TITLE	**Better Care Fund Programme Performance 2017/18**
FOR CONSIDERATION BY	Health and Wellbeing Board on Thursday, 14 June 2018
WARD	None Specific
DIRECTOR/ KEY OFFICER	Paul Senior, Interim Director of People Services, Wokingham Borough Council (WBC) and Katie Summers, Director of Operations, NHS Berkshire West Clinical Commissioning Group (CCG), Wokingham Locality

Health and Wellbeing Strategy priority/priorities most progressed through the report	This report meets three of the four priorities of the HWB Strategy Priority 1 – Enabling and empowering resilient communities; Priority 3 – Reducing health inequalities in our Borough; Priority 4 – Delivering person-centred integrated services
Key outcomes achieved against the Strategy priority/priorities	To provide assurance to the Board on the activities of the Better Care Fund Programme, this focuses on delivery of the Boards strategic priorities.

Reason for consideration by Health and Wellbeing Board	To provide an update of Wokingham's Better Care Fund (BCF) Programme performance for 2017-18.
What (if any) public engagement has been carried out?	None
State the financial implications of the decision	None

RECOMMENDATION

That the Health and Wellbeing Board notes the performance of the Better Care Fund in 2017/18.

SUMMARY OF REPORT

To provide a summary of Wokingham's BCF Programme performance for 2017-18 (financial year), including progress of integration, milestones, challenges, performance metrics and finances.

Background

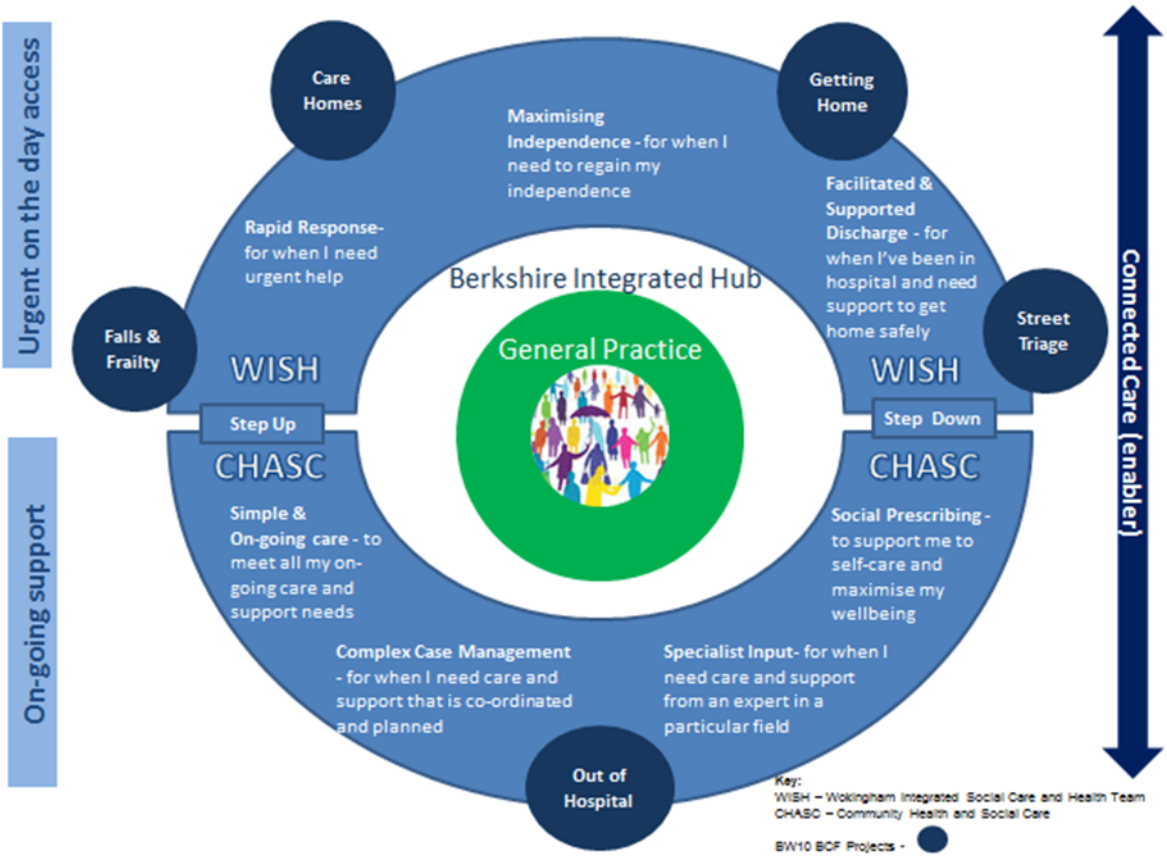
Wokingham's Better Care Fund (BCF) Programme is jointly funded by the Wokingham Borough Council and NHS Berkshire West Clinical Commissioning Group, Wokingham Locality.

The BCF Programme has the following key objectives which are seen as essential to delivering integrated health and social care services:

- Achieving the best outcomes for Wokingham residents through early intervention and prevention, case management and maintenance and end of life care
- Reducing unnecessary hospital admissions through a co-ordinated, focussed response
- Providing management and maintenance of people with long term conditions, including dementia, moving towards self-care
- Providing services which promote faster recovery and maximise independent living

This Programme began in January 2014 and has funding approved to March 2019, with an aim of integrated services being fully in place by 2020. Objectives are reviewed regularly to ensure they remain relevant and to set achievement criteria.

The Programme has 4 local schemes and 6 Berkshire West wide schemes.



Local Schemes:

- BCF 01 –Integrated Hub (Health and Social Care) – A 7 day single point of contact, resolving as many issues as possible at first point of contact, triaging

enquiries and handover to statutory teams if needed. *(TELLING YOUR STORY ONCE)*

- BCF 02 - WISH (Wokingham Integrated Social Care and Health) team. Integrating Short Term Health and Social Care Services; WBC Health Liaison team, Optalis START team and Berkshire Healthcare NHS Foundation Trust (BHFT) Intermediate Care Team and Step Down Beds – Reducing Delayed Transfers of Care, reducing avoidable admissions and reducing admissions to residential care homes, fewer handoffs for the public. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*
- BCF 03 - Step Up Beds (community medical model) – Sub-acute Intermediate care beds supporting the prevention of unnecessary acute hospital admissions and premature admissions to long term care via community based, in-patient facilities for residents experiencing an exacerbation of an existing condition or a decline in health. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 08 – CHASC (Community Health and Social Care) Integrating long-term social care and community health services; BHFT Community Nursing, Optalis Brokerage and Support, Primary Care and Involve Community Navigators. - Keeping 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. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*

Berkshire West Wide Schemes:

- BCF 06 - Care Homes (Community Support) Project incorporating Rapid Response and Treatment (RRAT) and Care Homes Support Team (CHST) - Offering care home residents a co-ordinated, joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of residents from home to acute and back to home, avoiding unnecessary delays in discharges back to the care homes. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*
- BCF 07 - Connected Care - Integrating IT systems sharing patient information with professionals across the partners. *(TELLING YOUR STORY ONCE)*
- BCF 10 - Getting Home - Reducing the time people spend in an acute, community or mental health inpatient bed at the point that they no longer need clinical care and to prevent avoidable admissions. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE)*
- BCF 11 - Out of Hospital - Promoting independence and improving quality of life by delivering community services to residents in their own homes and in places of residential care. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 12 - Street Triage – Mental Health - Reducing use of police custody and use of section 136 of the mental health act allowing the police to take the person to a place of safety from a public place. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 13 - Falls and Frailty - Improving the patient experience of emergency care by providing an acute, blue light multi-disciplinary response to the frail elderly who have fallen in their own homes to prevent conveyance and/or admission to an acute hospital. *(STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*

Wokingham's BCF Programme 2017-18 Performance Summary

1. Progress against Local Plan for Integration of Health and Social Care

Our local integration plan is based upon effectively developing and embedding our BCF schemes - The Integrated Hub, Wokingham Integrated Social Care and Health (WISH) [now including Time to Decide aka Step Down], Community Health and Social Care (CHASC) and Step Up services alongside the Berkshire West 10 (BW10) schemes in order to meet the four National Metrics – Non Elective Admissions (NEAs), Admissions to Residential and Care Homes, Effectiveness of Reablement (91 day target), and Delayed Transfers of Care (DToC) .

To support and build on this work, we have agreed that our governance will now be through a Memorandum of Understanding (MoU) between the partners; this has been implemented in a shadow format from the 1st April 2018.

2. Integration Success Story Highlights

2.1. Between April and September 2017 (Q1 & 2), our key success stories were:

2.1.1. National Metric Performance – we sustained or improved our performance in three out of the four National Metrics: DToCs, people remaining at home 91 days after reablement and permanent admissions to care homes.

2.1.2. Community Navigator Service – this service continued to grow with referrals increasing by 55% in Q2. Service user feedback also demonstrates the success of this service with users reporting that they have moved from being ready to accept help to believing and learning how to support themselves.

2.1.3. As a result of a 'deep dive' review to capture our learnings, BCF 03 Step Up/Step Down was split into 2 separate schemes for 2017/18. The Step Up PID was approved in Q2 with the remit of providing sub-acute care to reduce Accident and Emergency (A&E) attendance and NEAs, with the service due to launch December 2017. Step Down (renamed Time to Decide) was incorporated into WISH team provision.

2.1.4. Plans progressed for closer working between the Disabled Facilities Grant (DFG), with the Housing Services Manager attending Wokingham Integration Strategic Partnership (WISP) on a quarterly basis to report on agreed performance metrics. Adults and children's referral pathways were mapped in order to improve access and processes in the pathways.

2.2. Between October and December 2017 (Q3), our key success stories were:

2.2.1. National Metric Performance – continuation of sustained/improved performance as per 2.1.1.

2.2.2. Local Metric Performance – whilst we did not achieve the national NEA metric we showed significant improvement in our local NEA metric, which measures NEAs in the over 70s in 13 targeted conditions. We achieved a YTD monthly average of 99 NEAs, 13% lower than the 16/17 monthly average of 114 NEAs.

2.2.3. CHASC Staff Engagement Event held on the 31st October which brought together all the health and social care staff involved in supporting service users with long term needs. The overriding theme of the feedback was the positive outcomes created by bringing health and social care professionals together. The event provided a setting where stakeholders got to know each other and their respective roles in a locality setting, building a basis for closer working relationships in the future.

2.2.4. Continuation of development of an MoU. The 4 partners agreed to the proposal developed. Partner Governance arrangements were drafted and agreed. The

impact on this change was to move from a commissioner led model to a partnership between commissioners and providers to deliver integrated health and social care services.

2.2.5. Yearly Review of Schemes – In November 2017 all of the local BCF schemes were evaluated by WISP, with an action plan created to focus on further developments for schemes to be completed by May 2018. Actions focussed around performance, finances, processes and procedures, communication, workforce and dependencies.

2.3. Between January 2018 and March 2018 (Q4) our key success stories were:

2.3.1. National Metric Performance – continuation of sustained/improved performance as per 2.1.1.

2.3.2. Further CHASC Staff Engagement Event held in March 2018, which brought together all the health and social care staff involved in supporting users with long term needs in the West locality which will be the first locality area in Wokingham to test the CHASC model.

2.3.3. The MoU was drafted during March 2018, with the first consultation phase during April 2018. N.B. following consultation, Royal Berkshire NHS Foundation Trust (RBFT) was included as a fifth partner to the MoU.

2.3.4. Programme Plan/Roadmap to 2020 was drafted during Q4 for anticipated agreement in Q1 of 2018/19.

2.3.5. Review of Voluntary Sector Sustainability – Due to the move towards direct payments and reduction in the Partnership Development Fund monies, we reviewed CCG/WBC voluntary sector spend over previous years to see how much impact the reduction in funding would be likely to have and review all schemes funded to remove duplication and maximise investment.

2.3.6. Review of Time to Decide (aka Step Down) service – The review was carried out during January and February 2018 and presented to WISP in March 2018. It was agreed to retain the three Time to Decide flats and improve performance in order to continue to reduce DToC and meet agreed BCF targets for 2018/19. All changes to be implemented by the end of Q1 2018/19.

2.3.7. DFG Performance Metrics – Q3 metrics were presented for the first time to WISP in January 2018. The feedback on reporting was positive with further questions from the members of WISP for consideration. The BCF Programme Management Team worked with the DFG team during Q4 to further refine reporting and to start to explore benchmarking performance against other Local Authorities.

2.3.8. Agreed local Stakeholder Engagement and Communication Framework - Aim is to keep staff, public, Members, GPs etc. informed with progress of the BCF and integration, commencing Q2 of 2018-19.

2.3.9. During Q4 the Local Government Association (LGA) carried out a DToC Peer Challenge over 3 days, commissioned by the BW10 Integration Board. A draft report was released in March 2018 and Wokingham felt that the peer challenge was a positive exercise and we have identified potential learning and actions to take that will further improve DToC performance and the patient experience. Once the final report is published an action plan will be prepared and implemented.

2.3.10. A review of the BCF Programme management of risks was carried out during Q4 and a new risk register format developed to better manage and mitigate risks for the programme. This will be used from the 1st April 2018.

3. Milestones for 2017/18

3.1. Quarters 1 and 2

3.1.1. At the end of Q2 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained DToC performance and implemented all actions from the High Impact Model action plan.
- CHASC completed a review of the Multidisciplinary Team Meeting (MDT) process and redesigned the process for Wokingham, with go live planned for the 1st October 2017. The 3 locality areas for Wokingham were agreed around the primary care practices, Lower Super Output Areas (LSOA) deprivation and Strategic Development Locations (SDL). Plans were made for the first staff engagement event on the 31st October, using an external consultancy to support this. The Community Navigator Service (social prescribing) continued to grow with referrals up from 10 per month at the start of Q2 to 28 per month at the end of Q2.
- Step Up – all point of care equipment was identified and orders placed. The SOP and service specification were drafted. There were difficulties in recruiting to the ANP post.

3.1.2. The Integrated Hub did not meet its agreed milestones. Phase 2 roll out delayed as it is dependent on WBC's 21st Century Council restructure, which is complex.

3.2. Quarter 3

3.2.1 At the end of Q3 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained its reablement, permanent admissions to care homes and DToC performance. In order to support the maintenance of performance, iBCF funding was allocated to WISH to support funding of CHS Healthcare private brokerage service at RBFT, additional ASC staff for reablement and additional support for home care packages from December 2017 to March 2018. A review of Time to Decide beds was planned for Q4 to compare usage versus costs/benefits.
- CHASC launched its redesigned MDT process which went live as planned on the 1st October 2017, with 105 patients reviewed compared to 24 in the same period last year. The MDT design is being continually reviewed to ensure best processes and following a first review in December adaptations were made. The first CHASC Staff Engagement Event was held on the 31st October, with the highlights being what is working well, what the barriers are and the aspirations. The Community Navigator Service (social prescribing) maintained its growth in Q3.
- Step Up – this service went live on the 4th December 2017 with the ANP post filled. Whilst no suitable referrals were received there was an increase in community referrals into the community hospital beds.

3.2.1. As the Integrated Hub had not met its agreed milestones a partner meeting was held on 11th December 2017. It was agreed that the Integrated Hub team would review the scheme in the early part of Q4 against the following key lines of enquiry:

- Where they have got to against the plan?
- Is the plan still for purpose and where do we want to get to – perhaps a refreshed plan needs to be produced?
- What are the barriers/blockers to plan, what are the solutions to barriers/blockers and what actions need to be taken?

3.3 Quarter 4

3.3.1. At the end of Q4 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained its reablement, permanent admissions to care homes and DToC

performance. A review of the Time to Decide (Step Down) beds was completed.

- CHASC continued to review and develop the MDT process and this approach was shared with West Berkshire and Reading localities. Development of the CHASC locality model continued with a West Locality Workshop held in March 2018 to design elements of the model. The Community Navigator Service (social prescribing) maintained its growth in Q4 and is now available in 12 out of the 13 GP Practices in Wokingham.
- Step Up – Referral numbers were lower than expected since the launch in December 2017, therefore the source of referrals was expanded to include the Acute Trust and for the service to support capacity in the Rapid Response service.

3.3.2. The Integrated Hub Phase 2 milestone continued to be delayed. Review of the scheme and key lines of enquiries (as noted in 3.2.1) was initiated with a programme report review to be shared in May 2018 with the BCF Senior Responsible Officers for agreement and/or further consideration.

4. Challenges during 2017/18

4.1. Recruitment of staff remained the biggest challenge across Wokingham's health and social care system. In 2017/18 the lengthy delay in recruitment of the Advanced Nurse Practitioner (ANP) for the Step Up service being an example of this as well as recruitment and sustainability of the local care market. Mitigation was as follows:

4.1.1. Nursing staff were used in a slightly different way whilst there wasn't an ANP in post in order for the Step Up scheme to go live as planned in December 2017.

4.1.2 The 2017 spring budget Department of Communities and Local Government (DCLG) provided additional Adult Social Care funding, known as the Improved Better Care Fund (iBCF) of £169k in part supported sustainability of the care market, although this was a small sum.

4.1.3 During Q3 the BCF team carried out a high level workforce review in order to understand the key issues across all partners. The purpose was to inform the BW10 Workforce project, highlight the top 3 workforce issues to this programme and identify areas for development locally.

4.2 NEA performance was not sustained. The reasons for this are multifactorial, but one challenge that Wokingham did not resolve (and remains outstanding for 18/19) was the NEA target set, a reduction in growth of 1.8% on 16/17 outturn, which was not agreed locally by WISP as it was felt this was an overly ambitious target. Wokingham had been a top performer for years for numbers of NEAs per year, achieving a 1% growth reduction from 15/16 to 16/17, which was the first year in recent years where a reduction had been achieved (from 14/15 to 15/16 NEAs grew by 10.6%). Mitigation was as follows:

4.2.1. Two of our schemes, CHASC (MDTs) and Step Up, went on line in Q3 and Q4; both aim to reduce NEAs and contributed towards figures for 17/18.

4.2.2. Discussions with the CCG and NHS England (NHSE) around the reduction set to agree a more realistic target were unsuccessful.

4.2.3. Whilst the national NEA performance metric has not been sustained we sustained our local NEA performance metric for over 70s with 13 targeted conditions.

4.3. Performance across the Berkshire West system was not the same, with Wokingham achieving the greatest success overall. As the Berkshire West system is moving towards an Integrated Care System (previously Accountable Care

System) model it was felt it would be beneficial to have all 3 unitary areas performing at a similar level. Mitigation was as follows:

4.3.1. Sharing of best practice and support for other areas in Berkshire West in place. Monthly meetings between the Integration leads for Reading, West Berkshire, Wokingham and Berkshire West 10 Programme Office were held throughout the year and this will continue throughout 17/18 and into 18/19.

4.3.2. In particular, analysis of positive progress within WBC to identify ideas for improving DToC performance was a key factor.

4.4 Wokingham's iBCF for 17/18 was £169,000. Wokingham was one of the very few out of 150 LAs to receive only 10% of the iBCF money due of the Relative Needs Formula allocation methodology. Due to the small amount of funding Wokingham was unable to develop any new schemes or services. Mitigation was as follows:

4.4.1 The iBCF did not affect decisions on the budget and there were no new metrics introduced to isolate and measure the iBCF improvements

4.5 Demand and pressure on the health and social care system continued to grow. Mitigation was as follows:

4.5.1. We continually need to ensure our services and processes are fit for purpose. Our scheme review process and highlight reporting refinement aims to ensure we are able to capture performance and value for money, and make adjustments where necessary. These measures will continue throughout 18/19.

4.5.2 An integration programme plan/roadmap to 2020 was developed to understand the pressures and minimise the impact through an effective plan.

4.6 Change in Senior Leadership of the CHASC Team. The original Head of CHASC took a 9 month secondment within BHFT towards the end of Q4. There was a risk the change in leadership at a critical time in the project could lead to delays in planned implementation timescales. Mitigation was as follows:

4.6.1. Recruitment to an Interim Head of CHASC was actioned, alongside a review of the project plan to revise go-live dates once the Interim Head of CHASC was appointed.

5. Performance Metrics

The BCF performance is measured and reports against 4 National Metrics.

5.1 Non-Elective Admissions (NEAs)

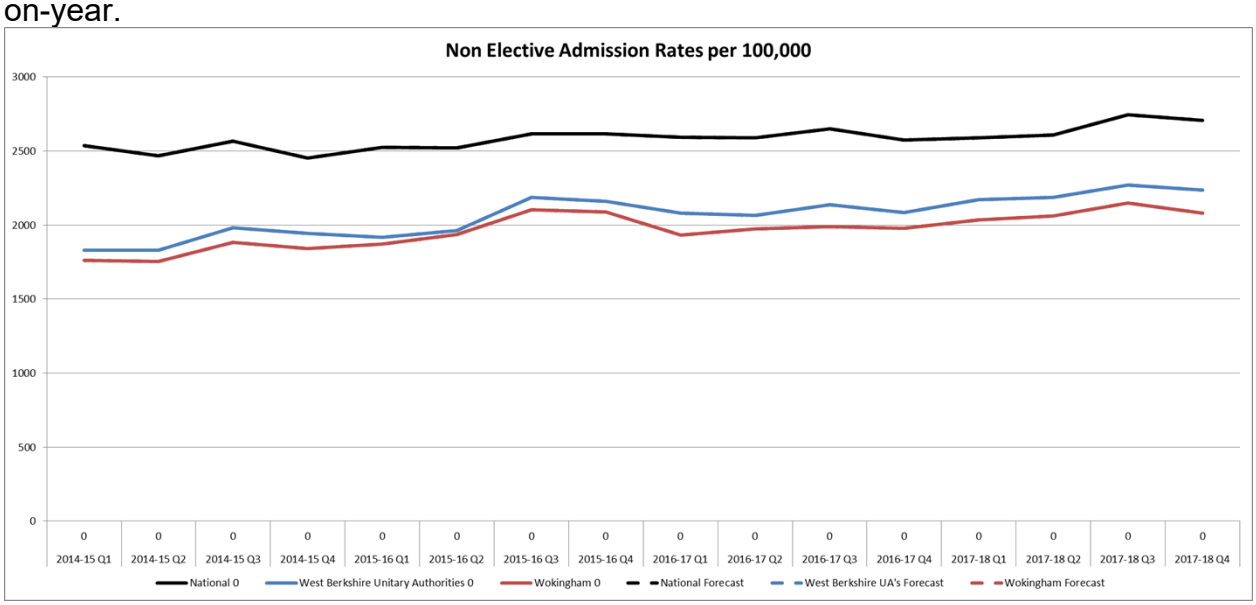
NEAs for 2017/18 were 13,630 versus plan of 12,612, (8.1% above plan). This compares to 12,845 in 2016/17, an increase of 6.1%. Following confirmation of the Quarter 4 figures, the overall RAG rating for 17/18 is now amber, having improved from the red rating which has been the case for most of the year.

		Baseline					Pay for performance period			
		2015-16 Q4	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
Total non-elective admissions in to hospital (general & acute), all-ages.	Plan	2,923	3,102	3,131	3,393	3,230	3,036	3,113	3,231	3,232
	Actual	3,401	3,151	3,219	3,245	3,230	3,324	3,367	3,512	3,427
Quarterly Variance		478	49	88	- 148	-	288	254	281	195
Quarterly Variance %		16.3%	1.6%	2.8%	-4.4%	0.0%	9.5%	8.2%	8.7%	6.0%
RAG Rating										

RAG
Less than 5%
Between 5 & 10%
Greater than 10%

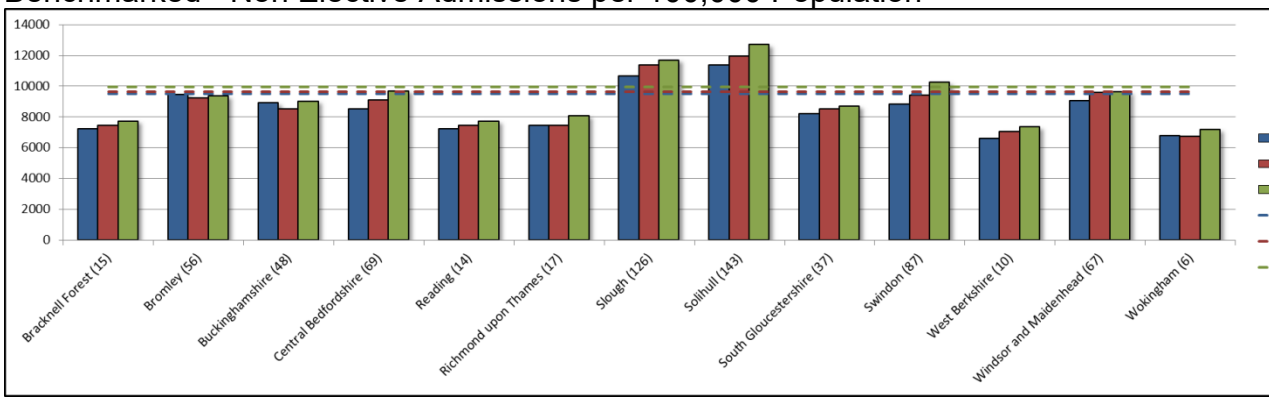
NEAs by Age Band continue to show a static picture for >75 years old for the last three years. Somewhat surprisingly the <18 year old band is showing a reduction during since November 2017.
Length of Stay (LoS) for < 24 hours is lower than the prior year. However > 48 hours is an increase of 4.4% on 2016/17.

WISH team NEAs for the Target Conditions and > 70 years of age are cumulatively 1,330 for 2017/18, compared to 1,329 for 2016/17. This is consistent with the picture shown by the overall statistics of a static level of admissions for the >75 age band year-on-year.



We have compared our performance regionally and nationally over 2017/18: Wokingham's Normalised for Population Monthly NEA rate is ranked 3rd best (out of 207 CCGs) for performance, the best performance of the 4 Berkshire West CCG areas. This is the same ranking as 2016/17.

Benchmarked - Non Elective Admissions per 100,000 Population



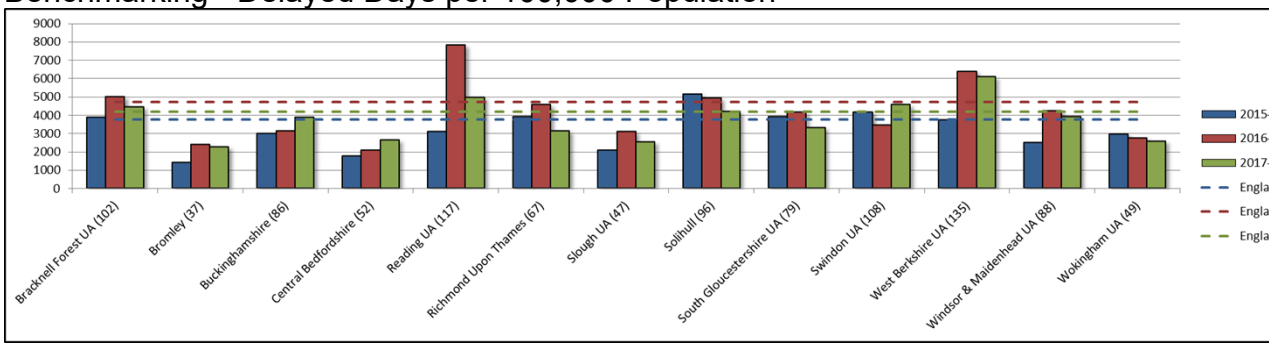
Source: National CCG Monthly Hospital Activity Return (MAR) data is used for this comparator as National Secondary Uses Services (SUS) data is not available. Local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Current rank in brackets (1 lowest, 150 highest)

5.2 Delayed Transfers of Care (DToC)
DToC for 2017/18 was 3,689 days compared to a plan of 3,840 (4% below plan). This compares to 3,751 days in 2016/17 and represents a 1.7% reduction on the prior year. Overall for the year the performance was good, but Q4 showed an above plan figure,

although a similar peak was seen in Quarter 4 in the prior year.

BCF SUBMISSION TARGETS		2015-16	16/17				17-18 plans			
		2015-16 Q4	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
Delayed transfers of care /delayed	*Plan*	924	924	924	839	829	960	960	960	960
	Actuals	#REF!	697	1,063	950	1,041	744	984	838	1,123
Quarterly Variance		#REF!	- 227	139	111	212	- 216	24	- 122	163
Quarterly Variance %		#REF!	-25%	15%	13%	26%	-23%	3%	-13%	17%
RAG Rating		#REF!								

Benchmarking - Delayed Days per 100,000 Population



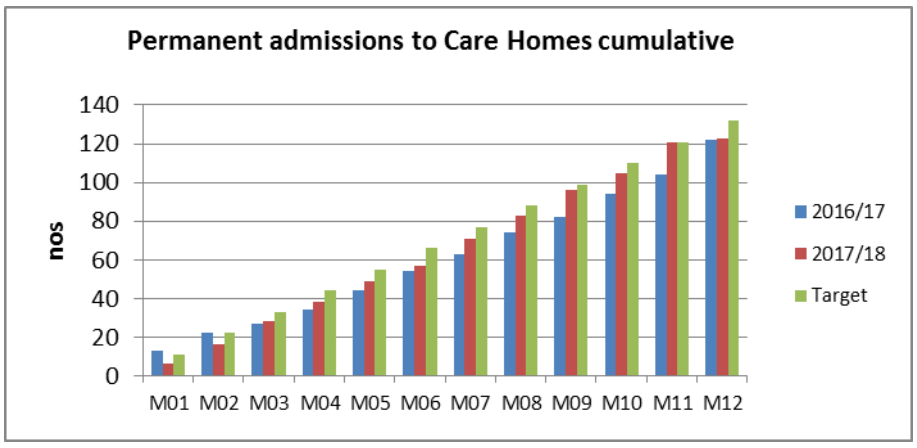
Local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Current rank in brackets (1 lowest, 150 highest)

We have compared our performance regionally and nationally over 2017/18:

- Wokingham's Absolute DToC ranking April 2017 to Feb 2018 24th out of 152 Authority areas
- Wokingham's Normalised for Population DToC ranking April 2017 to Feb 2018 49th out of 152 Authority areas
- Wokingham's Normalised for population South East and South West only ranking April 2017 to Feb 2018 4th out of 34 Authority areas

5.3 Permanent Admissions to Care Homes

For the 12 months to March 2018 admissions were 123, compared to target of 132 (9 less). This is 1 more than in 2016/17. March data is provisional and may be subject to revision.



Whilst we have reduced the demand on admissions to care homes year on year we

recognise that due to increasing care home costs WBC remain financially challenged, but without the work of the BCF schemes would be in an even more financially challenged position.

5.4 91 day target
YTD on average 79% of older people remain at home against a target of 78% for Q2 & Q3 for 17/18. Q4 target is higher at 85%.

5.5 Local Metrics
We do collect further metrics to understand our performance.

6. Finances (including initial benefits realisation)

6.1 BCF Budget 2017/18
The Wokingham BCF budget for 2017/18 was £9,865,900 and finished 2017/18 with a small aggregate overspend of £40.2k (0.4%) against budget. The Wokingham Borough Council hosted schemes finished on budget, while Wokingham CCG hosted schemes had an underspend of £29.9k. CHASC project management costs at £72.5k were £14.9k higher than budget, reflecting the slower than anticipated start-up of the scheme and hence increased project management required, but there were corresponding savings against budget for training and additional MDT co-ordinators.

Wokingham received £169k of funding from the iBCF, which was utilised as follows:

	£ 000's
Wokingham contribution to the CHS contract for the period Nov 2017 – Mar 2018	30
Reablement: Funding of short-term posts from Dec 2017 to March 2018 (1 x agency Social Worker + 2 x OTs)	75
Additional support for Adult Social Care (Home Care packages)	64

Cross Berkshire West schemes showed an overspend of £70.0k.This was made up of Connected Care £61k cost pressure, RBFT DToC scheme (CHS contract) overspent by £32k and a £23k underspend on the South Central Ambulance Service (SCAS) Falls & Frailty scheme.

The Wokingham Contingency of £113k was unspent during the year. In accordance with the terms of the Section 75 Agreement, an amount of £56.4k (50%) has been returned to NHS Berkshire West CCG, with the balance being carried forward to fund schemes in the BCF for 2018/19.

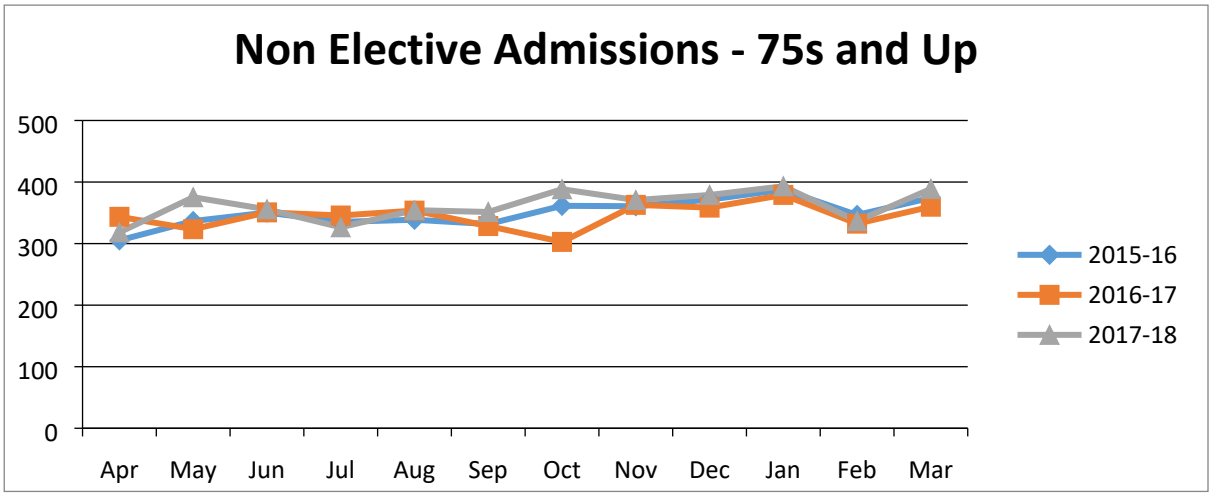
6.2. Risk share
The Wokingham BCF budget for 2017/18 included an amount of £477.3k in respect of risk share. Release of this money was contingent on the achievement of the NEA targets contained in the BCF Plan for 2017/18. The risk share was split up across the following BCF schemes: WISH; Step Up; CHASC and Care Homes/Rapid Response and Treatment. Each of these schemes individually contributed to reductions in NEAs; however the overall target for the year was not achieved (as shown in para 5.1 above). Actual was 13,630 v a plan of 12,612 (8.1% above plan). This compares to 12,845 in

2016/17, an increase of 6.1%. Since the NEA target was not met, the Risk Share has been retained by the CCG to cover the increased cost of the above plan NEAs.

6.3. Benefits realisation

6.3.1.Non Elective Admissions (NEAs)

The priority focus of schemes in the BCF was the Frail Elderly and the +75 age group. As can be seen from the graph and table below, this investment in BCF schemes and in particular the WISH team and the Rapid Response and Treatment scheme in Care Homes, has been successful in keeping the level of NEAs for this target group largely static over the last three years.



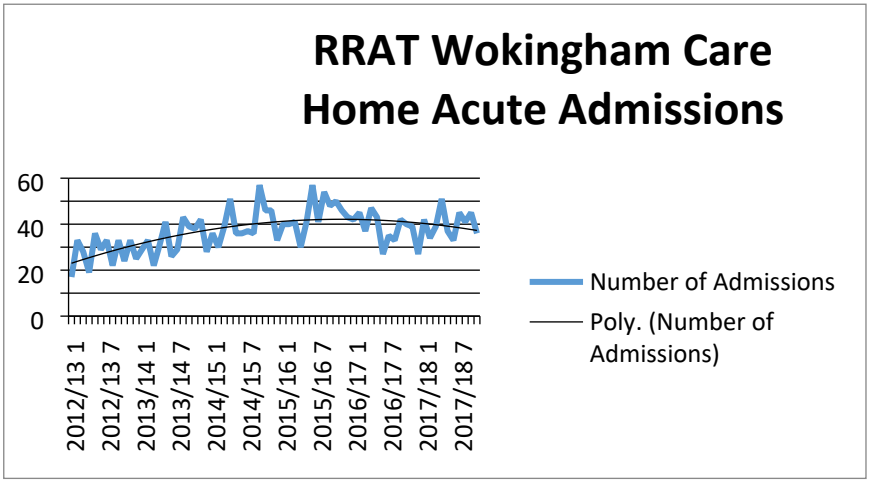
Non Elective Admission Actuals		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total non-elective admissions in to hospital (general & acute), 75s and Up	2015-16	305	337	350	335	339	332	361	361	372	387	347	374
	2016-17	344	323	351	346	354	329	303	363	358	379	332	360
	2017-18	318	375	356	326	354	351	388	371	379	393	336	389

Totals:	2015-16	4,200
	2016-17	4,141
	2017-18	4,338

This compares to an increase of 17% in NEAs over the same period for the aggregate total for all ages.

The Rapid Response and Treatment scheme in Care Homes has played a key part in achieving this performance as can be seen from the table and graph below for Wokingham Care Homes.

Year	Av monthly admissions from Care Homes	Total NEAs from Care Homes	Change from previous year	% increase/ (decrease)
12/13	27.6	332		
13/14	33.4	401	69	20.8%
14/15	40.2	483	82	20.4%
15/16	44.2	531	48	9.9%
16/17	39.3	472	-59	(11.1)%
17/18 Est	40.3	484	12	2.5%



The improvement over time is as shown above, but is understated as it does not take account of any demographic growth. Wokingham Care Homes had been on a 20% increase year-on-year prior to the introduction of the BCF scheme. Had this trend been maintained, then NEAs from Care Homes might have been of the order of 830 for 2017/18, which provides support for a reduction of 346 admissions annually from the Care Homes scheme.

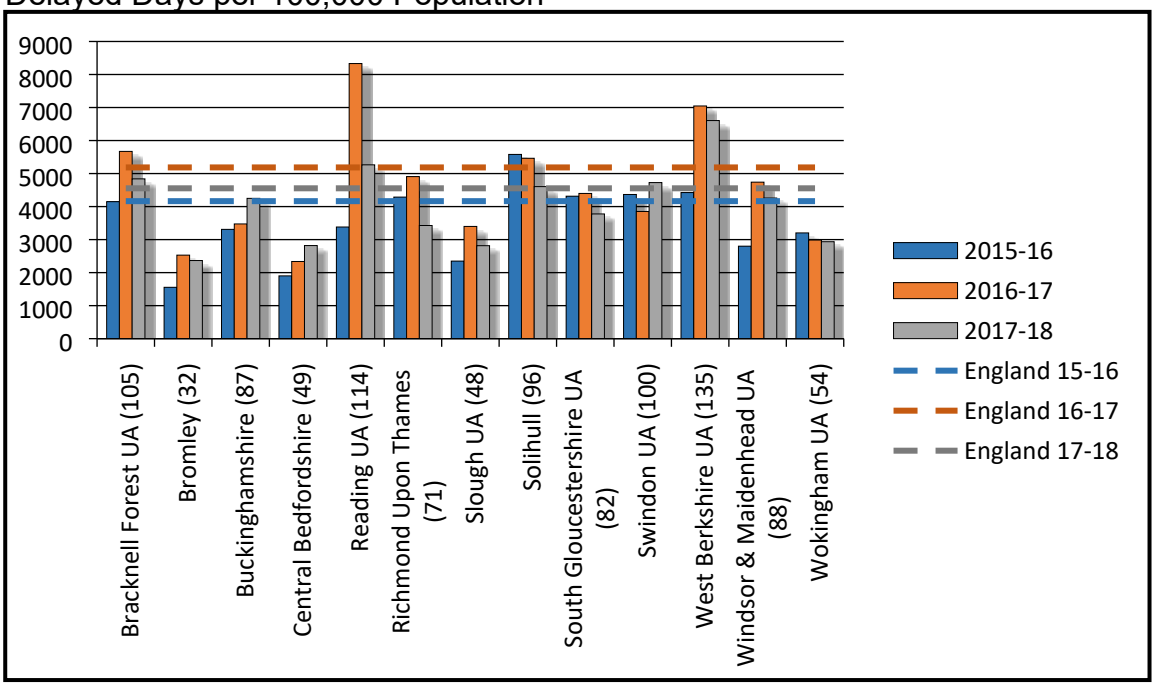
Despite only being in its first year of operation, CHASC achieved a reduction in NEAs of 118 and a reduction of 123 A&E attendances.

Based on the original business case cost of an NEA of £1,074 and the cost of an A&E attendance of £170 for these schemes, the financial benefit to the NHS in 2017/18 was £372,000 and £148,000 respectively.

6.3.2. Delayed Transfers of Care (DToC)
Wokingham has recorded a good performance against its DToC target in 2017/18 as is shown by the table below. DToC for 2017/18 was 3,689 days compared to a plan of 3,840 (4% below plan). This compares to 3,751 days in 2016/17 and represents a 1.7% reduction on the prior year.

Delayed Transfers of Care	BCF SUPPORTING METRIC (NATIONAL)									
BCF SUBMISSION TARGETS		2015-16	16/17				17-18 plans			
		2015-16 Q4	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
Delayed transfers of care (delayed	*Plan*	924	924	924	839	829	960	960	960	960
	Actuals	892	697	1,063	950	1,041	744	984	838	1,123
Quarterly Variance		- 32	- 227	139	111	212	- 216	24	- 122	163
Quarterly Variance %		-3%	-25%	15%	13%	26%	-23%	3%	-13%	17%
RAG Rating										

Delayed Days per 100,000 Population



Wokingham also benchmarks well against its peer group of local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Cumulative data for month 12 for each fiscal year.

The Wokingham Time to Decide (Step Down) scheme has operated at close to capacity for the whole year and has contributed to a saving of 128 bed days. Based on a cost of £400/day for an acute hospital bed, the financial benefit from Time to Decide to the NHS in 2017/18 was £51,000.

6.3.3. WISH

In 2015 a 5 Year detailed business case was prepared as part of the BCF submission of the total costs and benefits from the investment in WISH. The summary 5 year financial plan was as shown below.

WISH overall Business case		**Full Business Case**				
		Revised				
Costs of operation & implementation		**16/17**	**17/18**	**18/19**	**19/20**	**20/21**
Total costs		**999,729**	**1,294,410**	**1,344,662**	**1,344,662**	**1,344,662**
Total Benefits		**-495,858**	**-1,406,094**	**-1,919,930**	**-2,131,461**	**-2,211,345**
Net cost / (Benefit)		**503,871**	**-111,684**	**-575,268**	**-786,799**	**-866,683**
Cumulative Net Cost / (Benefit)		**503,871**	**392,187**	**-183,080**	**-969,880**	**-1,836,563**

Benefits were derived from reductions in residential care, nursing home care, Home Care packages, reductions in DToC and NEAs.

An assessment of actual costs and benefits as at the end of year 2 shows that in broad terms the aggregate benefits are in line with the original business case, while costs are £644,000 less than planned. This is due to savings made in the Time to Decide scheme and the early termination of the Domiciliary Care Plus Night Responder scheme. Cumulatively then, at the end of year 2, WISH is ahead of its planned net benefit position and is on track to meet or exceed the planned 5 year savings target.

In summary

- National Performance Metrics – We exceeded performance in DToCs and Admissions to Care Homes and we have further work to improve NEA and 91 day reablement performance
- Financial Performance – Overall with we came in on budget as we are expecting to receive £61,000 from the CCG for the Connected Care Overspend. More importantly we are able to demonstrate for our business as usual schemes (WISH and TTD) that the planned benefits are being delivered.

Partner Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
Nil

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