NHS South of England

BCF Plan 2016/17 - Cover Sheet

Health & Wellbeing Board Name	West Berkshire
Date of submission	21 March 2016
Has the plan been signed by CCG(s)?	
Date the plan was Signed off by HWB	14th April 2016
Are the minutes of the HWB at which the plan was agreed attached to this submission?	To follow – meeting is scheduled for the 14th April 2016

Section 1 – Confirmation of funding contributions

<table>
<tr><th>Requirement</th><th>Response</th></tr>
<tr><td>Describe how your BCF Plan meets the minimum contributions for:

• CCG minimum contributions
• DFG
• Care Act monies
• Formers ‘Carers Breaks’ funding
• Re-ablement funding</td><td>The total BCF for West Berkshire Locality has been confirmed as £10.669m. The minimum contribution from the CCG totals £8.807m, an increase of £279k when compared to the previous year.

Whilst the DFG has been transferred we understand that it includes the Social Care Capital grant, we have not received a determination letter for either so whilst we can see there is an increase of funding we don’t know the exact split.

As the Care Act (2014) is business as usual we no longer make specific reference to and the amount allocated to Protection of Adult Social care this year is £ £4.367m, this represents an increase of £346k when compared to the previous year.

Supporting carers is a key element of our prevention agenda and therefore our 16/17 expenditure plan allocated £627k for Carer Services, a 1.95% increase on our 15/16 allocation.

The importance of protecting reablement services is recognised by both the CCG and LA and therefore the sum allocated in 2015/16 has been increased by 1.95%. .
The table below outlines how each element of the minimum funding contribution:

<table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th></th></tr>
<tr><td>Local Authority Contribution(s)</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>West Berkshire</td><td>£0</td><td>£0</td><td></td></tr>
<tr><td>DFG (inc SCCG in 15/16)</td><td>£1,400,000</td><td>£1,005,000</td><td>39.3%</td></tr>
<tr><td>Carry forward of 15/16 scheme underspends</td><td>£462,000</td><td>£0</td><td></td></tr>
<tr><td>Total Local Authority Contribution</td><td>£1,862,000</td><td>£1,005,000</td><td>85.3%</td></tr>
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<table>
<tr><td>CCG Minimum Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td>NHS Newbury & District CCG</td><td>£5,977,666</td><td>£5,722,000</td><td>4.5%</td></tr>
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</td></tr>
</table>

<table>
<tr><th>Requirement</th><th>Response</th></tr>
<tr><td></td><td>
<table>
<tr><td>NHS North and West Reading CCG</td><td>£2,829,756</td><td>£2,806,000</td><td>0.8%</td></tr>
<tr><td>Total Minimum CCG Contribution</td><td>£8,807,422</td><td>£8,528,000</td><td>3.3%</td></tr>
</table>

<table>
<tr><td>CCG Additional Contribution</td><td>Gross Contribution</td><td>Gross Contribution</td><td>% change</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>NHS Newbury & District CCG</td><td>£0</td><td>£0</td><td></td></tr>
<tr><td>NHS North and West Reading CCG</td><td>£0</td><td>£0</td><td></td></tr>
<tr><td>Total Additional CCG Contribution</td><td>£0</td><td>£0</td><td></td></tr>
</table>

<table>
<tr><td>Total BCF pooled budget</td><td>£10,669,422</td><td>£9,533,000</td><td>11.9%</td></tr>
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</td></tr>
<tr><td>Is any additional funding from the LA or CCG(s) included?</td><td>Following a change of direction and redesign in relation to one of the West of Berkshire projects some funding allocated to help social care manage the impact was not utilised. This has created an underspend of £462k, which is being carried forward to 2016/17 and will be used to support project work.</td></tr>
<tr><td>Please confirm if this narrative plan, and the planning return template, has been signed by all parties and include the name, role, organisation and contact details of the authorising officer(s)</td><td>The narrative plan is due to go to Health Wellbeing Board on the 14th April where it will receive final sign off by all parties.

The Local Authority authorising officer is:
Rachael Wardell
Director Communities
West Berkshire Council
Rachael.wardell@westberks.gov.uk

The CCGs authorising officer is:
Cathy Winfield
Chief Officer
Berkshire West Clinical Commissioning Groups
cathywinfield@nhs.net</td></tr>
</table>

Requirement	Response
Your plan should provide a full overview of the funding contributions for 16/17 and set out any changes from 15/16. Please summarise here any changes from 15/16 and how these have been agreed.	The total BCF for West Berkshire Locality has been confirmed as £10.669m. The minimum contribution from the CCG totals £8.807m, an increase of £279k when compared to the previous year. The funding for 2016/17 is detailed below with the comparative 2015/16 figures

Scheme Name	16-17 Expenditure (£)	15-16 Expenditure (£)
Connected Care	333,000	248,000
7 Day Week service	500,000	500,000
Patients Personal Recovery guide	150,000	310,000
Joint Care Provider	408,000	400,000
Protecting Social Care services - the cared for	1,505,000	1,213,000
Protecting Social Care services - Carer	300,000	294,000
Protecting Social Care services - Reablement	433,000	425,000
Protecting Social Care services - Integrated Crisis & Rapid Response	433,000	425,000
Protecting Social Care services - Early supported discharge	377,000	370,000
Protecting Social Care services - universal preventitive services	584,000	573,000
Protecting Social Care services - Carers universal services	327,000	321,000
Protecting existing CCG reablement service	755,000	740,000
Care Homes	495,000	0
Speach and Language Therapy	64,000	0
Community Geriatrician	144,000	0
Intermediate Care	455,000	0
Health Hub	334,000	0
Intermediate Care night sitting, rapid response, reablement and falls	629,000	0
Care Homes in reach	263,000	0
Programme Management	209,000	0
Disabled Facilities Grant	1,400,000	726,000

Requirement	Response

Social Care Capital Grant	0	279,000
Contingency	328,422	231,000
Risk Share Agreement	243,000	243,000

The planning template, attached, provides more details and a full overview of the funding contributions for 2016/17. These have been jointly agreed by the CCG and Local Authority.

There are changes in the BCF plans for this year – the contribution to 'Maintain social care services' has been increased (see planning template) which meets the national condition as it has been maintained in real terms.

Following our programme evaluation (see attached) we are continuing with the two locality projects in the coming year; Joint Care Provider and Personal recovery Guides

- The Joint Care Provider Project has had a beneficial effect in supporting efficient discharges from hospitals back to the community; the first phase focus has been on patients using the Royal Berkshire Hospital as the dominant acute hospital; the second phase of the project has extended to the acute hospitals at Swindon and Basingstoke as well as the Community Hospital in Newbury.

- The impact of the Personal Recovery Guide project cannot yet be measured which has lead to a 3 month extension of the pilot phase to allow for a better informed contract specification to ensure that the project has a positive impact on the efficiency of hospital discharges, both in terms of speed and sustainability, and also on prevention of unnecessary admissions top hospitals or care homes. The funding allocation to the PRG project has been reduced from £310k in 15/16 to £150k in 16/17; this is a 'value for money' adjustment based on consideration of comparative schemes, and reflecting a view that the pilot using 3 voluntary organisations lead to higher than necessary management and set up costs.

For 2015/16 our programme included 3 Berkshire wide projects – Hospital At Home, Enhanced Care Homes and the Health and Social Care Hub. Learning from the initial work and a change programme in West Berkshire Adult Social Care has resulted in some changes:

In 2015/16 the CCG invested in a Care Homes project which moved to the BCF and an investment

Requirement	Response
	was provided to also support the Hospital at Home (H@H) project. Following monitoring and learning early during the implementation phase, The H@H project was reviewed and redesigned in September 2015 and was replaced by the Rapid Response and Treatment Service (RRAT) for Care Homes.(see in case for change further narrative) In 16/17 we continue to commission out of hospital services to deliver our ambitions from the frail elderly pathway work to decrease DTOC, reduce NEL admissions and manage patients in their homes.
Please summarise the impact assessment of any changes you have made	We have diverted investment from hospital at Home into the new Care homes (including RRAT) project. (see above for details) PRG – pilot extended for 3 months, collaboratively with the 3 voluntary organisations Other projects show an agreed 2% increase

Section 2 – Narrative overview

Please describe the local vision for health and social care services, including changes to patient and service user experience and outcomes.	Our vision for better care is based on improving outcomes for individuals through the delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with (rather than to) service users/patients and therefore meaningful engagement is a key part of how we will implement change. Our current system is already under pressure with a number of challenges including: • An increasing population, particularly in those over the age of 65 • Increasing growth in non-elective care • Increasing A& E attendances, and pressure on urgent and emergency capacity • Rising delayed transfers of care, and subsequent bed days lost • Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking • Increasing demand for planned (elective) care • Inequality of access to services across the “whole system :the whole week” • Care Workforce Availability • Increasing pressure on Social Care in relation to prevention and early intervention We recognise that the challenges facing the local health and social care system are significant. Demand for services is forecast to increase and this is not sustainable in the current systems. Funding pressures are set to continue and it is clear that without wide scale transformation we will not be able to meet future needs. We see the Better Care Fund as an opportunity to stimulate the integration of Health and Social Care Services both locally and across West of Berkshire and have created a range of projects to help us deliver this.

	By 2020 we expect to see: • Person centred services that focus on outcomes rather than outputs • Provision of good quality information and advice that empowers people to make good choices and self-manage • Care closer to home as the first option • Flexible services that operate across 7 days where appropriate. • Services will be simpler to access, have less duplication and reach service users/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. • A greater range of local services that promote independent living • Reduction in avoidable hospital admissions. • Lengths of stay in Hospitals will be kept to a minimum • Increased numbers taking up Health and social care personal budgets Delivery of our vision will achieve system sustainability and therefore deliver value for money. We will do this by commissioning new models of care based on integrated Health and Social care pathways that focus on outcomes for users/patients. In achieving transformational change we will draw on our patient's and population's views, and use robust health needs assessment in identifying our ongoing priorities. The commissioning and redesign of services will be informed by recognised best practice, and performance data analysis, in a context of an absolute requirement for improving health and social care outcomes and achieving system sustainability. As a partnership we will make commissioning decisions based on what works best for our communities. This may be across the West of Berkshire or on a more local level. All the work will need to deliver the following: • Enable us to respond to the needs of our local populations by targeting services to give the greatest impact on health and social care outcomes • Address the views expressed by our local populations of how they wish services to be provided through partnership and co-production

	• Avoid duplication, focus on strengths and ensures value for money & efficiency • Promote further health and social care integration where a case for change is made • Where appropriate we will combine resources, sharing best practice and expertise The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10, have developed a direction setting vision around integration which formed the basis for a Pioneer Bid in 2013. Despite being unsuccessful with this bid, the 10 partners are united in their ambition to undertake a methodical and systematic journey towards more integrated care for the people we serve. The integration programme presents an opportunity now underpinned by the Better Care Fund to test different models of integration across different settings and care groups. The first phase of our programme focus's on the frail and elderly population and we have developed a pathway through a multi-agency project supported by the King's Fund and by an economic modelling element. The model has been signed off and there is a steering group comprising representation from leaders across the health and social care system who are driving the work forward. The defined pathway aims to improve experience of patients and carers, make better use of existing resources, focusing on strengths and achieve significant cost savings across the system through reduction of duplication in provision and workforce changes. Our services will have an enablement focus to enable people to self-manage where ever possible. Where care is required it will be delivered by care workers skilled in health and social care tasks to enable consistency, it will be supported by identified care co-ordinators and multidisciplinary teams structured around localities: the overall aim being to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health. Crisis support will be streamlined with care being provided in the most appropriate setting according to service user/patient and carer need. When hospital admission is unavoidable, the stay will be of high quality with discharge supported by a personal recovery guide ensuring people don't get lost in the system and are able to be get back to a more settled environment promptly. Support will be enhanced to enable people living in residential and nursing homes to receive their care and treatment there, and end of life care improved so that people are not admitted to hospital unnecessarily. In bringing key elements of the frail elderly (older peoples) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning

	for other pathways for the outer years of this five year period. We also recognise that people need to access health and social care services flexibly. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Admission rates may also be affected by GP practices being closed over the weekend period. Where admissions occur there is a need to ensure that care and support is available so patients can be discharged from hospital when they are clinically fit. We have therefore established a range of health and social care services that are available seven days a week. Primary Care will play a pivotal role in delivering our vision to meet people's needs in the community wherever possible and we will look to facilitate this through the move to fully delegated primary care arrangements with NHS England which will enable us to improve quality in primary care. Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable clinician for patients who may be at risk of admission; co-ordinating care provided by a range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients As well as fulfilling this function within their practices, our GPs will increasingly play an active role alongside other professionals in multidisciplinary services locally.
Describe how the BCF contributes to the local implementation of the vision of the FYFV and the move towards fully integrated health and social care by 2020; and the aspects of the change the local area is intending to deliver using the BCF.	Over the next five years, the pattern and configuration of services will be changed in West Berkshire to implement the vision of the 5YFV by responding to local health needs by putting the patient at the centre of care to empower more people to live well at home. This will require a number of changes to the services that we provide. The Better Care Fund schemes will be critical to driving some of these changes. **Developing patient/service user centred care pathways across Health and Social Care** We will continue to create joint system wide integrated pathways across key areas such as frail elderly, mental health and children's services that transcend organisational boundaries to deliver high quality, efficient care for patients. In the longer term, we will also go beyond traditional health and social care services to include wider determinants of physical and emotional wellbeing, to include services such as housing, transport and leisure. We aim to give mental health parity of esteem with physical health, commissioning high quality evidence based services which reflect the national mental health strategy and

	other key guidance. In response to the high cost of care for older adults, and the growing numbers of older adults in West Berkshire, the frail elderly pathway has been developed to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health and are likely to need intensive social care support. As part of this, care will be delivered by care workers, supported by identified care co-ordinators. This pathway has been developed through a multi-agency project supported by the King's Fund and is supported by detailed economic modelling. In bringing key elements of the frail elderly (older people's) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period. **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 capacity of local people to self-care through embedding of the Care Act that enhances information advice, advocacy, carer support, with an overall preventative impact on intensive support and admissions • Our workforce development strategy will allow us to understand more clearly where the gaps are so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be

	supported by fewer people who get to know them better. • A proactive approach to provide information, advice and guidance that enables people to understand what universal services are available and, where appropriate, navigate the health and social care system making choices that support them to maintain their independence for longer. • We will strengthen our community based asset approach, building on our 'doing with' rather than 'to' approach. Assessments will be person centred; outcome focused and continues to develop re-ablement potential. • We will develop locality based working to ensure we know our patch really well and help people as close to their home as possible.
Please list the issues that the BCF will be used to address in the local area	Through our Better Care Fund schemes we aim to deliver the following improved outcomes; • 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. • Locality based around GP clusters, mutli-disciplinary social care teams, who will focus helping people remain in their community • 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. This will include the use of personal health and social care budgets to allow greater flexibility in how needs are met. We are committed to reducing the need for out of area placements enabling people to maintain family connections. Sometimes a local option is not available, where this occurs we will look at how we can support them to maintain family connections. • "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.

	In practice this should mean service users being able to say the following; • "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 provide me with 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"
Explain how the BCF will address quality and reduce costs based on segmented risk stratification. (Reference local issues and how integration will be used to drive improvement). If relevant please provide supplementary data to support the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery.	In West Berkshire we share with our Berkshire West 10 colleagues an understanding that integrated care delivers the best outcomes for our patients and service users. We believe(supported by evidence) that working in collaboratively, is the most effective way for us to ensure that we are providing person centred, personalised, co-ordinated care in the most appropriate setting. As a partnership of ten organisations, with a full range of services across the health and social care sector, we can deliver end to end integrated care for our population, radically reducing the number of assessments and transactions individuals are subjected to and improving their experience of care. There is a significant financial challenge facing West Berkshire with increasing demand for high quality services but a constrained and challenging financial position in the local health and social care economy. We have a strong foundation in our shared vision and our track record, but we know that we need to increase momentum to tackle the system pressures and demographic challenges described above. We simply do not have the resources to meet the expected increases in demand over the next few years if we continue to provide services in the same ways as we do now. Unless we find better ways of supporting people who are frail or living with long term health conditions, costs will increase exponentially. This will include the cost of care home placements, A&E attendances, and emergency admissions to hospital, readmissions, and ambulance conveyance costs. Co-ordinated community based care is what people are asking for and what we know works. Indeed it is the only way to build a sustainable future. Combining best practice examples, a sound evidence base, alongside local knowledge, analytics and intelligence, we have been able to identify potential new models that will meet the needs of our population and address the key challenges we face over the coming years. Using a variety of risk stratification tools and methodologies, we have identified the cohorts of individuals that are most likely to benefit and the

models of care most suited to meet the challenge in the most effective way. The key target populations are generally older adults and people with long term conditions.

Risk Stratification Methodology:

Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. A one size fits all approach is inadequate and different sets of people have different needs. Grouping has helped us create models that are based on similar, holistic, individually-focused needs, and will also help us think about the health- and social-care system in a more holistic way.

By making these groupings explicit, we are able to provide a more logical way of informing the new models of care that are likely to be needed, identifying the outcomes we plan to achieve and by which we will measure our success, as well as allowing us to create payment models to incentivise providers to achieve these outcomes.

Risk Stratifying our High Risk of an Emergency Admission Population

In 2009, nine of the then PCTs in South Central decided to collaboratively procure a risk stratification tool which would support case finding for community health staff as well as supporting other programmes for patients with long term conditions. The Adjusted Clinical Groups (ACG) tool was implemented into all 54 GP practices within the Berkshire West PCT, including the 14 GP practices in North and West (3) and South Reading (11) CCGs. This tool has allowed us, in collaboration with our Berkshire Community Health Service, to have a richer source of information about the health needs of the local practice population and to be able to support a reduction in emergency admissions.

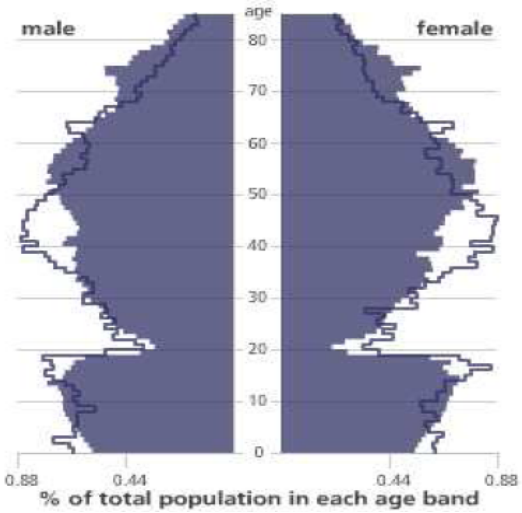
Challenge 1: Increasing Demand - A growing population particularly in those over the age of 65, with disproportionately high health and social care needs leading to a growth in health and social care requirements across the Berkshire West economy

The latest (2011) population *projections* by the Office for National Statistics, in predicting population growth across the country, estimate the population of West Berkshire to be 170,100 by 2021 – an increase of some 10%. This compares with an average increase in population across the South East of 9.3%.

Changes in population will not be universal across the age bands. Most graphically, the population pyramid below shows how the age profile of West Berkshire is expected to change over the next decade. The solid outline shows West Berkshire's population profile in 2011, whilst the shaded area represents the district's

new population profile in 2021

Projected population age profile for West Berkshire, 2011-2021.



Source: ONS, Interim 2011 sub-national population projections

Noticeable, is that, almost without exception, the reduction in the relative size of age groups under the age of 65. The district's 'waist band' remains reflecting a significant number of people leaving the district at around 20 years of age, but then returning over the proceeding two decades.

If the pyramid above shows how the relative size of age bands will change in relation to one another over the next decade, the table below describes this in absolute terms.

This estimates the number of 0-9 year olds living in West Berkshire to have grown by 3,300 by 2021 (or 17%). This compares to a similar expected growth across the South East of around 15%. The numbers of 10-19 year olds is anticipated to have increased by around 1,500 (or 8%), which is in line with the projected growth rate for the district as a whole.

At the other end of the age spectrum, the figures show an anticipated growth in the over 65 population of 34% (or 8,000 people) compared to 26% regionally. Breaking this down, the most significant growth is in

the oldest age groups (75+).

Projected change in population 2011-21 – by age						
	West Berkshire			Berkshire	South East	England
	Pop'n 2021	Change in pop'n (nos)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)
0-4	10,516	418	4%	5%	6%	9%
5-9	11,961	2,911	32%	27%	24%	23%
0-9	22,477	3,329	17%	15%	15%	16%
10-14	11,797	1,851	19%	19%	11%	9%
15-19	9,509	-304	-3%	1%	-6%	-8%
0-19	43,783	4,876	13%	13%	8%	8%
20-24	6,221	-1,060	-15%	0%	-4%	-4%
25-29	8,499	114	1%	6%	7%	9%
30-34	10,267	941	10%	7%	11%	16%
20-34	24,986	-6	0%	4%	5%	7%
35-39	11,314	342	3%	6%	5%	9%
40-44	11,613	-959	-8%	0%	-8%	-8%
45-49	11,688	-782	-6%	-2%	-9%	-10%
50-54	12,505	1,460	13%	15%	13%	11%

55-59	12,070	2,547	27%	29%	30%	26%
60-64	10,201	417	4%	8%	3%	2%
35-64	69,390	3,024	5%	8%	4%	4%
65-69	8,401	833	11%	12%	7%	7%
70-74	8,497	2,992	54%	41%	43%	37%
75-79	6,386	2,009	46%	29%	32%	26%
80-84	4,258	955	29%	24%	19%	18%
85-89	2,757	662	32%	36%	28%	26%
90+	1,664	629	61%	75%	63%	62%
65+	31,963	8,080	34%	29%	26%	24%
85+	4,421	1,291	41%	50%	40%	39%
All	**170,123**	**15,975**	**10%**	**11%**	**9%**	**9%**

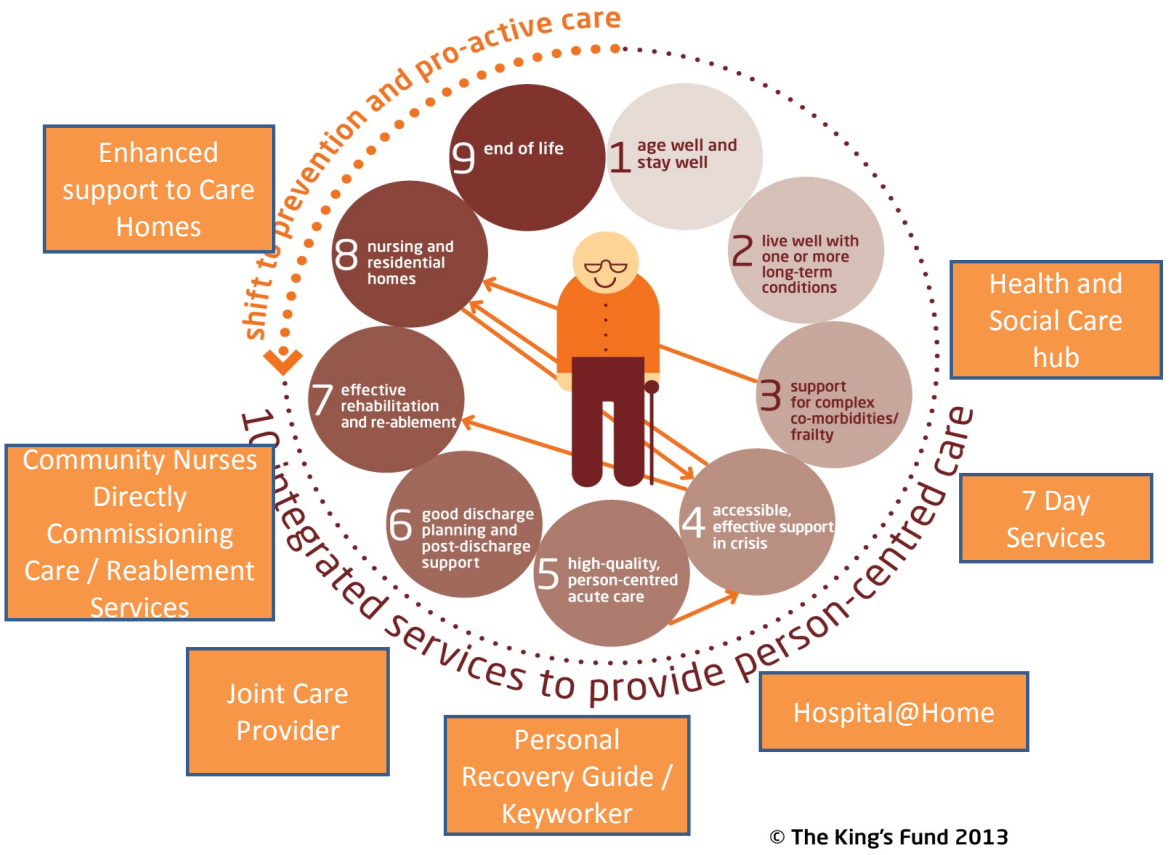
Source: ONS, Interim 2011 sub-national population projections

As the graph and table above indicates, it is predicted that the number of over 65s will increase 24% by 2021 and those over 85 years of age by 39%. The impact of this demographic change on the health and social care systems will be vast – 30% of the population in West Berkshire will be living with a long term condition and we expect there to be a large rise in the numbers of older people living with more than one long term condition, e.g. Cardiovascular disease, Dementia, Respiratory Disease, Liver disorders and Diabetes. West Berkshire has a significant number of older people living alone and consequently at risk of social isolation with the negative impacts on physical and emotional wellbeing which this brings; integrating across the whole health and social care system becomes an imperative. These increases are likely to present the biggest challenge to affordability and sustainability over the next five years.

We know that the Health and Social care requirements of the elderly population over the age of 65 population are set to grow significantly over the next seven years and that will place huge financial pressure on the health and social care system within West Berkshire.

The solution: Extensive work is already underway in the frail elderly pathway, which was Identified as a key Integration work stream in our 2013 Pioneer bid. This Berkshire West wide work stream forms the

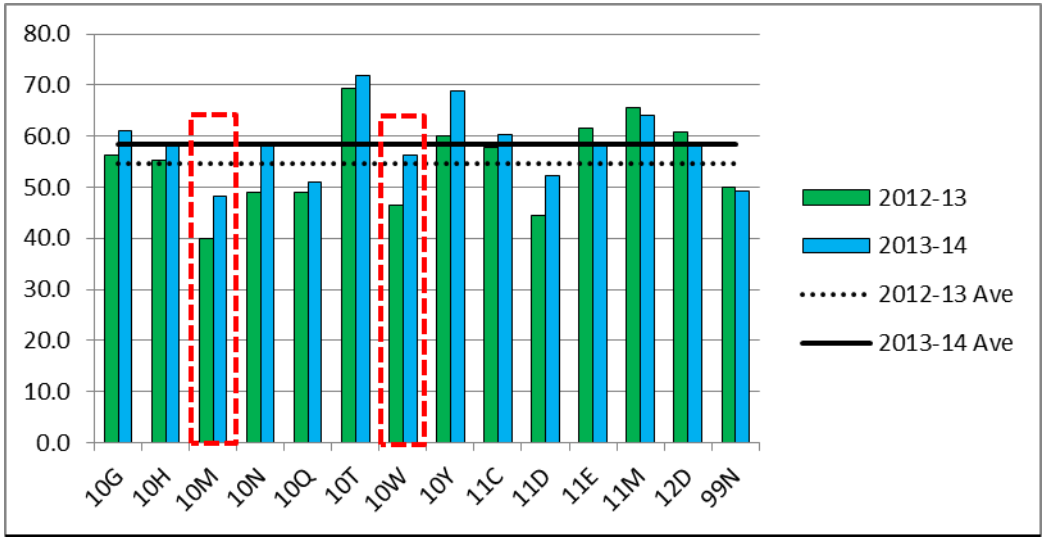
backbone of system change and our local West Berkshire BCF schemes are critical to delivering a number of elements of this as outlined in the orange boxes below:



Challenge 2: Growth in Non-Elective Admissions

Non-elective admissions are rising in West Berkshire, and future projections suggest that due to the increased age profile and expected double digit increase in certain long term conditions, this trend will continue unless there is system wide change. The graph below illustrates this trend across our local CCG geography,

Graph: A & E attendance rates resulting a Non Elective Admission 2012/13 compared with 2013/14



Analysis of these figures reveals two specific problematic areas which have the potential to be amenable to change:

1. Non elective admissions with a medical event where patients are clinically stable and do not require diagnostic input such as acute infections, deteriorating long term conditions, unstable COPD, dehydration.

Over 2012/13 there were 10,116* emergency admissions to hospital each year for Berkshire West residents with at least one long term condition, of which 4,590 were relevant to the patient type that with intensive support for a defined period of time, would be possible to manage in the community.

Note that these figures are for total Berkshire West not just Newbury & District CCG

2. Patients whose place of residence is a care home.

Within Berkshire West there were a total of 2770 people residing in care homes (residential and nursing care) who were associated with the following activity during 2013-14 and for the first quarter of 2014-15.

	Places	1 Calls		2 Conveyance		3 A&E		4 Admissions	
		2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Grand Total	2770	898	545	238	303	1326	354	961	260

In West Berkshire, during 2013/14 there were 201 Non elective admissions from Care Homes costing £640k. This therefore offers us a considerable level of opportunity to impact on this specific cohort of our population.

The Solution:

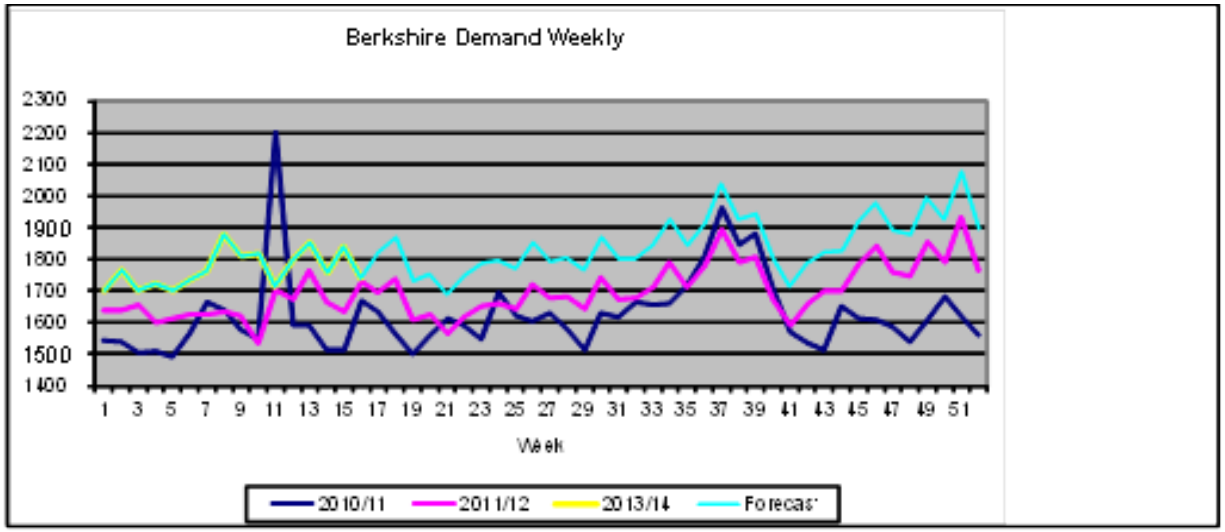
The outcomes for both of these cohorts can be dramatically improved by integrated care, and as such we have allocated in the Care Homes project to address these issues.

RRAT is a new service provided by the locality community teams which will respond within 2 hours of receipt of a referral or within 2 hours of a patient returning home from A&E. The RRAT provides increased and targeted Community Geriatrician input, including active treatment interventions including crisis support and the use of telehealth to support those at risk of admission. The enhanced rapid response pathway provides crisis response and treatment for patients in care homes. The service is available 8am – 8pm, 7 days a week with a proposed length of stay of up to 5 days on the pathway.
In April 2015 the GP CES was incorporated into and moved to the Anticipatory Care CES and funding adjusted.
The aim of the project to date has been to provide a common and consistent approach to improving

	outcomes for those people living in Nursing and Care Homes in Berkshire West through training and education of care home staff, medication review of all residents and anticipatory care planning and since October 2015 enhanced through the introduction of RRAT. Full review of each of these elements has been carried out and the learning has concluded: • Training & Education: The KPIs need to be more reliably measurable. It is proposed that going forward, further training options are considered especially to ensure we are able to better target the key four diagnoses that have the greatest impact on NEL admissions: UTI, Pneumonia, Falls and Dementia. In addition a focus on reducing calls to 999 through empowering staff in their decision making and ensuring all homes are aware of the alternative care options • Reduction in Non- Electives: The planned gross savings £292k across Berkshire West anticipated in the 2015/16 project will not be realised, however we have seen a reduction in non-elective activity in this cohort of patients of 72 unplanned admissions (20%) against a target of 50% reduction and an associated saving of £215k. 999 calls have not shown a decrease and with a 48% conversion to admission, there is still further work to be done to fully address this problem. There appears to be potential to further reduce the 0-1 length of stay admissions, of which 70% are considered potentially avoidable. • Medication review: further investment is required to maximise the savings on investment and to increase from 1 to 2 w.t.e pharmacists. (1 w.t.e.in 15/16 has released £107k of savings.) Whilst the RRAT service data is only very recent, and therefore limited, it does demonstrate an effective impact on the numbers of NEL admissions from the first phase of 15 Care Homes and this is demonstrated in both the QIPP and Care Home report. For phase 1, 15 NEL admissions have been avoided in the first 2 months of the scheme: a 23% reduction in NEL admissions for this cohort of care homes. Anecdotally all calls attended by the clinical staff were felt to be appropriate and all would have resulted in calls to SCAS and attendances at A&E in their opinion had the RRAT service not been in place. For 2016/17 the project will recommend continued investment in this service and roll out as planned across all 4 phases to cover all nursing and residential homes in Berkshire West. For 2016/17 a review of the reporting mechanisms and savings options across the pathway will be undertaken. Following review of the data the following savings for 2016/17 is recommended: • South Central Ambulance Service (SCAS) - Calls, Hear and Treat and See and Treat a 100% reduction. • SCAS - See, Treat and Convey is reduced by 50% • Secondary care 0-1 day Length of stay (LOS) is reduced by 75% • Secondary Care 2+ days LOS is reduced by 30% in line with national evidence of similar project outcomes.

Challenge 3: Increasing A&E Attendances and Pressure on Urgent Care Capacity

A&E is under increasing pressure in West Berkshire, as the chart below shows, with attendances increasing for the last three years.



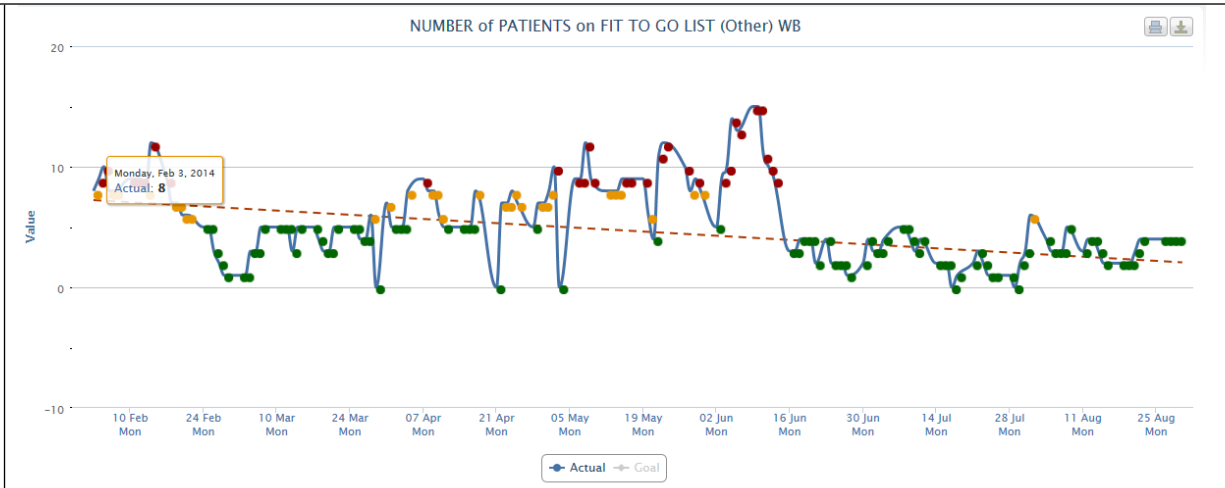
Between April–July 2013 and the same time period in 2014 West Berkshire has seen an increase in A&E attendance of 5.3%. In North & West Reading A&E increases are associated with a much older age group in line with their demography. This pattern is also seen across the other CCGs within Berkshire West.

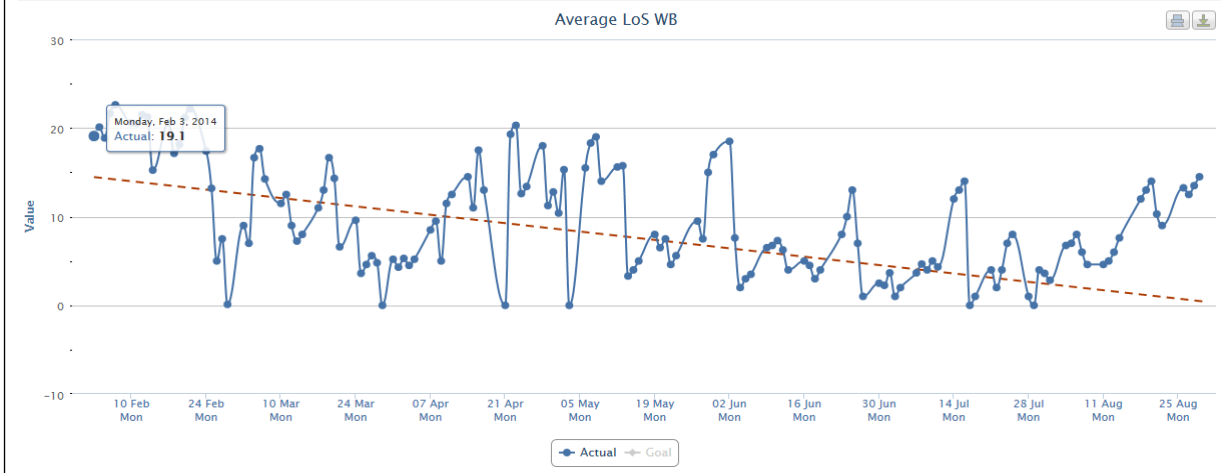
The Solution:

In addition to a review that was undertaken in January to assess the causes of A&E breaches, a number of Better Care Fund schemes will also seek to target key populations at high risk of A&E attendance to reduce the pressure on urgent care.

The first cohorts of patients are those with long term conditions and frail elderly patients. Both of these cohorts will benefit from the increased provision of care in the community, the extended availability

	throughout the week for this care via the 7 day working schemes and the changing eligibility threshold for social care in West Berkshire. The third group is care home residents, of which 48% across Berkshire West had an attendance at A&E in the last year. The Care Home project will address the training of care home staff, and the maintenance of relevant, up to date care plans and reviews to keep care home patients out of A&E. See above for details. **Challenge Statement 4: Rising Delayed Transfers of Care and Subsequent Bed Days Lost** An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs. the average patient. The following graphs show the number of patients and duration of time on the “Fit To Go” List (Feb to Aug 2014). Despite a significant amount of resource being focussed on this area we still experience widely fluctuating figures. Whilst we have had some success in bringing down the number of patients, the average length of time that patients remain on the “Fit to Go” List has remained above the system wide target of five days agreed as part of the A&E Recovery Plan and is currently above 9 days. This in turn contributes to the impeded flow through the inpatient beds.


NUMBER of PATIENTS on FIT TO GO LIST (Other) WB
Value
20
10
0
-10
Monday, Feb 3, 2014
Actual: 8
10 Feb Mon
24 Feb Mon
10 Mar Mon
24 Mar Mon
07 Apr Mon
21 Apr Mon
05 May Mon
19 May Mon
02 Jun Mon
16 Jun Mon
30 Jun Mon
14 Jul Mon
28 Jul Mon
11 Aug Mon
25 Aug Mon
Actual
Goal


Average LoS WB
Value
30
20
10
0
-10
Monday, Feb 3, 2014
Actual: 19.1
10 Feb Mon
24 Feb Mon
10 Mar Mon
24 Mar Mon
07 Apr Mon
21 Apr Mon
05 May Mon
19 May Mon
02 Jun Mon
16 Jun Mon
30 Jun Mon
14 Jul Mon
28 Jul Mon
11 Aug Mon
25 Aug Mon
Actual
Goal

Solution:

There are a number of factors that we have identified where integrated care can help reduce delayed transfers of care, and as result we have developed our BCF schemes accordingly.

1. The number of patient discharges on an average weekend day is less than half the number of patients who are discharged on an average weekday. A key reason for this is access to health and social care in the community over the weekend. In response we will use our 7 Day Services Scheme to enhance the existing 7 day arrangements across both health and social care.

2. Another key reason for delayed transfers of care is the cohort of patients who are waiting for social care packages, who often have to wait for their care, despite being fit to be discharged. Our Joint Care Provider Scheme will reduce these delays by the using the benefits of a single service, operating with a pooled budget, to provide an appropriate onward destination for this cohort of patients, with a focus on maximising their independence.

Challenge Statement 5: Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking.

Like every other local authority in the country, West Berkshire faces challenges in delivering its priorities against national government settlements. Through its Corporate Plan, the local authority has affirmed its commitment to caring for and protecting the vulnerable in its community However, there is an explicit acknowledgement of the need to work differently to avoid the consequences of a widening funding gap over the next 3 years.

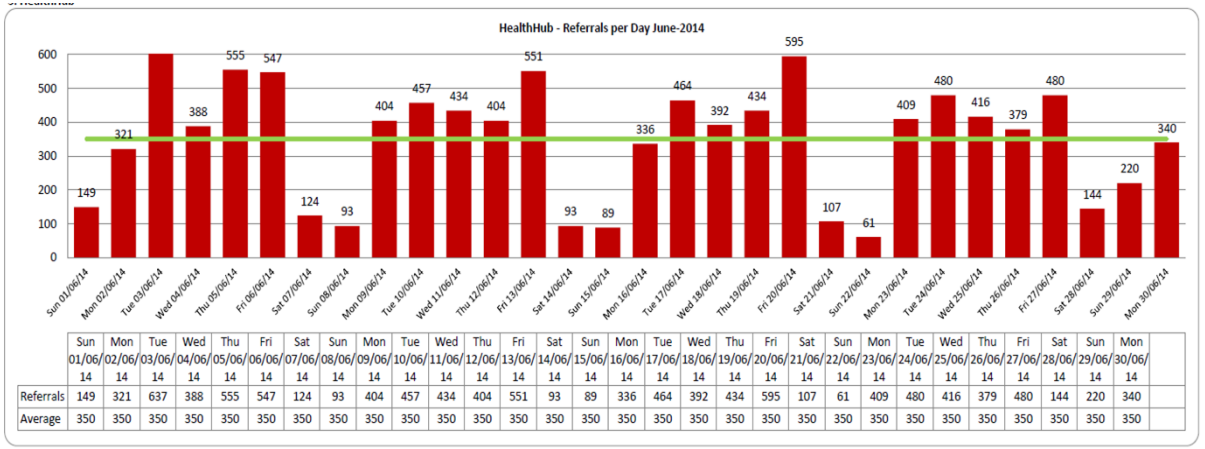
The key areas of demand for adult social care in West Berkshire are amongst those over 75 and those with dementia, both of whom have a longer than average length of stay due to waiting for community based services. As described above, the number of patients on the “fit to go” list continues to increase due to the increasing demand for nursing care, residential care and community reablement, and the lack of supply. This lack of supply is felt most acutely in the rural areas of West Berkshire where the distances involved in getting to and from client’s in the very sparsely populated communities is prohibitive for providers.

The Solution:

The Better Care Fund spending plans for 2016/17 include a significant sum to protect social care services,

	particularly the universal preventative services that have been established. The Personal Recovery Guide / Keyworker scheme (BCF03) will initially focus on helping move patients through the care pathway with one of the aims being to facilitate their prompt discharge from hospital. We understand that most people will not have had the need to access care services prior to a hospital admission and will be faced with the need to make life changing decisions. This scheme will prevent them from getting lost in the system and connect them to good quality information about what services are available and what the impact of their choices will be. As the scheme develops we will seek to expand the focus to support people to access community based services, both universal and commissioned, and link into some of the Public Health funded initiatives including the 'Village Agent' scheme. Most people want to stay in their communities and this scheme will be developed to support them to do that. **Challenge Statement 6 Increased Demand for Planned Care Services** Year on year we only seen a small increase in demand for planned care services. (0.4%) growth across Berkshire West providers. Although elective care is outside the scope of the BCF it is important to ensure the balance between elective and non- elective work is managed across the system. High levels of non-elective demand, combined with Delayed transfers of care have the potential to reduce capacity to carry out planned procedures. Clearly a balance is important and improvements in DTOC and reduction in NEL through the better care fund schemes and other initiatives will help free important capacity to carry out planned work, which in turn can reduce /address the burden of long term morbidity. **Challenge Statement 7: Inequity in Access to Services 7 Days a Week** It is widely accepted that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients in hospital, including raising the risk of mortality. Local acute data from Royal Berkshire Foundation Trust shows that there are far fewer discharges at the weekend vs. during the week with less than half the weekday average number of discharges. This is due to system that does not operate flexibly across the seven days, our 7Day Week service will address deficits in cover from the acute services, primary care and community based social. Since all requests for discharge support (health and social care) from our main acute provider (Royal Berkshire Foundation Trust) as well as requests for community support are processed through the current Health hub, the graphs below clearly demonstrate a marked reduction in referrals into the hub for these

services at weekends which is likely to affect discharge rages and admission rates.



	Sun 01/06/14	Mon 02/06/14	Tue 03/06/14	Wed 04/06/14	Thu 05/06/14	Fri 06/06/14	Sat 07/06/14	Sun 08/06/14	Mon 09/06/14	Tue 10/06/14	Wed 11/06/14	Thu 12/06/14	Fri 13/06/14	Sat 14/06/14	Sun 15/06/14	Mon 16/06/14	Tue 17/06/14	Wed 18/06/14	Thu 19/06/14	Fri 20/06/14	Sat 21/06/14	Sun 22/06/14	Mon 23/06/14	Tue 24/06/14	Wed 25/06/14	Thu 26/06/14	Fri 27/06/14	Sat 28/06/14	Sun 29/06/14	Mon 30/06/14
	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Referrals	149	321	637	388	555	547	124	93	404	457	434	404	551	93	89	336	464	392	434	595	107	61	409	480	416	379	480	144	220	340
Average	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350

Solution:

In response to issues created by a lack of provision over the weekend, our 7 Day work stream will seek to enhance the existing 7 day provision across both health and social care in a coordinated and affordable way. The Joint Care Provider Scheme will also play a key role in improving and simplifying the 7 day arrangements. These plans will support all patient cohorts but the provision is expected to be particularly effective for patients with complex needs, those identified as part of the national service to avoid unplanned admissions including the over 75 year olds.(see national condition narrative below for further details)

Challenge Statement 8: Workforce Availability

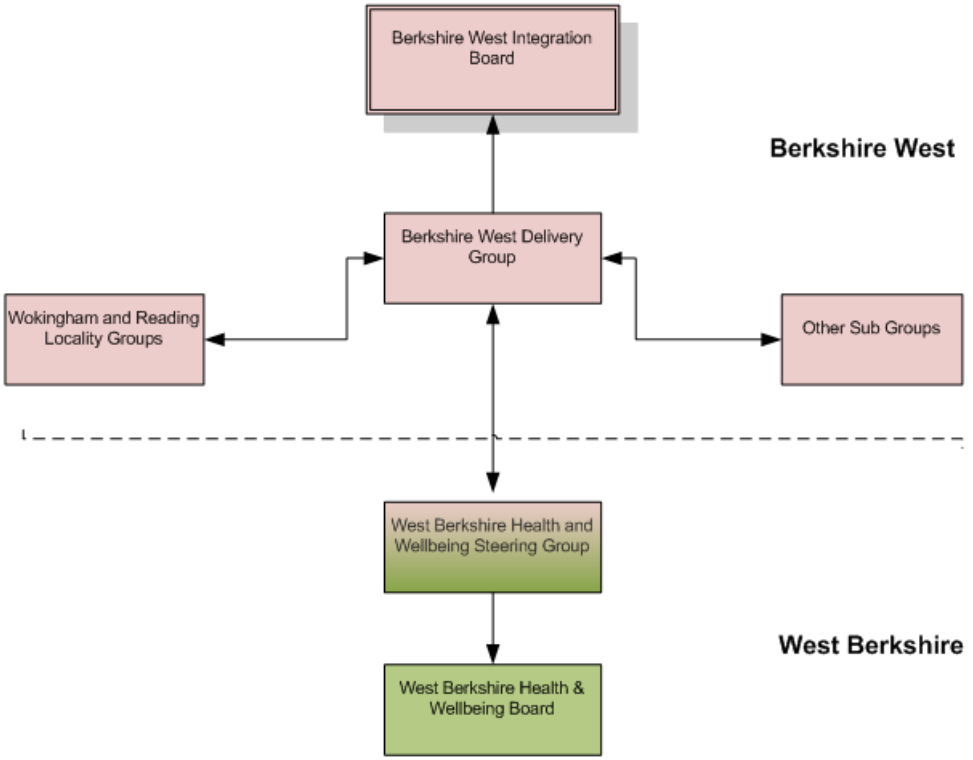
A major challenge already facing West Berkshire is the lack of carers both those directly employed by the local authority and those employed by private sector providers. The shrinking working age population (see census data above) and high employment rates in the area have resulted in a lack of people willing to enter into what are relative low paid carer jobs. This impacts on our ability to commission domiciliary care in particular where providers regularly turn down work due to their lack of staff.

	Solution: As one of the Better Care Fund Plan 'enablers', the Workforce Development project aims to help us understand more clearly where the gaps are so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be supported by fewer people who get to know them better. **<u>Challenge Statement 9: Care Act 2014 – increased duties</u>** West Berkshire District Council was one of just 3 local authorities in England that operated an eligibility criteria for social care of 'critical only no Over the last year we have seen a change in demand as we have worked to comply with the new national eligibility criteria. We have seen more people are eligible for support and we have increased support to existing clients. This additional demand has has placed pressure on capacity of care provision, as time goes on this is becoming more of challenge.. **Solution:** Within the constraints of the money available, the BCF spending plans include a significant contribution toward the Care Act costs, recognising that no specific allocation was made into the fund by the Department of Health to recognise the 'critical only' issue. **Delivering Change via the BCF** We have built our Better Care Fund submission around the key challenges in West Berkshire with a focus on those areas where we feel care can most be improved by integration, based on our experiences in West Berkshire and the evidence base.
Please provide a description of the specifics of the overarching governance and accountability structures in place locally to support integrated care, including: • A description of the specifics of the management and oversight in place to support the delivery of the BCF plan?	The West Berkshire Health and Wellbeing Board will have strategic oversight and governance for the West Berkshire Better Care Fund and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with Newbury & District CCG, North West Reading CCG and West Berkshire Council. This Board meets regularly and will receive 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

- An articulation of the arrangements in place to support joint working?
- Key milestones associated with the delivery of the plan of action in 2016-17?
- A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally including:
  - A quantified pooled funding amount that is 'at risk'
  - Demonstration that this has been calculated using clear analytics and modelling
  - An articulation of any other risks associated with not meeting BCF targets in 2016-17
  - An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements

updating of the risk register associated with such performance.

Because the local health and social care economy works across our Berkshire West boundaries many of the schemes within the plan are part of a wider Integration Programme, as outlined below:

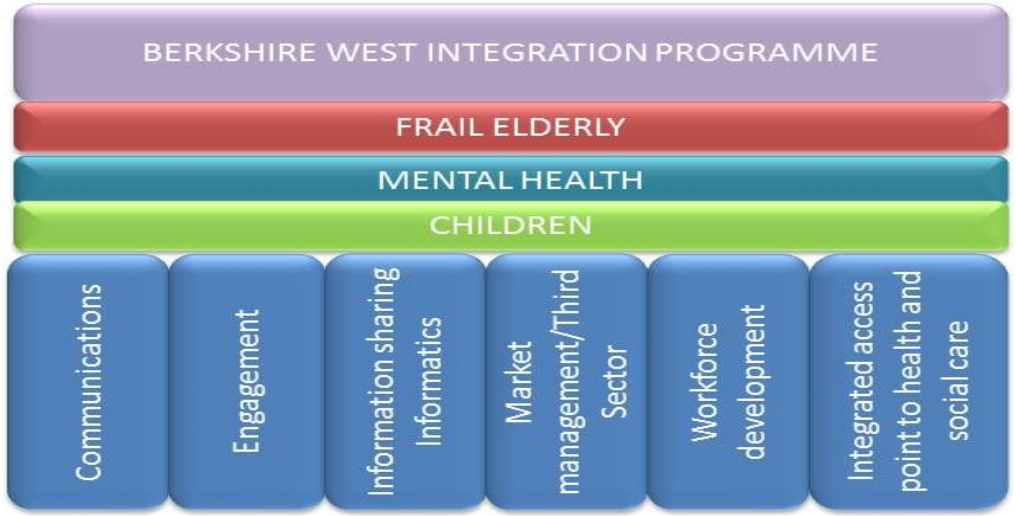


There are monthly Berkshire West Delivery Group meetings with representatives from each of the partner organisations in attendance. For projects that span all three unitary authorities in Berkshire West (Reading

Borough Council and Wokingham Borough Council as well as West Berkshire Council), accountability is held with the Berkshire West Integration Board.

This Board will oversee the delivery of the Workforce Development strategy and other overarching system wide schemes which are included within the BCF programme. The partnership has appointed an Integration Programme Manager who is responsible and accountable for ensuring the system wide objectives of the wider integration programme are delivered We recognise that both provider and voluntary sector representation is essential to ensure engagement and improvement of the workforce across the system.

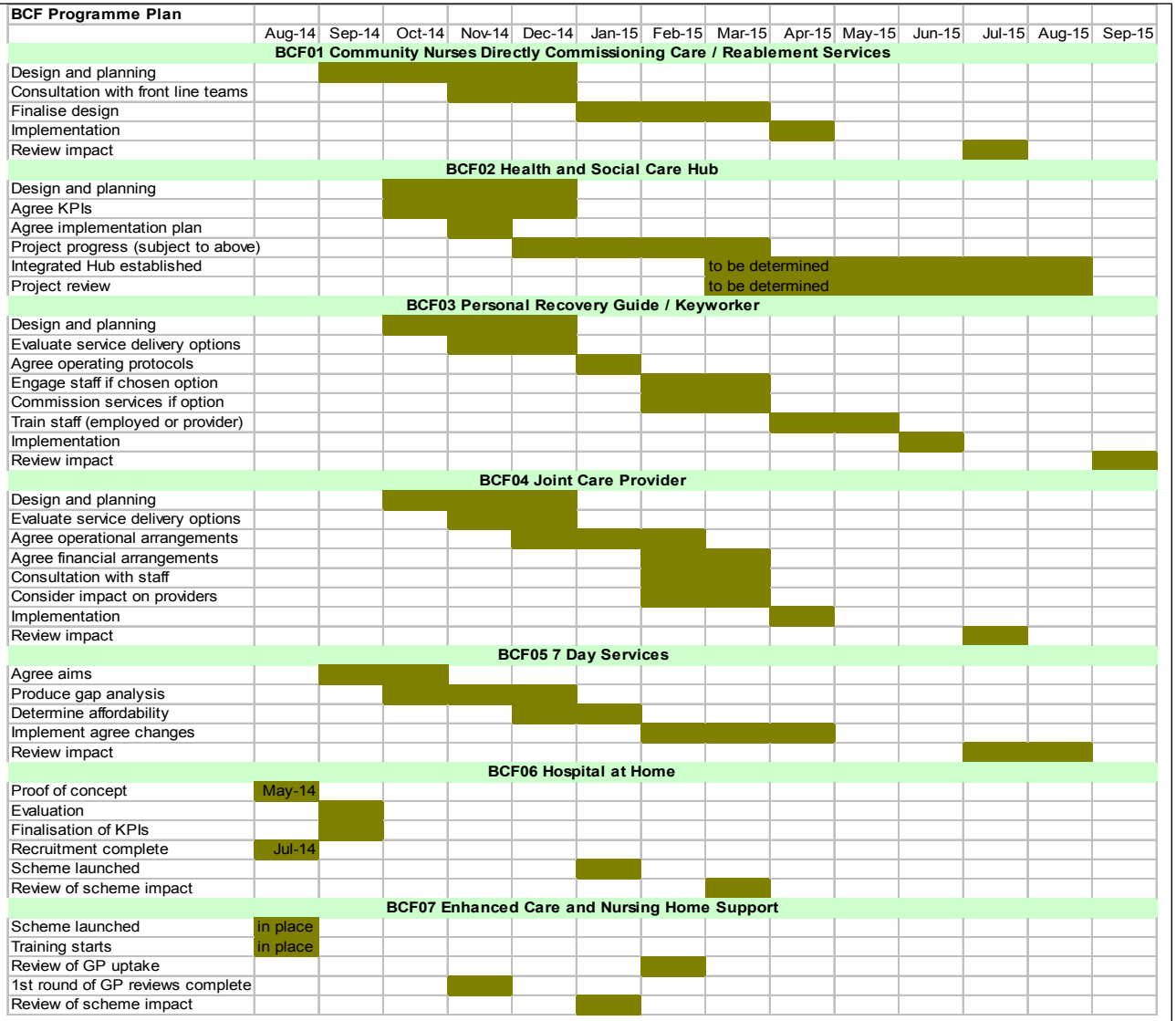
The structure and the relationship to the work streams within the Berkshire West integration programme is represented thus:



West Berkshire's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the district. The Health and Wellbeing Board has already overseen the production of the latest Joint Strategic Needs Assessment for West Berkshire, and led the development of a Health and Wellbeing Strategy and Delivery Plan. The Board is therefore well placed to ensure West

	Berkshire's integration plans draw on local evidence of need and health inequalities. We now have a Programme Office across Berkshire West in order to ensure there is sufficient project management capacity to deliver both the local and wider enabling schemes identified within this submission. The next section describes the management and oversight which monitors project delivery to ensure our identified schemes remain on track. Within the Programme Management Methodology being used to implement the BCF the Health and Wellbeing Board act as the Programme Board and the West Berkshire Health and Wellbeing Steering Group as project board. Every project is sponsored by one or more senior managers and a clinician from across the health and social care economy. There are implementation teams for each of the named projects with assigned Project Managers We are utilising the Office of Government Commerce (OGC) best practice framework "Managing Successful Programmes" to manage the overarching programme and the Prince 2 Project Management Methodology for management of the individual projects within it. Project Managers will report to the Projects Board at regular intervals. Terms of reference exist for all groups and specific responsibilities have been documented for named roles, e.g. Programme Manager Governance Strategies for the Programme have been formulated and documented to ensure consistency across the projects and encompass the following: • Benefits management • Information management; • Risk management; • Issue resolution; • Monitoring and control • Quality management; • Programme resource management;

	• Stakeholder engagement/consultation/communication For example project issues or risks which have been identified and logged at the project level but cannot be resolved/managed there, will be escalated to the Health and Wellbeing Steering Group through regular Highlight Reports and if they cannot be resolved/managed there, they will be escalated to the Delivery Group and so on. Programme risks will be regularly reviewed by the Steering Group and an action plan put in place for any risks that remain red following mitigation. This programme will have the support of an experienced Programme Office **Milestones** The programme plan below illustrates the high level key milestones by scheme for the delivery of the Better Care Fund plan over the past year. A new plan is being developed for 2016/17. The key milestones for each scheme are laid out in the relevant project briefs and project initiation documents. Under the governance arrangements these milestones are approved and progress monitored by the Steering Group, West Berkshire Delivery Group and the Health and Wellbeing Board.


BCF Programme Plan
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
BCF01 Community Nurses Directly Commissioning Care / Reablement Services
Design and planning
Consultation with front line teams
Finalise design
Implementation
Review impact
BCF02 Health and Social Care Hub
Design and planning
Agree KPIs
Agree implementation plan
Project progress (subject to above)
Integrated Hub established
to be determined
Project review
to be determined
BCF03 Personal Recovery Guide / Keyworker
Design and planning
Evaluate service delivery options
Agree operating protocols
Engage staff if chosen option
Commission services if option
Train staff (employed or provider)
Implementation
Review impact
BCF04 Joint Care Provider
Design and planning
Evaluate service delivery options
Agree operational arrangements
Agree financial arrangements
Consultation with staff
Consider impact on providers
Implementation
Review impact
BCF05 7 Day Services
Agree aims
Produce gap analysis
Determine affordability
Implement agree changes
Review impact
BCF06 Hospital at Home
Proof of concept
May-14
Evaluation
Finalisation of KPIs
Recruitment complete
Jul-14
Scheme launched
Review of scheme impact
BCF07 Enhanced Care and Nursing Home Support
Scheme launched
in place
Training starts
in place
Review of GP uptake
1st round of GP reviews complete
Review of scheme impact

Risk Register

A risk register is kept for each project and project managers are required to review on a regular basis and escalate unmanageable risks up through the governance structure.

Risk Share Agreement

By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The general principles for risk-sharing are:

The financial impact of unpredictable incidences on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effectively delivery of the schemes

Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to ensure that their service delivery arrangements mitigate the impact as far as is possible.

Scope of Agreement

2.1 Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board).

2.2 Responsibility for the management of the Better Care Fund that is the Pooled budget is split between the CCGs and The Local Authority by mutual agreement. The assigned responsibility for the different elements of the Pooled budget is shown in pooled budget responsibility table below.

2.3 All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual organisational budgets outside the Better Care Fund.

2.4 The principle risks to the CCGs are those associated with failure to achieve the savings associated with the delivery of the QIPP schemes incorporated into the BCF and in particular the failure to reduce non-elective activity in the acute sector which means that the CCG is also likely to incur additional costs in terms of financial over performance.

	2.5 As most of the Better Care Fund has been provided from CCG budgets the principle financial risk to The Local Authority is the failure to earn the performance elements of the fund. In order to fully mitigate this risk for the Local Authority the performance element of the fund is held by the CCGs and is not factored into the BCF schemes expenditure plans. This also avoids the opportunity costs and effort in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the 1.1% reduction in non-elective activity. 3. Risk Categories 3.1 Financial Risk • Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation (as set out in the table below) and will not be funded through the BCF, unless agreed by all parties. • Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end. • Under achievement of planned savings and KPIs will be met from contingency and retained performance fund. 3.2 Delivery Risk The Local Authority and the CCGs are responsible for ensuring that they deliver their inputs required to deliver the BCF KPIs. 3.3 Performance Risk • Failure to achieve the non-elective admissions reduction will mean that the performance element of the fund is not payable for use on the BCF schemes. • Achievement will be on a proportionate basis:- o 100% achievement 100% performance fund payable

	o 75-99% achievement 75% performance fund payable o 50-74% achievement 50% performance fund payable o 25-49% achievement 25% performance fund payable o < 25% achievement No performance fund payable • The performance fund remaining for non/reduced performance will be used by CCGs to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector, subject to agreement of Health and Wellbeing Board. 3.4 Reputational Risk • Reputational risk will be managed through an aligned communications and engagement plan. 4. Risk Management Framework& Governance Arrangements 4.1 A comprehensive risk register will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan. 4.2 Resources to support the development and maintenance of the risk register will be identified by the parties. 4.3 The Risk Log will be reviewed by groups that are responsible for the individual identified risks – e.g. the finance risks will be reviewed on a monthly basis by the finance group who will update the Risk log for the Programme and provide these updates to the Programme manager for inclusion into the Master Risk Log. The Programme Manager has overall responsibility for ensuring the Risk Log is updated regularly and reported to the Integration Board. Significant risks will be escalated to the Partnership Board and the Health and Well Being Board and up to the key decision making bodies in both organisations as appropriate 4.4 The Risk Log will also be reviewed in both health and social care individual governance frameworks. 5. Accounting Arrangements 5.1 In determining the pooled budget arrangements the following factors have been considered

	(a) Whether the funds are being transferred or not from health to social care (b) Who is commissioning the service associated with the budget (c) Which organisation is providing the resources to run/manage the service (d) Who are parties to any associated contracts (e) Which organisation bears the risk of any overspend (f) Where any cost savings benefit arise (g) Which staff are involved 5.2 The appropriate accounting standards of each organisation will apply in relation to any joint arrangements that are put in place. 5.3 Each of the CCGs and the Local Authority will recognise its share of the pooled budget in it individual accounts and memorandum accounts will be maintained.

Section 3 - National Conditions

Plans Jointly Agreed Does the BCF Plan cover a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, and is it signed off by the HWB itself, and by the constituent Councils and CCGs? Explain how, in agreeing the plan, have you engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. Please illustrate: • There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan • This includes an assessment of future capacity and workforce requirements across the system • The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences? As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, please confirm that local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.	Our Better Care Fund projects have been developed and rolled out over a series of meetings and the West Berkshire locality board involving acute trust, community health providers, social care and primary care. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes. Going forward with our Phase II Better Care Fund plans, we expect that the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospitals Trust, local GPs and the Adult Social Care Service will all continue to be part of the integration implementation teams.
Maintaining the Provision of Social Care Please specify the total amount from the Better Care Fund that has been	As set out in the BCF planning submission, contribution to adult social care this year has been increased from 4.021m in 15/16 to 4.367m in 2016/17. This represents a real terms increase on last year and fulfils the requirement of this

allocated for supporting of adult social care services and confirm: • That at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified • The amount of funding that will be dedicated to carer-specific support from within the BCF pool? Please describe how the local adult social care services will continue to be supported in a manner consistent with 2015-16. Has this support been agreed locally and, as a minimum, does the funding and services maintain in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16? In setting the level of protection for social care in your local area, please describe how you have ensured that any change does not destabilise the local social and health care system as a whole? Please include a comparison to the approach and figures set out in 2015-16 plans and confirm this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14.	national condition. This real terms increase should help ensure some stability for ASC. However it should be remembered that the overall gross commissioning budgets for ASC are £35m.
7-Day Services Please detail your plans to deliver 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care, and how your approach to 7-day services will: • prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week • support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care	The Berkshire West CCGs have made significant progress on achieving 7 day services access across a range of primary, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the Better Care Fund and in line with the BCF national conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 15/16 (a core part of the 15/16 planning guidance). To date we have invested in an Enhanced Access CES for Primary Care, Better Care Fund schemes which have increased same day access to social workers in hospital, an integrated discharge team, rapid access and treatment teams for care homes, and increased reablement and rehabilitation capacity, and in a 24/7 Psychological Medicine Service, all of which have enabled patients to not only

• is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17	receive appropriate levels of care in a timely way and as close to home as possible without the need to be admitted to hospital, but also to enable patients who are medically stable to be discharged to their normal place of residence without delay. Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number for any health or social care referral. During 2015/16 we increased service provision within our GP practices to provide routine care in the evenings and on Saturday mornings. In addition pre-bookable resilience appointments are available at peak times over the winter period to support the reduction in A & E attendees. Further consideration will be given in 16/17 to provide enhanced access cover and to extend to Sundays. It is likely this will be addressed as part of our primary care strategy which focuses on further collaboration between practices and/or alternative commissioning arrangements to achieve full coverage. Additionally West Berkshire Council offers a 7 day week service within the hospital setting. There is Social worker availability to work closely with the clinical discharge liaison staff within the acute hospital setting to ensure there is timely assessment and assistance to support discharge as soon as possible. This service will also work alongside the admission avoidance team which liaises with the A&E team to return people home from Hospital rather than admit. There is also an OT service working within the community 7 days per week who are available to follow up Hospital discharges with care and to work with the local Reablement service to provide guidance on care provision, moving and positioning and specialist equipment provision.
Data Sharing on the NHS Number Please use this section to demonstrate that the right cultures, behaviours and leadership exists locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. In your response please confirm if: • you are using the NHS Number as the consistent identifier for health and care services, and if not, your plan to do so	1. The NHS number is used as the consistent identifier and currently applies to 95% of cases engaging with the Council. The Council has a system in place for maintaining this system but acknowledges that there will always be a small percentage of people to whom the NHS number will not be readily available when making contact with the Council. 2. The technical solution for enabling systems in Berkshire to share information is the Grafnet solution. West Berkshire Council is in the process of changing it's Client record system from RAISE to Care Director

	and it working on the interface development between Care Director and Grafnet. 3. To satisfy the necessary Information Governance controls the Council has a project to meet with the Level 2 requirements of the Health and Social Care Information Centre. The Toolkit supplied by HSCIC is expected to be completed by September 2016. Following HSCIC approval the Council will be able to proceed with the installation of an N3 Connection. 4. All clients will be asked to consent to the sharing of their information, and will have the right to withhold their consent. Public information is being developed through the BW10 Connected care Board which oversees the interoperability development.
• you are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls	As part of the procurement there were a number of technical requirement s which the preferred bidder has signed up to in relation to Open APIs. The benefit to the use of APIs. The APIs will define what data is shared between the various systems and is what will support the real time access to data. Open APIs will then future proof going forward data exchanges between the multiple systems any changes in technology and legislation.
• you have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when you plan for it to be in place	The Connected Care Implementation team consists of an Information Governance Group across Berkshire made up of the Caldicott Guardians, business representatives and technical people to ensure that the appropriate controls are put in place in the new solution. The guiding principles and development of the group were defined around the principles developed by Dame Fiona Caldicott, the Information Governance Oversight Panel and Information Governance Alliance. Copies of the ToR and the Principles have been attached for reference.  IG Principles  Terms of Reference

• you have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review)	All organisations are obliged to ask for consent to share and disclose information to other organisations and inform the person how and what data they will be sharing with what organisation. The Connected Care projected has an overarching Communication Work stream which is chaired through the NHS and made up of representatives from each of the organisations and members of various patient groups. Depending on the organisation there will be different points of consent models and again part of the IG work stream have developed a consent model which will be adopted by all organisations. Once the Connected Care projected is implemented all organisations who are involved will be updating their websites to direct the person to the guidance around the consent to share model and the opting out process. Attached for reference is the consent model and the communication plan.  Communication Plan  Consent Model
Please also describe how these changes will impact upon the integration of services.	Currently across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different culture, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time. What the Connected Care solution is offering the is ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways:

	• No need for multiple laptops to access health and social care data separately • Access to real time data reducing the need for phone calls to various organisations to collate pieces of information • Reduce the amount of time required to contact the relevant organisations in relation to a person. • More accurate data • The ability to streamline the integrated services better by creating true single assessments The ability to streamline the transfer of a person from one service to another by developing health and social care pathways
Joint Approach to Assessment Please identify which proportion of the local population will be receiving case management and named care coordinator and which proportion of the local population will be receiving self-management help - following the principles of person-centred care planning. Please demonstrate if you plan to identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors). Please include a description of plans for health and social care teams to use a joint process to assess risk and plan care, and agreed milestones demonstrating how and when this condition will be fully complied with.	Since 2015, West Berkshire Council and the Berkshire Healthcare Foundation Trust have adopted a Joint approach to dealing with people within Hospital settings. The approach is to streamline the assessment and discharge process and to work jointly with health to get people home and support together once home. All Hospital discharges have a joint assessment approach. Within the hospital setting there is work between Social services and the Discharge liaison service (OT/PT). Once back home with care, the individual will have a clinician from either health or Social care to follow up within 48 hours of discharge as well as having access to other clinical staff from the Joint care Pathway team. Occupational Therapy, Physiotherapy, Nursing, Social Worker. The Council is reconfiguring it's services under a "New way of working scheme"; Within this the integrated functioning of services for people with dementia is being reviewed as a priority to ensure that there is a secure pathway through services provided by Primary care teams, Council Adult Social care services and the specialist dementia services provided by the Berkshire Healthcare Foundation Trust. All patients (as identified by risk stratification) on the 2% at risk register as being at the highest risk of an unplanned admission have an agreed assessment and care plan. MDT meetings are held to discuss these residents/patients, the accountable

	professional is determined at these meeting, this could be the Social worker, community nurse or GP. This will be developed further through the BCF Joint Care Provider Project. Within Primary Care the Anticipatory Care CES has been commissioned to ensure primary care focussed coordination of vulnerable patients is improved year on year promoting and providing better, more appropriate community care and admission avoidance. The enhanced service is commissioned over and above the requirements of the National DES for Avoiding Unplanned Admissions to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs
Agreement on the Consequential Impact of Change Please describe how the impact of local plans has been agreed with relevant health and social care providers and whether there been public and patient and service user engagement in this planning, as well as plans for political buy-in. Your response should demonstrate that these align to provider plans and the longer term vision for sustainable services. Please also articulate how mental and physical health are considered equal, and that your plans aim to ensure these are better integrated with one another, as well as with other services such as social care. You should also demonstrate clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans.	Our Better Care Fund projects have been developed and rolled out over a series of meetings and the West Berkshire locality board involving acute trust, community health providers, social care and primary care. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes. Going forward with our Phase II Better Care Fund plans, we expect that the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospitals Trust, local GPs and the Adult Social Care Service will all continue to be part of the integration implementation teams. The CCG and Local Authority have engaged in a range of consultation activity both at individual project level, patient/service user feedback is a key part of assessing the impact, discussion with independent organisations at the local authority provider forum, Local Account consultation event, Call to action events and with Councillors and Senior Health and Social Care Leaders through the Health & Wellbeing Board. The West of Berkshire system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance

	structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign. To meet our challenges and overcome the barriers to change in the current system, Berkshire West CCGs along with RBFT and BHFT are proposing to establish a New Model of Care and to operate as an Accountable Care System (ACS). The ACS is a collective enterprise that will unite its members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West. The key characteristics of our ACS will be: • We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live. • We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy • We will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system • Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system. • Finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism.

	• We will develop and use long term contracts to promote financial stability of the providers • It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations. • We will seek to gain support from the three Local authorities in Berkshire West to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. • The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. • The implementation of the Five Year Forward View will see the production of Sustainability and Transformation Plan (STP) at a Thames valley footprint alongside the development of an ACS for Berkshire West. This will be our vehicle going forward for delivering the service transformation locally that will lead to wider financial sustainability. Further detail on our plans can be found in the Berkshire West CCGs Operational Plan 2016/17 (ref: Berkshire West CCGs Operational Plan 2016/17).
Agreement to invest in NHS out of hospital commissioned services Please detail your agreed plan for using your share of the £1 billion that had previously been used to create the payment for performance element of the fund, in line with the national condition guidance, linking back to the summary and expenditure plan tabs of your BCF planning return template. Please describe if you have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance. Please make reference to the consideration of the long term trend in admissions, and the success of schemes implemented to date. If a risk sharing arrangement has been agreed please explain how the decision was arrived at, and illustrate the conditions are appropriate and consistent with guidance. For NHS commissioned out-of-hospital services, and services that were	Our Out of Hospital vision is underpinned strategically by the development of our Accountable Care System, and more operationally for 16/17 through the work of the CCGs Long Term Conditions Programme Board, the Better care Fund and the Frail Elderly Pathway Programme. Our aim is to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising the opportunities for patient self-management. Within this programme of work are a number of key work streams, supported in many cases by the Strategic Clinical network and Academic Health science network to help drive transitional change. An investment is being made for the new Enhanced Support for Care Homes project builds on the schemes funded through the 15/16 Better Care Fund Programmes across Berkshire West incorporating both the Care Homes scheme and the Redesigned Hospital at Home: Rapid Response and Treatment (RRAT) for Care homes. Both projects will be combined and expanded to include a wider perspective across health and social care which enables all those living in long term care settings to remain in their normal place of residence where ever

previously paid for from funding made available as a result of achieving your non-elective ambition, please confirm if these continue in a manner consistent with 15-16 and provide evidence to support any changes to service provision from 15-16 plan.	possible should they experience a non-emergency episode of ill-health or a sudden deterioration in a chronic illness. The main aim is to prevent avoidable admissions or attendances to hospital, reduce delayed discharges of care back into care homes, reduced length of stay for care home residents during an acute illness, improve patient outcomes and support care homes in providing high quality care. For 2016/17-2020/21 an overarching programme will be developed in line with the outputs from the Frail Elderly Programme providing an opportunity for Health and Social Care to work together, to address a wider range of aims and objectives that addresses the responsibilities both have to residents within the Care homes setting and to enable those homes most in need of support to be supported. The CCG and the Local Authority have agreed on the need to include within the BCF 16/17 Plan an amount to be set aside for risk share and have established the following agreed approach to financial risk sharing in line with the national guidance. The BCF risk share fund meets the principle that “the money follows the patient” and “the same pound can’t be spent twice” on the emergency admissions that have not been avoided, and on alternative services. The value of the fund is withheld by the CCG from its BCF allocation, the remainder of which is paid into the pooled budget at the beginning of the financial year. Where admissions avoidance schemes are successful, payments will be made into the pooled fund on a quarterly basis, in arrears, which are equivalent to the value of admissions avoided, up to the maximum risk share fund. Unreleased funds are retained by the CCG to cover the cost of additional non-elective activity. If the planned levels of activity are achieved and, as such value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the partners. Otherwise it is retained to cover the cost of any additional activity which

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<td>results from BCF schemes not having the expected impact in reducing hospital demand.

The risk share fund comprises the non-elective admission reductions in 16/17 from the following schemes included in the BCF:

<table>
<tr><th>Scheme</th><th>Activity – NEL reduction</th><th>Benefit</th></tr>
<tr><td>Care Homes</td><td>88</td><td>£243k</td></tr>
</table>

The Pool Fund Manager and scheme Project Manager will be responsible for setting out a phased budget for both costs and benefits at the commencement of the financial year and for reporting actual costs and benefits year-to-date with a forecast for the full year on a monthly basis to the West Berkshire Integration Board and BW10 Finance Sub Group to monitor progress against plan targets.</td>
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<td>Agreement on Local DToC Plan

Please provide assurance, with supporting evidence that you have established a stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. Please describe how your plan sits within the context of an overall plan across the health and care system to improve patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge)?

Please confirm your target is reflected in the relevant CCG(s) operational plan, and that you have considered the use of local risk sharing agreements with respect to DToC, with clear reference to existing guidance and flexibilities and with reference to the track record of current performance

In agreeing the plan, please detail you methods of engagement with the relevant acute and community trusts and confirm that the plan has been agreed with your providers. Please also detail any engagement with the independent and voluntary sector</td>
<td>West Berkshire council works closely with the local CCG and neighbouring authorities to ensure there is a robust jointly agreed approach to DTOC figures and plans to reduce where possible. With one of the main Hospitals we use a system called Alamac which is where daily data is added. This system is both used by 3 unitaries, Berkshire Healthcare Foundation trust (Community Based health services) and the Royal Berkshire Hospital. For West Berkshire council, we gather daily data on:

<table>
<tr><td>NUMBER of PATIENTS on FIT TO GO LIST (Other) WB</td></tr>
<tr><td>NUMBER of PATIENTS on FIT TO GO LIST (Self funders) WB</td></tr>
<tr><td>Total on fit to go list – WB</td></tr>
<tr><td>Average LoS WB</td></tr>
<tr><td>- those awaiting social care service.</td></tr>
<tr><td>Number of people awaiting nursing care - WB</td></tr>
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Please demonstrate clear lines of responsibility, accountabilities, and measures of assurance and monitoring, taking into account national guidance and best practice (as set out in technical guidance)	Number of people awaiting residential care - WB Number of people awaiting an assessment at any hospital or health care setting - WB No of patients referred to WBC on a daily basis from AMU, ECU and ISU. This generates a daily report of progress which is also followed up by 3 conference calls per week. The current target is to have less than 5 cases on the fit list at any 1 time which are attributable to the council for care. **Fit lists** We have a system in place where daily fit lists are put together to ensure those cases which are ready to leave Hospital are on everyone's radar. This aids communication between the Hospital and the Local Authority. This system is used within the Royal Berkshire Hospital and the Basingstoke and North Hampshire Hospital **Local plan** A joint document has been put together by the Berkshire West 10 delivery group. This is an agreed plan for 2016/17. **Escalation plan** There is a Berkshire West escalation plan which is put into action when the system status reaches Amber status up to Black status. This has been put together by the NHS England South Central and is known as the Escalation Framework. The framework highlights the responsibilities of the Local Authority, Community Health services, Community Hospitals and the Acute Hospital site.
Scheme Level Spending Plan Please confirm if your scheme level spending plan, submitted as part of the BCF Planning Return template, accounts for the use of the full value of the budgets pooled through the BCF.	Yes, we can confirm that the spending plans submitted on the planning return account for the full value of the budgets pooled through the BCF

National Conditions If you have not already done so, please include here an explanation of how the targets against the National Conditions have been set, and your plans for how these targets will be met, and whether they represent a realistic assessment of the impact of BCF initiatives on performance in 2016-17.	I believe this is covered above. The BCF template pulls through the non-elective activity plan from the CCG operating plan template by apportioning the figures to the appropriate health and well-being board. The BCF template to be submitted on 21st March pulls through the data from the CCG submission on 2nd March. This submission used the NHSE baseline figures for the CCG that were pre-populated in the template. The CCG then applied a factor of growth to this plan based on a national tool called the Indicative Hospital Activity Model which gives the CCGs a guide of what growth levels should be expected. This equated to 2.2% across the 4 CCGs in Berkshire West. It is expected that this level of base growth is likely to change for future submissions of the plan based on review of the 2015/16 trend and also based on the outcome of contractual negotiations with the acute providers. The CCG also needs to apply the transformational change projects (QIPPs) that are expected to deliver reductions in non-elective admissions and this was not ready at an appropriate level of detail for the 2nd March submission. The reductions that will be applied to the NEL expected plan are made up of the following: i) CCG QIPP schemes outside of the BCF; ii) savings from CCG hosted BCF schemes and iii) savings from Local Authority hosted BCF schemes. In this way the NEL net increase/decrease shown in both the CCG operating plans and the BCF plans will be aligned. Therefore the non-elective activity plan that can be seen in the BCF submission template for 21st March is not the final version of the plan and is likely to change.