TITLE	**Better Care Fund (BCF) Programme 2018/19**
FOR CONSIDERATION BY	Wokingham Borough Wellbeing Board on Thursday, 13 June 2019
WARD	(All Wards);
DIRECTOR/ KEY OFFICER	Matt Pope, Director of Adult Social Care, 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	• Creating physically active communities • Reducing social isolation and loneliness • Narrowing the health inequalities gap Integrated health and social care services are essential building blocks to enable the 3 priorities of the Wellbeing Board.
Key outcomes achieved against the Strategy priority/priorities	• Improved physical health of adults • Creating healthy and resilient communities • Support and collaboration of partners • Those most deprived will enjoy more years in good health • Greater access to health promoting resources

Reason for consideration by Wokingham Borough Wellbeing Board	For information
What (if any) public engagement has been carried out?	N/A
State the financial implications of the decision	N/A

RECOMMENDATION
That the board notes the performance of the Better Care Fund in 2018/19

SUMMARY OF REPORT
To provide a summary of Wokingham's BCF Programme performance for 2018-19 (financial year), including progress of integration, 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. This Programme began in January 2014 and has funding approved to 31st March 2020, with an aim of integrating adult health and social care services. Objectives are reviewed regularly to ensure they remain relevant and to set achievement criteria.

The Better Care Fund (BCF) was developed to pool resources and deliver the integration of adult health and social care services. We are delivering our BCF plan through a pioneering public sector partnership bringing together the NHS community health, primary care, social care and voluntary sector services in the borough. We have been set up to make a positive contribution to help people in Wokingham live longer and enjoy healthier lives than they do now.

Our mission is to achieve this by:

Leading local care and improving lives in Wokingham, with you – right care, right time and right place

Our vision is simple. We believe that by working together and providing responsive and pro-active integrated services, we can help the people of Wokingham to:

- Receive services that meet their needs at the earliest possible opportunity
- Have equal access to health and social care
- Receive safe, effective and compassionate care closer to their homes
- Live healthy, fulfilling and independent lives
- Be part of dynamic, thriving and supportive local communities

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

1. **Partnerships** with other health, social and voluntary sector providers working towards integration and collaboration
2. **Better Care** through targeting investment to improving services, which will be organised and delivered to provide the best, most effective support for all
3. **Better Health** by promoting and supporting healthier lives at the earliest opportunity, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management
4. **Better Value** by making the most cost effective use of our resources and the most efficient and consistent delivery, focusing on prevention and early intervention

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

Local Schemes:

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

2. *Wokingham Integrated Social Care and Health (WISH) Team, including Step Down* WBC's and BHFT's health and social care teams have joined forces to create a more flexible urgent access service. The team provides 3 main functions:
   - Rapid Response - For when I need urgent help
   - Maximising Independence - For when I need to regain my independence

- Facilitated and Supported Discharge - For when I've been in hospital and need support to get home safely

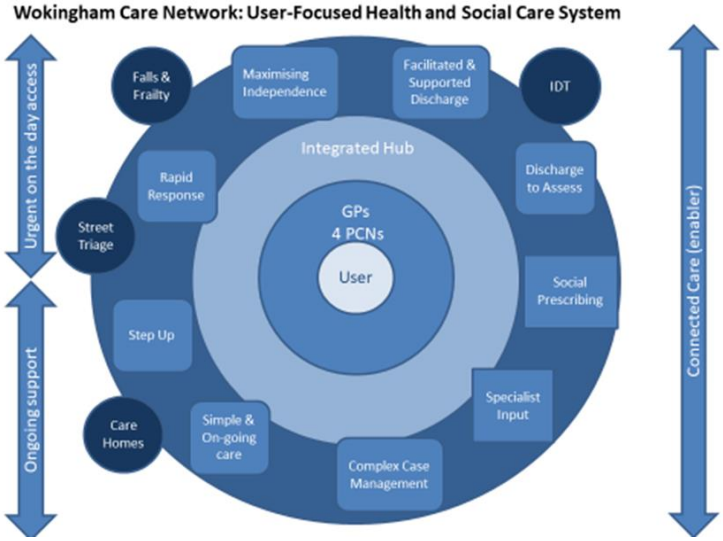
The aim of this integrated service is to reduce the number of people needing to be admitted to hospital or to residential or nursing care and avoid more people being delayed in hospital when they are fit to return home.

3. *Community Health and Social Care (CHASC) including Community Navigators* WBC's, Optalis and BHFT's health and social care teams along with Wokingham GP Alliance and Involve have joined forces to create an integrated service for those people with on-going and longer term needs. The team provides 4 main functions:
   - Simple & On-going care – To meet all my on-going care and support needs
   - Complex Case Management - For when I need care and support that is co-ordinated and planned
   - Specialist Input - For when I need care and support from an expert in a particular field
   - Social Prescribing - To support me to self-care and maximise my wellbeing

   The aim of this service is to support the top 10% of health and social care users focussing on early interventions and prevention, working with GPs in defined neighbourhood/network areas in Wokingham. This year we have introduced revised community MDTs to support our more complex residents, who have one or more needs spanning more than one service that requires goal planning across those services.

4. *Step Up* - Since December 2017 we have provided 6 Step Up beds in Wokingham Community Hospital for our residents providing an alternative to acute hospital admission, in order to avoid the need for a hospital admission or permanent placement in a residential or nursing home. Service delivery will ensure priority is given to optimising patients' health, well-being, function, and independence through a service that may include rehabilitation, nursing, medical or therapy support.

   The aim of this service is to provide community based, in-patient facilities for Wokingham Borough residents experiencing an exacerbation of an existing condition or a decline in health. Admission is for short term, active rehabilitation to promote recovery and return to independence. The service will provide an alternative pathway to acute hospital admission, enabling the provision of care closer to home.



Berkshire West Wide Schemes:

1. *Care Homes (Community Support) Project - incorporating RRAT (Rapid Response and Treatment)* - Offers residents of care homes a co-ordinated, joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of patient from community to acute and back to community and avoiding unnecessary delays in discharges back to the care homes.

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

2. *Connected Care* - This is an integrated IT system, covering NHS and social care services across Berkshire. Currently information is supplied to the system by most GP surgeries, local authorities, acute hospitals and our community health provider. It will allow GPs, ambulance staff, hospital staff, community health workers and social care teams to share some of the key items of information needed to deliver improved care to patients and service users.

3. *Integrated Discharge Team and Trusted Assessment* - This scheme has been business as usual since April 2018 when the IDT service was launched. Achieved by establishing a multi-disciplinary integrated discharge service including LA social workers, focused on 'Home First', co-located in RBH which also continues to look to develop as a system wide service. The aim is to reduce 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.

4. *Street Triage – Mental Health* - The Berkshire West street triage service became operational 7 nights a week on the 3rd July 2017 and is delivered by Band 7 Advanced MH Practitioners working alongside an allocated officer between 17.30 and 03.00. They operate out of Reading or Newbury Police Station. The aim of the service is to reduce use of police custody and use of section 136 of the mental health act which allows the police to take the person to a place of safety from a public place. Enabling people to access the right support at times of potential crisis can also reduce avoidable hospital admissions and A&E attendances.

5. *Falls and Frailty* - To improve the user 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 reduce A&E attendances. The service has recently increased to a seven day service for a two-month trial period to evaluate the effectiveness and impact of the service. Non-conveyance rate is maintained between 75% and 80%.

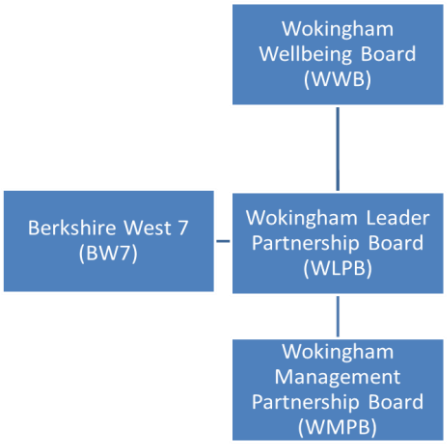
Brokerage service for self-funders at the RBFT (provided by CHS) - It was identified in 2017/18 that people who have to self-fund care were frequently delayed in a hospital bed. A pilot ran in 2017/18 and a 3 year contract was then awarded to CHS in Sept 2018 to place 35 self-funders, who are on the DToC list, a month with a SLA of a placement within a median of 5 days. To support people who are patients at the Royal Berkshire Hospital who are self-funding and require care services or care home placement find this in a timely manner to prevent delayed days in hospital.

Wokingham's BCF Programme 2018/19 Performance Summary

1. Governance

During 2017/18 we recognised that a change to the governance was needed in order to further support and build on our integration plan, as our partnership was led by the 2 commissioning organisations in Wokingham Borough with all other organisations being members of the partnership. Through consultation with our members and the Wokingham Wellbeing Board (WWB) we agreed to form The Wokingham Integrated Partnership and explored multiple governance options.

Following a final review by the CCG in December 2018 and being mindful of the developing ICS and the NHS Long Term Plan it was proposed that a set of Guiding Principles would be preferable to an Memorandum of Understanding; this had final sign off at February 2019 Well Being Board.



The Partnership has 2 boards, the Wokingham Leader Partnership Board (WLPB) and the Wokingham Management Partnership Board (WMPB) which have operated in shadow format for much of 2018/19 whilst the mechanism for the partnership was agreed and signed off by the relevant organisations.

WLPB - a sub-partnership of the HWB; leads the development of and provides strategic direction to the Partnership. Responsible for the business and overall performance of BCF projects and Wokingham's Health and Social Care Integration programme. This Board is chaired by the Executive Member for Adult Social Care, Health and Well Being and Housing

WMPB - responsible for the day to day leadership, management and support of the activities of the Partnership. The focus is to have a tactical level of detail, ensuring the processes are in place to support high quality outcomes for services and the population of the Wokingham Borough.

The Wokingham Leader Partnership board has 5 partners:

- Berkshire West Clinical Commissioning Group (CCG)
- Wokingham Borough Council (WBC)
- Berkshire Healthcare NHS Foundation Trust (BHFT)
- The Royal Berkshire NHS Foundation Trust (RBFT)
- Wokingham GP Alliance

And it has 3 members:

- Optalis
- Healthwatch
- Involve

To support the development of our emerging governance Wokingham's Integration Position Statement (IPS) for adult health and social care was developed and agreed this year to set out our long-term vision for the future of public services in Wokingham, explain what new approaches and services are needed, and encourage our partners to help us formulate new ideas and ways of doing business. The purpose of this statement is to let people know where we in Wokingham stand with regards to Integration of Adult Health and Social Care.

It aims to set out clear, concise messages to be communicated to all stakeholders about:

- What is Integration in Adult Health and Social Care?
- Why should Integration be a focus for all?
- Where have we got to with Integration in Wokingham?
- Where are we heading with Integration?
- How are we going to get there?

It was signed off by the Wokingham Wellbeing Board in November 2018. The IPS is recognised by the Board as important and significant steps in the development of the new collaborative partnership for health and social care in Wokingham.

2. Integration Success Story Highlights

2.1 We have developed and published our first Integration Position Statement; our clear statement, available to everyone, about our approach to making sure that Adult Social Care and Health in Wokingham is the best that it can be. Setting out as clearly as possible our vision and strategy which will shape integration going forward.

2.2 Keeping people at home safe and for longer as demonstrated by our 91 day target and reduction in permanent care home placements (see section XX for further detail).

2.3 For our Integrated Hub user satisfaction of the service is high with 100% of users reporting that all their questions are answered and that staff are polite and respectful and 89% of users report that they are satisfied with the ease of contact.

2.4 The Care Homes Project reported that at the end of Q3 of 2018/19 the project is reporting a 4% decrease in See, Treat & Convey (STC), a 7.5% decrease in A&E contacts and an 11% decrease in Non elective Admissions (NEAs) from care homes in Berkshire West.

2.5 We have implemented a Care home live bed state portal which can be accessed by the relevant health and social care staff across Berkshire West.

2.6 Our Street Triage team reported the following success:

- In 2017/18 that it avoided 150 section 136's which resulted in a saving of £256,500 (the service costs - £222,000)

- A significant decrease in the number of individuals with mental health presentations being detained in Police Custody (cost of holding a person in custody overnight is £418).
- In 2018/19 Q1 and Q2 avoided 69 section 136's which resulted in a saving of £117,990.

2.7 For our residents that have been through the MDTs we have seen a reduction in emergency admissions of 30%, a reduction in attendances at A&E of 25% and a reduction in calls to our out of hour GP service of 27%. The article below is a patient story that we published in the Borough News and there is a video available on YouTube, Integration of health and social care in Wokingham, Berkshire, showing the full interview. https://www.youtube.com/watch?v=9ZwFpgPQTG8&feature=youtu.be

MDTs have also supported joint working, as well as an effective complex case management tool, developing health and social care partnership working on the ground.

Working as one for Guy

Guy has chronic diabetes and has had two brain aneurysms and two strokes.

"For the first two months of the year I was in and out of hospital every other week, or every two weeks, so I spent half my time in hospital."

Now he's under the care of an integrated health and social care team, Guy has not been admitted to hospital in six months.

"I have what is called a multi-disciplinary team for the different aspects of my needs. We meet every month and I explain to them what's needed and they sort things out."

GUY'S TEAM:

Social worker • Occupational therapist
District nurse • Diabetic nurse
Housing officer • GP
Transform Housing & Support charity

Guy's kitchen is one of the things the team has sorted. "I'm not having ready meals anymore. I can cook what I like, within reason, and I think one of the biggest reasons I haven't been back into hospital is because I can provide for myself."

He says integrated teams give him a better outcome and a better leave of life. "It's like a proper networking system and is a lot faster and a lot more informative. It's one of the best ideas."

Guy's multi-disciplinary/integrated health and social care team in the Wokingham Borough is thanks to the Better Care Fund (BCF).

Launched in 2014, the BCF brings together us, the NHS, and community organisations to create joined-up health and care services directly in people's homes. By doing this, people can manage their own health and wellbeing to live independently for as long as possible.

WOKINGHAM'S ADULT INTEGRATED TEAM:

Wokingham Borough Council • Berkshire Healthcare NHS Foundation Trust • Berkshire West CCG
Wokingham GP Alliance • Involve charity • Royal Berkshire NHS Foundation Trust • Optalis

This new approach means people only need to tell their story once because their information is shared among all the professionals involved. It also gives people more power to shape their own care to what they need. This helps them stay at home, which in turn shifts traditional hospital care into the community where it has the most effect.

More information:
rhian.warner@wokingham.gov.uk

2.8 Our year-end forecast underspend reported in Q2 was redistributed in Q3 to fund 3 short term schemes (4 month duration to 31.03.19) – Paramedic Home Visiting Service, Therapy Demand for Reablement and Demand Management in ASC to support NEAs and DToC performance through the winter period. We reviewed the performance of

these schemes in Q4, which all achieved their planned outcomes. These schemes will not be continuing into 2019/20.

2.9 Community Navigators (Social Prescribing) - In 2018/19 the service received 242 referrals with 87% of users reporting that they felt more self-reliant, shown in the chart below.

CNS User Quotes

21 year old man with cerebral palsy and mobility issues, looking for social opportunities/ activities.

"My son has found help and we have a much better understanding of how to find help now."
Mother

A lady called on behalf of her father who needed support with transport and was becoming isolated.

"Your info was very helpful, things have been set up for my father now. Will definitely contact you in future if we need further help."

Patient told to contact us by his GP – after navigator appointment he phoned to say thank you to the Volunteer. He had contact from a local 'home care for the elderly' organisation who had been out to visit him. They are going to arrange for someone to visit him once a week and take him out.

2.10 Our step up service is now operating at planned capacity following a 9 month ramp up. In 2018/19 the service supported avoidance of NEAs (102 avoided) and A&E attendances (127 avoided).

3. Risks/Challenges during 2018/19

3.1 Top 3 Risks
1. Non-delivery of emergency admissions target **-** Further embedding and developing our established integrated care model fails to translate into the required reductions in emergency admissions, impacting the overall funding available to support core services and future schemes. Financial risk impacts mainly on Council and CCG, operational risk is borne by provide.
Mitigations: We have a number of controls in place including regular reporting and monitoring in which we have been able to identify the age bands with the highest

percentage activity growth. Moving to a population health management approach to provide more targeted interventions.

2. Recruitment and retention of workforce - All organisations in Wokingham and Berkshire West are experiencing this issue which impacts service delivery and patient experience and outcomes.
Mitigations: Berkshire West ICS have a workforce work stream where they are exploring options which Wokingham are linked in with. Joint commissioning is also being explored across Berkshire West, with one area to be explored is the sustainability of the care market.

4. *Culture change* - Culture, physical and structural change within and between organisations is a critical to the success of integrating systems, organisations and services. Culture change is always challenging and can take long periods of time to embed.
Mitigations – Development of the Adult Health and Social Care Integrated Position Statement. Monthly Partnership Newsletters. A specific work stream for 19/20 to develop culture change opportunities.

3.2 Top 3 Challenges
1. 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.
Mitigations:
- 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 7 Programme Office were held throughout the year.
- In particular, analysis of positive progress within WBC to identify ideas for improving DToC performance was a key factor.

2. Wokingham's iBCF for 18/19 was £112,780. 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:
- The iBCF did not affect decisions on the budget and there were no new metrics introduced to isolate and measure the iBCF improvements

3. Services underperforming due to lack of utilisation. At present, elements of services (MDTs, CNS, Step Up and Step Down) are not receiving sufficient referrals. Mitigation:
- Escalation process for MDTs
- Regular comms and meetings e.g. GP Council Meeting and sharing of performance
- Access to the IPA Risk Stratification tool to pro-actively select users

4. Performance Metrics

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

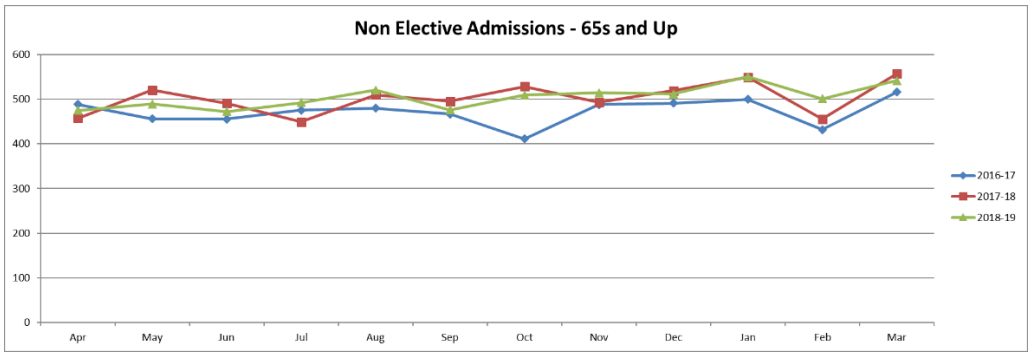
4.1 Non-Elective Admissions (NEAs)
NEAs for 2018/19 were 14,789 compared to a Plan figure of 12,848 (15.1% higher) and for the same period in the prior year of 13,630 (8.5% higher).NEAs for 2017/18 were 13,630 versus plan of 12,612, (8.1% above plan).

Non - Elective Admissions (General and Acute)										
		Baseline					Pay for performance period			
		2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	2018-19 Q3	2018-19 Q4
Total non-elective	Plan	3,230	3,036	3,113	3,231	3,232	3,093	3,170	3,291	3,294
	Actual	3,230	3,324	3,367	3,512	3,427	3,564	3,555	3,799	3,871
Quarterly Variance		-	288	254	281	195	471	385	508	577
Quarterly Variance %		0.0%	9.5%	8.2%	8.7%	6.0%	15.2%	12.1%	15.4%	17.5%
RAG Rating										

When looking at NEAs by Age Band we continue to show a static performance for the >65 Age Bands over the past two years:

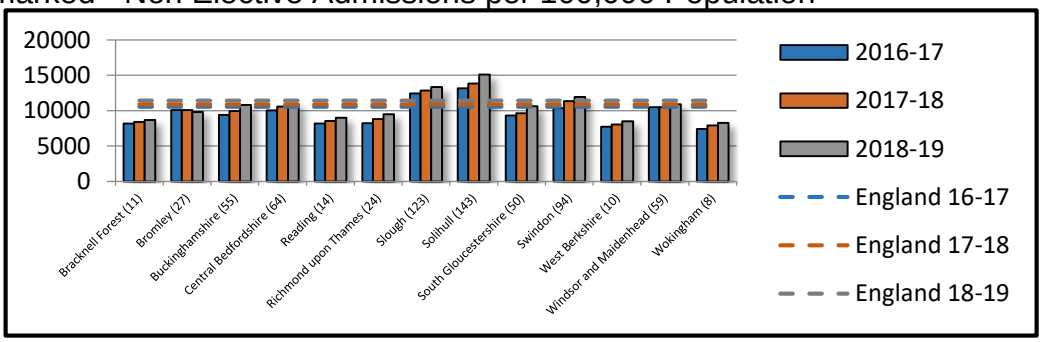
- 2016/17 5,660
- 2017/18 6,026
- 2018/19 6,054

With the population of this age band growing by 3% year on year.



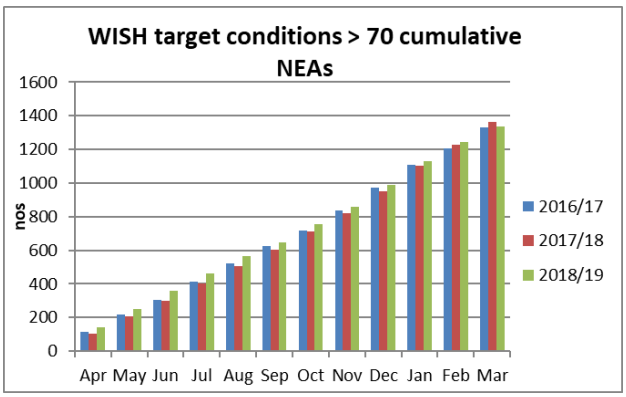
We have compared our performance nationally and Wokingham is the 8th best performer in England for non-elective admissions, a slight reduction in our performance compared with 17/18 when Wokingham's NEA rate is ranked 3rd best (out of 207 CCGs) for performance, the best performance of the 4 Berkshire West CCG localities.

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)

WISH team NEAs for the Target Conditions and > 70 years of age were 1,336 for 2018/19. This compares to 1,365 in 2017/18 and 1,329 for 2016/17. This demonstrates that overall figures for the target group have remained static over the past three years.

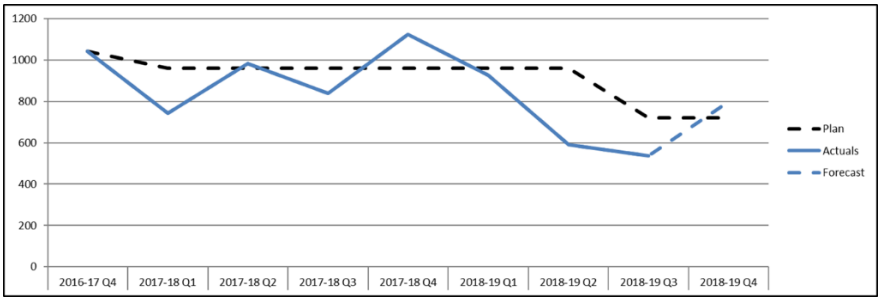


The priority focus of schemes in the BCF was the Frail Elderly and the +70 age group. The investment in BCF schemes and in particular the WISH, CHASC and the Rapid Response and Treatment scheme in Care Homes, has been successful in keeping the level of NEAs for this target group largely static over the last three years.

4.2 Delayed Transfers of Care (DToC)

DToC days for 2018/19 were 3,001 days v Plan of 3,360 (10.7% better than plan). This compares to 3,689 days for the same period in the prior year (18.6% reduction year-on-year). Overall for the year we have met the target in 3 of the 4 quarters, Q4 was above plan figure, although a similar peak was seen in Q4 of all prior years. This might have looked differently had the plan been phased to recognise the higher number of days during the winter quarter, but this request was not agreed by NHS England.

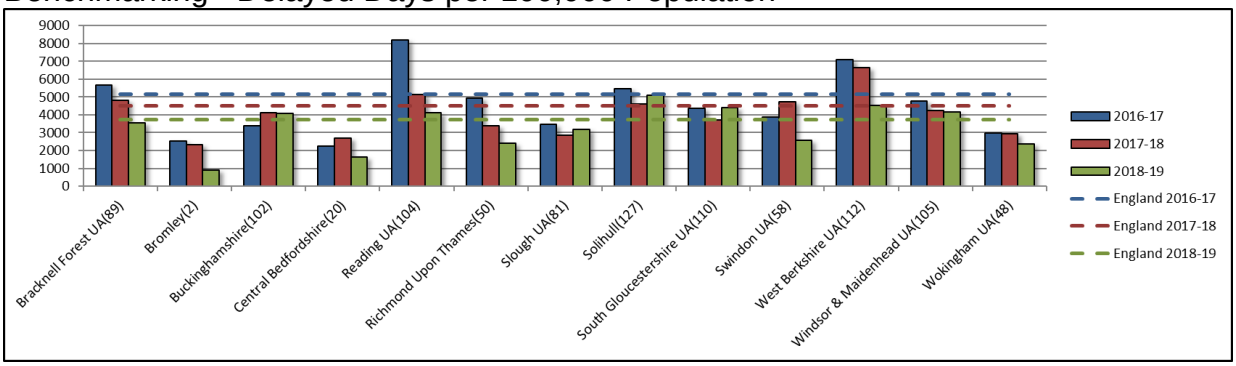
Delayed Transfers of Care	BCF SUPPORTING METRIC (NATIONAL)									
		2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	2018-19 Q3	2018-19 Q4
Delayed transfers of care	*Plan*	1,041	960	960	960	960	960	960	720	720
	Actuals	1,041	744	984	838	1,123	927	591	537	946
Quarterly Variance		-	- 216	24	- 122	163	- 33	- 369	- 183	226
Quarterly Variance %		0%	-23%	3%	-13%	17%	-3%	-38%	-25%	31%
RAG Rating										



It must also be noted that we have made a significant improvement in delayed days for social care, which has reduced from 765 days (Nov–March 2017/18) to 320 days (Nov-March 2018/19), a 58% reduction on the previous year.

We have compared our performance nationally and Wokingham is now ranked 48th, improved from 54th in 2017/18.

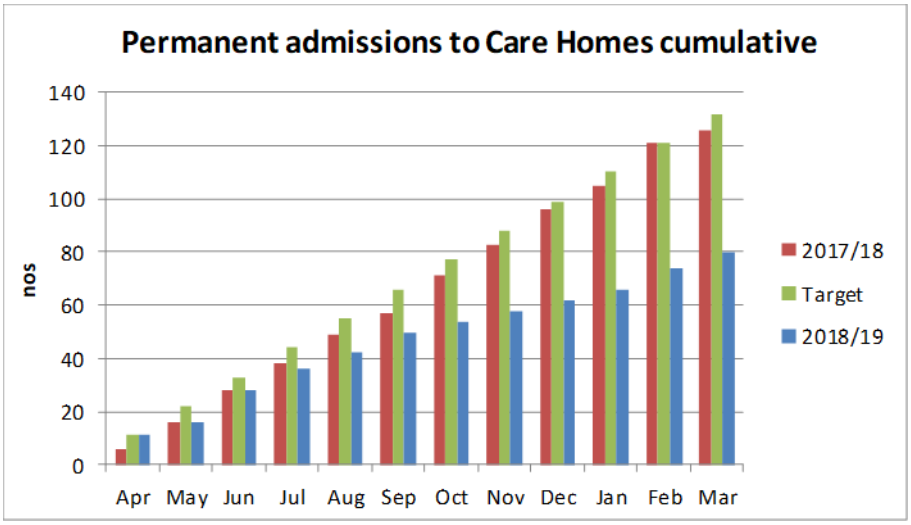
Benchmarking - Delayed Days per 100,000 Population



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)

4.2 Permanent Admissions to Care Homes

Permanent Admissions to Care Homes for 2018/19 were 80 against a target of 132 and 126 for 2017/18.



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.

4.3 91 day target

This relates to the number of people who have been discharged from hospital into rehabilitation/reablement services that are still at home 91 days after discharge. We achieved an average 87% for 2018/19 against a target of 85%.

4.4 Local Metrics

We do collect further metrics to understand our performance.

5. Finances (including initial benefits realisation)

5.1 BCF Budget 2017/18
The Wokingham BCF budget for 2018/19 was £10,011,100 and for the 12 months ended 31st March 2019, there was a net underspend against budget of £32.0k. Any net underspend on the BCF will be returned to the Section 75 Partners pro-rata to their original contributions, (Berkshire West CCG 80%; WBC 20%). The CCG has requested a credit note to be issued in April. The WBC share of the underspend will be carried forward into 2019/20 to contribute to funding the next year's BCF.

Year-to-date there were underspends on the following schemes:
- Berkshire Integrated Hub £8.8k
- WISH £90.7k
- Step Up £40.8k
- CHASC £48.1k
- Local Programme Office £11.7k
- BW PMO £6.9k
- Contingency £8.4k

The following schemes were overspent:
- Step Down Beds £12.9k;
- SCAS Falls & Frailty £4.7k
- CHS £27.3k
- Connected Care £7.0k

5.2. Risk share
The Wokingham BCF budget for 2018/19 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 2018/19. 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 4.1 above). 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.

5.3. Benefits realisation

During 2018/19 we have worked hard to be able to demonstrate the financial benefits of the Wokingham BCF schemes. We went back to the original business cases and are now in a position to demonstrate the planned and actual savings during the last year. Benefits were derived from reductions in residential care/nursing care, DToC and NEAs.

The table below shows the overall performance for 2018/19. We planned to save £2,513,448 and we actually saved £2,466,209.

The main reasons we have performed well are:
- Permanent Admissions to Care Homes - assuming each reduction avoids a permanent admission to a Care Home by at least 12 months and an annual cost of £40,720 per placement, the savings for 2018/19 are £2,117,440, which exceeds the Planned Year Savings in the 5 Year Business Case
- Step Up NEAs and A&E attendances – combined savings from NEAs and A& E attendances for 2018/19 are £131,135

We recognise that whilst we didn't achieve the planned benefits for MDT NEAs and A&E attendances - reductions averaging 8 NEAs a month vs. a target of 28, but the MDT referrals are not at capacity and as an average have been 40% lower than planned. The same applies to A&E attendance reduction.

Metric/KPI	Month Activity Plan	Month Activity Actual	Month Savings	Full Year Activity Plan	YTD Total Activity	YTD Actual Savings	YTD Out-turn Savings	Planned Year Savings
WISH Reduction in NEAs over 70s with 13 specific conditions	114	93	£23,117	1,365	1,336	£31.923	£31.923	£412,809
WISH Reduction in DToCs	240	306	n/a	3,280	3,111	£59,150	£59,150	£129,180
WISH Reduction in care packages	-	-	-	-	-	-	-	£145,229
WISH Reduction in care home admissions	11	6	£203,600	132	80	£2,117,440	£2,117,440	£1,232,784
91 Day Reablement	78%	86%	N/A	78%	87%	N/A	N/A	N/A
MDT NEA reduction	28	4	£4,295	331	96	£103,101	£103,101	£355,484
MDT A&E reduction	42	2	£340	499	138	£23,460	£23,460	£84,830
Step Up NEA reduction	10	20	£21,479	119	102	£109,545	£109,545	£127,802
Step Up A&E reduction	13	25	£4,250	149	127	£21,590	£21,590	£25,330
TOTAL BENEFITS	[redacted]	[redacted]	£257,081	[redacted]	[redacted]	£2,466,209	£2,466,209	£2,513,448

NEA (for WISH) = £1,100.82 DToC (for WISH) = £350/bed/night
Permanent Admission to Care Home =£40,720 p.a. NEA (for MDTs and Step Up) = £1073.97
A&E attendances (for MDTs and Step Up) = £170

At present, WISH CHASC and Step Up, are ahead of its planned net benefit position and is on track to meet or exceed the planned 5 year savings target.

5.4 Review of Schemes

Each year we carry out a review of our schemes to assure and ensure that they are delivering against plan. We completed our yearly BCF Review of Schemes in November 2018, all Wokingham BCF schemes were reviewed in detail by stakeholders to inform decisions as to how the schemes may progress in the next financial year – continue as is, with changes or for the schemes to cease. In order to do this in an objective manner we have created a template and scoring system, which can be seen on the next page.

The partners and members of both WLPB and WMPB, all partners agreed the following:

1. Step Down – service to cease in current format as not delivering on any of its outcomes and has been in place for 2 years. The scheme used 3 beds in an extra care facility (Alexandra Place), with a focus on supporting Delayed Transfers of Care (DTOC) from acute hospital beds. It has been agreed that the funding from the Step Down scheme would be utilised to support DToC in 2019/20 and onwards.
2. Step Up – It was acknowledged that this service has been a slow burn and that November was the first month referral capacity had been reached. If the activity is maintained the scheme does not require further review. Step Up has maintained its activity and all other KPIs.
3. All our schemes have been implemented as planned with schemes becoming business as usual within our current model, this has put us in a strong position to further develop our schemes into a single network model.

2018/19 BCF Review of Schemes Scores

		Risks/ Dependencies		Performance				Finance				
Scheme	Maturity	What is the risk that this scheme doesn't deliver its benefits?	Is the scheme delivering against its activity plan?	Is the scheme delivering against its KPIs?	Is the scheme demonstrating its ability to support people effectively and improves user satisfaction?	Does it meet Wokingham's integration goals/targets?	Has it delivered on its planned outcomes?	Does the scheme meet the goals of the ICS and the priorities of the Wokingham HWB?	Is the scheme achieving its planned costs/ expenditure?	Is the scheme achieving its planned benefits?	Total	%age
Hub	BAU	80	60	N/A	60	70	70	70	70	70	550	69%
WISH	BAU	80	80	70	60	70	80	70	80	80	670	74%
Step Down	BAU	30	20	10	40	40	10	70	70	10	300	33%
CHASC	Implement	50	40	40	70	70	70	80	70	40	530	59%
Step Up	Implement	40	20	30	40	40	30	70	70	10	350	39%
CNS	BAU	80	60	70	80	70	70	80	70	70	650	72%

6. Forward Plans for 2019/20

In order to further develop our Integration Programme for Wokingham and to ensure alignment with the emerging Berkshire West ICP, the Wokingham Well-being Board Key Priorities and the NHS Long Term Plan we held an Annual Planning Day Workshop on the 4th April. The outcomes from this day will be to identify and agree our key priorities and next steps for 2019/20.

In summary

- National Performance Metrics – We exceeded performance in DToCs, Admissions to Care Homes and 91 day reablement performance, we continue to have further work to improve NEA performance
- Financial Performance – Overall we came in on budget but more importantly we are able to demonstrate for our schemes that the planned benefits are being delivered.

Partner Implications
The Better Care Fund Programme is delivered by the Wokingham Integrated Partnership, a partnership of commissioners and providers in Wokingham Borough.

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

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