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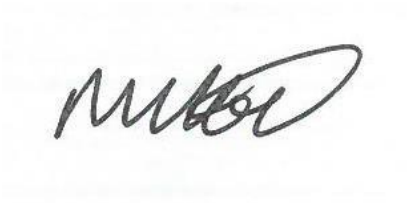
WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held in David Hicks 1 - Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 12 OCTOBER 2017** AT **5.00 PM**



Manjeet Gill
Interim Chief Executive
Published on 4 October 2017

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Our Priorities

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Mark Ashwell	WBC
Nick Campbell-White	Healthwatch
Shaun Virtue	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Charlotte Haitham Taylor	WBC
Ian Pittock	WBC
Nikki Luffingham	NHS England
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
Judith Wright	Interim Director of Public Health

31. **APOLOGIES**
To receive any apologies for absence

32. **MINUTES OF PREVIOUS MEETING** **7 - 14**
To confirm the Minutes of the Meeting held on 10 August 2017.

33. **DECLARATION OF INTEREST**
To receive any declarations of interest

34. **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

35. **MEMBER QUESTION TIME**
To answer any member questions

36. None Specific **DEVELOPMENT OF THE WOKINGHAM COMMUNITY SAFETY STRATEGY 2018/21** **15 - 18**
To receive a report on the development of the Wokingham Community Safety Strategy 2018/21.

37.	None Specific	**UPDATES FROM BOARD MEMBERS** To receive an update on the work of the following: • Business, Skills and Enterprise Partnership; • Community Safety Partnership; • Place and Community Partnership; • Voluntary Sector; • Healthwatch Wokingham Borough	**19 - 20**
38.	None Specific	**LOCAL ACCOUNT OF ADULT SOCIAL CARE SERVICES 2016-17** To receive the Local Account of Adult Social Care Services 2016-17.	**21 - 36**
39.	None Specific	**MERGER OF THE FOUR BERKSHIRE WEST CCGS** To receive a briefing regarding the merger of the four Berkshire West CCGs.	**37 - 44**
40.	None Specific	**HEALTH AND WELLBEING STRATEGY ACTION PLAN AND DASHBOARD** To receive the Health and Wellbeing Strategy action plan and dashboard.	**To Follow**
41.	None Specific	**RESOURCES AND INITIATIVES WHICH SUPPORT THE HEALTH & WELLBEING STRATEGY ACTION PLAN.** To consider a report regarding the resources and initiatives which support the Health & Wellbeing Strategy Action Plan.	**45 - 52**
42.	None Specific	**INFLUENZA VACCINE CAMPAIGN 2016-17 REVIEW** To receive an update on the Influenza Vaccine Campaign 2016-17 Review.	**53 - 58**
43.	None Specific	**PUBLIC HEALTH OUTCOMES FRAMEWORK** To be informed of the exceptions from the the Public Health Outcomes Framework for the quarter.	**59 - 62**
44.	None Specific	**WOKINGHAM INTEGRATION AND BETTER CARE FUND (BCF) NARRATIVE PLAN 2017/19** To consider the Wokingham Integration and Better Care Fund (BCF) Narrative Plan 2017/19.	**63 - 108**
45.	None Specific	**FORWARD PROGRAMME** To consider the Board's work programme for the remainder of the municipal year.	**109 - 112**

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

CONTACT OFFICER

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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 10 AUGUST 2017 FROM 5.00 PM TO 6.55 PM

Present

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Mark Ashwell	WBC
Nick Campbell-White	Healthwatch
Shaun Virtue	Community Safety Partnership
Ian Pittock	WBC
Clare Rebbeck	Voluntary Sector representative
Dr Cathy Winfield	NHS Wokingham CCG
Darrell Gale (substituting Judith Wright)	Consultant in Public Health

Also Present:

Madeleine Shopland	Democratic & Electoral Services Specialist
David Cahill	Berkshire NHS Foundation Trust
Vicki Elliot King	Service Manager, Intelligence & Impact
Phillip Sharpe	Interim Head of Adult Social Care & Safeguarding
Dr Amit Sharma	Brookside Practice
Georgina King	Impact & Inspection Analyst
Luka Zestic	Senior Performance Analyst
Angela Morris	Operations Director, Optalis

18. APOLOGIES

Apologies for absence were submitted from Beverley Graves, Councillor Charlotte Haitham Taylor, Nikki Luffingham, Judith Ramsden, Jeremy Sharpe, Jim Stockley, Nicola Strudley, Katie Summers, Kevin Ward and Judith Wright.

19. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Board held on 15 June 2017 were confirmed as a correct record and signed by the Chairman.

Clare Rebbeck commented that the MICE bus was terminating but that work was being undertaken to pick up the localities that it had covered.

20. DECLARATION OF INTEREST

There were no declarations of interest.

21. PUBLIC QUESTION TIME

There were no public questions.

22. MEMBER QUESTION TIME

There were no Member questions.

It was clarified that the Member question section of the agenda was for Wokingham Borough Council Members who were not members of the Health and Wellbeing Board, to submit questions to the Health and Wellbeing Board, should they wish. All members of the Health and Wellbeing Board were able to ask questions throughout the meeting.

23. COMMUNITY HEALTH & SOCIAL CARE

David Cahill, Berkshire Healthcare NHS Foundation Trust, Dr Amit Sharma, Phillip Sharpe, Interim Head of Adult Social Care & Safeguarding and Angela Morris, Operations Director, Optalis, presented the business case for Community Health and Social Care.

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

- David Cahill outlined what the Community Health and Social Care (CHASC) project was seeking to address including pressures in primary care, financial pressures across the system, stretched resources and increased demands on services. If nothing was done to meet these challenges, costs would exceed funding by approximately £7m over the next year across the Wokingham health system.
- CHASC would create a single long term Health and Social Care Team focused on early interventions and prevention and would remove organisational boundaries, meaning that users would only have to tell their story once.
- The Board noted the proposed system model, objectives and deliverables and benefits; both financial and for people.
- Dr Sharma commented that the multi-disciplinary team meetings were very helpful and that the Community Navigators were proving successful.
- Clare Rebbeck commented that more could be made of the prevention agenda.
- Councillor McGhee-Sumner questioned how certain it was that sufficient funds would be in place for the next five years. David Cahill commented that the financial information was based on information that was currently available.

RESOLVED: That

1) the business case be supported.

2) the update on Community Health and Social Care be noted.

24. BERKSHIRE WEST ACCOUNTABLE CARE SYSTEM

Dr Cathy Winfield updated the Board on the Berkshire West Accountable Care System (ACS).

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

- The ultimate aim of the ACS was to have a single programme for the whole health and care system, delivering new care and business models.
- Board members were reminded that the Berkshire West 10 Integration Programme (BW10) and local integration programmes would continue.
- The reporting mechanism for the ACS and local authority joint commissioning programme would be via the BW10 governance and through on to the three Berkshire West Health and Wellbeing Board.
- In June 2017 the Berkshire West ACS had been selected as one of only eight systems nationally to operate as an ACS in shadow form for 2017/18.
- Dr Winfield outlined why an ACS had been considered locally. Reasons included different parts of the health system being funded differently, primary care in

particular being under pressure and financial challenges across the entire health system.

- Board members were informed that the ACS would create a more collaborative approach to the planning and delivery of services with collective responsibility for resources and population health. It would operate on a single budget for the whole health care system.
- Organisations were starting to work more closely in partnership and system wide governance arrangements had been put in place. A Memorandum of Understanding had been agreed in June 2016.
- Board members were informed of progress made to date including the award of 'exemplar' status in June 2017.
- Next steps would include the agreement of a performance contract with NHS England and NHS Improvement. Faster movement on the Five Year Forward View key deliverables would be required.
- In year 2 the BW10 and ACS would begin to be brought together. It was noted that Nick Carter, Chair of the BW10 Integration Board had joined the ACS leadership Group. Councillor McGhee-Sumner asked how the Integration Board would report back to Wokingham and was informed that the Chairmen of the Health and Wellbeing Boards were sent the papers for the Board meetings and also that Judith Ramsden, Director of People Services, was a member of the Integration Board.
- Clare Rebbeck commented that the voluntary sector had a huge part to play in the success of the ACS.
- Darrell Gale emphasised that from a public health perspective the ACS was very welcome.

RESOLVED: That the update on the Berkshire West Accountable Care System be noted.

25. URGENT AND EMERGENCY CARE DELIVERY PLAN: SUMMARY BRIEFING

Dr Zylstra provided the Urgent and Emergency Care Delivery Plan: Summary Briefing. The briefing outlined plans for a modernised and improved urgent and emergency care service as described in the Urgent and Emergency Care Delivery Plan published by NHS England in April 2017. It also highlighted the proposed local response to the Plan.

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

- The winters of 2015-2016 and 2016-17 had been particularly difficult. There had been a consistent failure to meet the 4 hour wait time for A&E across the country and increased demand for urgent care services.
- Dr Zylstra outlined the seven priorities within the Urgent and Emergency Care Delivery Plan.
- The NHS 111 service would be reviewed and updated and had been recommissioned across Thames Valley. There would be improved clinical input in the call process. How the clinical input would be implemented was discussed.
- Board members were informed of the new integrated NHS 111 service for Thames Valley – the new 'front door' for urgent care which was due to go live shortly. The service would offer access to a 24/7 urgent clinical assessment and treatment service and bring together NHS 111, GP out of hours and other clinical advice, including dental, medicines and mental health. It was noted that the new service had been developed around the patient, with a team of clinicians available on the phone when needed, and would be linked into a new NHS Clinical Hub. The Board asked how the changes would be communicated to the public. Dr Winfield

indicated that a soft roll out would take place and that it was important that clinicians and GPs were on board. Patient communication would follow.

- Expanding evening and weekend GP appointments to 50 per cent of the public by March 2018 and then 100 per cent by March 2019 was a priority.
- Around 150 standardised 'urgent treatment centres' which would offer diagnostic and other services to those who do not require A&E attendance would be rolled out. Whilst this would be considered as part of the development of the Berkshire West local plan, it was unlikely that there would be such a centre in the Borough.
- By October 2017 there would be comprehensive front-door clinical screening at every acute hospital. Streams would include: minor illness, minor injuries and ambulatory.
- Dr Zylstra outlined the work which would be undertaken around Hospital at Home.
- The recommendations of the Ambulance Response Programme would be implemented by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying people to hospital only when clinically necessary.
- Dr Zylstra highlighted some of the next steps that would be taken, including hospitals developing a more consistent interface with Councils for Drug and Alcohol services.
- In response to a question from Nick Campbell-White, Dr Zylstra indicated that there would be a GP present at the front door of A&E from September.
- Nick Campbell-White also questioned whether the A&E at the Royal Berkshire Hospital would be expanded. Dr Winfield stated that funding had been received from NHS England to reconfigure the A&E department.
- Clare Rebbeck questioned whether there continued to be proposals to introduce prescribing nurses into GP practices to help free up GP time and was informed that there was.
- Clare Rebbeck informed the Board of an initiative regarding the winter crisis fund that Age UK Berkshire was hoping to put into place.

RESOLVED: That the report be noted.

26. LETTER FROM THE PLACE AND COMMUNITY PARTNERSHIP

The Board considered a letter from the Place and Community Partnership.

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

- The Place and Community Partnership had a broad representation from agencies across the Borough. However, the Partnership had previously been tasked with little by the Health and Wellbeing Board.
- A previous proposal from the Partnership regarding engagement with the public had not been taken forward.
- The Partnership felt that it could contribute to the implementation of the Health and Wellbeing Strategy Action Plan and the production of a communications strategy.
- Nick Campbell-White commented that there needed to be a greater focus on wellbeing.
- Work would need to be carried out to reinvigorate the Partnership.
- The Chairman indicated that he would meet with Judith Ramsden, Director of People Services and Darrell Gale, to discuss the Partnership's proposal and bring an update to the Board's October meeting.

RESOLVED: That the letter from the Place and Community Partnership be noted.

27. UPDATES FROM BOARD MEMBERS

The Board was updated on the work of a number of Board members:

Voluntary Sector:

- It was noted that the Voluntary Sector had undergone its second review in three years.
- Clare Rebbeck requested up-to-date information on the structure of the commissioning team within the Council.
- Board members were reminded that it was often difficult to attract external funding as Wokingham was an affluent area.

Healthwatch Wokingham Borough:

- Nick Campbell-White commented that Healthwatch Wokingham Borough had reissued its report on Extra Care following input from Readibus.
- The quarterly reports produced were now more streamlined.
- Board members were updated on the outcome of the World of Opportunities event which had been held at Bulmershe School.
- Two Enter and Views were due to take place; one at Suffolk Lodge and a joint visit with Reading Healthwatch to Prospect Park.
- Clare Rebbeck commented that there was a large number of people in the Borough who self-funded their care. She asked who the current provider of advocacy services was and the number of self-funders who had been provided with this service.
- Following some discussion by the Board, Councillor Ashwell agreed to investigate the possibility of appointing a young person to the Health and Wellbeing Board to help give an insight into young people's views on health and wellbeing, locally.

RESOLVED: That the update from Board members be noted.

28. WOKINGHAM BOROUGH HEALTH AND WELLBEING STRATEGY 2017-2020 - ACTION PLAN UPDATE

The Board received the Wokingham Borough Health and Wellbeing Strategy 2017-2020 Action Plan update.

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

- The Board was reminded of the four main priorities in the Health and Wellbeing Strategy.
- The aims of the dashboard for the Action Plan were: to describe the direction and magnitude of progress in implementing the Health and Wellbeing Strategy Action Plan, to identify concerns with progress so that these may be rectified and to identify and celebrate good progress.
- Previous dashboards had attempted to indicate the health of the local health and social care system.
- Darrell Gale, Georgina King and Luka Zestic presented the proposed dashboard and some suggested behind the scenes indicators to the Board.

- Dr Winfield commented that nationally data was being collected routinely on a number of issues, and suggested that the dashboard include such information where it related to hot spots such as mental health. Darrell Gale stated that there was a need for baseline data on mental wellbeing in the Borough to be collected.
- The Board congratulated the Analysts on their good work.
- Dr Winfield expressed caution with regards to ad hoc data collection. The Board was informed that a Public Health Analyst would be starting in September.
- The completed dashboard would be taken to the October meeting for agreement.
- Newer Board members in particular were requested to highlight any areas which they felt were not currently covered.

RESOLVED: That measures that the Board wishes to monitor in order to assess the implementation of the Strategy Action Plan and the measures the Board wishes to monitor in order that it may have a clear understanding of the health of the local health and social care system, be discussed.

29. PUBLIC HEALTH OUTCOMES FRAMEWORK - EXCEPTIONS

The Board considered the exceptions for the Public Health Outcomes Framework.

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

- The Public Health Outcomes Framework profile for Wokingham had last been updated on 15 June 2017.
- Indicators which had shown significant changes since they were last reported to the Board, were highlighted.
- It was noted that Emergency Hospital Admissions for Intentional Self-Harm had shown an increase from 91.1 to 176.3. Whilst this was still below the England value of 196.5 the rise was concerning and investigating self-harm would form part of the Health and Wellbeing Strategy Action Plan. Darrell Gale informed the Board that national work on suicide prevention would also look at reducing intentional self harm.
- In addition Emergency hospital admissions due to falls in people aged 65 and over had shown increases across five of nine indicators.

RESOLVED: That the changes in performance outcomes contained in the Public Health Outcomes Framework (PHOF) be noted.

30. FORWARD PROGRAMME 2017-18

The Board considered the forward programme for the remainder of the municipal year.

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

- The proposal from the Place and Community Partnership would be discussed at the Board's October meeting.
- Councillor Pittock requested an overview of the range of initiatives supported by the Board and the funds committed by the different organisations which made up the Health and Wellbeing Board.
- Dr Winfield indicated that the Chief Executive, Leader of the Council and the Chairman of the Health and Wellbeing Board had been written to, to inform them that the member practices of the four Berkshire West CCGs had recently voted on the proposal to create a single CCG with four localities. This proposal had been supported. An expression of interest would be put to NHS England which would

make the decision on 27 September as to whether this proposal could proceed. It was anticipated that approximately £200,000 in savings could be made with the reduction of duplication across the CCGs. Dr Zylstra emphasised that contacts would remain the same at this stage. The Board requested an update at the October meeting.

RESOLVED: That the forward programme be noted.

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TITLE	**Development of the Wokingham Community Safety Strategy 2018/21**
FOR CONSIDERATION BY	Health and Wellbeing Board on 12 October 2017
WARD	None Specific
KEY OFFICER	Julia Mlambo, Interim Community Safety Partnership Manager

Reason for consideration by Health and Wellbeing Board	To improve partnership links between community safety and public health policy.
Relevant Health and Wellbeing Strategy Priority	The Community Safety Strategy links to the 'enabling and empowering resilient communities' priority. The CSP has adopted 'Champion the resilience of local communities as one of its four priorities.
What (if any) public engagement has been carried out?	Statutory guidance states that Community Safety Partnership should include the community when setting priority, this is planned for the early part of 2018.
State the financial implications of the decision	There are no additional costs associated with this report. The costs of developing the community safety strategy will be included in within existing budgets.

OUTCOME / BENEFITS TO THE COMMUNITY

This paper concerns the development of a Community Safety Strategy for 2018 to 2021. The aim of the strategy is to reduce crime within Wokingham by supporting victims, reducing offending and diverting individuals away from the criminal justice system, by directing resources and interventions to people and communities most in need.

Addressing community safety priorities has a documented beneficial effect on Health and Wellbeing of the local population. Examples of this include addressing the health and related needs of victims and offenders by enabling them to access relevant support services, reducing fear of crime thus improving mental wellbeing and addressing public health concerns for example reducing alcohol misuse by encouraging responsible licensing practices.

RECOMMENDATION

It is there recommended that the Health and Wellbeing Board support the development of a Community Safety Strategy to drive forward the Borough's crime reduction activities from 2018 to 2021.

The development of the strategy will be led by the interim Community Safety Partnership (CSP) Manager, with the support of key officers within the Council and partnership agencies such as the Police, CCG, the National Probation Service etc.

SUMMARY OF REPORT The report outlines the process of developing a community safety strategy within Wokingham Borough Council. It outlines the Borough's statutory responsibilities as well as potential benefits for the Council and its partners.

Background
Wokingham Council does not have a current Community Safety Strategy. This is despite the 1998 Crime and Disorder Act (as amended by Police and Social Responsibility Act 2011) placing a statutory duty on all Community Safety Partnerships (CSPs) to prepare and implement a partnership plan to reduce crime, substance misuse and Anti-Social Behaviour (ASB) within their areas.

The 1998 Act also requires that Community Safety strategies be informed by document called a strategic assessment which comprises of local data aiming to provide a comprehensive picture of crime and disorder related need in their area. Although Wokingham CSP has not produced a strategy for a number of years, it has a current strategic assessment, which was written in 2016.

This strategic assessments comprises of data and information from Thames Valley Police, Wokingham Council, Public Health, the Community Rehabilitation Company (CRC) and National Probation Services etc. The assessment has enabled Wokingham CSP to set priority areas and address them in order to reduce overall crime, support victims and build resilient communities.

The CSP identified the following as their crime reduction priorities:

- **Priority One** - **Domestic Abuse**, the CSP has produced a three year domestic violence strategy includes actions to prevent domestic violence, improve provision and reduce the risk from domestic violence perpetrators.

- **Priority Two - Serious Organised Crime** which looks to disrupt organise crime networks and making sure that Thames Valley Police have access to intelligence from members of the community, in order to have an impact on the activities of organised crime networks.

- **Priority Three - Child sexual exploitation (CSE)** focussing on cyberbullying, children sharing personal images inappropriately and working with the Local Safeguarding Children Board (LSCB) to improve the safety of children and young people.

- **Priority Four** - **Champion the resilience of local communities** by working with them to improve their own ability to address crime and community safety priorities within their own communities.

Analysis of Issues
Currently, the CSP reviews progress against priorities at each community safety meeting. As part of the performance management framework an analyst from the Council gives an overview of performance, highlighting any issues of concern. This seems to have worked well and the CSP currently has a good handle on short term community safety issues within the borough. However, it would seem that there is a need for a Wokingham wide Community Safety Strategy.

In addition to enabling the partnership to meet its statutory duty as outlined above, a comprehensive strategy would have a positive impact on the CSP's activities in the following ways:

1) It will enable it to mainstream crime and community safety issues by integrating CSP priorities into wider Wokingham Borough Council and Partnership strategies and plans for example:

- The 21st Century Council model
- Wokingham Borough Health & Wellbeing Strategy Action Plan 2017-2020
- Council Plan 2014-2017
- Police and Crime Commissioner's Police and Crime Plan 2017-21
- LCSB Child Sexual Exploitation Strategy 2017

2) Bring together the strategies which the CSP oversees e.g. Prevent, Substance Misuse, Domestic Abuse Strategies, and ensure that they work together effectively.

3) Have an impact on areas of need which have not been addressed by the current CSP priorities due to the low numbers of incidents, for example addressing sexual violence.

4) Enable the CSP review its subgroup structure in order to make it more streamlined, reduce any duplication, maximise the case management function and clarify lines of accountability.

5) Better direct the partnership's financial resources and improve commissioning. In addition, a clearer idea of needs and priorities could support the development of bids for additional funding where it is available.

6) Improve partnership working by CSP members by enabling them to more clearly identify shared strategic priorities and outcomes, addressing them through joint working.

Next steps

- The next step in the process will be to refresh the 2016 strategic assessment to include data on recent and emerging issues.

  The CSP Manager will be part of the Joint Strategic Needs Assessments (JSNA) working group, which will facilitate the sharing of relevant data key intelligence leads.

- The Community Safety Partnership will consult with partners including public health colleagues when setting its priorities for 2018 and 2021.

Partner Implications
As stated above the community safety strategy aims to improve partnership work by enabling the mainstreaming of crime and community issues into wider Wokingham Borough Council and Partnership strategies and plans.

Reasons for considering the report in Part 2
N/A

List of Background Papers
None

Contact Julia Mlambo, Interim Community Safety Partnership Manager	**Service** Strategy and Commissioning (People Commissioning)
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Date 3 October 2017	**Version No.** 1

Report to Health and Well-being Board
Thursday 12 October 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 finished reporting 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

	February 2017	**April 2017**	**August 2017**
The average NEET (16-24 years) for the year will be no higher than 3.2% (excluding July and August)	0.9% – NOMIS	0.8% -NOMIS	0.8% -NOMIS

1e.

Levels of unemployment in the over 50s *210 people aged 50-64 years on job seekers (Feb 2014)*	**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%)	**August 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*	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.	18 people have attended workshops specifically aimed at over 50s seeking work between June 1st 2017 and August 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*	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	4 new registrations of people aged 50+ between June 1st 2017 and August 31st 2017

TITLE	**Local Account: Annual Report for Adult Social Care 2016/17**
FOR CONSIDERATION BY	Health and Wellbeing Board on 12 October 2017
WARD	None specific
DIRECTOR	Judith Ramsden, Director of People's Services

RECOMMENDATION That the Health and Wellbeing Board review the report**.**
SUMMARY OF REPORT This report outlines the activity and performance of Adult Social Care for the period 2016/17.

Financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

List of Background Papers
N/A

Contact Phillip Sharpe	**Service** People's Services
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Date 28.9.2017	**Version No.** 1

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WOKINGHAM
BOROUGH COUNCIL

Local Account

Annual Report for
Adult
Social Care

2016/17

Local Account 2016-17

Our local account of services

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

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

To find out more about adult social care services see the WBC web page Care and support for adults.

Contents

Our vision for adult social care

- co-produced by staff and customers as well as voluntary and statutory partners

We want our customers to lead fulfilling and healthy lives and, should they require care and support, to access services directly and arrange and manage their own care if they are willing and able to do so.

We will support carers to stay well and healthy and we will assist them with carrying out their caring responsibilities.

We are integrating social care services with health to ensure that it is easier to access support, our customers and carers do not need to give the same information to different organisations and we are able to draw on a wide range of resources to offer responsive and flexible services.

To ensure sustainability, value for money and offer better services, we also work on developing flexible and personalised services in partnership with all our customers, carers, voluntary, private and statutory sector organisation.

We will not only focus on meeting our customers' care and support needs, but also help to fulfil their aspirations. We will do this by connecting our customers with local communities and facilitating access to a wide range of education, employment and leisure opportunities.

We will ensure that appropriate and well-balanced safety measures are in place to protect our customers from harm whilst maximising choice and control of care and support.
Our workforce will be well supported and trained to offer the highest quality advice and support.

Progress on last year's priorities

A. SERVICES PROVIDED UNDER THE BETTER CARE FUND
The Better Care Fund (BCF) is the pooling of resources and integration of health and social care services to deliver better outcomes to our communities. We are delivering our BCF plan in partnership with Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT), South Central Ambulance Service (SCAS) and Optalis.
There were four main developments that took place under the Better Care Fund during 2016-17:

1. Integrated Front Door
The Health and Social Care Hub, managed by Berkshire Health Foundation Trust (BHFT), provides a single point of contact for all health and social care contacts and referrals. The staff offer advice and information to residents about how they might meet their needs in the community, providing small items of equipment, as well as carrying out assessments for rehabilitation and social care needs. The Hub dealt with 3,103 contacts during 2016/17.

2. Wokingham Integrated Social Care and Health (WISH) Team
WBC's and BHFT's health and social care teams have joined forces to create a more flexible service where people no longer have to repeat their details again and again. Service users are offered an assessment and then referred for short term support to increase their mobility and independence and/ or longer term support to support them in their own homes. This integrated service has reduced the number of people needing to be admitted to hospital or to residential or nursing care and has avoided more people being delayed in hospital when they are fit to return home. Its success has led Wokingham Borough Council to become one of the high performing local authorities for managing to reduce Delayed Transfers of Care (older people who are delayed in hospital once they are medically fit to leave) and to reduce emergency admissions into acute hospital by managing patients in their own home.

3. Community Health and Social Care (CHASC)
CHASC – Community Health and Social Care (Previously called Neighbourhood Clusters, Primary Prevention and Self-Care)

This is a partnership project between WBC, Wokingham CCG, BHFT and Wokingham GP Alliance. The overall 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. CHASC will deliver the following:

- A single long-term Health & Social Care Team focused on early interventions and prevention
- Remove organisational boundaries
- Users only tell their story once
- A single key worker
- Development around 3 localities
- Target top 10% of health & social care users
- Work with the 3rd Sector – Community Navigators (social prescribing)

The aim is to go live testing the integrated service in one locality in November 2017. The main deliverables will be a reduction in A&E Attendances of 499, a reduction in NELs of 331, a reduction in GP appointments 99 per year, full year effect.

Community Navigators

A new service that has recently started as part of the above initiative is the Community Navigators Scheme. This service aims to provide up-to-date information about local community resources to service users and their families to help support them self-care and maximise their wellbeing. The service is live in five GP practices and will be fully rolled out by December 2017. In 2016-17 the service received 126 referrals with 90% reporting an improvement in health and wellbeing.

4. Connected Care

This is an integrated IT system, covering NHS and social care services in Berkshire, which was launched in February 2017. Currently information is supplied to the system by most GP surgeries and two local authorities, one being Wokingham. When fully implemented later this year it will allow GPs, ambulance staff, hospital staff, community health workers and social care teams to share some of the key items of information needed to deliver improved care to patients and service users. For more information about how your information is used in Connected Care, please see https://www.shareyourcareberkshire.org/

B. SUPPORT TO CARE HOMES – RAPID RESPONSE AND TREATMENT SERVICE (RRAT)

The Rapid Response and Treatment Service is a medically led multidisciplinary service whose aim is to assist people to remain in their care home with the right support to meet their needs, and avoid hospital admission.

The RRAT service has reduced Non-Elective Admissions from Wokingham Care Homes into acute hospitals by about 15% in 2016-17 with approximately 80 less admissions into hospital than expected.

C. THE STEP UP/STEP DOWN SCHEME

Step Up

This project, due to commence in December 2017, and provided in partnership with Wokingham Community Hospital will provide 6 hospital beds for intensive rehabilitation to those people at risk of an acute hospital admission or premature admission to long term care with the aim of prompting their recovery and maintaining their independence in the community.

Step Down

Three flats are available locally enabling families to stay in touch and visit. The flats have been used in a variety of ways for both single occupancy and couples, where one person is the main carer and there has been anxiety about returning directly home from hospital. The flexibility these flats provide enables timely hospital discharges where either, further intense reablement is required which cannot be undertaken at home, or where there are reasons which prevent an immediate return home and a short stay is required. This benefits the person, as all the time they are in hospital waiting to leave they are at risk of acquiring a hospital infection and

ensures that hospital as the beds are not being used inappropriately for people no longer requiring medical interventions.

CASE STUDY

Mr B was admitted to hospital with an infection. He was living in unsuitable accommodation with no sanitation or heating. On discharge he could not return to this accommodation and was admitted to the Step Up / Step Down accommodation at Alexandra Place (Extra Care Housing).

A package of care was organised to support Mr B and assess his abilities with regard to personal care and meal preparation. He was given help to apply for sheltered accommodation from Wokingham Housing Department, information on benefit entitlements and local services and a property was offered locally in a sheltered housing unit. Mr B moved into the property and he is now living independently.

What we do for you

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

WHO CONTACTED US?

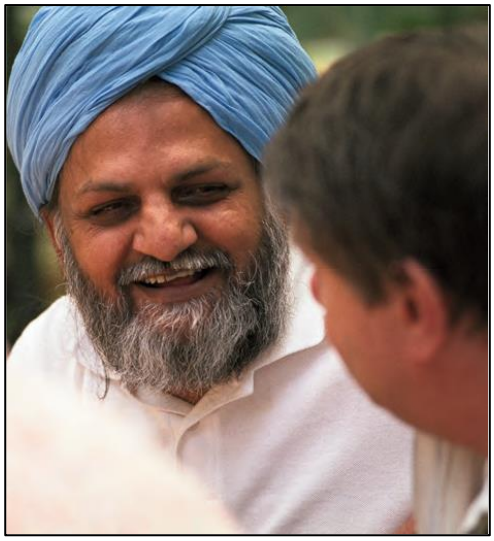
Our Adult Social Care teams were contacted by 4,988 people in 2016-17 (based on local unpublished figures).

WHAT HAPPENED FOLLOWING REQUESTS FOR SUPPORT?

Short Term Support

In 2016-17 275 new clients went on to receive **Short Term Support to Maximise Independence** (down from 320 in 2015-16). 27 of these were aged 18-64 (10%) and 248 were aged 65+ (Of these 110 went on to receive a long term service, 56 ended early, 47 had no identified needs after the service ended, 31 went on to receive ongoing low-level support, 6 were signposted to other services, 24 still had identified needs after the service ceased but became self-funders, 1 declined further support.

Long Term Support
In total, 1,776 people accessed **Long Term Support** during 2016-17 (which is similar to the figure for 2015-16 of 1,785). Of these, 720 clients were aged 18-64 (41%) and 1,056 were aged 65+ (59%). As of 31st March 2017, 657 people aged 18-64 and 739 aged 65+ were still receiving services, making a total of 1,396.



Residential and Nursing Care
Of those clients receiving Long Term Support in 2016-17, 326 people accessed residential care of which 220 were 65+ and 106 were aged 18-64. 207 people accessed nursing care of which 194 were 65+ and 13 were aged 18-64.

Autism and Asperger's Syndrome
As of 31st March 2017, there were 73 clients with Autism (down from 75 the previous year) and 48 with Asperger's Syndrome (down from 50) in receipt of long term support.

CASE STUDY

Jordan is a young man with Autism and a learning disability who would at times become overwhelmed when faced with busy and noisy places. He found it hard to understand information people were giving him and could not communicate how he was feeling and what he wanted. When faced with these situations he would become very distressed.

Jordan attended an Optalis learning disability day service where the staff team worked hard to understand and support him with his anxiety. He was helped to

develop an understanding of how he expressed himself and learnt relaxation techniques to use when anxious. This helped him to feel in control of his environment and reduce his anxiety.

Carers

In 2016-17, the combined figure for carers requesting services or already receiving services was 620. Of these, 452 resulted in support provided directly to the carer (73%). Of the remainder, 110 requests resulted in respite or other forms of support being given to the person they care for (18%) and 58 resulted in no direct support (9%). The number of carers receiving help has decreased from 2015-16 when 625 had support provided directly to them and 195 were helped by respite or other forms of support being given to the person they care for.

CASE STUDY

Mrs B, aged 69, is the main carer for her husband who has Parkinson's and depression, and her father who is in the early stage of dementia. Her husband has very limited mobility, however, her father is fairly mobile. Mrs B receives domiciliary care for her husband but not for her father who requires supervision to maintain his independence. Although her husband has once a week day care, caring for two people has had a detrimental effect on her well-being, especially her emotional health. She feels stressed, isolated, depressed and trapped. Following a carers assessment Mrs B was referred to our **Carer's Flexible Sitting Service, provided by Crossroads,** which provides breaks twice a week to support the whole family, and with an overnight stay when required. Mrs B now has 2 breaks a week which she uses to meet up with friends to reduce her stress and isolation. She also uses the time to go for a walk which has improved her depression and physical heath. Above all, she feels that she can have a 'normal' conversation with the regular care worker who understands her worry and frustration.

Outcomes for people

Care and support is something which affects us all. We all know someone, a family member or friend, who needs some extra support to lead a full and active life. The Adult Social Care Outcomes Framework (ASCOF) measures how well that support achieves the things we would expect for ourselves and for our friends and relatives. It measures the outcomes which matter the most to people who use social care services.

Anyone can use this information to see how well their council is performing, making local
authorities answerable to their communities for the quality of care. Councils themselves use the measures to help them drive up standards, and give people choice and control over the services they use. To see all of the ASCOF measures please see the following link:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/263783/adult_
social_care_framework.pdf

The following section sets out how well Wokingham has performed against these measures during 2016/17.

ENHANCING THE QUALITY OF LIFE FOR PEOPLE WITH CARE AND SUPPORT NEEDS

In 2016-17, Wokingham scored 19.3 out of a maximum possible score of 24 (up from 19.0 in 2015-16) for the overall measure for enhancing the quality of life.

CASE STUDY

Clive has autism and a learning disability. He needs a high level of care and support as his needs are complex. Clive's parents are preparing for a time when they will no longer be able to care for him in the family home. They want Clive to grow in confidence away from his home environment and develop his independence.

Clive was already attending the Optalis Learning Disability Day Service when he joined the Out and About service also run by Optalis. Initially he took part in day sessions and outings, which worked well. Building on this success, the Out and

About team started to prepare for Clive's first overnight stay. He thoroughly enjoyed his time away and then went on to enjoy two nights away.

His mother says Clive has blossomed in the last two years. She largely attributes the Out & About service for this positive change. She believes the exposure to new places has made him willing to accept different situations. She feels attending Out & About has also had a knock on effect in other areas of his life. He is able to communicate better and will more readily engage in activities. The service has enabled him to pursue new interests and try new things and he has a new found independence and sense of self-esteem.

Another outcome we measure looks at whether people using services feel in control of their daily life i.e. has their wellbeing and what is important to them and their family been taken into account? 79% of people using services in 2016-17 felt they had control over their daily life. This has reduced from 81% in 2016-17. This may have reduced in part due to the number of people in receipt of a personal budget or direct payment having reduced in 2016-17. However, the proportion of carers in receipt of a personal budget and receiving a direct payment remained at 100%.

During 2017-18 we aim to increase the number of people with a personal budget as well as the number receiving all or part of their personal budget through a direct payment to give people more flexibility, choice and control about the type of service and provider they want.

People with a learning disability

The number of people with a learning disability in paid employment has increased during 2016-17 to 14.4%, up from 11.8% in the previous year. This compares very favourably with the figure of 6.2% for South East England.

The proportion of adults with a learning disability who live in their own home or with their family has also increased from 74.7% in 2015-16 to 78% in 2016-17. Again this compares favourably with 70.2 % for South East England.

CASE STUDY

A young 19-year-old woman with a learning disability living in the community was referred for a Safeguarding Enquiry following concerns regarding sexual exploitation. The situation was complicated as she also had a history of non-engagement with services and professionals. A social worker met with the young woman and worked hard to gain her trust and to ensure that she was safe from exploitation. She is now fully engaged with services and is taking part in a life skills development programme, education and training as well as engaging with a support worker.

Mental Health
The proportion of adults in contact with secondary mental health services in paid employment has risen from 15.8% in 2015-16 to 26.7% in 2016-17. The proportion of adults in contact with secondary mental health services living independently, with or without support, has also increased from 84.4% in 2015-16 to 93.5% in 2016-17.

CASE STUDY

A 40-year-old man was diagnosed with treatment-resistant schizophrenia. This major mental health problem started when he was at university. He lives with his parents and they provide support.
During his recovery he received various psychiatric and psychological support and his family also received support as carers. During the final stages of his recovery a support worker helped him build his confidence and manage his voices to enable him to go out into the community.
He started voluntary work in a charity job at the beginning of this year and has now been discharged from Community Psychiatric Nurse support. He still hears voices and can get paranoid but, the support he has received has made a really positive change to his self-esteem.

DELAYING AND REDUCING THE NEED FOR CARE AND SUPPORT
The council has a range of reablement programmes provided in partnership with health colleagues to support people to relearn lost skills to promote their independence and enable them to continue with their life. One measure of the effectiveness of this support is to see how many people who have been given reablement services when they leave hospital are still at home 91 days later. For Wokingham, the figure for 2016-17 was 72.7%. This has reduced from 76.8% in 2015-16 and is lower than the South East England figure of 81.1%. We are exploring why this figure has reduced and believe it may be due to a recording issue.

However, the Council's policy of enabling people to stay living independently in their own homes has seen the number of older people admitted to residential and nursing care homes in Wokingham reduce to 444.48 per 100,000 people 65+ in 2016-17 from 646 the previous year.

Some people who contact the Council for help will only need short-term support to get them back on their feet. We can see how effective this is by measuring what percentage of the people required no further support (or only support of a lower level) after they received short-term support. For Wokingham this was 46.4% in 2016-17 (down from 82.7% in 2015-16). We are currently looking into why this figure has reduced so drastically.

CASE STUDY

John has a diagnosis of Ataxia, which effects his coordination, balance and speech. Following discharge from hospital after a fall, John spent three weeks recuperating at Alexandra Place step up/step down service and then returned home with support from the START service. In the first week of his 5 week rehabilitation the START reablement workers spent time with John to assess his abilities and agree achievable goals. They would regularly assess and record progress and plan their ongoing support. John's motivation to regain his independence was a strong contributing factor to his success; combined with the skills and experience of the reablement workers who understood when and how to give him the time, encouragement and space to do things for himself.

Since START's involvement John has greater control over his daily life as he is much less reliant on paid support services and his care has reduced from 4 calls to 1 call per day.
John said of START, "strangely I wasn't very well when I came out of hospital. I couldn't have coped without help from START. I found it very good. They helped me to help myself".

HOW SAFE DO OUR SERVICES MAKE YOU FEEL?
The proportion of people using services who say that those services make them feel safe and secure has increased from 78.8% in 2015-16 to 90% in 2016-17.

Safeguarding referrals
During 2016-17 we investigated 510 concerns about people to ensure that they were safe.

CASE STUDY

"I am writing on behalf of my wife and myself to express my appreciation and gratitude for your efforts in helping us to recognise and come to terms with the 'Adult Abuse' we have experienced in our daily lives as we grew older - I am 78 and my wife is 77.Your involvement was a bit like having someone shine a light in a dark corner where you know something is wrong but you don't know what it is or what to do about it. It was a life-changing moment for me and I am grateful to you and your organisation for that."

What you think about our services

ADULT SOCIAL CARE SURVEY

Overall, 66% of users reported that they were extremely or very satisfied with the care and support services they received in 2016-17. This is down from 67.3% in 2015-16 but higher than the South East Region average of 65.7%.

CARERS SURVEY

Overall 37.5% of carers reported that they were extremely or very satisfied with the support services they received in 2016-17. This is down from 39.7% in 2015-16 and lower that the South East region average of 41.2%.

COMPLAINTS

In 2016-17 Adult Social Care teams received five formal complaints (the same as in 2015-16).

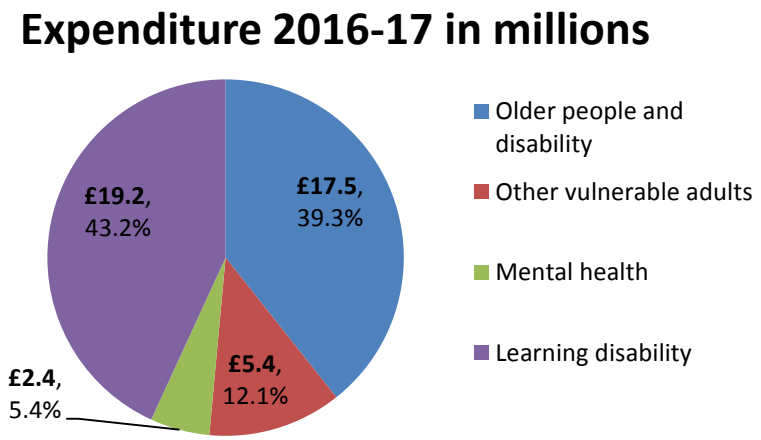
The reasons for the complaints were:

- Attitude/Conduct of Staff: 1
- Accuracy of File/Report: 1
- Contact with Relative/Carer: 1
- Financial Assessment: 2

Of these five complaints, four were resolved at Stage 1 of the complaints process and the other at Stage 2.

How we spend your money

EXPENDITURE ON ADULTS OVER 18 2016-2017 IN £MILLIONS



Priorities for 2017-18

Delivery of adult social care is one of the biggest challenges the country faces with the sector under severe pressure nationally. In the next 20 years the number of older people aged 65 years and over will increase, placing a greater demand on the health and social care system in the Borough as there is a higher likelihood of people living with Long Term Conditions, dementia or frailty. This highlights the importance of prevention, to ensure people age well and avoid dependency and self-manage their health effectively.

- WBC is working in partnership with health and the voluntary sector to ensure we have integrated services that provide responsive, cost effective and efficient services.
- We want to stimulate a diverse range of care and support services in Wokingham to ensure that people and their carers have choice over how their needs are met and that they are able to achieve the things that are important to them.
- We will be developing a 0-25 service which will ensure that the transition from Children's to Adult's services is efficient and seamless.
- We will be opening two new extra care units
- Our Carers' Strategy will be reviewed and brought up to date in line with government policy
- We want to ensure that we use assistive technology to support prevention and maintain the independence of older and vulnerable adults.

NHS
North and West Reading
Clinical Commissioning Group
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NHS
South Reading
Clinical Commissioning Group

Summary Report for Wokingham Health and Wellbeing Board

12th October 2017

Name of Report	Merger of the four Berkshire West CCGs
Author of Report	Dr Cathy Winfield, Chief Officer
Organisation	Berkshire West CCGs
Date of Report	14th October 2017
Date of Meeting	12th October 2017
Subject Information	To brief the Health and Wellbeing Board on the proposal to merge the four Berkshire West CCGs into a single CCG with four localities.

PURPOSE OF REPORT

1. The purpose of this paper is to brief the HWB on the proposal to merge the four Berkshire West CCGs into a single CCG with four localities, effective from April 2018. Further to the letter of 31st July from the CCGs to the Chair of the Health and Well Being Board and CEO, the Board are invited to comment on the proposals.

BACKGROUND

2. In July and August of this year, the GP membership of the four Berkshire West CCGs voted to merge to create a single CCG with four strong localities.

3. The key rationale was to reduce the duplication and inefficiency created by running four separate organisations so that clinical and managerial effort could be focused on developing primary care Alliances and supporting the Accountable Care System.

4. In accordance with this vote, the CCGs have submitted an application to merge to NHSE, and the NHS E National Commissioning Committee will consider this and make a decision at the end of October.

5. The CCGs will begin to work in new ways in shadow form during the current year and, subject to NHSE approval, the new CCG will be established on April 1st 2018.

6. The attached Merger Proposal paper articulates in more detail the rationale, benefits, risks and some elements of an operating model for a single CCG.

NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

Berkshire West CCG Configuration: A proposal to merge the 4 CCGs into 1, with four localities (from 1 April 2018)

1. Introduction

The 4 CCGs in Berkshire West were established with a unique model of governance, working in a federated way. CCGs are clinically led organisations made up member GP practices. The CCG configuration was primarily driven by the GP practices who comprise the membership and the need to engage closely with local practices. It also supported the establishment of closer working relationships with local government and the three Health and Well Being Boards in Berkshire West, especially important in view of the emerging agenda of integration between health and social care.

The CCGs share the majority of the management team and run joint committees and joint programmes of clinical transformation. The model allows for locally sensitive commissioning to meet the needs of particular populations whilst providing some opportunity to work across Berkshire West where required. The CCGs have operated this way for four years but a number of factors have now prompted them to reconsider this arrangement

A number of key changes have taken place since the CCGs were established in 2013 which merit review of the current configuration:

- **Changing NHS landscape:** The NHS is now in a period of transition from the structures established by the Lansley Reforms to new emerging concepts of Accountable Care Systems and Primary Care Provider organisations that bring groups of practices together. Whilst no plans to make changes to statutory organisations have been announced, CCGs must respond flexibly to the new landscape and consider where best to focus clinical and managerial leadership.
- The successful Berkshire West drive to develop an **Accountable Care System (ACS)** along with the ambitious programme of reform outlined in the NHS Five Year Forward View requires a shift in focus for senior management and clinical leaders and it is felt that in this context, a proposal for a merger of 4 CCGs into 1 should now be explored.
- We are seeing the emergence of **new primary care provider organisations** across the patch and they require managerial resource and support. This can only be provided by refocusing the current management team and it is reminiscent of the period when PCTs assigned resource to shadow CCGs. The CCGs need to review their own configuration in the context of these changes.
- **Financial position.** The financial challenge facing the 4 CCGs is unprecedented with a £25m QIPP target in 17/18. In this context it is necessary to make the best use of every pound and there is a responsibility to hand on a strong financial legacy to new organisational forms. One of the duties of CCGs, where the Accountable Officer must specifically ensure compliance, is the duty regarding effectiveness and efficiency. "Each CCG must exercise its functions effectively, efficiently and economically." The CCGs have invested in a team to support primary care as part of the delegation of commissioning responsibility from NHS England without any transfer of resource. This has put pressure on the CCGs' running cost budget and a merger would alleviate that.
- The **integration of health and social care.** In the period since CCGs were established there has been good progress in joint working with our three local authority partners. In addition to strong locality working, the system also works on a Berkshire West footprint through the BW10 Delivery Group and Integration Board.

In the light of these factors a case for change to the CCG configuration was considered by the four Councils of Member Practices to whom decisions on CCG configuration are reserved. The fifty member practices of the four CCGs were asked to vote on the proposal to create a single CCG with four localities and the proposal was supported.

2. Merger Benefits

- **Strategic:** A merger will support the development of the Berkshire West Accountable Care System and enable sharing of commissioner and provider clinical input into pathway redesign and service transformation. As the focus of primary care leadership moves towards **primary care sustainability and delivery of the 5 Year GP View**, the merger will limit the duplicated committee work and allow some resource to be directed to supporting provider alliances and clusters.
- **Operational:** There is duplication of effort across the 4 CCGs e.g. servicing of 4 Governing Body meetings, production of 4 sets of plans, monitoring returns and accounts and annual reports. This is seen across many functions including those outsourced to the Commissioning Support Service e.g. IG Toolkit production. Operating 4 CCGs places a considerable additional workload on the team that work across all 4 CCGs at a time when there is an increasing workload required around ACS development and primary care sustainability.

  A single CCG with four localities would enable the GP led locality teams to meet as often as they do now but to be liberated from the responsibility of organisational governance and focus instead on the development of clinical services and improving outcomes and experience for patients in their locality.
- **Quality:** By merging the 4 CCGs, there will be a reduced focus on assurance on small numbers of outliers against constitutional targets at individual CCG level. This will enable the CCG Quality and Operational teams to have more time to focus on the important issues for the CCG and localities with overall compliance at a Berkshire West level.

  Financial: It has been estimated that the cost of the current duplication is between £150k and £200k per annum. Although only a small amount of the resource reduction would be cash releasing, there would be an opportunity to secure better value for money through the redeployment of expensive resource.

  Some cash releasing savings can be made to support the CCGs' £25m QIPP target and to prepare for NHS England's plan to reduce NHSE/CCG running cost funding by £150m by 2020/21 (potentially £600k for Berkshire West). A shared back office function is already part of the ACS work programme and the CCGs have already in housed some CSU functions to increase quality and reduce cost with further in housing planned. Furthermore, the work associated with the CCG programme boards has grown significantly and these are now major transformation programmes supporting delivery of the Five Year Forward View and underpinning the ACS programme. As the CCGs move forward with the ACS and an ambitious programme of transformation, the work of the programme boards will gain further importance.

3. The proposed operating model for a single CCG:

The proposed operating model has been designed to retain the features that support close working with member practices, patients and partners in each locality whilst providing efficiency gains and supporting the emerging ACS and primary care providers.

- **A single Governing Body** with four localities: A structure that retains optimal engagement with GP practices and patients to ensure responsiveness to local health needs, whilst reducing the bureaucratic burden of being 4 separate organisations and ensures a robust separation of duties in order to avoid any Conflicts of Interest as the ACS develops.
- **Four localities based on the current CCGs**: A structure that maintains and builds on effective working relationships with local government and Health and Well Being Boards and supports the integration of health and social care
- **Four Councils**: Under the scheme of delegation they would have devolved responsibilities for local decision making and devolved budgets. This model would preserve the levels of engagement that are required for success and is one that is seen operating effectively in some neighbouring CCGs and likely to be adopted by others as CCGs review effectiveness and efficiency.
- **Retains PMS funding in the localities that will replace current CCGs**: This ensures that commitments made in 2015-2016 are met. With a merger there will be an opportunity to invest differentiall in the other localities to achieve **parity of primary care funding for PMS and GMS practices** across Berkshire West.
- **The shared management structure will be supported by local operational teams** as is currently the case and there will continue to be Clinical Management Team/Organisational Leadership Team meetings. It is anticipated that these meetings may have a part B focussing on primary care provider development, but it is essential that the localities continue to help meet the commissioning obligations of the CCG as they evolve over the next years. The locality groups would retain responsibility for:
  - Key decisions and financial management of agreed budgets
  - Locality strategy and vision, bearing in mind the need relate to the Berkshire West ACS
  - Local operating plans that feed into the a single Operating Plan for the CCG in line with NHSE Planning Guidance
  - Development of QIPP ideas, service redesign and quality improvement
  - Development of primary care including the implementation of the GP5YFV
  - Ensuring that services are sensitive to the needs of the local population
  - Prescribing budget and incentive schemes
  - One of the ACS programme boards e.g. urgent care
  - BCF budgets and management of associated locality projects
  - Performance reported at Locality level where it is amenable to influence by GPs e.g. immunisations, screening, GP survey, radiology, pathology, NEL referrals per 1,000, quality premium etc.
  - Actively participating in their Health and Well Being Boards and electing a representative to attend HWB meetings (likely to be the Locality Board Chair)
  - Working with their Healthwatch (they are likely to attend the statutory Board)
  - Participating in Board committees e.g. Quality, QIPP and Finance, but with a focus on avoiding duplication where it does not add value.

4.2 Councils

- There would be a statutory requirement for a single GP council but to retain engagement the proposal is to retain 4 Councils working with the relevant locality group.
- At locality level differential voting could be locally agreed to reflect practice size if required.
- The four locality Councils would come together (possibly twice a year) to share good practice, provide input to the planning process and take those decisions that are reserved to them such as signing off the Operational and Strategic Plan.

4.3 CCG Governing Body

The proposed Governing Body structure ensures that a clinical majority is maintained and is suggested below but this is not yet finalised:

- Accountable Officer
- Chief Finance Officer
- Nurse Director
- Secondary Care Consultant
- 3 or 4 lay members (one for each locality, with one non-voting)
- 1 GP for each of the 4 localities (one being the Chair)
- 1 Operational Director for each of the localities (non-voting)
- Director of Strategy (non-voting)
- Director of Joint Commissioning (non-voting)

The member practices have made a number of proposals with regard to the constitution of the new CCG and the CCGs will work them through a period of co-production to develop the new constitution.

Our key stakeholders should not notice any change in the way we do business but the statutory entity will change to reduce the bureaucratic burden and maximise managerial and clinical capacity

4. Process

The CCGs must obtain approval from NHS England to change their configuration.

The CCGs submission will need to demonstrate that member practices support this change and show that the views of Health and Well Being Boards have been taken into account. Due to the tight timelines some of these processes will need to happen in parallel.

5. Timeline

The proposed timeline for the merger is as follows

Action	Date
Review of draft business case by Clinical Commissioning Committee	April 2017
Council of Member Practices to be briefed on the Merger Option	May 2017
Approval of the final business case by Clinical Commissioning Committee	May 2017
Practices to vote on the Merger proposal	27 July 2017
Submission of expression of interest to NHS England	31 July 2017
Engagement with partners	31 July – 18th August 2017
Submission to NHSE	18th August 2017
NHSE Commissioning Committee decision	27th September 2017
Berkshire West CCG to operate in shadow form	1 October 2017
Merged CCG fully operational	1 April 2018

Annex 1: The Five Legal Factors

Whilst there are provisions under section 14G of the NHS Act 2006 (as amended) allowing for mergers of CCGs, there are specific legal factors that NHS England must consider when deciding whether or not to agree the merger. Each of the five factors has been considered below:

1. Coterminosity with local authorities

There will be no changes to the overall boundary, with the merged CCG having coterminosity with the 3 Local Authorities in Berkshire West.

2. Clinically-led: the new CCG should demonstrate that it will remain a clinically-led organisation, and that members of the new CCG will participate in decision-making in the new CCG.

Strong clinical leadership has been an important feature of the CCGs during the 4 years to date and will have even greater importance over years ahead given the levels of transformational change required across the health and social care system in Berkshire West. The Accountable Care System and the development of sustainable primary care providers involves change supported by high levels of leadership and engagement at all levels throughout the organisations involved. It is proposed that the only reduction in clinician time is as a result of reducing the number of governing body meetings and committees that clinical leads attend and in fact some of the time saved will be reinvested in the transformation programme.

3. Financial management: NHS England will consider whether the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.

The individual CCGs currently maintain separate ledgers. However, the overall financial position is managed on a Berkshire West basis with risk sharing agreements in place between the CCGs. The controls and procedures operate in the same way across all CCGs and consolidated reports are produced for key meetings e.g. QIPP and Finance Committee. A move to a single ledger and set of reports should not result in any significant change to the control environment and it will facilitate the management of the position across Berkshire West. It is anticipated that finance resource will be released to support key developments. However, an important piece of work to undertake quickly is to ensure that reports are available at locality level, something that is achieved by local CCGs that operate multiple localities.

4. Arrangements with other CCGs: the new CCG will have appropriate arrangements with others, for example lead commissioning arrangements.

None of the current arrangements will be changed as a result of the merger. It is anticipated that arrangements will develop further under the STP arrangements.

5. Commissioning support: NHS England can take into account whether the new CCG has good arrangements for commissioning support services.

The CCGs share their CSU support and are currently procuring jointly their future support services through the Lead Provider Framework. It is anticipated that the merger would significantly reduce duplication of tasks and the CCG would expect to see a reduced price for support.

TITLE	**Resources and initiatives which support the Health & Wellbeing Strategy Action Plan.**
FOR CONSIDERATION BY	Health & Wellbeing Board on 12 October 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Graham Ebers Director of Corporate Services

Reason for consideration by Health and Wellbeing Board	This paper has been prepared following In response to question by Member,
Relevant Health and Wellbeing Strategy Priority	Relates to all priorities as set out in Appendix 1 of this document.
What (if any) public engagement has been carried out?	None necessary at this stage.
State the financial implications of the decision	No decision is required. However, the information will be useful to inform discussion about resource allocation across a number of budgets.

OUTCOME / BENEFITS TO THE COMMUNITY

There are a range of benefits to the community through the activities and work programmes set out in appendix 1. These relate to the principles and objectives set out in the HWB Strategy in terms of:

- Enabling and empowering resilient communities
- Promoting and supporting good mental health
- Reducing health inequalities in our Borough
- Delivering person-centred integrated services

RECOMMENDATION

That the Board note the report.

The paper sets out that easily stratified resources directly pertaining to projects within the Health & Wellbeing Strategy Action Plan and is for information only at this stage in order to answer a member question.

SUMMARY OF REPORT

This report has been produced as a response to a specific question from a Member who wished to understand the resource allocation for the range of projects funded in line with HWB Strategy priorities. In appendix 1 is a list of the key areas for action, the related work stream and resource allocated. The resources given to each project vary and may consist of both financial, in kind and other support specified.
It highlights the range of activity currently operational that link to a range of agencies and initiatives linked to the needs of our communities. Funding has been allocated through Public Health to support health and wellbeing goals and long term outcomes.

Background

Context

Wokingham is on the whole, a prosperous place, but we believe there is much that can be done to make it a better place to live and work, and to address the deep inequalities that exist within the population of the Borough.

Also, increasing demand for health and social care services, at a time of downward pressure on NHS and local authority budgets, means that local authorities, the NHS and their partners have to consider new ways of working to deliver the outcomes that people need.

Local public bodies are re-drawing their roles and re-shaping their 'organisational boundaries', alongside a recognition that individuals and communities need to have a much greater say in promoting and maintaining their own health and well-being. We believe that delivering on our priorities through this action plan will help to carry that forward.

This Health and Well-Being Strategy sits alongside a number of other plans and strategies that cover either Wokingham Borough or a wider footprint. This wider planning framework (which includes the NHS-led Sustainability and Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire West) is very complex and it is important that this Health and Wellbeing strategy adds value to the system overall. The focus of it therefore is to look at the 'bigger picture' and underlying approaches and particularly to address those areas where better and closer co-ordination is needed.

Analysis of Issues

Wokingham is the least deprived upper tier local authority in the country and enjoys better outcomes than most of England. However, inequalities do exist across the Borough and we need to focus on those areas where need is greatest. The most deprived areas are Norreys, Southlake Crescent and Finchampstead South. The people living within those areas are more likely to be unemployed and in receipt of benefits and have higher needs as ranked in the Indices of Multiple Deprivation (2015). These areas are within wards which all have child poverty levels at or above the Wokingham Borough average, although this data is not available for each LSOA separately. Concentration on LSOAs to highlight areas of need comes from the overall ranking of these in the Indices of Multiple Deprivation (IMD) 2015. It is a particular feature of areas of relative affluence such as Wokingham Borough that the low levels of deprivation mask areas with higher levels when dealing with larger populations such as wards. LSOAs, with populations between 1,000 and 2,000 people provide smaller populations which highlight more effectively the differences between neighbouring populations, although many datasets do not disclose full data at this level.

There are also groups spread across Wokingham that suffer significant degrees of deprivation, including the Gypsy, Roma and Traveller (GRT) community and people with Learning Disabilities.

2,000 children were living in poverty within the Borough in 2015, many concentrated in the above areas.

Partner Implications
This overview of resource allocation may be helpful in identifying gaps or duplication in resources allocated to the strategy action plan.

Reasons for considering the report in Part 2
Not applicable

List of Background Papers
Appendix 1 –Priority areas and resources allocated.

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Date 2 October 2017	**Version No.** 3

Appendix 1

The resource allocated to HWB priority areas as set out in the HWB Strategy.

Enabling and empowering resilient communities		
Priority Area	**Projects related to this area,**	**Resources Allocated (budgetary, staff time, other)**
Build social capital in most deprived LSOAs and each SDL	Supported by the Community Development Team and the Community Engagement Team	The Public Health Ring-fenced Grant funds half of the Community Development Team costs at £115,000
	1.6 commissioned Bracknell and Wokingham College to deliver a programme of adult education courses aimed at residents aged 19+ with low to moderate mental health issues for the academic year 17-18 (Wellbeing In Mind)	• £18,380
	• Commissioned Norwood to deliver Independent Living Skills to adults with learning disabilities	• £36,940
	• **Commissioned SMART to deliver a programme of employability courses aimed at Substance misusers and those who are long term unemployed*	• *£14,644**
	• Commissioned Bracknell and Wokingham College to deliver accredited English Maths and ESOL courses at Entry Level from a range of community venues across the borough	English & Maths • £27,580 ESOL • £15,350
	• Delivering a range of internal courses covering introductory vocational courses, non-regulated maths, English and ESOL	• £25,000

	courses, Parenting, family learning, Employability and IT courses All adult education courses are delivered from various venues across the borough including Brambles, Redkite, Ambleside, and Starlings Children's Centres, Loddon, Highwood, and Hillside primary schools and other community venues including FBC, Norreys Church, community flats and local libraries **As of September 2017, options are being assessed for how this service can now be delivered, following an internal reorganisation in the provider.*	The Adult Education team has 3 FTE posts • Adult Education & NEET Manager • Quality Assurance Coordinator • Targeted and Community Learning Coordinator Internal courses are mainly 10-15 hours and ae delivered by self-employed tutors who are contracted for the duration of the course
Co-terminosity of boundaries between the CHASC localities and Children centres in each area, along with the Thames Valley Neighbourhood Policing teams and emerging designs within the Council.		No specific resources allocated
Promoting *'Making Every Contact Count'* approach across all services, beginning with most deprived LSOAS and new SDLs	Public Health Team to develop the MECC work stream	No specific resources allocated as yet.
Testing in one or more Neighbourhood Policing Teams a Police Officer taking role of Community Navigator.		No specific resources allocated
Development of the Borough Council Locality Service	21st Century Council Project	No specific resources allocated
Commissioning for 2017/18 Adult Education courses specifically aimed at improving the health and well-being outcomes of the targeted groups - vulnerable young adults, parents who have no qualifications, work in the most derived LSOAs, those with Learning Disabilities (LD).	Adult Education resources as detailed above	Adult Education resources as detailed above

Explore with other services the scope for a strong locality focus in their activity (with an emphasis upon the most deprived LSOAs)	21st Century Council Project	No specific resources allocated
Scope the potential of the schools nursing service to contribute to the development of resilience in children and young people.	Public Health to lead development of new service.	Current School Nursing service £330,160 No specific new resources allocated
Promoting and supporting good mental health		
Priority Area	**Please list Projects related to this area,**	**Resources Allocated (budgetary, staff time, other)**
Review of the CAMHS Service/ EWHBS		Mental Health - £23,000
Berkshire Health Trust Mental Health Strategy Implementation Plans for • Child and adolescent mental health • Adults of working age • Older adults		No detailed information
Closer integration of adult mental health services in Wokingham		No detailed information
Perinatal mental health support		No detailed information
Mental Health support to Carers		No detailed information
Local Suicide Prevention Action Plan, in line with the Berkshire Suicide Prevention Strategy, 2017-2020		No specific funding allocated, but this is the focus of the Public health Team's contribution to Berkshire-wide work programmes, and therefore officer time is allocated.
Reducing health inequalities in our Borough		
Priority Area	**Please list Projects related to this area,**	**Resources Allocated (budgetary, staff time, other)**
Reducing the gap in school achievement between identified disadvantaged children and the wider population.	Work with schools – school improvement team: - Sharing key data and messages with schools and settings at briefings, network meetings etc - 'Narrowing the gap' network meetings, courses and conferences for school staff	All school improvement team activities with this focus are provided free of charge to all schools, other than the annual conference. Staff time: Approx. 100 officer days per year = approx.. £30,000 Venues/ refreshments for termly network meetings

	- Support and challenge in schools for staff with responsibilities in this area - Gathering and sharing good practice	and courses: Approx £400 per year Annual conference: self-funding
Increase smoking cessation rates in targeted areas in ways and model that is supported by the community.	Under contract to Solutions 4 Health	£150,000 maximum capped smoking cessation contract per annum – supporting quite attempts across the population with a focus on routine and manual workers
Increase in proportion of the adult population achieving the CMO's physical activity guide levels and reduce the number of those who are deemed inactive in the priority areas and in ways that community support	**Public Health commission the Sports Development Team to provide a suite of initiatives to meet these objectives,	** £246,140
Produce a profile of the most deprived LSOAs across the Borough to inform how all targeted services work in these areas.	Public health team to develop this.	No specific resources allocated
An increase in the proportion of the adult population achieving the advised CMOs physical activity guide levels from 66% to 68% in the next 2 years particularly those who live in the HWB prioritised areas	As at ** above	As at ** above
Reduce percentage of those who are deemed inactive from 20.9% to 18% by 2018 in the specific areas	As at ** above	As at ** above
Increased access to physical activities suitable for adults with mental health illnesses and learning disabilities	As at ** above	As at ** above
Delivering person-centred integrated services		
Priority Area	**Please list Projects related to this area,**	**Resources Allocated (budgetary, staff time, other)**
We are delivering our BCF both locally and through a wider Berkshire West approach. The Berkshire West system has a shared governance structure to ensure effective delivery. The Berkshire West Integration		BCF funding

programme has identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health.		

TITLE	**Influenza Vaccine Campaign 2016-17 Review**
FOR CONSIDERATION BY	Health & Wellbeing Board on 12 October 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Wright, Interim Director of Public Health for Berkshire

Reason for consideration by Health and Wellbeing Board	To update the Board on the 2016-17 Influenza Vaccine Campaign and to appraise them of plans for 2017-18.
Relevant Health and Wellbeing Strategy Priority	• Enabling and empowering resilient communities • Reducing health inequalities in our borough
What (if any) public engagement has been carried out?	Locally the Public Health team has worked closely with key partners to design and implement the campaign.
State the financial implications of the decision	The budget for the 2016-17 campaign was £3.5k

OUTCOME / BENEFITS TO THE COMMUNITY

Flu occurs every winter in the UK and is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Protecting staff against the flu is key to business continuity. This Flu plan aims to reduce the impact of flu in the local population through a series of complementary measures.

RECOMMENDATION

The Board is asked to;

1) Agree and endorse the multi-agency approach;

2) Support respective organisations to fulfil their responsibilities as set out in the national flu plan, be flu champions - take every opportunity to promote the vaccine and debunk myths and lead by example , take up the offer of a vaccine where eligible.

SUMMARY OF REPORT

This paper is to update the Health and Wellbeing Board on the performance of the influenza vaccine campaign in winter 2016-17 to summarise lessons learned and to inform the board of changes to the national flu programme for the coming flu season and how these will be implemented locally.

Background
Seasonal influenza (Flu) is a key factor in NHS winter pressures. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu.

Key aims of the immunisation programme in 2016-17 were to;

- Actively offer flu vaccine to 100% of people in eligible groups.
- Immunise 60% of children, with a minimum 40% uptake in each school
- Maintain and improve uptake in over 65s clinical risk groups with at least 75% uptake among people 65 years and over, 55% among clinical risk groups and 75% among healthcare workers

Multi-Agency Approach
Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu and vaccination is provided by a mix of providers including GP practice, community pharmacy, midwifery services and school immunisation teams.

The role of local authorities is to provide advocacy and leadership through the Director of Public Health and to promote uptake of flu vaccination among eligible residents and among staff providing care for people in residential and nursing care. Local authorities are also responsible for providing flu vaccine for frontline health and social care workers that are directly employed. Local authorities may also provide vaccine to staff members as part of business continuity arrangements.

CCGs are responsible for quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines. The CCG also monitors staff vaccination uptake in Providers through the CQUIN scheme.

A collaborative multi-agency approach to planning for and delivering the flu programme is taken in Berkshire, beginning with a flu workshop in June. Public Health Teams used output from the workshop to develop their local flu action plan, setting out the steps they will take to engage and communicate with local residents about flu, promote the flu vaccine to eligible groups and support partners to provide and manage the programme.

Actions taken in 2016-17 as part of this approach included;

- A joint flu plan between local authority public health and the CCGs in the East / West of Berkshire
- Participation in the twice-monthly NHSE telecom to share flu data, best practice and ability to raise concerns with representation locally
- A CCG monthly local meeting is held which has representation from across all providers and local authority public health. This meeting monitors local uptake of the flu vaccination and flu activity and sharing of good practice and any concerns. Providers also have signed up to the Health and wellbeing of staff CQUIN which includes staff flu vaccination uptake
- In the East of Berkshire the CCG Quality team supporting low performing GP practices with practice visits
- Sending a flu communication pack to care homes

- Local communication is linked to the national flu campaign as well local alignment of communications between the local public health and the CCG commination teams.

There is good collaborative working

- Linking with the Thames Valley Health Protection Team around management of flu outbreaks
- The public health team supporting the BHFT schools immunisation team to engage with those schools where initial engagement was less effective
- Working with local groups to promote flu vaccine through presentations to key groups such as Carers, Providers and Learning Disability Forums as well as providing targeted campaign materials to these and other key local organisations such as Children's Centres, older people's groups, LTC, learning disabilities. Staff flu clinics were held and promoted through the intranet and internal communications.

Analysis of Issues

1. GP-registered patient groups

In keeping with the national and regional picture, uptake of vaccine among GP-registered patients in Berkshire was generally higher in 2016-17 than in 2015-16. Along with Bracknell and Ascot, Windsor Ascot and Maidenhead and Wokingham CCGs, Slough CCG reported improved uptake across all GP-registered patient groups.

CCG	Summary of Flu Vaccine Uptake %					
	65 and over	Under 65 (at-risk)	All Pregnant Women	2 Years old	3 Years old	4 Years old
NHS WOKINGHAM	72.7	50.7	50.4	48.1	53.5	42.9
2015/16 Variation	1.1	4.9	2.1	1.1	3.5	1.6
Thames Valley Total	**72.1**	**50.7**	**47.2**	**43.3**	**47.0**	**38.1**
2015/16 Variation	0.6	4.1	1.0	3.1	4.4	3.2
England Total	**70.4**	**48.7**	**44.8**	**38.9**	**41.5**	**33.9**
2015/16 Variation	-0.6	3.6	2.5	3.9	3.8	3.9

Data source: Seasonal influenza vaccine uptake amongst GP Patients in England

LA	Summary of Flu Vaccine Uptake %					
	65 and over	6mo - 65y (at-risk)	All Pregnant Women	2 Years old	3 Years old	4 Years old
Wokingham LA	72.3	50.5	50	49.8	55	44.4
2015/16 Variation	1.3	5.1	2	0.6	2.9	0.5
England Total	**70.5**	**48.6**	**44.9**	**38.9**	**41.5**	**33.9**
2015/16 Variation	**-0.50**	**3.5**	**2.6**	**3.5**	**3.8**	**3.9**

Data source: **Seasonal influenza vaccine uptake amongst GP Patients in England**

2. Children in school years 1 to 3

The children's nasal vaccine was delivered in primary schools by a team of school immunisation nurses from Berkshire Health Foundation Trust. The team arranged and carried out visits at nearly 300 schools across Berkshire, including special schools where all year groups were offered vaccine. The BHFT school immunisation team delivered over 23,000 doses of vaccine and succeeded in reaching and exceeding the 40% overall uptake target in every Berkshire LA. In keeping with the national picture, uptake was lower in older children.

LA	Flu Vaccine Uptake %		
	Year 1 (age 5 - 6 years)	Year 2 (age 6 - 7 years)	Year 3 (age 7- 8 years)
Wokingham LA	74.4	72.9	71.9
England	57.6	55.3	53.3

Data source: Seasonal influenza vaccine uptake for children of primary school age, Provisional monthly data for 1 September 2016 to 31 January 2017 by Local Authority

3. NHS Healthcare workers

Uptake in Royal Berkshire Foundation Trust was 60.6% compared to the 48.6% previous flu season, while in Frimley Health NHS Foundation Trust uptake also fell from 49.3% to 38.7%. Uptake in South Central Ambulance Trust rose from 30.5% to 54.7%, while Berkshire Healthcare Foundation Trust achieved a 76.2% uptake rate, an increase from 64.1% and the highest in Thames Valley.

4. LA Health and Social Care staff and others

Wokingham Borough Council promoted the campaign through presentations to provider and carer forums and the Learning Disabilities Partnership Board. The campaign was supported by internal communications to all staff and social media messages.

Staff were offered vaccinations at an on-site drop in clinic at various times over a number of days, this was delivered by a local pharmacist. A total of 198 WBC staff took up the offer of the vaccination. Twenty care staff from Optalis were vaccinated at the Tesco pharmacy under an agreement between WBC PH and Tesco.

5. Learning from 2016-17 season

- Local Authority public health teams actively promoted flu vaccination to eligible groups using a range of channels and worked collaboratively with commissioners and providers before and during the season to identify issues.

- Whilst uptake among school children was good, uptake in other risk groups remains below the desired level; this is in line with other areas of the country.

- There remains considerable variation in uptake between GP practices, both within and between CCGs. Sharing of best practice across practices and better communication of uptake to practices throughout the flu season and ensuring patients are invited for vaccination in a way that suits them may help to reduce variation in uptake between practices.

- Use of national materials and good multi-agency working enabled consistent flu messaging to the public however there is scope to improve the reach of these messages to eligible groups

- Myths and misconceptions regarding vaccines remain an important barrier to uptake.

- Other barriers may include variation in access to GP flu clinics, lack of health literacy and inclusion of porcine element in the children's vaccine making it inappropriate for some groups.

- Uptake among front line local authority social care workers remains difficult to measure; there is scope to improve data collection in this area.

- Providers of residential and nursing care are not consistently offering flu vaccine to employees in line with national recommendations, this remains challenging for local authorities and CCGs to influence.

6. Plans for 2017-18 Flu Season

A successful flu planning workshop took place on 14th June at the Open Learning Centre, Bracknell. This was well attended by a range of stakeholders from across Berkshire and focussed on reducing variation in performance between GP practices and working to consider actions to help increase the offer and uptake of flu vaccine among residential and nursing home front line staff in line with national guidance.

- Following the workshop, the Shared Pubic Health Team developed a high level Berkshire Flu Plan which enabled Wokingham public health team to create a local flu action plan for the 2017-18 season. Key points from the plan include:
    - Increase staff vaccination uptake by extending staff flu clinics to other sites such as Children's Centres and the Old Forge
    - Promote flu vaccinations through targeted communications to key at risk groups

- The CCG in the West of Berkshire is developing a communications plan and will work with the Public Health Team to ensure there is a collaborative approach

- Wokingham public health team is supporting the school immunisation team to engage directly with information governance leads to discuss data sharing requirements and enable the immunisation team to receive class lists ahead of school visits

- Multi-agency East and West of Berkshire Flu Action group meetings will start from September with Providers, Local Authority Public Health and NHSE

- Local NHS Providers again have a CQUIN to deliver the flu vaccine to 70% of their frontline clinical staff.

Partner Implications
Flu vaccination programmes are one of the most effective ways of protecting populations from flu and reduce pressures on the NHS, GP practices and the wider

health and social care system and is a protects business continuity to the Council and other employers.

Reasons for considering the report in Part 2
N/A

List of Background Papers
• National Flu Plan 2017-18 • Berkshire Flu Summary 2016-17 • Presentation from Berkshire Flu Workshop June 2017

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Date 29th September 2017	**Version No.** 1

TITLE	**Public Health Outcomes Framework**
FOR CONSIDERATION BY	Health & Wellbeing Board on 12 October 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Wright, Interim Director of Public Health for Berkshire

Reason for consideration by Health and Wellbeing Board	It is agreed, as part of the performance metrics for the board, to update the Board when the quarterly update to the Public Health Outcomes Framework (PHOF) is received.
Relevant Health and Wellbeing Strategy Priority	All.
What (if any) public engagement has been carried out?	Not Necessary The PHOF is, like all Public Health England (PHE) health profiles, available for full public access.
State the financial implications of the decision	None directly. Investigation and new initiatives to change outcomes with which the Board is concerned may require shifts in resources for partners directly involved.

OUTCOME / BENEFITS TO THE COMMUNITY

Monitoring the PHOF will inform the Board of areas where performance is improving or deteriorating, and thus services and partners can be asked to intervene where necessary.

RECOMMENDATION

That the Board notes the changes in performance outcomes contained in the Public Health Outcomes Framework.

SUMMARY OF REPORT

Significant exceptions highlighted by this report are:

- No significant improvement in the cumulative percentage of the eligible population aged 40-74 who were offered a Health Check; and
- No significant change in Chlamydia detection rate in population aged 15-24.

Work is underway to invite the remaining eligible population to an NHS Health Check. The chlamydia detection rate will always be low in an area of low prevalence such as Wokingham Borough.

Background

The PHOF profile for Wokingham was last updated on 1st August 2017, and contains a number of indicators where performance had changed since the previous update. Updates are generally all based on annual measures, which are reported at different

periods throughout the year, meaning that in each quarterly update there is usually some exception to report upon where performance has changed.

New indicators are sometimes added, or those that have formed part of the PHOF are updated. In the August 2017 there were no new indicators.

Updates were made to two indicators for all geographic areas. These indicators were 1.09i – Sickness absence – the percentage of employees who had at least one day off in the previous week, and 1.09ii – Sickness absence – the percentage of working days lost due to sickness absence.

Updates were made to six indicators for England, regions and Upper tier LAs only. The indicators that were updated were: 4.12 – Preventable sight loss, 1.04 – First time entrants to the youth system, 1.13iii – First time offenders, 2.22 Take up of the NHS Health Check programme, 3.03xiv – Population vaccination coverage – Flu (aged 65+), 3.03xiv – Population vaccination coverage – Flu (at risk individuals).

Indicator 1.07 - People in prison aged 18 or over who have a mental illness or a significant mental illness was updated only for England and indicators 3.03i – Population vaccination coverage – Hepatitis B (1 year old), 3.03i – Population vaccination coverage – Hepatitis B (2 years old) were updated for Upper tier Las only.

Three indicators were updated partially. An update on the inequalities data by gender, ethnicity and income deprivation affecting children index decile was added to indicator 1.03 - Pupil absence. Similarly, an update on inequalities data by ethnicity, religion, socioeconomic class, age and gender was added to indicator 2.14 – Smoking Prevalence in adults – current smokers (APS). Indicator 3.02 – Chlamydia detection rate (15-24 year olds) had an update on inequalities data by gender.

Changes to four indicators to take account of revisions to the underlying data or changes in methods. Indicator 1.08i – Gap in the employment rate between those with a long-term health condition and the overall employment rate was revised due to changes in the source data. Confidence limits data was added to Indicator 1.08ii – Gap in the employment rate between those with learning disability and the overall employment rate. Confidence limits to existing persons data, and additional back series data for males and females were added to indicator 1.08iii – Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate. The definition of indicator 4.16 Estimated diagnosis rate for people with dementia was revised due to new data source as outlined in policy refresh.

Analysis of Issues

The table below shows the changes in the indicators that have been updated/modified:

Indicator Name	Period	Value	Unit	Change from previous	Recent Trend	Compared to England value or percentiles
1.03 - Pupil absence	2015/16	4.1	Proportion%	⟷	↑	Better
1.04 - First time entrants to the youth justice system	2016	204.8	Crude rate per 100,000	↑	⟷	Better
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2015/16	19.7	Percentage point*	↑	CBC*	Better
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2015/16	66.4	Percentage point	⟷	CBC	Same
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2015/16	62.4	Percentage point	⟷	CBC	Same
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	2013 - 15	1.8	Proportion%	⟷	CBC	Same
1.09ii - Sickness absence - the percent of working days lost due to sickness absence	2013 - 15	1.0	Proportion%	⟷	CBC	Same
2.14 - Smoking Prevalence in adults - current smokers (APS)	2016	9.5	Proportion%	⟷	CBC	Better
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	13/14 - 16/	48.1	Proportion%	CBC	CBC	Worse
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	13/14 - 16/	44.1	Proportion%	CBC	CBC	Worse
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	13/14 - 16/	21.2	Proportion%	CBC	CBC	Worse
3.02 - Chlamydia detection rate (15-24 year olds)	2016	1169.6	Crude rate per 100,000	⟷	⟷	Not compared
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2015/16	62.5	Proportion%	↑	⟷	Not compared
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2016/17	72.3	Proportion%	↑	↑	Better
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2016/17	50.5	Proportion%	↑	↑	Better
3.03xviii - Population vaccination coverage - Flu (2-4 years old)	2016/17	49.6	Proportion%	↑	CBC	Better
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2015/16	122.9	Crude rate per 100,000	↑	⟷	Same
4.12iv - Preventable sight loss - sight loss certifications	2015/16	31.2	Crude rate per 100,001	↑	⟷	Better
4.16 - Estimated dementia diagnosis rate (aged 65+)	2017	66.3	Proportion%	CBC	CBC	Same

Red arrows indicate that the increase or decrease in a measure show a negative impact on the public health outcome.

Green arrows indicate that the increase or decrease in a measure show a positive impact on the public health outcome.

Amber arrows indicate that the increase or decrease in a measure show no significant change on the public health outcome.

*CBC stands for Cannot Be Calculated.

*The indicator is constructed as outlined below: Numerator for employment rate of people with a long-term condition: Number of people with a health problem or disabilities that they expect will last for more than a year (based on response to Q1 of Annual Population Survey (APS)) and who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker â€“ ILO definition of basic economic activity) and are of working age (aged 16-64).Denominator for employment rate of people with a long-term condition: Number of people with a physical or mental health conditions or illness that they expect will last for more than a year (based on response to Q1 in APS) and are of working age (aged 16-64).Numerator for employment rate of population as a whole: Number of people who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker â€“ ILO definition of basic economic activity) and are of working age (aged 16-64).Denominator for employment rate of population as a whole: Number of people who are of working age (aged 16-64).The indicator is

constructed by calculating the percentage points gap between the employment rate for those with a long-term condition and the population as a whole.

The proportion of eligible population aged 40-74 who are offered a Health Check is still worse than the national average.

There is no significant change in the Chlamydia detection rate in 15-24 year olds.

Smoking prevalence in adults – current smokers (APS) has not changed since the last update.

The gap in the employment rate between those with learning disabilities and also those in contact with secondary mental health services and the overall employment rate has not changed significantly since the last update.

Partner Implications
Partners are advised to note changes in the outcomes that affect their objectives and / or populations served.
Reasons for considering the report in Part 2
None.

List of Background Papers
PHOF Wokingham Borough Profile 2017 PHE PHOF Indicators at a glance (August 2017)

Contact: Chrisa Tsiarigli	**Service:** Public Health
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Date: 29th September 2017	**Version No: 3**

TITLE	**Wokingham Integration and Better Care Fund (BCF) Narrative Plan 2017/19**
FOR CONSIDERATION BY	Health and Wellbeing Board on 12 October 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Ramsden, Director of People's Services, WBC and Katie Summers, Director of Operations, Wokingham CCG.

Reason for consideration by Health and Wellbeing Board	To ratify the BCF narrative submission for 2017/19, part of the national BCF assurance process.
Relevant Health and Wellbeing Strategy Priority	• Enabling and empowering resilient communities • Promoting and supporting good mental health • Reducing health inequalities in our Borough • Delivering person-centred integrated services
What (if any) public engagement has been carried out?	As part of the BCF programme there is public engagement.
State the financial implications of the decision	To maintain the funding of Wokingham's pooled BCF of £9.87million.

OUTCOME / BENEFITS TO THE COMMUNITY

Preventing ill health within a growing population and supporting people with more complex needs within the community, through three core aims: to tell your story once, to remain in your own residence and to shift care to the community by delivering a joined up, coherent health and social care service for adults leading to improved outcomes and user satisfaction.

RECOMMENDATION

To ratify the narrative submission

SUMMARY OF REPORT

The Better Care Fund (BCF) primarily aims to improve patient user experience and outcomes by facilitating joint working between health agencies and social care. Performance is measured using nationally reported and accepted health and social care indicators, including non-elective admissions, delayed transfers of care, reductions in residential and nursing home placements and numbers re-abled.

The narrative submission is our third since the inception of the BCF in 2014 and is a requirement of the national BCF process.

Due to the size of the appendices they have not been included within the agenda but are included on the Council's website where in the public domain and are available on request from Democratic Services.

Background

The Better Care Fund is a nationally prescribed ring-fenced fund derived as a top slice of the Clinical Commissioning Groups Budget along with some other smaller elements of grant funding e.g. Disabled Facilities Grant, Care Act specific funding and held as a pooled budget between the CCG and the Local Authority.

We are very proud of our success in integrating services. Our approach to integration focuses on:

- supporting Wokingham residents in only telling their story once.
- working on keeping people at their usual place of residence.
- shifting traditional hospital provided care delivery into the community.

Our integration programme is centred around the service users' journey, as illustrated in 'Sam's Story' https://youtu.be/Z3XDy2jzSb4.

We are pleased to present the third Better Care Fund (BCF) plan, following on from the 2014 and 2016 plans. This plan covers two years, from 2017 to 2019. In 2014 Wokingham Clinical Commissioning Group (CCG) and Wokingham Borough Council (WBC) made a commitment to work in partnership towards true integration. Since this time we have seen an improvement in services, the delivery of financial benefits, and most importantly, an improvement in resident's care experience.

We will broadly continue with our original plan, with some moderation to reflect progress made and lessons learnt from challenges and successes from the 2014 and 2016 plans. Given our success so far, we aim to achieve BCF graduation status in 2017/18 in order to build on our integration plans, also incorporating mental health services. Our plan describes how we will continue to meet the national conditions with CCG and WBC contributions above the minimum required pooled funds.

The total pooled fund for Wokingham has increased from £9.54m to £9.87m. The CCG is committed to supporting and maintaining the levels of spends in social care and has increased the minimum contribution by 1.8% for 2017/18 and 1.9% for 2018/19.

Partner Implications
Interdependency with 21st Council, Adult Social Care, Berkshire West 10, Wokingham GP Alliance, Berkshire Healthcare Foundation Trust, Involve

Reasons for considering the report in Part 2
N/A

List of Background Papers	
N/A	
Contact Rhian Warner	**Service** Better Care Fund Programme
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Date 02.10.17	**Version No.** 1

Wokingham Integration and Better Care Fund Narrative Plan 2017/19

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1. Introduction

The Wokingham health and social care system is very proud of our success in integrating services. Our approach to integration focuses on:

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The total pooled fund for Wokingham has increased from £9.54m to £9.87m. The CCG is committed to supporting and maintaining the levels of spends in social care and has increased the minimum contribution by 1.8% for 2017/18 and 1.9% for 2018/19.

The plan was signed off by the Wokingham Health and Wellbeing Board (HWB) Chair, the CCG Accountable officer, the CCG Chair, and the WBC Director of People Services on the 8th September 2017 and will be ratified by the HWB on 12th October 2017 and the Wokingham CCG Council on 19th September 2017.

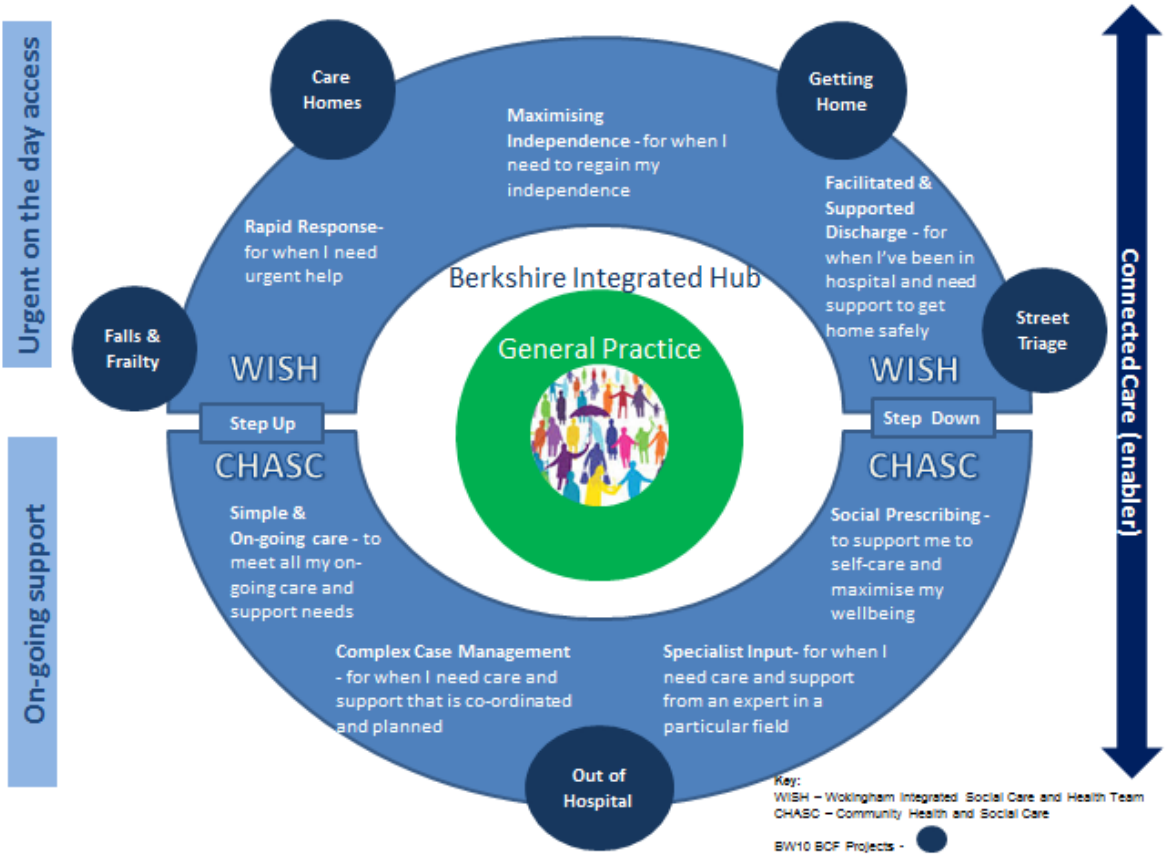
2. What is the local vision and approach for health and social care integration?

Our vision statement: 'Preventing ill health within a growing population and supporting people with more complex needs within the community.'

Our vision for integrated health and social care was developed after Call to Action consultation events and in partnership with all stakeholders in view of the impact of the Care Act 2014, utilising Wokingham's JSNA and Berkshire West CCG's Primary Care Strategy.

Since 2014 we have shaped our vision to reflect stakeholder feedback, developing three core aims: to tell your story once, to remain in your own residence and to shift care to the community. We have translated our vision of Wokingham's integrated services as illustrated below:

Figure 1 Wokingham: User-Focused Health and Social Care System



The new service model focuses on the priorities identified by local people, whilst shifting care out of hospital and delivering effective and efficient services in the community. This aligns completely with the BCF Plan aims of reducing non-elective admissions to hospital, preventing delayed discharges of care, investing in out of hospital services and focusing on preventative services.

We have and plan to continue to deliver on our overall key aims by:

- Providing the right care, by the right people at the right time and in the right place.
- Delivering more easily accessible care seamlessly, across health and social care.
- Supporting people to manage their care and promote health and wellbeing.
- Making the experience of care a more positive one.

Feedback locally and through National Voices has told us that people want the following and we have delivered or plan to deliver this by:

- **People told us they want more care closer to home** – Community Health and Social Care (CHASC) will organise services around GP practices to provide people with access to a wider range of health and care professionals in their local

community. Step-up will enable sub-acute care locally as opposed to attending the acute trust.

- **People told us they want to be seen as people, not conditions** - CHASC and Wokingham's Integrated Health and Social Care team (WISH) will place equal importance on mental and physical health, taking into account people's lives, interests and preferences to provider more holistic and personalised support.
- **People told us that the separation between different services can make it harder to get the right support** – Berkshire Healthcare Foundation Trust (BHFT) has set up the Berkshire Integrated Hub (BIH) so people only need to make one call to access all the services that can help them.
- **People told us they only want to tell their story once** - Connected Care will join up health and social care records so that everyone involved in a person's care has access to the information they need and will help each member of the local health community to look at key items in a person's health and social care record, to improve the integration of services.
- **People told us that waiting for something to go wrong before they get the right support does not make sense** - CHASC supports people to take control of their health and wellbeing to prevent ill health and reduce the amount of time people spend in hospital, through community navigators and MDTs.

By rethinking the way we deliver health and care services across Wokingham Borough, we will transform the system, to secure better outcomes and a more sustainable system for the future. This will include:

- An increased emphasis on prevention, early intervention and empowering individuals to be more independent.
- A further shift of investment from acute and specialist health services to support investment in community-focused provision.
- Exploration by commissioners and providers of new approaches to sharing resources, including knowledge and expertise, where there are demonstrable benefits in doing so.

We are delivering our BCF both locally and through a wider Berkshire West approach. The Wokingham Integrated Strategic Partnership (WISP) comprises of the NHS, social care and voluntary organisations across Wokingham: CCG, WBC, Royal Berkshire Foundation Trust (RBFT), BHFT, Involve (Wokingham voluntary & community sector umbrella organisation), Optalis (social and domiciliary care arms-length provider for WBC) and the Wokingham GP Alliance.

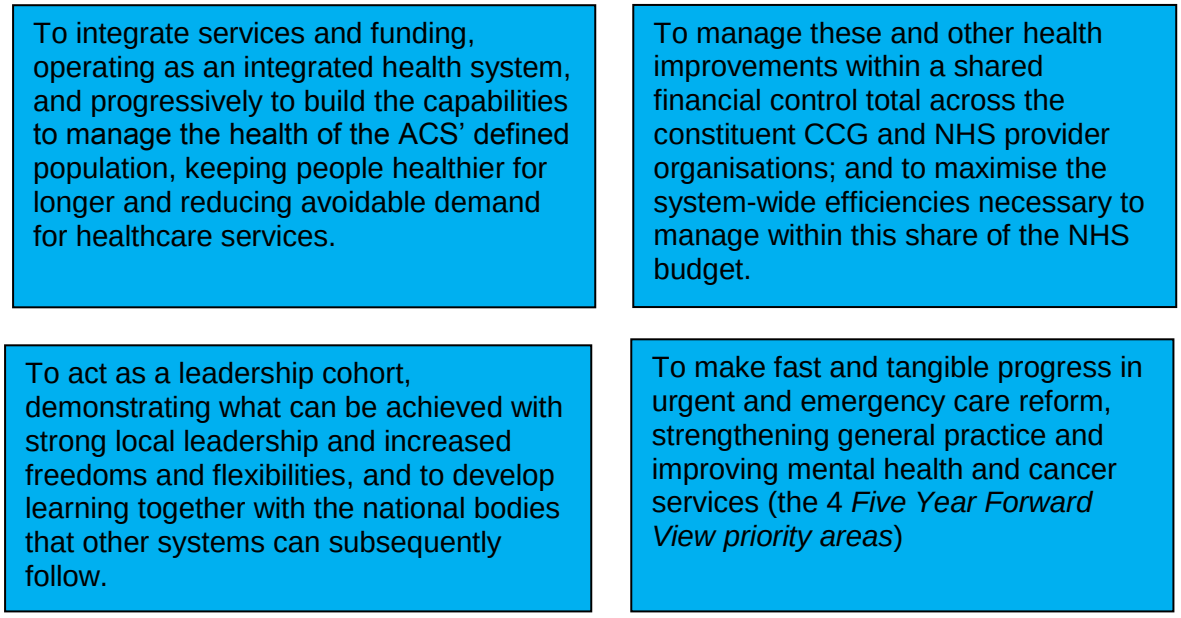
The Berkshire West 10 (BW10) system first came together in 2013, and has continued to progress with the development of a BW10 Integration Programme. The Programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system - Frail Elderly, Children and Young Peoples services and Mental Health. The journey to closer integration is set out our BCF scheme overviews which can be found in Appendices 1, 2 and 3 and the Proposal for Wokingham Adults Integrated Health and Social Care Governance, Appendix 4.

Our partners within the BW10 Programme consist of the four CCGs, the three local authorities, RBFT, BHFT, South Central Ambulance Service (SCAS). Some of our providers - RBFT, BHFT and SCAS provide services across a large footprint,

therefore our Programme feeds into a wider BW10 vision for integration of health and social care.

The Wokingham health and social care system also sits within the Berkshire West Accountable Care System (ACS), which is one of the exemplar sites identified within the Five Year Forward View Next Steps and will support our drive for care integration by 2020. As part of our BCF graduation application we have aligned our programmes of work to fit alongside the Berkshire West ACS. This is in relation to both initiatives and governance.

Figure 2: ACS Key Priorities



Whilst BW10 and ACS are the main drivers for integration across the wider health and social care system, the CCG remains a committed partner to the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability Transformation Plan (STP). The CCG Director of Operations leads on prevention work stream across the BOB footprint.

We are committed to integrating all our adult health and social care services by 2020 and our BCF Programme is the vehicle to deliver this. We have already integrated our short term health and social care teams (BIH) and WISH) and we have robust plans in place to do the same for the long term health and social care teams (CHASC) by the end of 2018/19.

Following a Wokingham workshop in 2016/17 on Integration 2020 with all partners, we are already in development for the following:

- Undertake wider stakeholder consultation – planned for October 2017.
- Implementation Plan rollout - by March 2018.
- More in depth briefings for WISP, HWB and other stakeholders on the rollout – commenced June 2017.
- Undertake wider engagement with town and parish councils – commencing from March 2018.

3. Background and context to the plan

Wokingham borough is a prosperous and a healthy place for most of its residents, but we believe there is much that can be done to make it a better place to live and work. Increasing demand for health and social care services, at a time of downward pressure on NHS and local authority budgets, means that WBC, the CCG and their partners have to consider new ways of working to deliver the outcomes that people need. As a system we have consistently been a top quartile performer whilst being one of the country's lowest funded health and social care systems. Building on successful service transformation, the BCF is providing a platform for developing deeper service integration.

3.1 Key Challenges

In Wokingham, our health and social care system is addressing many challenges:

- Continuing financial pressures, both health and social care budgets need to be made financially viable for now and the future.
- Primary care is under pressure and is at risk due to workforce issues, significant housing growth in the borough and small practices no longer being viable models of delivery.
- Recruitment and retention of adequate numbers of appropriately skilled and experienced staff, that is reflective of pressures being faced across the country,
- The 2015 Autumn Position Statement and Comprehensive Spending Review mandated Upper Tier Local Authorities and the NHS to deliver health and social care integration.
- Increasing demands on services due to an ageing population and increased prevalence of long-term conditions.
- 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 may become overwhelmed, and services are not always accessible in an easy or timely manner.
- Not intervening early enough in a person's disease journey or increasing frailness, which creates bigger demands and greater need.
- The aspirations and needs of the community are changing as people expect more personalised services and more choice and control over how their individual needs are met.

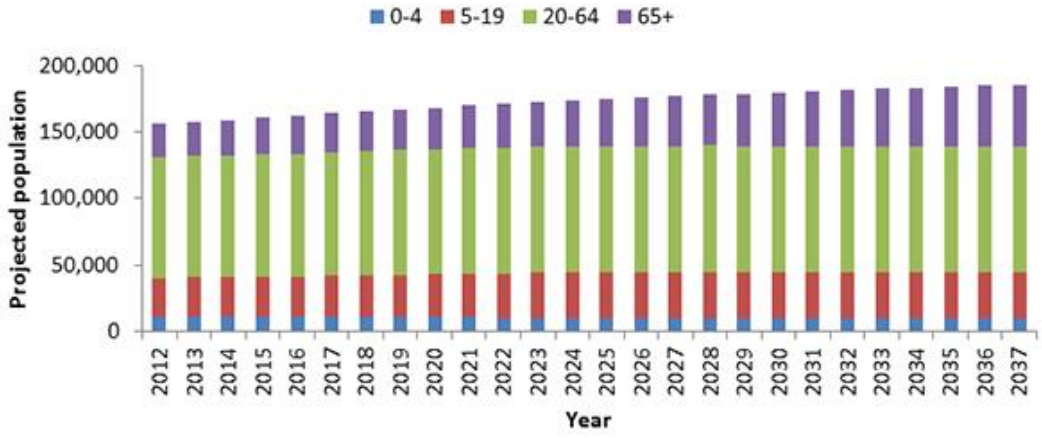
By addressing these challenges we are ensuring that we reduce the variability in health outcomes, inequitable resource allocation, increasing inequalities and increasing costs.

3.2 The needs of our population

The Joint Strategic Needs Assessment (JSNA) identifies three areas of health and wellbeing specific to Wokingham borough to shape our BCF Programme and most recently in the development of CHASC. These areas are "living and working well", "ageing well" and "people and places".

Figure 3 below indicates that there will be an 11.3% rise in the population to 182,256 by 2037 with the number of over 75 year olds set to increase by 83.6%.

Figure 3: Population projection by age groups for Wokingham borough



Source: ONS

Wokingham borough is undergoing a large degree of housing developments, in the form of Strategic Development Locations (SDL). 13,500 new homes are being built between 2016 and 2026; with this influx in housing the population projections produced by the ONS under represent the future populations.

It is important to note that the ethnic mix is becoming more diverse across the Wokingham Borough, with an increase of 1.55% of BME pupils in Wokingham schools in 6months (from July 2016 to January 2017). This is an important trend to monitor as different ethnicities can have differing health needs and co-morbidities.

Figure 4: Wokingham Borough Demographic trends

POPULATION

Additional services for older people, people with long term conditions and carers will be required to meet the needs of the growing population.

- The population of the borough is predicted to increase from 161,400 to 169,000 by 2020
- In addition by 2026 there will be 13,500 new homes in Wokingham Borough
- The number of people living in the borough aged over 75 will increase by 18.5%, from 14,615 in 2015 to 17,320 by 2020

Older People

An increased number of older people will require support, particularly in terms of home care, specialist accommodation and dementia services.

By 2020 it is predicted that:

- The number of people over 65 in the borough living with a long term illness which limits their day to day activity a lot will increase by 19% from 4,442 to 5,290.
- The number of people over 65 living in the borough with dementia will increase by 25%, from 1,873 to 2,340

(source: POPPI)

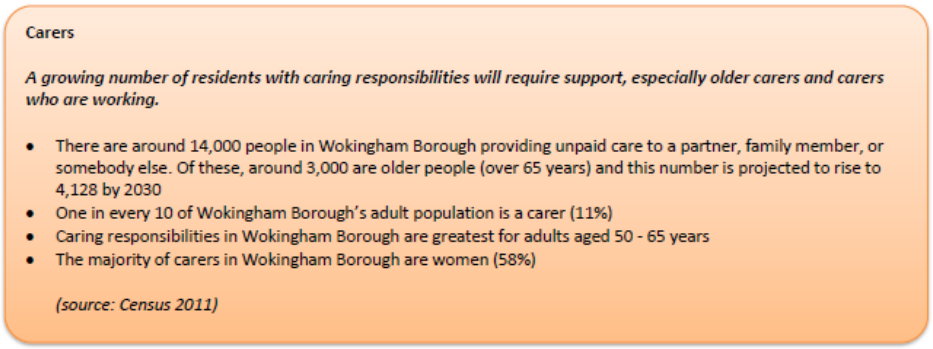
YOUNGER ADULTS

Whilst there is no significant increase in the number of younger adults with social care needs predicted in the near future, more personalised services are needed to better support these residents.

By 2020 it is predicted that:

- The number of people with a moderate to severe learning disability will increase by 2% from 536 to 547
- The number of people aged 55-64 predicted to have a moderate or severe learning disability will increase by 13% from 93 to 107
- The total number of people aged 18-64 with a moderate or serious physical disability living in the borough will increase by 5%, from 10, 093 to 10,570
- The total number of people aged 18-64 with a mental health problem (including personality disorders) living in the borough will increase by 2% from 25,565 to 26,093

(source: PANSI)



Source - Adult Social Care Services - Commissioning Strategy 2016-2021

3.3 Joint Health and Wellbeing Strategy

The Health and Wellbeing Strategy for Wokingham borough has been co-produced with our residents and updated for 2017-2020, with a new action plan to accompany the high-level priorities. This new Health and Wellbeing Strategy sits alongside a number of other plans and strategies that cover either Wokingham borough or a wider footprint.

Rather than looking to cover the whole health and wellbeing agenda, the HWB has agreed four priority areas that it wishes to focus upon:

- Enabling and empowering resilient communities
- Promoting and supporting good mental health
- Reducing health inequalities in our borough
- Delivering person-centred integrated services

These have been chosen as priority areas because of their importance to improving the health and wellbeing of the people in the borough and they each require a co-ordinated approach from across the health and social care economy. They are closely connected to each other and provide an interlocking set of priorities.

There is also a commitment by the HWB to move beyond the integration of health and social care bringing together a wide range of partners to influence the wider determinants of health including housing, education, regeneration and economic development and, importantly, build on the assets of our people and communities.

3.4 Financial Priorities

A key component of both the CCG and WBC's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the most effective and safe care for people at the best obtainable value.

Both the CCG and WBC have challenging financial targets to meet in 2017/18; the CCG needs to deliver savings of £8m and WBC needs to deliver savings of £6.6m, £1.15m of which is within Adult Social Care (ASC).

Planning ahead to achieve a community delivery system that has a real impact on shifting care out of hospital and delivering quality and efficient services in the community is imperative to ensure we find a way to achieve more and better services with less money. This will result in:

- Better clinical outcomes for people.

- Reducing pressures on acute hospitals.
- Preventing crises in the first place rather than rather than responding to them.

3.5 The Local Care Market

WBC's ASC Market Position Statement 2013-14 and 2016-2021 Commissioning strategy identify key issues (which link to those in **Section 3.1**) within the local social care provider market include:

- Ongoing reduction in the public sector funding.
- High cost of living / shortage of affordable housing in Wokingham Borough
- Impact of a large number of self-funders on local prices.
- Competing for services with other Berkshire Local Authorities.
- Demographic pressures, particularly in terms of meeting the needs of the ageing population, development of services for people with dementia, autism and those with complex needs.
- Transformation of the local market (statutory and non-statutory services) to ensure personalisation and outcomes focused services.

Through BCF monies, the care market is being supported to stabilise and innovate. In particular, BCF funding is being used to develop new models of residential and nursing care; support providers of complex and specialist packages develop services that support residents to manage themselves before reaching a crisis and directing them to services that are run by the third sector e.g. community navigators.

3.5.1 Current Market Position

In advance of publishing a current Market Position Statement (MPS) – the MPS is currently being reviewed by WBC but no timelines for the new document have been set - WBC and the CCG are clear on the type of risks within the market following engagement with providers, particularly in terms of sustainability and priority actions that need to be taken as a result. A summary of these is provided below.

Market Sustainability Risks & Pressures

- Shortfalls in supply in the face of increasing demand and a challenged care home market is resulting in fees levels above the WBC rate agreed.
- Concerns that an unintended consequence of very rigorous and robust safeguarding and regulatory action can contribute to the conditions for provider failure.
- Insufficient diversity of providers in the local market for provision of care for those with complex needs.
- Providers' preference for private clients can reduce availability to take social care referrals.
- Housing stock becoming outdated for modern care service requirements.

In response to these pressures, the following priorities have been identified, some of which are included specifically within the BCF schemes and others are being progressed within WBC and/or CCG.

Market Development priorities

- Specific commissions for Discharge to Assess beds are underway which will support the bed mix available and ensure that more people can make decisions

about their long-term care needs away from a hospital setting.

- Further developing commissioner contingency planning systems and providing training for smaller providers on business continuity.
- Demand management through:
  - Better quality conversations with service users and families on alternative ways of meeting needs that promote independence
  - Clearer expectations from published policy positions on choice of care services, top-ups etc.
  - Better outcomes from providers being appropriately incentivised across preventative partnerships, and signposting to more community options to promote independence, avoid escalation of need and reduce the need for intensive packages of care and care home placements.

3.6 General Practice

Wokingham GP Alliance is now part of the National Association of Primary Care's Primary Care Home - Community of Practice. Primary Care Home is about sharing and using best practice and knowledge across the country. A Wokingham cluster-based model has been in development for three years. In April 2017, all 13 practices in Wokingham came together in an alliance structure, underpinned by a memorandum of understanding and run by an executive board. Several early work streams have been identified including shared clinical pharmacist roles, piloting emergency care practitioner-led home visiting, providing pre-operative assessments in primary care and working with the broader adult community services on redesigning outpatients. The GP Alliance is a key member of both WISP and CHASC.

4. Progress to date

4.1 Self-Assessment

In September 2016 WISP used the BCF self-assessment tool to help reflect and review 2016/17 and plan towards 2017/19. The partnerships considered return on investment in terms of impact on reducing non-elective activity and whether the schemes have delivered the High Impact Changes and meet the strategic vision for integrated care across Wokingham. Through this process we identified:

- Areas of activity that are performing well and how we want to build and develop these.
- Projects that have been slower to get off the ground and what might help in terms of resource and/or linking and scheduling with other planned project activity. Areas which aren't performing so well and taking steps to further review, evaluate or redesign.

The scheme summaries of the self- assessment can be found in **Section 4.4.**

4.2 Efficiency

The review builds on the efficiency programme of WBC's 21st Century Programme, an increased focus around the customer journey rather than traditional service directorates or teams. The programme will ensure customers have access to the right people, with the right knowledge and understanding at the right time. Services

will be significantly faster and more cost effective. This includes a plan to review WISH and pathway processes in2017/18. Together we were able to do some detailed analysis of several of our BCF schemes and projects which tracked specific cohorts of people and their ED attendances, outpatient's appointments and admissions. There was positive impact demonstrated in relation to:

- BI Hub.
- WISH Care Homes – Rapid Response and Treatment Team.
- Connected Care – Information Sharing – Infrastructure team.

4.3 Performance

Wokingham's performance against BCF metrics is on a positive trajectory. Notably our baseline performance in many of the metrics was already in the upper quartile, therefore a stretch in improving an already good performance, but as demonstrated below, truly integrating health and care can lead to cost savings, reduction in activity and overall improved satisfaction and experience for users. Throughout 2016/17, a dashboard of measures was monitored to show performance against the four national metrics and multiple local metrics. The 2016/17 performance dashboard can be found in Appendix 5.

In summary, the full year measures showed:

National Metrics:

- Non-elective admissions – Continued improvement - In 2016/17 NEAs were 12,845, a 1% reduction from 2015/16, 12,940.
- Delayed transfers of care – Continued improvement – In 2016/17 monthly average delayed days were 242 a month, a reduction of 16 %, from 2015/16.
- Permanent admissions to care homes – Sustained – In 2016/17 new admissions were 140, a minimal increase from 138 in 2015/16.
- People remaining at home 91 days after reablement – Underperformed- In 2016/17 metric is 73% of people remained at home, a decrease of 4% from 2015/16 when 77% of people remained at home. N.B. This is largely attributable to the recording of customer information into the care management system and taking the metric from ASCOF, which only captures social care activity.

Further detail on the National Metrics can be found in **Section 10.**

4.4 Progress Review

A yearly BCF review of schemes was carried out in September 2016 by WISP. Schemes were reviewed individually, with opportunity for comment/queries/ suggestions by all stakeholders. Each scheme was subsequently evaluated using the 'Evaluating Performance of BCF Schemes' template (Appendix 6). Key points were:

- **The Berkshire Integrated Hub (BIH)-** *Evaluation Performance Score: 84%*
  - Client experience/feedback to be reviewed in the next phase.
  - Measurability to include number of calls resolved at first contact. No issues reported from general practice or acute hospital although social workers felt more information was needed to allow them to progress the call initially.
  - No other health and social care economy has this integrated process at this point. Slough local authority is interested in learning from us about the BIH.

- Marginal savings compared to having previous separate call centres.

- **WISH -** *Evaluation Performance Score: 86%*
  - DToC performing well, with further positive increase expected.
  - Redesign of reablement with therapy led assessment model being implemented – live date from 1 October 2016.
  - Reablement Support Worker enhanced skills set being implemented – to be completed by end of January 2017.
  - Integrated working has been progressed and this is making a key difference – DToC and permanent placement performance improvements.
  - Reported NEA figures and nursing/ care home avoidance figures encompass all WISH related schemes – project lead working on clarifying WISH impact.
  - Reduction in numbers of permanent care placements – more people are receiving domiciliary care in the home instead.
  - Savings on course for delivery against trajectory.

- **Step Up/Step Down -** *Evaluation Performance Score: 68%*
  - Usage had been predominantly Step Down. Lack of referrals for Step Up.
  - As well as reablement opportunities, the scheme had been extended to include complex discharge packages.
  - Benefit to health in the estimated DToC days saved in acute hospital. Small element of NEA benefit.
  - Home First project may affect demand for Step Down. Consideration to be taken to use the flats for 'discharge to assess' to ensure this resource is used to full effect.
  - Service had been pared down to meet demand – staff night cover reduced, 3 flats in use rather than target 8 flats. This provided some financial savings.

- **Domiciliary Care Plus Night responder –** *Evaluation Performance Score 40%*
  - In the planning stages of this scheme, anecdotal evidence suggested it would be well used. In actuality referrals were minimal, despite extensive promotion.
  - Initially there were some issues around bookings and pathway processes, but these were suitably addressed.
  - Client feedback was very positive.
  - This is a costly service and not offering value for money, however targets were almost achieved and some NEA benefits realised.
  - It was agreed the service isn't sustainable as a stand-alone service, but would work well embedded into another service.
  - 6 month pilot was due to end 24 October 2016 – options for the service were offered.
  - There were mixed feelings for the progress of this scheme however stakeholder recommendation was to continue the pilot for a further 3 months. Project management changed to Intermediate Care service, and staffing reduced to better suit service demand, benefits/targets also reduced to reflect changes.
    N.B Following the extension period, this service ceased 26 January 2017. See Appendix 7: Domiciliary Care Plus Night Responder service end project report

- **Care Homes –** *Evaluation Performance Score: 71%*
  Berkshire West-wide:

- Q1 ED activity had been reviewed – 50% activity outside of hours that Care Homes project responds.
- Not quite meeting target on medication review, but more staff recruitment planned which should improve figures.
- Data review - all but one postcode is unique to care homes in the area, so quality should be considered as 99% accurate.
- Self-reported performance is different to the business case profile. Baseline targets were initially forecast against month 9 of 2015/16. Updated data now available and more realistic targets set.
- Phased roll out complete to all 52 care homes in Berkshire West area.
- Unfilled geriatrician post may have impacted on RRAT success in Q1, although local geriatricians have supported in the interim.
- Review underway of a number of care homes contributing to NEA.

Wokingham Locality relevance:

- Of 176 residents treated by RRAT, 94 were Wokingham residents.
- Wokingham has the greater amount of care homes in Berkshire West (22:55)
- WISH team has seen an improvement in reduction of NEA admissions to Wokingham care homes in Q1.
- Risk share monies for Q1 were discussed – Commissioning Support Unit (CSU) are evaluating Care Homes project across Berkshire West. Q1 calculations received, targets not achieved therefore no risk share monies released. Understaffing of the project has been recognised, with will provide some cost savings – CSU to investigate further.

- **CHASC**

  Primary Prevention and Self Care **-** *Evaluation Performance Score: 74% Evaluation scoring did not include: Plans and outcomes (as yet unidentified) and it was uncertain whether the scheme evidentially supported people at that point.*

  - Project title change from Neighbourhood Clusters to CHASC.
  - Progress had been delayed for a 3 month period whilst a new project manager was appointed (July 2016).
  - PID being reviewed.
  - Scheme reflects a whole system approach with links into secondary services/specialists when needed. May help to reduce referrals.
  - No scheme investment, only project costs (reduction on previous year).
  - Agreed to continue supporting this scheme and invest in the service.

  Community Navigator **-** *Evaluation Performance score (separate to Primary Prevention and Self Care element of CHASC): 76%*

  - Service delivery underway (prior to CHASC service implementation)
  - Communication strategy and implementation underway to drive growth of the service. Referrals mainly received from GPs, need to encourage other services to refer and promote this scheme.
  - Benefits measured by self-reporting using the ‘Ladder of Change’ tool (outcomes based measure).
  - Running costs are minimal; budgets for 2017/18 & 2018/19 include costs for provision of voluntary/charity services.
  - Outcomes need to be reviewed, including NEAs.

4.5 Key initiatives

Key initiatives in our BCF Plan relate to implementing the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care. The High Impact Change Model sets out eight high impact changes that can support local health and care systems reduce delayed transfers of care:

Change 1: Early Discharge Planning.
Change 2: Systems to Monitor Patient Flow.
Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
Change 4: Home First/Discharge to Assess.
Change 5: Seven-Day Service.
Change 6: Trusted Assessors.
Change 7: Focus on Choice.
Change 8: Enhancing Health in Care Homes.

Getting Home has been identified as a key priority by the Berkshire West A&E Delivery Board and BW10 Delivery Group to support the delivery of 3 of the high impact changes. It aims to promote good practice across the system to reduce both DToCs and NEAs, by improving patient flow. The system will then move towards a position whereby a complete, integrated and trusted assessment is undertaken at the front door of the hospital. Common documentation will be developed to support completion of a clinical and functional assessment which is trusted, shared and not repeated.

The aspiration would be for fully integrated discharge to assess arrangements to be in place for all complex discharges with full assessment of long-term needs being carried out outside of hospital. This will support the majority of patients being able to be discharged from the hospital on their Estimated Date of Discharge with flow maintained 7 days per week.

WISH is our main local scheme which supports the transfers of care with all other schemes acting as enablers. Further information can be seen in **Section 11**.

4.6 Progress of the 2016/17 national conditions

The table below summarises our progress in 2016/17.

Figure 5: National conditions achievements 2016/17

National Conditions 2016/17	Progress achieved in 2016/17
Plans Jointly Agreed	As detailed in our plan BHFT, RBFT, local GPs and ASC all continued to be part of the integration implementation teams. Providers are represented on WISP and are invited to HWB on a regular basis to present information on specific issues. WISP undertook a joint review of schemes for 2016/17.
Maintaining the Provision of Social Care	The core funding for protecting ASC has been maintained year-on-year. Within the total funds available for 2016/17 in the Local Authority hosted Pool, we increased the investment in the Integrated Short Term Health & Social Care teams by £248k compared to 2015/16.
7-Day Services	We have developed a number of 7 day services, including our BI Hub that is available to take referrals and pass onto relevant services seven days of the

	week, facilitating discharge over the weekend. We adopted a whole system whole week approach to ensure that a full range of health and social care services is available 7 days a week. This has been achieved by our integrated short-term team working across a seven day pattern and increasing weekend working by the social work element of this team embedded in the acute trust at weekend, this supports flow of delivery on the weekend and early on a Monday . The delivery of a 7 day rapid response service has been achieved and is ongoing; this has significantly supported the prevention of unnecessary admissions across the 7 day a week. The expansion and refocus on a 7 day rapid response service will significantly support prevention of unnecessary admissions and will be available 7 days a week.
Data Sharing on the NHS Number	We have established a BI Hub call centre at which staff can access both their legacy systems (Rio and Frame Work I) and Connected Care records. All referrals going through the BI Hub can share information with the WISH team, and look up more detailed medical information as appropriate; facilitating the "right service at the right time" aspiration for our local services.
Joint Approach to Assessment	Health and social Care providers evaluated our 2016/17 schemes along with other stakeholders agreed the continuation and varied business cases through our Local integration board. At a more strategic level both main provider trusts have articulated the impact of the BCF in their operating plans. Our BCF projects have been developed and rolled out over a series of WISP meetings involving RBFT, BHFT, WBC, Optalis, Involve and primary care. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes. Providers are represented on WISP and are invited to HWBB on a regular basis to present information on specific issues. This will all continue in 2017/19.
Agreement on the Consequential Impact of Change	To meet our challenges and overcome the barriers to change in the current system, Berkshire West CCGs along with RBFT and BHFT have established a New Model of Care to operate as an ACS. The ACS is a collective enterprise that will unite its members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West. Under the new ACS chair, Luke March, a draft strategy has been produced for the NHS in Berkshire West. The ACS is planning to 'see primary care organised into larger "hubs" of practices, around which extended community services can be organised.' This fits with Wokingham's schemes within the BCF, for example - BCF 02 WISH short term team, BCF 03 Step Up /Step Down, BCF 08 CHASC.
Agreement to invest in NHS out of hospital commissioned services	£2,171k of ring fenced funding for out of hospital commissioning and risk share element on NEA reductions was included within the Wokingham plan. The plan included spends totalling £3,644k on out of hospital commissioning and £448k on risk share, exceeding the ring fenced funding by £1,922k. The investment made was predominantly in short term intervention activity, aimed to providing greater support in the home and in care home settings to avoid NEA activity and allow for earlier discharge. In addition, the plan included further investment in Step Up / Step Down beds to provide greater capacity to provide an intermediate care facility with reablement support to avoid admissions and assist with earlier discharge.

We will continue to progress work against the former national conditions 3, 4 and 5 by:

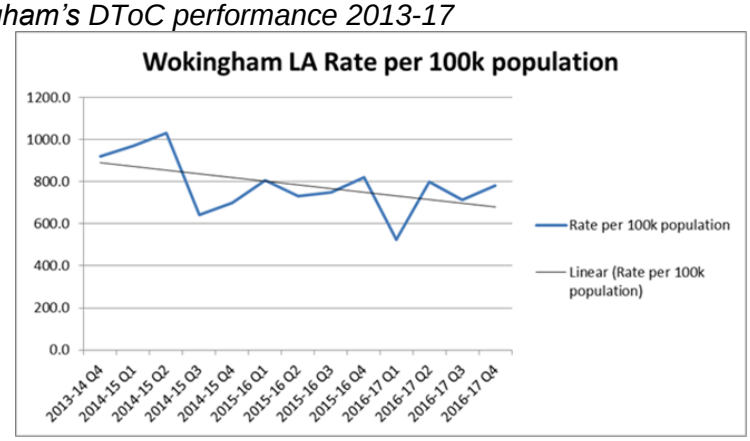
- National condition 3: 7 day services. Continuing to develop 7 day services where they are appropriate and financially viable e.g. Step Up.

- National condition 4: Data sharing on NHS number. A key enabler to supporting the patient's journey is the sharing of health and social care records. Connected Care is the first programme (Appendix 3) in the country whereby all health and social care records from our partner organisations are shared at this scale and is already showing demonstrable benefits from patient's experience, workforce efficiency and reducing duplication. Across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different cultures, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time, and these are mitigated by strong leadership from the Connected Care project board and strategic planning across health and social care, developing our Local Digital Roadmap. What the Connected Care solution offers is the ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways:
    - No need for multiple laptops to access health and social care data separately
    - Access to real time data reducing the need for phone calls to various organisations to collate pieces of information
    - Reduce the amount of time required to contact the relevant organisations in relation to a person.
    - More accurate data
    - The ability to streamline the integrated services better by creating true single assessments
    - The ability to streamline the transfer of a person from one service to another by developing health and social care pathways
- National condition 5: Joint approach to assessment. A key element of the CHASC service is the development of a joint approach to assessments and care planning ensuring that, where funding is used for integrated packages of care, there will be an accountable professional.

4.7 DToC Review of 2016/17 performance

We have improved our performance on 2015/16 and narrowly missed achieving our targets set for 2016/17, with our overall performance year on year showing a continued downward trajectory, the reverse of the national trend (Figure 6).

Figure 6: Wokingham's DToC performance 2013-17



We set our DToC 2016/17 target of 3516 delayed days in March 2016 and excluded mental health delayed days in this target. Once we started measuring our performance it became clear that BHFT include mental health delayed days in their figures, with a total of 3751 delayed days for 2016/17, 7% above our target. We have adjusted our target for 17/18 to take this into account. If we remove the mental health delayed days we would have over performed against the target by 13% (445 delayed days).

There are a number of factors that drove our DToC performance:

- The WISH team is now co-located for better cooperative working.
- Joint management meetings are held regularly.
- Our Hospital Liaison Team (HLT) is a dedicated hospital discharge team with a clear focus on facilitating timely discharges thus reducing delayed transfers of care. The team work to clear aims and objectives and understand their roles and what is expected of them.
- Information sharing, for example, the weekly circulation of the delays, enabling the team to understand exactly where there are pressures, performance targets are very clear and the team have goals to aim for.
- Analysis of any delay over 5 days is completed weekly, which informs exactly where the delays are situated, within Health, Social Care or self-funding patients. This provides information on the areas where Social Care needs to focus on improvements.
- Compulsory meeting agendas on integration and Nurse Led Rapid Response service commenced in September 2016, with the aim of reducing NEAs.
- The Berkshire West Choice policy has been implemented to address one of the two key areas resulting in delays, that being private funders. This is a work in progress and is monitored for support to the delay avoidance. Continued Health Care (CHC) was the second area of delay, there is now a target set by RBFT that all CHC check lists are to be achieved in 48 hours, feedback is that they are achieving 24 hours.

5. Better Care Fund plan

The table below shows the Wokingham and BW10 BCF Schemes and the associated partnership leaders that are overseeing the schemes and which will be monitored. Some of the year 2 detail will be confirmed during year 1.

Figure 7- 2017-19: Wokingham and BW10 BCF Scheme management

Scheme No	Scheme Name	Health and/or Social care	Scheme Leadership
BCF 01	The Berkshire Integrated Hub. Includes Wokingham Information Network (WIN)	Health and Social care	SRO - David Cahill, Director – Wokingham Locality, BHFT
BCF 02	WISH – Wokingham Integrated Health and Social Care team. Incorporating Step Down project from Jul 2017 (split from BCF 03 SUSD); project renamed Time to Decide.	Health and Social care	PM/SRO -Martin Sloan, Head of WISH Team, BHFT
BCF 03	Step Up (previously Step Up/Step Down, aka SUSD)	Health	SRO - Heidi Ilsley, Head of Adults and Older People's Services, BHFT
BCF 06	Care Homes Berkshire West scheme incorporating Care Homes scheme and reframed Hospital at Home service, and Rapid Response and Treatment (RRAT) for Care Homes	Health	PM - Kam Purewall, Transformation Lead – Care Homes Programme, Wokingham CCG, and Martin Sloan, Head of WISH Team, BHFT SRO – Sam Burrows, Director of Strategy, Berkshire West CCGs
BCF 07	Connected Care	Health and Social care	PM - John Devine, Project Manager - Digital Transformation, NHS South, Central and West CSU. Barbara Sorkin, Project Lead for Wokingham implementation SRO – Katie Summers, Director of Operations - NHS Wokingham CCG
BCF 08	CHASC – Community Health and Social Care (Includes Community Navigator service) Previously titled Neighbourhood Clusters, Primary Prevention and Self-Care	Health and Social care	PM - Michele Hayman-Joyce, Service Transformation Lead, CHASC, WBC SROs – Katie Summers, David Cahill and Judith Ramsden, Director of People Services, WBC
BCF 10	Getting Home	Health	PM - Jenny Reaper, Berkshire West CCGs SRO- Tandra Forster, Head of ASC, West Berkshire Council & Janet Lippett, Care Group Director, RBFT
BCF 11	Out of Hospital	Health	SRO – Eleanor Mitchell, Director of Operations, South Reading CCG
BCF 12	Street Triage – Mental Health	Health	SRO – Bev Searle Director of

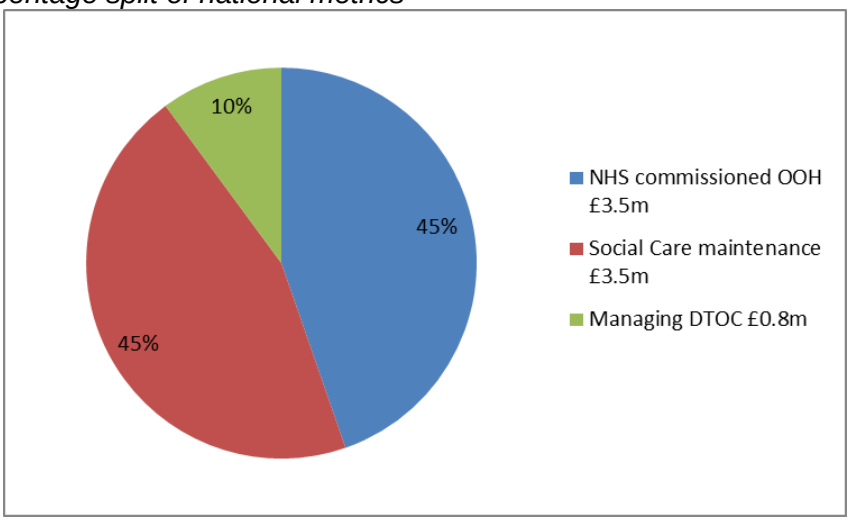
			Corporate Affairs, BHFT
BCF 13	Falls and Frailty - South Central Ambulance Service project	Health	SRO – Carolyn Lawson, Transformation Manager Urgent Care, Berkshire West CCGs

Our programme over the next 2 years (see Wokingham's Summary on a Page – Appendix 8) will continue in the work stream areas outlined in Wokingham's 2016/17 BCF submission. However there have been 3 changes to the Wokingham BCF plan to reflect learning:

- Our BCF programme will move in line with the BW10 ACS. During 2017/18, Wokingham will build on our integration success to bolster governance and partnership working. During Q1, WISP will work towards establishing an enhanced Section 75 agreement. The purpose of this does not seek to replace or in any way override existing service contracts (i.e. contracts between the Commissioner and the Provider for delivery of care). Instead, it will bring organisations together around a common aspiration for joint working across the Wokingham system. It will set out a number of shared objectives and principles, and a set of shared governance arrangements allowing organisations to come together to take decisions.
- As a result of a 'deep dive' review to capture our learnings, BCF 03 Step Up/Step Down has split into 2 separate schemes for 2017/18. A Step Up PID has been approved (BCF 03), providing sub-acute care to reduce ED attendance and NEAs. Step Down has been renamed 'Time to Decide' and governance has been absorbed into the WISH team (BCF 02).
- BCF 04 Domiciliary Care Plus Night Responder Service was underperforming; the service was not accessed as frequently as expected. The service was put under review and a decision was taken to cease the service in January 2017.

For this year's plan, we highlight and focus on a number of existing schemes and also refresh a couple of existing schemes. These are explained below, with scheme plans setting out objectives, milestones, performance indicators and scheme level spending plans which are attached at Appendix 1. Each scheme identifies which national metric it will support and the pie chart below shows the split of the national metrics across these key schemes.

Figure 8: Percentage split of national metrics



As part of our 2 year plan, for 2018/19 we will review progress of our 2017/18 BCF plan, enhancing where necessary. Figure 9 shows a breakdown of our schemes and their funding for 2017/18 and 2018/19.

Figure 9 – Wokingham BCF Schemes and Funding 2017/19

Scheme	Scheme Name	Scheme Type (see table below for descriptions)	Source of Funding	2017/18 Expenditure	2018/19 Expenditure	New/ Existing
1	Health and Social Care Hub	2. Care navigation / coordination	CCG Minimum	£16,038	£16,038	Existing
2	WISH1 Wokingham Integrated Social care Health - LA/LA (fund/provide)	11. Intermediate care services	Local Authority	£842,260	£807,680	Existing
2	WISH2 - LA/BHFT (fund/provide)	11. Intermediate care services	Local Authority	£103,740	£138,320	New
2	WISH3 - CCG/LA (fund/provide)	11. Intermediate care services	CCG Minimum	£292,590	£381,669	Existing
2	WISH4 - CCG/BHFT (fund/provide)	11. Intermediate care services	CCG Minimum	£345,655	£345,655	Existing
2	WISH - Time to Assess (Step Down)	11. Intermediate care services	CCG Minimum	£157,744	£157,744	Existing
3	Step Up	11. Intermediate care services	CCG Minimum	£60,800	£120,000	New
8	CHASC Community Health and Social Care	2. Care navigation / coordination	CCG Minimum	£132,395	£150,993	Existing
6	Care Homes	8. Healthcare services to Care Homes	CCG Minimum	£207,106	£207,106	Existing
11	Speech and Language Therapy	16. Other	CCG Minimum	£54,749	£55,986	Existing
11	Care Home in-reach	8. Healthcare services to Care Homes	CCG Minimum	£165,280	£169,015	Existing
11	Community Geriatrician	12. Personalised healthcare at home	CCG Minimum	£143,587	£146,832	Existing
11	Intermediate Care including integrated discharge, discharge to assess services	11. Intermediate care services	CCG Minimum	£686,945	£702,470	Existing
11	Health Hub	2. Care navigation / coordination	CCG Minimum	£314,032	£321,129	Existing
11	Intemediate Care - night sitting, rapid response, reablement and falls	8. Healthcare services to Care Homes	CCG Minimum	£337,791	£345,425	Existing
7	Connected Care	7. Enablers for integration	CCG Minimum	£300,000	£312,000	Existing
12	Street Triage	11. Intermediate care services	CCG Minimum	£23,000	£40,000	New
13	SCAS Falls & Frailty	11. Intermediate care services	CCG Minimum	£35,000	£70,000	New

5.1 Improved Better Care Fund (iBCF)

We received the following iBCF funding for 2017-19. The Department of Communities and Local Government (DCLG) has allocated the following funding:

2017/18	2018/19
£169,000	£112,780

The iBCF has not affected decisions on our budget. It should be noted the funding received is very minimal compared to other local authorities, this is related to Relative Needs Formula as it affects Wokingham. At this level, we will use the monies to further support existing projects to enable higher success in meeting the national targets and we will continue to do this and report at a national level. We will allocate the iBCF according to where improvements can be made or further sustained. Following Q1 and Q2 2017/18, we will review our existing schemes to identify where the iBCF monies will best support the achievement of the BCF metrics. In the main, this will be with the aim to meet B - Reducing pressures on the NHS (including DToC).

5.2 Support to the Care Homes Market

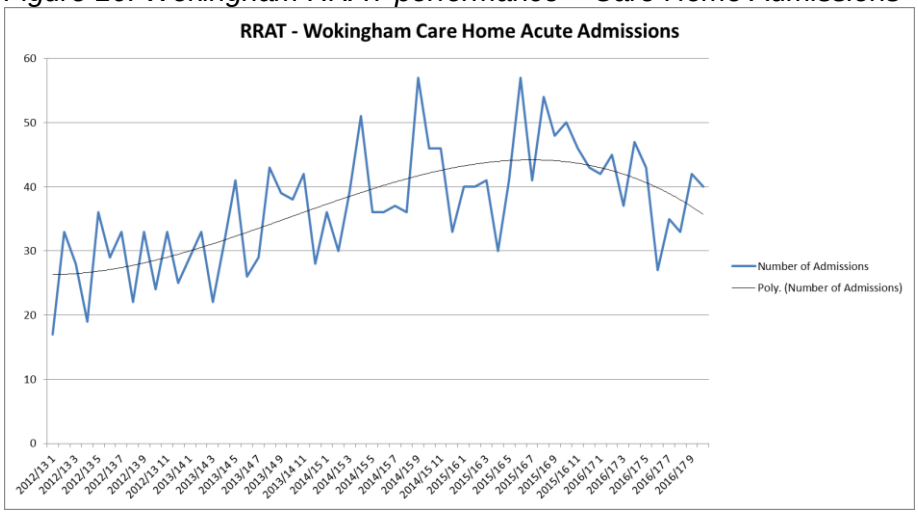
The Care Homes project was established in April 2015 with the aim to provide a consistent approach to improving outcomes for those people living in Nursing and Residential Homes in Berkshire West. The project has the following work streams:

- Rapid Response and Treatment (RRaT) and care home support team - provides 7 days a week, 9am – 7pm treatment via a multidisciplinary team linking in with specialist nurses and therapists and training and education of care home staff.
- Medicines Management - medication reviews of all residents.
- Protocols and Standard.
- Primary Care Provision.
- Quality and Commissioning.

The services offers residents a co-ordinated and joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of patient from community to acute and back to community and avoiding unnecessary delays in discharges back to the care homes.

The project is showing signs of success; over the last 6 months (M6 to M11) we have demonstrated a 5% reduction in NEAs when compared to M6-M11 15/16 across Berkshire West. Figure 10 below shows our performance locally, with NEAs reducing over time as the service becomes embedded within our borough.

Figure 10: Wokingham RRAT performance – Care Home Admissions



In 2017/18 it will continue to support:

- The Rapid Response team and on-going evaluation of the impact of the service on the delivery of 30% reduction of NEAs.
- A Protocols and Standards process that is supported by all providers focusing on the delivery of quality social and health care and reducing the impact of any necessary interventions outside the care home, in particular length of stay in secondary care.
- A health and social care process for the monitoring of Care Home performance through collaborative working with all providers. Working in partnership to develop a central reporting function that provides comprehensive data on each Care Home, its facilities, specialist competence, staffing skill mix and case reports that share the learning across Berkshire West.

- The Medicines Optimisation Team to ensure medication reviews continue in a timely manner and explore how the team can work more closely/in partnership with the new GP provision to care homes to, increase efficiency.
- The delivery of a new model of GP support to care homes that moves away from the traditional 'reactive' model of care towards a 'proactive 'care model that is centred on the needs of the resident, their families and care home staff.

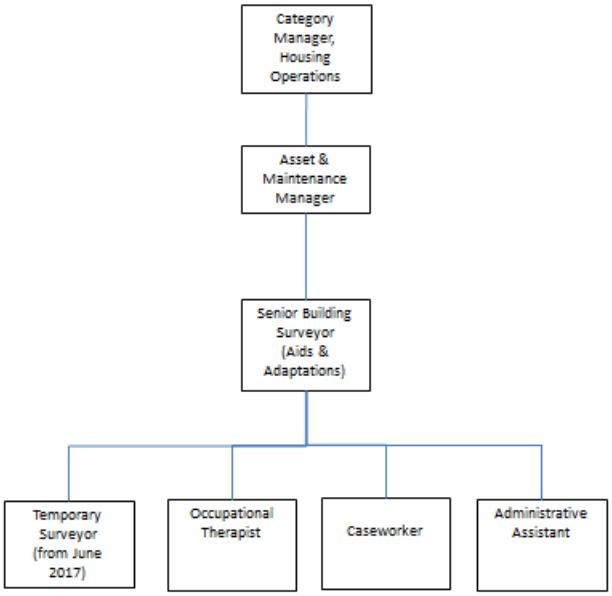
In addition the project will explore the integration of community services and the enhancement of the current provisions to provide clinical support/advice to care homes 24 hours a day, 7 days a week.

5.3 Disabled Facilities Grant

This year's BCF plan aims to see closer working between housing, health and care commissioners and regular liaison meetings and a seat on WISP have been established to evaluate the impact of DFGs and to strengthen the links between DFGs, Community Equipment services and Assistive Technology. This will become a more prominent theme in year 2 of the BCF plan.

WBC's Housing Operations Manager will attend WISP quarterly to present the scheme's use of DFG and pathway for the BCF schemes. The DFG is managed by WBC through the structure shown below:

Figure 11: WBC's DFG Team Hierarchy



In 2016/17:

- A qualified Occupational Therapist now sits alongside the Surveyor within the team to triage requests, prioritising cases which need a quick response, with the best solution.
- A project to refurbish kitchens and bathroom for a sheltered housing scheme has just been completed. Tenants were consulted with directly on how there flat can best meet their needs. This resulted in 12 kitchen and 11 bathroom refurbishments, which will support tenants to stay in their homes and to retain their independence.

In 2017/18:

- We have plans for a 2nd surveyor to minimise waiting time, supporting adaptions required for hospital discharges.
- The team will use learning to for future projects whereby prevention and proactive measures can support people staying in their own homes for longer. There are 2 extra care schemes coming on line later this year.
- The Housing Department have engaged a consultant to review housing needs of the ageing population in Wokingham; this report is due May 2017, the results of which will be used to refresh the Housing Strategy 2015/18.

The CCGs Operating Plan and the Health and Well Being strategy recognise the impact dementia has on health and social care services. A significant proportion of carer's funding is aimed at carer's supporting people with dementia e.g. advice services for YPWD ,Dementia 'Champions' and WBC and the CCG are developing a dementia pathway review from prevention services through to MDT working on those with more advanced dementia.

The DFG is a key opportunity and priority through the coming years to create and enable a strategic approach to use of Assistive Technology as integral to our Adult Social Care health approach and intervention/enabling practice framework.

6. Risk

6.1 A Brief Summary of Risk and Risk Assessment

Our risk register attached in Appendix 9 sets out the key risks affecting BCF plan in 2017/19. WISP has oversight of all scheme risks which are classified by delivery, financial and engagement. They are reviewed in detail on a quarterly basis and if required escalated to other areas charged with governance such as the BW10 Delivery Group dependent on the nature of the risk.

Key risks to both the CCG and WBC will be identified and managed as required under their respective risk management strategies.

6.2 Financial Risk

The existing schemes are investments in long-term services provided in the main by WBC, BHFT and Optalis. Strategic risk of the collapse of one of these providers is therefore assessed as relatively low. Financial risk, therefore, arises primarily from instability within the care home market which may result in increased costs associated with securing care home placements in a "suppliers market" and an associated failure to achieve the required savings targets. These savings targets are challenging and the scale of the challenge when taking into account the state of the care market.

Any further mitigation required if these risks were to crystalize would be agreed in the first instance through WISP, with recommended actions approved through the individual organisation's governance arrangements.

6.3 Risk Share

Our local risk share is based around the approach used in 2016/17 and has been agreed between the CCG and WBC with the risks sat between both parties as commissioners and not with the providers. The risk share is measured on the underlying performance of the individual schemes. Each scheme is reported on a monthly basis including an assessment of risk. This is then consolidated into a single Wokingham Integration Portfolio – Risk Register and reviewed at the monthly WISP meetings by all partners. The key risks are categorised into two sections of high level and low level to provide both strategic level of clarity and completeness.

Locally, financial risk is monitored by WISP and regular meetings with the Senior Responsible Officers. This runs alongside monthly finance meetings of the BW 10 finance sub-group.

Activity performance is monitored for benefits versus spend on a per scheme basis. Where the benefits are forecast to underperform, a financial decision can be taken to mitigate in a timely way. A performance dashboard of Key Performance Indicators is maintained, monitoring the progress against national local metrics of avoidance, saved or reduction. Combined with monthly reporting against budget, with variances flagged for amounts greater than £50k enable the programme to be reviewed.

The baseline NEA in the planning template is a 1.8% reduction on the 2016/17 outturn. Wokingham is fully committed to risk share to incentivise delivery and protect the system. The value of 2017/18 risk share is £477k, a small increase on 2016/17 risk share of £448k. The 2018/19 risk share is £442k. For 2017/18 the NEA will be aggregated and not split per scheme and will be stated in the Section75 agreement.

Figures 12 and 13 show the allocation of risk share across our schemes. The target NEA avoidance activity is mapped to the risk share amount.

Figure 12: Wokingham's allocation of risk share across schemes 2017/18

Scheme	Levels of activity	Average unit rates	NEA Avoidance savings	Weighting	Allocation to Risk Share
WISH - Wokingham Integrated Health & Social Care	184	£1,775	£326,600	11%	£51,391
Step Up	78	£1,775	£137,563	5%	£21,646
CHASC - Community Health and Social Care	166	£1,775	£294,650	10%	£46,364
Care Homes - Rapid Response & Treatment	80	£1,775	£142,000	75%	£357,947
Total	**508**		**£900,813**	**100%**	**£477,347**

Figure 13: Wokingham's allocation of risk share across schemes 2018/19

Scheme	Levels of activity	Average unit rates	NEA Avoidance savings £000's	Weighting	Allocation to Risk Share £000's
WISH - Wokingham Integrated Health and Social Care	184	£1,775	£326,600	5%	£22,122
Step Up	186	£1,775	£330,150	5%	£22,362
CHASC - Community Health and Social Care	332	£1,775	£589,300	8%	£39,916
Care Homes - Rapid Response & Treatment	80	£1,775	£142,000	75%	£357,947
Total	**782**		**£1,388,050**		**£442,347**

6.4 Contingency Funds

We have 2 contingency funds within our plan and are detailed in the table below.

	17/18 £k	2018/19 £k
Wokingham contingency	113	57
CCG contingency	57	47

There is a process through WISP for the allocation of any contingency funds. The WISP partners would review request and through our new Section 75 partnership agreement the funds would be allocated.

7. National Conditions

7.1 National condition 1: jointly agreed plan

This Plan was jointly agreed by WISP on the 6 September 2017. The BCF plan covers the minimum fund specified in the Spending Review and has been through the individual governance structures within commissioning organisations for approval and subsequent approval by the HWB. Health and social care providers evaluated the Wokingham 201616/17 schemes along with other stakeholders agreed the continuation and business cases through WISP. At a more strategic level both main provider trusts have articulated the impact of the BCF in their operating plans.

WISP meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

Going forward with our BCF plans, we expect that BHFT, RBFT, local GPs, ASC and Involve will all continue to be part of the integration implementation teams. Providers are represented on WISP and are invited to HWB on a regular basis to present information on specific issues.

WBC was awarded £806k of Disabled Facilities Grant (DFG) funding in 2017/18, an increase of £73k (8%) on 2016-17. Within the DFG, an allocation of £82k has been

set aside to support the development and roll out of assistive technology across Wokingham. Appendix 10 - DFG Budget 2017/19 contains further information and detail.

Funding for DFGs is transferred from BCF to WBC Housing where it is managed as capital funding in line with its DFG policy, supporting people to remain independent and living in the community.

7.2 National condition 2: social care maintenance

The 2017/19 BCF plan aims to maintain a consistent level of protection of social care with the BCF funding.

CCG investment of £7.64m in 2016/17 has been increased in line with the NHSE guidance on growth figures of 1.79% to £7.78m in 2017/18, and by a further 1.9% to £7.92m in 2018/19.

Figure 14: 2017-19 Gross Contributions

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total LA contribution exc. iBCF	£1,919,863	£1,973,546
Total iBCF contribution	£169,002	£112,780
Total minimum CCG contribution	£7,777,052	£7,924,816
Total additional CCG contribution	£0	£0
Total BCF pooled budget	**£9,865,918**	**£10,011,142**

The use of this funding covers a range of schemes that will add stability to the local social and health care system, including continued investment into an integrated model of reablement. The existing investment has been reviewed in-year and as part of the two year consultation around jointly commissioned community services.

Wokingham confirms that all partners will continue to meet or exceed contributions agreed via a system-wide approach related to maintaining social care contributions as seen in Figure 15 below. The 2017/19 plan confirms the social care spend from CCG minimum has been uplifted by 1.79%/1.9%, with amounts of £3.66 m/£3.73m for 2017/18 and 2018/19 respectively.

Figure 15: Underlying social care spend schemes

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Comments
1	Health and Social Care Hub	2. Care navigation / coordination	2. Single Point of Access		£16,038	£16,038	
2	WISH3- CCG/LA (fund/provide)	11. Intermediate care services	5. Other	£329,000	£292,590	£381,669	HLT, reablement, Rapid, discharge. In 17/18, includes funding Health Liasion Team previously funded by LA. In compliance to NC2.
2	WISH - Time to Assess (Step Down)	11. Intermediate care services	1. Step down	£282,700	£157,744	£157,744	SUSD is split in to Step Down and Step Up
	Domicilliary Plus	Intermediate care services		£76,300			service ceased due to lack of demand
8	CHASC Community Health and Social Care	2. Care navigation / coordination	1. Care coordination		£132,395	£150,993	
21	CCG Carers Fund - LA host	3. Carers services	1. Carer advice and support	£278,000	£195,387	£195,387	Split into two. See below
23	Protection of Adult Social Care	16. Other		£944,000	£960,898	£960,898	
24	Care Act	3. Carers services	2. Implementation of Care Act	£180,639	£183,222	£183,222	
27	Wokingham Contingency - new	16. Other			£68,476	£31,891	
29	IMHA	16. Other			£39,000	£39,000	
30	S256 LA spend	16. Other		£1,506,000	£1,532,957	£1,532,957	
21	Carers Funding - prevention - YPWD+SA	3. Carers services	1. Carer advice and support		£82,613	£82,613	Split away from 11 - CCG Carers Fund
			Total	£3,596,639	£3,661,320	£3,732,413	
					1.80%	*1.94%*	

N.B. Scheme 2 – WISH 3, consists of reablement, rapid response and hospital discharges and Health Liaison Team. WISH 3 has been uplifted the meet National Condition 2 by funding Health Liaison Team £104k which was previously funded by WBC. WBC has agreed to fund an equal amount in BHFT reablement £104k service in WISH2.

The preparation of our BCF plan has been undertaken alongside the planning rounds of both WBC and the CCG and the funding has been aligned to both plans. The approach to planning for the BCF has been consistent with the Department of Health guidance for funding transfers to social care.

Both organisations face increasing cost pressures and savings targets. The schemes within the plan have therefore been identified to specifically address the area of intermediate care services which supports the aim of the plan and will mitigate these key factors.

The protection of social care covers areas of ASC spend which have an indirect impact on prevention such as provision of good quality, fit for purpose, accessible housing, support to the care market, and reablement pathway redesign. Our 2017/19 Plan has built on previous years and continues to invest in schemes which support reablement and step down services. Figure 16 below shows the planned expenditure and percentage of investment by type of scheme.

Figure 16: Social Care spend by type

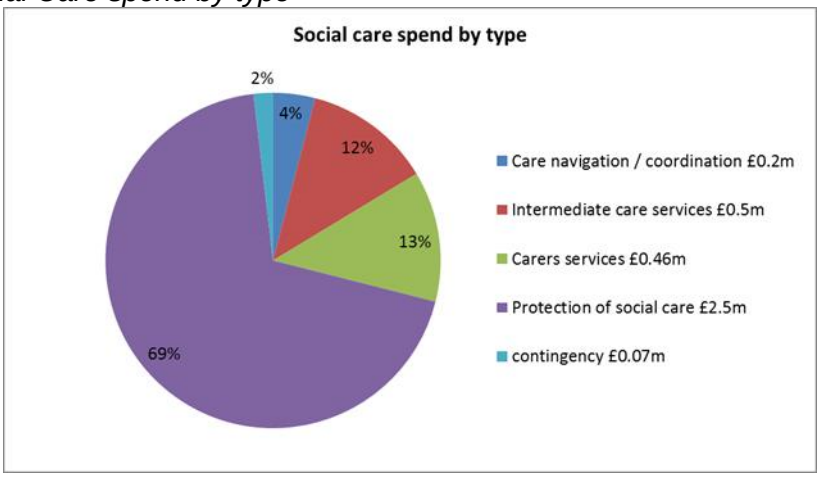


Figure 16 shows that £0.60 m, 25% of the planned social care spends, is from the CCG minimum contribution funds schemes for the integration of health and social care. Funding for Protecting ASC, Care Act duties and S256 has been uplifted by 1.79% in 2017/18. At this time funding for 2018/19 has not been uplifted but will be reviewed during 2017/18 replan with the intention to uplift by at least 1.9%.

7.3 National condition 3: NHS commissioned out-of-hospital services

The CCG minimum allocation for NHS commissioned out-of-hospital services for 2017/18 is £2.21m and for 18/19 is £2.25m, showing that the minimum has been exceeded for both years.

Figure 17 shows how the funding is made up within the plan and the minimum has been exceeded in both years.

Figure 17: Out-of-hospital services scheme funding

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	2017/18 Expenditure (£)	2018/19 Expenditure (£)
2	WISH4 - Rapid response	11. Intermediate care services	3. Rapid/Crisis Response	£345,655	£345,655
3	Step Up - new scheme	11. Intermediate care services	2. Step up	£60,800	£120,000
40	CCG reablement funds	11. Intermediate care services	4. Reablement/Rehabilitation services	£662,153	£677,118
41	BCF BW10 programme office	7. Enablers for integration	3. Programme management	£110,000	£110,000
42	CCG Contingency	16. Other		£56,853	£47,320
43	Risk Share performance fund	16. Other		£477,347	£442,347
6	Care Homes	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£207,106	£207,106
11	Speech and Language Therapy	16. Other		£54,749	£55,986
11	Care Home in-reach	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£165,280	£169,015
11	Community Geriatrician	12. Personalised healthcare at home	2. Other - Physical health / wellbeing	£143,587	£146,832
11	Intermediate Care including integrated discharge, discharge to assess services	11. Intermediate care services	4. Reablement/Rehabilitation services	£686,945	£702,470
11	Health Hub	2. Care navigation / coordination	2. Single Point of Access	£314,032	£321,129
11	Intemediate Care - night sitting, rapid response, reablement and falls	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£337,791	£345,425
13	SCAS Falls & Frailty	11. Intermediate care services	3. Rapid/Crisis Response	£35,000	£70,000
			Total	£3,657,298	£3,760,404

As outlined in the 2016 BCF submissions for all three local authorities in Berkshire West, we have identified five key NHS commissioned Out of Hospital service investments which sit within the scope of the BCF and it is our intention that these will be carried forward into the 2017/19 plans. These out of hospital services were chosen due to their potential contribution either directly or indirectly to reducing delayed transfers of care, non-elective admissions and supporting effective reablement across the system. For 2017/19 we plan to revise our KPIs where possible for these service lines so as to improve the monitoring against these key performance indicators. We will also continue to review the service lines on a quarterly basis, through the BW10 Delivery Group and to review levels of investment versus impact and make any necessary substitutions or additions with other out of hospital services as part of our integration journey.

The specific services constitute a small proportion of a much wider range of services provided within a block contract held by the Berkshire West CCGs with BHFT, our main community and mental health provider. The specific services are listed in Figure 18 below:

Figure 18: OOH BCF Contribution

OOH Service description	BCF Measure Contribution
Adult Speech & language Therapies	NEAs / Reablement
Care Home In-reach support	NEAs/DToC
Care Of the Elderly (Community Geriatrician Service)	NEAs/DToC/Reablement
'WISH' for Wokingham - Intermediate care (Includes rapid response, night sitting, equipment, integrated discharge team, intermediate care services and reablement	NEAs, DToC
Berkshire Integrated Hub - Single Point of Access	NEAs/DToC/Reablement
DFG	Reablement

During 2016/17 we have reviewed the services above and have identified the importance of each service function in stemming the flow of rising non elective admissions and in particular avoiding care home admissions and ED attendances. Intermediate care, night sitting and reablement have also been significant contributors to help manage delayed transfers of care. The BIH operates as a 24 hour, 7 day a week service.

The key objectives of our services are to:

- Promote independence and improved quality of life for the population of Berkshire West through the delivery of community services to residents in their own homes and in places of residential care.
- Provide support to carers and other health and social care colleagues to facilitate effective care for people with acute and long term health care needs across Berkshire West.
- To contribute to baseline reduction in non-elective admissions, admissions to residential care, DToCs and reablement across Berkshire West.
- Support baseline demand management for urgent care by contributing to the avoidance of ED visits across Berkshire West.

7.4 National Condition 4: Managing Transfers of Care

Our 2017/19 DToC Action Plan, which can be found in **Section10**, sets out our approach to implementing the eight High Impact Changes for Managing Transfers of Care. This plan sets out specific actions which will be collaboratively undertaken by our system partners to deliver each of the eight High Impact Changes, ensuring measured steps are taken to reduce DToC rates within Wokingham. The metrics we submitted to reduce our DToCs are set out at **Section 10**.

The local schemes which support the managing of transfers of care are:

- The Berkshire Integrated Hub.
- WISH – including Step Down.
- Step Up.

In May 2017 the BCF Project leads undertook a self-assessment of the High Impact Change Model, in order to support the development of the DToC action plan, a summary is below:

Figure 19: Wokingham's Self-Assessment against High Impact Model

High Impact Area	Where we are at	Where we are going
Early Discharge Planning	Established	→ Mature
Systems to Monitor Patient Flow	Established	→ Mature
Multi-Disciplinary/Multi Agency Discharge teams	Established	→ Mature
Home first Discharge to Assess	Established	→ Mature
Seven Day Services	Mature	Signs of Exemplary
Trusted Assessors	Plans in Place, working in Partnership	→ Established
Focus on Choice	Established	→ Mature
Enhanced Health in Care Homes	Mature	→ Exemplary

7.4.1 Trusted Assessment

Trusted Assessment is one of the 3 key work streams of the Getting Home project which takes a Berkshire West wide approach. It plans to explore examples of 'Best Practice' used in other areas and then agree a trusted assessment process based on a key worker approach who can undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols. The plan is that the inpatient therapists will share their assessments as part of this.

A successful trusted assessor workshop was held in May 2017 with stakeholders across Berkshire West. The focus was to understanding what is meant by a trusted assessor, the operational challenges faced, how to overcome them and what a good trusted assessor approach looks like.

This led to a decision to focus on the reablement pathway. A smaller task and finish group has developed a standard operating procedure, agreed the use of a single referral form and a shared care plan. A scoping exercise is underway and to be completed in September 2017. This will include agreeing a set of targets, who and what is being assessed, agree who can be the trusted assessor, a robust feedback loop and the review mechanism. The group will also explore the option of including the care home element. A pilot will run for 3 months will a provisional start date of October 2017.

In addition to this a small pilot was started in Hurley Ward, RBFT, in June 2017 using the 'discharge to assess' model and the trusted assessor approach. A process was agreed with each locality. The RBFT occupational therapists from Hurley ward being the trusted assessors taking patients home and assessing them in their home with the view to reducing the package of care and freeing up a hospital bed. This pilot will be reviewed at the end of September 2017.

At present within RBFT, an Integrated Discharge Service (IDS) exists to support assessment and discharge. A single IDS referral form has been agreed and signed off, providing a basis for subsequent referrals and assessments reducing duplication.

CHASC plans to link with both Getting Home and Connected Care as it develops a single assessment process across community health, social care and primary care.

8. Overview of funding contributions

Figure 20 sets out the planned contributions for our BCF together with the previous year's figures for comparison. The first four rows are WBC's contribution with the remaining figures being the CCG's investment.

Figure 20: Funding Contributions 2017 - 2019

	2016/17 Gross Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Local Authority Contribution	£1,065,000	£1,070,000	£1,070,000
Carry forward of 16/17 scheme underspend	£101,000	£44,300	£25,000
DFG	£733,000	£805,563	£878,546
Total Local Authority Contribution excl iBCF	£1,899,000	£1,919,863	£1,973,546
iBCF		£169,002	£112,780
Total Minimum CCG Contribution	£7,640,291	£7,777,052	£7,924,816
Total BCF pooled budget	**£9,539,291**	**£9,865,918**	**£10,011,142**

The proposed funding has been included in both the plans and budgets of both WBC and the CCG for the year 2017/19.

The use of the BCF funding is to be agreed by both WBC's Section 151 Officer and the CCG Chief Financial Officer to give transparency on the use of funds for both organisations.

The total funding is shown within the planning template which has been signed off as per the sign off process detailed in **Section 1**.

8.1 Care Act

The BCF will contribute £183k towards WBC's implementation of Care Act. This has been uplifted by 1.79% from 2016/17. At present, 2018/19 has not been uplifted but will be reviewed during the 2017/18 replan with the intention to uplift by at least

1.9%. The funding will contribute towards WBC's costs for implementing Care Act duties.

8.2 Reablement

The existing BHFT contract is uplifted by 3.3% and 2.26%.

Funding for Reablement	16/17	17/18	18/19
- Existing BHFT contract	641	662	677
- Expand BHFT capacity	0	104	138
- Existing START reablement contract	342	347	347
- Expand START capacity		73	146
	983	1186	1308

The WISH team has budgeted an increased spend in reablement in health of £104k/£138k in 2017/18 and 2018/19. This raised an error in the Planning Template of sufficient "Planned Social Care expenditure from the CCG minimum". This could not be funded by the iBCF amounts allocated to Wokingham of £169k/£113k.

To meet the "Planned Social Care expenditure from the CCG minimum", WBC has agreed to fund this from its existing pooled budget. On a bilateral basis, the BCF CCG minimum contribution will fund social care services to the same amount.
The expansion of START capacity is dependent on recruitment. Homecare packages may be substitute to achieve a similar reablement outcome.

8.3 Carer's breaks

The CCG minimum contribution continues to fund £402k into carer support and the voluntary sector. The commissioning arrangements are changed for simplification. Whereas £278k of services were commissioned by WBC, in 2017/18 will be commissioned £195k/£83k by WBC/CCG respectively.

8.4 Social Care

Protection of ASC and S256 spend is increased by 1.79% in 2017/18 and this funding has been confirmed. As per **Section 8.1** 2018/19 funding maintenance will be confirmed during the replan stage.

8.5 iBCF

The iBCF funding has been formally acknowledged and the plan to spend this as outlined in **Section 5.1** has been through formal governance.

8.6 DFG

WBC has agreed with the CCG the use of DFG, which meets the conditions stipulated for its use. It was agreed to spread the funds across a range of schemes for a best outcome:

- Home adaptation £1.3m.
- Assistive technology £83k.
- Joined up approach to improving outcomes across health, social care and housing £35k.

The DFG total consists of £806 new allocation plus £624k carry forward.

	16/17	17/18	18/19
Disabled Facilities Grant	733	806	879
brought forwards	423	624	8
1) home adaptations	497	1304	803
2) use of technologies to support people in their own homes		83	70
3) joined-up approach to improving outcomes across health, social care and housing	35	35	0

9. Programme Governance

9.1 Current Governance

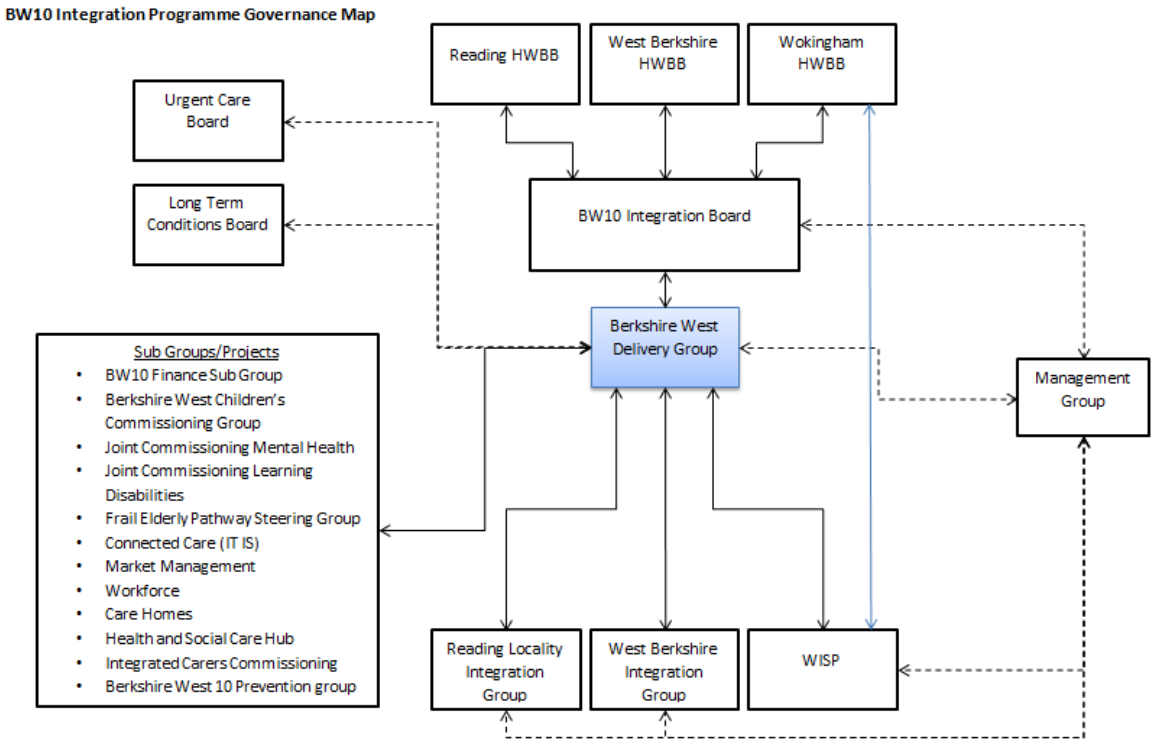
The HWB has a high-level oversight of this BCF plan, governed through WISP and delivered through a local implementation team. WISP specifically looks at bringing together management responsibilities and accountability across health and social care services locally.

The governance and operational structures, which set out the commitment, aims and practical supporting arrangements for joint working, are underpinned by legal agreements as follows:

- S113 agreements allowing managers with joint responsibility employed by either body to perform functions for and be accountable to the other body within an agreed HR framework and within the Schemes of Delegation of each organisation.
- S75 and s10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision.
- S256 agreements (both nationally required and local) to support expenditure on social care which has a benefit for health services.

Our governance structure and how it is integrated into the wider Berkshire West governance is in Figure 21.

Figure 21: BW10 Governance Structure



Because our local health and social care economy works across unitary authority boundaries, some of our BCF schemes are part of a Berkshire West programme. Therefore governance arrangements are also part of a BW10 Delivery Group and above that the BW10 Integration Board. Both Boards have representatives from each of the partner organisations. The Boards:

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

Senior leaders from the Berkshire West Health and Well-Being boards meet on a monthly basis in the BW10 Integration Board.

9.2 Governance Plans for 2017/19

As we move forward within 2017/18 we plan to our enhance Section 75 agreement to work alongside the Berkshire West ACS with a memorandum of understanding of partnership working between commissioners and providers. The purpose of memorandum aims to strengthen the relationship between commissioners and

providers together around a common aspiration for joint working across the Wokingham system. It will set out a number of shared objectives and principles, and a newly formed governance structure allowing providers to come together to take decisions.

Our proposed enhanced governance seeks to widen the focus of schemes and will draw up our draft expenditure plan for 2017/19 to meet the BCF policy framework March 2017. For example during this year we shall be expanding our plan to incorporate mental health services. All new projects and schemes within BCF go through an Equality Impact Assessment process as part of the development of full business cases. The proposed changes will build on our existing leadership and governance.

More detail can be seen in Appendix 4 - Proposal for Wokingham Adults Integrated Health and Social Care Governance

9. National Metrics

Our BCF schemes support the delivery of the BCF National Metrics. A summary of the impact of the schemes can be seen in Appendix 8 BCF Summary on a Page 2017 -2019.

We also have a wide range of local metrics to ensure balance with the national metrics. Our three key local metrics are:

1. To ensure that we reduce pressure, improve flow in the system and provide better local crisis management we will be monitoring ED attendances for users in Wokingham.
2. To ensure that MDTs are able to support the top 10% of users of services we will be monitoring the number of users reviewed and the impact of the intervention on NEAs, ED attendances and use of out of hours services.
3. To monitor residents ability to manage their own health and well-being we will be monitoring self-reported improvement in their health and wellbeing following contact with Community Navigators.

Our BCF Dashboard in Appendix 5 monitors both the national and local metrics and has been considerably redeveloped in 2016/17.

9.1 Non-elective admissions

We achieved our performance in 2016/17 by integrating health and social care teams (WISH); investing £150k in nurse led rapid response; proactive identification of users with multiple conditions combined with an MDT meeting and highly developed reporting, all of which supported our success. Figures 22 and 23 show our NEA performance.

Figure 22 - 2015/16 vs 2016/17 NEA performance in 75+

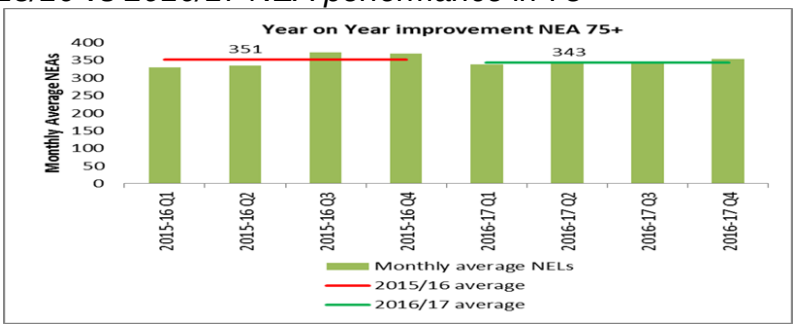
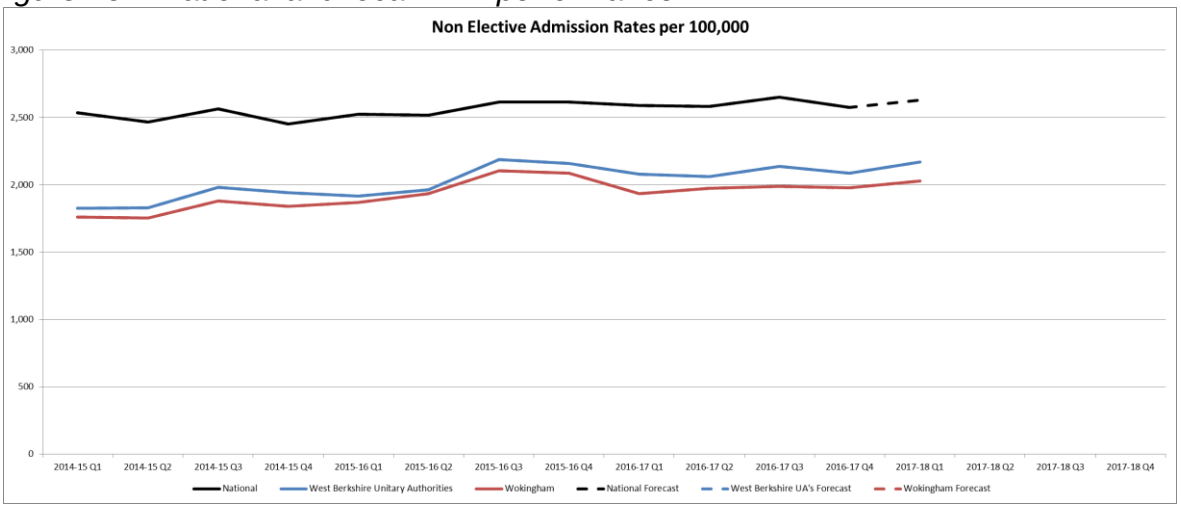


Figure 23 – National and local NEA performance



Our performance over the last 4 years can be seen below and we remain in the upper quartile for NEA performance in England.

Year	Total Wokingham NEAs (general & acute), all-ages	Percentage change in NEAs on previous year
2013/14	10,470	N/A
2014/15	11,586	11%
2015/16	12,940	12%
2016/17	12,845	-1%
2017/18	12,612	-1.8%

The CCG operating plan for NEAs was set following the NHS planning rules and includes IHAM (Indicative Hospital Activity Model) growth including demographic growth and a QIPP reduction with a net reduction of 1.8% against 2016/17 out turn. The net reduction target of 1.8% will be a real challenge considering that we are already a high performing system, therefore reductions in NEAs for 2017/18 are challenging.

Based on analysis of year to date performance, and realistic impact of BCF schemes, we have no additional NEA reductions planned for our BCF plan and we are continuing to investigate the inconsistencies, which appear to be a national issue post submission and we expect to revise our submission accordingly.

2017/18 Quarter 1 NEA performance was 5% greater than Q1 2015/16 and 9% greater than the 2017/18 plan. Our plan is currently set as a reduction of 1.8%, which we already believed to be an extremely ambitious target. CHASC and Step Up will be coming on line in Q3 and Q4 which may support us to improve on our current position. We are currently investigating all the reasons for Q1 performance and if we will be able bring performance in line with the plan.

The following BCF 2017/19 schemes will have an impact on NEAs:

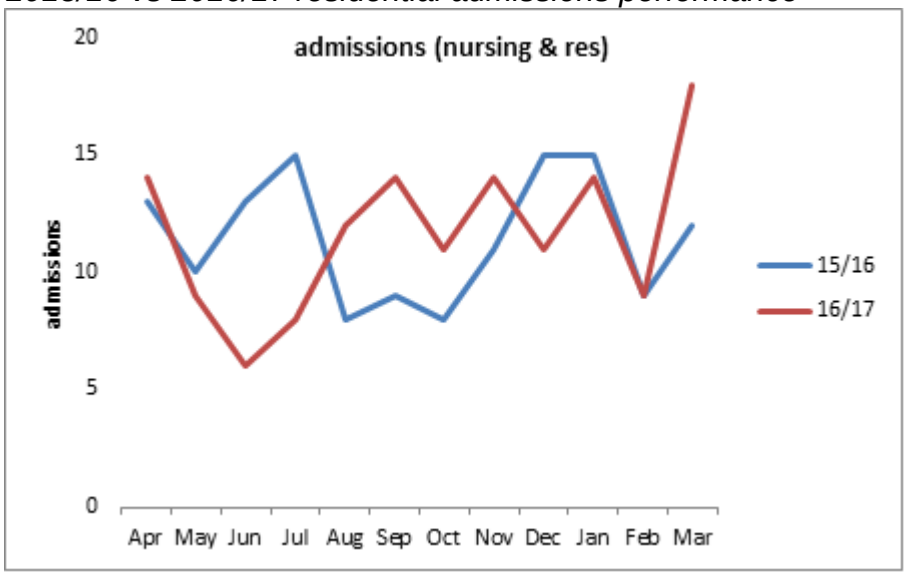
- **WISH** – Rapid response services will have some capacity increases and therefore be more responsive to avoid NEAs.
- **CHASC** – reviewing and scaling our current MDT process to support the top 10% of service users and therefore preventing them from reaching crisis and requiring admission. In 2016/17 we demonstrated a 64% reduction in NEAs for those users who have had an MDT.
- **Step-up** – introducing sub-acute beds in the community setting preventing acute hospital admissions.
- **Falls & Frailty** – This service is both a BCF and QIPP scheme and started as a pilot in October 2015. It involves an advanced paramedic and therapist in a fast response car and has demonstrated excellent outcomes in reducing conveyance rates and thus admission to hospital.
- **Berkshire Integrated Hub –** acts as an enabler reducing NEAs by acting as the single point of access with pathways that ensure that referrals are received in a timely manner and directed to the most appropriate service for need.

The NEA reductions for the above schemes were calculated based on performance in previous years to provide realistic targets for the schemes.

9.2 Admissions to residential care homes

We sustained our performance in 2016/17, with a minimal increase of 2 new admissions than 2015/16. Figure 24 shows our 2016/17 admission trends vs 2015/16, which shows our sustained performance.

Figure 24: 2015/16 vs 2016/17 residential admissions performance



In 2016/17 we have been working hard to keep people in their own homes rather than entering permanent residential placements. Part of this has been through introducing extra care places in the Borough, giving individuals the ability to maintain their independence, through WISH and stay local with support available 24/7 as well as developing Step Down beds.

Our target for 2017/18 is no more than 129 new admissions to residential care homes; this would be 11 less placements than 2016/17. For 2018/19 the target is 131. These targets have been agreed by the operational teams and are based previous year's performance and the plans we have within our schemes for a downward trajectory.

2017/18 first quarter performance is very promising with 26 new to residential and nursing care homes admissions versus a planned target 32. We have to be a little cautious as these numbers do get revised as we get more information from the commissioning teams and care homes.

The following BCF 2017/19 schemes will have an impact on care home admissions:

- **WISH** – Increased capacity with the Reablement service provided by ICT and START enables more people to remain in their own homes for longer, along with the social care team being integrated, providing a more holistic care plan.
- **Step Down** – Delivery as a 'time to decide' model for 2017/18, which has demonstrated in other areas nationally to reduce care home admissions
- **Step Up** – Prevent admissions to the acute hospital with a clear 7 day pathway focussed on reablement.
- **Getting home** - Reduced delays in the wrong setting has a detrimental effect on a person, both physically and mentally, by improving the flow of people through the system, people will be kept in the right place, which maximises independence and reduces the need for long-term care
- **CHASC** - by integrating the long term health and social care teams, social and health care pathways will improve and closer working between them will enable better information for social care assessments therefore brokers can negotiate the most appropriate placements. Earlier intervention in a disease journey will reduce the demand for placements in the longer term.

9.3 Effectiveness of Reablement

There are a number of reasons why we did not improve our performance of the 91 day target in 2016/17:

- Lack of focus on this target.
- Data for this was coming from ASCOF and therefore only the social care reablement data was being captured and not health.
- Ineffective reporting for prior years.

We therefore believe that as we have now resolved the data capture and reporting issues that for 2017/19 we have a target of 74% for 2017/18 and 85% for 2018/19. We have set these targets with the Head of WISH who is certain that once the reporting errors are resolved that the targets are achievable.

2017/18 first quarter performance is not currently available due to some local recording issues that are currently being corrected. We expect to be able to start reporting by October 2017.

The following BCF 2017/19 schemes will have an impact on the effectiveness of reablement:

- **WISH** – Additional funding of £104k for ICT and £73k for START, will make the services more responsive and have increased capacity.
- **Step Down** – The scheme has moved under the management of WISH for 17/18 as part of their suite of reablement services, the right pathways can then be implemented.
- **Step Up** – Focuses on reablement following a sub-acute medical deterioration, and will reduce user's lengths of stay as not in a large acute hospital, which lead to improved reablement outcomes.
- **Getting Home** – Improved flow through the system and avoiding admissions all support the reablement of users in the community.

10. Delayed transfers of care

DToC planning for 2017/18 has been produced in line with the request from NHSE and DOH which requested reduction of delays in terms of average bed days in hospitals.

Figure 25: Wokingham's 2017/18 DToC trajectory

Adult population of **Wokingham**		123,900		
NHS	**Social**	**Both**	**Total/month**	**Total/year**
190	90	40	320	3840
*Using population figure above, 3,840 equates to **8.5** DToC per 100,000*				

Our agreed target for 2017/18 is realistic but ambitious and Figure 26 shows the DToC plan split by organisation.

Figure 26: DToC Trajectory by organisation

Organisation	**Total days delayed (or less) per month**	**Total days delayed (or less) per quarter**
RBFT	173	519
Wokingham Community Hospital	78	234
Mental Health (Prospect Park Hospital)	50	150
FPFT + Other hospitals	19	57
Total	**320**	**960**

The target has been set in this way having given consideration to the delays which WBC is unable to speed up or influence. These continue to account for approximately 70% of our total days delayed, with 38% of this figure being self-funder delays, where the Choice Policy would need to be implemented robustly by the acute and community hospitals to help to reduce this figure. Figures for 2016/17 did not include the mental health delays however these have been included for 2017/18 based on the last year's performance.

In order for RBFT to achieve its target of no more than 3.5% of beds occupied by DToCs, we must have no more than 207 delayed days per month and have set a target of 173 for RBFT, as we believe we can achieve this stretching target with our integrated team.

Our DToC action plan has been developed with all partner agencies across Berkshire West, led by the A&E Delivery Board and is in Figure 27. Governance and oversight of the DToC Action Plan is delivered through a multi-agency WISP which reports back into the A&E Delivery Board, with remedial actions for non-delivery. The DToC metrics agreed have also been shared at the A&E Delivery Board and with each organisation individually.

In Quarter 1 our main aim for DToC's was to sustain our performance. We had a total of 744 delayed days against the plan of 960 and we are delivering against the 3.5% target for the RBFT. We have shared our DToC good practice with the Reading and West Berkshire localities at BW10, to help build a robust approach to DToC across Berkshire West.

We have received minimal iBCF funding which limits further improvement – we can however maximise the current services to manage the DToC delays and ensure that we sustain our current position.

Figure 27 – Wokingham's 2017/18 DToC Action Plan

High Impact Change Area	Action	When
Early discharge planning	• Contract with British Red Cross to support discharge for customers with low level of support network, working jointly with the assessor – **Improve** • Social Worker engagement starts early after admission so that we minimise assessment delays once patient is medically fit - **Sustain**	August 2017
Systems to monitor patient flow	• Having identified customers requiring EMH services where placements can be slow to arrange or become available, by making use of the respite beds for discharge to assess for Social Services funded customers who require EMH residential or return home with high level support - **Improve**	Service level agreement – September 2017
Multi-disciplinary/multi-agency discharge teams (including the voluntary and community sector)	• See Trusted Assessor below - **Sustain** • Project with BHFT – reconciliation of DToC recording, prior to submission to the DoH, have been errors, look to work together to improve accuracy - **Improve**	Review October 2017

Home First/Discharge to Assess	• Work in progress to refine eligibility criteria (in line with the Care Act) and response times with START to achieve 2 hour response to referrals, with service starting promptly to facilitate discharge – **Sustain** • Agreement with extra care schemes to allow tenants to return to their homes following a significant change in need with high level support whilst alternative accommodation is being arranged -**Sustain**	October 2017 June 2017
Seven day services	• Social Worker onsite on Saturday morning - attends the Saturday morning ED meeting for any actions required to prevent an admission. Out of working hours referrals are made directly to Rapid Response to avoid admission – **Sustain**	Review June 2018
Trusted Assessors	• Working with the BW10 Project leads on the Getting Home project to implement Trusted Assessors and MDT working on the acute site	October 2017
Focus on Choice	• An Independent Broker to advise and support self-funding patients. Monitor to ensure sufficient capacity to meet demand – **Sustain** • The Trusts have implemented the Choice Policy - **Sustain** • Work with commissioning and intelligent purchasing to ensure there are sufficient agencies registered with WBC to provide choice - **Sustain**	October 2017 Quarterly capacity review & actioned accordingly
Enhancing health in care homes	• Rapid response and treatment team are working within care homes to support residents to avoid unnecessary admissions into hospital -**Sustain**	April 2017

12. Approval and sign off

The Better Care Fund plan 2017-19 was signed off by the following representatives:

Signed on behalf of Wokingham Clinical Commissioning Group:

Date: 11th September 2017

Dr Cathy Winfield, Chief Operating Officer

Signed on behalf of Wokingham Borough Council:

Date: 11th September 2017

Judith Ramsden, Director of People Services

Signed on behalf of Wokingham Health and Wellbeing Board:

Date: 11th September 2017

Councillor Julian McGhee-Sumner, Chair of Health and Wellbeing Board and Executive Member for Adults' Services

The plan will be ratified by the Wokingham HWB on 12th October 2017 and Wokingham CCG Council on 19th September 2017.

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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
14 December 2017	**Place and Community Partnership proposal update**	To discuss the proposal from the Place and Community Partnership	Update	Place and Community Partnership / Judith Ramsden/ Councillor McGhee Sumner/ Darrell Gale	Organisation and governance
	West of Berkshire Adult Safeguarding Report 2016-17	To monitor performance	To monitor performance	Judith Ramsden, Director People Services	Performance
	Health and Wellbeing dashboard	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Action Plan dashboard	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	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	**Public Health Outcomes Framework - exceptions from each quarter**	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Action Plan dashboard	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Progress report on the Health and Wellbeing Strategy action plan	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	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 Action Plan dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	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	