NHS South of England

BCF Plan 2017 - 2019 Cover Sheet

Health & Wellbeing Board Name	West Berkshire
Date of submission	
Has the plan been signed by CCG(s)?	
Date the plan was Signed off by HWB	
Are the minutes of the HWB at which the plan was agreed attached to this submission?	

NHS South of England

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 £10,364m (less carry forward from 2016/17 scheme underspend) for 2017/18 and £10,534m for 2018/19.

In 2016/17 the £10,669,442 included £462,000 under spend carried forward from the 2015/16, without this the total BCF would have been £10,237,422. Therefore when compared to 2016/17, 2017/18 will see a 1.24% increase and 2018/19 will see a 1.61% increase when compared to 2017/18.

The DFG, including the Social Care Capital grant of £1.4m is included in the BCF plans.

<table>
<tr><th>Local Authority Contributions</th><th>2016/17 Gross Contribution £</th><th>2017/18 Gross Contribution £</th><th>2018/19 Gross Contribution £</th></tr>
<tr><td>West Berkshire</td><td>0</td><td></td><td></td></tr>
<tr><td>DFG</td><td>1,400,000</td><td>1,400,000</td><td>1,400,000</td></tr>
<tr><td>Carry forward of 15/16 Scheme underspends</td><td>462,000</td><td></td><td></td></tr>
<tr><td>Carry forward 16/17 Scheme underspends</td><td></td><td>134,982</td><td></td></tr>
<tr><td>Total Local Authority Contribution</td><td>1,862,000</td><td>1,400,000</td><td>1,400,000</td></tr>
<tr><td>CCG Minimum Contribution</td><td>Gross Contribution £</td><td>Gross Contribution £</td><td>Gross Contribution £</td></tr>
<tr><td>NHS Newbury & District CCG</td><td>5,977,666</td><td></td><td></td></tr>
<tr><td>NSH North & West Reading CCG</td><td>2,829,756</td><td></td><td></td></tr>
<tr><td>Total Minimum CCG Total contribution</td><td>8,807,422</td><td>8,964,000</td><td>9,134,000</td></tr>
<tr><td>Total BCF Pooled Budget</td><td>10,669,422</td><td>10,498,982</td><td>10,534,000</td></tr>
</table>
</td></tr>
<tr><td>Is any additional funding from the LA or CCG(s) included?</td><td>The Local Authority will be bringing a 60 bed Care Home in-house with effect from 1st June 2017 and we will invest £398K from the BCF budget in 2017-18 and £186K contingency funding from 16/17 budget for 7-8 step down beds to facilitate Hospital Discharge from Acute Hospitals in order to improve DTOC in West Berkshire.

The additional capacity project was agreed in November 2016 utilising £146K under spend from the Patient Recovery Guide Project. However, due to recruitment issues the Additional Capacity project didn’t commence</td></tr>
</table>

NHS South of England

<table>
<tr><td></td><td>until 20th February 2017 therefore there will be a small amount of under spend that will be carried into 2017/18 to continue with this project beyond March 2017.</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 was presented to the Health Wellbeing Board on the 4th May 2017 where it was signed 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>
<tr><td>Your plan should provide a full overview of the funding contributions for 17/18 and 18/19 and set out any changes from 16/17. Please summarise here any changes from 16/17 and how these have been agreed.</td><td>The funding for 2017/2018 is £10,364m and £10,534m for 2018/2019. The funding for the next 2 years is detailed below with comparative figures for 2016/17.

<table>
<tr><th>Scheme Name</th><th>2016-2017 Expenditure £</th><th>2017-2018 Expenditure £</th><th>2018-2019 Expenditure £</th></tr>
<tr><td>Connected Care</td><td>285,000</td><td>285</td><td>230</td></tr>
<tr><td>7 Day week Service</td><td>500,000</td><td>155</td><td>155</td></tr>
<tr><td>Patient Recovery Guide/Additional Capacity Scheme</td><td>150,000</td><td>134,982</td><td>0</td></tr>
<tr><td>Protecting Social Care Services – under 65 LD residential/supporting living</td><td>1,505,000</td><td>1,535,000</td><td>1,570,000</td></tr>
<tr><td>Protecting Social Care Services - Carers</td><td>300,000</td><td>306,000</td><td>312,000</td></tr>
<tr><td>Protecting Social Care – Reablement</td><td>433,000</td><td>441,000</td><td>450,000</td></tr>
<tr><td>Protecing Social Care U65 LD Supported Living</td><td>433,000</td><td>441,000</td><td>450,000</td></tr>
<tr><td>Protecting Social Care M&C Over 65</td><td>377,000</td><td>383,000</td><td>390,000</td></tr>
</table>
</td></tr>
</table>

NHS South of England

	Protecting Social Care – Carers Support	584,000	595,000	610,000
	Exising CCG S256 – Carers	327,000	327,000	327,000
	Existing CCG Reablement Spend	755,000	755,000	755,000
	Joint Care Provider	408,000	416,000	420,000
	Rapid Repoonse & Treatment (Care Homes)	543,000	393,000	393,000
	BCF Project Management	109,000	120,000	120,000
	BCF Locality Lead and admin support (funding to for LA and CCG joint support)	100,000	100,000	100,000
	IMHA & Veterans		39	39
	Step Down Bed Scheme in WB Care Home		398,000	542,000
	Street Triage			
	Capital			
	Disabled Facilities Grant	1,400,000	1,400,000	1,400,000
	Social Care Capital Grant	0	0	0
	Contingency (1)	253,000	164,000	160,000
	Contingency (2)	75	0	0
	Performance fund	243,000	222,000	222,000
	Total	**10,669,000**	**10,498,982**	**10,534,000**
	The planning template, attached, provides more details and a full overview of the funding contributions for 2017-2019. These have been jointly agreed by the CCG and Local Authority.			
Please summarise the impact assessment of any changes you have made	Following an evaluation of The Patient Recovery Guide (PRG) pilot project, a decision was taken by the local integration board to cease funding this project in June 2016. (The evidence suggested the project did not meet all of its expected outcomes and that the money could be used better elsewhere) The under spend from the PRG was allocated to create additional capacity in the Market in providing 120 hours of community care and 3 step down beds to assist hospital discharge and DTOC. Due to a delay in recruiting carers the community care did not start until 20th February 2017 and we are still trying to secure the 3 step down beds. The intention is to carry forward the unspent budget allocated to the additional capacity to plug the gap before our new project of 7-8 step down beds at Birchwood Care home starts on 1st June 2017. JCP will continue as business as usual in 2017/18 and following an evaluation of the 7 day services project, (using the tool developed through the BCF in 2015/16) this will be re-configured with a much smaller budget.			

NHS South of England

	West Berkshire will be introducing 2 new projects in 2017/18: 1) 7-8 step down beds at Birchwood Care Home to reduce DTOC and 2) Integrated Care Teams to look at further opportunities to work closer with primary care, model examples of good practice with MDT meetings and work with the top 5-10% of patients most at risk of hospital admissions with the aim of reducing Non-elective admissions across the community in West Berkshire. The later will not be supported with any budget in the initial phases.

NHS South of England

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: 1. An increasing population, particularly in those over the age of 65 2. Increasing growth in non-elective care 3. Increasing A& E attendances, and pressure on urgent and emergency capacity 4. Rising delayed transfers of care, and subsequent bed days lost 5. Increasing pressures on adult social care for community packages (particularly in rural areas) and care homes at a time when the overall Council budget is significantly shrinking 6. Increasing demand for planned (elective) care 7. Inequality of access to services across the "whole system :the whole week" 8. Care Workforce Availability 9. 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. The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10 (BW10), have been working together since 2013 within a shared governance structure. The BW10 integration programme is an ambitious transformation programme involving a number of projects across these 10 organisations. The projects operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients and achieving long term financial sustainability. Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 has focused on specific improvements for the frail elderly population, Mental Health Care and Children's Services.

	The West Berkshire locality integration board informs the strategic direction for Health and Social Care Services both in the locality and across West of Berkshire. This board is responsible for the business and overall performance of projects within the BCF and Integration Programme and their focus is to steer and provide direction to deliver the agreed outcomes, benefits and efficiencies of each project contributing towards greater integration of health and social care. We see the Better Care Fund as an opportunity to further 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. West of Berkshire Projects for 2017/18 and 2018/19 include: Connected Care, Care Homes, Getting Home, Street Triage for Mental Health Patients and Integrated Health and Social Care Hub. The workforce project which ran in 2016/17 will now be aligned with the STP workforce aspirations. Locally in 2017/18 and 2018/19 the Joint Care Pathway will become business as usual. The 7 day services project will continue to run but will be reconfigured with a smaller budget as the evidence from this project over the last 12 months suggested that it was not offering value for money in its current format. Towards the later part of 2016/17 we introduced the Additional Capacity project, offering 80 extra hours of community care to assist with our DTOCs – this project will also continue into 2017-18, ramping up to 120 hours of additional community care and 3 step down beds. We will also be investing in 10 step down beds in a local Care Home to facilitate hospital discharge from acute hospitals to improve our DTOC and doing some further work on integrated care teams, working closer with primary care and looking at both risk stratification and models of MDT's to help avoid non-elective hospital admissions for those with frequent attendances. This work will not have any funding attached to it in the early stages, but this is something that may be considered in the future. In addition a deep dive into Mental Health will take place at our next Locality Integration Board on 17th May 2017 and we envisage allocating some funds to at least one preventative project targeted at Mental Health. 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 **Reablement** Our services will continue to 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 through the Joint Care Pathway 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. **Dementia Care** By 2020 we expect to have 1614 living with Dementia in Berkshire West. This is expected to rise to 2165 by 2030 (50% more than in 2015). Identifying those living with Dementia and the provision of high quality diagnosis care is a priority for all four Berkshire West CCG's. A new refreshed Berkshire West Dementia stakeholders group has been established with the specific aim of sharing good practice and identifying solution to current gaps in order to deliver against the Prime Ministers challenge on Dementia 2020. The West Berkshire Dementia Alliance is working with other Alliances in Reading and Wokingham as part of this group to shape and inform a new integrated approach to joint assessment, care planning and ongoing management of people with Dementia. Younger people, as well as older people with Dementia have integrated commissioning of services already in place and Dementia Care Advisors in addition to an admiral nurse resource to ensure support is provided in a patient centred approach. Over 2017/18 and beyond we will be working to update and deliver our Local Berkshire West implementation plan, which will include improving timely diagnosis and delivery quality ongoing management and support for people with Dementia and their carer/s. A separate Dementia action plan and plan on page with key milestones is available alongside the Berkshire West CCG's Operating Plan submission for 2016/17. **Anticipatory Care Planning** During 2016/17 we progressed our work around the frail elderly pathway (outside of the BCF but within the

	integration portfolio at BW10 level). This has allowed us to identify those costing us the highest amount of resources in the system. Our NEL analysis has progressed significantly in year and we have identified a cohort of around 100 people who have frequent multiple admissions and attendances at hospital A&E. We have begun a targeted approach led by our urgent care board and implemented through GP practices, to better manage people with frequent attendances to identify blocks and barriers that prevent these individuals from remaining well/stabilised in their home environment. In 2017/18 we plan to amend our Anticipatory Care (CES) to progress this work at GP Practice level, with clinicians focusing specifically on quality care planning, reducing non elective admissions and continued focus on care home patients. In 2017-19 we will also use this intelligence to address and identify resources that can support individuals and communities in those wards with the highest attendances. This targeted approach will help us address and manage non-elective attendances further to improve health of those in our most deprived areas of West Berkshire. Many of our schemes as well as the wider integration programme aim to specifically target the highest risk/cost segment of our population. Moving into 2017-18 and beyond our vision for supporting patents with long term conditions is underpinned strategically by development of our Accountable Care System and more operationally for 2017/18 and 2018/19 through the work of the CCG's Long Term conditions (LTC) Programme Board, aligned with to BCF and Frail Elderly Pathway. We will also continue to look at further opportunities for Health and Social Care to work closer by through our Integrated Care Team project. **7 day Services** 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. **Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP)** Clinical Commissioning Groups (CCG's) and providers operating in Berkshire West are members of the Buckingham, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP). This is a large STP with three distinct local health economies that are effectively driving place based commissioning to deliver a five year forward view. The local health economies provide the best mechanism to transform primary care, redesign the interface with local hospitals and drive integration with social care. Much of the delivery of the five year forward view will take place at local health economy level with the STP ensuring the rapid adoption of innovation across BOB. Nevertheless each of the member organisations recognises the opportunities of working together with partners at this larger scale and will be progressing initiative to improve quality and realise benefits for the wider system.
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.

NHS South of England

	• 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"

NHS South of England

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.	The 9 challenges referred to in our vision and identified in our Better Care Fund submission in 2016/17 have in main continued to challenge our local economy and will continue to do so over the next 2 years. We will continue with a number of the Berkshire West projects in 2017/18 and 2018/19 and introduce the Mental Health Triage project in April 2017. **Connected Care** – is a new system that enables data sharing between Health and Social Care Professionals across Berkshire and a single point of access for patients wanting to view their care information. It also supports the delivery of the 10 universal capabilities as defined in the Berkshire Local Digital Roadmap and enables service transformation as specified in the Berkshire, Oxfordshire and Buckingham Sustainable Transformation Plan (STP). There are 3 tranches within the overall project, Tranche 1 went live in February 2017, Tranche 2 will go live in June 2017 and Tranche 3 which involves West Berkshire LA goes live in October 2017. **Care Home Project** – The Care Homes project was established in Berkshire West in April 2015 with the aim to provide a common and consistent approach to improving outcomes for those people living in Nursing and Residential Homes in Berkshire West. This was through the training and education of care home staff, medication reviews of all residents and since October 2015 enhanced care through the introduction of a Care Home Rapid response and Treatment Service (RRAT) that provides 7 days a week, 8am – 7pm treatment via a multidisciplinary team linking in with specialist nurses and therapists. The services offers the residents a co-ordinated and joined up health and social care service, reducing unnecessary hospital admissions to hospital, improving the flow of patient from community to acute and back to community and avoiding unnecessary delays in discharges back to the care homes. There are 54 care homes in Berkshire West that have engaged with the Care Home Services. The project is showing encouraging signs of success and proposes to build on the work already undertaken to reduce NEL admissions from care homes and the supporting pathway to ensure residents of care homes in Berkshire West are able to remain in their place of residence as far as is reasonably practicable and appropriate. Over the last 6 months (M6 to M11) we have demonstrated a 5% reduction in NELs when compared to M6-M11 in 2016/16. **Getting Home Project** – In 2016/17 Local Authorities and CCG's in Berkshire West agreed a local action plan to reduce DTOC, which included 8 high impact actions. This project focuses on implementation of three of the high impact changes for DToC's – Multi-agency discharge team, discharge to assess and trusted assessment. Some improvements have been achieved in 2016-17 but this project will carry forward into 2017-18 **Mental Health Street Triage** – Through the provision of a street triage service operating 7 days per week, 5pm – 1am this service will ensure that a Mental Health Professional is available to provide on the spot advice/support to police officers dealing with possible mental health problems. This will lead to people receiving

	the appropriate care more quickly, reduce avoidable use of Section 136 and non-elective hospital admissions. **Workforce** – This project was derived as a key enabler from the work to develop the Frail Elderly Pathway to support the BW10 ambitions to transform the workforce to meet current and future challenges faced by health and social care providers. The project will be aligned with STP workforce aspirations. Locally we have seen a slowing of non-elective growth in 2016/17 but an increase in delayed transfers of care. Newbury & District CCG is the 2nd best performer in the Country for non-elective admissions and we have carried out some detailed analysis of our Non-Elective admissions. A working group has been set up to look at how we can offer a more targeted approach to NEL's during 2017-18. We will also be creating a new project in 2017/18 on Integrated Care teams looking at more opportunities to work closer with primary care with MDT meetings to reduce non-elective admissions from both frequent flyers and patients that are in the top 5-10% cohort. In 2016-17 the CCG's worked with Local Authorities in Berkshire West to develop a system wide "Delayed Transfers of Care Action Plan" which was signed off by all partner organisations across the health and social care system. The plan contained locality targets for a realistic but ambitious improvement in DToC performance which would deliver the 3.5% target in acute bedsw and an improvement of 5% in performance in community beds. The Urgent Care Programme Board, now A&E Delivery Group and Health and Wellbeing Boards took oversight of delivery of the plan. The key deliverables withing the plan were: - • Coding review – a new local coding set for DToC's which align to the national codes is now in use and LA's meet with BHFT on a weekly basis to agree and sign off the DToC reporting. • Improvements to the Continuing Health Care (CHC processes) • Choice Policy: Berkshire West adopted the new national framework and the new Choice Policy was signed off by the Urgent Care Programme Board in September 2016. • Getting Home Project – this project focuses on implementation of three of the high impact changes for DToC's – Multi-agency discharge team, discharge to assess and trusted assessment. Some improvements have been achieved in 2016-17 but this proj3ect will carry forward into 2017-18. A decision was taken in-year to support RBFT in letting a short term contract to CHS, a company providing specialist support to self funders and complex discharges. This contract commenced on 8th January 2017 and the impact and learning will be closely monitored by the Integration board. West Berkshire has introduced

	weekly scrutiny meetings to review all patients regardless of length of stay in hospital – early indications are that delays are improving as a result of this. Despite this progress BCF targets in 2016/17 were missed and further improvement is required. It should, however, be noted that an issue with reporting of delays in mental health beds that was corrected in-year meant that the targets were set artificially low as these delays were not in the baseline. In 2017/18 we will work with our Health Partners to fully understand the reasons for delay, look at how these delays are reported and coded and work with them to reduce what can sometimes be lengthy delays. Our key focus in the 2017/19 BCF will be to improve our DTOC performance. We will continue with the Joint Care Pathway for all hospital discharges and locally we redirected BCF monies from the Patient Recovery Guide project to create some additional capacity in the market with 120 hours of community care and 3 step-down beds starting in February 2016 – this project will also run into the start of 2017/18. In addition we will be investing in 7-8 step-down beds in a West Berkshire Care Home from 1st June 2017 with money from the BCF plan in 2017/18 and the use of contingency funding from 2016/17 to facilitate hospital discharge and help improve our DTOC performance. There is now a significantly heightened financial challenge within all organisations within our economy. Our plans to address this going forward include a move to an Accountable Care System (ACS). The Berkshire West Accountable Care system is a complete transformation of how 3 NHS trusts and four CCG's within Berkshire will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price. By moving to this new contractual relationship, providers and commissioners will need to share the risk of delivering services across the geopgraphy within an overall cost allocation rather than individual organisations being required to protect their own financial positions. Further details can be found within the Berkshire West CCG's Operating Plan submission (December 2016) and the STP. West Berkshire Council, like manage across the Country faces challenges in delivering its priorities against National Government settlements. 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. As outlined in our BCF in 2016/17 we have been able to target specific BCF schemes at different cohorts of the

	population. In line with what is known nationally within health, 5% of our population will cost us 50% of our spend. This cohort generally will include the elderly with multiple complex conditions who have frequent requirement for hospitalisation and utilisation of health and social care resources. During 2016/17 we have progressed our work around the frail elderly pathway (outside of the BCF but within the integration portfolio at BW10 level. This has allowed us to identify those costing us the highest amount of resources in the system). In 20217-19 ??? During 15/16 we have seen this borne out in analysing our rise in non-elective admissions It was found that although the over 65s did not constitute the largest number of non-electives by age group; they did consume the highest level of cost for their non-elective admissions. During 15/16, the o*ver 65s were found to account for 38% of the non-elective activity but 53% of the total cost.* Many of our schemes, as well as the wider integration programme aim to specifically target this section of the population. For example, during 15/16 and continuing into 16/17 we rolled out the ACG risk stratification tool to all GP Practices. We are not sure how many of our GP Practices are actively utilising this tool but in 2017-19 we are planning for the BCF Lead to have access and training with this tool to allow analysis and sharing of information. This information will assist our Integrated Care team Project and support successful Multi-disciplinary Team Meetings along with the local knowledge from within the GP Practices to identify segments of the population who have the highest risk of an unplanned admissions and allows us to actively roll out a programme of joint health and social care assessment and care planning. Our Integrated Care Team Project will look to build on this over the next 2 years. Also 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

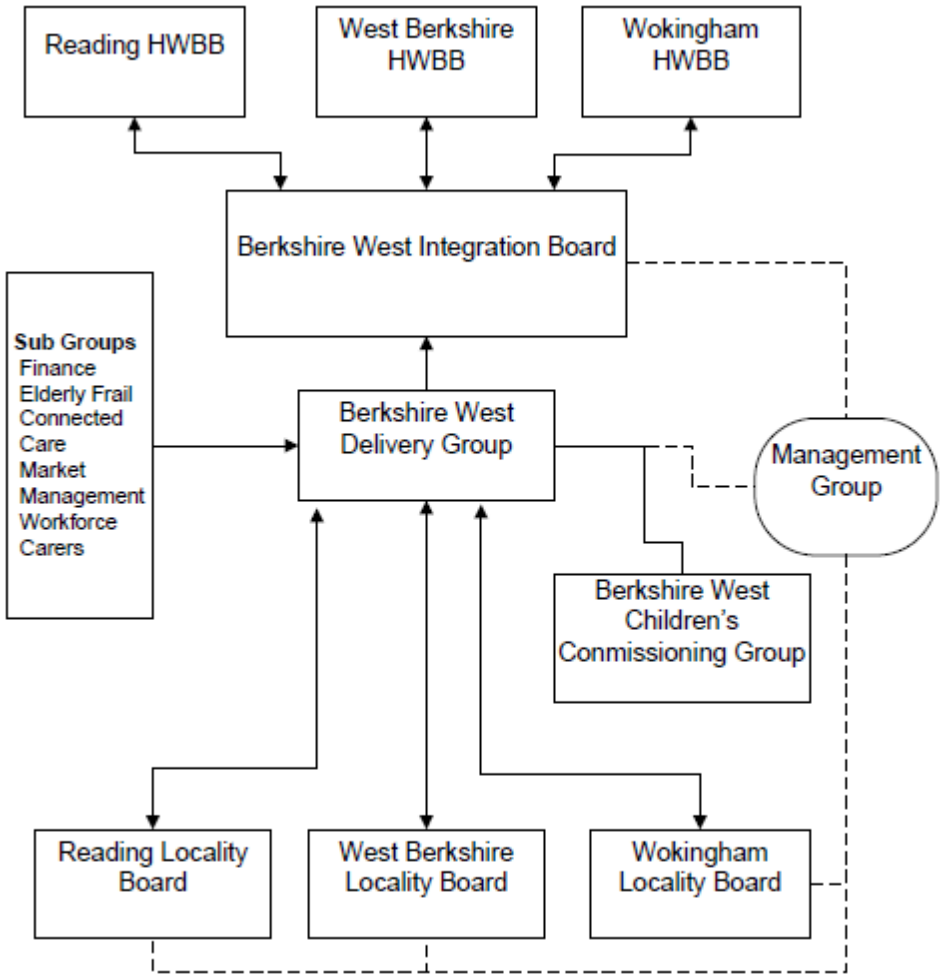
NHS South of England

	of information about the health needs of the local practice population and to be able to support a reduction in emergency admissions.
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? • 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	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 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:

NHS South of England

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



NHS South of England

	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. All projects that span the three localities are required to submit a monthly highlight report, which includes milestone and financial status, key achievements, next steps, issues and risks. 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. The Programme Office across Berkshire West ensures 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

NHS South of England

	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. From 2017-19 , within West Berkshire's locality any exisitng projects or projects that are deemed business as usual have a PID on a page, which summaries the objectives, benefits etc. A full project PID is required to be submitted to the locality integration board for any new projects. These full PIDs are also presented to the Finance sub-group who under the new Chair are currently developing a value for money model, which will be used for any future projects. **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 arrangements for risk share, overspends and underspends in the BCF are set out in Schedule 3 of the Locality S75 Agreement. **S75 Agreement** 2.1 The risk share fund in the BCF comprises the value of the aggregate reduction in non-elective admissions expected to be achieved in the year from the successful implementation of the specified schemes. 2.2 At the commencement of the agreement the value of the risk share fund is withheld by the CCG from its BCF allocation. 2.3 Where admission avoidance schemes are successful and the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then the risk share funding may be released to be spent as agreed by the partners. Any payments made from the risk share fund will be on a quarterly basis, in arrears, which are equivalent to the value of the savings made, up to the maximum risk share fund. 2.4 Any amount released from the risk share fund cannot exceed the amount set aside for the schemes listed in the Locality S75 Agreement. 2.5 Where the anticipated savings benefits are not achieved, any unreleased funds are retained by the CCG to cover the cost of additional non-elective activity. 3. Pooled Fund Manager 3.1 The Pooled Fund Manager will at all times be responsible for managing schemes within the budget available, including any amounts which may have been released from the risk share. 3.2 The Pooled Fund Manager will be responsible for setting out a phased budget for both costs and benefits for schemes 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. 3.3 Overspends which cannot be otherwise mitigated, shall be met in the first instance from the respective scheme's Pooled Fund Contingency. Should this be insufficient, then any residual overspend shall be met by the Pooled Fund holder for the respective scheme.

NHS South of England

	3.4 In the event that expenditure from any Pooled Fund in any financial year is less than the aggregate value of the financial contributions made for that financial year, the surplus monies will be returned to the Partner contributing to the Pool unless alternative arrangements are agreed by the Partners. 3.5 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

NHS South of England

	(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.**

NHS South of England

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 Integration Board involving Acute Trust, community health providers, social care, primary care and Voluntary Sector. 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 BCF plan for the next 2 years, we expect that the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospitals Trust, Local GP's, Adult Social Care, Public Health and Healthwatch to continue to be part of the integration implementation plans. In addition we have held a number of public engagement events to let the public know about our achievements and plans over the next 2 years.
Maintaining the Provision of Social Care Please specify the total amount from the Better Care Fund that has been allocated for supporting of adult social care services and confirm:	As set out in the BCF planning submission, contribution to Adult Social Care in 2017/18 has been increased from ? to ? and from ? to ? in 2018/19. This represents a real terms increase on 2016/17 and fulfils the requirement of this

• 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 Adult Social Care. However, it should be remembered that the overall gross commissioning budgets for Adult Social Care are ?.
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.	Our out of hospital vision is underpinned by the development of our Accountable Care System and more operationally for 17/18 through the work of the CCG's 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

NHS South of England

For NHS commissioned out-of-hospital services, and services that were 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.	to help drive transitional change. Our investment in the Connected Care, Care Homes Project