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Notice of Meeting

Extraordinary Health and Wellbeing Board

Thursday, 6 February, 2014 at 9.00am

in Committee Room 1 Council Offices
Market Street Newbury

Date of despatch of Agenda: Tuesday, 4 February 2014

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss on (01635) 503124
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason, Councillor Graham Pask (Non-voting), Rachael Wardell (WBC - Community Services), Councillor Quentin Webb and Dr Rupert Woolley (North and West Reading CCG)

Also to: John Ashworth (WBC - Environment), Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Balwinder Kaur (WBC - Adult Social Care), Matthew Tait (NHS Commissioning Board), Cathy Winfield (Berkshire West CCGs) and Lesley Wyman (WBC - Public Health & Wellbeing)

Agenda

Part I

Page No.

1 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

2 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.

3 **Better Care Fund** 1 - 38
Purpose: To update Health and Wellbeing Board of the Better Care Fund and seek agreement to the high level plan as to how the single pooled budget will be used.

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

NHS
Newbury and District
Clinical Commissioning Group

West Berkshire
COUNCIL

Title of Report:	**Better Care Fund**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	6 February 2014

Purpose of Report: To update Health and Wellbeing Board of the Better Care Fund and seek agreement to the high level plan as to how the single pooled budget will be used.

Recommended Action: The Health and Wellbeing Board to approve the joint plans agreed between the CCGs and the Council for use of the Better Care Fund.

Reason for decision to be taken: To allow for the joint plans to be submitted to NHS England and the Local Government Association.

Other options considered: None

Key background documentation: Better Care Fund report considered by HWBB at its meeting on the 23rd January 2014.

Agenda Item 3

1. Introduction

1.1 The principle of the Better Care Fund (BCF) is for health and social care services to work more closely together. It supports a local commitment to moving towards better integrated services, working closely in partnership through a single pooled budget, better outcomes and better value for money. The BCF provides for £3.8 billion worth of funding nationally in 2015/16 to be spent locally on health and care with the aim of "achieving closer integration and improve outcomes for patients and service users and carers".

1.2 In 2014/15, a transfer of £900m is already planned from the NHS to adult social care and a further £200m will be transferred to enable localities to prepare for the Better Care Fund in 2015/16.

1.3 A detailed explanation of the BCF was provided at the HWBB on the 23rd January 2014.

1.4 Local areas Clinical Commissioning Groups (CCGs) and Local Authorities are required to formulate a joint plan for integrated health and social care and to set out how their single pooled BCF budget will be used to facilitate closer working between health and social care services. The first draft of these plans has to be submitted to NHS England and the Local Government Association by the 14th February 2014 as required by the Department of Health under guidance issued on 20th December 2013.

1.5 BCF plans must deliver on national conditions:

- Protecting social care services
- 7 day services to support discharge
- Data sharing and the use of the NHS number
- Joint assessments and accountable lead professional

1.6 The Better Care Fund is integral to the NHS Strategic & Operational Planning process and local government planning.

- NHS England launched a 'Call to Action' in July this year, which outlines the key national challenges facing the NHS over the next 10 years.
- Clinical Commissioning Groups (CCGs) are required to submit 5-year strategic, operational & financial plans, with the first two years at an operational level of detail.

- Timing for the BCF is aligned with the CCG 2-year operational plans:
- Draft BCF plan due by 14 February 2014
- Final BCF plan due by 4 April 2014

1.7 Further additional work is needed to link and align the BCF submission with local CCG's two and five year plans, due for completion alongside the final version of the BCF plan by 4th April 2014. The finance section below outlines the current understanding around how the BCF will impact local Health/ Social Care economy.

1.8 The first cut BCF submission, due on 14th February 2014, requires the agreement of HWB. Further detailed work will then be undertaken in February and March to ensure that detailed plans are developed and in place for final submission by the 4th April 2014.

1.9 The report outlines the main issues and the attached draft submission and associated papers are presented for consideration by the West Berkshire Health and Wellbeing Board

2. The Fund

2.1 Individual Better Care Fund allocations were announced on the 19th December 2013 with the headline figure for 2015/16 being £9,585,000 for West Berkshire. However there are a number of key points to be made regarding the fund;

- There is no new money being provided, The fund is predominately being created by transferring £8.58m from local CCG budgets.
- The BCF includes the £726k Disabled Facilities Grant, this has to be passed to the relevant Housing service.
- The BCF includes £279k of capital monies
- The BCF includes £1.793m of existing base budget spending by WBC under a Section 256 agreement
- The BCF includes £1.061m of existing base budget funding of Carers grants and Reablement.

and most significantly of all for West Berkshire Council as one of only 3 Councils who will be required to change its social care eligibility criteria

- The BCF guidance states that it includes funding for local authorities to meet their new responsibilities in 2015/16 arising from the Care Bill.

- WBC modelling of the new Care Bill duties currently shows an expected cost of £7.075m in 2015/16. The Local Government settlement includes an Adult Social Care New Burdens Grant however the provisional allocation for WBC is just £595k. It would appear that the Department of Health consider that the remaining Care Bill funding has been provided via the BCF.

3. Issues

3.1 The West Berkshire Better Care Fund will take a "whole systems" approach to health and social care provision whereby budgets are aligned and pooled to improve outcomes for local residents. This will maximise, on a sustainable and practical basis, the budgets that can be incorporated into the pooled budget to promote the joint planning and sharing of risks over time to ensure sustainable health and social services.

3.2 There is a requirement to consider the impact of BCF proposals on NHS providers. Both NHS trusts have been directly involved in the planning process for BCF and discussion on the future vision of services. The NHS providers are being asked to see how best they can focus service delivery in West Berkshire for more local, person centred delivery that can be integrated across health and social care to achieve improved outcomes for residents.. Other stakeholders will be included in an engagement plan that will follow in the coming months.

3.3 There is a process of NHS (E) assurance and feedback that will need to be incorporated in the final version. It is proposed that an update will be provided to the Health and Wellbeing Board in time for any feedback to be incorporated into the final version of the BCF Plan, which is to be agreed with NHS England by 4th April 2014.

3.4 The performance measures required under the BCF guidance are mainly nationally prescribed, and are outlined in the draft submission in Appendix 1.

4. Proposed Use of BCF

4.1 A planning template and a financial summary template have been provided by the DH to be used to submit the draft BCF plans, these are attached as Appendix A and Appendix B. What follows is a very high level explanation of each new proposal:-

4.2 **Direct Commissioning of Care by Community Nurses and other community clinicians** - At present all requests for social care from community Nurses and other community clinicians have to be routed through the Council's Access for All service who then arrange for a member of staff to visit the patient and assess what social care is required. Once this is complete a service request goes to the Council's Enablement Service. This proposal is that the Community Clinician etc. would make the request for care direct to the joint Health and Social care Provider (see point 4.5 above). The Community Nurse is in contact with most patients who need care and are best placed to make an initial estimate of care that is needed. The role of the joint Health and Social Care Provider, together with the keyworker from the coordinating service is then to work with the client to ensure that there ongoing care needs, if any, are appropriately met.

4.3 **Access to Health and Social Care services through the HUB** - to build on the new Health HUB there is potential to develop this into a Single Point of Access for both health and social care professionals. When the service carries out its triage service users will be linked to the appropriate service(s) irrespective of whether delivered by Health or Social Care professionals.

4.4 **Creating the role of a Personal Recovery Guide / Keyworker** - consistent with the Elderly Care Pathway initiative the creation of a new role of a Personal Recovery Guide / Keyworker is recommended. This person will help to progress individuals through a complex array of services, and if needed help them to access a Personal Budget to maintain momentum for the Individual and allow them to be more in control of their 'journey'. Creating this new role may include the re-deployment of some existing staff, recruiting new staff and working with the voluntary sector.

4.5 **Joint Care Provider** - The Council's Maximising Independence Team and Homecare Team, and the Berkshire Health Foundation Trust's Intermediate Care as part of the Integrated Community Health services have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system. Developing these three staffing units into a combined service would simplify the deployment to support individuals, would cut out artificial service transfers, increase continuity of service, and create efficiencies by avoiding duplication; initially this could be created as a 'Pooled' service, developing into a Pooled Budget.

4.6 **Social Care 7 day working** – there is already an emergency response service in place separately for both the Council and the BHFT, together with separate services for routine care and support between 7am and 10pm 7 days per week. Integrating this network of response services would make access simpler and would remove the need to decide which service should take responsibility.

4.7 **Hospital at Home –** this service will enable people with long-term health problems who are heavily dependent on health and social care services to receive the best possible, affordable care in their own homes.

This scheme will offer a safe alternative to hospitalisation and prevent unnecessary admissions. The service will operate within each Berkshire West CCG including Newbury & District, supported by the Berkshire Healthcare Foundation Health Hub. The aim of is to provide a service that standardises practice in relation to the management of patients with complex care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

The benefits Hospital at Home will deliver include:

- Improved healthcare experience for Newbury & District patients;
- An integrated approach to care;
- Reduction in unnecessary admissions;
- Reduction in outpatient attendances;
- Improved access to Intravenous Therapy;
- Improved quality of life for patients;
- Improved coordination of crisis management.

Locally to Newbury & District CCG, the CCG is leading on an initial feasibility study into an 'Urgent Care Unit' which would directly interface with, and sit under, the Hospital at Home proposal but based in existing facilities within West Berkshire Community Hospital.

4.8 **Nursing / Care Home project** – The aim of the group is to improve the quality of care and provision of service to and within care homes within West Berkshire. To support this aim the group identified 8 work strands

- Analysis of activity data
- Improving access to services
- Developing clinical pathways/standards/protocols
- Skills development for staff
- Leadership development and management in care homes
- Medication Optimisation
- Communication and engagement
- Resident and relative views

This scheme will provide a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents.

The aim is to reduce non-elective hospital admissions from care homes through introducing a GP enhanced community service. It will do this through strengthening partnership working between care home providers, community geriatricians, health and care staff to improve the quality of life for residents by reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents.

4.9 **Meeting the requirements of the Care Bill** - this includes expanding eligibility for Council Services to meet the new lower eligibility criteria and providing far more support to carers It will mean that individuals will receive care at an earlier stage which will have a positive impact on admission avoidance, and on maintaining independence. . The guidance makes it clear that the BCF includes funding for certain elements of the Care Bill and this has been covered in more detail at Section 5 below.

4.10 As mentioned at 4.1 above, further details of the plans along with performance measures are provided on the DH template appended to this report.

5. Financial Risk

5.1 All of the schemes outlined in this paper would make good use of the BCF and present opportunities for improved services and eventual cost reductions from both more efficient arrangements and downward pressure on long term

care costs. However for the Council there is a very significant risk arising from the statement in the BCF guidance that it includes the funding for some of the most important changes arising from the Care Bill 2013.

5.2 The Council's current modelling of the financial impact of the Care Bill suggests costs of £7.075m in 2015/16, reducing to around £5.7m in the following 3 years before rising to £8.76m in 2019/20.

5.3 The following table provides a breakdown of the key elements and the source of the funding (based on the wording on the NHS England Planning Guidance document). For a number of items it is not possible to identify the likely costs, if any, until more details of the changes are available.

Item	**Expected Cost 15/16**	**Funding Available**	**Residual Financial Risk**
Items listed in planning guidance as funded via BCF			
New entitlements for Carers	£3,575,000	£1,507,000	£5,568,000
National Minimum Eligibility Threshold	£2,510,000		
Better information & advice	Not known		
Advocacy	Not known		
Safeguarding	Not known		
'Other' (loss of client income from change in assets threshold)	£990,000		
Total	**£7,075,000**	**£1,507,000**	**£5,568,000**

Items listed in guidance for LG New Burdens Grant 2015/16			
	Expected Cost 15/16	**Funding Available**	**Residual Financial Risk**
Deferred Payments	Not known	£595,000	-£595,000
Cap on Care Costs – transitional arrangements	Not known		
Total		**£595,000**	**-£595,000**
Combined	**£7,075,000**	**£2,102,000**	**£4,973,000**

5.4 The above costs have been predominantly based on guidance provided by the Department of Health. For instance the guidance stated that Councils currently with eligibility criteria above 'Substantial' should expect to see costs rise between 3% and 5%. As a Council currently at 'Critical only' than we would be at the top end of that range.

5.5 The provisional figures for 2015/16 Local Government Settlement include an Adult Social Care 'New Burdens' grant of £595,000.

5.6 There is no detailed information available to clarify what amount of the BCF has been allocated for Care Bill costs. All that can be done is to make an assumption based on the £135 million nationally that has been identified for these new duties. This would provide a suggested figure in the BCF of £1.02m. The plans outlined in this report would allow £1.507m of the BCF to be made available for the Care Bill costs.

5.7 Appendix C provides a full breakdown of the proposed BCF spending. Appendix D shows the position the BCF would be in should it be used to fully fund those Care Bill costs listed in the DH guidance document.

5.8 West Berkshire is one of just 3 councils in England that currently operate at 'critical only' and therefore face significant new costs arising from the change to a new minimum eligibility level. The formula for setting the BCF does not include any additional funding to meet this cost.

5.9 Back in August 2013 the Chartered Institute of Public Finance and Accountancy highlighted that assessments of the financial implications of the Care Bill had been produced by the Department of Health and a number of Councils. These assessments showed very different results and the scales of these differences were such that they could absorb all of the funding set aside to support integration.

5.10 Further clarification on the funding arrangements for the Care Bill has been sought but as yet we have no assurances that additional funding over and above the BCF and New Burdens Grant will be provided. If this proves to be the case then it will present a funding gap for West Berkshire Council in the region £5.46m. Clearly dealing with that shortfall would have a significant impact on social care services.

6. Summary

6.1 The first cut BCF submission is required by the 14th February 2014. Given, the very tight timescales, the draft attached to this report will require final sign off from the Chair and Vice Chairs of Health and Wellbeing Board after discussion of the version presented here at the extraordinary Health and wellbeing Board on 6th February 2014.

6.2 There will be feedback from NHS (E) and further work on the BCF implementation plans, which will also reference to West Berkshire CCGs, two and five year plans. Therefore, a revised BCF plan will be produced by 4th April 2014 and a further report on progress will be presented to the Health Wellbeing Board in March 2014.

6.3 April 2015 will see the new BCF pooled budget formally take effect, and the integrated services put in place.

6.4 2014/15 will be a year which will be used to evaluate integration pilots, develop Joint Commissioning capacity, and prepare with partners and providers for the changes planned for 2015/16 onwards.

6.5 There remains a major risk that the new costs for the council arising from the Care Bill will not be fully funded.

Appendices

Appendix A – BCF Planning Template
Appendix B – BCF Financial Summary and Metrics Template
Appendix C – BCF Financial Model – Balanced
Appendix D – BCF Financial Model – Full Cost of Care Bill

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Better Care Fund planningtemplate – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**West Berkshire Council**
Clinical Commissioning Groups	**Newbury and District CCG**
	North West Reading CCG
Boundary Differences	The main focus is partnership with Newbury and District and the principles drafted by this partnership will be negotiated with North West Reading CCG to ensure consistency; the BHFT serves both CCG's and partnership with BHFT ensures consistency across the 3 Unitary Authorities.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£417,000**
2015/16	**£8,580,000**
Total agreed value of pooled budget: 2014/15	**£417,000**
2015/16	**£8,580,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Newbury & District CCG

By	Dr A Irfan
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Clinical Commissioning Group	North West Reading CCG
By	Dr R Smith
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Council	West Berkshire District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is well established West Berkshire Integration Steering Group and has representatives from all relevant stakeholders across health and social care, including key providers. The proposals outlined in this draft have been worked together, including at a system-wide joint workshop held in December 2013 which included acute and community providers.

Service provider engagement will be further developed through integration work during 2014/15.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Consultation and engagement has been through a variety of methods, most noticeably through the NHS 'Call to Action' event. This event involved good high quality engagement with patients and the public about the future of both health and social care services in the district, which has in turn shaped our collective planning submissions.

Further and ongoing engagement is being planned, with follow-up 'Call to Action' events scheduled to continue an inclusive and open dialogue with the public.

Within the CCG, the Patient Voice Group has also been actively involved in feedback on plan developments.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Better Care Project Plan for West Berkshire	The Plan sets out 8 projects that meet the requirements of the Better Care Fund
Joint Strategic Needs Assessment (JSNA)	
Hospital at Home (including Newbury Urgent Care Unit) Business Case	
Care Homes Business Case	
Newbury & District CCG 'Call to Action' Report	Agreement on the consequential impact of changes in the acute sector
7 day working	As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Medical Intra-operability Gateway business case	Better data sharing between health and social care, based on the NHS number

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

A) Vision for West Berkshire 2018/19:

The Vision for West Berks has the following key features:

- An increased level of services that are formally integrated under a Pooled Budget.
- A 7 day service by expanding existing services to cover weekends.
- The services will be simpler to access, have less duplication and reach patients earlier. Delivery of health and social services to be localised wherever possible including access to crisis, A&E and other services that meet local residents' needs – with appropriate specialist or wider access to regional services that improve outcomes on a sustainable basis. This includes children and adults with a view to preventing out of area long term placements, and institutional settings in general
- Unnecessary admissions to Hospitals or Care Homes will be avoided.
- Lengths of stay in Hospitals will be kept to a minimum
- Include the Joint Health and wellbeing strategy vision with added objectives of integration, sustainability, and greater efficiency across all sectors.
- Promote care closer to home and promotion of family centred approach where appropriate

B) Changes to health and social care services over the next five years:

Build capacity in the community across primary, community health and social services to work collaboratively and through integrated services to better meet the needs of local residents that avoid their admissions to hospital or care homes.

Expand the reablement capacity linked closely to integration with appropriate primary and community healthcare on a localised basis (via Locality Hubs).
As community capacity is increased overall including targeted in-reach to acute, realign acute sector capacity to achieve improved patient outcomes, greater efficiency and sustainable acute provider capacity on a reduced basis.

Develop cross sector working that targets intervention and support to those most at risk of admissions, including enhancing clinical capacity in the community that also supports those admitted to acute hospitals to return home quickly.

Maximise the local people's and their communities' capacity to self care through implementation of the Care Act that enhances information advice, advocacy, carer support, with an overall preventative impact on intensive support and admissions.

C) Improved patient and service user and carer outcomes:

Improved outcomes will include:

Less duplication between sectors, faster and more efficient joint assessments with lead professionals for those with long term conditions.

Earlier diagnosis, treatment, and support that prevents crises or better enables responses to crises without admissions to hospitals or care homes.

Improved access to information, advice, advocacy and community capacity to manage health and social care needs at low or nil cost to the user or carers. This will include online and flexible locally developed access.

Improved choice and control through better access to a wider range of care and support in the local health and social care market especially for those with long term conditions including the use of personal budgets and direct payments for those receiving continuing health care or social services. Local services should therefore prevent out of area placements separating users from their families and communities on a sustainable basis.

"Hard to reach" groups with health and social care needs that then require higher levels of intervention will have better access to tailored information, advice, care and support which is person centred and aligned to cultural, faith, or other requirements. During the Newbury Call to Action event, our plans for integrating care were discussed and some of comments on what Newbury's new integrated system will make to patients and service users are provided below:

- "There are no gaps in my care"
- "I am fully involved in the decisions and know what is in my care plan"
- "My Team always talk to each other to get the best care"
- "I will always know who is in charge of my care and who to contact"
- "I won't have to wait in all day for lots of different people to come at different times"
- "it is less time consuming if all services are together in one place"
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

As above.

Measures will be :

1) The options outlined in the project plan will require more detailed analysis and costing to go into the metrics submission

2) Also it is assumed that whilst acute commissioning remains the duty of the Local CCG's outside of the BCF, the targets in the BCF will include investment and capacity to reduce acute activity, improve outcomes, and achieve sustainable financial investment across the whole health and social care system.

3) These aims will be measured by lower rates of admissions to acute hospitals for unscheduled care, shorter lengths of stay, lower rates of admissions to care homes, and significantly higher rates of early diagnosis, treatment and support for those most at risk of hospital or care home admissions, including dementia, end of life care, and those with long term conditions (children and adults).

4) Health gain measures will include: with public health) rates of diagnosis of key conditions linked to hospital and care home admissions including strokes, falls, complex older peoples conditions, dementia, pressure sores, lower instances of carer and care support crises for self funders or those not previously assessed. The increased targeting of health and social care resources on those most at risk will also help reduce health inequalities as well as through prevention/voluntary sector commissioning being joined up across the whole system. We will work with partners to implement the local measures.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Scheme 1. Community Nurses directly commissioning Care/ Reablement Services.

The point of contact for the majority of patients in the community who are either eligible for Council services, or who are at risk of admission to care homes or hospitals is the Community Nurse. Currently if a Community Nurse identifies the need for care they will have to refer the case for assessment by Council staff or other Health teams who may then refer for Crisis, Reablement, Carer's, Council commissioned or in house care provision services; in all cases the Community Nurse is able to initiate and commission in broad terms the care that is needed; if the initial care delivery for all services is through the in house care provision system Community Nurses could directly prescribe this service, leading to safe care being put in place and then worked up to the practical on going solution for that individual.

In addition, It is hoped that WBC's physical disability team will build upon joint working with Health's Long Term conditions teams to progress integration further.

Process developments

- Identification of range of Health Clinicians from Unscheduled Services to be licensed under scheme.
- Training of licensed Health Professionals.
- Health Professionals will commission services directly to provide a prompt response to patient needs; the change should not create extra work for Health Professionals and therefore there should not be any ongoing cost implications
- The service that provides the care will be supported by the coordinating service which will establish the eligibility and need keeping control over the Council's commissioning budgets.

Scheme 2. Access to Health and Social Care Services through the BHFT HUB:

For hospitals, GP's, and Access for All we need one entry point, preferably routed through the Health Hub for Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown. This will require setting new protocols with the HUB and with AFA.

Process development:

Hillcroft front door upgrading for access to Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown, Urgent Care, End of Life.

Negotiation with Hub to build on success of this new service

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Scheme 3. Patient's Personal Recovery Guide / Keyworker:

Each patient will be supported for the journey through the service. This may be a single role, or it could be a function depending on complexity of the role of a Personal Budget Support worker, a Social Worker, a qualified clinician or a trained Care Worker; there would be a strong attraction of building on the latter as a model detaching the function from other more defined roles.

i. Recovery Agreement: as a deliberate discipline to centralise the Customer/Patient. An agreement will frame the journey ensuring that the priorities are set by the patient, and creating flexibility as circumstances, speed of progress and conditions change along the way.

ii. Delivery of service elements: the Recovery Guide can engage the different service elements as would a Personal Shopper, ensuring that the right choices are made and the practical delivery arrangements are in place.

iii. Case Manager: when the active intervention is complete monitoring will be needed initially to ensure the transfer to normal life is successful, and in cases where long term support is indicated to ensure that this is successful and appropriate. Currently this is covered by a Council review system which cannot effectively deliver. For many stable low cost long term support plans it may be possible for Community Nurses, or other health staff who regularly visit patients to deliver other services to periodically 'sign off' an annual renewal of service.

Process Developments:

- Link with Elderly Care Pathway Project for definition, resposibilities, duties and powers of keyworker role.
- Defining role and host organisation, including option of Voluntary Organisation.
- Development of Business Case to include redefining of some roles within existing services to release funding.
- Drafting and sign off of protocols for role across whole range of Health and Social Care operation.

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Scheme 4. Joint care provider as a 'pooled' service with the potential to be funded through a Pooled Budget:

The Council's Maximising Independence Team and Homecare Team, and the Berkshire Health Foundation Trust's Intermediate Care as part of the Integrated Community Health services have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system. Developing these three staffing units into a combined service would simplify the deployment to support individuals, would cut out artificial service transfers, increase continuity of service, and create efficiencies by avoiding duplication; initially this could be created as a 'Pooled' service, developing into a Pooled Budget.

The service is available for people in the community as well as hospital discharge.

The current annual budgets for these services are

Maximising Independence	1,020,760
Home Care	1,780,000
Intermediate care	1,700,000

Whilst efficiencies would be expected from this project, the initial reconstruction of services would require additional project management of £75-100k.

Process Developments:

There are a range of staff working within the two current care services who would need to be merged into a single service.

In Health reablement is provided by a mix of Team Leader Occupational Therapy, Nurses, Physiotherapy and 3 grades of multi therapy assistant staff:

- Band 2 assistants deliver care to fixed care plan, or 2nd on a double up
- Band 3 assistants support patient in working on their goals
- Advanced assistants can progress individuals through goals
- These staff are supported by a multi therapy and care assistant coordinator and a group of Therapists.

In the Council's service there are;

- Team Managers,
- Senior Carers,
- Care Assistants
- Occupational Therapists
- Social Workers

- Personal Budget Support Workers.

The pooled service would be supplemented by the purchase of agency care to deal with fluctuating demand. However the flexibility of this proposed single service may make it possible for both Health and Social Care to reduce their commissioning of external care.

Scheme 5. 7 Day Week service

Between the Health Trust and the Council there is already a combination of services that are available 7 days per week; a small amount of adjustment could be made to provide an adequate 7 day response service.

An initial structure can be developed that would match the wider Health and Social Care economy which currently has only limited services available on 7 days per week, However, with a structure in place it will be a simple step to build more comprehensive 7 day per week services if the wider 'economy' starts to spread it's services over 7 days. This scheme links with scheme 4 above.

Process Development:

- Review the current out of hours services:
  - WBC Extended hours, WBC Homecare inc Nightwardens and the Emergency Duty Team run by Bracknell Forest Council.
  - 24 Community Nursing Cover, managed centrally for Reading, Wokingham and WBC area
  - Rapid Response 9am -10pm x 7 days (at weekend covered across 3 areas)
  - Rapid Discharge Service for patients admitted for less than 48 hours.
- Proposal to Integrated Steering Group re realistic 7 Day week service that is currently required in context of whole health economy. This needs to include access for to Carer Breakdown service, e.g. Ambulance Service, or relatives may need access, etc.

Scheme 6 Hospital at Home:

This project reduces the pressure on hospital beds by 10,920 bed days per local authority area. Additional health services are costed at £2.4m for Berkshire West; to support this the Council will be required to manage additional care during treatment episodes and a discharge service to support patients after the treatment episode. The additional funding would be built into the Pooled Budget at 4 above.

The Hospital at Home initiative aims to support patients through the introduction of a clinician-led sub-acute service that interfaces with the wider health system to appropriately stream protocol-driven cases to an out of hospital care setting. In common with the proposed Newbury Urgent Care unit, the clinical treatments considered include:

- Short-term IV therapy/fluids;
- High level of pathology;
- High intensity monitoring; and
- Functional assessment / management.

The presenting patient may have:

- Acute infections e.g.
  - Cellulitis
  - ENT
  - Pyelonephritis/UTI
  - Pneumonia/influenza
- Chronic Obstructive Pulmonary disease/asthma;
- Dehydration and gastroenteritis;
- Decompensation of LTC; and
- Falls and/or mobility issues that cannot be managed within the existing services

Principles of the model that will underpin the service

- To reduce non-elective admissions from ambulatory sensitive conditions by 50%;
- The service is open to anyone over the age of 18 years;
- The service will operate 7/7 365 days;
- Clinical responsibility for patients within the Hospital at Home service will be overseen by the Community Geriatrician;
- In-hours responsibility will held by Community Geriatrician, Out of hours responsibility will be held by WestCall (with support from medics at RBFT);
- All patients presenting to A&E (Self referrers, 999, or GP referral) will be reviewed as Hospital at Home patients as default;
- Virtual ward rounds for patients within the H@H will be undertaken daily;
- All patients will have a dedicated Ward Matron assigned to their care, supported by Case Coordinators;
- Each UA will be assigned with 30 virtual ward beds; and
- Max length of stay in the H@H ward will be 7 days.

Specifically within Newbury, the CCG will evaluate the development of a local Diagnostic and Assessment Unit within West Berkshire Community Hospital (or other suitable location) that standardises practice across the Newbury registrant population in relation to the management of patients with complex +care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive diagnostics and assessment, then 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Scheme 7. Nursing and Care Homes

As the UK population ages, GPs and NHS providers face an increasing difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. A case for change is unequivocal; In 2011 more than 400,000 people were living in care homes across England, equivalent to the population of Bristol. Over the next 40 years, this is expected to rise to 825,000.

Within Berkshire West there are 22 registered Nursing Homes with a total of 1248 beds. The average nursing home has 67 beds with a range of 22-137 beds. There are 2 dual registered care homes which provide residential and nursing care but the admission data does not differentiate which part of the care home the patient was admitted from. In addition there were 26 Residential homes (48 in total), with a total of 922 beds, average number of beds is 33 and the range is 8-192 beds.

This lead to the establishment of the Care home working group in January 2013 by Berkshire Healthcare Trust.The group includes membership from BHFT, CCG, LA, RBFT, SCAS, Marie Currie, and Berkshire Care Home Association.

The aim of the group is to improve the quality of care and provision of service to and within care homes within West Berkshire. To support this aim the group identified 8 work strands

1. Analysis of activity data
2. Improving access to services
3. Developing clinical pathways/standards/protocols
4. Skills development for staff
5. Leadership development and management in care homes
6. Medication Optimisation
7. Communication and engagement
8. Resident and relative views

Since August the Care Home working group has been chaired by the CCG. Operational support for the group, currently will continue to be provided by BHFT.

In addition to Care Home working group, Dr Charles Gallagher had been developing a "Good Model of GP care for Care homes" for Wokingham. The proposed model would include the following:

- Each care home should have a named GP who is their principle point of contact with the general practice looking after their residents. Practices that have such an arrangement will be eligible for payment under a proposed New Patient Assessment (NPA) LES.
- All residents will have an initial multidisciplinary assessment about a month after admission to the home using the CCG NPA protocol.
- GPs will actively encourage advanced care planning.
- Joint medication reviews will be performed annually between the GP and the Care Home Pharmacist from the Medicines Management Team using the CCG protocol.

Prescribers to adhere to the CCG antipsychotic prescribing protocol.

The project provides support to care Homes; before confirming this project health and social care partners need to work through this jointly to decide the actual scale of the project, because a major part of what is being highlighted is actually the normal delivery of good quality care and as a service purchasing such care we would expect contract compliance to cover at least some of the items for focus in the project.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The ASCOF data will be used to monitor performance together with data from the

Alamac System adopted by the Royal Berkshire Hospital. The Hospital at Home Project will reduce the demand on the Acute Hospitals.

There needs to be an economically viable local acute hospital within the network of other regional hospitals, to provide the access and treatment the West Berkshire population require.

The improvements in outcomes for patients of the BCF plan would be: shorter lengths of stay more personalised tailored treatment and reablement plans that ensure successful returns to their homes, and clinicians that support those with complex and long term conditions in both acute and community settings.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The West Berkshire Health and Wellbeing Board (HWB) will have strategic oversight and governance for the West Berkshire BCF and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with West Berkshire CCG, West Berkshire Council. This Board meets regularly and will receive summary reports on progress, outcomes and exceptions on performance and risks. This board will ensure appropriate monitoring of progress against national and local performance in the BCF, and regular updating of the risk register associated with such performance.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Adult Social Services have to provide a range of statutory services to all residents who are eligible under the Fair Access To Care criteria; for West Berkshire this represents and increased number of eligible residents as the level of eligibility changes from ‘Critical’ to ‘Substantial’ under the Care Bill.

The local definition of protecting adult social services is to focus upon prevention, early intervention and for health and social services delivery aimed at avoiding admissions to institutional care (especially care homes and hospitals) together with maximising people and their communities’ capacity to self care. It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.

The social services lead on multi agency safeguarding adults will be developed under the

Care Act, with local priorities secured within the BCF for Mental Capacity Act assessments, Deprivation of Liberty assessments, and general multi disciplinary safeguarding adults activity.

Please explain how local social care services will be protected within your plans.

The inclusion of reablement (Council funded as well as transfer funded), and in reach to hospital social work services in the BCF will help protect the social services outcomes for those at risk of admission or admitted to hospital.

The capital funding associated with Disabled Facilities Grants (DFG) within the BCF will also build upon the successful record West Berkshire has in working with housing partners in securing wider investment in homes that promote independence, as well adapting existing housing stock

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Council is committed to planning jointly with health partners the increasing availability of services at weekends. The Council provides and funds a large range of services on a 7 day basis but it will further explore the development of processes to allow increased movement between services at weekends. A key element is to secure the cooperation of the range of domiciliary and care home providers to provide flexibility to assess and set up services at short notice outside normal working hours.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This primary identifier is not currently used across the whole health and social care system in West Berkshire.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS number is being introduced as standard to all new clients from 1st April 2014. A separate project will be required to install the NHS number for all existing clients by 1st April 2015**.**

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is a qualified yes. We try to adopt systems that are open but sometimes the 'best systems' in terms of our business needs adopt their own proprietary standards. We seldom reject anything where this is the case

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

The Council would need to fully understand the relevant IG controls before it would be in a position to commit to them.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

All Surgeries are engaged with the Case Coordination process for identifying high risk patients and agreeing joint tasks to minimise the risk of hospital admission. The CCG Tool, together with local; intelligence is used to identify high and medium risk patients.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1 Not realising the benefit of increased community capacity by ongoing increases in demand upon on acute		Integrated and joint commissioning capacity Close monitoring of demand in community and acute to align resources working with external providers to ensure that they understand the current and future demands and recruit workforce accordingly
Risk 2 Double running costs during changes in the health and social care system		Detailed planning to follow BCF submission to ensure and providers meet cost

		targets
Risk 3 Insufficient funding for responsibilities arising from Care and support Bill		Detailed modelling of available funds and ongoing discussions with DH and LGA
Risk 4 Provider failure to deliver better ways to meet needs in the community that trigger risk 1		Ensure preparation in 14/15 on integration and joint assessments in community builds capacity by 2015
Risk 5 Failure to protect social services as set out in BCF		Detailed planning after BCF submission to ensure long term resource planning matches efficiencies from integration.
Risk 6 Failure by acute sector to realign to meet BCF aims and targets		Linked to whole system implementation of BCF and CCG plans.
Risk 7 – the funding for the Care Bill contained within the BCF is insufficient to meet costs of new responsibilities.		

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
West Berkshire District Council			*0*	*0*
Newbury and District CCG			*5,722,000*	*5,722,000*
North West Reading CCG			*2,858,000*	*2,858,000*
BCF Total			*8,580,000*	*8,580,000*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

These plans are currently under development

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1 - District Nurses direct commissioning of social care/reablement services		0	0	0	0	0	0	0	0
Scheme 2 - Access to Health and Social Care services via single Hub		0	0	0	0	0	0	0	0
Scheme 3 - Hospital patient's Personal Recovert Guide		0	0	0	0	310,000	0	0	0
Scheme 4 - Joint Health & Social Care Intermediate Care Assessor and Care Provider service		0	0	0	0	556,000	0	426,000	
Scheme 5 - 7 day week service		0	0	0	0	1,886,000	0	1,444,000	
Scheme 6 - Hospital at Home		0	0	0	0	1,128,000	0	2,580,000	0
Scheme 7 - Nursing & Care Homes		0	0	0	0	167,000	0	850,000	
Care Bill costs		0	0	0	0	1,507,000	0	0	0
Existing S256 spend		0	0	0	0	2,114,000	0	0	0
Existing CCG reablement spend		0	0	0	0	740,000	0		0
Contigency		0	0	0	0	172,000	0		0
Total						8,580,000	0	5,300,000	0

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metric - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
The combined impact of the package of proposed new schemes will be to help people maintain their independence longer, avoid the institutionalisation that often follows a sustained hospital stay and therefore reduce the number of nursing and care home placements.
Metric - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Scheme 1. District Nurses directly commissioning Care/ Reablement Services : resulting in speedier commencement of service, and maintenance of independence at higher levels. Measured by shorter waiting times for service, and admission avoidance.
Scheme 4. Joint Health and Social Care Intermediate Care Assessor and Care provider as a single 'pooled' service with the potential to be funded through a Pooled Budget: will reduce duplication, reduce numbers of overlapping professionals being involved with individual patients; measured by patient satisfaction, and marginal increase in capacity of overall service to meet increased demand.
Metric - Delayed transfers of care from hospital per 100,000 population (average per month)
Scheme 3. Patient's Personal Recovery Guide : each complex patient will be supported for the journey through the services. Measured by reduction in Delayed Transfers of Care (DTOC).
Scheme 4. Joint Health and Social Care Intermediate Care Assessor and Care provider as a single 'pooled' service with the potential to be funded through a Pooled Budget: will reduce duplication, reduce numbers of overlapping professionals being involved with individual patients; measured by patient satisfaction, and marginal increase in capacity of overall service to meet increased demand.
Scheme 5. 7 Day Week service: outcome will be reduced DTOC
Scheme 6. Hospital at Home: the project reduces the pressure on hospital beds by 10,920 bed days per local authority area.
Metric - Avoidable emergency admissions (composite measure)
Scheme 1. District Nurses directly commissioning Care/ Reablement Services : resulting in speedier commencement of service, and maintenance of independence at higher levels. Measured by shorter waiting times for service, and admission avoidance.
Scheme 5. 7 Day Week service: outcome will be reduced DTOC
Scheme 6. Hospital at Home: the project reduces the pressure on hospital beds by 10,920 bed days per local authority area.
Scheme 7. Newbury Urgent Care Unit - The Newbury Project is to explore the potential of introducing a Diagnostic and Assessment Unit within West Berkshire Community Hospital (or other suitable location) that standardises practice across the Newbury registrant population in relation to the management of patients with complex +care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive diagnostics and assessment, then 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The assurance process for all of the metrics would be as follows;

The performance measures are all existing national measures and are routinely reported.
All performance targets will be included in annual service planning.
A Performance Group will monitor outcomes on a regular basis
Performance reporting is an embedded procedure throughout the Council
Performance will be routinely reported into the Health and Wellbeing Board
Performance is reported quarterly to elected members
Key performance data is published externally and available to the public

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at...)	NOTES	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	
Permanent admissions of older people (aged 65 and over) to residential and	*Metric Value*	741	(x/y)*100000		667	10% DECREASE
	Numerator	186	ASCOFSummary_2011213		167	

over) to residential and nursing care homes, per 100,000 population	Denominator	25110	Population of 65 + in area -- ASCOFSummary_2011213 (from the mid-year ONS data)	N/A	25110	Population is static - will increase at next ONS update
		(April 2012 - March 2013)			(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	81.6%	x/y	N/A	86.5%	6% INCREASE
	Numerator	31	ASCOFSummary_2011213		33	
	Denominator	38	ASCOFSummary_2011213		38	
		(April 2012 - March 2013)			(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	102.8	(Rate from x/y)/number of months *100000	99	95	4% DECREASE
	Numerator	1468	DTOC Summary, total DTOCs for 12 months	1409	1353	
	Denominator	118994	Population of 18+ in area -- ONS Website --> Population Estimates for England and Wales, Mid 2012 (ZIP 812Kb) --> Mid-2012-unformatted-data-file	118994	118994	Population is static - will increase at next ONS update
		(April 2012 - March 2013)		(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure)	Metric Value					
	Numerator	For Health to provide				
	Denominator	118994	Population of 18+ in area -- ONS Website --> Population Estimates for England and Wales, Mid 2012 (ZIP 812Kb) --> Mid-2012-unformatted-data-file			Population is static - will increase at next ONS update
		(TBC)		(April - September	(October 2014 - March 2015)	
Patient / service user experience *[for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]*				N/A		
Offer 90% of eligible carers identified during 2013/14 baseline a Cardiovascular Disease Healthcheck	Metric Value	To be confirmed in March 2014 - actual numbers of carers identified in 13/14 baseline exercise	Baseline assessment year is 2013/14, thus 90% standard (of identified carers) to be offered a CVD healthcheck during 14/15	% of carers offered a CVD healthcheck	% of carers offered a CVD healthcheck	
	Numerator	TBC	TBC	TBC	TBC	
	Denominator	TBC	TBC	TBC	TBC	
		April 2014 to March 2015		*April 2014 to March 2015*	*April 2014 to March 2015*	

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Better Care Fund - 2015/16 — Balanced Version

Initial Better Care Fund for WBC		9,585,000	
Capital only element		-279,000	
Disabled Facilities Grant to Housing		-726,000	
			8,580,000
WBC			
Existing Spend			
as per 2013/14 S256 agreement	1,793,000		
		1,793,000	
New Proposals			
Merger of MI, Reablement and Health provision	400,000		
7 Day Social Care	500,000		
Personal Recovery Guides	310,000		
Direct prescribing by District Nurse etc.	0		
Use of Health Hub	0		
		1,210,000	
Cost to WBC of CCG proposals			
Hospital at Home	390,000		
Nursing and Care Homes	0		
		390,000	
Care Bill			
Care Bill - BCF contribution to costs	1,507,000		
		1,507,000	
			4,900,000
CCGs			
Existing Spend			
Carers funding (some passed to WBC)	321,000		
Reablement	740,000		
		1,061,000	
New Proposals			
Hospital at Home (14/15 scheme)	738,000		
Nursing / Care Home Projects (14/15 scheme)	167,000		
Primary Care 7 day working	857,000		
		1,762,000	
			2,823,000
Other			
Frail Elderly Pathway Project	685,000		
2% Contingency	172,000		
		857,000	
			857,000
Total Commitment			8,580,000
Balance			0

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Better Care Fund - 2015/16	**Using Detailed Care Bill Modelling**		
Initial Better Care Fund for WBC		9,585,000	
Capital only element		-279,000	
Disabled Facilities Grant to Housing		-726,000	
			8,580,000
WBC			
Existing Spend			
as per 2013/14 S256 agreement	1,793,000		
		1,793,000	
New Proposals			
Merger of MI, Reablement and Health provision	400,000		
7 Day Social Care	500,000		
Personal Recovery Guides	310,000		
Direct prescribing by District Nurse etc.	0		
Use of Health Hub	0		
		1,210,000	
Cost to WBC of CCG proposals			
Hospital at Home	390,000		
Nursing and Care Homes	0		
		390,000	
Care Bill			
Carers - assessment of needs	620,000		
Carers - increase in cost of support packages (net of carer contributions)	2,180,000		
Carers - financial assessment	775,000		
Eligibility change - reassessment of existing clients	670,000		
Eligibility change - increase in cost of care packages (net of client contributions)	1,800,000		
Eligibility change - financial assessment of new clients	40,000		
Asset thresholds - loss of client income	990,000		
less New Burdens Grant via LG settlement	-595,000		
		6,480,000	
			9,873,000
CCGs			
Existing Spend			
Carers funding (some passed to WBC)	321,000		
Reablement	740,000		
		1,061,000	
New Proposals			
Hospital at Home (14/15 scheme)	738,000		
Nursing / Care Home Projects (14/15 scheme)	167,000		
Primary Care 7 day working	857,000		
		1,762,000	
			2,823,000
Other			
Frail Elderly Pathway Project	685,000		
2% Contingency	172,000		
		857,000	
			857,000
Total Commitment			13,553,000
Shortfall			-4,973,000

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