BW10 INTEGRATION PROGRAMME

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

Project Initiation Document

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BETTER CARE FUND REF:
BCF 08

PROJECT/ SCHEME NAME AND BRIEF DESCRIPTION

This paper sets out the business case for continued BCF funding in 2016/17 for the Community Health and Social care project.

The Community Health and Social Care projects overarching aim is:

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

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

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

- Pro-active care
- People will only need to tell their story once
- Everyone will have a single care plan
- People will have an accountable key worker
- Reduce duplication of effort by providers

The benefits the project plans to deliver are:

- Reduced NELs
- Reduced A&E attendances
- Reduced/delayed cost of social care packages

- Reduced/delayed care home placements in the long term
- Improved satisfaction of care
- Care and support are centred on the person's needs
- People have a high quality of life, and enjoy their improved health status
- People feel empowered, capable of and engage in self-management
- Care is of high quality and safe
- People experience pro-active, coordinated care and support
- Reduction in use of GP appointments for non-medical problems

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

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

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

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

The proposal requires gross investment of £688,722 up to 20/21 and will deliver gross savings of £1,614,026 at the end of year 20/21. The project is expected to return a net saving in 2018/19 and with savings expected to continue. The funding source is the BCF.

SENIOR RESPONSIBLE PERSON (SRO)	PROJECT / SCHEME MANAGER
Stuart Rowbotham, Director Health and Wellbeing Wokingham Borough Council **Katie Summers, Director of Operations, NHS Wokingham CCG**	**Rhian Warner, Project Manager**

Contents

Purpose of Document

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

Specifically the paper aims:

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

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

Recommendations

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

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

Section 1 – Project Definition, Description & Purpose

Strategic Case – Project Description and Aims

1.1 Background

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

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

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

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

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

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

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

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

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

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

- The continuing financial pressures, both Health and Social care budgets need to be made financially viable for now and the future, eliminating inefficient duplication of work and hand offs between parties.
- Primary care is under pressure and is at risk of falling over due to workforce issues, the development of Wokingham as an SDL (strategic development location) and single handed practices no longer being

viable models of delivery.

- The 2015 Autumn Position Statement and Comprehensive Spending Review mandated Upper Tier Local Authorities and the NHS to deliver health and social care integration plans by April 2017 and full implementation by April 2020. Integration planning is consequently a condition of the 2016/17 Better Care Fund.
- Increasing demands on services - Complex patients in Wokingham Clinical Commissioning Group (CCG) account for 2% of the population and they form 14.9% of Wokingham CCGs spend on acute hospital care (out-patient appointments, A&E attendances and inpatient admissions), nationally this patient cohort spend is 15%. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system.
- In 2013/14[1] (Full data on the population and demographics for Wokingham Borough and Wokingham CCG can be found in Appendix 1 of this paper):
    - 30 patients had a total of 308 A&E attendances between them
    - 309 patients had a total of 2,649 outpatient appointments in an acute hospital setting
    - Wokingham's average complex patient has 5 inpatient admissions per year across 3 different conditions.
    - Wokingham's CCG spends most on Circulation, Cancer and Musculo-skeletal
    - 60% of these complex patients are aged 65 or over
    - 34% of these complex patients are aged 75 or over
    - 10% of these complex patients are aged 85 or over
- Feedback from service users – they feel that health and social care staff work in silos and that care is not joined up, the voluntary sector will become overwhelmed, services are not always accessible in an easy or timely manner.
- Not intervening early enough in a patient's disease journey, which creates bigger demands and greater need
- The population is getting older which will lead to greater care demands
- The prevalence of long term conditions is increasing as the population get older
- Traditional care services will not meet the demand for, and expectations of, care across the Borough's population possibly contributing to inequalities of health and wellbeing in Wokingham.

These drivers have led to:

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

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

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

1.1.2 Pyramid of Need - The projects target cohort

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

- Case Management- Very high intensity services users (and their carers) with complex co-morbidities, the top 2% of users. They require multi-disciplinary teams focussing interventions to avoid, anticipate

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

and manage crisis to avoid admission.

- Disease Management – High risk service users often with complex needs. They require responsive teams focused on managing disease and preventing further ill-health
- Supported Self-Care – Moderate risk service users (70-80% of LTC population). They require supported self-care to maximise independence involving third sector and voluntary organisations
- Prevention & Promotion of Wellbeing – Low risk service users, their carers and the general population. This group need to maintain health and well-being through healthy lifestyles within a cohesive community and might benefit from local information and support to self-care and enhance their health & wellbeing. This group would be predominantly supported by the Public Health services.

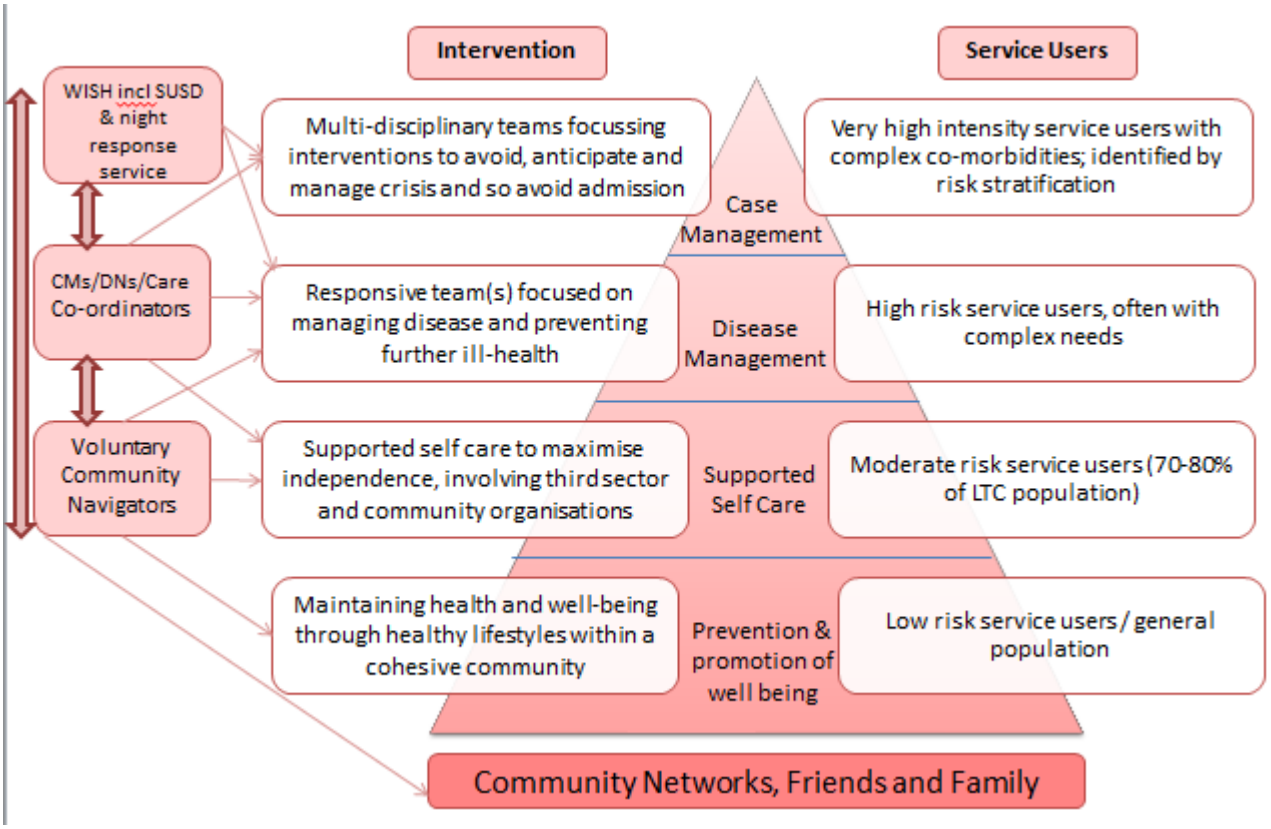


Figure 1 – Pyramid of Need

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

1.2 Strategic Fit

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

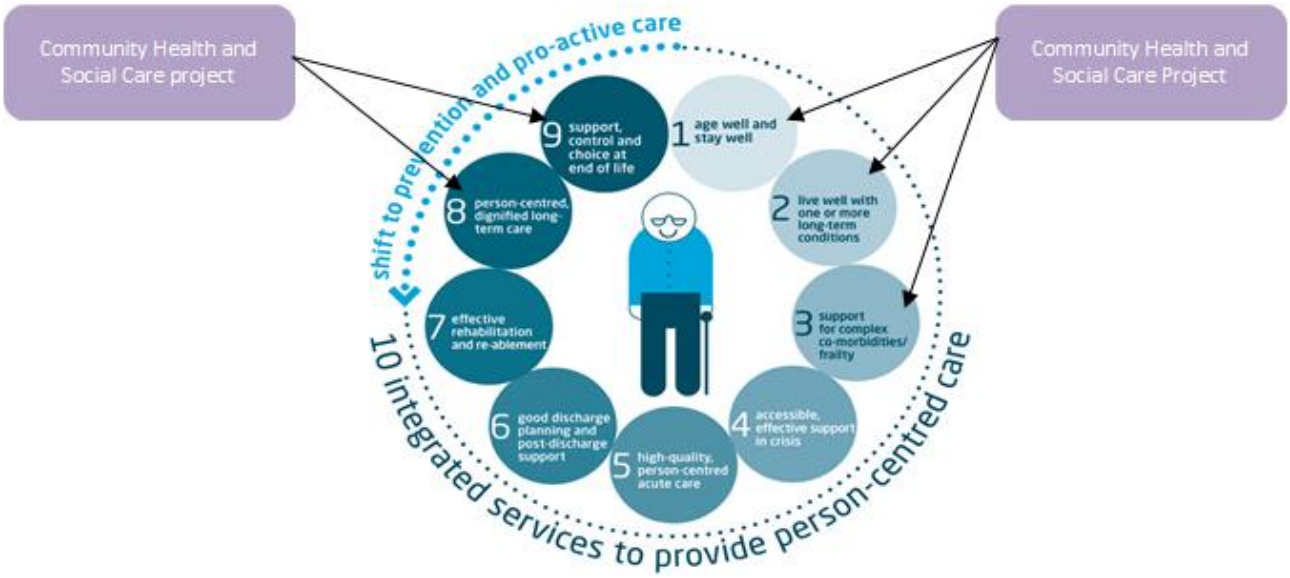


Figure 2 - Sam's Story – BCF 08

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

General practice is experiencing unprecedented workload and workforce challenges. When general practice fails, the NHS fails[2]. A big reason to develop CHASC is to provide practical help to sustain general practice right now. CHASC will support practices to work at scale and also to benefit from working with larger community based teams. CHASC opens up new options for partners, clinicians and managers.

Over time it should also help with managing demand for general practice, by building community networks, connecting with the voluntary sector, and supporting patient activation and self-care.

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

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

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

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

control as possible.

It provides an opportunity for Health and Social Care, working together to meet the requirements within:

- Care Act, 2014
- The NHS England Five Year Forward View, October 2014.
- The Berkshire West 10 Frail Elderly Programme (FEP) recommendations and implementation plan

Alignment to CCG objectives

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

Fit with CCG 16-17 Operational Priorities

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

Alignment with 16-17 BCF Priorities

- People's experiences of care
- Care outcomes in terms of changes to people's health and wellbeing
- Better use of resources.

1.3 Community Health and Social Care Overview

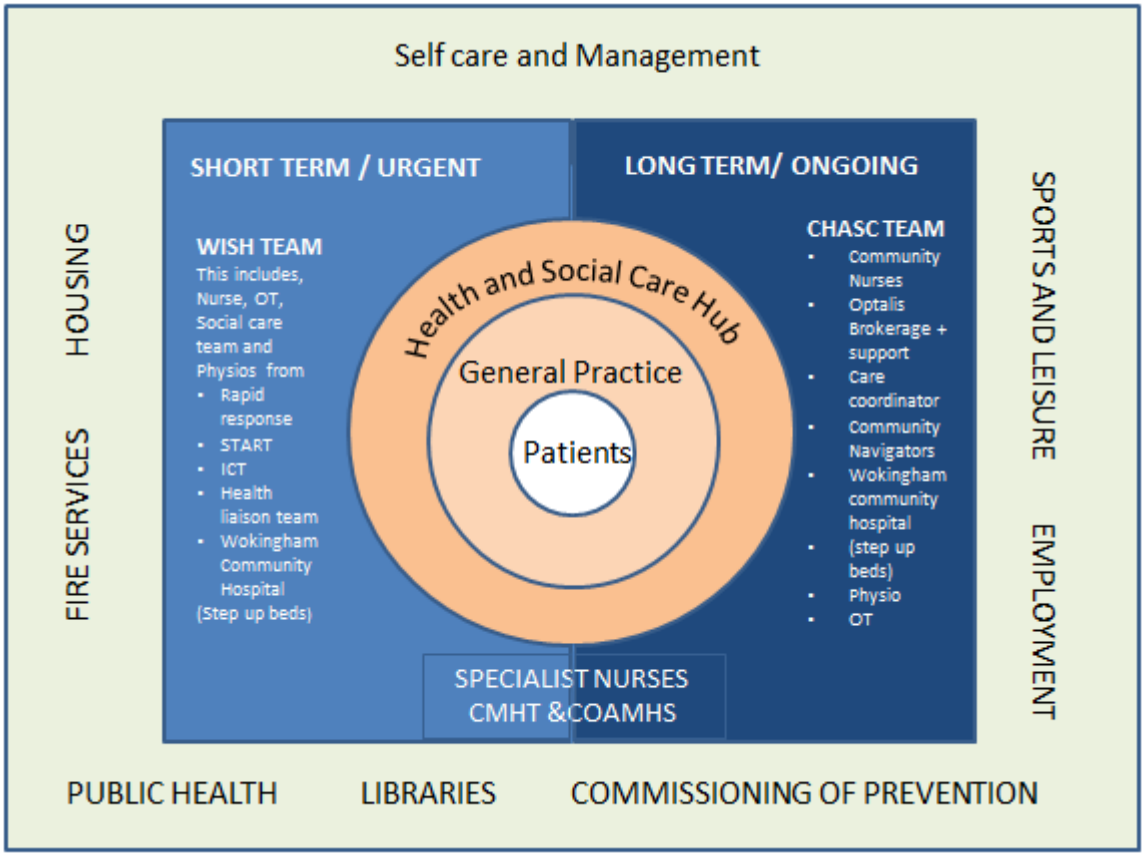


Figure 3 – The proposed system Model

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

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

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

We therefore need to design and deliver a service that:

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

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

Figure 4 – Proposed Localities
(Practices and changes in population from now to 2022 – taking into account new housing developments)

The idea of localities has emerged within the context of:

- The MCP vanguard results to date.
    - The building blocks of an MCP are the 'care hubs' of integrated teams. Each typically serves a

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

community of around 30-50,000 people. These hubs are the practical, operational level of any model of accountable care provision. The wider the scope of services included in the MCP, the more hubs you may need to connect together to create sufficient scale.
    - An MCP model is a place-based model of care. It serves the whole population, not just an important subset (such as people over the age of 65).
- Under-developed relationships between health and social care, housing and the voluntary sector, a particular issue given that some people receive care from all or many of these services
- Unwarranted variations in practice
- Local people telling us that they want better access to services and more joined up services
- Financial and demand pressures on the health and social care system, and the need to address these through new ways of working

The Community Health and Social Care project has 2 elements:

1. *Integration of long term health and social care* - Localities are being developed to focus service planning and delivery around local communities with the aim of more effectively coordinating care and support for people with complex needs and emphasising self-care and early, targeted prevention. Within each Locality, Primary Care, Community and Social Care teams will work together to provide integrated out-of-hospital services in the right place at the right time to improve outcomes and will work closely with appropriate local voluntary and community organisations to support people to self-care and prevent further ill health.

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

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

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

Social prescribing has been shown to:

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

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

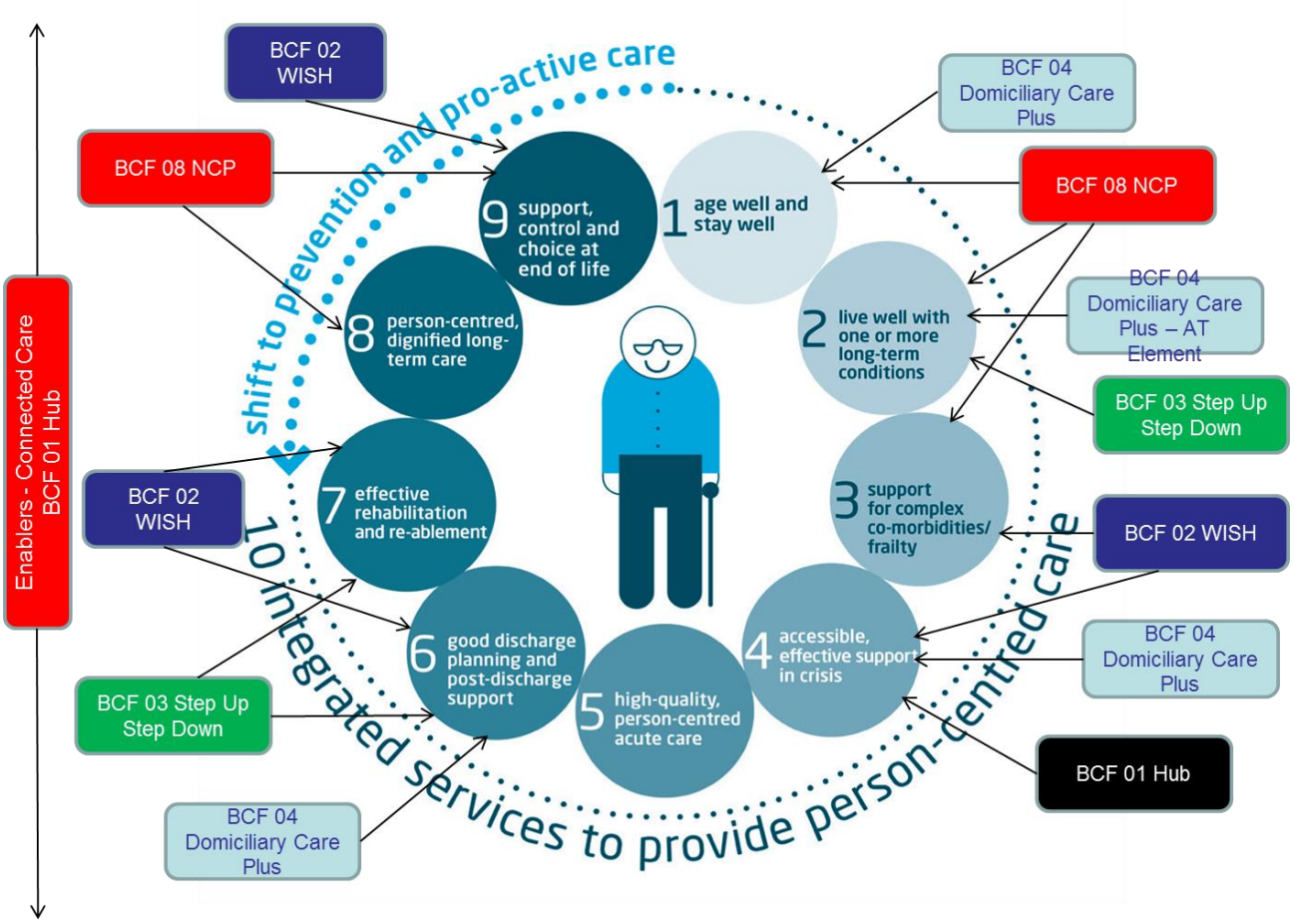


Figure 5 – Sam's story – Wokingham's BCF Programme overview

1.4 CHASC Aims and Impacts

The projects overarching aim is:

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

The objectives of the project are:

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

- Ensuring that the response is proportionate to the individuals needs

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

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

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

The impacts of the project will be:

- better health for the whole population
- reduced inequalities in access to health and social care, including improved access to the right service at the right time
- reduced variation in outcomes
- increased quality of care and safety for all patients
- better value for the taxpayer

- supporting people to live well in their own homes for as long as they wish and are able to
- improve patients experience of health and social care
- contribute to a more sustainable system for the future by reducing demand

1.5 CHASC - How are we going to do it?

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

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

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

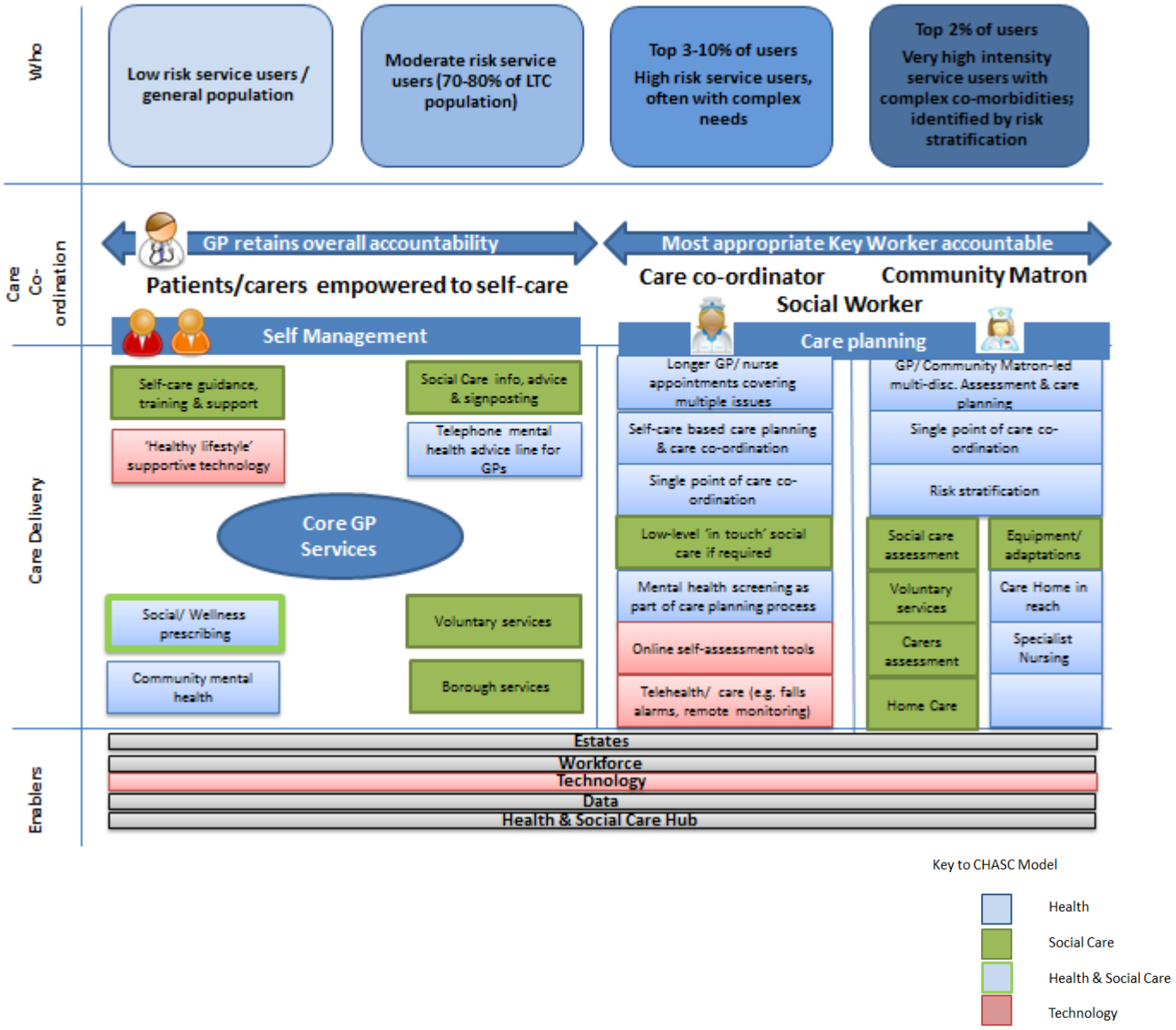
This Business Case lays the foundations for whole systems integration. Achieving the initial savings through the reduction in NELs is critical to enabling further investment in pro-active and preventative services, however through better co-ordination of existing services we can ensure that the benefits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

Key objective deliverables:

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

1.5.1 Proposed Care Delivery Model – LONG TERM CARE

Figure 6 – Proposed Care Delivery Model



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

The transformation of care involves major shifts:

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

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

main source of value is clinicians doing things to people.

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

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

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

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

Under the new model of care people will receive:

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

1.5.2 Phase 1 – Volunteer Community Navigator Scheme – delivery 16/17 in year

In order to keep users fit and well early intervention is required as shown in the proposed model. It is aimed at people who might benefit from local information and support to self-care and enhance their health & wellbeing; including low to moderate risk service users, their carers, families and the general public. The overall aim being to promote integrated health and social care, partnered with the voluntary and community sector by improving access to local voluntary and community resources by providing targeted, up to date information to service users and their families.

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

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

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

Service Description

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

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

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

Community Navigators will assist users by:

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

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

1.5.3 Phase 2a – Developing CHASC Model of Care (delivery in year 16/17) and Phase 2b - Implementing CHASC Model of Care (delivery Q1 & Q2 of 17/18)

Phase 2a - Developing CHASC Model of Care

The proposal requires significant organisational change and coordination across multiple organisations – GPs, BHFT, WBC, Optalis and Involve (voluntary sector). The current services are fragmented with many separate teams. The proposal is to form a single MDT team of social workers, nurses, MDT coordinators and volunteer community navigators to lead on assessment, care planning and coordination to improve the efficiency of the service.

The integration of services across organisations requires governance and accountability arrangements to be clearly set out. This work will be progressed through a RACI model as part of the next phase to prepare a detailed project plan by the end of November.

The MCP vanguard sites have shown that a single contractual solution is unlikely to work best everywhere. Three broad versions are emerging. The first is the ‘virtual’ MCP, under which individual providers and commissioning contracts are bound together by an ‘alliance’ agreement. The second is the ‘partially integrated’ MCP contract, the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration. The third is the ‘fully integrated’ MCP contract model with a single whole-population budget across all primary medical and community based services. For CHASC one of these options is likely to work.

The services in the system are commissioned currently by WBC and Wokingham CCG and this will continue to be the case. It is proposed in phase 2 that BHFT will be the single organisation that will manage and deliver the services provided in the system. In the medium term they will sub-contract services e.g. Optalis and Involve, in order that one organisation has the management and oversight of the whole system. There would also be a need for a partnership agreement between BHFT and the locality GPs around resources and care delivery.

It is also proposed that a Head Of Community Health and Social Care is employed, as soon as is practicable. This would provide the level of oversight required for the planning and development of the model and system.

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

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

Figure 7 - High Level Project Plan for Development of CHASC Phase 2a

Overall Project Fit	Objective	Implementation Milestone	Task Owner	RAG rating	01/07/2016	01/08/2016	01/09/2016	01/10/2016	01/11/2016	01/12/2016	01/01/2017	01/02/2017	01/03/2017	01/04/2017	Current Status/Additional
Community Health and Social care	Localities Development	Development of new system/services	RW												
		Continued comms and engagement around new locality service	RW												
		Contracting arrangements to be agreed	RW/SROs												
		Appointment of Head of CHASC	RW/SROs												
		CHASC Engagement and design sessions with staff	RW/Staff												
		CHASC Engagement and design sessions with public/users	RW/Citizens												
		KPIs - ensure all baseline measures and audit tools developed and agreed	RW/Head of CHAS												
		Appoint 3rd Locality MDT coordinator	BHFT Head of												
		Agree design of system/model of care	Steering Group												
		Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right	RW/Head of CHAS												
		Governance and Accountability arrangements across organisations required	RW/SROs												
		Delivery of statutory duties	RW/SROs												
		Revised MDT structure and delivery across localities	RW/Head of CHAS												

Phase 2b Implementing CHASC Model of Care

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

Figure 8 – High Level Project Plan for Implementation of CHASC Phase 2b

				01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017	01/10/2017	01/11/2017	01/12/2017	01/01/2018	
Localities Implementation	Implementation phase (6 months)	RW/ Operational Lead												
	Continued comms and engagement around new locality	RW												
	Alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS												
	Clarification of staff roles and responsibilities	RW/Head of CHAS												
	Reviewing and updating all processes to provide efficiency and consistency	RW/Head of CHAS												
	Review of health and social care pathways and integrate/update as required	RW/Head of CHAS												
	Improving the way in which professionals share information within and between organisations	RW/Head of CHAS												This will have dependencies with the Connected Care Project
	Single point of access to all services in CHASC	RW/Head of CHAS/Hea												
	A single physical location for health and social care teams as well as locality based locations and	RW/Estates/Head of CHAS												If appropraite, will be agreed during the planning phase
	Development and implementation of shared paperwork	RW/Head of CHAS												
	Development and implementation of single assessment	RW/Head of CHAS												
	Development of integrated policies and procedures	RW/Head of CHAS												
	Development of single shared risk stratification tool	RW/Head of CHAS												
	Investigate and implement technology where needed	RW												

1.5.4. Phase 3a – Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC – Now to May 2017) and Phase 3b Testing Phase with a single locality (September 2017 to December 2017)

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

The benefits to primary care will be:

- A reduction in the number of GP appointments for social problems, through the use of Volunteer community navigators and enhanced signposting. West Wakefield Health and Wellbeing Ltd MCP vanguard has increased the number of its patients signposted by care navigators by forty per cent over three months. A care navigation framework (directory of services) is embedded across practices and receptionists use this to signpost patients to cost effective and appropriate services to meet their needs in a timely manner.
- Provide alternatives to face-to-face appointments, including video calls, email and telephone consultations; and are also redefining professional roles. Modality MCP vanguard (Birmingham and Sandwell) recognised the high-level of smartphone use in its population. It developed an app that allows people to book appointments, send messages to clinicians, and receive real-time feedback. The participating practices are increasingly using Skype and the telephone for consultations, with 90% of such consultations obviating the need for a surgery visit. These initiatives have been associated with a 72% fall in 'did not attends' and were introduced as a response to a 10% rise in activity. Average remote consultation times have fallen to under five minutes, and 70% of patients say the new system has improved access.
- Provide accessible and responsive urgent and emergency care by delivering enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access. Integrated access means that the CHASC is able to appropriately divert a proportion of potential urgent and emergency care patients away from secondary care but ensure the patient has access to the right point in the system. Better Local Care (Southern Hampshire) MCP vanguard has created a 'same-day access service', which pools together the urgent workload for the participating GP practices into a single service that is operated from a central location and is resourced by the practices. In the six weeks from opening in December 2015, the service handled 5,500 patients - almost two thirds of whom had their needs met over the telephone.

Phase 3a - GP alignment in localities and formal agreement on working arrangement – between practices and CHASC

Considerations for this phase need to include:

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

Phase 3b – Testing phase with 1 locality

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

1.5.5 Phase 4 – Development of future plans with wider partners, to work up as a model in 17/18

There are a wider range of services that could be included in this model. In order to ensure that the new model of care becomes embedded and successful it was decided that in the early phases that these would not be included but would be looked at as a future development for 17/18.

1.6 Outcomes

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

The **outcomes** will be:

- Better health for the whole population – by providing targeted, pro-active care and intervening early in a person's illness pathway. Analysing and using health and social care data collected to target interventions where needed.
- Reduced inequalities in access to health and social care – the system is currently provided by multiple organisations working separately, making navigation of the system difficult for people and users. GPs are the first point of access for many people and they will use the health and social care hub as a single point of access to services.
- Improving access to the right service at the right time – by wrapping services around primary care and developing social prescribing services and use of the voluntary sector.
- Reduced variation in outcomes - by removing the complexity that has resulted from different policy initiatives over the years; ensuring clear lines of accountability and responsibility for staff
- Increased quality of care and safety for all patients – through timely, targeted care co-ordination provided by one responsible organisation
- Better value for the taxpayer – by ensuring the response is proportionate to the person's needs; that resource utilisation is streamlined and economies of scale are utilised; targeting the top 10% of users of services and not the top 2%.
- Supporting people to live well in their own homes for as long as they wish and are able to
- Improve patients experience of health and social care- by reducing/removing barriers between services and professionals; aligning teams to localities to meet the populations needs
- Contribute to a more sustainable system for the future demand - More efficient working by reducing hand-offs, duplication of effort, organisational boundaries and wasted time and reviewing all processes, allows for more and better quality interventions. Implementing appropriate technology where required. Introduction of enhanced urgent care services to reduce pressure on GPs

1.7 Benefits

The **financial** benefits will be:

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

The **people** benefits will be:

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

The **Professionals** benefits will be:

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

The **whole system** benefits will be:

- *The system is flexible to meet people's changing needs over time***.** People's needs will vary over time with periods with more or less intensive care. The system supports people through these in a seamless way.
- *Reduction in use of GP appointments for non-medical problems*
- *On-going co-ordination and integration between health and social care partners.* Establish integrated services that provide co-ordinated and multi-disciplinary care & support with a Single Point of Access.
- *The relations between local providers have strengthened and matured.*
- *Financial pressures on local health and social care providers are reducing and stabilising.* The current resources are able to meet people's need in the community cost effectively.

1.8 Project Outputs

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

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

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

Impacts & Outcomes

	Expected Long Term Impact	Project Benefit/s	Metric / Measure*
Scheme/Project	**Improving people's experience of health, care and support**	Improved satisfaction of care.	The proportion of people satisfied with the care and support services they receive should increase. Friends and Family Test or locally devised patient questionnaire
		Care and support are centred on the person's needs.	Audit of patient care plans
	Better Outcomes for patients and service users	People have a higher quality of life, and enjoy their improved health status.	Reduction in NELs, A&E attendances, LOS and readmission rates
		People feel empowered, capable of and engage in self-management	Involve devised outcome measure – Ladder of Change
		Care is of high quality and safe	Reduction in safeguarding reports, complaints, etc.
		People experience pro-active, co-ordinated care and support.	Audit of notes and locally devised patient questionnaire
	Better Use of Resources	Reduction in NEL admissions (BCF metric)	Reduction of 331 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduction in A&E attendances	Reduction of 165 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduced/delayed cost of social care packages	Social Care packages - Will be monitored in first instance to form a baseline. Will monitor on a monthly basis, total spend of cost of long term care packages, number of social care packages, and average cost of social care packages. Referrals through to the volunteer community navigator scheme and the impact this has on the numbers entering long term care. Reduced numbers on waiting lists as

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

Performance Metrics

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

		carer or professional care co-ordinator)?	meeting	forwards	
	Quality	Quality of life and improved health status – Can the person fulfil their desired activities of daily living (with support)? Is their mental wellbeing is good? Is their physical wellbeing is good? Has there been an admission into acute care?	BHFT /Optalis Audit - Analyse the care documentation of a random sample of people that has been cared for and ask feedback from a number of service users. Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Increase in quality of life and health status
		People's experience and satisfaction of care – Is care centred on the person? Does the person feel listened to? Does the person understand their care and do they feel involved? Is care consistent and co-ordinated? Is quality of care good? Does the person feel safe?	BHFT/Optalis- Use the outcomes of the Friends and Family test (will need to consider use for social care). In addition get feedback from a number of service users. Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved patient experience
		Pro-active Care – People experience pro-active, co-ordinated care and support. Have the appropriate assessments been conducted? Has a care plan been established? Is the care plan being implemented?	BHFT/Optalis Audit - Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved pro-active care
		Quality and Safety – Does care meet NHS and ASC standards? Are evaluation processes on-going? Have there been incidents related to whole systems approach?	BHFT/Optalis - Review quality, incidents and evaluation Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved quality and safety
		Person Centred Care - Care and support are centred on the person's needs Has the person been engaged with? Is shared decision making taking place? Has the person contributed to their care plan? Does the person self-manage? Is the person's carer involved when applicable?	Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved person centred care
	Financial	Reduction of 299 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 299 NELs
		Reduction of 150 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 150 A&E attendances

Options

Two options were considered:

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

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

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

Recommendation

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

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

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

Assumptions and Constraints

Assumptions

- That all Wokingham health and social care organisations will agree to the project and the integration of their services to work in the best possible way for patients/users. To date there has been no feedback from any of the Wokingham organisations that they are opposed to the project.
- There will be a framework to support, and set expectations for, locality working
- Strong leadership to facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and patient-centred care
- Effective IT systems in place to support delivery of care via localities and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Suitable accommodation is available within each locality or centrally to provide a team base. This will require review of community asset mapping work previously undertaken, discussion with the Core Strategy group and planners, and approaches to local businesses to enquire about possible assets.
- Patients are open to the concept of "patient activation" (Hibbard, J; Gilburt, H; 2014). This refers to a person's knowledge, skills, ability and willingness to manage their health and care. Staff need the necessary skills and training to support people within a model of self-care, as this goes beyond the provision of information and understanding of their condition(s) to train and empower patients and carers.
- BHFT will be the main provider of the Community Health and Social Care Project and will sub-contract the services required to deliver the project. This assumption has been made as for the following reasons:
    - It enables the project to be delivered at speed as it will be the least disruptive

- Optalis has no experience of managing health services but BHFT have experience of managing social care services
- As part of the 21st century council plans, WBC plans to be a commissioner and not a provider so this meets the council's needs.

Constraints

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

Scope and Exclusions

Scope

The following 'core' services are proposed to be included in the first phase of Neighbourhood Cluster development:

- Community matrons and District nurses
- Adult long term care - Brokerage & long term support
- CMHT (18-65 yrs.) and COAMHS (65 yrs. +) – in scope but in a longer term approach
- Volunteer Community Navigators
- Commissioning of prevention services and Carer's services that support long-term care

NOT in scope, as least initially, although the ambition would be to coordinate development of future plans in association with these partners:

- GP surgery staff
- Public Health
- Services where there are a limited number of professional resources (e.g. Specialist nursing teams)
- Community development
- Libraries
- Sport & leisure
- Employment support
- Housing support
- Children's services – transition services
- Acute services

Exclusions

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

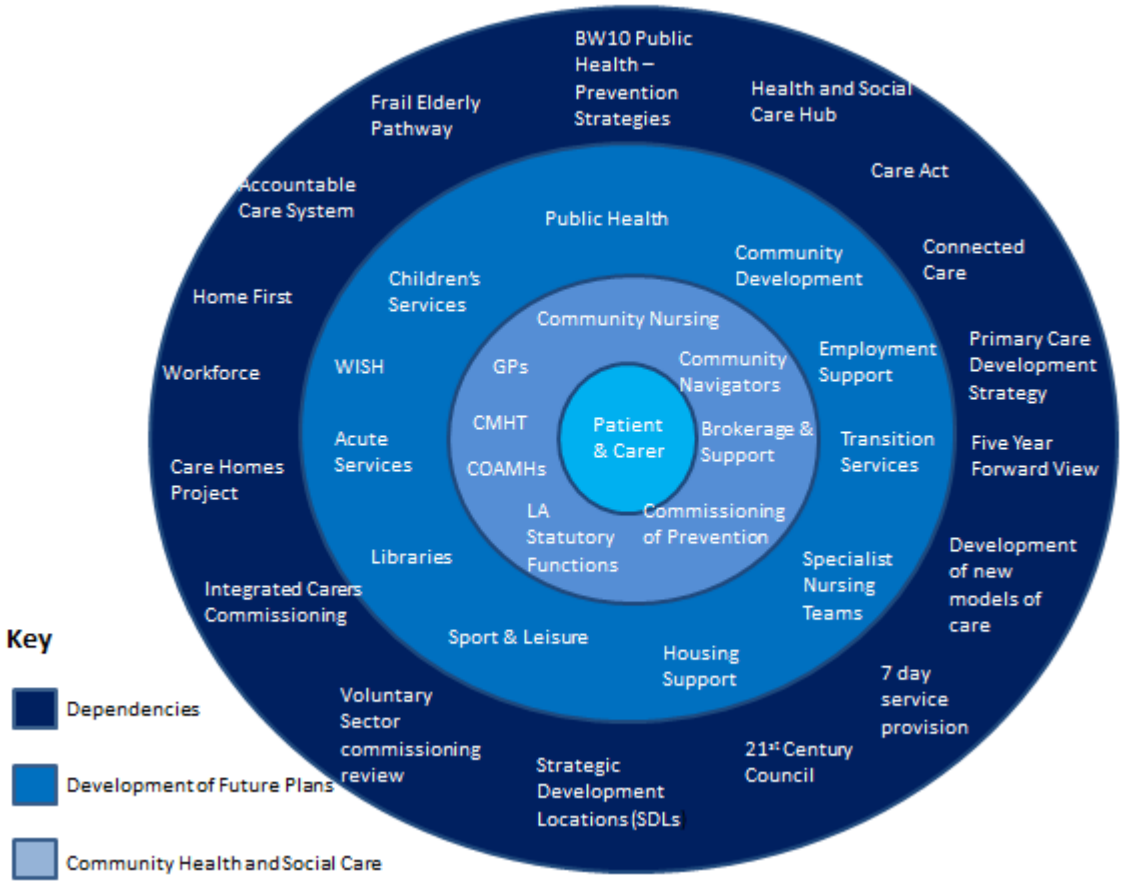
- Children's services

GPs

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

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

Dependencies



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

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

Specifically within the Better Care Fund Programme:

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

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

Section 2 - Economic and Affordability Case

Budget / Cost Summary

Costs of operation & implementation	16/17	17/18	18/19	19/20	20/21
Localities					
One off costs for implementation	83,000	82,100	0	0	0
On-going costs for running operations	25,552	200,341	99,243	99,243	99,243
Total costs	**108,552**	**282,441**	**99,243**	**99,243**	**99,243**

A breakdown of the cost calculations can be seen in Appendix 2

Source of Funding:

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

One-off costs for implementation

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

1. *Project Manager Costs*

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

- Interim post £450 per day

2. *Local programme office support*

All BCF projects in Wokingham have access to local programme office support provided by the BCF programme manager and support officer. These costs are split between all the Wokingham BCF projects.

On-going costs for running operations

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

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

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

2. *Voluntary / Charity provision (17/18)*

A one off placeholder for charity and voluntary sector has been added in 17/18 as increased numbers of users may be directed towards them. We will carry out a review in 17/18 to assess the impact and whether we would need to provide additional funding for this sector.

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

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

4. *IT infrastructure costs(17/18)*

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

5. *Property costs (17/18)*

There may be moving costs and impacts on rents. It is unlikely that additional assets or equipment will be required in year as each team will have those and it should be a case of moving these if required. The project is proposing to co-locate and integrate the services that are involved in long term health and social care, there may be some costs to make existing premises fit for purpose or finding new premises, but as yet this is an unknown at present. The current rental cost of the space used by the teams is circa £160,000 which is the current market rate for the equivalent space.

The on-going costs that will be incurred year on year are:

1. *Volunteer Community Navigator Scheme, including travel and training costs (from 16/17)*

The volunteer community navigator scheme will be staffed by volunteers but a part-time service lead is needed to manage, recruit and train the volunteers. This role will also lead the development and

implementation of the scheme in practices and across the borough as the service rolls out. Volunteers will require training and there are costs associated with this and volunteers will need to be offered travel expenses incurred whilst performing the role.

2. Investment in MDT (from 17/18)

MDTs will be the central tool for care coordination and ensuring care delivery. We have recognised that there may be additional support requirements for the MDT process to be able to manage the top 10% of users and have built in some investment here for review in 17/18.

3. Marketing and promotion (from 16/17)

The programme will require a robust communications plan and may require some professionally produced information for service users and staff. At this stage of the programme there are no confirmed requirements.

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

Planned Savings/Efficiencies

Benefits	16/17	17/18	18/19	19/20	20/21
A&E admissions avoidance	0	-14,025	-28,050	-28,050	-28,050
NEL's avoidance	0	-177,742	-355,484	-355,484	-355,484
GP Appointments avoided	0	0	0	0	0
Care Home avoidance	0	-119	-10,068	-10,068	-10,068
DTOC days reduced	0	0	0	0	0
Early intervention opportunities	0	-20,421	-73,637	-73,637	-73,637
Total Benefits	**0**	**-212,307**	**-467,239**	**-467,239**	**-467,239**
Net cost / (Benefit)	**108,552**	**70,134**	**-367,996**	**-367,996**	**-367,996**
Cumulative Net Cost / (Benefit)	**108,552**	**178,686**	**-189,311**	**-557,307**	**-925,303**

Net present value **-£774,959**
Payback **18/19**
ROI **134%**

A breakdown of the savings calculations can be seen in Appendix 2

The business case uses SUS data for non-elective admissions (NELs) during 2015/16 within the Wokingham locality as the basis for determining savings to the programme. There are 2 elements of the service that have a direct contribution the overall total savings – Community Navigators and Community Health and Social Care

Efficiency/Savings

An indication from other similar schemes is that there is a potential for savings and these will come predominantly from:

- Reduced NELs
- Reduced A&E attendances

We recognise that this project also has the potential for savings from:

- Reduction in care home placement
- Reduction in care package funding

Assumptions

We have had to build in assumptions for the targets, based on estimates of the impact of an evolving project over its first few years. More ambitious targets will undoubtedly be achieved from year 2 onwards, as locality based working becomes 'business as usual' and as more volunteer Community Navigators are recruited and confidence in their effectiveness increases and as improved provision of targeted information

to enable people to self-care and prevent further ill health further delays or prevents people's dependence on health and social care services.

1. Reduced NELs

In order to be able calculate the number of NELs the project can reduce a year the following information was reviewed.

Wokingham 15/16 NEL activity

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

This activity demonstrates the use of health by very high intensity service users (top 2%) and the high risk service users (top 3-10%). By changing the model of care it will be possible to better support these users and reduce the NELs. NEL growth is reported at approx. 5% and by integrating services and taking a system approach the project aims to reduce NELs in this group by 7.5%.

Therefore we propose the following reductions:

- Top 2% - 117 NEL reduced
- Top 3-5% - 96 NELs reduced
- Top 5-10% - 118 NELs reduced

TOTAL NEL reduction – 331 per year.

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

2. Reduced A&E Attendances

The reduction in A&E attendances has been conservatively calculated based on NEL admission avoidance, based on 50% of the NEL activity reduction for the top 10%. Calculated at £170 per admission

3. Reduction in funding of social care packages

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

4. Reduction in care home placements

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

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

Phasing Assumptions

- There will be a slower uptake in year 1 and 2 as the scheme develops and is implemented
- There will be greater impact in year 2 and subsequent years, as more volunteer Community Navigators are recruited and the Community Health and Social care system integrates, there is greater awareness of their presence and increased confidence in their effectiveness
- For community navigators implemented a year 1 & 2 uptake to reduce levels of activity as scheme is

embedded into GP's practices (referrals roughly aligned with current activity)
- Benefits realised from home care is 1 year post referral
- The percentage of those benefiting from community care and avoidance of home care will result in a longer term saving to Res care.
- In the longer term, more admissions and more A&E attendances will be prevented through the impact of targeted early self-care / prevention

Impact of Non-Financial Outcomes

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

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

Payback period

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

Section 3 - Project Approach & Governance

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

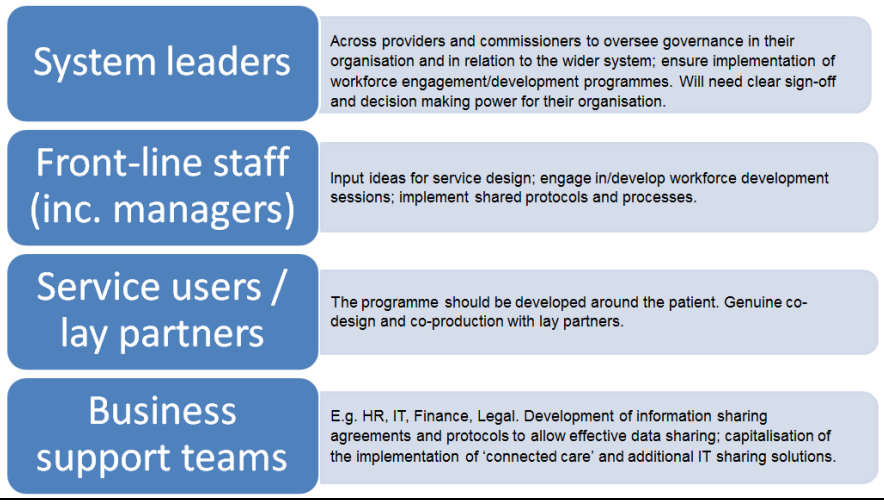
Delivery Chain

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

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

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

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



Project Organisation, Governance and Controls

Project implementation

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

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

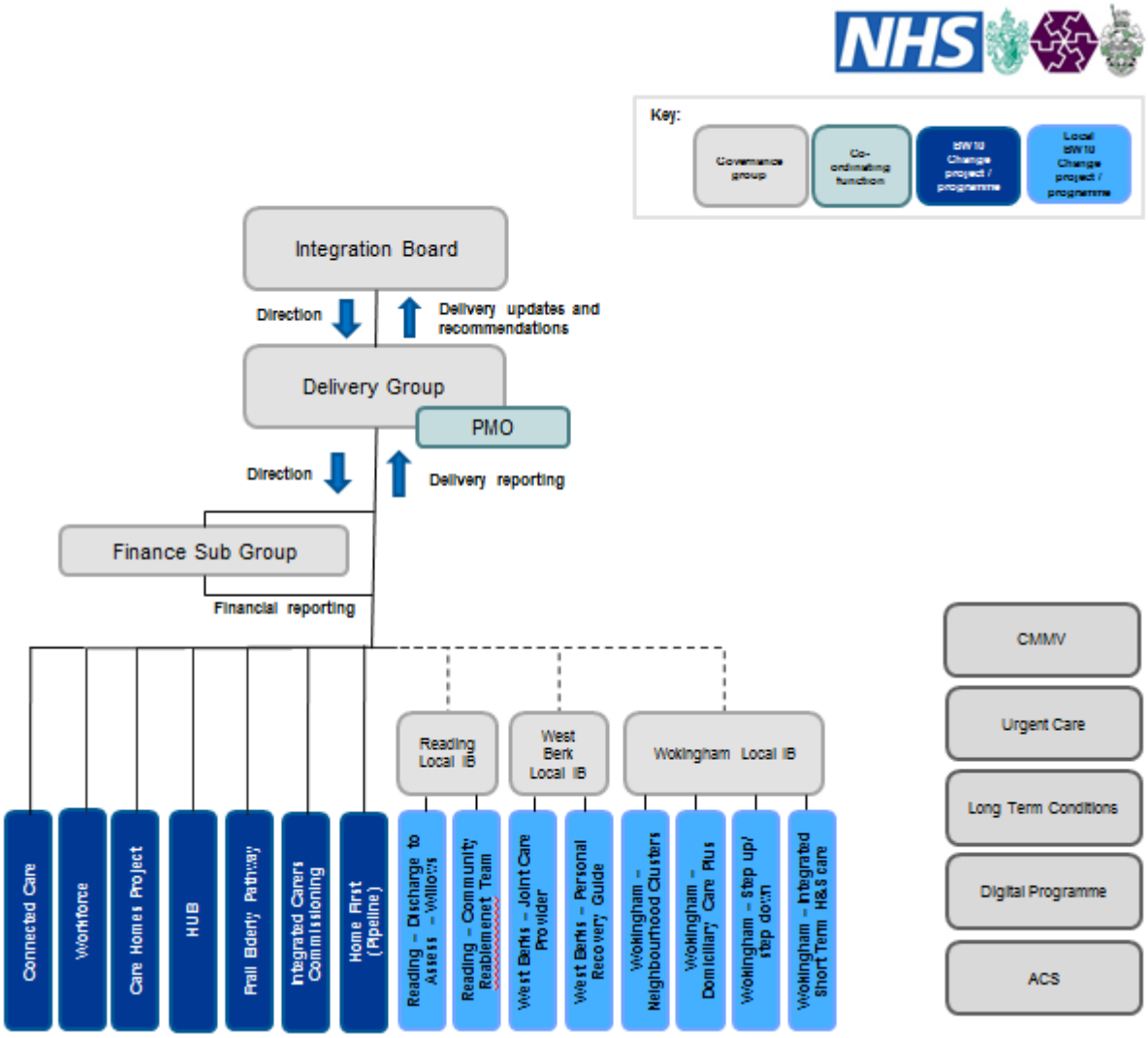
The Steering Group will report into WISP via Highlight reports and where necessary exception report to the SRO outside of these meetings. The steering group will work within the scope of the project as identified within the PID.

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

Project Structure

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

Governance Structure



Governance Group and Roles

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

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

Monthly written update reports will contain details of progress to date, achievements in the current period and achievements expected in the next period, details of actual or potential problems and suggestions for their resolution. Exception reports will be produced when any stage of the project plan deviates outside

tolerance limits. Exception reports will detail the problem, outline the available options and identify the recommended option;

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

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

Membership

Joint SROs:

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

Scheme Project Manager: Rhian Warner

Steering Group Members

Name	Role
Katie Summers	Director of Operations, NHS Wokingham CCG; Joint SRO for this scheme
Stuart Rowbotham	Director Health and Wellbeing; Wokingham Borough Council; Joint SRO for this scheme
Johan Zylstra & Matt Shaw	GP, Finchampstead; Clinical Lead for East Cluster GP, Brookside: ACS GP Provider Lead
David Cahill	Director- Wokingham Locality, Berkshire Healthcare Foundation Trust
TBC (vacant post)	Wokingham BCF Programme Manager
Mette Jakobsen	Optalis
Philip Cook	General Manager; Involve – Wokingham
Kevin Ward	Service user representation - joint chair of the Place and Community Partnership
Darrell Gale	Consultant In Public Health, Wokingham Borough Council
Nicola Strudley	Healthwatch Wokingham
Mike Chow	Finance Lead Wokingham BCF, Wokingham Borough Council
Rhian Warner	Community Health and Social Care Project Manager

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

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

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

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

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

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

Information Governance

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

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

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

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

Risks Management and Contingency Plans

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

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

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

Risk Description	RR	Required controls and actions to reduce/mitigate risk
Risk that not all key stakeholders will be committed to the development and implementation of a NCT model (also potential barriers due to conflicting organisational priorities / different internal processes and sign-offs for decision making); also inability to agree what should be included in NCTs and how they are designed and governed	Med	Full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the scheme from all key stakeholders, the identification and resolution of any conflicting organisational priorities / different ways of working between the various professionals and any perceptions of professional boundaries that may hinder the project
Some services are currently provided at Berks West level and it may not be easy, nor sensible, to cluster -base.	Med	Consider phased approach - identify those services / resources that are 'cluster-able' for 1st phase and aspiration list of those services / resources to include later when/if possible
Risk of creating a "postcode lottery" within the borough with different clusters providing different services / access	Med	Careful co-ordination and planning, to focus on Wokingham residents as a whole... although Clusters could provide essentially similar services but slightly differently targeted for particular areas of local need.
Risk that success of the project cannot be demonstrated - in particular need to agree some outcomes that matter to service users and carers	Med	Assessment, review and evaluation of the scheme will involve both qualitative and quantitative evaluation to ensure that the NCTs are operating effectively and achieving the agreed objectives, including the NCTs contribution to the achievement of targets within the Better Care Fund metrics.
Risk of lack of engagement for focusing on, supporting and implementing self care, from staff and / or service users and / or other key stakeholders	Med	to be managed through full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the scheme from all key stakeholders
Lack of "User Activation" (research demonstrates that the success of increasing self-care and primary prevention requires high levels of 'user activation') and / or insufficient staff with the necessary skills and training to support and empower people within a model of self-care (research demonstrates that staff need to be equipped with skills to support people in self-care; focus on building relationships between service users and practitioners and exploring the most effective strategies for encouraging behaviour change.)	Med	to be managed through appropriate training for relevant staff and appropriate support for service users
Risk of resistance to information sharing across the constituent parts of the local health and social care system that might impinge on the ability of the voluntary Community Navigators to provide accurate and up to date accessible information and signposting	Med	to be managed through co-production - full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the project from all key stakeholders; to include the identification and resolution of any conflicting priorities within / between relevant professionals and organisations
Risk of insufficient volunteers being recruited in each cluster to provide the focused support and information required for identified service users	Med	to be managed through effective recruitment – i.e. innovative advertising and wide-ranging publicity and the assurance of comprehensive training and support to carry out the role
Risk that suitable, fully accessible "base(s)" for the volunteer Community Navigators is/are not available in each cluster	Med	to be managed through identifying existing available assets and exploring potential assets through developing links with local businesses
Risk of poor availability of accessible transport so patients and service users are unable to benefit from available support within the community	Med	to be managed through proactive recruitment of additional volunteer drivers / transport schemes throughout the borough, focusing particularly on areas where a greater need is identified
Risk of under-utilisation of the service due to reluctance of professionals and organisations to use social prescribing to refer people to the volunteer Community Navigators / no agreement regarding accountability and liability for 'referred' patients.	Med	to be managed through development of the project by co-production so all key stakeholders are engaged; accurate and clear communication about social prescribing, the role of this project and its aims and objectives; volunteer Community navigator induction will include personal meetings with key personnel in the relevant cluster; and the volunteer Forum will act as an additional opportunity to engage with relevant professionals and organisations
Provision of services at a Neighbourhood Cluster level: o MUST ensure a simplified system o MUST NOT result in inequalities in access to essential services (Risk of conflicting and un-coordinated plans between individual Clusters – need oversight of Borough-wide view)	Med	Agreement of project scope, aims and objectives by all stakeholders Monitoring and evaluation through Cluster Steering group and reported to WISP
Risk of duplication with other BCF schemes: Integrated H&SC Hub, Short term H&SC Team, Step up-Step down, Dom care plus; also with Care Act implementation – (? esp. re provision of co-ordinated care and provision of information and advice about care and support services in the local area)	Med	Agreement of project scope, aims and objectives by all stakeholders in discussion with SROs/PMs of other initiatives Regular review of all other related projects & effective coordination/monitoring of the dependency register Monitoring and evaluation through Cluster Steering group and reported to WISP
Risk of Information governance issues (especially re info sharing – e.g.: with Voluntary Community Navigators)	Med	Training, support and supervision of volunteers Raise awareness of information governance requirements with staff as rqd
Need to be aware of and address any potential resource implications for all organisations to ensure required 'buy-in' from key stakeholders at each stage of the project This includes consideration of any impact of increasing workload on WISH, Comm matrons / DNs through reducing NELs	Med	Agreement of project scope, aims and objectives by all stakeholders Monitoring through Cluster Steering group and reported to WISP
Risk of overwhelming local voluntary and community organisations with referrals from Volunteer Community Navigator scheme	Med	Regular contact with VCOs through Involve; and monitoring through Cluster Steering group

Section 4 – Co-production, Engagement and Communications

Patient/Service User Engagement and Co-production plan outline

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

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

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

Key stakeholders to be engaged with are:

- Service users (including patients and carers) and / or their representatives, including local voluntary organisations
- Borough and parish councillors
- Service providers: general practice; community nursing teams; local authority teams; mental health staff, voluntary sector organisations; acute and community trusts
- Public health team regarding prevention and self-care in particular

In order to ensure co-production and engagement of users/patients a plan will be devised which would include:

- A patient/user representative on the steering group - COMPLETED
- Regular workshops/engagement sessions with staff and service users
- Regular feedback to Integration board, Health and Well-being Board and Healthwatch

Equality Impact Assessment

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

None of the aspects has scored over the threshold of 8 and therefore does not require sign off by the quality team. See Appendix 3.

Key Stakeholders/ Clinical Engagement and communications plan outline

Key Stakeholders

- Director of Adult Services, Wokingham Borough Council
- Director of Operations, Wokingham CCG
- Berkshire Healthcare Foundation Trust (Community Nursing, Adult Mental Health Services and specialist services)
- Optalis
- Involve and volunteer community navigators
- Public Health
- Public/Patient representatives (Service users/lay partners)
- Healthwatch
- Front-line staff (inc. managers)

- Service development staff
- WBC Commissioners
- WISP
- Wokingham Health and Well-being board
- Voluntary sector
- Estates services, WBC and BHFT
- Adult Safeguarding, WBC
- Housing support, WBC
- BW10 Project Management Office
- Community development
- Libraries, WBC
- Sport & leisure, WBC
- Employment support, WBC
- Children's services – transition services

Details of partner engagement already undertaken

Clusters:

- Stakeholder (GP / WBC) workshop (December 2014)
- Stakeholder (GP) workshop (January 2015)
- WISP (January 2015)
- Practice Managers (January 2015)
- Council Executive members (January 2015)
- Have Your Say events (March 15)
- Patient Participation Group Forum (March 2015)
- Health and Wellbeing Board (May 2015)

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

Prevention:

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

Partner Engagement Planned

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

Clinical Input Requirements

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

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

Communications Plan

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

Section 5 - Document Information

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

File path\Filename	Format	Comments
BW10 PID and Business case Wokingham Community Health and Social Care Sept 2016 vs. 1.3	MS Word	Main Document

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

Responsibilities

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

Distribution of Final Version

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

Version History

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

1.3 Final	October 2016	Rhian Warner	1st November 2016	TBC	Adding in GPs into the model, minor changes to steering group board members

Sign Off & Approval (of finances, proposed development)	
Name & Lead function (e.g. Finance, CCG lead, LA Lead):	Authorisation signature:
Wokingham Integrated Strategic Partnership - Stuart Rowbotham	
BHFT	
Wokingham Borough Council	
Wokingham Health and Wellbeing Board	

Appendix 1 – Wokingham CCG and Local Authority Population Demographics

This data has been taken from:

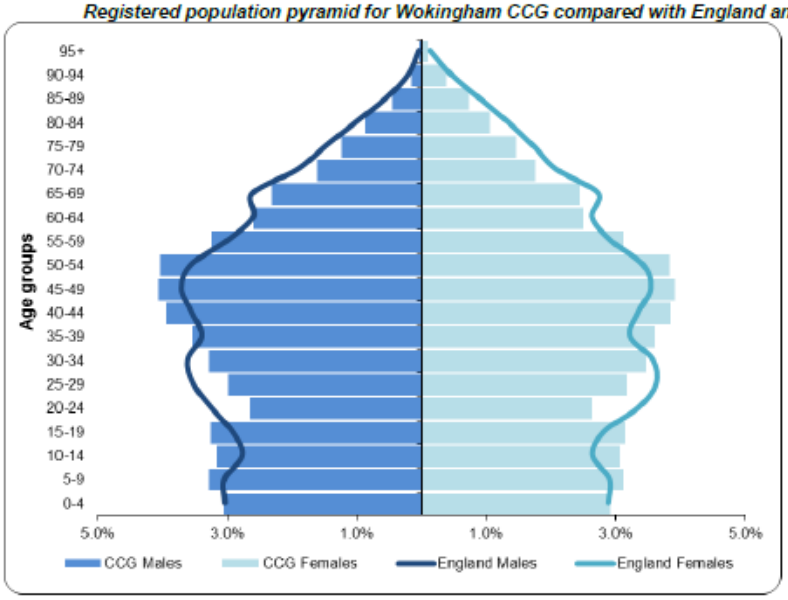
- Wokingham Clinical Commissioning Group: Locality Profile 2015, Public Health Services for Berkshire, November 2015
- Commissioning for Value: Where to Look, January 2016, Right Care Profile, Gateway ref: 04599

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

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

Population Profile

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

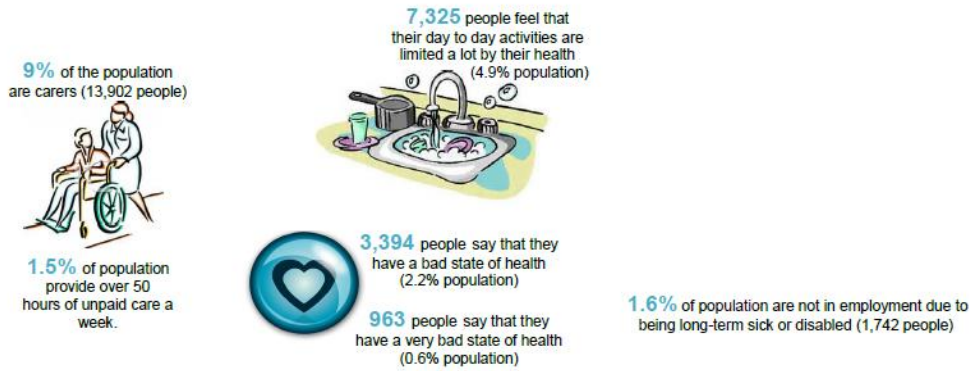


Source: Health and Social Care Information Centre (July 2015)

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

Demography

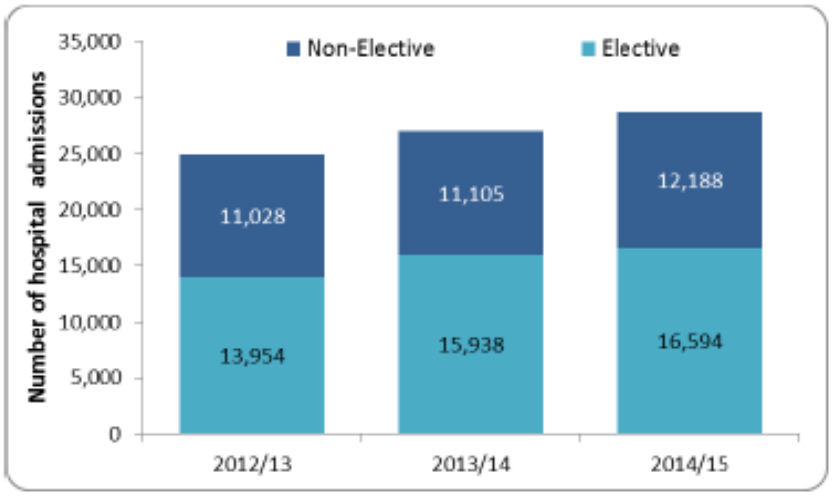
Key demographics from the 2011 census show the following:



Hospital Activity

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

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



Source: Dr Foster (2015)

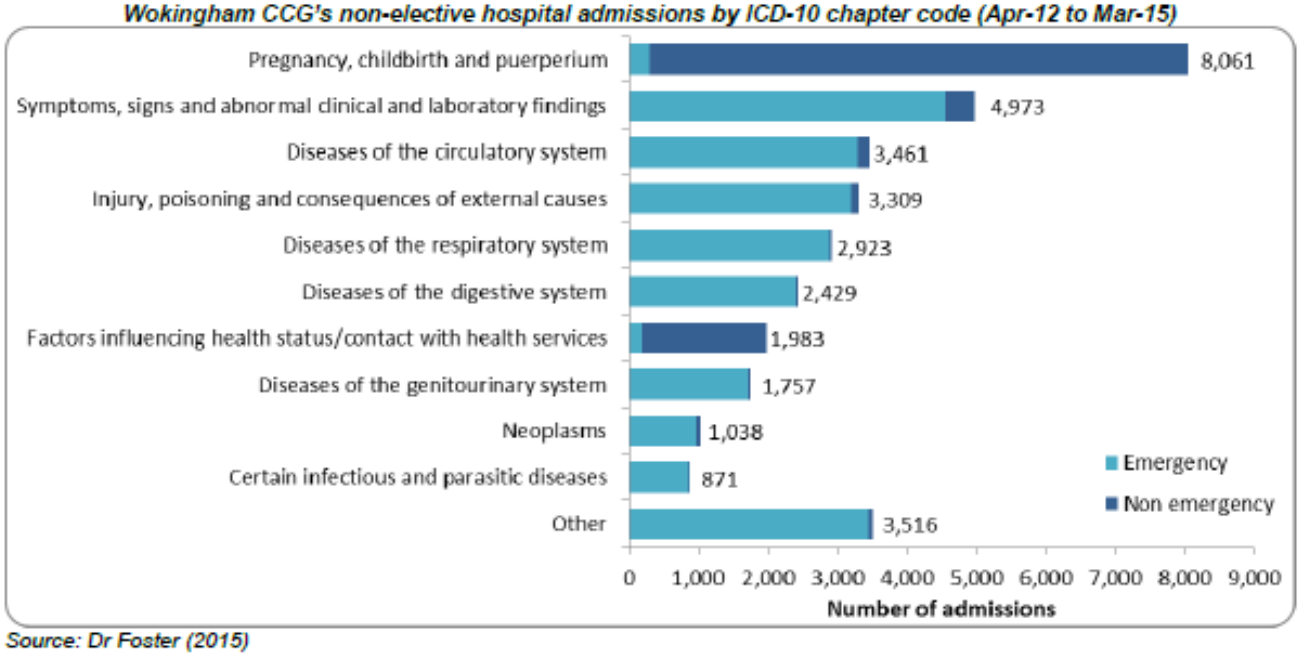
42.5% of hospital admissions for Wokingham CCG residents (aged 18 and over) were non-elective and these made up 82% of bed days from April 2012 to March 2015.

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

Source: Dr Foster (2015)

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

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



Source: Dr Foster (2015)

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

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

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

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

Complex Patients

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

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

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

Public Health England RightCare NHS England

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

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

Appendix 2 – Finance Detail

Cost profiles

Cost base 16/17		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Totals
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day, reduced to 1 day a week for latter 6 months of 16/17	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**£62,100**
Local programme office support		1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	**£20,900**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - additional staff member from 1 Sept	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	**£19,848**
Volunteer Navigators Training costs	Room hire, refreshments, training materials etc	250	0	0	250	0	0	250	0	0	250	0	0	**£1,000**
Volunteer Navigators Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	92	92	92	92	92	92	114	114	114	137	137	137	**£1,304**
Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**£2,400**
Voluntary / Charity provision	Review of voluntary sector provision - assumes 1 year assignment	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Investment in MDT	Additional support requirements for MDT process	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Restructure of MDT	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**£1,000**
Training for new virtual model of delivery		0	0	0	0	0	0	0	0	0	0	0	0	**£0**
IT infrastructure costs	Firewall issues etc	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Property costs	Moving costs and impacts on rents	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Total Costs		9,196	8,946	8,946	9,196	8,946	8,946	9,218	8,968	8,968	9,241	8,991	8,991	**£108,552**

Cost base 17/18		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Totals
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day, reduced to 1 day a week for latter 6 months of 16/17	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**£62,100**
Local programme office support		0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - additional staff member from 1 Sept	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**£39,696**
Volunteer Navigators Training costs	Room hire, refreshments, training materials etc	250	0	0	250	0	0	250	0	0	250	0	0	**£1,000**
Volunteer Navigators Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	229	229	229	229	229	229	229	229	229	229	229	229	**£2,748**
Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**£2,400**
Voluntary / Charity provision	Review of voluntary sector provision - assumes 1 year assignment	8,625	8,625	8,625	8,625	8,625	8,625	8,625	8,625	8,625	8,625	8,625	8,625	**£103,500**
Investment in MDT	Additional support requirements for MDT process	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	**£50,004**
Restructure of MDT	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**£996**
Training for new virtual model of delivery		5,000	0	0	0	0	0	0	0	0	0	0	0	**£5,000**
IT infrastructure costs	Firewall issues etc	10,000	0	0	0	0	0	0	0	0	0	0	0	**£10,000**
Property costs	Moving costs and impacts on rents	5,000	0	0	0	0	0	0	0	0	0	0	0	**£5,000**
Total Costs		42,037	21,787	21,787	22,037	21,787	21,787	22,037	21,787	21,787	22,037	21,787	21,787	**£282,444**

Cost base 18/19		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Totals
CHAS and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day, reduced to 1 day a week for latter 6 months of 16/17	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Local programme office support		0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - additional staff member from 1 Sept	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**£39,696**
Volunteer Navigators Training costs	Room hire, refreshments, training materials etc	250	0	0	250	0	0	250	0	0	250	0	0	**£1,000**
Volunteer Navigators Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	381	381	381	381	381	381	477	477	477	477	477	477	**£5,148**
Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**£2,400**
Voluntary / Charity provision	Review of voluntary sector provision - assumes 1 year assignment	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Investment in MDT	Additional support requirements for MDT process	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	**£50,004**
Restructure of MDT	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**£996**
Training for new virtual model of delivery		0	0	0	0	0	0	0	0	0	0	0	0	**£0**
IT infrastructure costs	Firewall issues etc	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Property costs	Moving costs and impacts on rents	0	0	0	0	0	0	0	0	0	0	0	0	**£0**
Total Costs		8,389	8,139	8,139	8,389	8,139	8,139	8,485	8,235	8,235	8,485	8,235	8,235	**£99,244**

Saving Profiles

Totals		2016/17	2017/18	2018/19	2019/20	2020/21
Levels of activity						
	A&E admissions avoidance	0	83	165	165	165
	NEL's avoidance	0	166	331	331	331
	GP Appointments avoided	19	39	74	99	99
	Care Home avoidance	0	0	4	9	16
	DTOC days reduced	0	0	0	0	0
	Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity		2016/17	2017/18	2018/19	2019/20	2020/21
	A&E admissions avoidance	£ -	£ 14,025	£ 28,050	£ 28,050	£ 28,050
	NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
	GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
	Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
	DTOC days reduced	£ -	£ -	£ -	£ -	£ -
	Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits		**£ -**	**£212,307**	**£467,239**	**£586,585**	**£744,839**

Volunteer Navigators		2016/17	2017/18	2018/19	2019/20	2020/21
Levels of activity						
	A&E admissions avoidance	0	0	0	0	0
	NEL's avoidance	0	0	0	0	0
	GP Appointments avoided	19	39	74	99	99
	Care Home avoidance	0	0	4	9	16
	DTOC days reduced	0	0	0	0	0
	Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity		2016/17	2017/18	2018/19	2019/20	2020/21
	A&E admissions avoidance	£ -	£ -	£ -	£ -	£ -
	GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
	Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
	DTOC days reduced	£ -	£ -	£ -	£ -	£ -
	Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits from volunteer Navigators		**£ -**	**£ 20,540**	**£ 83,705**	**£203,051**	**£361,304**

Community Health & Social Care		2016/17	2017/18	2018/19	2019/20	2020/21
Levels of activity						
	A&E admissions avoidance	0	83	165	165	165
	NEL's avoidance	0	166	331	331	331
£ benefit realisation from above activity						
	A&E admissions avoidance	£ -	£ 14,025	£ 28,050	£ 28,050	£ 28,050
	NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
Total benefits from Community Health & Social Care		**£ -**	**£191,767**	**£383,534**	**£383,534**	**£383,534**

Appendix 3 - Integrated Impact Assessment Tool - Stage 1 Proforma

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

	Could the proposal impact negatively on integration?	1	3	3	No	The project is based around integration of services and providers so should improve integration. There is a possibility that an adverse event could affect integration.
Duty of Equality **Could the proposal impact negatively on:**	Age?	1	4	4	No	The services are for over 18 year olds, therefore there is no access for patients under the age of 18, but there are already equivalent non-integrated services in place for children.
	Disability?	1	1	1	No	There are no restrictions on disability
	Race?	1	1	1	No	There are no race restrictions
	Religion or belief?	1	1	1	No	There are no religious or belief restrictions
	Sex?	1	1	1	No	There are no restrictions based on a patients sex
	Sexual orientation?	1	1	1	No	There are no restrictions based on a patients sexual orientation
	Gender re-assignment?	1	1	1	No	There are no restrictions based on a patients gender re-assignment
	Pregnancy or maternity?	1	5	5	No	The services do not deliver pregnancy or maternity services as these are provided by other services. Pregnant or new mothers would not be excluded from accessing these services if they required them.
	Marriage & civil partnership?	1	1	1	No	There are no restrictions based on a patient marriage or civil partnership

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