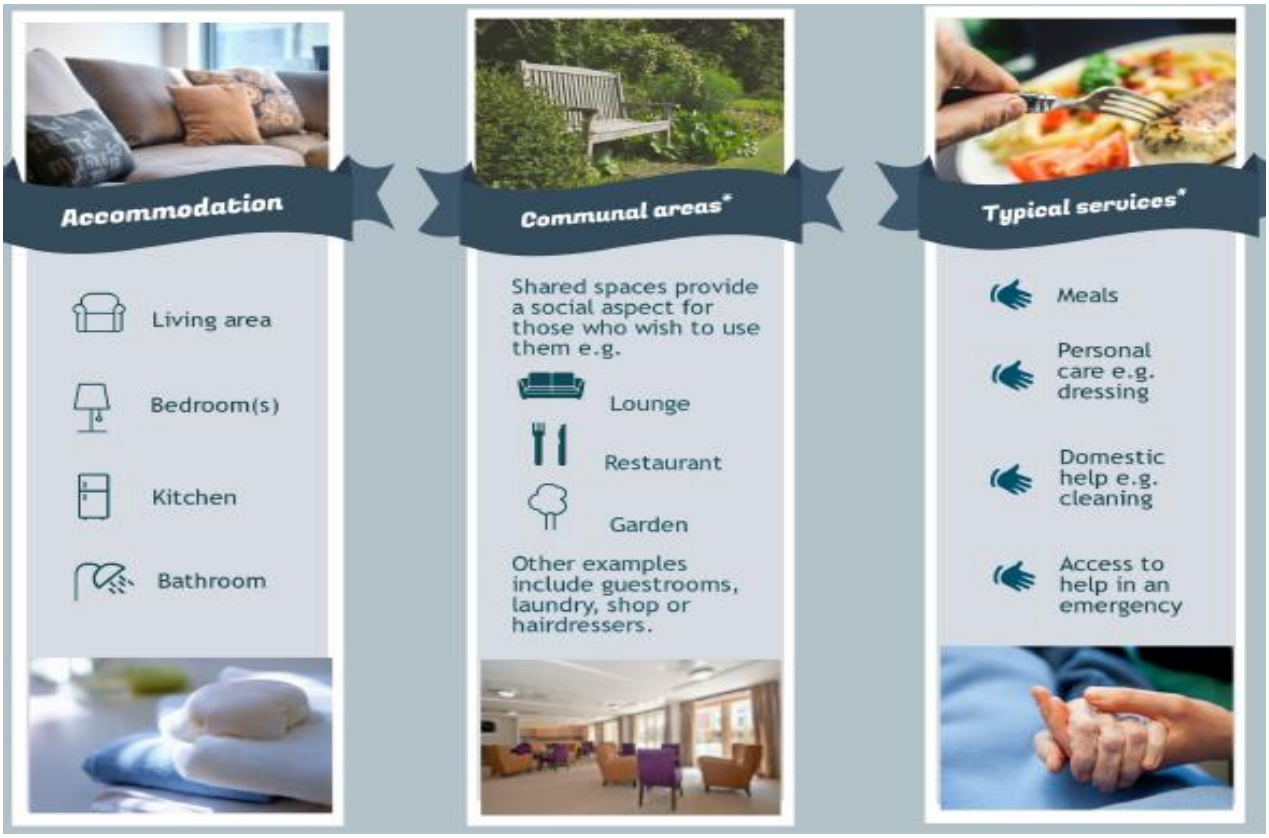
Grounded theory methodology was used to analyse interviews and the following themes have been identified; the importance of good design, managing expectations of what Extra Care schemes can and can't provide, a tension existed between staff seeing Extra Care as independent living but residents wanting coordinated support to enable opportunities for social gatherings, the importance of having a diverse and varied range of activities available, the importance of transport links in ensuring residents do not get cut off from town and quality of

care. The intention is that the lessons learnt and recommendations made in this report are used by Wokingham Borough Commissioners and providers to inform the 2 new Extra Care Schemes opening in the Borough late 2017.

What is Extra Care?

An Extra Care development offers the opportunity for independent living with flexible services available to help support people in their daily lives. Extra care housing is made up of two parts: the physical building comprising of self-contained units and communal areas, and the care and support services that can be bought in by individuals.

Extra Care schemes aim to foster a community feel where people can get involved with events, daily activities or just enjoy spending time with neighbours.



See our factsheet for a fuller description of Extra Care
https://magic.piktochart.com/embed/18234265-extra-care-housing-factsheet-healthwatch-wokingham

Why we decided to explore extra care

- There is not much information available about the quality and safety of these types of services
- With a rapidly ageing population in Wokingham and the resulting demographic pressures, such as conditions like dementia, demand for these services are increasing
- Wokingham Borough Council is planning to expand extra care provision with 2 new facilities due to open late 2017
- There is an opportunity to better understand the views and the extent to which people are satisfied with living in extra care housing.
- Discussions with members of the Optalis team helped bring to life the issues and complexities around Extra Care. (Optalis is the care provider in relation to all the services featured. Optalis will also be the care provider in the new schemes)

Wokingham Borough Context

Wokingham Borough currently has 3 extra care schemes

Alexandra Place South Lake Crescent, Woodley, Reading, Berkshire, RG5 3QW. (landlord Central & Cecil Housing)

Beeches Manor Reading Road, Wokingham, Berkshire, RG41 1AA. (landlord Housing 21)

Cockayne Court 109 Arnett Avenue, Finchamstead, Wokingham, Berkshire, RG40 4ED.(landlord Wokingham Borough Council)

Wokingham Borough Council, in the *Older People's Housing Strategy 2014-19*, has made a strategic commitment to provide sufficient options for people to remain independent in their own homes for as long as possible. "***The Council's long term vision is to increase diversity of provision for older people in the Borough, which will require intense growth of extra Care facilities over the next 10 years."*** (Wokingham Borough Council's Older People's Housing Strategy 2014-19)

There are plans for 2 further extra care schemes underway; A £4 million development on the site of the former Fosters Care Home in **Fosters Lane**, 34 self- contained flats for elderly people will include communal facilities such as a lounge and dining room, as well as a specialist dementia facility. To be run by Optalis

and

The Birches will offer a range of one and two bedroom apartments aimed at over 55s, with a maximum purchase of up to 75% shared ownership or to rent to be run by Housing Solutions

National Context

Where there is "regulated activity" such as personal care, delivered by a care provider in an Extra Care Setting, the Care Quality Commission (CQC) inspection framework for adult social care which considers whether services are safe, effective, caring, responsive and well-led, and also pass the 'mum' test that prompts inspectors to consider whether they would be happy for a member of their own family to receive the service.

The Care Act 2014 requirements places a central duty on local authorities and housing associations to consider how to meet each person's specific needs, rather than simply considering what service they will fit into. 'Wellbeing' is a broad concept. It is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over their day-to-day life (including over care & support provided and the way they are provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal domains

- suitability of the individual's living accommodation
- the individual's contribution to society.

Our objectives

We wanted to hear what those living in Extra Care schemes thought and were interested in how Extra care enabled people to have a good quality of life and in particular whether it:

- improves and maintains people's independence whilst keeping them safe
- decreases social isolation and loneliness.

To help us build a picture of life in extra care, we focused on residents' experience of services both within and beyond the scheme, the social opportunities on offer, and levels of resident engagement in the running of the scheme. As all but one of the schemes had a separate landlord and care provider, we also looked at collaboration between the services at each site.

We intend that the lessons learnt from this study will prevent older Wokingham Borough residents experiencing the same issues and isolation.

What we did

In order to get a sense of how much older people have thought about their future living arrangements we got a group of volunteer drivers to asked their passengers if they had considered where they would live if they couldn't stay in their own home. Overwhelmingly 95% respondents had not given any thought to or made plans about future living arrangements. Leaving it too late to make decisions about your future may limit the possibilities and choices.

We surveyed residents and staff from the 3 existing extra care schemes: Alexandra Place, Beeches Manor and Cockayne Court.

Findings

In this section, we present the themes that we found from speaking to residents and aim to assess how successful Wokingham's extra care schemes are in enabling independence, preventing isolation and supporting residents to enjoy a good quality of life.

Design of Extra Care schemes

Research has shown that the way a building is procured, designed and configured, and the services that are provided within it, has a direct impact on the ability of Extra Care housing to deliver successful outcomes for older people

The planning process needs to be considered There is frequently a mismatch between the design used to obtain planning permission and that which is actually built. Holistic planning and co-ordination throughout the whole process from concept to materialisation is needed, rather than a number of interested parties each making an uncoordinated contribution, with no overall supervision or monitoring of the process.

Most importantly, commissioners and developers of Extra Care schemes, need to recognise that first and foremost they are designing people's homes not institutions. There should be

consideration for the space being created to meet not only the needs of its future residents but also the staff that will use it as a place of work, and visitors who may use it as a community resource.

There is a need to consider scheme "rules" e.g. residents with 2 bedrooms at Alexandra Place are not supposed to have guests stay in their 2nd bedroom but are expected to pay £25 per night for the Guest Suite.

We found that attention paid to small details, just as you would have a snag list when buying your own home, would vastly improve the usability of the building

"I have only had 2 showers in 2 years. In my walk in shower they put up a grab handle that just uses suction to attach to the wall, I am not confident it will not detach if I grab hold of it as it is not permanently secured into the wall, so I don't have regular showers."

"Top flats the sun beams in through the large windows all day and it's blinding but I am not allowed to put up a sun shade on the balcony so I retreat into my bedroom."

Communal areas within Extra Care were seen as being very important. Having a communal area that was set up to enable the provision of additional services such as meals etc. Having a place like a coffee shop was seen as a good place to informally get together and chat rather than having to attend an activity in the day room.

Many people spoke to us about their desire for a small shop whether run by the community or by a local business to act as a social hub for the community, as well as supporting independent living.

The furnishing of the Extra Care scheme communal areas contributes to the atmosphere created. We saw drab furnishings and armchairs that were not suitable for the elderly to get of due to being low and the seats tilted backwards.

Wokingham Borough Council setting out the following criteria at the outside of building Beeches Manor :

"the design must offer a safe and secure environment, which provides flexibility to meet future needs and requirements of an ageing population. The council expects all dementia residents to have care needs with an estimated average of 20 hours of care per week needed.

The development should include appropriate technology and telecare systems capable of supporting individuals with dementia in their own home. Key partnerships with health, social care and supported housing are absolute requirements to ensure the development and delivery of housing. Care and support services that are coordinated ad responsive to the changing needs and aspirations of older people."

(taken from HousingLIN case study https://www.housinglin.org.uk/_assets/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy96_BeechesManor.pdf)

With regards security, we found that Beeches Manor had an open-door policy with no secure areas at any time of day or night, despite housing people with dementia. If a resident goes wandering off or is missing staff would call next of kin and then the police. The daily Welfare Check by staff is free here in some schemes across the country this is a paid for service. This poses a true difficulty trying to balance individual's choice with safety. The Care Quality Commission takes a view on independent living environments having to coax residents back into the schemes as bordering Deprivation of Liberty, seeing the individual as being entitled to leave when they wish to and of their own free will. This has led to confusion of responsibilities between the provider and Local Authority, leading to the service being penalized for not safeguarding residents. Guidance needs to be provided to prevent confusion.

Key location factors have been summarized by HousingLIN

Whilst many residents were complimentary about the garden areas, they were not always supported to get out, some men spoke about the desire to have a "men's shed" they could retreat to. It was suggested that local volunteers could come in and help with the upkeep and maintenance of the gardens. The pleasantness of the outdoor environment is known to be significantly associated with people's perception of their quality of life.

Housing LIN have produced resources on including Extra Care design guides, case studies of design in practice and tools for evaluating design features (https://www.housinglin.org.uk/Topics/browse/Design-building/Design/)

Key messages

Design of the building and design of the services provided within the building impacts on how the building is used, how people live and ultimately their health and wellbeing. A lack of on-site facilities can limit opportunities for social interaction: a shop, a restaurant and an accessible garden are particularly important in this respect

Lots of people we spoke to said they wanted the facilities but the reality was that they were not used extensively.

Consideration to be given as to how the Extra Care Scheme will integrate with the local surrounding community.

The absence of a comfortable and affordable guest room can discourage friends and relatives from visiting residents and providing essential social contact.

Clarity is needed between provider, regulator and local authority, around independent living environments enabling resident choice and free will to come and go as they wish, balanced with safeguarding those who may have diminished capacity.

Managing Expectations of Extra Care schemes

There is no single model of "Extra Care." Extra Care means different things to the many different stakeholders; resident, family members, care providers, landlords, builders, commissioners/funders.

For all parties, clarity over boundaries, roles and responsibilities is crucial. There is a danger that marketing material can overplay Extra Care environments as vibrant retirement lifestyles. We heard many residents feel disappointed that they had been sold something to different to what they got. The concept of a "home for life! In this setting cannot cover physical nursing needs.

"I was told when I moved here there would be a doctor or nurse visiting once a week in a purpose built consulting room,. It has never happened."

"I thought the scheme was closer to the shops than it is, I was shown the shops in a car so it seemed like a short trip."

We found variation in resident characteristics that can include their tenure (shared ownership or renting), financial position, the level and nature of care and support needs and the extent of their support networks (including whether they have a partner, or family who are involved in their care and support). There was evidence of some tensions between residents with different

characteristics, and the knock-on effects on boundaries, roles and responsibilities and partnership

"I was told that the dementia unit would be separate and the dementia residents would not use the communal areas which they do and this causes problems"

Information in the printed materials could be misleading.

"The handout I was given said that things could be arranged and done for me, but after moving in I was told this is independent living not a care home."

We recommend that all printed materials, leaflets and communications about Extra Care living is clear, including stating which support services depend on assessment of need or having to be paid for. Older people's uncertainties need to be addressed such as "*What happens if I can't afford to stay here?" "If my care needs increase will I be able to get the support I need?" "Will I be able to stay here until the end of my life*?"

When Alexandra Place was first built the average age of residents was on average late 60s early 70s, now years on, the scheme has more older residents (average age is in the 80s), less able to organize things, more frail and with greater care needs. This has fundamentally changed the day to day feel of the place.

Key messages

There may well be a plethora of organisations involved in Extra Care schemes, across housing management, support, care, catering and other roles, each with a slightly different view on what Extra Care should be. We anticipate that what may matter more than number of organisations involved is how relationships are established (at the commissioning stage) and then managed, both formally (e.g. with protocols) and informally at all levels including on the frontline.

Consider the role of information and marketing materials and how it is used to set the scene for Extra Care

Consideration to be given to managing variation in resident characteristics and staff management expectations of residents' capabilities.

Tension between independent living & the need for coordinated support

It is recognised that independence is one of the most important things to people as they get older. Most people want to be able to do what they want, when they want. Support from either family and friends or formal carers to maintain a level of independence, particularly when mobility is limited is key to maintaining independence. Healthwatch recognises that people who are supported and able to adapt to changing health needs are able to enjoy a better quality of life.

In all 3 of the Extra Care schemes we visited we picked up on a palpable tension between staff saying "*this is independent living, residents are free to arrange activities themselves"* and residents saying *"we are not supported in activities or getting out."* Staff to recognize the need for many older people to be reminded about activities when they are about to happen,

rather than rely on a plan sent round in advance. The café staff at Alexandra were observed doing this.

We asked what residents thought of the communal facilities:

"alright but only a few people come together. There is not a social life really.

"There is not enough to do to create a social life here, there is a real need for more variety of events"

We know that it takes time and effort to get an active social life going. It is much more complex than putting up a poster and inviting people. The endeavour needs to be resourced.

We asked how they would describe the atmosphere in general;

"not very enthusing. Lots of people keep themselves to themselves"

Almost all interviewees said that they felt isolated or lonely and wanted more opportunity for social contact. Our interviews posed a real issue between staff wanting to respect the independence and privacy of residents but residents craving more coordination and support from staff to mobilize opportunities to get together and socialize.

This presents a challenge to front line staff who are busy doing their day job, some staff we spoke to gave up their own time to enable social activities or outings. The discreet involvement of staff with resident-led groups can ensure that residents with higher support needs are given the opportunity to participate in resident-led activities

Consideration should be given as to how staff can facilitate more interaction between residents. In each of the 3 schemes we visited we were able to identify an informal resident champion or mobiliser … the person that encourages others to chat or get involved. This should be an idea that is formalized and built upon to ensure sustainability.

The facilities can actually provide barrier free accessible environments that foster social interaction. Residents at Alexandra Place spoke about how the restaurant was a hub that brought people together. It was seen by residents as the place to meet other people and where friendships developed. When it closed for 4.5 months no temporary arrangements were put in place ad residents had to make do with getting frozen meals and cooking for themselves. This was an advertised facility for which some people had moved from other supported housing. Other Extra Care schemes across the country have opened their restaurants to the wider public as a community resources which increased opportunities for residents to engage with others. Alexandra Place has done this but it doesn't seem widely known or advertised. Insufficient use risks such facilities closing down.

The physical environment of Extra Care schemes, and the willingness of organisations and staff to share these facilities and work with external groups, is an important incentive that will ultimately reduce social isolation.

Key messages

Health, social care & housing service providers to reflect on the importance of supporting social interaction amongst residents in Extra Care settings, rather than relying exclusively on resident led approaches.

Health, social care & housing service providers to make a commitment to change and devote resources to supporting the development of inclusive, active communities.

Lack of diverse range of activities

Activities are a crucial way that older people can build and maintain social networks with other residents, staff, and others beyond extra care. In extra care schemes, these can include daily activities such as the traditional bingo or arts and crafts sessions however this is not enough! A wide range of activities need to be made available such as Tai Chi, wheelchair aerobics, mindfulness sessions, hand massage and entertainment such as karaoke or theatre trips. There is a need to take into account a wide range of ability levels and interests when planning activities so that all residents have the opportunity to take part. Even more mundane things such as eating together or coffee mornings can provide opportunity for social interaction.

A substantial body of literature on social isolation and loneliness among older people finds that activity based interventions are often the most effective in reducing isolation and loneliness. Activities can either be arranged by staff or be resident led. We found that residents wanted and needed staff support to avail of opportunities to be more socially active, especially as they age. However we found some staff to have the attitude that residents can arrange things for themselves if they wish.

"Better activities inside and outside the home. We are missing a bit of fun in our lives. We need things to do."

"I have never been asked what activities I particularly like. I would enjoy going to the cinema and the theatre as a group or coach trip to the coast but don't know if that is possible, We need people joining up doing shared things also be nice if someone could bring in pets for us to see, like a visiting dog"

Care Homes will usually employ an activities coordinator, Extra Care schemes usually don't usually have a designated person to coordinate activities. It can be difficult to draw the line between the needs of residents in Extra Care and Residential Care Homes. Some schemes rely on the goodwill of volunteers in organising activities in their spare time.

"There are not many men here so difficult to have a male focused activity. I used to have a volunteer who came into help me with computer but due to my hospital appointments I could not always guarantee I would be here so he stopped coming."

Reducing social isolation is one of Wokingham Borough Council's strategic commissioning priorities with less than 50% of Wokingham Borough Council's customers have as much social interaction as they would like (source: Adult Social Care Outcomes)

An important aspect of how activities are organized is funding. It is important that sufficient funds are available to support the provision and enablement of a range of activities in order to promote social well-being. It would be helpful if activities did not clash – at Alexandra Place residents had to choose between getting the Readibus to Sainsbury's for their shopping or going to the computer class, which both took place on a Wednesday morning.

In 2015, Healthwatch Lambeth reviewed the borough's Extra Care schemes. Although the level of care and amenities at schemes were generally good many residents said they felt lonely and cut off from the community. In response, in spring 2016 Lambeth Council provided a grant of £4,000 to each scheme for activities, which it hopes to make available on an annual basis.

Key messages

There is a real appetite amongst Extra Care residents for opportunities to socialize and play an active part in the community, with some support from staff to get off the ground.

It will remain important for Commissioners to invest in and monitor the impact of social interaction, particularly in older people in Extra Care schemes in reducing social isolation and loneliness.

Incorporate detailed information on care and support plans for each individual, their interests, hobbies and preferences for activities.

Encourage volunteering: find ways to enable people in the local community to help out with specific events and take part in fund-raising activities. Former staff or residents' family contacts and friends can be 'champions' for promoting voluntary work within extra care settings

Poor transport links

Mobility is a fundamental component of our lives; shaping the way we behave and our independence. Residents in all 3 schemes shared frustrations at the difficulty in accessing activities in the community due to poor transport links.

"not a lot of transport available in Finchampstead. If you don't have a car, family members visiting or a support worker under a care plan it is difficult to go anywhere other than walk to the local community shop."

"Readibus is not flexible enough and taxis are too expensive"

"I tried to use Redibus but was told as I am mobile and I can walk to the bus stop I should use public transport. There are no shops locally. I have dietary needs due to a diary intolerance so have to get 2 buses when I want to go and get my shopping"

"Readibus changed their timetable recently, the bus comes later and we only get 30 minutes in Woodley before we have to come back. We used to have longer, now we cant meet friends in a local café as there is not enough time"

The bus stops nearest to Alexandra Place, to go to Woodley centre, have been moved and residents expressed concern about having to now cross a busy road to get the bus.

Give consideration to approaching bus companies to see if this could be addressed by agreeing to add extra stops on existing routes as close as possible to any Extra Care facility. Possibly on a 'hail and ride' basis.

The state of Wokingham pavements meant that many of the residents we spoke to felt unsteady and unsafe going into town, this particularly impacted on those with impaired mobility. Several residents talked about using their scooters as a way of getting out and about, allowing them access to local pubs and amenities. They also identified how poorly maintained footpaths and anxiety about crossing local roads could act as barriers to visiting local amenities.

"I have an electric scooter but don't use it as the pathways aren't good and are narrow"

Residents spoke about not having a nominated GP for the Extra Care scheme meant that they had to make their own way to the surgery. Having a flu clinic on site would prevent many individuals making a difficult journey, particularly if frail or disabled to the surgery. Some Alexandra Place residents found it impossible to contact their surgery by telephone and were taking a taxi (cost £5 each way) to go and make an appointment for a later date, which then involved a second taxi fare for the actual appointment.

Key messages

A lack of affordable, accessible transport can be a barrier to residents who want to access facilities and social networks in the wider community

Wokingham Borough needs to support more flexible transport solutions for older people to keep mobile – for example organisation such as Wokingham Volunteer Car drivers offering a driver for a couple of hours on a pre-arranged day to take people to the shops.

Community transport such as Redibus to allow for more flexible journeys and consider a more passenger centric approach to timetabling and eligibility.

Planners to ensure good access to local footpaths, bus routes, post boxes and pedestrian crossings in order to allow residents to get out and interact with the local community.

Health providers to consider providing focused clinics at Extra Care schemes to prevent lots of frail elderly people have to make journeys to the surgery

Links with local community

Residents of an Extra Care scheme can be linked to the local community in a variety of ways – for example, through maintaining links with friends and family in the community, by using the local amenities or via people coming into the scheme, either to provide a service (e.g. entertainment) or to use the facilities.

The ability to engage with community activities was linked to a range of factors, including the availability and accessibility of transport, the quality of pavement access for electric scooters and the support of care staff.

Those residents who were not able to access the community because of lack of mobility or ill-health suggested that this affected their general sense of well-being, largely because they felt restricted and missed doing activities they had enjoyed in the past.

Location within the community is of considerable importance in the development of Extra Care housing and can mean the difference between a scheme and its residents being part of an external community, or remaining segregated and isolated.

Many residents told us that they felt isolated and were unable to access the local community:

"People from the community come in rarely. A local day centre for the learning disabled comes in once a week to the communal area"

"I am happy in my home but there is not a feel of community here and I don't get to mix regularly with the outside community"

Quality of Care: Tasks focused vs. person focused

All of the residents that we spoke to were very complimentary about the staff that worked within the Extra Care schemes – whether that be the manager, carers or chest, however staff that visited from external agencies or Agency staff were found often to be in a rush, which made people feel like they were not cared for.

If residents have a package of care, there will be a plan of what this should entail – this is costed and has a time period for the task to be carried out in. The difficulty that care staff have is being able to fit in is not deviating from the task list and carrying out personal care within a set (limited) period of time.

I am sure that every care agency aspires to a person-centred approach to care provision, which in turn can contribute towards social wellbeing. Recognizing the value and importance of investing in relationships

A key working systems can maximize the benefits of interaction with staff, particularly for residents at the greatest risk of social exclusion.

Key messages

For some residents, care staff are a major source of social interaction. Task-led systems of care provision can limit the opportunities for staff and residents to interact.

Provision of a free of charge "Daily Welfare Check" at all sites would assist in making residents feel secure and an opportunity to build relationships. This is applied inconsistently - free at

Cockayne Court but is charged for at Alexandra Place, where one resident expressed her concern about people being found dead in their apartment.

Recommendations for the new Wokingham Borough Extra Care Schemes

We have identified a range of recommendations from our review which we would welcome the opportunity to explore with commissioners, providers and residents. We hope that lessons learnt can be incorporated into the new schemes

1. **Design**

Attention to small design details such as grab rails and blinds can make a huge difference to how residents use a space.

Create opportunities for people to meet in casual communal areas such as a coffee shop or shop, not necessary formal spaces like an activities room.

When choosing sites for future schemes, commissioners should consider good public transport links and proximity of appropriate community facilities and amenities.

Consider use of volunteers to maximize the use of outside garden space. Consider projects for men such as “men’s sheds”

Clarity is needed between provider, regulator and local authority, around independent living environments enabling resident choice and free will to come and go as they wish, balanced with safeguarding those who may have diminished capacity.

2. **Managing expectations**

Commissioners to consider how relationships are established between all the stakeholders and then managed, both formally and informally, at all levels, including on the front line.

Marketing materials to provide clear information about what Extra Care can and can’t offer

Potential residents to spend a “try before you buy” weekend in the Extra Care Scheme in order to gauge distance to shops etc.

Create opportunities for residents views, opinions, concerns and preferences to be heard and addressed.

3. **Tension between independent living and coordinated support**

Consideration how staff can facilitate more interaction between residents

Identifying a resident mobilizer or champion and creating a role description for that person

Commissioners and Providers to commit to resourcing the development of inclusive, active communities within each scheme.

4. Diversifying activities

Incorporate detailed information on residents interests, hobbies and leisure pursuits into their care plans

Encourage volunteering and ways to enable people from the community to help out

Commissioners and providers should consider investing in a borough-wide collaborative programme to support activities including:

- volunteer recruitment and management for activities and befriending
- shared trips programme with accessible transport
- enabling resident access to other existing community activities/schemes & devising joint initiatives with appropriate voluntary and community organisations eg intergenerational activities with youth groups and schools.

5. Transport links

Wokingham Borough Council to consider the development of more flexible transport solutions to keep people mobile

Community transport to allow for more flexible journeys and a passenger centric approach to timetabling.

Town planners and Public Health to be mindful of access to footpaths wide enough to accommodate an electric scooter

Health providers to consider holding clinics within Extra Care schemes to maximize take up and minimize individuals travelling to surgery

6. Care: Task focused vs. person focused

Schemes to consider a key working system to maximise the benefits of interaction with staff

Table 1 – Summary Findings from surveys

	Alexander Place Provider: Optalis Landlord: Central & Cecil	Cockayne Court Provider: Optalis Landlord: Wokingham Council	Beeches Manor Provider Optalis Landlord: Housing & Care 21
Profile	64 1 & 2 bed flats	43 1& 2 bed flats	26 flats Provides support for those with a dementia diagnosis
Physical Environment - Exterior	Pleasant and well sized, well maintained, lawns, shrubs, planters and seating areas	Large rear garden	Set in woodland
Physical Environment - Interior	Wide corridors and doorways, communal spaces underused lounge decoration, furnishings, carpets very drab in colour	Older building so corridors and doorways narrower. 2 brightly, invitingly decorated communal lounges separated by bright dining area	Very new building, wide corridors and doorways. Bright and light but underused central open plan kitchen/dining area. Underused bright communal lounge area
Safety and Security	Good although one person said ensure what to do in event of fire, one said feel isolated when icy weather as paths around scheme not de-iced	Good	Good although some concern about dementia residents being able to walk out of scheme towards busy road
Communal Eating Facilities	Underused facility. Some residents unhappy that it was closed for a period, some said not enough choice, didn't cater for one resident dietary need	Residents positive about choice and cost and ability to use for breakfast and lunch	Whilst there is communal kitchen and dining area no meals are prepared by staff/contractor there so very underused. Residents eat in their flats
Friendships & Activities	Evidence of Neighbourliness but not a lot of apparent strong friendships. Feeling of isolation due to distance from town and infrequent transport. Some activities but the	Some friendships evident as some residents have been living there some time. Concerns that very few men residents/staff so lacking male interaction Not a lot of activities and question about whether	Concerns about lack of activities although there was an activities book that said all the right things and included variety. There had been some in the past including variety

	'usual suspects' with low take up. Lack of activities evenings/weekends and support for residents to create their own programs of interest as they are classed as independent livers. Residents not doing the activities they did before moving into scheme	they match residents interests. Some isolation due to location and infrequent transport. Belief that volunteers could improve things like volunteer gardeners involving residents, 'men in sheds' type projects. Volunteers coming in to teach things like IPAD use	e.g. eukalale players coming into scheme. Whilst close to town some residents felt isolated and said they wouldn't use their mobility scooter or walk as pathways and pavements around Wokingham Town were too uneven.
Community Integration	Little evidence of community regularly coming into scheme apart from visit once a week by users of Woodley Day Centre. Residents feeling isolated from community due to poor and infrequent transport	No evidence of community coming into the scheme on a regular basis. Some residents said they feel isolated due to location of the scheme and infrequent transport	No evidence of community regularly visiting the scheme, primarily family visitors. Residents would rely on family members to take them out into local community, one resident regularly went into town each day

Next steps

Recognition that suitable housing only goes so far in maintaining health and wellbeing. The neighbourhoods in which homes are located provide resources that people need such as transport, shops, social contact, involvement in local issues and services, information and access to green space. With 2 new Extra Care Schemes about to come on board we are keen to understand how citizens of all ages are involved in designing and improving the space they live in

We have met with Debbie Wright, Wokingham Borough Council Interim Commissioner overseeing Extra Care, who agreed to draw up an action plan going forward.

We will present our findings to the Health Overview and Scrutiny Committee and Health and Wellbeing Board in Summer 2017

We will invite commissioners and providers to a seminar early 2018 to discuss the issues and recommendations raised here and to encourage stakeholders to identify practical actions to pledge.

The seminar will be followed immediately afterwards by a tea and chat session for extra care residents to talk about the ideas we have explored. Residents and families from all 3 schemes will be invited.

We will provide a summary of this progress to each extra care scheme for consideration at their residents meetings.

We will also feed our recommendations to Wokingham Clinical Commissioning Group and the Public Health team with a focus on tackling social isolation and loneliness.

With thanks to our project team

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TITLE	**Independent Annual Report of the Director of Public Health**
FOR CONSIDERATION BY	Health & Wellbeing Board on 15 June 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Wright - Interim Director of Public Health for Berkshire

Reason for consideration by Health and Wellbeing Board	So that the Board will note and learn from the Independent Annual Report of the Director of Public Health, and apply the learning to issues that the Board addresses during the forthcoming year, alongside other public health intelligence such as the Joint Strategic Needs Assessment (JSNA).
Relevant Health and Wellbeing Strategy Priority	The Report's theme of avoidable and preventable mortality and morbidity is relevant to all priorities of the Strategy.
What (if any) public engagement has been carried out?	None required. The report is a public report, independent of any organisation, and should be disseminated widely to the public and stakeholders alike.
State the financial implications of the decision	None.

OUTCOME / BENEFITS TO THE COMMUNITY

Understanding the proportion of deaths in the Wokingham population that can be prevented; their causes; and the evidence base for interventions which can prevent them is crucial to improving the health of the population and in narrowing and eliminating inequalities between the most and least affluent residents.

RECOMMENDATION

That the Board notes the content of the Independent Annual Report of the Director of Public Health, and disseminates the report widely.

SUMMARY OF REPORT

The report outlines preventable and avoidable deaths in the Wokingham Borough population and the causes of these including: smoking; high blood pressure; alcohol; physical inactivity and obesity. The report outlines these issues, the local impact, and evidence based interventions to reduce the harms.

Background

Directors of Public Health in England have a statutory duty to write an Annual Public Health Report to demonstrate the state of health within their communities. It is a major opportunity for advocacy on behalf of the health of the population and as such can be

extremely powerful both in talking to the community and also to support fellow professionals in public health.

The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be useful for both professionals and the public. However it is not just the annual review of public health outcomes and activity. The annual report is an important vehicle by which DsPH can identify key issues, flag up problems, report progress and thereby serve their local populations. It will also be a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities they serve. It will be a tool for advocacy as well as a statement of needs, current priorities and action and continuing progress. It can also be a valuable process for internal reflection and team prioritisation as well as external engagement and awareness-raising (ADPH and FPH, 2016).

Analysis of Issues

This year's annual report focusses on Prevention, as that is a key work stream of the Sustainability and Transformation Plan (STP) for the Berkshire west, Oxfordshire and Buckinghamshire (BOB) area, and one where Public Health departments across this area are leading new thinking together with the Clinical Commissioning Groups (CCGs) serving the same area.

The Strategic Director of Public Health for Berkshire has identified that the age standardised rate of preventable deaths in Wokingham is 130 per 100,000 (2013-2015), being lower than the England rate for preventable deaths at 184 deaths per 100,000. In men, the rate of preventable death is lower than the national average, and reducing, whilst the impact in women is also less than the England average, though static. Wokingham's rate is the 3rd best in England. Nevertheless the impact on health, early death and health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand on our services, and improve health considerably at the local level .

Partner Implications
Partners should have access to the report and use it in the planning and commissioning of services alongside the JSNA and other public health intelligence.

Reasons for considering the report in Part 2
Not Applicable.

List of Background Papers
Independent Report of the Director of Public Health 2016. Independent Report of the Director of Public Health 2015. ADPH/ FPH Guidance on Annual reports. Available at: http://www.adph.org.uk/our-work/about-dph-annual-report-competition/ [Accessed 2nd June 2017]

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Date 2nd June 2017	**Version No.** 1

Director of Public Health Annual Report – Wokingham

Lise Llewellyn

2017

Avoidable and preventable mortality

Life expectancy has improved through the ages. In the middle ages the average life expectancy was thought to be around 35 years, rising to 47 in 1900, 65 in the 1950's, and 65 in 1971 and in 2015 it was 79 (men) [1].

Now the focus is on reducing avoidable deaths. Avoidable deaths can be divided into 2 major area: amenable and preventable deaths. Avoidable deaths in general focus on those deaths that occur prematurely before 75 years.

> **"People who die prematurely from avoidable causes lose an average of 23 potential years of life"**

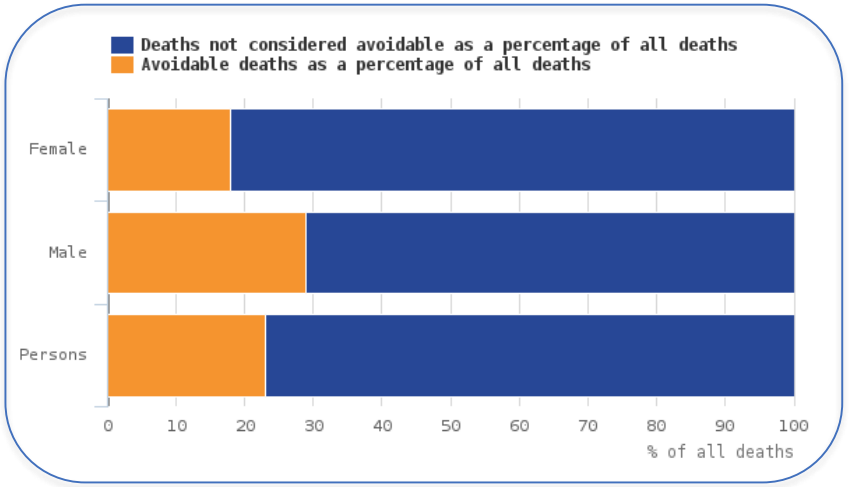
In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable either through timely and effective healthcare (amenable) or public health interventions (preventable) [2].

While we may say that a particular condition can be considered avoidable, this doesn't mean that every death from that condition could be prevented. Analysis focuses on deaths prior to 75 years.

Males were more likely to die from an avoidable cause than females and accounted for approximately 60% of all avoidable deaths.

Approximately 29% of all male deaths were from avoidable causes (70,108 out of 245,142 deaths) compared with 18% of all female deaths (46,381 out of 256,282 deaths).

Figure 1: Percentage of deaths nationally that are avoidable



Source: *ONS: Avoidable Mortality England and Wales 2014*

Cancers were the leading cause of avoidable deaths accounting for 35% of all avoidable deaths in England and Wales in 2014.

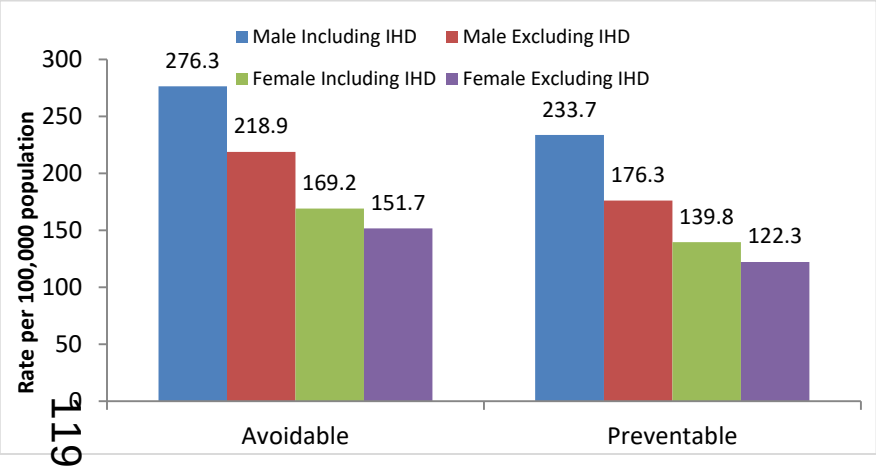
Ischaemic heart disease is the most common single disease that leads to avoidable death.

Amenable deaths are those where the causes of death are amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare.

Preventable deaths are those that through our understanding of the determinants of health at time of death, all or most deaths from that Cause (subject to age limits if appropriate) could be avoided by public Health interventions in the broadest sense.

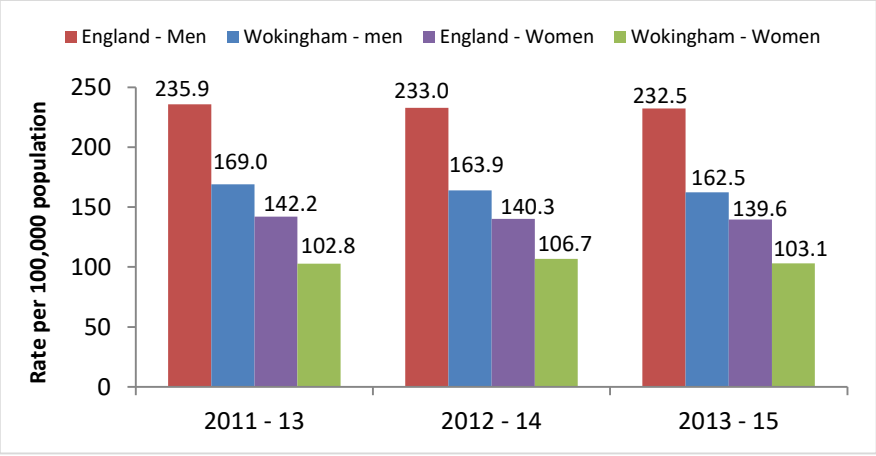
Local preventable deaths

Figure 2: Rates of avoidable and preventable deaths



Source: PHE: Public Health Outcomes Framework

Figure 3: Mortality rate from causes considered preventable 2011-2015



Source: PHE: Public Health Outcomes Framework

As shown in **Fig 2,** addressing these would have the biggest impact on reducing total numbers of avoidable deaths . Sadly though the emphasis does appear to be on increasing health care interventions.

We can measure preventable death rates in our own locality. The England age standardised rate for preventable deaths is 184 deaths per 100,000, with the rate in Wokingham being lower at 130 per 100,000 (2013-2015) which is the lowest preventable death rate in Berkshire **(Fig 3).**

We can see that in men the rate of preventable deaths are lower than the national average, and reducing, whilst the impact in women is also less than the England average though static.

These figures could be expected given that Wokingham has a low rate of premature deaths 248 /100,000 (2013-15)[26], the 3rd best in England. Nevertheless the impact on health, early death and health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand on our services, and improve health considerably at the local level .

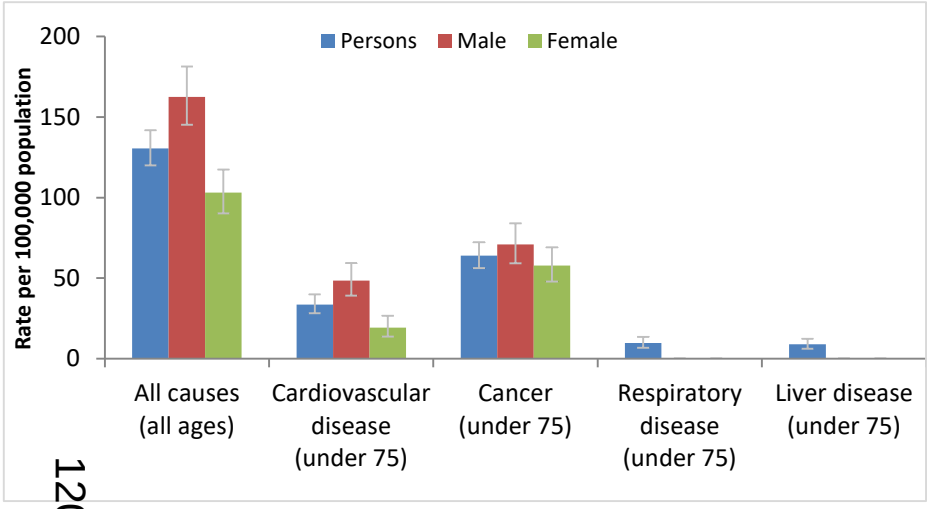
Causes

If we look at the major causes of early preventable death within Wokingham, we see a similar picture to that seen nationally with the biggest single generic cause being cancer for all persons, and the impact being greater for all preventable causes on male deaths. In Wokingham the impact of cancer on men is the highest single cause **(Fig 6)**.

If we examine preventable premature mortality rate across Wokingham in more detail by clinical groups then we see that mortality rates are higher in men for all causes except cancer.

Local preventable deaths

Figure 4: Preventable mortality per 100,000 population in Wokingham (2013-15)



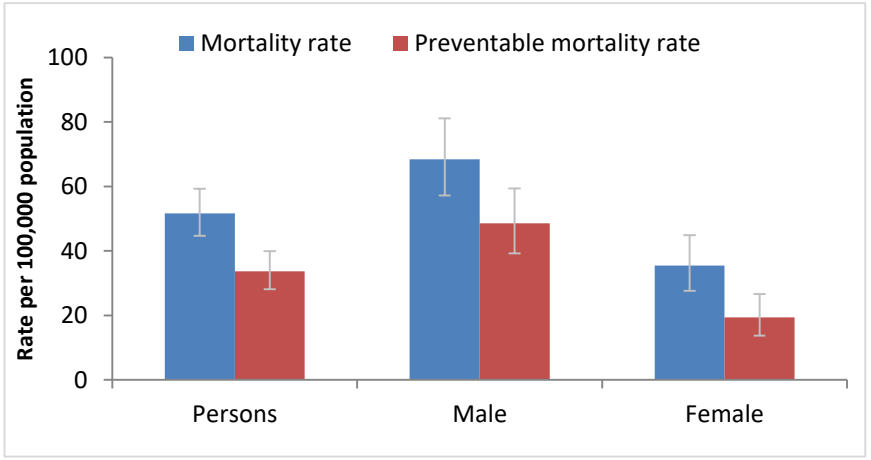
Source: PHE: Public Health Outcomes Framework

For cardiovascular causes, Wokingham has the lowest cardiac premature mortality in Berkshire (almost half that of Slough).

In liver and respiratory disease the numbers of preventable deaths in males and females are too small to be calculated.

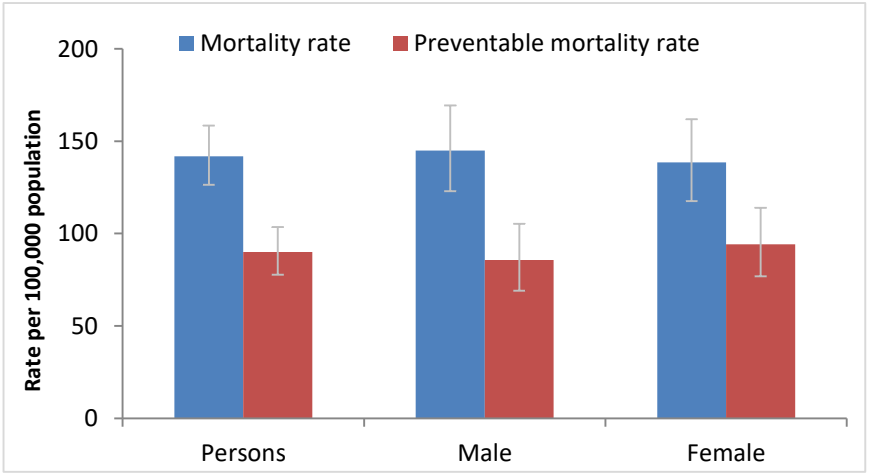
In cancer locally we see that the rate of preventable deaths due to cancer is higher than the national picture for men than women, which is the same for preventable deaths by gender.

Figure 5: Under 75 mortality rates for Cardiovascular disease in Wokingham (2013-15)



Source: PHE: Public Health Outcomes Framework

Figure 6: Under 75 mortality rates for Cancer in Wokingham (2013-15)



Source: PHE: Public Health Outcomes Framework

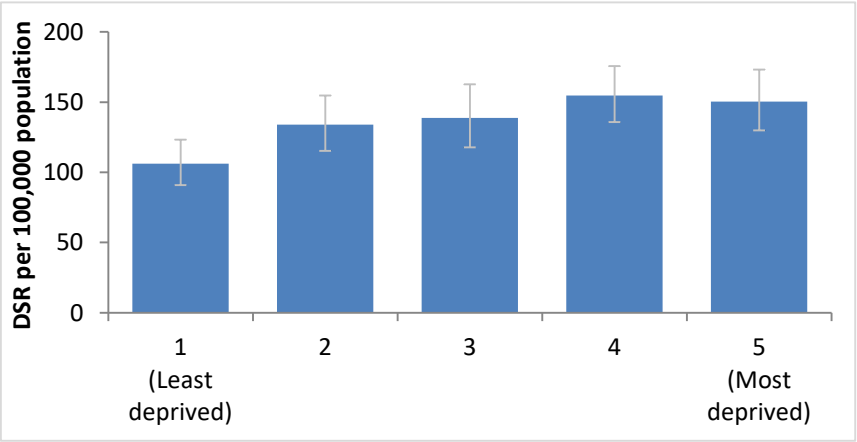
Preventable deaths

The impact of premature mortality from preventable causes can be examined by geography and deprivation. Across all preventable deaths there is a link with deprivation when we group wards by their level of affluence [3].

This is not unexpected since the evidence shows a consistent pattern in the prevalence of multiple unhealthy behaviours, at the core of preventable causes of ill health, with men, younger age groups and those in lower social classes and with lower levels of education being most likely to have exhibited these multiple lifestyle risks [4].

In 2008 4.2% of professional men exhibited all 4 unhealthy lifestyle behaviours, compared to 8.4% of male unskilled manual workers. Similarly, 3.1% of professional women exhibited these behaviours, compared to 7.0% of female unskilled manual workers.

Figure 7: All cause preventable mortality rate per 100,000 population in Wokingham by deprivation quintile (2011-2015)



Source: NHS Digital (2016); Primary Care Mortality Database – Restricted

Worryingly this pattern is persisting with improvement in lifestyle being greatest in those in most affluent groups so the gap is widening [4].

The strongest risk factors for avoidable hospital admission are age and deprivation [5].

Clustered poor health behaviours are associated with increased risk of hospital admissions among older people in the UK. Life course interventions to reduce the number of poor health behaviours could have substantial beneficial impact on health and use of healthcare in later life [6]. Studies have shown that among men and women, an increased number of poor health behaviours was strongly associated ($p<0.01$) with a greater risk of long stay and emergency admissions and 30-day emergency readmissions.

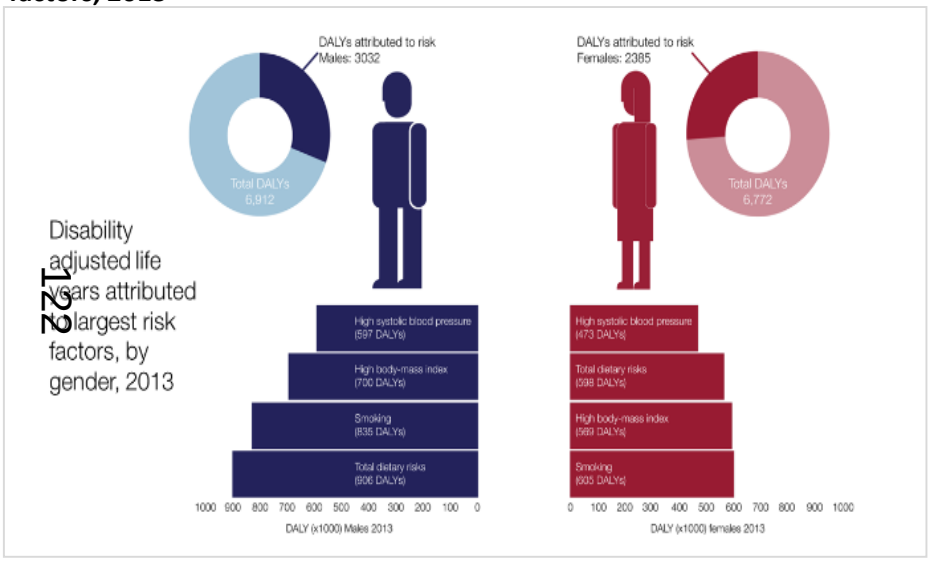
Those with three to four poor health behaviours were, in men, 1.37 [95% CI:1.11,1.69] times more likely to be admitted to hospital than those with no poor health attributes. In women, this figure was 1.84 [95% CI:1.22,2.77]. Associations were unaltered by adjustment for age, BMI and co-morbidity.

The impact of improving lifestyle behaviours is not restricted by age. In a study of over 65 year olds that examined the impact of having higher self-care confidence and being on an exercise program on decreasing avoidable hospitalizations, it was found that starting an exercise program at an older age decreased hospital admissions and utilization of emergency services in the short and medium term [7].

Addressing early preventable deaths

There are eight commonly agreed risk factors that if addressed would reduce preventable deaths; alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake and physical inactivity.

Figure 8: Disability adjusted life years attributed to largest risk factors, 2013



Source: [PHE: Burden of Disease Study for England]

It is estimated that 80% cases of heart disease, stroke and type 2 diabetes, and 40% of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

An estimated 42% of cancer cases each year in the UK are linked to a combination of 14 major lifestyle and other factors [8]. The proportion is higher in men (45%) than women (40%), mainly due to gender differences in smoking (CRUK).

The impact of these lifestyle factors is not only key in causing early death within our communities but also as a major cause of illness it drives our increasing utilisation of health and care resources.

In the following section we will briefly review five of the major lifestyle and risk factors for preventable deaths, where there is significant evidence regarding interventions that make a difference. We will briefly describe the pattern of these factors in our community, the impact of each in terms of illness and death, but also in terms of impact on our services.

It should be noted that whilst we look at each individually there is data that shows that risky health behaviours interact and have a multiplicative rather than simply additive impact. That is, they have a greater effect together than the sum of each individual risk. For example, obesity and alcohol consumption which interact to increase risks of liver disease mortality to a greater extent than the sum of each individual risk [9].

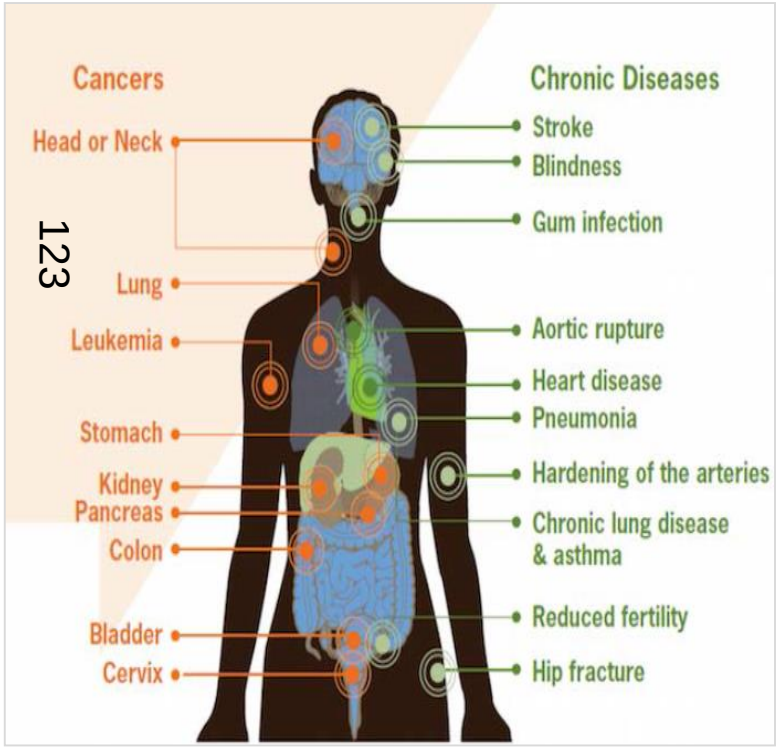
Or alcohol and smoking, which together are associated with a greater combined risk for cancer than the sum of the two individual effects [10]. This may be one reason why we see greater alcohol related harm in socioeconomically deprived groups compared to affluent groups, even when the level of alcohol consumption is held constant. It's because the more deprived groups are more likely to be engaging in multiple risky lifestyle behaviours.

Smoking

Smoking remains the biggest single lifestyle cause of preventable mortality and morbidity in the world. The Tobacco Control Plan for England states that it accounts for 1 in 6 of all deaths in England.

Its impact is seen on every organ of the body.

Figure 9: Health Effects of Tobacco Use



Source: [CDC: Smoking & Tobacco Use - Health Effects of Tobacco Use]

Nationally the prevalence of smoking is decreasing; 19% of people smoked in 2016 v 46% at its peak in 1976 and average daily consumption is also reducing; 11 cigarettes a day in 2016 from 16 in 1974.

Smoking is more prevalent in adult men (20% v 17%), more prevalent deprived communities (30% routine and manual v 11% professional) and more prevalent in those with less formal education (9% in those with degrees). Younger people are more likely to smoke (9255 16-34 v 11% >60). In children and young people, more girls smoke regularly and the major influence is smoking in the home [11].

Figure 10: Local Tobacco Profiles Annual Population Survey

2015/16	West Berks BC	England
Never smoked (APS*)	51.8%	48.6%
Adults resident smoking rate (APS*)	9.5%	16.9%
Manual and routine smoking rate (APS*)	26.7%	26.5%
Current smokers aged 15 – 2014/15 (WAY Survey)	4.9%	5.5%
Smoking in residents with severe mental illness	31.2%	40.2%

Source: [PHE: Local Tobacco Control Profiles for England]

**APS – Annual Population Survey*

It is recognised that smoking has a profound impact on health inequalities. There is greater health inequality between smokers and people who have never smoked than between people of the same sex and smoking status but different social positions.

In both women and men, people who are the most deprived in our society who had never smoked had substantially better survival rates than smokers in even the highest social classes [12]. 85% of the observed inequalities between socioeconomic groups can be attributed to smoking [13].

Smoking - impact

In 2012-14, there were 275 smoking attributable deaths per 100,000 population in England. In 2012/14 in Wokingham the rate was 197 per 100,000, aged 35+.

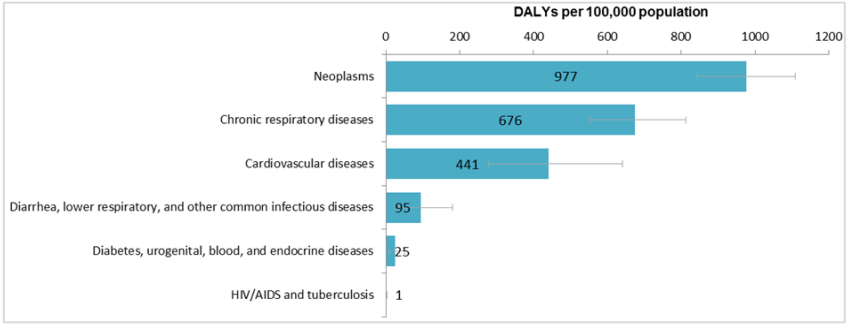
In 2012/14 476 deaths were attributed to smoking in Wokingham. That's 3 deaths per week.

Disability adjusted life years (DALYs) are an important measure used in health care as they not only measure the number of years of life lost (early deaths) but also the number of years lived with disability – so give an assessment of the impact on the life of the individual affected and the impact on health and care service usage. This analysis is now available for the South East.

Smoking is the most significant single lifestyle factor that causes the highest number of DALYs lost both regionally and nationally. 9.1% of DALYs in the South East Region were attributable to smoking in 2013 (2,215 per 100,000 population).

Figure 11 shows the wide impact of tobacco in the South East [14]. The largest numbers of DALYs attributable to smoking in general causes were for cancers, chronic respiratory diseases and cardiovascular diseases.

Figure 11: DALYs attributable to smoking in South East England (2013)



Source: *Global Burden of Disease (GBD)*

If we look at data for specific clinical illnesses and the impact of smoking on each of these then we see a different pattern; smoking accounts for at least 56% of all chronic lung disease conditions, 70% of COPD and 80% of lung cancer [14].

23% of DALYs for neoplasms were attributable to smoking. Again, this was higher for certain cancers; 79% of DALYs for tracheal, bronchus and lung cancer, 54.1% lip and oral cavity cancer, 53% oesophageal cancer.

We know that smoking prevalence is greater in men and in the most deprived communities and its impact increases over time.

If we look at men aged 55-79, smoking is, as could be expected, the single largest cause of DALYS (accounting for 12 – 14%) in the most affluent areas. In the most deprived communities however smoking accounts for 19 – 21% of DALYS which translates into one in five. This is significantly more than in wealthier areas. A similar pattern is seen in women.

In a study which looked at chances of survival and smoking after 28 years, people in the lowest socioeconomic groups who had never smoked had substantially better survival rates (56% women and 36% of men) than smokers in the highest social classes (41% women and 24% men) [12].

Tobacco accounts for 90% of health inequalities

Smoking - impact

With the major impact on illness, it is not surprising that smoking is also responsible for significant care use both in primary and hospital settings. Tobacco use accounts for approximately 5.5% of the NHS budget.

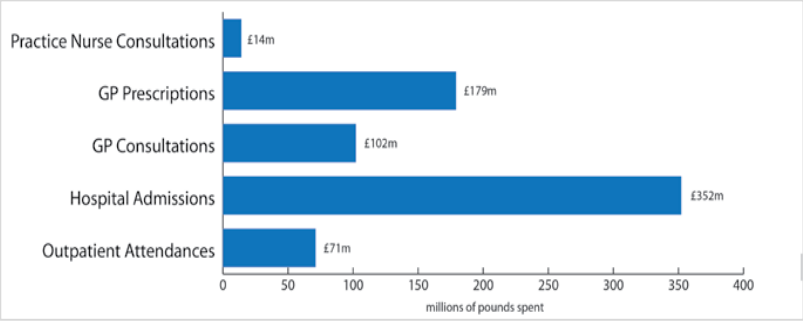
There were 1.7 million admissions in 2014/15 across the UK for conditions that could be caused by smoking, an increase of 22% from 2004/5. With 475,000 hospital admissions attributable to smoking in 2014/15, up from 452,000 in 2004/05. This represents 4% of all hospital admissions (6% of male admissions and 3% of females) [14,16].

23% of respiratory, 15% of cardiac and nearly 10% of Cancer admissions are attributable to smoking.

Individuals with mental health problems smoke more heavily than the general population, contributing to as much as 43% of tobacco consumption in the UK [16] and it is estimated 3 million UK adults with mental health disorders who are also smokers incur Total smoking-attributable costs of £2.34 billion .

A total of £719 million was spent treating smoking-related disease among people with mental health disorders of which £352m were due to hospital admissions, while other cases were treatments of cancer, cardiovascular disease and respiratory diseases [18].

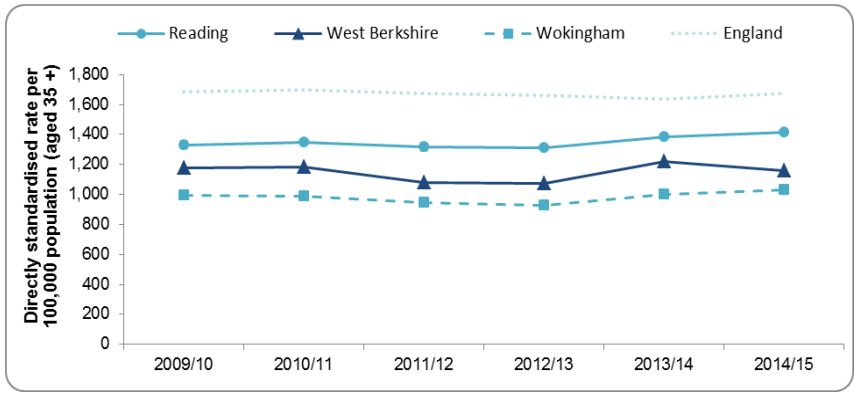
Figure 12: Costs due to smoking-related diseases among people with mental health conditions (2009/10)



Source: Ash: The Stolen Years, the mental health and smoking action report

Locally, in line with the lower prevalence of smoking (and our lower than average admissions in general) our rates of smoking related admissions are lower than the England average, with Reading having the highest rates across Berkshire [15,17].

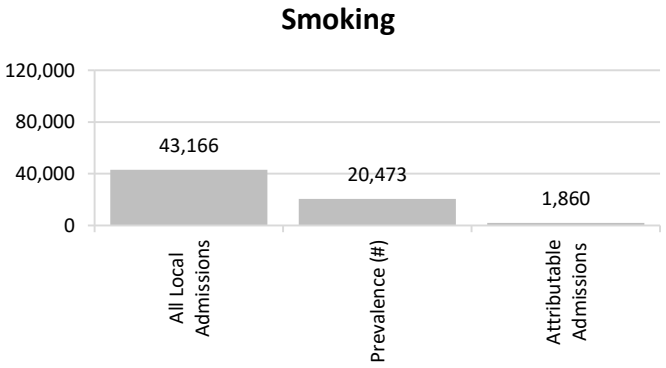
Figure 13: Smoking attributable hospital admissions in people aged 35 and over



Source: PHE: Local Tobacco Control Profiles for England

Though in Wokingham it can be seen that over 1800 admissions a year are solely attributable to the effects of smoking [16].

Figure 14: Smoking Figures



Source: LKIS 2017

Smoking - impact

The costs of smoking to the NHS and to the economy in general are well understood, however, there are also costs to the social care system, which are less well known [19].

Recent research, based on adults over 50, compared the care needs of current and former smokers with those of never smokers. The key findings were that whilst no difference could be seen in use of residential care (small sample size), smokers were more likely to have difficulties in the majority of activities of daily living and so were at double the risk of developing care needs. In just over half of the activities of daily living, ex-smokers also showed more difficulties.

The impact of smoking related ill health on the social care system, is estimated to be a cost of £1.4 billion every year, up from £1.1 billion in 2014. This is made up of £760 million in costs borne by local authorities, with a further £630 million being spent by those who have to self-fund their care.

Figure 15: Smoking Cessation figures

2015/16	Rates per 100,000 population (actual numbers)		
	Setting quit date	Successful quitters	Validated quitters (CO)
England	862	440	314
South East	674	375	271
Wokingham BC	709 (902)	500 (636)	350 (445)

Source: Calculated figures from PHE: Local Tobacco Control Profiles for England and ONS 2015 Mid Year Estimates

Interventions - What Works

The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS to quit. The greatest long-term savings would come from preventing people from ever smoking altogether. Prevention of smoking requires strong partnership working including the promotion of smoke free environments and reducing counterfeit and illegal tobacco sales.

Smoking cessation services are widely available and the local council services see fewer residents than the England average. In 2015/16, 709 per 100,000 set a quit date (v 862 England) but 500 per 100,000 reporting quitting at 4 weeks (v 440 England) [20] which is higher than the England average.

Interventions - Local Gaps

Although we offer some support to patients within health care settings to give up smoking, we have still to maximise this approach.

Recently Berkshire Healthcare Foundation Trust have been proactive in ensuring that all mental health facilities are smoke free, with patients being offered nicotine replacement therapy. However all smokers should be identified during treatment and at minimum offered brief intervention and advice to promote smoking cessation as part of their treatment plans. Pregnant women should be screened via carbon monoxide screening and offered specialist support [20] as a matter of course [21].

For those unable or unwilling to stop smoking permanently then temporary abstinence supported by nicotine replacement medication will deliver harm reduction. Smokers having elective surgery are six times more likely to have a surgical site infection and so have lengthier post operative stays and recovery periods. Simply supporting abstinence prior to surgery can reduce this risk, improve outcomes and reduce costs associated with care .

Lifestyles – High blood pressure

Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which your heart pumps blood around your body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They are both measured in millimetres of mercury (mmHg).

As a general guide:

- high blood pressure is considered to be 140/90mmHg or higher
- ideal blood pressure is considered to be between 90/60mmHg and 120/80mmHg

High blood pressure is normally distributed in the population and the risk associated with increasing blood pressure is progressive, with each 2 mmHg rise in systolic blood pressure being associated with a 7% increased risk of death from ischaemic heart disease and a 10% increased risk of mortality from stroke.

Risk factors for high blood pressure

Overweight or obese
Poor diet: high salt & less than 5 a day fruit and vegetables
Low physical activity levels
High alcohol use
Smoker
Over the age of 65
Don't get much sleep or have disturbed sleep
African or Caribbean descent
Family history of high blood pressure

At least one quarter of adults (and more than half of those older than 60) have high blood pressure [22].

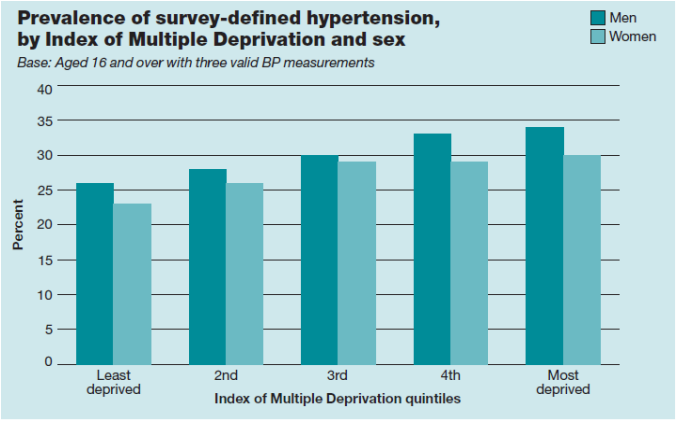
Over 24% of people in England are estimated to have high BP and it is one of the leading causes of premature death and disability in England. At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure, stroke, myocardial infarction and vascular dementia.

Lowering blood pressure per se reduces risk for myocardial infarction by 20% - 25% [23].

High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher.

High BP is much more common in deprived communities. The Department of Health's 2010 'Health Survey for England' noted that prevalence increased from 26% of men and 23% of women in the least deprived fifth of the population to 34% and 30% respectively in the most deprived 20%.

Figure 16: Prevalence of hypertension by Index of Multiple Deprivation (IMD) and sex (2011)



Source: NHS Digital: Health Survey for England (2011)

High blood pressure

For every ten people diagnosed with high BP, seven remain undiagnosed and untreated - this is more than 5.5 million people in England. Those in more deprived communities are less likely to have high BP detected though with the introduction of the quality scheme this gap has reduced [24,25]. In addition we can see the percentage of those in treatment and also adequately controlled reduces with increasing deprivation [25].

Figure 17: High Blood Pressure

Income level	n	Aware (%)	Treated (%)	Controlled (%)
High	6263	49.0	46.7	19.0
Upper Middle	18123	52.5	48.3	15.6
Lower Middle	23269	43.6	36.9	9.9
Low	10185	40.8	31.7	12.7
Total	57840	46.5	40.6	13.2

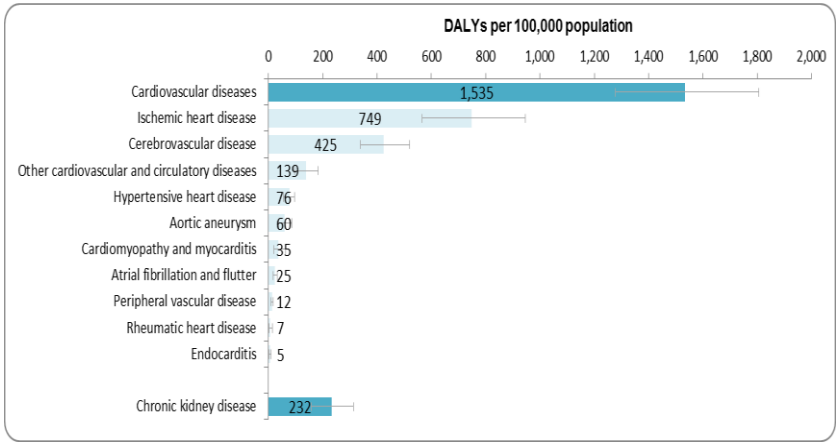
Source: PHE: Health matters: combating high blood pressure

13.1% of all deaths in South East England were attributable to high blood pressure [14].

7.2% of all disability-adjusted life years (DALYs) in the South East Region were attributable to high blood pressure in 2013 (1,766 per 100,000 population).

The largest number of DALYs attributable to high blood pressure were for cardiovascular diseases and chronic kidney disease. Within the cardiovascular diseases group, ischemic heart disease and cerebrovascular disease had the largest number of DALYs attributable to high blood pressure.

Figure 18: DALYs attributable to High Blood Pressure in South East England (2013)



Source: Global Burden of Disease (GBD)

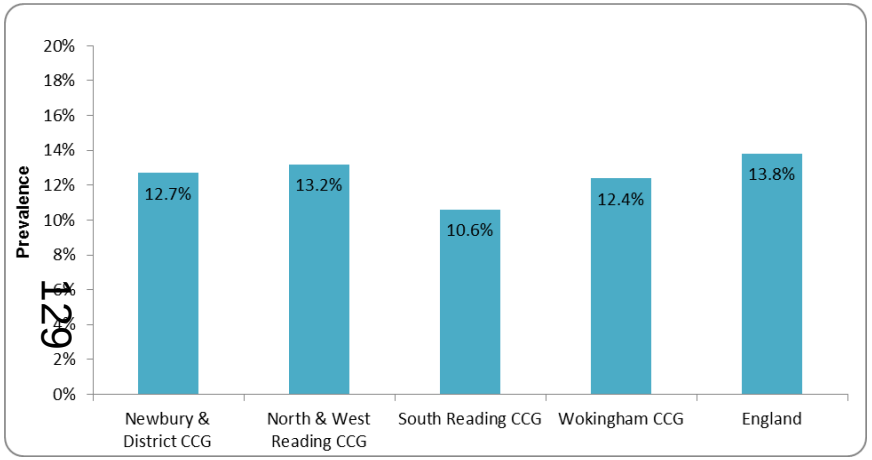
For all cardiovascular events high systolic BP accounts for 43% DALYs; 1,535 per 100,000.

In reviewing premature deaths (deaths before age 75) Wokingham fares well with regards to heart disease and stroke being ranked 2nd out of 150 authorities, with 52 deaths per 100,000 (2013-2015) and ranked 1st out of 15 in comparison to similar local authority areas [26].

High blood pressure - Impact

Across the Wokingham CCG, there are estimated to be 34,200 people with high blood pressure, with 19,700 currently being treated. This means that there are 14,550 people unaware of their high BP.

Figure 19: High Blood Pressure Prevalence by CCG



Source: NHS Digital: Quality and Outcomes Framework 2014/15

In addition, of those that are being treated by their GP not all are achieving target BP control: 681 patients [27].

Locally it is possible to measure the impact high BP has on disease and deaths but we can also estimate the impact of reducing high BP by 10 mm Hg in those with this condition in Wokingham CCG . Every 10 mm Hg reduction in systolic BP reduces the risk of major cardiovascular events by 20%.

Thus it is possible to calculate the impact of this improvement on Cardiovascular disease locally.

Figure: 20

Condition	Current number of events	Current number if treated	Reduction in number of deaths
Stroke	84	89	5
Heart failure	43	31	12
Cardiovascular disease	199	165	33
Deaths	1,189	1,034	155

Source: British Heart Foundation: How can we do better?

However, treatment is not simply reliant on medication. Across the long term conditions, more than half of all patients do not take their medication as prescribed. Modification of lifestyle factors can have a major impact on high BP with no side effects (and additional positive health impacts).

Studies show this impact and in one, the clear results were that in those who changed lifestyle behaviour for a period of 10 weeks a significant percentage achieved a 10 mmHg reduction in BP: [28]

- Weight reduction 40%
- Increased physical activity 30%
- More relaxation 25%
- Reduced alcohol intake 30%
- Reduced salt intake 25%

Advice given during the consultation for high BP is likely to be acted upon. Compared with those who did not recall being given advice, adults with high BP who recalled being given advice were more likely to change their eating habits, reduce salt, exercise and reduce alcohol consumption [29].

Indeed lifestyle modification is indicated for all patients with high BP, regardless of drug therapy, because it may reduce or even abolish the need for antihypertensive drugs.

High blood pressure - Intervention

High blood pressure management in the community from a long term perspective is focussed on reducing the risk factors within the population; obesity, physical inactivity, smoking and high salt intake. However in the short and medium term there are clear programmes that can reduce the impact of high BP [21].

A clear priority is to reduce the number of patients with known high blood pressure for whom treatment is not adequate. This can be achieved by annual audits of GP practice registers to identify affected patients and develop the role of pharmacists and other professionals to maximise achievement of treatment goals through lifestyle changes and drug therapy. A 20% improvement in blood pressure control can be cost saving within 5 years.

Another key priority is the wider use of self-monitoring by patients. They can be encouraged to develop the skills and understanding to monitor their blood pressure in their daily lives to minimise false readings.

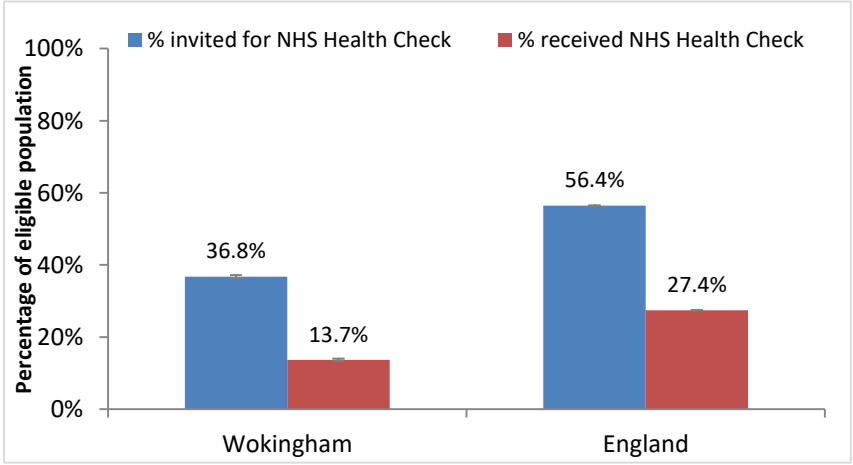
Of course it is also key to identify residents in the community who are unaware that they have high blood pressure. Programmes such as NHS Healthchecks identify those with high blood pressure and support them to make lifestyle changes or provide them with medical management will help to prevent longer term damage and reduce demands for more specialist health and social care.

Figure: 21 The number of people who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.

	Invited for NHS Health Check (2013/14 to 2015/16)		Received NHS Health Check (2013/14 to 2015/16)	
	No. of people	% of eligible population	No. of people	% of eligible population
Wokingham	17,993	36.8%	6,698	13.7%
England	8,792,518	56.4%	4,271,889	27.4%

This is cumulative, as part of the 5-year cycle of the programme.

Figure: 22 Percentage of eligible population who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.



Source: PHOF 2017

Lifestyle - Alcohol

It is known that alcohol is harmful to health and the CMO guidelines to reduce risk state that it is safest for men and women not to drink more than 14 units a week on a regular basis. These should be spread over 3 or more days [29,30].

Alcohol is measured in units - one unit is 10ml or 8g of pure alcohol. Since drinks differ in the proportion of alcohol the number of units varies. Alcohol drinks are often described as alcohol by volume percentage e.g. some wines are 11% ABV - this means that a 1 litre bottle contains 11 units .

Therefore one 125ml glass contains 1.64units, a 175 ml glass has 1.9 units and a 250 ml glass has 2.5 units.
A pint of 4% beer has 2.3 units [30].

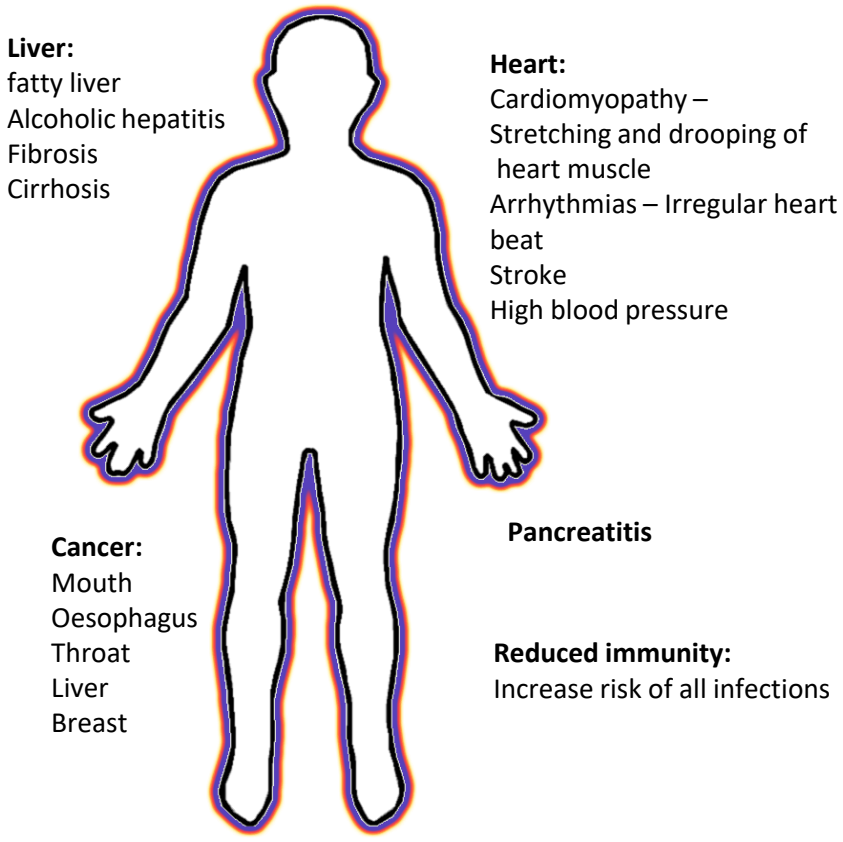
To keep to safe limits, an adult in a week should not drink more than

Figure 23: Alcohol limits and unit guidelines

Source: *Drinkaware.co.uk: Alcohol limits and unit guidelines*

Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions [31].

Figure 24: Effects of Alcohol on the body



Alcohol - Impact

The burden of health, social and economic alcohol-related harm is substantial, with estimates placing the annual cost to be between 1.3% and 2.7% of annual GDP.

Currently over 10 million people are drinking at levels that increase their risk of harm to their health.

- 5% of the heaviest drinkers account for one third of all alcohol consumed

Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined. in 2015 there were 167,000 years of working life lost [32].

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability.

With increasing consumption, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship [33].

Figure 25: Alcohol Harm Map

Condition		
	3 units of alcohol per day	6 units of alcohol per day
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension	1.7 times	3 times
Ischaemic stroke	No change	2 times
Haemorrhagic stroke	1.8 times	3 times
Pancreatitis	1.3 times	2 times

Source: Alcohol Concern: Alcohol Harm Map

The health and social harm caused by alcohol is determined by:

- the volume of alcohol consumed
- the frequency of drinking occasions
- the quality of alcohol consumed

In addition a number of individual risk factors moderate alcohol-related harm, such as [34]:

- age: children and young people are more vulnerable
- gender: women are more vulnerable
- familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders (AUD)

Also in the English population, rates of alcohol-specific and related mortality increase as levels of deprivation increase and alcohol-related liver disease is strongly related to the socioeconomic gradient [32].

This despite the fact that lower socioeconomic groups often report lower levels of average consumption. This gives rise to what has been termed the 'alcohol harm paradox' whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. The reason for this is not known but may be due to a greater impact of alcohol due to lower resilience: possible higher rates of binge drinking or poorer access to services

Public Health England has estimated the increase on average life expectancy for men and women if all alcohol-related deaths were prevented. Nationally, this would be 12 months for men and 5.6 months for women (Source: Alcohol Concern, Alcohol Harm Map).

Alcohol - Impact

Figure 26:

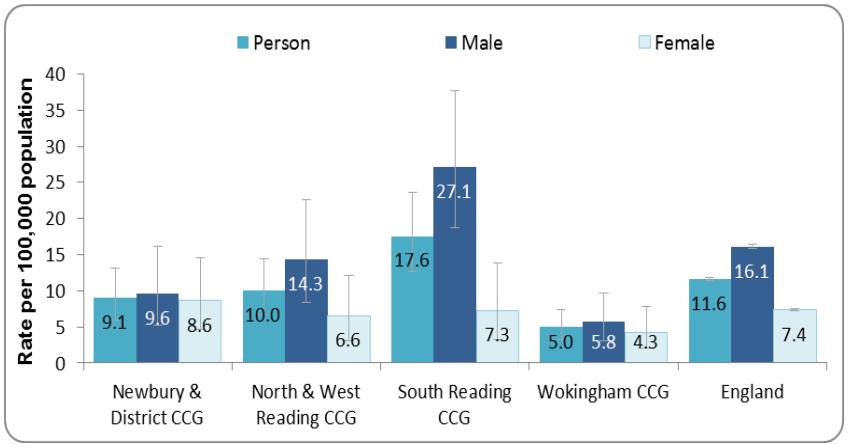
Cause of death	No. of deaths	Average age at death
All causes (England & Wales	501,424	77.6
All alcohol-specific causes	4,329	54.3
Mental and behavioural disorders due to use of alcohol	489	57.5
Toxic effects of alcohol (unspecified)	395	42.4
Accidental poisoning by exposure to alcohol	369	49.1

3.9% of all early death and poor health (DALYs) in the South East Region were attributable to alcohol use in 2013 (965 per 100,000 population)[12].

The largest number of DALYs attributable to alcohol use were for cancers, cirrhosis, mental and substance use disorders and unintentional injuries

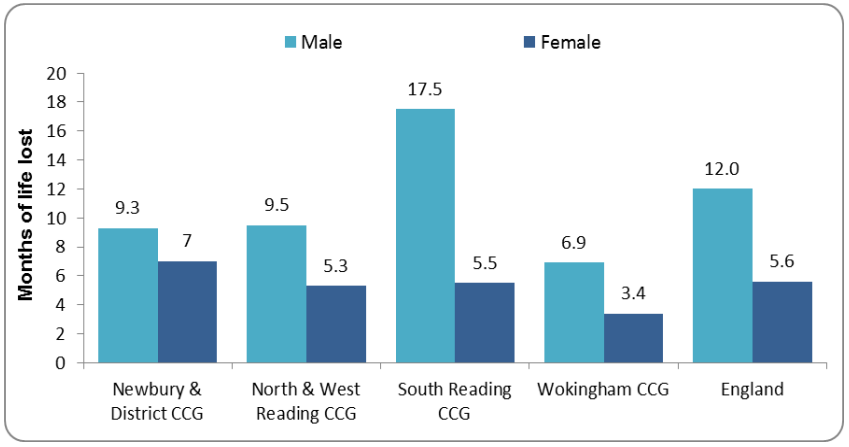
In 2012-14, 130 people died from alcohol-specific conditions in the 4 Berkshire West CCGs. 67% of these were men. The rate of deaths per 100,000 population varied in the area from 5.0 per 100,000 population in Wokingham CCG to 17.6 per 100,000 in South Reading CCG – with male deaths in South Reading being significantly higher [16].

Figure 27: Alcohol-specific mortality per 100,000 population (2012-14)



If we look at the months of life lost due to alcohol locally then we can see a similar picture where men in South Reading lose 17.5 months – the biggest impact with Wokingham having the lowest months lost [15,17] – 6.9 months (Fig.28).

Figure 28: Months of life lost due to alcohol (2012-14)



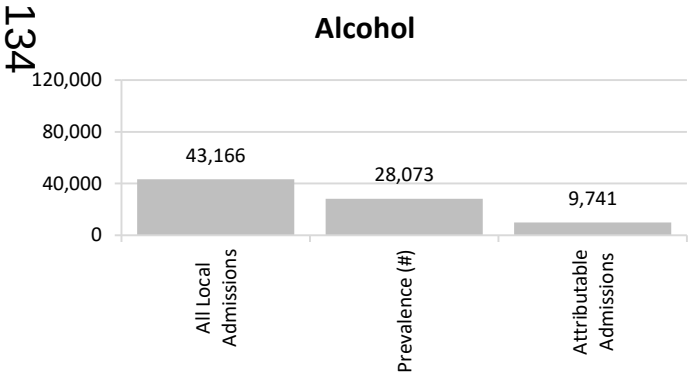
Source: Public Health England (2016); Local Alcohol Profiles for England

Alcohol - Interventions

With such an impact on early death and illness alcohol has a significant impact on hospital use. Nationally alcohol related and attributable admissions have been rising: According to the broad measure, admissions for cardiovascular disease account for almost half of all alcohol-related admissions in 2014/15. For the narrow measure, hospital admissions for cancer represent the most common condition for admissions accounting for 23% of all alcohol-related conditions.

Within Wokingham there are over 28,000 residents who consume alcohol and just under 10,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs [16].

Figure 29: Alcohol figures



Source: LKIS 2017

The impact of alcohol in our society is driven by a variety of factors including limited awareness of health risks from alcohol consumption, addictive nature of alcohol, failure of health professionals to address alcohol as a causal factor in patients' ill health and lack of local system join-up [34,31].

The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and the wider society [31].
This will result in:

- A reduction in alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs
- A reduction in the burden on NHS, police and social care services from high volume service users
- A reduction in the impact of parental alcohol misuse on children

Much of the work on addressing alcohol needs to be done at a national level: continued media and awareness raising on safe alcohol consumption, national policy changes in minimum pricing, taxation and licensing of alcohol.

However there are further key actions that can be taken forward locally including:
Screening patients throughout health care settings to deliver a brief intervention, including giving advice to raise knowledge on safe alcohol levels, potential harm and ways to reduce alcohol intake [21].

The development of alcohol care teams, to support patients admitted to hospital through alcohol with specialised support , coupled with assertive outreach and case management for patients and residents in whom alcohol is causing repeated hospital admissions or use of other services.

Lifestyle - Physical Activity

Physical Activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure

Physical activity levels can be measured either through asking people to report how much exercise they do, or by objectively measuring the amount of exercise a person is doing. Most reports use self reported activity.

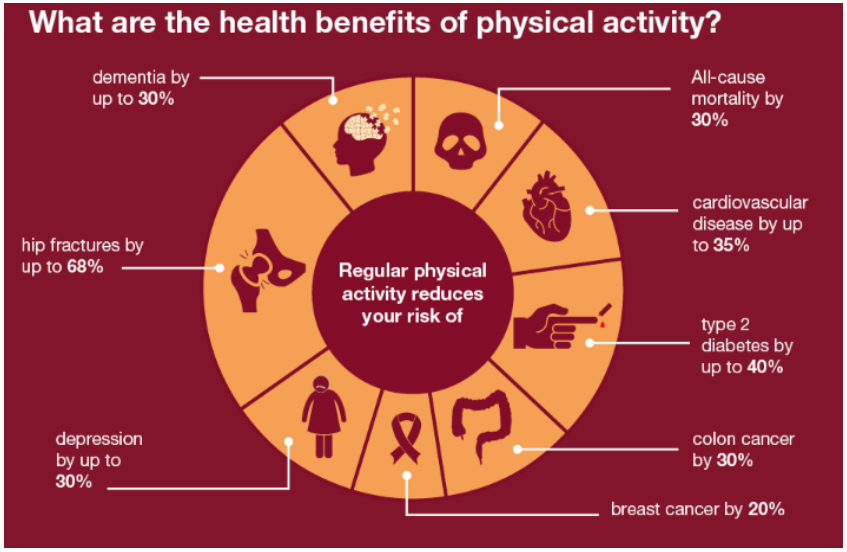
Physical inactivity is defined as less than 30 minutes of physical activity a week. The Chief Medical Officer guidelines for physical activity not only suggest recommended activity levels but also recommend the amount of time in which we are sedentary, and encourage weight bearing exercise [35] .

Figure 30: Adult activity recommendation

Source: Health matters: getting every adult active every day

The link between physical inactivity and obesity is well known, but physical activity is not just a way of addressing obesity.
Low physical activity is one of the top 10 causes of disease and disability in England.

Figure 31: Health benefits of physical activity



Source: Health matters: getting every adult active every day

UK studies have estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.

1 in 8 women in the UK are at risk of developing breast cancer at some point in their lives. By being active every day they could reduce their risk by up to 20% [36].

Physical activity is also important for people diagnosed with cancer and cancer survivors. Not only increasing ability to manage recovery but also reducing rate of recurrence in key cancers.

Macmillan has estimated that in the 2 million cancer survivors in the UK - 1.6 million do not meet the recommended levels of physically active [37].

Physical Activity

One in four women and 1 in 5 men are inactive. Only 24% of women and 34% of men do muscle strengthening exercises twice a week. Men are more likely to be sedentary for more than 6 hours a Day [36].

Levels of activity are reducing. People in the UK are around 20% less active now than in the 1960s. This pattern is also seen in children and young people with the proportion who met the weekly physical activity guidelines falling between 2008 and 2012 [36].

People living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas [38].

South East England has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest.

Age

Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health.

Disability

Disabled people are half as likely as non-disabled people to be active. Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability.

Race

Only 11% of Bangladeshi women and 26% of and Bangladeshi men are sufficiently active for good health, compared with 25% of women and 37% men in the general population.

Sex

Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity [38].

Sexual orientation and Gender Identity

Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club [26].

Lack of physical activity is costing the UK an estimated £7.4 billion a year, including £0.9 billion to the NHS alone [36].

Inactivity causes 9% (range 5·1–12·5) of premature mortality, or more than 5·3 million of the 57 million deaths that occurred worldwide in 2008 [14].

Physical inactivity in developed countries is responsible for :
an estimated:

22-23% of CHD
16-17% of colon cancer
15% of diabetes
2-13% of strokes and
1% of breast cancer [16]

It is estimated that physical inactivity contributes to almost one in ten premature deaths (based on life expectancy estimates for world regions) from coronary heart disease (CHD) and one in six deaths from any cause.

Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent:
- one in ten cases of stroke and heart disease in the UK and
- one in six deaths from any cause [38].

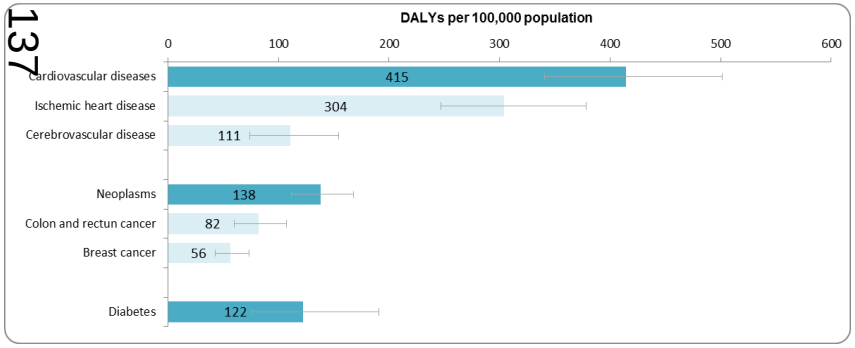
Physical Activity - Interventions

In the UK the Global Burden of Diseases found physical inactivity to be the fourth most important risk factor in the UK for limiting illness and early death [14].

In the South East, 2.8% of all disability-adjusted life years (DALYs) in the South East Region were attributable to low physical activity in 2013 (675 per 100,000 population) [12].

The largest number of DALYs attributable to low physical activity were for cardiovascular diseases, neoplasms and diabetes

Figure 32: DALYs attributable to low physical activity in South East England (2013)



Source: Global Burden of Disease (GBD)

The Health Impact of Physical inactivity (HIPI) tool quantifies the impact of physical inactivity for people aged 40 – 79. Within Wokingham each year if 100% of this group were active then:

- 79 out of 442 annual deaths (40-79) could be prevented
- 22 out of 110 annual cases of breast cancer could be averted
- 761 new cases of diabetes could be prevented

A body of evidence now exists that links physical inactivity to increasing risk of hospital admission - emergency and other use of health and social care [39].

In Scotland it was shown that minutes of moderate-to-vigorous physical activity (MVPA) per day predicted subsequent numbers of prescriptions: those with less than 25 minutes of moderate to vigorous physical activity per day had 50 per cent more prescriptions over the following four to five years.

Similarly the number of steps taken per day and MVPA also predicted unplanned hospital admissions. Those in the most active third of the sample were at half the risk of emergency hospital admissions than those in the low active group [40].

The solution is clear: Everybody needs to become more active, every day [36]. Physical activity does not need to be strenuous, it can be 30 minutes of brisk walking, a swim, gardening or dancing .

Each ten minute bout that gets the heart rate up has a health benefit. Being active is not just about moving more, we need to build our muscle strength and skills.

In addition adults need twice a week muscle strength and stability improvements which helps prevent the development of musculoskeletal disease.

A number of common characteristics are apparent in effective action to increase population levels of physical activity. These include two common factors: persistence and collaboration [40].

Four areas of action are identified by Public Health England, at national and local level.

- active society: changing our attitude to physical activity
- moving professionals: professionals across all sectors promoting activity in their work
- active lives: creating environments that make activity easy
- moving at scale: scaling up interventions that make us active

Lifestyle - Obesity

Being overweight or obese is when a person has more body fat than is optimally healthy. Poor diet and physical inactivity are causal factors of obesity with excess weight being caused by an imbalance between energy consumed and energy expended.

In the UK obesity is estimated to affect around one in every four adults and around one in every five children aged 10 to 11.

The annual costs associated with obesity to the NHS and social care systems are estimated to be £6.1 billion a year and £352 million respectively [41].

For most adults, BMI measures are :

- healthy weight 18.5 to 24.9 kg/m_2
- overweight 25 to 29.9 kg/m_2
- obese 30 to 39.9 kg/m_2
- severely obese 40 or above kg/m_2

Another simple measure of excess fat is waist circumference. Normal waist size values are for men - 94cm (37in) or more
For women - 80cm (31.5in). If these measures increase an individual is more likely to develop obesity-related health problems.

Obesity prevalence increased steeply between 1993 and 2000. Rates of obesity and overweight were similar in 2013 to recent years. *Health Survey for England 2013* [41].

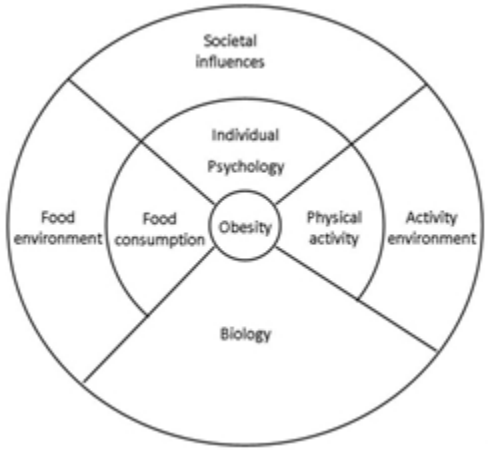
Mortality

9.0% of all deaths in South East England were attributable to a high body-mass index (GBD2013) . This was the 3rd most important risk after smoking and high blood pressure (12).
The impact of weight on life expectancy is linked to the levels of excess weight.

People with a BMI of 22 – 25 kg/m_2 have the best life expectancy:
obese individuals live 2 – 4 years less
People with BMI of over 40 live 8 – 10 years less [42]

Increased mortality is as a result of higher rates of cardiovascular disease, high BP and type 2 diabetes and hormone sensitive cancer - e.g. breast .

Figure 33: Foresight Obesity Systems Map (2007)

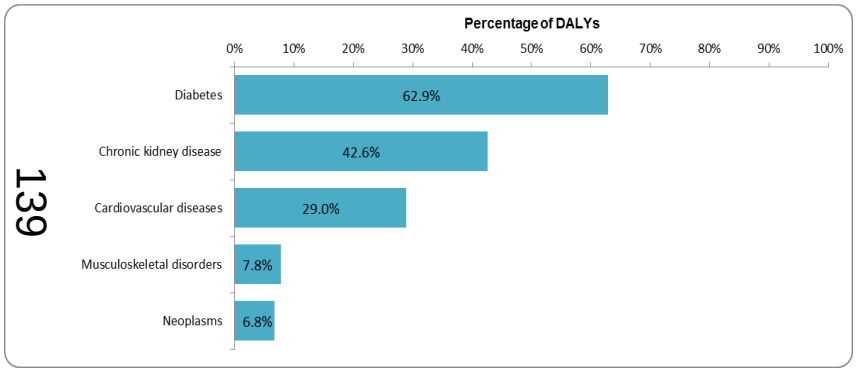


Source: Foresight Systems Map (2007)

Obesity – local impact

Obesity causes 9% of all DALYs lost in the South East of England, with most overall impact being seen through cardiovascular disease and diabetes. But its impact as a cause of diabetes (63%), chronic kidney disease and cardiovascular disease due to high BP (56%) is very stark [14].

Figure 34: Percentage of DALYs attributable to High BMI in South East England by cause (2013)



Source: Global Burden of Disease (GBD)

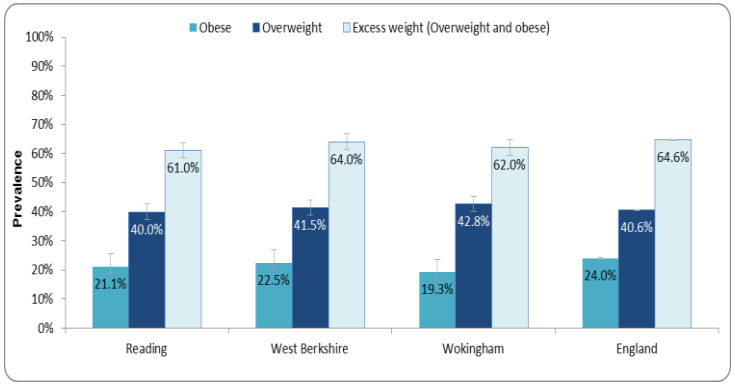
Obesity levels in the population vary with a variety of factors e.g. obesity levels increase until late middle age and then reduce in old age. More women in communities with higher deprivation are obese (NICE guidelines 2014).

Women from the higher socioeconomic groups have the lowest prevalence of obesity while those in the lowest groups consistently have the highest prevalence of obesity [42,43]. This is not seen in men, though for both men and women obesity is significantly reduced in those with a degree or equivalent.

Prevalence of obesity is highest in women from Black African, Black Caribbean and Pakistani ethnic groups.

Locally in Wokingham we can see that we are below the national average with regards obesity levels . However it can be seen that we have higher than the England average for percentage of residents who are overweight where we still see adverse health impacts.

Figure 35: Prevalence of obesity and being overweight in (2012-14)



Source: Active People Survey (2012-14)

In our children the figures are a concern. In Wokingham in 2015/16 18.6% of children in reception were measured as overweight or obese, rising to 28.3% in year 6 (England figures were higher at 22.1% and 34.2% respectively).

We know that obesity is linked to health conditions and so impacts on hospital admissions. We would therefore expect that with our lower rates of obesity, this would have less of an impact on our adult hospital admissions. However even with our lower than average obesity levels there are still just over 5000 admissions being attributable to obesity [16].

Obesity - Interventions

Interventions to reduce obesity are less visible and accepted than others such as smoking cessation. There are a number of ways that can be adopted to reduce the burden of obesity for the individual and the community.

Our environments tend to promote obesity: encouraging high calorie food intake and physical inactivity. Local government partners, employers and communities can work together to change this. Promoting active travel and ensuring healthy food options in work are two examples of work to address our environment.

In addition we need to ensure our weight management services are evidence based and cost effective. However the first step is for professionals to consistently raise the issue of weight at every opportunity. There is evidence that professionals believe programmes to have no lasting impact. However the evidence from published research is that interventions do work, with community based approaches being more effective than those based in primary care (44). Primary care can increase the effectiveness of community based approaches through discussion and referral. People referred via primary care had greater weight loss [45] - 50%, but even just mentioning weight loss as part of a consultation results in weight loss still seen at 2 years [45].

A brief intervention, resulting in 1.5 kg weight loss, delivered once a year to all eligible people visiting their GP, could halve the prevalence of obesity by 2035 (Jebb 2017).

One other reason given for reluctance to refer is the belief that impact is short lived, whilst weight does gradually increase weight loss is still seen at 2 years and crucially even in patients who regain their weight the incidence of diabetes is significantly reduced at 10 years - the impact of the weight loss outlives the actual weight loss [47].

Furthermore Health professionals do not routinely address weight loss issues as some voice concern about the impact of the topic on the clinical relationship. However research on patients receiving weight loss advice showed that less than 2% found it to be unacceptable or unhelpful and over 40% very helpful. Moreover 77% accepted the referrals to weight management services with nearly 50% completing the course [47].

It should be remembered that weight management interventions aim to have lifelong benefits. In Berkshire in the second year of a locally developed intervention, Eat for Health, 529 people have attended courses with more than 50% losing more than 3% of their original body weight. 197 people with high BP attended and 55 (28%) lost weight with a resultant return to normal levels in their BP, needing no on-going medication and achieving significant on going health benefits.

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TITLE	**Pharmaceutical Needs Assessment Delivery Plan**
FOR CONSIDERATION BY	Health & Wellbeing Board on 15 June 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Wright - Interim Director of Public Health for Berkshire

Reason for consideration by Health and Wellbeing Board	Since April 2013, every Health & Wellbeing Board in England has had a statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area. This is referred to as the Pharmaceutical Needs Assessment (PNA). Each Health & Wellbeing Board had to publish their first PNA by 1st April 2015, and is required to undertake a revised assessment at least every 3 years. All Berkshire Authorities need to public their next PNA by April 2018.
Relevant Health and Wellbeing Strategy Priority	The provision of pharmacy services is relevant to all four priorities of the Health and Wellbeing Strategy 2017-2020.
What (if any) public engagement has been carried out?	Public Engagement is crucial to the preparation of the PNA, and this paper highlights the need for and opportunities for this in the development of the PNA for 2018-2021.
State the financial implications of the decision	None to the Board or the Council. The recommendations of the PNA relating to the need to increase, decrease or redistribute community pharmacy provision may lead to financial implications for the providers of these services.

OUTCOME / BENEFITS TO THE COMMUNITY

That the population of Wokingham Borough, and visitors and workers alike, have access to high quality community pharmacy services to both meet their needs for prescription and non-prescription medicines and devices; and for any other health service s which may be provided through community pharmacy.

RECOMMENDATION

That the Health and Wellbeing Board note the content of this report and that constituent organisations work with the Public Health Team at Wokingham Borough Council to facilitate the public consultation required to complete the assessment.

In October 2017, the Health and Wellbeing Board Chairman will sign off the draft for public consultation. From October to December 2017, the Health and Wellbeing Board will support public consultation on the draft PNA. By 31 March 2018, the Health and Wellbeing Board will agree the final PNA at its public meeting, including any recommendations and this will be published in formal papers, and the PNA made available on the Council website.

SUMMARY OF REPORT
This report outlines the plans being put in place to deliver the new Pharmaceutical Needs Assessment 2018-2021 for Wokingham Borough.

Background

The PNA is a key priority in the Shared Public Health Team's 2017/18 Business Plan, under the direction of Judith Wright, Interim Strategic Director of Public Health.

The major components of the PNA will be informed by the results of two surveys: one of residents using local pharmacy services; and the other of pharmacy staff in each borough. In 2017 it is proposed that these surveys will be carried out in June, July and August. They will be electronic and managed through the usual dissemination channels for a public survey of the member organisations of the Health and Wellbeing Board.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs and detail the minimum information to be contained. These also state that there should be a minimum period of 60 days for public consultation on the draft PNA, before they can be adopted and signed-off by the Health & Wellbeing Board. The proposal is to carry out the public consultation between October and December. While the PH Shared Team will lead on the development and delivery of the PNA on behalf of HWBBs, certain actions need to be undertaken at a local level to ensure success of the project including promotion to local residents.

- Initial Support – This paper seeks support from the Health and Wellbeing Board for the PNA project as outlined above
- Communication and promotion of PNA with residents - A Communication Plan for the dissemination of the electronic survey in Wokingham Borough will be developed by the Shared Team, in collaboration with our Public Health team.
- Consultation - The public consultation period for the PNA will be between October and December 2017. Health and Wellbeing Board members are asked to add this to their corporate consultation schedule for this period and to identify any processes that need to be completed to ensure this consultation occurs.

Analysis of Issues

Wokingham Borough Council through its Core Strategy (Local Plan) has made provision for over 13,500 new homes being built in the plan period tom 2026. The growth in population and the redistribution of settlements and population density including four new strategic development locations; makes it essential that the PNA addresses these future population needs as well as those of the existing population.

Since the last PNA was published in 2015, there have been 570 new homes completed in the Borough, and a further 1,368 to be completed in the PNA plan timescale. For the new 2018-2021 PNA timescale, there are current planning consents for 3,781new homes in the Borough. Previous forward planning estimates for primary healthcare services has estimated the occupancy of new homes in the Borough to be 2.52 people per unit. This equates to a population growth estimated as 4,884 people for the current PNA period; and 9,528 people for the new 2018-2021 PNA period.

Partner Implications
The PNA will set out the needs for pharmacy provision for our population during the 2018-2021 period. This will impact upon Council services providing health and social care including Optalis the council's care provider, as many clients of these services will have prescriptions for medicines and medical devices provide through community pharmacy. The move through the Councils 21st Century Council transformation programme to more resident self-service; may provide a model for how council service clients access pharmacy services in the future. As the owner of property assets across the Borough, and the planning authority, the Council has further interests in the provision and re-provision of pharmaceutical services in these areas.

Reasons for considering the report in Part 2
No Applicable

List of Background Papers
Wokingham Borough Health & Wellbeing Strategy 2017-2020. Wokingham Borough Pharmaceutical Needs Assessment 2015-2018. Wokingham Borough Core Strategy. Meeting the Health Needs Of Wokingham Borough Council's Major Growth Areas, 2014.

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Date 2nd June 2017	**Version No.** 1

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Report to Health and Well-being Board
Thursday 15th June 2017

1d.	Improving the life chances and wellbeing of disadvantaged young people (Not in Employment Education or Training (NEET), aged 16-25 years) in the borough (projects -Elevate, Aspire, Construction brokerage)	- Number of IAG (information, advice and guidance) contacts - Numbers placed in work experience - Number of apprenticeship starts - Confirmed apprenticeships after six months - Number of new employments starts - New employment sustained after six months - The average NEET for the year will be no higher than 3.2% (excluding July and August)
1e.	Enabling the older working population to work in fulfilling, productive employment for longer - Including volunteering (Projects, promoting lifelong learning, vocational training for older people - including older apprenticeships, & promoting volunteering)	- Levels of unemployment in the over 50s 210 people aged 50-64 years on job seekers (Feb 2014) - Number of over 50s seeking older apprenticeships or vocational training - Number of over 50s seeking Careers information and advice - 40 people attended workshops specifically aimed at over 50s seeking work in 2013 - Number of over 50s clients seeking IAG from Wokingham Job Support - for the year 2013 105 people over the age of 50 used this service

1f. and 1g. No suitable partners/resource have been identified so these targets cannot be reported on.

1d. Targets to date, across Elevate City Deal project. (Work experience targets are low across the whole of Berkshire.) This project is due to finish reporting on in March 2017.

Measure	**Wokingham**		
	Target	**No. to date**	%
IAG Contact	519	392	76
Work Experience – 5 days with same employer	173	74	43
Apprenticeship Start	35	51	146
Apprenticeship sustained 6 months	17	31	182
New employment Start	150	177	118
New employment sustained 6 months	75	103	137

	December 2016	**February 2017**	**April 2017**
The average NEET for the year will be no higher than 3.2% (excluding July and August)	0.9% – NOMIS	0.9% – NOMIS	0.8% -NOMIS

1e.

Levels of unemployment in the over 50s *210 people aged 50-64 years on job seekers (Feb 2014)*	**August 2016** 170 people 50+ claiming JSA. (0.6%)	**December 2016** 180 people 50+ claiming JSA. (0.6%)	**Feb 2017** 195 people 50+ claiming JSA. (0.6%)	**April 2017** 205 people 50+ claiming JSA. (0.7%)

Number of over 50s seeking Careers information and advice – *40 people attended workshops specifically aimed at over 50s seeking work in 2013*	12 people have attended workshops specifically aimed at over 50s seeking work between June 2016 – September 2016	11 people have attended workshops specifically aimed at over 50s seeking work between September– December 2016	9 people have attended workshops specifically aimed at over 50s seeking work between November 2016 and February 2017.	28 people have attended workshops specifically aimed at over 50s seeking work between March 1st 2017 and May 31st 2017.
Number of over 50s clients seeking IAG from Wokingham Job Support – *for the year 2013 105 people over the age of 50 used this service*	31 new registrations of people aged 50+ June – September 2016	36 new registrations of people aged 50+ September – December 2016	37 new registrations of people aged 50+ between November – February 2017	46 new registrations of people aged 50+ between March 1st 2017 and May 31st 2017

Agenda Item 16.

HEALTH AND WELLBEING BOARD

Forward Programme from June 2017

Please note that the forward programme is a 'live' document and subject to change at short notice.

The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda.

All Meetings start at 5pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.

HEALTH AND WELLBEING BOARD FORWARD PROGRAMME 2017/18

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
10 August 2017	**Local Account of Adult Social Care Services 2016-17**	To monitor performance	To monitor performance	Judith Ramsden, Director of People Services	Performance
	Health and Wellbeing dashboard	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
12 October 2017	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
14 December 2017	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
8 February 2018	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
5 April 2018	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance

	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	