Bracknell Forest Council

NOTICE OF MEETING

Health and Wellbeing Board
Thursday 5 June 2014, 2.00 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health and Wellbeing Board

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr William Tong, Bracknell Forest & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Glyn Jones, Director of Adult Social Care, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group
Lise Llewellyn, Director of Public Health
Matthew Tait, Thames Valley Area Team
Andrea McCombie-Parker, Local Healthwatch

ALISON SANDERS
Director of Corporate Services

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If you require further information, please contact: Priya Patel
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Published: 28 May 2014

Health and Wellbeing Board
Thursday 5 June 2014, 2.00 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

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AGENDA

Page No

1. **Apologies**

   To receive apologies for absence and to note the attendance of any substitute members.

2. **Declarations of Interest**

   Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

3. **Urgent Items of Business**

   Any other items which the chairman decides are urgent.

4. **Minutes from Previous Meeting**

   To approve as a correct record the minutes of the meeting of the Board held on 10 April 2014. 1 - 8

5. **Matters Arising**

6. **Public Participation**

   QUESTIONS: If you would like to ask a question you must arrive 15 minutes before the start of the meeting to provide the clerk with your name, address and the question you would like to ask. Alternatively, you can provide this information by email to the clerk Priya Patel: priya.patel@bracknell-forest.gov.uk at least two hours ahead of a meeting. The subject matter of questions must relate to an item on the Board's agenda for that particular meeting. The clerk can provide advice on this where requested.

   PETITIONS: A petition must be submitted a minimum of seven working

days before a Board meeting and must be given to the clerk by this deadline. There must be a minimum of ten signatures for a petition to be submitted to the Board. The subject matter of a petition must be about something that is within the Board's responsibilities. This includes matters of interest to the Board as a key stakeholder in improving the health and wellbeing of communities.

7. **Child & Adolescent Mental Health Service (CAMHS) - Service Mapping**

A verbal update from the Director of Public Health.

8. **Better Care Fund Update**

This report updates the Board on progress, highlights changes to the initial joint plan submitted to NHS England 4 April 2014 and outlines the next steps. 9 - 44

9. **Future Population Growth and the Effect on Surgeries in Bracknell Forest**

A verbal update from Board Members.

10. **Update on the Frimley Park Acquisition of Heatherwood and Wexham Park Hospitals**

A verbal update from the Bracknell & Ascot Clinical Commissioning Group.

11. **Deprivation of Liberty Safeguards: Implications of Supreme Court Ruling**

To inform the Health and Wellbeing Board of the potential implications of a recent Supreme Court Ruling in relation to the Deprivation of Liberty Safeguards. 45 - 50

12. **Actions taken between meetings**

Board members are asked to report any action taken between meetings of interest to the Board.

13. **Forward Plan**

Board members are asked to make any additions or amendments to the Board's Forward Plan as necessary. 51 - 52

14. **Dates of Future Meeting**

4 September 2014
11 December 2014
5 March 2015

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HEALTH AND WELLBEING BOARD
10 APRIL 2014
2.00 - 3.55 PM

Bracknell Forest Council

Present:
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr William Tong, Bracknell & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children, Young People & Learning
Zoe Johnstone, Chief Officer: Adults and Joint Commissioning
Dr Janette Karklins, Director of Children, Young People & Learning
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Dr Lise Llwellyn, Director of Public Health
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group
Mark Sanders, Local Healthwatch
Helen Clanchy, NHS England, Local Area Team

Apologies for Absence were received from:
Glyn Jones, Director of Adult Social Care, Health & Housing

In Attendance:
Lisa McNally, Public Health Consultant

82. **Declarations of Interest**

There were no declarations of interest.

83. **Urgent Items of Business**

There were no urgent items of business.

84. **Minutes from Previous Meeting**

RESOLVED that the minutes of the Health & Wellbeing Board held on 13 February 2014 be signed by the Chairman and approved as a correct record.

85. **Matters Arising**

Minute 74: Royal Berkshire Healthspace: Urgent Care Centre (UCC)
It was reported that the UCC had opened on 7 April 2014 as planned. The Board thanked all those involved that had worked hard to ensure these services were secured for Bracknell Forest and Ascot residents. Particularly the services for children and families. It was acknowledged that a former Councillor, Terry Mills had campaigned tirelessly for over forty years to secure a hospital for local residents, allowing them to access services locally and this aspiration had finally been realised. The Board were also heartened that Windsor and Maidenhead colleagues had also attended the opening of the UCC and showed their support.

86. **Public Participation**

It was noted that Democratic Services had received notice of some questions; however the questions did not relate to any of the business on the agenda and so had not been accepted, in line with the Board's public participation scheme.

87. **Berkshire Healthcare Foundation Trust's Quality Account Quarter 3**

The Board was asked to comment on the Quality Account for Quarter 3 of the Berkshire Healthcare NHS Foundation Trust (BHFT).

David Townsend, Chief Operating Officer at BHFT reported that Francis had featured heavily in the quality accounts in the previous year but this year, the Francis elements were more implicit. Consultation responses had suggested that actions around Francis needed to be more explicit and this would be addressed.

It was also recognised from feedback received; that priorities around the Child and Adolescent Mental Health Service (CAMHS) needed to be more prominent and this would be addressed.

The results of the GP Survey would also be fed into the quality accounts where relevant.

The Board made the following comments:

- The Better Care Fund would be key in driving and achieving transformational change and BHFT would be a critical player in this. The Board looked forward to having discussions on the Better Care Fund in the future with BHFT. There was little mention of the Better Care Fund and its impact in the Quality Accounts.
- Trips and falls, the Board viewed this as a priority not just for BHFT but for all trusts and community care. Considering how all partners could get better at preventing trips and falls, it was recognised that this was a large and wide ranging area of work.
- The Board were keen to see more information around the work with children and young people, this was not presented very strongly in the quality account report, yet lots of work was being undertaken in this area. A greater prominence of the work of CAMHS was also important. It was also crucial to ensure that the waiting times for young people were measured prior to them becoming a patient.
- The Board asked that within the BHFT priorities for improvements 2014-15, they would like to see information on the physical ill health of people with mental health issues. Evidence showed that this group, suffered inequalities when requiring healthcare.

David Townsend reported that the Trust had done some work around the physical health of people with mental health issues. This work presented an opportunity to consider integrated teams across mental and physical health. He reported that this work did not feature in the quarter three quality accounts, as the results of the work would be seen in 2015. BHFT would be undertaking work over the next six to twelve months in this area.

The Chairman stated that this work should also encompass long term conditions and the lifestyle of people with mental health issues. It was also noted that it would be crucial to involve primary care.

The Chairman thanked David Townsend for his attendance and presentation and asked that he take on board the comments of the Board.

88. **Update on Child and Adolescent Mental Health (CAMHS) Services Tiers 1-4**

The Director of Children, Young People & Learning introduced the report as a joint report from her directorate, Public Health for Bracknell Forest, the Bracknell & Ascot Clinical Commissioning Group (CCG), Berkshire Healthcare Foundation Trust and NHS England. The Director reported that tiers 3 and 4 were undergoing small changes to commissioning. It was key to note that any changes to any tier would impact the other tiers, given the interrelationship between tiers.

The Director reported that the emphasis would be on prevention, to ensure service escalation wasn't necessary wherever possible and children and young people could be dealt with at the earliest possible stage.

The Chief Operating Officer of the Royal Berkshire Healthcare Foundation Trust (RBHT) reported that Children's Services were undergoing a challenging time, increased numbers had been seen in tier 1. RBHT had put in additional funding to address increased pressure on CAMHS. He stated that it was crucial for all partners to work together, this service area presented a complex landscape and anything that one partner did would have an impact across the whole system.

Bracknell and Ascot CCG representatives reported that they had held a number of meetings around this and recognised the complexities given that several commissioners were involved across the service. It would be important to consider what children's services should look like in the future and a steer from the Board would be essential. Dr Tong stated that children should be dealt with between the ages of 3-5 wherever possible, to reduce use of tiers 3 and 4. He stated that he would like to see the Local Area Team add to that budget. He also stated that services were cross cutting in terms of local authorities and a steer from the Board would be useful as to how this be addressed at pace.

The Executive Member for Children, Young People & Learning stated that he accepted the complexities of this service area; however the savings and benefits to reap for all partners would be tremendous if prevention could be achieved at a greater level. The number of children facing fixed term school exclusions, the impact of mental health and the pressure on teachers could all be reduced if this work was successful. He wasn't interested in national averages when looking at waiting times, only the impact on local youngsters. A 12 week waiting time would mean that a young person would struggle to function at school for this period and lose a huge part of the school year.

The Executive Member stated that the Board needed to consider how support could be brought in from other areas for example, what strategies could be used in schools and the ability to respond to an event in a young person's life.

The Director of Public Health stated that it would be important to evaluate and consider what success would look like. There wasn't a strong evidence base to suggest that if additional funding was put into tier 1 that this would alleviate pressure on tiers 3 and 4. The largest grouped being referred were children and young people with ASD and ADHD. It would therefore be key to look at the triggers and signs for this group.

The Chief Executive stated that it was clear that the landscape was complex given the various commissioners and geographical boundaries. In addition, two national reviews of the service were also currently being undertaken. The ideal would be to design an integrated commissioning system across all tiers. If leads could be

identified for each tier, the first step would be for these leads to meet within a working group to progress this work.

The Chairman stated that it was crucial that all work from reviews be joined up. The national review and the review undertaken by RBHT would need to be considered jointly as well as any other individual reviews undertaken by any other partners. The Chairman stated that he would be happy to assist with this work, the outcomes of all reviews would be critical in assuring the success of this work.

RBHT reported that they had commissioned their own review, which had included benchmarking work. This had been shared with commissioners. The review had resulted in the formation of a task and finish group which the Chief Operating Officer was leading on and meetings every three weeks with commissioners of CAMHS. A tier 4 review would take place at the end of May 2014.

The Healthwatch representative reported that he would like to see local services commissioned informed by the views of local children; young people and their families, who had been through the system. Perhaps by a pan Berkshire survey. The Director of Children, Young People & Learning stated that local views would be welcomed and sought.

The Board agreed that a report be brought back to them at their September 2014 meeting. It was noted that the Council would be undertaking their budget setting process in October 2014 and therefore the September meeting would be timely. It was agreed that if the September 2014 meeting proved to be too ambitious, a special meeting could be convened in October 2014. An outline specification of what local CAMHS services would look like would be submitted to the Board in September/October 2014. This would include the consideration of commissioning an integrated system of all tiers.

The Chairman stated that the timescales of this work were critical; any delay to this work would directly impact the lives and schooling of local young people and children. It was paramount that in September 2014, partners did not state that a further lengthy period of time was needed to let contracts or complete block contracts.

It was agreed that the following officers would lead for each tier:

Tier 1 and 2: Janette Karklins and Lisa McNally (Local Authority)
Tier 3: Sally Murray and a clinician (CCG)
Tier 4: Lisa Noble (BHFT)
Pan Berkshire: Angela Snowling

NHS England agreed to confirm who their lead officer would be and what other support and resources they could offer to this work.

The Director of Children, Young People & Learning stated that she would call the first meeting between leads.

It was **RESOLVED** that the Health & Wellbeing Board:

i) endorsed what good looks like and supported the ambition to improve Bracknell Forest's emotional health and well being support for children and young people and CAMHS services to achieve at this level

ii) noted the arrangements in place for commissioning and the plans for re-commissioning services for children with emotional and mental health issues.

iii) endorsed the determination for early intervention and prevention of escalation where possible to higher tiers of service.

iv) agreed leads for each tier as detailed above and that a report be submitted to the Board in September/October 2014, outlining a specification for the future of CAMHS.

89. **Better Care Fund**

The Chief Officer: Adults and Joint Commissioning reported that the first draft of the Better Care Fund application had been submitted on 14 February 2014. Feedback had been received from NHS England over the last few weeks and this had stated that further work was needed to engage with providers and on metrics. The latest plan had been submitted on Friday 4 April.

The Programme Board would include:

- Co-Chairs:-
  Director of Adult Social Care, Health and Housing, BFC
  Clinical Director, Bracknell and Ascot CCG
- Executive Member, Adult Social Care, Health and Housing
- Chair, Bracknell and Ascot CCG
- Chief Officer: Adults and Joint Commissioning
- Deputy Chief Officer: Bracknell and Ascot CCG
- Healthwatch Bracknell Forest
- Head of Operations, CCG
- Head of Joint Commissioning, BFC
- Programme Manager

The vision for the Better Care Fund by 2018 would be:

"Our population will be happier, healthier and active for longer; through having better information, support to make the right choices, and access to expert health and care services when required."

- People would only have to tell their story once
- There would be shared records based on the NHS unique identifier
- People's needs would be met with minimum time spent in hospital or travelling to access services needed
- Care and support will respond to the individual's choices as well as their needs.

The Board was keen that the emphasis of children and young people should be developed and explored further as the work around the Better Care Fund progressed. The Child and Adolescent Mental Health Service would be a central deliverable of this work.

The Chairman stated that it would be crucial to view the whole spectrum of health and social care when considering the Better Care Fund and be mindful to not get bogged down with any one particular area.

90. **Update on the Progress of the Frimley Park Foundation Trust (FT) Acquisition of Heatherwood & Wexham Park Hospitals NHS Foundation Trust**

It was reported that whilst the report stated that the new Trust would commence in July 2014, this had now been pushed back to August 2014.

Healthwatch reported that the Care Quality Commission had showed that Frimley Park Trust had not scored highly in terms of listening to patients views and responding to patients complaints, this would need to be addressed by the Trust and the Quality Committee had given the Trust a clear steer to take action on this.

The Board stated that patient experience would be key and hoped that the Frimley Park Trust would be able to impact the culture of the Trust it proposed to acquire.

91. **Two Year and Five Year Clinical Commissioning Group Plans**

The Chairman stated that as Board members hadn't been given any time or opportunity to consider the Clinical Commissioning Group's (CCG) two and five year plans, it was proposed that only the two year plan be considered and if Board members wanted to submit any comments or proposed amendments that they feed these through to Mary Purnell by Friday 25 April 2014.

It was reported that the CCG's two year commissioning plan incorporated the following details:

- The population and the CCG
- Current health systems, opportunities and challenges
- Strategic deliverables and innovation
- Prioritisation
- Partner engagement
- Enabling plans
- Delivery and governance arrangements

It was reported that the full commissioning plan had been circulated to Board members.

CCG representatives reported that the health priorities behind the CCG's commissioning plan would be shaped by the Joint Strategic Needs Assessment, the local Health & Wellbeing Strategy and the seven ambitions as follows put forward by the CCG:

- Additional years of life
- Improving health of patients with long term conditions
- Reducing amount of time in hospital throughout hospital care
- Increase the number of older patients living independently at home following discharge from hospital
- Positive experience of hospital care
- Positive experience of out of hospital care
- Eliminating avoidable deaths

The commissioning plan was also aligned with the Better Care Fund submission. Both the CCG Commissioning plan and the Better Care Fund had now been submitted to the Local Area Team.

CCG representatives stated that it would be particularly useful to get feedback from partners around the seven ambitions in the commissioning plan.

In terms of the ambition around positive experience of hospital care, CCG representatives reported that it would be important to hold quality where it currently stood as in a climate of acquisition this would be challenging.

Healthwatch asked that plain English be used in the commissioning plan wherever possible, to make the document more accessible to the public.

92. **The Health & Wellbeing Board - First Year Review**

The Board considered a report that set out a process to review the membership of the Health & Wellbeing Board and to establish the Board's priorities for 2014/15.

The Chief Officer: Adults and Joint Commissioning reported that extra capacity in the joint commissioning team had been created to ensure a more proactive approach could be undertaken as the Board moved into its second year and established its priorities going forward. Lynne Lidster would be taking on the role of Business Manager for the Board two days a week. This had been created using 'one off' resources and would need to be reviewed at the end of 2014/15.

The Chairman reported that he had attended a number of Peer Challenges, where the value of Health & Wellbeing Board's had been analysed and considered. It was clear that it was now timely for the Board to review its membership and in particular consider whether providers should be members of the Board.

It was noted that Lynne Lidster would be contacting members to arrange the first meeting of the workshop to review the role and function of the Board.

It was **RESOLVED** that;

i) the action in paragraph 5.1 of the report in the agenda papers, to provide additional support to the Board from the Joint Commissioning Team, be agreed.

ii) the Board agreed to hold a workshop with the aim of:-
- reviewing the role and function of the Board, including membership (paragraph 5.2 of the report)
- establish the Board's priorities for 2014/15 (paragraph 5.3 of the report)

93. **Protocol Between the Health & Wellbeing Board, Healthwatch and the Health O&S Panel**

The report before the Board set out a draft protocol between the Board, Healthwatch and the Health Overview & Scrutiny Panel. It was agreed that whilst at times there may be some overlap between the work of Healthwatch and the Health Overview & Scrutiny Panel, they would work together to ensure there was no duplication. It was noted that it would be important to review this working arrangement over time.

It was **RESOLVED** that;

i) the protocol between the Health & Wellbeing Board, Healthwatch and Health Overview and Scrutiny be agreed

ii) the Board recommended that the protocol be presented to the Health Overview and Scrutiny Panel for agreement.

94. **Actions taken between meetings**

No actions were reported.

95. **Forward Plan**

There were no additions or amendments made to the forward plan.

96. **Dates of Future Meeting**

5 June 2014
4 September 2014
11 December 2014
5 March 2015

CHAIRMAN

TO: Health & Wellbeing Board
5 JUNE 2014

BETTER CARE FUND
Director of Adult Social Care, Health & Housing
Chair of Bracknell & Ascot Clinical Commissioning Group

1 PURPOSE OF REPORT

1.1 The purpose of the report is to update the Board on progress, highlight changes to the initial joint plan submitted to NHS England 4 April 2014 and the next steps.

2 RECOMMENDATIONS

2.1 That the Health and Well Being Board note the progress to date and the resubmission of the template attached as annex 2

2.2 Agree Section 256 of the 2006 NHS Act - Memorandum of Agreement (See attached draft Memorandum of Agreement at Annex 4)

3 REASONS FOR RECOMMENDATIONS

3.1 To keep the Board appraised of the progress made to deliver the Board's strategy, and ensure the opportunity to influence its implementation and enable the transfer of NHS s256 funding.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 Background information on the Better Care Fund

The previous Board paper of 13 February 2014 relating to the launch of the Better Care Fund is set out at annex 5 for reference.
Summary, the Better Care Fund, background approach and objectives annex 1

5.2 FINANCES

There are no material changes to the finances set out in the previous Board report arising from the publication of the DH Local Authority Social Services funding letter or Care Act 2014.

DH Local Authority Social Services, capital and revenue grants and Care Act funding are confirmed as:

NHS s256 Funding	
The main NHS transfer	£1,356,414
Better Care Fund Preparation	£302,000
	£1,658.414

Capital and Revenue grants	
Specific Revenue Grants	£65,000
Capital Grant allocations	£98,506
Care Act	
Care Act funding	£314,720
Care Act implementation	£125,000

The resubmitted Better Care Fund (BCF) template makes no changes to the total agreed value of the pooled BCF budget of £3.008m. This already includes seed investment funding of c. £1.3m from BACCG. Additional funding could be made available from other funding sources as part of BCF service developments and improvement programmes that deliver the BCF objectives.

However, NHSE have requested changes to the allocation of its main NHS s 256 transfer previously advised to the Board. The changes do not affect the overall value of the transfer and are set out Annex 3. The new s 256 Memorandum of Agreement (MoA) reflecting the changes to allocation are set out at annex 4.

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Community Response and Reablement and Equipment services c£2m are funded separately under NHS s75 agreements

There are no changes to the part of the fund linked to NHSE performance indicators (5 national PIs and 1 Local PI or the payment periods previously advised to the Board. However, it remains for the BCF Board to learn of the maximum values it can achieve by delivering service which meet or exceed the PI thresholds.

5.3 PLAN

5.3.1 Strategic direction

It is clear that Better Care funding is conditional on organisations demonstrating year on year improvements against National and Local service indicator(s). Performance against these measures is being linked to a payment mechanism that could penalise under-achievement. This has led the BCF Steering Group to propose a focus on those service improvements and changes that combine the highest impact on meeting peoples' needs together with National and Local service specific performance targets.

5.3.2 Progress

5.3.2.1 Progress Bracknell Forest care services

The delivery of the BCF objectives is presently focused on a review of on-going service work streams, including progress on specific strategies and service improvement projects within the context of the Adult Social Care (ASC), Public Health and NHS Outcomes Frameworks and BCF specific national conditions and 6 performance indicators (PIs) on which the success of the BCF is to be measured.

An overview of the progress on service developments and initiatives that deliver the objectives of the Better Care Fund is summarised below. It is too early to report on the achievement of 5 National and 1 local PI. However, the table maps the new and ongoing work streams against each of the PIs

National Performance Indicators (NPI) against which projects are being specifically mapped comprises:

[1]= Reducing permanent admissions older people to residential/nursing care homes

[2]=The proportion of older people who at still at home >91days after discharge from hospital into re-ablement/rehabilitation services

[3]=Delayed Transfers of Care, from hospital

[4]=Avoidable emergency admissions

[5]=Patient Experience (Note the PI for Patient Experiences was not put forward in the BCF technical guidance. However, if the board agree, given the importance of assessing and benefitting from patient experience, it is proposed to use the Adult Social Care survey outcomes as defined by the Health and Social Care Information Centre (HSCIS) guidance as a proxy to assess patient experience until the national metric is made available. These outcomes are provisionally published early July 2014 (based on data collected early 2014)

[6]=Falls (Bracknell Forest's chosen PI)

Table 2 chart identifying service developments in progress mapped to national criteria

Work Programme	**Lead**	**Stage**	**NPIs (see above)** 1 2 3 4 5 6
Specific projects			
• Falls programme and development of integrated pathways	LMcN	Feasibility (BFC)/ Mandate (BACCG)	
• Rapid Access Assessment Clinic for older people at Bracknell Healthspace		Business case	
• Care Homes Project – review of quality indicators for care homes via a standardised 'dashboard' with an associated improvement plan. An overview of the WAM programme is attached for discussion	MP/IS	Initial data being collected	
• Prevention and self-care. Three tier programme	MP/ LMcN	Phase 1 Underway	
• Integrated Care teams – further development of the teams (already established) following a 12 month service and King's fund review	MP	Phase 2 Implementation	
• Permanent admissions – causes of increases in admissions	LL	Mandate /Feasibility	
• Personal Health Budgets further embedding within ASC Personal health budgets	EB	Phase 2 Implementation	

Table 3 Chart identifying the strategies being refreshed that will contribute to the national criteria

Work Programme	**Stage**	**Project lead**
Strategies & implementation plans		
Carers Strategy	Refresh / Consultation	ZJ
Intermediate Care	Refresh	ZJ
Older people	Action plan being delivered	ZJ
Mental Health	Refresh	ZJ
Dementia	Action plan being delivered	ZJ
Learning disabilities	Action planning	ZJ
Long Term Conditions	Refresh	ZJ
Sensory Needs strategy	Current strategy implemented, new strategy planned for 2014	ZJ
Autistic Spectrum Disorder (ASD)	Current strategy implemented, new strategy planned for 2014	ZJ

Work Programme	Stage	Project lead
Strategies & implementation plans		
Community Support Commissioning Strategy	Refresh	ZJ
Assistive Technology Approach	Original plan delivered Review of learning and action plan	ZJ

Key BF – Bracknell Forest; WAM – Windsor & Maidenhead; ICT – Intermediate Care Team
Project leads. Mary Purnell, Head of Operations, Bracknell and Ascot CCG; Zoë Johnstone, Chief Officer: Adults & Joint Commissioning, BFC ; Lisa McNally, Consultant in Public Health (Local), BFC; Eve Baker, Deputy Chief Officer, CCG; Lynne Lidster, Adult Social Care and Health; Ian Stoneham, Better Care Fund Programme Manager

5.3.2.2 Progress -The updating and the resubmission of the "Better Care Fund" plan

Updates to the BCF template were made to NHSE Area Team, under delegated authority. The principal changes within the submission:

- Clarifications around risk
- Updating the target achievement levels (PIs) to be used to assess the performance of the BCF in particular the re-profiling the A&E reductions admissions target of 3% pa
- Adjusts to the Delayed Transfers of Care, out of hospital target to a more realistic forecast
- Adjustments to "Older people being at home >91days after discharge" PI which could be adversely affected by the low numbers involved

5.3.2.3 Progress – governance, management/systems and "cross cutting" services enablers

- Governance
  - Drafting of new BFC/NHSE S256 funding agreement/memorandum of Understanding (see annex 4)
  - Completed drafting of a feasibility /mandate template to meet joint governance reporting requirements of BCF/CCG
  - Shared with Steering Group 1st draft of BCF risk logs which meets governance reporting requirements of BCF/ CCG (included on the agenda)
- Business systems
  - Management structure - proposals drafted for an improved management structure involving a Steering and Leads groups to support the BCF Board
  - Development of draft Full Business Case for the Interoperability programme supporting the sharing of IT business systems across the BF health economy (Outline plans for Interoperability were presented to the April 2014 Board)
- Service enablers
  - Implementation of the software programme "Huddle" - a joint CCG/BFC shared data base- a project control and communications web-based system allowing remote access by the joint team (Possibly a first true NHS/LA data sharing)

- Populate “Huddle” data base including project history, current documentation, BCF related reports, articles and press coverage
- Completed 1st draft of the BCF Communication and Engagement strategy

5.4 Legal basis for the NHS 256 transfer

The payments from the NHS are to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with each local authority and will be administered by the NHS England Area Teams (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to local authorities once both parties have signed the Section 256 agreement.

A draft copy of an earlier agreement / memorandum of understanding is set out at annex 4. A final memorandum of understanding will be presented at the Board for approval and signature

5.5 Next Steps

- Assess existing health and social services and public health workstreams to consider how best to improve the effectiveness of individual’s care pathways and achieve best value for money
- Determine how the “proposed seed” funding can be best allocated to services and enabling projects as a catalyst for change to deliver the NHSE metrics (PIs) (on which future funding depends)
- Compete an assessment of on-going projects within a sound project management framework
- Complete outstanding project governance tasks
- Complete final draft of the BCF Engagement and Communications Strategy

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Comments to follow

Borough Treasurer

6.2 No issues

Background Papers

Contact for further information

Glyn Jones, Adult Social Care and Health - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Zoë Johnstone, Adult Social Care and Health - 01344 351609
Zoe.Johnstone@bracknell-forest.gov.uk

Lynne Lidster, Adult Social Care and Health - 01344 351610
Lynne.Lidster@bracknell-forest.gov.uk

Mary Purnell, Head of Operations, CCG – 01753 636176
mary.purnell@nhs.net

Eve Baker, Deputy Chief Officer, CCG – 01753 636024
evebaker@nhs.net

Annex 1 Background Information to the section 5 - The Plan

BCF Funding in Bracknell Forest	The BC Funding currently covers 2014-15 and 2015-16. 2014-15 essentially comprises grants, existing services and new/seed funding totalling £3m (c£1.3m being incremental funding) 2015-16 essentially comprises 2014-15 recurrent and incremental work streams totalling c8.1m.
BCF Approach	Central to the BCF is the integration of health and social care to provide individuals with good quality of care that is affordable. This is being achieved in Bracknell Forest by reviewing how existing services can be provided more effectively and efficiently and assessing how the seed funding provided by BACCG can best be invested meeting the demand for services e and in enabling projects such as systems and assistive technology
BCF objectives in Bracknell Forest	Its proposed that the BCF Board is specific on the objectives against which service developments will be assessed focusing on :: • The National performance indicators:- 1. *Reducing permanent admissions to care homes* 2. *Older people being at home >91days after discharge* 3. *Delayed Transfers of Care, out of hospital* 4. *Avoidable emergency admissions* 5. *Patient /service user experience* 6. *Falls - Local metric* • National Healthcare and BFHWB priorities e.g. appropriate care for people with dementia, support for carers, PH priorities • National Conditions -7 day working, the protection of social services, Joint Assessment & Lead Practitioner, impact of change on local Acute Hospitals and the risk to these of changes, data sharing and the adoption of the NHS Number
Agreement of BCF National performance targets	BF's BCF "Final" national performance activity targets on which future payments are to be based, were submitted in April 2014 to the NHS England area team (NHSE). These reflected changes to the profiling of the A&E admissions targets and some reduction in Delayed Transfer of Care forecasts, having regard to risks of being unfairly penalised because of the small numbers involved. The submission was made to time and was acknowledged by NHSE to be complete. Subsequent feedback from NHSE shows that Bracknell Forest's forecast for the reduction of Older people being at home >91days after reablement looks comparatively high. The rules for measuring performance are complex and clarification is therefore being sought from the CSU informatics team to ensure that assumptions made by team are correct. If not, a request will be made to NHSE to amend the forecast.

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Bracknell Forest Council**
Clinical Commissioning Groups	**Bracknell and Ascot CCG**
Boundary Differences	**3 Ascot practices are within the boundaries of Royal Borough of Windsor and Maidenhead and these are reflected in the plans for RBWM HWBB**
Date agreed at Health and Well-Being Board:	**12/02/2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£1.658m**
2015/16	**£6.643m**
Total agreed value of pooled budget: 2014/15	**£3.008m**
2015/16	**£8.183m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr William Tong
Position	Clinical Chair - Bracknell and Ascot CCG
Date	04/04/2014

Signed on behalf of the Council	

By	Glyn Jones
Position	Director of Adult Social Care, Health and Housing
Date	04/04/2014

Signed on behalf of the Health and Wellbeing Board	Bracknell Forest
By Chair of Health and Wellbeing Board	Cllr Dale Birch
Date	04/04/2014

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

Provider engagement has taken place via briefings and workshop discussions at governance meetings for existing partnership arrangements, such as the partnership board for the intermediate care S75 agreements, and via dedicated workshops. Providers include:

- 3 Acute Trusts – Frimley Park Hospital NHS FT, Royal Berkshire Hospital NHS FT, Heatherwood and Wexham Park Hospitals NHS FT
- Community and Mental Health provider – Berkshire Healthcare NHS FT
- Bracknell Forest Council as lead provider of the integrated community response and reablement services, as funded through S75 pooled budget.

Significant engagement events have included:

- Whole system workshop on 6 Dec 2013 for the Frimley system including all commissioners and providers (acute, community, social care and voluntary sector), and HealthWatch representation considered 5 year vision following integration transformation across the whole health and social care system (outputs available)
- Bracknell Forest Health and Wellbeing Board workshop 24 Oct 2013 attended by acute and community providers and other stakeholders to develop understanding and vision across the Bracknell Forest system
- GP event to engage member support and to foster new vision in Primary Care strategy including the potential of integration
- Frimley system collaborative commissioning forum – agenda item attended by Frimley Park Hospital to discuss contract and commissioning implications of BCF
- Joint Strategic Event – Frimley Park Hospital and CCG Managers and Clinicians to further develop the vision
- Integrated Care Teams project board with community health and social care providers – workshop discussion to discuss potential of BCF to further develop the Integrated Care Teams which are already well established across the whole CCG

Through the above forums, and building on the Joint Strategic Needs Assessment (JSNA) and Joint Health and Well Being Strategy (JHWS), local priorities and options for further development have been identified, building on the current successful approaches. Relevant providers will be engaged in the indentified workstreams to develop the detailed plans for delivering the required outcomes.

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

- Presentations have been made at public Health and Wellbeing Board (HWB) meetings and CCG Governing Body meetings
- Discussions at Intermediate Care Partnership Board meetings, where people and carer representatives are members
- Plans for service priorities have been the subject of public engagement and consultation, examples include the Health and Well Being Strategy, joint commissioning strategy for people with dementia and the carers strategy

- The priorities for the Better Care Fund in Bracknell Forest are firmly rooted in the JHWS, which in turn is based on the JSNA and the outcomes of public consultations underpinning the full range of Joint Commissioning Strategies. The JHWS is currently the subject of a public consultation exercise to elicit local people's views on the priorities identified
- The newly established BCF Board includes Healthwatch in its membership
- The BCF has been the subject of a 'Community Forum' meeting discussion, which involved a cross section of patient and public representatives

e) Related documentation

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

Document or information title	**Synopsis and links**
JSNA	http://www.bracknell-forest.gov.uk/jsna-executive-summary-2011-12.pdf
JHWS	The purpose of the strategy is to identify common goals across health and social care services and how local services might work together more closely to improve the health and wellbeing of local people. http://www.bracknell-forest.gov.uk/BF-JHWS-v10-1.pdf
Joint Commissioning Strategies • Mental Health • Dementia • Autistic Spectrum Disorders • Learning Disabilities • Sensory Needs • Older People • Long Term Conditions • Carers • Advocacy	The Joint Commissioning Strategies respond to national agenda and local priorities, as identified through JSNA, consultation and other information sources. They set out commissioning priorities for a five-year period. http://www.bracknell-forest.gov.uk/Healthy-Minds-strategy.pdf http://www.bracknell-forest.gov.uk/commissioning-strategy-for-people-with-dementia-2009-to-2014.pdf http://www.bracknell-forest.gov.uk/autism-joint-commissioning-strategy.pdf http://www.bracknell-forest.gov.uk/learning-disability-commissioning-strategy-2008-to-2013.pdf http://www.bracknell-forest.gov.uk/commissioning-strategy-for-sensory-impairment-large-print-version.pdf http://www.bracknell-forest.gov.uk/Bracknell_Forest_Older_People_Strategy.pdf http://www.bracknell-forest.gov.uk/long-term-conditions-commissioning-strategy.pdf http://boris.bracknell-forest.gov.uk/sc_strat_caring_about_carers.pdf http://www.bracknell-forest.gov.uk/advocacy-commissioning-strategy.pdf
Schedule 2 to the S75 Agreement	Detailing the specification for Intermediate Care including Enhanced Intermediate Care (24/7) Document not available on the public website, however, can be made available if required.
Information sharing protocols	The Information Sharing Policy explains the circumstances under which relevant organisations may share personal

Document or information title	Synopsis and links
	information with other organisations. It also provides a mechanism for, and explanation of, ad-hoc information sharing requests. It establishes the principles, purposes and processes, for information sharing. Document not available on the public website, however, can be made available if required.
Integrated care teams • Community Team for People with a Learning Disability • Community Mental Health Team • Community Mental Health Team for Older Adults • Community Response and Reablement	Operational policies and specifications http://www.bracknell-forest.gov.uk/healthandsocialcare
CCG 2 Year operational plan	TBA

TBA=To Be Advised

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Our local vision is that: "Our population will be happier, healthier and active for longer; through having better information, support to make the right choices, and access to expert health and care services when required."

People will only have to tell their story once, as there will be integrated, shared records based on the NHS number as a unique identifier. People's needs will be met with the minimum time spent in hospital or travelling to access the services they need. Care and support will respond to the individual's choices as well as their needs.

In setting out this vision Bracknell Forest HWB wishes every resident who needs it to have care that reflects the National Voices definition of integrated care as meaning person-centred, coordinated care reflected in the statement: "I can plan my care with people who work together to understand me and my carer (s). I will have control, and services will work together to achieve the outcomes that are important to me".

Bracknell Forest Council and Bracknell & Ascot CCG were instrumental in the whole systems workshop for the Frimley system, where a joint model of care was developed. This has 4 key aspects

1. **The system will be better at supporting people to stay well and to remain as healthy and independent as possible.** This will include
    a. Increasing people's awareness of how they can manage and improve their own health, with support where required
    b. Making every person's contact with health and social care count
    c. Optimise the use of technology and increase the range and scale of opportunities within the Voluntary Sector, in order to make it easier for people to help themselves and get support, and participate in the community.

2. **There will be a new model of integrated primary and community based health and social care, which is better at supporting those with chronic conditions, provides integrated care and results in fewer admissions to hospital.** This will include
    a. Ease of access for people to an increasingly wide range of services
    b. Service being provided locally or in people's homes, rather than people having to travel long distances.
    c. Engaging with people and their families and carers about their needs, which may be met through personal budgets
    d. Use of Telecare to monitor effectively the health of individuals at risk.
    e. Significant expansion of the numbers supported by a predictive care plan.
    f. Development of the workforce to provide both general and expert care in the community.
    g. Full consideration of both mental and physical needs, including recognition of the higher incidence of depression in people with long-term conditions. Investment in 'Talking Health' has already commenced

3. **Patients will only go into hospital when only acute care can meet their needs and will be discharged from hospital promptly.** This will be supported by
    a. 7-day access to services and medical support in the community.
    b. All people in hospital having a clear care plan including plans for discharge.
    c. Organisational boundaries to be broken down enabling in-reach, out-reach and integrated working.

d. Excellent information for health professionals, and residents of Bracknell Forest.

4. **Significant financial and expert resources will have shifted from acute to community settings, and we will have strong and sustainable hospital services.**

In Bracknell Forest residents will be able to say

- I have a health and wellbeing advisor who visits me when needed and helps me stay healthy
- I have a 24 hour helpline for all services and access to a wide range of services in a few locations
- I have a health and wellbeing record that I own, have easy access to, and I have agreed who can share it.
- I have consistent access to services and I have access to tools and technologies that support my health and wellbeing.

b) Aims and objectives

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

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

Our aim is to be ambitious in our intentions for the community, and recognise that small, well-planned changes are the pathway to achieving that ambition – empowering people to lead on change so that the overriding objective set out in the JHWS is met.

"to make sure that every resident of Bracknell Forest lives in a healthy, safe and caring place, and gets good service and support when they need them"

This will mean that

- The same total funding is spent differently to meet growing demand
- For practices – help GPs move from referring in to joining in. Mobilising clinical leadership for integration
- For social care –working with a range of organisations within and outside of Bracknell Forest boundaries
- For acute trusts – reaching out to support different pathways, which will lead to a permanent reduction in acute capacity, but at a sustainable pace
- For community trusts – putting neighbourhood needs first
- For all - breaking down of traditional organisational boundaries
- For people – seamless services which keep them well in their own home with less reliance on acute hospital or long term care home admissions.

In the 4 Key Areas of Strategy

1. Protecting Social Care Services

Maintaining and strengthening our policy to support people to remain in their own homes wherever possible, with ambitious plans for continuous improvement of outcomes for people in the areas they have themselves identified as a priority. This will be at a scale and with a multi-disciplinary approach, which accommodates growth in demand and increased complexity of needs.

2. Seven-Day Services

Through our collaborative commissioning arrangements, we will be reviewing the 7-day working arrangements in our acute providers, and putting in plans to ensure these are comprehensive so that no person is admitted to, or stays in hospital longer than is necessary. Schemes to strengthen 7 day working around acute trusts (Frimley Park and Heatherwood

and Wexham Park NHS Trusts) have been piloted using winter pressures monies. Following evaluation, successful pilots will be extended further

Currently enhanced intermediate care is available, seven days a week through bed based and community reablement services. There is a 2 hour response time for urgent referrals to avoid hospital admission. Emergency Duty Service (BFC), Crisis Response Team (Mental Health – BHFT) Forest Care (BFC) and Home Treatment Team (Mental Health - BHFT) ensure access to services for crisis responses for people with physical and mental health needs. These will be reviewed to ensure optimum scale, scope and integration.

The new Bracknell Urgent Care Centre, due to open in April 2014, will offer a 7 day service, 8am till 8pm, for all minor injuries and illnesses. This will be primary care led, and there will be integrated pathways into intermediate care, and social care support as well as the existing Primary Care (GMS) and GP Out of Hours service.

The plan is for a full Community Response and Intermediate Care service to be available seven days a week, in order to facilitate hospital discharge and prevent inappropriate admissions. This will have implications for local independent sector providers which will need to be addressed as well as NHS and Local Authority provision.

Acute Trusts will ensure that Consultant led assessment are undertaken in all urgent care situations i.e. home, Acute Assessment Unit / A&E hospital environments in order to ensure that admissions only occur when absolutely necessary.

Agreed discharge processes will be followed, to include Consultant /GP discharge letters delivered prior to leaving hospital.

3. <u>Data Sharing</u>

This is seen as a key enabler.

All organisations will record the NHS number for all relevant people, to be used as the "unique identifier".

When the Community Trust has completed the procurement of their Patient Record System, the Council will include the requirement for a suitable interface with this system into the specification for the Social Care Record System (SCRS). Procurement of the SCRS has been delayed to accommodate this.

4. <u>Joint Assessment and Accountable Lead Professional</u>

People with Mental Health needs, Learning Disabilities or with a need for reablement are currently supported through multi-disciplinary teams, with a lead coordinator for each person. This enables the development of person centred holistic care and support plans.

Integrated Care Teams (ICTs) have been set up to support people with complex support needs arising from long term conditions, and who are therefore at high risk of non-elective hospital admissions. The ICTs have been operational now for 12 months with 100% practice participation and coverage. Evaluation is informing the future development of the ICTs, for example the inclusion of mental health professionals in all ICTs and access to other services such as substance and alcohol mis-use. At the end of 5 years the ICTs will have expanded to support all people who would benefit from them, and the approach within the Learning Disability and Mental Health teams will be maintained for all. The specification will be designed to underpin the procurement of the support services required to keep people well, and out of hospital.

The Council, in partnership with the Community Health Trust, has commenced a programme of work which has reviewed current business processes, and will ensure:

- that the experience of people needing social care, and/or and joint approaches with community health are as smooth, integrated and timely as possible.
- the early identification of a lead practitioner for each person to coordinate contributions from all relevant specialisms

- availability of response seven days a week
- The identification of activity information to inform the development and delivery of a workforce strategy which will include:-
  - Integrated Community Teams
  - Intermediate Care which will build on the current successful integrated services
  - Community Support, including Domiciliary Support, to ensure there is sufficient appropriately skilled support available.

In addition to the national measures we will monitor

- the achievement of outcomes for individuals, as identified in their person-centred plan and the impact on non-elective admissions
- People and carer satisfaction with community based services
- Reduction in falls and falls-related admissions
- Improvement in number of people feeling supported to manage their own condition
- Reductions in overall levels of emergency care admissions of people over 65years
- Reductions in the rate of emergency admissions for the over 65yr population due to falls"
- Numbers of people supported to die at home where this is their place of choice

c) Description of planned changes

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

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

Bracknell Forest is building on strong foundations of integrated and jointly commissioned services, but there is no complacency regarding the challenges ahead. All of the approaches outlined below are commensurate with the priorities identified through/within the JSNA, the JHWS, the CCG 2-year commissioning plan and the Joint Commissioning strategies detailed in 1(e). Lead officers for the BCF programme are also lead officers for the implementation of the above strategies and will ensure that all the work streams are coordinated.

We have undertaken extensive modelling of risk stratified health data which identifies the following areas for prioritisation.

Priorities already jointly agreed and aligned with local needs analyses and strategies as identified are:

- Further development of 7 day working, building on the existing 2 hour response by enhanced intermediate care, and the 24/7 capability of 'Forest care', and the range of crisis responses as identified in 2a above. This will include more robust hospital in-reach, robust pathways with NHS 111 and the new Bracknell Urgent Care Centre, and enhanced domiciliary responses, including use of the voluntary sector.
- Development of capacity and capability in the local care market, particularly domiciliary response, to reduce the need for hospital admissions and improve quality and equity of response
- Commissioning an integrated local falls prevention service which is accessible and tailored to local need, building on a pilot currently in place
- Understanding and acting to reduce the variation between GP practices in non-elective admissions

Key success factors for implementation include:

Capacity and capability

- Of the workforce, including the local care market
- Accommodation needs, including a range of appropriate housing
- Access to transport to maximize independence
- The successful implementation of the Bracknell Urgent Care Centre

Prevention and intervention

- Reducing the deterioration in health of BF individuals through the adoption of evidence based prevention and early intervention programmes

Joint working

- The continuation and further development of the current partnership and collaborative working practices between the LA and NHS organisations, as evidenced by the range of joint commissioning and joint implementation approaches.
- The successful implementation of IT system interfaces (interoperability)
- Effective engagement with stakeholders

Investment

- The ability to invest to save: "pump-priming" approaches to develop approaches which will then enable disinvestment from existing services
- Appropriate evaluation built into programme workstreams to ensure the approaches are appropriate and delivering the required outcomes. Resource has been invested in gathering robust baseline data to underpin meaningful evaluation

People focused services

- Ensuring that each workstream responds to the entire BF population, by attending to cross-cutting/underlying themes/issues as identified in the attached document. Examples are:-
  - Responding to the needs of people with dementia
  - Responding to issues of social isolation
  - Ensuring that self-care is fundamental to pathways, thus supporting sustainability.

Outline of the processes, end points and time frames for delivery

Clear service processes will be reflected in the business plans which support each project forming part of the BFC programme. Quality will be at the centre of the actual delivery of services and will reflect quality impact assessments, alongside performance objectives , resourcing needs and delivery timescales

Service performance measures will be determined for each workstream, and will focus on personal experience and outcomes. These, together with quantitative data, will form the basis of an evaluation "scorecard".

d) Implications for the acute sector

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

The position we have signalled to acute providers is that we will be looking to reduce investment in emergency care by up to 3% per annum over the 5 years of the strategic plan. This will build to the 15% reduction as outlined in the planning guidance, but at a pace which means that providers can respond to the change and remain sustainable.

Our plans will result in fewer people needing to go to hospital and those who do will be discharged earlier, potentially requiring tariff prices to be unbundled to fund different models of provision along the pathway.

Our system is unusual in that our two most significant acute providers are planning to merge through the acquisition of Heatherwood and Wexham Park FT by Frimley Park FT. We are currently engaged with the Trusts and all other significant commissioners in creating an activity and financial model for the Final Business Case. The timescale is that the FBC will be completed by the end of April in order for the Frimley Board to consider in May. While this is not exactly aligned with the planning timetable it means that, through the FBC process, we will understand what financial gap is created by CCG commissioning intentions and be required to map out the process for service transformation in order to close the gap.

Through the acquisition and other stakeholder engagement events there has been, and are still planned, a number of strategic events whereby we have discussed our emerging BCF strategies with providers, and begun the process of service redesign. The table below shows the key events.

Process of local stakeholder development	Timetable
CCGs engage the Kings Fund to support system wide relationship development. Telephone interviews of all system leaders, individual organisation feedback followed by facilitation of strategic workshops	November 2013 to January 2014
Area Team facilitate a series of Transaction meetings to enable co-ordination of commissioner response to the Acquisition	November 2014
CCG/Local Authority Partnerships consolidated, Joint Strategies developed and signed off by HWBs, BCF Governance agreed and in place.	January 2014
Commissioner/Provider Joint clinical strategic events – Frimley Park Hospital FT, Heatherwood and Wexham Park Hospital FT, Berkshire Healthcare FT. Workshop national strategies – 15% reduction emergency, 20% increase elective efficiency, 7 Day working	February 2014
Health and Social Care Leaders Forum created across the Unit of Planning.	February 2014
Stakeholder event Integrated Care Team development – outcome of Kings Fund review of current ICT and joint workshop on expansion and development	April 2014
Clinical Vision for merged acute trust created.	April 2014

It is expected that the service redesign will result in an outreach model for many pathways, including falls prevention, frail elderly, heart failure, and respiratory disease which will bring secondary care teams out into the community to support people and avoid admissions

The following approach will be taken to reduce risk for the acute sector

- The pace of change envisaged is realistic and will enable Trusts to reduce their cost base in a planned way.
- Alternative support systems for people will be invested in up front so that Trusts have the confidence to take out excess capacity and cost.
- Acute providers are fully involved in the redesign of services and, either through collaborative or competitive processes will have the opportunity to provide services or expert support outside traditional acute boundaries.
- The HWB recognises that the BCF will, in the short term, be continuing to support activity in secondary care, until service transformation results in the planned changes.
- The HWB also recognises the need to share in the cost risk if plans do not result in the expected outcomes.

The HWB recognises that a virtual cycle of saving and reinvestment has to take place in order to free CCG funds for investment in BCF priorities. In order to start that virtuous cycle the CCG has made the entirety of its 1% transformation funds available to the BCF Programme Board in 2014/15. This will be invested in resource, system enablers, and the commencement of implementation of new models of care.

e) Governance

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

The HWB has established a Better Care Programme Board to oversee the development and implementation of these plans. This will be co-chaired by CCG and Council and will initially comprise of:

- Director of Adult Social Care, Health and Housing, BFC
- Clinical Director, CCG
- Deputy Chief Officer, CCG
- Chief Officer: Adults and Joint Commissioning BFC
- Head of Operations CCG
- Head of Joint Commissioning BFC
- HealthWatch

It will report to the HWBB as well as the CCG Governing Body and the Council.

This Programme Board is supported by a working group of technical and operational experts. Delivery of joint strategies and implementation plans will be through the existing multi-agency Partnership Board arrangements. All Terms of Reference and memberships are regularly reviewed to ensure they are appropriate to deliver the required outcomes.

Working groups are being established to progress work streams which are not already overseen by existing Partnership Boards.

Work is underway to secure ongoing wider stakeholder involvement and influence, notably from providers and also influential stakeholders such as housing, police, ambulance service and others.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

The protection of access to services and thresholds, to ensure that support to residents is not reduced. Increase in the range of integrated working options will enable improved outcomes, and efficiencies which in turn will contribute to meeting increasing demand arising from increasing complexity of need and other demographic pressures.

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

£770K was allocated in the NHS monies for protecting social care against demographic pressures in 13/14 and this will be increased to £1.292m 14/15 to offset increases in demand arising from higher levels of need and other demographic pressures.

b) 7 day services to support discharge

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

Bracknell Forest residents can already access enhanced intermediate care with a 2 hour response time for urgent needs, from a multi-disciplinary team. This part of the service is aimed at preventing unnecessary hospital admissions, while a social care "in-reach" team to 3 local acute hospitals facilitates early discharge. The social care in-reach is available five days per week, and there are plans in place to extend it to 7 days.

Additional services are being piloted using 'winter pressures' funding such as an in-reach nurse and discharge matron as part of the integrated response. These will be reviewed and made substantive where it is proving to be effective

Bracknell Forest Council has a 24/7 response capacity in Forest Care and the Emergency Duty Service which can be built upon as a portal to a wider range of services in response to local needs. The community trust has an out-of hours crisis response team to respond to people with mental health needs.

The Home Treatment team provides a 24/7 preventing inappropriate admission and facilitating discharge for people with non-acute needs arising from Dementia.

c) Data sharing

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

The Social Care Record system (Protocol) has the functionality to use the NHS number as the unique identifier, and arrangements are in place to record these where they have not been recorded in the past.

The changes in system configuration required to make this the unique identifier are under discussion at the Departmental IT Board.

Together with partners and neighbours we will be reviewing the requirements of a comprehensive care records system across health and social Care.

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

There is a commitment across health and social care to use the NHS Number as a primary identifier and IT systems have the capability to record them. The workforce are mandated to collect this data and it is anticipated that it will be fully implemented in 2015.

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

LiquidLogic, the developers of Protocol, have an interface solution for RiO (local Community Trust NHS record system). However, the Community and Mental Health provider are currently considering future options for the provision of the person record system, which will inform social care system procurement/interface options. Capital funds have been committed to support this work.

The Council is fully compliant with the IG Toolkit, and PSN requirements.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Integrated Care Teams have been established with due regard for Caldicott principles and signed data sharing agreements are in place between participant organisations, including arrangements for individual personal consent. The LA is compliant with the NHS IG toolkit, and PSN requirements. The lead commissioner from the LA is the Council's Caldicott Guardian.

d) Joint assessment and accountable lead professional

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

Integrated care teams serving clusters of GP practices with populations of around 50,000 have been in place since Feb 2013. This covers all GP practices in Bracknell Forest, with 100% engagement. Risk stratification via ACG tool has been applied, and supplemented by interrogation of community health and social care systems as well as informal case finding mechanisms. At Dec 2013, 200 people have been the subject of multi-disciplinary review and case management

There are also integrated teams well established for people with Learning Disability (CTPLD) and mental ill-health (CMHT and CMHT-OA)

4) RISKS

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

Risk	Risk rating 1-5 (5 High)	Mitigating Actions

Risk	Risk rating 1-5 (5 High)	Mitigating Actions
Recruitment and retention of key skilled community staff	3/5	• Review of the reablement service to inform joint workforce strategy. • Flexible employment options to enable retention of Conditions of Service
Market capacity for good quality domiciliary care	4/5	• Increased capacity identified as a priority workstream within this programme of work. • Robust Quality Assurance Framework • Market Position Statement has been developed to inform and encourage prospective providers
Ability of acute hospitals to respond to support community based models of care	4/5	• Establishing a Health and Social Care Leaders Group to ensure alignment of strategic vision • Detailed activity and financial modelling of acute providers through development of the acquisition FBC • Ensure the pace of change envisaged is realistic and will enable Trusts to reduce their cost base in a planned way. • Alternative support systems for people will be invested in up front so that Trusts have the confidence to take out excess capacity and cost. • Acute providers are fully involved in the redesign of services and, either through collaborative or competitive processes will have the opportunity to provide services or expert support outside traditional acute boundaries.
Engagement with primary care strategy	3/5	• Work on the primary care strategy was launched on 6 Feb and is a long term project. There is recognition that this needs to keep pace with, and reflect, the BCF development
Secondary Care activity does not reduce, thus limiting the funds available to fund transformation	4/5	• Integrated services at the scale and scope necessary, as indicated by the risk stratified opportunity analysis • Analysis of NEL data used to identify priority areas for community based interventions. • Create a virtual cycle of saving and reinvestment through using the CCG 1% transformation funds in 2014/15 to invest in change resource, system enablers, and the commencement of implementation of new models of care. • The HWB recognises that the BCF will, in the short term, be continuing to support activity in secondary care, until service transformation results in the planned changes

Annex 3 - Better Care Fund Changes to the allocation of the main NHS s 256 transfers

Main NHS s256 funding inc BCF preparation	**2014/15 H&WB**	**2014/15 Per LLASSL 2014**		**2014/15** Per NHS Gateway 01597
Service Areas-	**2014**		New Service Areas-	
Improving capacity to support programmes	40,000	40,000	Other social care (please specify)	
			Long Term Conditions/Integrated Care	71,000
			Improving capacity to support programmes	40,000
Long Term Conditions/Integrated Care	71,000	71,000		
Autism	80,000	80,000	Integrated assessments	80,000
Public Health	100,000	100,000	Other preventative services (please specify)	
			Falls	100,000
Dementia Support	73,000	73,000		
Dementia Advisor	35,000	35,000	Dementia services	108,000
Stroke Support	26,000	26,000	Reablement services	26,000
Carers support	100,000	100,000	Joint health and care teams/working	100,000
Demographic pressures		770,000		
Increased therapy time at Bridgewell	60,000		Bed-based intermediate care services	60,000
Maintaining Eligibility	620,000		Maintaining eligibility criteria	620,000
Therapist support hospital discharge	60,000		Early supported hospital discharge schemes	90,000
Unidentified	30,000			
Other funding (unearmarked)	0	414	Integrated records or IT	414
Sub total	1,295,000	1,295,414		
Other funding (not earmarked)		61,000	Integrated records or IT	61,000
Sub total transfer for social Care 2014/15	**1,295,000**	**1,356,414**		
Other funding (not earmarked)	61,000			
Preparing for BCF S256/integration payment	302,000	302,000	Integrated records – interoperability and Improving capacity to support programmes	302,000
Incremental funding	**363,000**			
Total funding	**1,658,000**	**1,658,414**		**1,658,414**

Annex 4 NHS s 256 Memorandum of Agreement

PERIOD	2014/15
BETWEEN	NHS England (Thames Valley) and
	Bracknell Forest Council
	Together referred to as "the Parties"
PURPOSE	Giving effect to a transfer of monies from NHS England to the Bracknell Forest Council pursuant to Section 256 of the NHS Act 2006.
Section A: Background and Principles	
1	The purpose of this Memorandum of Agreement (MoA) is to provide a framework within which the Parties will enable transfers of funding pursuant to Section 256 of the NHS Act 2006 and in line with the National Health Service (Conditions relating to payments by NHS Bodies to Local Authorities) Directions 2013, to enable those funds transferred to be invested by social care for the benefit of health and to improve overall health gain.
2	Gateway reference 01597 states that NHS England will transfer £1,658,414 from the 2014/15 mandate to local authorities. The funding must be used to support adult social care services in each local authority, which also has a health benefit.
3	NHS England (Thames Valley) on the recommendation of NHS Bracknell and Ascot Clinical Commissioning Group ("BACCG") and the Bracknell Forest Council Health and Wellbeing Board ("BF HWB") through approval of s256 paper at its meeting on 5 June 2014, is satisfied that: • The transfer of this funding is consistent with their Strategic Plan(s) that it is likely to secure a more effective use of public funds than if the funds were used for solely NHS purposes, in line with the conditions relating to Section 256 payments the Act. • The transfer of these funds has had regard to the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and the commissioning plans of both the Clinical Commissioning Group (CCG) and Bracknell Forest Council. • The funding transfer will make a positive difference to social care services, and outcomes for users, compared to service plans in the absence of a funding transfer
Section B: Purpose of this Memorandum of Agreement	
	This MoA gives effect to those arrangements to benefit the population of the Bracknell Forest Council. Through the use of these monies the partners intend to secure more efficient and effective provision of services across the health and social care interface as outlined in Schedule 1.
	Monies defined in Section C below will be transferred to the Local Authority under Section 256 and used in accordance with the terms of this MoA. If this subsequently changes, the MoA must be amended and re-signed, as a variation to the original. This MoA governs the transfer, monitoring and governance arrangements for the monies and the projects associated with delivering the objectives.

Section C: Terms of Agreement - The sums of money		
	The money, which shall be transferred from NHS England to Bracknell Forest - Adult Social Care, is shown below:	
	2014/15	
	Allocations for social care	£1,356,414
	Allocation for Integration 2014 payment	£ 302,000
	Total allocation	£1,658,414
	Payments will be made quarterly based on invoices issued by the Bracknell Forest Council. The invoices must quote the relevant purchase order number.	
	Where a payment is made under this MoA, the Bracknell Forest Council will provide an annual voucher In the form set out in Schedule 3 to Agreement. This voucher must be authenticated and certified by the Director of Finance or responsible officer of the recipient.	
	Recipients must send completed vouchers to their external auditor by no later than 30th September following the end of the financial year in question and arrange for these to be certified and submitted to the paying authority by no later than 31st December of that year. A Certificate of Independent Auditor opinion is set out in Schedule 3 to the MoA.	
Section D: Terms of Agreement - The uses of money		
	Uses of this funding will be as follows and will be subject to review as part of the joint governance arrangements set out in Section E below:	
	Analysis of adult social care funding in 2013-14 for transfers to Las Service Areas - 'Purchase of social care'	
	Other social care (please specify):	
		£
	Long Term Conditions/ Integrated Care	71,000
	Integrated assessments	80,000
	Other preventative services (please specify) • Falls	100,000
	Dementia services	108,000
	Reablement services	66,000
	Joint health and care teams/working	100,000
	Bed-based intermediate care services	60,000
	Maintaining eligibility criteria	620,000
	Early supported hospital discharge schemes	90,000
	Integrated records or IT	61,414
	Integrated records – interoperability and improving capacity to support programmes	302,000
		£1,658,414

Section E Terms of Agreement Governance Reporting and Monitoring		
	In the Bracknell Forest Council the MoA shall be held by Director of Adult social Care, Health and Housing and appointed nominees to manage, monitor and deliver.	
	In NHS England the MoA shall be held by the NHS England (Thames Valley) Director and appointed nominees to manage, monitor and deliver NHS interests.	
	In NHS Bracknell and Ascot CCG the appointed nominee for governance and monitoring purposes will be the "Head of Operations".	
	The Better Care Fund Board shall monitor and review the programme of work monthly and ensure corrective action where required. At least one officer of the CCG shall be a member of this Board. The Bracknell Forest Council HWB will receive quarterly reports on the progress of the programme of work from the Better Care Fund Board and ensure the programme supports the delivery of the Health and Wellbeing Strategy and Joint Strategic Needs Assessment. NHS England will be represented on the BF HWB. The Health and Wellbeing Board will review the annual expenditure of the allocation.	
	Any under spend on the transfer money will be discussed by the Bracknell Forest Council and Bracknell and Ascot CCG via the Better Care Fund Board and agreement reached as to how the under spend should be dealt with. This may include retention of the under spend with the Bracknell Forest Council for use on additional activity for the benefit of health or an alternative arrangement.	
	Any under spend on the transfer money will be discussed by the Bracknell Forest Council and Bracknell and Ascot CCG via the Better Care Fund Board and agreement reached as to how the under spend should be dealt with. This may include retention of the under spend with the Bracknell Forest Council for use on additional activity for the benefit of health or an alternative arrangement.	
	Bracknell Forest Council will report expenditure plans on a monthly basis to NHS England (Thames Valley) categorised into the following service areas (annex 1) as agreed with the Department of Health.	
Section F Terms of Agreement Renewal, Disputes, Variation and iteration		
	The agreement may be altered by mutual consent by an exchange of letters	
	In relation to continuation beyond 1st April 2015, such provisions as shall be directed by the Secretary of State on continuation and transferral of agreements shall apply.	
	Disputes shall be resolved by informal means wherever possible and thence by formal meeting of the Better Care Fund Board and referral to the Health and Wellbelng Board If agreement cannot be reached.	
Section G: Signatures		
	In respect where of the Parties to this agreement have caused to be affixed their hands and seal	
	Signature	Signature
Name		
Date		
Parties	FOR AND ON BRACKNELL FOREST COUNCIL	FOR AND ON BEHALF NHS ENGLAND

Annex 1 NHS s 256 Memorandum of Agreement
Analysis of the adult social care funding in 2014-15 for transfer to local authorities

Table 1 - Analysis of adult social care funding in 2014-15 to local authorities

Service Areas-
Community equipment and adaptations
Telecare
Integrated crisis and rapid response services
Maintaining eligibility criteria
Reablement services
Bed-based intermediate care services
Early supported hospital discharge schemes
Mental health services
Housing projects
Employment support
Learning disabilities services
Dementia services
Support to primary care
Integrated assessments
Integrated records or IT
Joint health and care teams/working
Other preventative services (please specify)
Other social care (please specify)
Other intermediate care (please specify)
(Subjective codes to be set up in level 8 52131000 parent ‘purchase of social care’)

SCHEDLE 3

Section 256 Voucher Bracknell Forest Council

PART I STATEMENT OF EXPENDITURE FOR THE YEAR TO 31 MARCH 2015

(If the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme
Reference

Number
Revenue

Expenditure
Capital Total

Title of

Expenditure

Project £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme approved by the NHS England and NHS Oxfordshire Clinical Commissioning Group in accordance with the National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions 2013.

Signed:……
Date:……

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions).

Certificate of independent auditor

I/We* have:

- examined the entries in this form (which replaces or amends the original submitted to me/us* by the authority dated) and the related accounts and records of title and
- carried out such tests and obtained such evidence and explanations as I/we* consider necessary

(Except for the matters raised in the attached qualification letter dated)*

I/we* have concluded that;

- the entries are fairly stated: and
- the expenditure has been properly incurred in accordance with the relevant te1ms and conditions.

Certification by the independent auditor

	Certification by the independent auditor	
Signature		
Name (In Block capitals)		
Company/Firm*		
Date		

*Delete as necessary

Annex 5 Better Care Fund - Previous Board paper (13 February 2014) for information

TO: HEALTH AND WELL BEING BOARD
13 FEBRUARY 2014

BETTER CARE FUND
Director of Adult Social Care, Health and Housing
Chair of Bracknell and Ascot Clinical Commissioning Group

1 PURPOSE OF REPORT

1.1 The purpose of this report is to set out the initial joint plan for the use of the Better Care Fund in accordance with the guidance received to-date.

1.2 The Better Care Fund Plan must be signed off by the Council, Clinical Commissioning Group (CCG) and the Health and Well Being Board. It is required to be submitted by 15 February 2014.

2 RECOMMENDATIONS

That the Executive/CCG Governing Body/Health and Well Being Board:-

2.1 approve the submission of the template attached as Annex A;

2.2 approve the establishment of a Better Care Board as set out in 5.3.5; and

2.3 agree additional resources for staff to programme manage our approach to be delegated to the Director of Adult Social Care, Health and Housing in conjunction with the Executive Member within the funding envelope.

3 REASONS FOR RECOMMENDATIONS

3.1 The Better Care Plan for Bracknell Forest must be agreed and submitted to NHS England Area Team by 15 February 2014.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None

5 SUPPORTING INFORMATION

5.1 Articulating the Vision

5.1.1 The Council and CCG have already established in the Joint Health and Well Being Strategy (JHWS), its overriding objective which chimes with the intentions set out in national voices and in the guidance on Better Care Fund:-

'To make sure that every resident of Bracknell Forest lives in a healthy, safe and caring place, and gets good service and support when they need them.'

5.1.2 This was underpinned by 4 principles:-

- People should be supported to take responsibility for their own health and wellbeing as much as possible
- Everybody should have equal access to treatment or services
- Organisations should work together to make the best use of all the resources they have to prevent and treat ill-health
- The support and services that people get should be of the best possible quality,

5.1.3 In looking specifically at what this means for our approach with the Better Care Fund programme, we need to ensure an unwavering commitment to outcomes for individuals encapsulated by the following:-

"Our population will be happy, healthy and active for longer; through having better information, access to health and care (expert) services when required; and support to make the right choices."

In practical terms, this will mean that people:-

- will only have to tell their story once, as there will be integrated, shared records based on the NHS number as the unique identifier
- need will be met with the minimum time spent in hospital or travelling to access the services they need
- care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve best outcomes

5.2 National Conditions

The following national conditions are a requirement of the plan. The detail of this is in the template itself.

5.2.1 Plan must be jointly agreed

The Integration Task Force established by the Health and Well Being Board on 12 December 2013 has been instrumental in driving progress. There has been some discussion with providers, but a strong recognition that more detailed involvement is needed as well as other stakeholders in the identified activity areas.

5.2.2 Protection for Social Care Services

The CCG and Council have a strong track record in working well together. The use of the NHS monies for social care has demonstrated a joint commitment to ensure the level of social care services remain in a position to maintain outcomes for individuals and on the health economy. This is evidenced in sustained performance over some years.

5.2.3 7 Day Services

Currently, enhanced intermediate care is available 7 days per week. Plans are in place to deliver a full Community Response and Intermediate Care Service to be available 7 days per week. This will have implications for local independent sector providers as well as the NHS and the Local Authority as a consequence of the shift to seven day working.

5.2.4 Better Data Sharing

The current social care system has the capability to use the NHS number as the primary identifier. No system currently meets healthcare and social care requirements. Procurement of a social care system has been delayed pending the procurement approach of the community health provider.

5.2.5 Joint Approach to Assessment and Care Planning

There is a strong track record of multi-disciplinary teams across a range of care groups. However, there is more to do to expand this to all residents who could benefit from this approach.

5.2.6 Agreement on Consequential Impact on Acute Sector

The position that has been signalled to acute providers is that we will be looking to reduce investment in emergency care by 3% per year over the 5 years of the strategic plan. This will build to the 15% reduction as outlined in the planning guidance, but at a pace which means providers can respond to the change and remain viable.

5.3 Integration Task Force & Governance and Resource Required

5.3.1 The Integration Task Force (ITF) has met regularly since its establishment via Health and Well Being Board in December 2013. This group has been supported by a working group of technical and operational experts.

5.3.2 The content of the template has been framed by the ITF for consideration on behalf of both organisations. A number of 'events' have been held to seek views and opinions to influence this plan.

5.3.3 A key requirement going forward from the submission of the plan is clarity on the governance arrangements for the development of the proposed plan.

5.3.4 Whilst the Health and Well Being Board has a fundamental role in ensuring that the plan delivers the changes necessary to achieve the vision, it is not the right vehicle to manage the detail of the operational changes required. Consequently, it is proposed to reframe the ITF into the Better Care Programme Board.

5.3.5 It is proposed that the Board should comprise of the following and be co-chaired:-

- Director of Adult Social Care, Health and Housing, BFC (co-chair)
- Deputy Chief Officer, CCG
- Chief Officer: Adults and Joint Commissioning, Adult Social Care, Health and Housing, BFC
- Clinical Lead, CCG (co-chair)
- Head of Joint Commissioning, Adult Social Care, Health and Housing, BFC
- Head of Operations, CCG
- Healthwatch

The Board will be supported by a range of operational and technical experts as required. It will report to the Health and Well Being Board as the CCG Governing Body and Council.

5.3.6 A programme of this magnitude will require dedicated support in order to drive progress, working across all agencies. At the current time, it is envisaged that a small team working on behalf of, and accountable to the partner organisations, via the Programme Board, will be established using new S256 NHS monies for social care, plus additional CCG funding. The work will be focussed on specifying and delivering new areas for integrated working, including the development of benchmarking, baseline data and evaluation criteria.

5.4 Performance

5.4.1 There will be a limited number of national measures to demonstrate progress towards better integration health and social care.

5.4.2 The national metrics underpinning the funding are:-

- admissions to residential and care homes
- effectiveness of reablement
- delayed transfers of care
- avoidable emergency admissions
- patient/service user experience

5.4.3 Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	**April 2015 payment based on performance**	**October 2015 payment based on performance**
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient/service user Experience	N/A	Details TBC

5.4.4 In addition to this, local areas will be required to choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

NHS Outcomes Framework

2.1 Proportion of people feeling supported to manage their (long term) condition

2.6i Estimated diagnosis rate for people with dementia

3.5 Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 30/120 days

Adult Social Care Outcomes Framework

1A Social care-related quality of life

1H Proportion of adults in contact with secondary mental health services living

independently with or without support

1D Carer-reported quality of life

Public Health Outcomes Framework

1.18i Proportion of adult social care users who have as much social contact as they would like

2.13ii Proportion of adults classified as "inactive"

2.24i Injuries due to falls in people aged 65 and over

6 FINANCES

6.1 This section is in two parts; the first will deal with the NHS monies for social care in 2014/15 and the second, with the Better Care Fund in 2015/16.

6.2 2014/15 NHS Transfer for Social Care

6.2.1 There is an increase in the amount of funding available from NHS England in 2014/15. The allocation for BFC is £1.658m, an increase of £363k.

6.2.2 During 2013/14, the expenditure profile has sustained (and in some case, improved) what is by and large good performance when benchmarked. It is suggested that last year's agreed expenditure is continued and built on to start to progress our developments to meet the national conditions. In addition to this, there are investments made via winter pressures (one-off) that would require longer term funding. Table A below indicates 2013/14 expenditure to continue and Table B potential new areas.

Table A

Activity	**Cost (£000's)**
Managing Demographic and System Capacity Pressures	770
Carers Support	100
Stroke Support	26
Dementia Adviser	35
Public Health Initiatives	100
Autism Support	80
Long Term Conditions/Integrated Care	71
Improving Capacity to Support Programmes	40
Dementia Support	73
TOTAL	**1,295**

Table B

Area	**Commentary**	**Amount (£000's)**
Demographic Pressures	We have experienced additional demand due to our maintained performance this year and changes to support (The Winter Pressures identified End of Life Care (20k) increased demands for ASC (30k) additional support to Frimley Park Hospital system (80k) and therefore given the o/s we are clearly spending more than this and would suggest we use	90

	90k of the additional to help guarantee access and performance at current levels. The Council is putting in circa 270k towards the demographic pressure around OP from its own resources.	
Clinical Support to Bridgewell	One off funding from Winter Pressure really needs to be continued to deal with increasing acuity or we lower threshold.	50
Falls	This is another area that we have paid for year on year with no real strategic plan or commitment and yet we know fractures are high in Bracknell Forest & Ascot and this will be an essential plank of the Better Care Fund.	50
Increasing CR+R access 7 days a week	Builds up front line team to facilitate discharge avoid admission, support earlier discharge including weekends.	112
Other Opportunities	Potential programme management and technical information	63

6.2.3 The CCG intends to put a sum of £0.302m in addition to the increase in S256 funding for 2014/15. Plans will be developed in order to ensure both CCG and Council use the resource to support the transformation required.

6.2.4 Further the CCG has identified funds equivalent to 1% of total budget during 2014/15. This sum will be used to secure a strong position in preparation for 2015/16 by investment in sustainable community based services in support of the outcomes. This would include, for example, making services sustainable that were piloted using one off monies where they have proven to deliver good outcomes and reduce non elective admissions.

6.3 Better Care Fund 2015/16

6.3.1 The Better Care Fund will comprise of the following elements:-

	£
• Local Authority Funding	
○ Disabled Facilities Grants	0.348m
○ Social Care Capital Grant	0.201m
	0.549m
• Section 256 Funding	
○ 2013/14	1.295m
○ 2014/15 additional	0.363m
	1.658m
• CCG Core Funding	
○ Carers	0.228
○ Reablement	1.594
○ Other	2.636
	4.458m
TOTAL	**6,665m**

6.3.2 The fund does not in itself address the financial pressures faced by Councils and CCGs. The local funding brings together NHS and Local Government resources that are already committed to existing core activity. Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that will deliver better outcomes for individuals. This calls for a shared approach to delivering services and setting priorities.

6.3.3 Part of the fund will be linked to performance. The detail on how this element will work is yet to be decided by Government. It is likely that that the performance metrics to be used will be determined by data that is already available. What this means is that circa £1m of the available monies will be 'held back' in some way.

6.3.4 It is recognised that the CCG funding is already invested in services. Some of these services are already integrated. As an example, our Section 75 Agreement for Community Response and Reablement includes circa £1.6m from the CCG.

6.3.5 The challenge for the health and social care system is to ensure that the services invested in, deliver the magnitude of change required to avoid additional activity in institutional settings.

6.3.6 The attached plan sets out those areas which require more detailed analysis as areas in which we want to focus on initially.

7 PLAN

7.1 The overarching plan is set out in the template at Annex A to this report. It sets out the approach and the identification of the relevant workstreams currently identified. It is recognised that in doing further detailed work, these programmes may well change from those envisaged in February 2014. What is critical to success of the approach in Bracknell Forest is 'To think big and act small (local).'

7.2 The scale of ambition in the plan needs to be capable of future proofing services and our approach. It will require improved relationships and trust across the system and securing sign up to the principles across organisations. In doing this, grasping the scale of cultural changes for all organisations whilst maintaining stability through managing risk for all partners in the approach.

7.3 The journey has already begun in Bracknell Forest, there is much to consolidate and build on. Key to success is to support local leaders to innovate and allow local variation to deliver outcomes for people. There is no prescription so whether it's virtual or actual teams working more closely together, outcomes should determine.

7.4 In doing all of the above to deliver the plan, there will be a need to monitor, evaluate and improve as we progress.

8 CONCLUSION

8.1 This report and attached templates are work in progress. The next iteration is due early April. Key to success will be securing early agreement on the transformational opportunities and the capacity to deliver the potential changes.

8.2 The Council and CCG are starting from a strong base, in terms of joint working, integrated services and generally strong performance.

9 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

9.1 The relevant legal issues are addressed within the main body of the report.

Borough Treasurer

9.2 Since then, the allocations have been published, and the numbers are slightly different, however, the thrust of the comments should be the same, may I suggest:

There are considerable financial implications for the Council from the expansion of the NHS money for Social Care, and the introduction of the Better Care Fund.

In 2014/15 the increase of NHS money for social care has been confirmed as being approximately £363k, which is as per the funding formula for adult social care. In respect of 2015/16, the minimum size of the Better Care Fund is £6.65m.

It should be noted that £1bn of the total national fund of £3.8bn is payable on results, which could amount to £1.75m for Bracknell. There is a risk that money to this value will be spent on efforts to achieve outcomes, but will not be reimbursed if those outcomes, are not achieved. The current judgement is that Bracknell performs well on the outcomes that are likely to be used as a basis for awarding the performance element of the money, for example delayed discharges from hospital, but the risk should not be ignored. In particular with this latter performance metric, this is measured once a year, and there are very small numbers involved. Performance is therefore vulnerable to small changes in outcomes. This risk can be mitigated by measuring the score locally on a monthly basis.

However, the introduction of the Better Care Fund should be regarded as an opportunity to achieve better outcomes for people locally, and potential efficiencies in the local Health and Social Care economy.

Equalities Impact Assessment

9.2 An Equalities Impact Assessment will be undertaken as part of any service changes where appropriate.

Strategic Risk Management Issues

9.3 Elements of existing BFC and CCG funding will be transferred to the ITF. Early indications show that this will include the Disabled Facilities Grant alongside existing NHS funding to social care e.g. for Intermediate Care and demographic pressures. Securing budgetary provision for existing services will be critical to the development of the Integration Plan.

9.4 It is a requirement of the ITF that Clinical Commissioning Groups and Councils understand the implications of decommissioning services from NHS providers, both Acute and Community Foundation Trusts. CCGs and Councils must agree the sharing of risk around the destabilisation of NHS Acute Sector and Community Services. The ITF guidance states, “CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including,

for example, the use of non-recurrent funding to support disinvestment from services".

9.5 Both the CCG and the Council must be in agreement to the priorities for funding from the ITF. This will require a shared understanding of the needs of the population and future demand.

9.6 The performance framework for the ITF is still to be determined. Bracknell Forest Council is a high performing authority. It is not yet clear whether the implementation of the performance related part of the ITF will require meeting "stretch targets". Sufficient funding must be allowed in the ITF to improve performance relating to existing services.

9.7 In developing the Integration Plan, it is critical to ensure that services are planned to meet the needs of the people in Bracknell Forest. This will require local pathways and services that are tailored for the area rather than generic services across the east of the county.

9.8 There is a further joint risk implicit in the performance area around Acute hospitals.

Background Papers

Annex A – ITF Letter
Annex B – Draft Integration Plan Template
Health and Well Being Report – 12 December 2013

Contact for further information

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Unrestricted

TO: HEALTH AND WELLBEING BOARD
5 JUNE 2014

DEPRIVATION OF LIBERTY SAFEGUARDS: IMPLICATIONS OF SUPREME COURT RULING
Director of Adult Social Care, Health and Housing

1. PURPOSE OF REPORT

1.1. To inform Health and Wellbeing Board of the potential implications of a recent Supreme Court Ruling in relation to the Deprivation of Liberty Safeguards.

2. RECOMMENDATIONS

2.1 That the potential implications for the Council are noted and

2.2 that the Board agrees arrangements for ensuring appropriate availability of S12/DoLS doctors.

3. REASONS FOR RECOMMENDATIONS

3.1 If the potential implications are not considered and planned for appropriately the Council is at risk of not meeting its statutory requirements in a safe and timely manner.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 The Council could encourage all providers to respond to the revised “definition” of deprivation of liberty immediately, rather than according to the staged approach we are suggesting. This would result in demand that cannot possibly be met within current resources, and in resources being diverted from other more urgent requirements, thus potentially placing people at risk.

5. SUPPORTING INFORMATION

5.1. Background

5.1.1. The Deprivation of Liberty Safeguards (DoLS) were developed as a result of the Bournewood judgement in 2005. This situation related to a young man with profound learning disabilities and an autistic spectrum disorder. He was informally kept in hospital (i.e. not detained under the Mental Health Act) against the wishes of his family. The situation as considered through the Court of Appeal, House of Lords, and European Court of Human Rights, where it was finally determined that he had been unlawfully detained.

5.1.2. Part of the Mental Capacity Act 2005, but not implemented until 2009, DoLS are intended to ensure that people who lack capacity to consent to specific arrangements are not deprived of their liberty or restricted any more than is necessary, and that there are legal routes to challenge situations where it is felt that the level of deprivation is inappropriate. The specific arrangements have, until recently, related to people being accommodated in a Registered Care Home (including Nursing

Homes), or staying in a hospital, **for the purposes of receiving care or treatment.** This excludes people who are detained under the Mental Health Act, as this legislation affords them the appropriate protections.

5.1.3. The process for assessing whether a person is

- being deprived of their liberty, and
- whether or not this is in their best interests, and
- whether this is the least restrictive option available

is **very** prescribed, and many believe it to be overly bureaucratic. It involves specifically trained staff (Best Interests Assessors –BIAs- and S12 Doctors[1]), and specialist advocacy (Independent Mental Capacity Advocates).

5.1.4. From 2009, Local Authorities were the Supervisory Bodies (i.e. responsible for authorising Deprivations of Liberty) for people with local Ordinary Residence, in both Registered Care Homes, and in April 2013 assumed this responsibility in relation to Hospitals, the latter having previously been the responsibility of PCTs.

5.1.5. Further detail on the Mental Capacity Act and DoLS can be found on Boris, or provided on request.

5.2. Deprivation of Liberty

5.2.1. The level of restriction of freedoms and choices that amounts to "deprivation of liberty" has never been well defined, and has recently been subject to legal challenge. Broadly, what was happening until the recent Supreme Court rulings (*P v Cheshire West and Chester Council* and *P&Q v Surrey County Council)* was that whether or not a person was being deprived of their liberty was a judgement based on:

- Whether the level of restriction on a person's freedoms were of such a level that they amounted to deprivation of liberty, and if so,
- how reasonable/minimised the restrictions were.

Requests for DoLS authorisations were often triggered by extent to which a person appeared to disagree with, be unhappy with, or challenge through their behaviour, the restrictions placed upon them in order for them to receive the required care and support, or treatment.

5.2.2. However, the Supreme Court has now judged that exactly the same test of deprivation must be applied to all people regardless of their disability or lack of capacity, and makes reference to the level of intrusion that results from the care and support arrangements, irrespective of whether a person appears to object to them.

[1] S12 Doctors have specific responsibilities under Section 12 of the Mental Health Act, but with additional DoLS training.

> "If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage."
>
> Baroness Hale

5.3. **Implications**

5.3.1. People living in Residential Care Homes and Nursing Homes

5.3.2. The implication is that every person who lacks capacity to agree to being accommodated in a residential care home and/or to their care plan will now be considered to be deprived of their liberty, and therefore the processes for authorising deprivation must be followed. This will relate to many/most people with dementia or a severe or profound learning disability.

5.3.3. Cost/Resource implications will include See attached for further detail

- payment for S12 Doctors for every assessment undertaken
- the time taken by Council employees (BIAs, Authorising officers etc.), and the recruitment and training of any additional BIAs that may be required
- IMCA time for assessments and for ongoing involvement as the person's representative where appropriate. Currently, IMCA are commissioned through a low cost contract in partnership with the other Berkshire LAs, but this contract will not cover new the demand.

5.3.4. Deprivation of Liberty authorisations can only be for an absolute maximum of a year, after which the full process must be undertaken again. Should a deprivation be authorised for a shorter period, that authorisation cannot be ended or extended without the full process being undertaken.

5.3.5. People receiving treatment in hospital

5.3.6. In addition to the current cohort of people, the NHS should now be applying to the Council for authorisation for deprivation of liberty for people who cannot consent to being in hospital or their treatment, because they are unconscious, unless they have given prior consent such as for elective surgery.

5.3.7. This might therefore involve people who are hospitalised for treatment following an incident that results in temporary or permanent loss of consciousness, such as a stroke or road traffic accident.

5.3.8. Many Acute Hospitals have not fully recognised or implemented their current obligations under the Mental Capacity Act, and it is not anticipated that it will be an easy task to ensure that they comply with the revised requirements.

5.3.9. People living in the Community

5.3.10. Significantly, neither P nor P&Q in the Supreme Court cases above were

accommodated in Registered Care Homes, or in hospitals. This judgement therefore widened the concept of deprivation of liberty to all other accommodation and support arrangements. The current Deprivation of Liberty Safeguards **only** relate to people living in Registered Care Homes, or staying in hospital. Those living at home who may be receiving state arranged care support via a LA and whose liberty may be deprived currently will have to be subject to a S 16 MCA welfare application to the Court of Protection.

5.3.11. Any issues of decision making for people who lack capacity – wherever they live - are covered by the Mental Capacity Act 2005, and there are very carefully prescribed processes that must be followed. However, significant issues such as those circumstances where there is disagreement about what arrangements are in a person's best interests, or the appointment of Deputies or Power of Attorney must be referred to the Court of Protection for a decision. This will now include all people living in the community who are assessed as needing to be deprived of their liberty: subject to care arrangements that may be deemed intrusive, or who are unable to leave their homes alone, AND do not have capacity to agree to those care and support arrangements. This would include people in hospital who, for example, may be unconscious following a road traffic accident.

5.3.12. Where there has been any Council involvement in arranging or advising on care and support arrangements for a person, regardless of funding arrangements (excepting NHS funded support), the Council may be considered to be responsible for the deprivation, and therefore would have to ensure that appropriate authorisation processes are followed. This may be recharged to a person if they fund their own support.

5.3.13. Every referral to the Court of Protection involves significant preparation, and has a minimum cost of £400 (at 04/2014). In addition, the Court may decide to appoint an Official Solicitor and require the appointment of a range of independent practitioners (for example Social Worker or Psychiatrist) to carry out independent assessments to assist the Court to make a decision on what arrangements are in the person's best interests. The costs of such appointments are borne by the parties involved, and in the circumstances under consideration here, by the party seeking authorisation of the deprivation of liberty. This will either be the NHS or the Council, although depending on the outcome of the financial assessment, the person who is the subject of the Court referral may be required to pay themselves or refund the council if they are not eligible for Legal Aid.

5.3.14. The implications for families will be considerable, and may deter them from seeking support ,or making appropriate arrangements.

5.3.15. The Court of Protection is currently unable to meet demand arising from obligations prior to this ruling, and has already had to prioritise work. Meeting this additional demand would require a considerable increase in resource. They have advised that they will be issuing guidance "in due course", and proceedings have to determine the authority of the Court in relation to Deprivation of Liberty. .

5.3.16. <u>Other</u>

5.3.17. There is significant concern nationally that the implications of this judgement are unworkable: the burden placed upon Councils and the NHS is significant, and the implications for families cannot be underestimated. The increase in Council involvement with people who fund their own support as a result of the Care Bill will increase this burden even further, as even advising families on how to support

people safely may result in involvement in a referral to the Court of Protection.

5.3.18. It is understood that the Department of Health have yet to consider the implications of these judgements, but until they do, and changes to the Mental Capacity Act and/or DoLS result, the Council is expected to implement the law as it has now been established.

5.3.19. It is already extremely difficult to find appropriately trained S12 doctors: the bulk of the referrals locally are currently undertaken by one doctor. There will be insufficient capacity to undertake the additional work required. Ensuring sufficient availability of appropriately trained doctors is an NHS responsibility, although it is unclear which part of the NHS, following the recent structural changes.

5.4. **Resources**

An analysis if the potential resource implications in relation to Deprivation of Liberty in registered care homes and the community has been undertaken. The CCG is assisting with a similar analysis for people in hospital. Unless there are changes to the arrangements as we currently understand them to be, the costs to the Council will be significant.

5.5. **Strategy**

5.5.1. It is worth noting that the Deprivation of Liberty Safeguards were already under review before the Supreme Court ruling, and they are widely considered to be disproportionately complex and bureaucratic. It is impossible to pre-empt the outcome of this review, but it is to be hoped that it would take account of the issues that have arisen from this ruling.

5.5.2. In the meanwhile it is expected that Local Authorities will demonstrate how they are responding to these rulings by September. Rather than make a “knee-jerk” response, which may result in unmanageable demand as has happened in some Councils, it is advised that a pragmatic and proportionate approach is taken. To this effect, a small group of officers, has convened to analyse risks and agree priority areas for implementation.

5.5.3. Local Care Homes have been advised of this, and asked to cooperate with this approach to ensure that we are able to respond appropriately. This will enable the Council to thoroughly assess each situation in a timely manner, whilst ensuring that resources remain available to meet the usual day-to-day demands.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The Cheshire implications are set out above.

A consolidated case currently going through the Court of Protection has joined about 6 LAs (including the parties to the Cheshire case), the Law Society and various bodies representing interest groups is expressly looking at the implication of the Cheshire decision. The President of the Court of Protection gave directions on the 21st of May 2014 with a return date in early June when all interested bodies who are joined to the consolidated proceedings will be able to submit evidence on what approach should be taken to streamline the deprivation of liberties procedures. The

Official Solicitor and the Court of Protection are feeling as over whelmed as LA' s and providers are about the implications of the Supreme Court judgement and the President is committed to try and find a way to streamline the process, to make it workable whilst maintaining the principles of Article 5 and the availability of suitable review processes where a person is deprived of their liberties.

Borough Treasurer

6.2 As the report makes clear, there are significant financial implications for the Council arising from the recent Supreme Court ruling in relation to the Deprivation of Liberty Safeguards, and financial modelling work is on-going to estimate what this might be.

Background Papers

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Health & Wellbeing Board: Forward Plan 2014/15

(Scheduling of agenda items are subject to change)

Last meeting of the Board: 10 April 2014

Item	Decision	Responsibility	Submitted to Board:
Update on Child & Adolescent Mental Health Services Tiers 1-4	For comment	Janette Karklins, Mary Purnell and William Tong	**SUBMITTED**
Protocol between the Health & Wellbeing Board, Healthwatch and the Health Overview & Scrutiny Panel	For comment	Lynne Lidster	**SUBMITTED**
2 Year and 5 Year Clinical Commissioning Group Plans	For comment	Mary Purnell/ William Tong	**SUBMITTED**
Better Care Fund	For comment	Glyn Jones	**SUBMITTED**
Update on the Progress of the Frimley Park Foundation Trust Acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust	For comment	Mary Purnell/ William Tong	**SUBMITTED**
Berkshire Healthcare Foundation Trust Quarterly Service Report 3	For comment	Berkshire Healthcare Foundation Trust	**SUBMITTED**

5 June 2014

Item	Decision	Responsibility	Submitted to Board:
Child & Adolescent Mental Health Service – Service Mapping	For comment	Lise Llwellyn	

Better Care Fund Update	For comment	Glyn Jones	
Future Population Growth and the Effect on Surgeries in Bracknell Forest	For comment	All Board Members	
Deprivation of Liberty Safeguards Following Recent Supreme Court Ruling	For comment	Zoe Johnstone	

4 September 2014

Item	Decision	Responsibility	Submitted to Board:

11 December 2014

Item	Decision	Responsibility	Submitted to Board:
Pharmaceutical Needs Assessment	For comment	Lisa McNally	