Bracknell Forest Council

NOTICE OF MEETING

Health and Wellbeing Board
Thursday 3 March 2016, 2.00 pm

To: The Health and Wellbeing Board

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr Tong, Bracknell & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Philip Cook, Involve
Alex Gild, Berkshire Healthcare NHS Foundation Trust
Jane Hogg, Frimley Health NHS Foundation Trust
Dr Janette Karklins, Director of Children, Young People & Learning, Bracknell Forest Council
John Nawrockyi, Director of Adult Social Care, Health & Housing
Mary Purnell, Bracknell & Ascot Clinical Commissioning Group
Lise Llewellyn, Director of Public Health
Mark Sanders, Healthwatch
Fidelma Tinneny, Berkshire Care Association
Hilary Turner, NHS England South Central Region
Linda Wells, Bracknell Forest Homes
Timothy Wheadon, Chief Executive, Bracknell Forest Council

ALISON SANDERS
Director of Corporate Services

EMERGENCY EVACUATION INSTRUCTIONS

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If you require further information, please contact: Priya Patel
Telephone: 01344 352308
Email: priya.patel@bracknell-forest.gov.uk
Published: 24 February 2016

Health and Wellbeing Board
Thursday 3 March 2016, 2.00 pm

Sound recording, photographing, filming and use of social media at meetings which are held in public are permitted. Those wishing to record proceedings at a meeting are however advised to contact the Democratic Services Officer named as the contact for further information on the front of this agenda as early as possible before the start of the meeting so that any special arrangements can be made.

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 December 2015. 5 - 10

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. **Actions taken between meetings**

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

8. **Better Care Fund**

To receive a report providing an update of the process for planning for 2016/17 and to seek delegated authority to approve the Better Care Fund Plan to be submitted. 11 - 50

9. **Child and Adolescent Mental Health Service Transformation Tracking**

To receive an update on the work to transform the Child and Adolescent Mental Health Service (CAMHS).

10. **Joint Health and Wellbeing Strategy Performance Monitoring**

To consider a report setting out a proposed suite of performance indicators, and reporting mechanisms that will be used to ensure the Health and Wellbeing Board is informed about progress on the priorities identified in the Health and Wellbeing Strategy. 51 - 64

11. **Joint Council and Clinical Commissioning Group Funding for Emotional Health and Wellbeing**

To receive a report providing an update on the Clinical Commissioning Group Innovation Fund and Adult Social Care funded schools project in relation to emotional health and wellbeing. 65 - 74

12. **NHS Sustainability and Transformation Plan**

To receive a presentation from Paul Sly, Interim Accountable Officer Berkshire East Clinical Commissioning Group, on the NHS Sustainability and Transformation Plan.

13. **Asset Review and Management**

A verbal update on the co-ordination of asset planning arrangements.

14. **LGA Peer Review**

To receive an update on the LGA Peer Review. To follow

15. **NHS Restructuring**

An update on the restructuring of the NHS. To follow

16. **Forward Plan**

Board members are asked to make any additions or amendments to the Board's Forward Plan as necessary. 75 - 76

HEALTH AND WELLBEING BOARD
10 DECEMBER 2015
2.00 - 4.35 PM

Bracknell Forest Council

Present:
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing
Dr William Tong, Bracknell & Ascot Clinical Commissioning Group
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Philip Cook, Involve
Alex Gild, Berkshire Healthcare NHS Foundation Trust
Mira Haynes, Chief Officer: Older People and Long Term Conditions (Representing the Director of Adult Social Care, Health and Housing)
Jane Hogg, Frimley Health NHS Foundation Trust
Christine McInnes, Chief Officer: Leraning and Achievement (Representing the Director of Children, Young People and Learning)
Lise Llewellyn, Director of Public Health
Linda Wells, Bracknell Forest Homes

In Attendance:
Vincent Paliczka, Director of Environment, Culture and Communities
Lynne Lidster, Head of Joint Commissioning
Dr Lisa McNally, Consultant in Public Health
Louise Noble, Berkshire Healthcare NHS Foundation Trust

Apologies for absence were received from:
Dr Janette Karklins, Director of Children, Young People and Learning
John Nawrockyi, Director of Adult Social Care, Health and Housing
Rachel Pearce, NHS England
Mary Purnell, Bracknell and Ascot Clinical Commissioning Group
Mark Sanders, Bracknell Forest Healthwatch
Fidelma Tinneny, Berkshire Care Association
Timothy Wheadon, Chief Executive, Bracknell Forest Coucnil

27. **Declarations of Interest**

There were no declarations of interest.

28. **Urgent Items of Business**

It was noted that with the agreement of the Chairman an additional item ‘A Year of Self Care’ had been added to the agenda.

29. **Minutes from Previous Meeting**

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 3 September 2015 be approved as a correct record and signed by the Chairman.

30. **Matters Arising**

There were no matters arising.

31. **Public Participation**

No submissions had been received under the terms of the Health and Wellbeing Board's public participation scheme.

32. **Actions taken between meetings**

It was reported that the Children and Young People Mental Health Transformation Plan had now been approved and the Chairman thanked all those who had assisted with the Plan's development.

33. **Mental Health Street Triage Pilot for East Berkshire**

Chief Inspector Gavin Wong and Chief Inspector Dave Gilbert attended the meeting to present a report proposing the introduction of a Mental Health Street Triage Pilot in the Berkshire East area.

It was reported that under the current arrangements patients suffering from mental health disorders in public and in need of immediate care or control could, under Section 136 of the Mental Health Act, be detained by the Police and taken to a place of safety for up to 72 hours in order for a mental health assessment to be carried out. Currently the nearest designated place of safety was Prospect Park Hospital in Reading however if no space was available at the Hospital then a police cell may be used. Between 2013/14 and 2014/15 there was a 33% rise (from 265 cases to 352cases) in the number of Section 136 detentions in Berkshire and in 2014/15 135 of the detentions occurred in the east Berkshire area. This has placed a significant strain on the service and analysis of those detained in the police custody suites across the Thames Valley Policing area has found that the average length of time that a patient waited before receiving a mental health assessment was 10 hours. A situation that could exacerbate and cause a deterioration in a patient's condition.

In order to improve the experience and outcomes of service users it was proposed that a Mental Health Street Triage Pilot be launched across east Berkshire on 1 April 2016. The pilot would involve teaming up a Police officer with a Mental Health Professional who would provide a rapid response between the hours of 5pm and 1am. Outside these times dedicated telephone support would be available. The Street Triage Team would be able to assess a patient at the scene and quickly identify an appropriate treatment route thus negating the need to spend time waiting for a mental health professional to arrive and reduce the number of patients having to be detailed.

Evidence showed that in areas running a Mental Health Street Triage system were experiencing a lower number of Section 136 detentions, fewer referrals made to inappropriate places of safety and patients were experiencing much better outcomes as a result of the immediate medical attention they had received.

Arising from the Board's questions and comments the following points were noted:

- Analysis of a pilot in Cleveland had found that two thirds of those assessed by the Triage Team were not known to services at the time of the assessment and that 55% of those assessed did not have a mental health condition.

- Out of hours emergency care centres were able to access primary care records and this information sharing was expected to be expanded more widely
- The Emergency Duty Service had out of hours access to the local authority systems for the six Berkshire local authorities
- Bracknell Forest Council currently provided the out of hours Emergency Duty Service for the six Berkshire local authorities. This service had recently been reviewed in advance of a relaunch in April 2016 and care would be needed to ensure that duplication did not occur
- The Mental Health Professional in the Street Triage Team would be a new additional role and it was expected that the demand on the Emergency Duty Team would reduce as a consequence of the pilot's introduction
- It was agreed that the Chief Officer: Older People and Long Term Conditions would work with Thames Valley Police to ensure that the Emergency Duty Service and the Street Triage Pilot worked in a cohesive and complimentary fashion
- The times that the Mental Health Professional would be available on the ground had been determined by local evidence.
- Clear and measurable indicators of success would need to identified
- A decision would be taken on whether to continue the one year pilot towards the end of 2016
- It was requested that an full update, including measures of success, on the work of the pilot be given at a future meeting

RESOLVED that;

i. The Health and Wellbeing Board support the introduction of the Mental Health Street Triage Pilot
II. A full report on the work of the pilot would be brought to the Health and Wellbeing Board's meeting in December 2016

34. **Bracknell Forest Local Safeguarding Children Board Annual Report**

Alex Walters, Independent Chairman of the Local Safeguarding Children Board (LSCB, attended the meeting to present the Local Safeguarding Children Board's Annual Report for 2014/15.

Arising from The Board's questions and comments the following points were noted:

- The LSCB acknowledged the issues around child and adolescent mental health but had recognised the valuable work that the Health and Wellbeing Board was focusing on this and had agreed that rather than duplicate this work they would keep a watching brief on the area and focus instead on parental mental health because it was known to impact directly on children.
- The LSCB's future audit activity would be exploring the support looked after children received from mental health services.
- The number of homeless children continued to rise and the LSCB was keeping a watching brief on both the number of homeless families and children and where these families were being placed. It was noted that the Family Support Workers in schools did work with families where it was known that there was a risk however it was acknowledged that more still could be done to help these families.
- Adult Services worked closely with Children's Services where it was known that a child had carer responsibilities. However many young carers were

reluctant to identify themselves as carers or become involved in activities put on for young carers.

- When young carers were identified then additional support was put in place through the schools. The Council also commissioned the charity Kidz to carry out targeted work with young carers.
- The LSCBH had an agreed partnership protocol with the Adult Safeguarding Board, the Health and Wellbeing Board and the Community Safety. Partnership. This was due for review and renewal and it was agreed that the Health and Wellbeing Board would continue to be a signatory to the protocol.
- The LSCB would be involved in any review of the Health and Wellbeing Strategy.

RESOLVED that the Health and Wellbeing Board note the Local Safeguarding Children Board Annual report 2014/15 and the key messages arising from it.

35. **Children and Young People's Mental Health Transformation Planning Update**

Louise Noble, Interim Head of the Child and Adolescent Mental Health Service (CAMHS), presented a report providing an update on the work taking place to improve the service.

In 2014/15, the number of referrals to CAMHS had continued to rise with an 5.6% increase in referrals across the East Berkshire Clinical Commissioning Group area. Data showed that 100% of the initial referrals were triaged for clinical urgency within 24 hours of a referral being made and of the 579 young people in Bracknell Forest waiting for an initial assessment the majority received a face to face assessment within twelve weeks of their being referred. In Bracknell Forest, the longest waiting lists were for those young people requiring an Autistic Spectrum Disorder (ASD) Assessment with 141 young people in Bracknell Forest waiting for longer than 12 weeks for an assessment.

Additional funding had been given to CAMHS to enable additional staff to be employed. These new members of staff had now been through the required induction and training programme and were now starting to take on their own caseloads. It was anticipated that the number of young people waiting over twelve weeks for an assessment would have reduced significantly by the end of the current financial year.

CAMHS had been working with Kooth to improve the referral process and the interface between the two services. It had now been agreed that CAHMS would refer young people directly to Kooth rather than signposting them to the service. The CAMHS waiting lists had been reviewed and all young people currently waiting for CAHMS support had been contacted and given the option of receiving additional support from Kooth whilst they waited.

Arising from Members' questions and comments the following points were noted:

- In addition to counselling, CAMHS also offered a range of additional support through workshops targeting specific concerns for example anxiety
- 60% of those being referred to CAMHS were too young to access Kooth's services and it was essential that appropriate support was available to this group
- The wider CAMHS Transformation Plan would be circulated to the Board for information

- The ADHD pathways were heavily reliant on receiving information from other agencies and delays in this information exchange was impacting on waiting times
- Differing opinions from GPs and schools over whether a referral to CAMHS was necessary did have an impact on waiting times
- It was agreed that data relating to the number of children and young people waiting for longer than six and twelve months would be included in the next update
- The cases of all those on the ASD Pathway had been reviewed to ascertain whether the pathway was this diagnostic pathway was the most appropriate way forward for the young person
- An internet search for 'Young people mental health' directed the searcher to the CAMHS web pages. This was not always the most appropriate initial pathway for many young people and it was suggested that links could be added to the web page directing young people and their families to alternative sources of advice and support for example Youthline and Kooth. It was agreed that the Public Health Team would liaise with CAMHS to take this piece of work forward.

The Board thanked Louise Noble for her update.

36. **Draft Joint Health and Wellbeing Strategy**

The Board received a report seeking approval of the joint Health and Wellbeing Strategy 2016-2020.

It was a statutory requirement for the Health and Wellbeing Board to develop and publish a joint Health and Wellbeing Strategy that identified local priorities in relation to the health and wellbeing of the local population and where relevant organisations needed to work in partnership to develop and implement plans to address these priorities.

The draft Strategy was the Board's second strategy and had a clear focus on the prevention of ill health and encouraging and supporting people to understand the actions that they could take to keep themselves fit and well. Arising from the Board's questions and comments the following points were noted:

- The final sentence in the third paragraph of the Foreword would be amended to read 'We remain focused on joining things up in order to better provide…'
- Input would be required from all partners to develop proper measurable business orientated outcomes
- The proposed performance indicators under Priority 1: Prevention of ill health and the things that cause it only focused on the elderly and needed to be expanded.
- It was agreed that a draft list of Performance Indicators would be considered by the Board at their next meeting
- It was agreed that performance management of the Strategy outcomes would be added as a standing agenda item to all future Health and Wellbeing Board meetings
- The Strategy currently made no explicit mention of the need to transform adult social care. It was agreed that this would be added to Priority 4: Workforce

RESOLVED that, subject to the comments and amendments discussed, the Health and Wellbeing Strategy 2016-2020 be approved.

37. **Forward Plan**

The Board noted the items for consideration at future meetings of the Health and Wellbeing Board. It was agreed that the following items would be added:

- Health and Wellbeing Strategy Performance Monitoring (To be a standing agenda item)
- Child and Adolescent Mental Health Service (CAMHS) Transformation Tracking
- Joint Protocol for Partnership Boards

38. **Year of Self Care**

The Board received a presentation proposing the introduction of 'A Year of Self Care.'

The Year of Self Care would build on the success of November's Self Care Week by bringing together the wide range of programmes being run by partners to improve the Health and Wellbeing of Bracknell Forest residents under a single coherent common identity. It was proposed that the Year of Self Care be launched in January 2016 with each month would be assigned a specific theme for example mental well-being, physical activity, healthy ageing and workplace health and partners would be able to focus collectively on the month's theme and promote their activities as being another step towards improving well being. Partners would be encouraged to register their initiatives centrally with the Public Health Team and brand them with the Year of Self Care Logo providing greater visibility and awareness of the self care agenda.

It was noted that work undertaken over the past 18 months towards embedding the notion of "wellness" into all the health and well-being activity that was being carried out across the borough included not only mainstream initiatives such as healthy activity but also recognised that issues such as debt, mental health, housing could also have a significant impact on wellbeing. It was also noted that a longer term ambition was the designation of Bracknell Forest as a "wellness town" or "wellness borough".

Research undertaken by The People's Lottery into wellbeing had identified four pillars of wellbeing: physical activity; healthy eating; mental health; and personal well being and it was these areas that would be focused on in the first instance. Four specific groups had been identified as being representative of the Borough and initiatives would be targeted at the following groups during the year business, education, vulnerable and elderly and resident adults

It was stressed that the proposals would bring together existing work into a single programme of events and as such would not require additional resources. It was hoped that the programme would attract a wider range of businesses and agencies into the health and wellbeing agenda a situation that might provide opportunities to generate additional resources via increased volunteering, partnership or sponsorship opportunities.

The Board agreed to support the initiative.

CHAIRMAN

TO: HEALTH AND WELLBEING BOARD
3 MARCH 2016

BETTER CARE FUND
Director – Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health and Wellbeing Board of the process for planning for 2016/17 and to seek delegated authority to approve the plan to be submitted.

2 RECOMMENDATION

2.1 That the Health and Wellbeing Board gives delegated authority to the Director – Adult Social Care, Health and Housing to submit the 2016/17 plan to the Department of Health.

3 REASONS FOR RECOMMENDATION

3.1 As at 23rd February, the detailed guidance and timetable for approval for the 2016/17 had not been published. It is likely that the guidance will be published and the date for submission will both be before the next meeting of the Health and Wellbeing Board.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 There is no alternative to following the BCF planning guidance.

5 SUPPORTING INFORMATION

5.1 In June 2013, the Government announced the Better Care Fund. It was designed to bring improvements to the way health and social care services to work together through the mechanism of a pooled budget. It was designed to bring an opportunity for change, so that people receive the right care and support at the right time, in the right place.

5.2 The Bracknell Forest BCF plan can be viewed at the following link Bracknell Forest Better Care Fund (PDF, 1820kb)

5.3 The plan was approved by the Department of Health in December 2014. The vision agreed by the Bracknell Forest Health and Wellbeing Board has three key elements

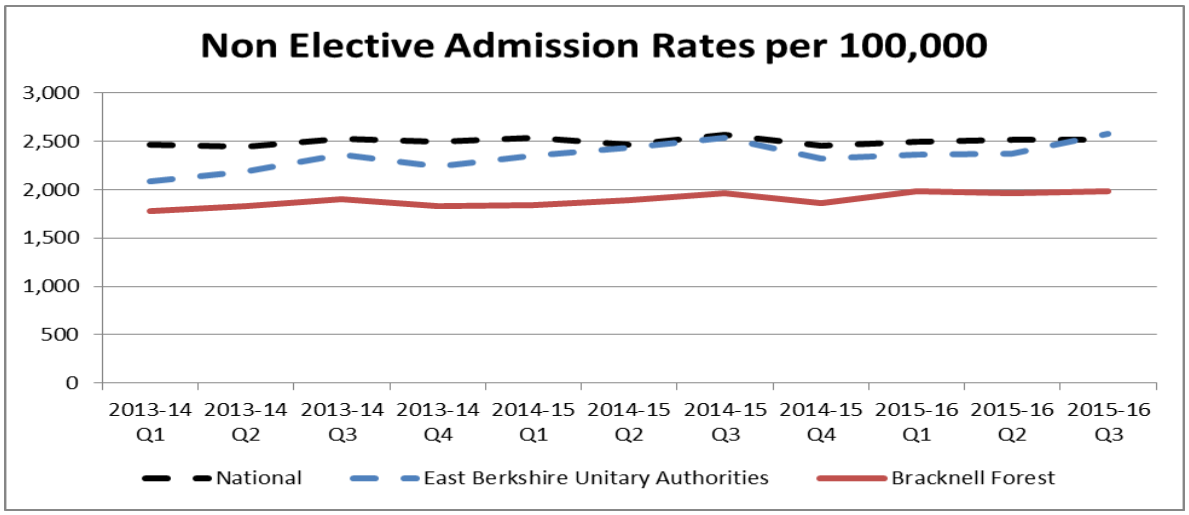
- Prevention – The focus is on health and not illness. The population will be happier, healthier and active for longer through having access to better information and support to make the right choices

- Personalisation – Care and support will respond to the person's choices and needs. This will begin with ensuring that people only have to tell their story once. People and their carers will be supported to achieve the outcomes that are important to them.

- Partnership – An integrated system across health and social care will develop with the person at its centre. Improvement will also be driven by the BCF partnership with local people and learning from what they say about their experience of using health and social care services and support.

5.4 The BCF programme is governed by the BCF Steering Group, the BCF Programme Board and the Health and Wellbeing Board. Highlight reports and risk logs are reported monthly to the Steering Group and quarterly to the Programme Board. Minutes of the Programme Board are sent to members of the Health and Wellbeing Board following each meeting.

5.5 The BCF reports quarterly to the Department of Health; the latest report, for quarter 3, can be found at Appendix 1 to this report. About half of Health and Wellbeing Board areas are on target to achieve a 3.5% reduction in Non-Elective Admissions. Although the 3.5% target for the reduction of Non-Elective Admissions to hospital has not been achieved, Bracknell Forest already performs significantly better than the England average and the other HWB areas in the East of Berkshire as can be seen from the graph below.



5.6 Early planning guidance for BCF 2016/17 has been published by NHS England and can be found at Appendix 2. Key headlines from the guidance includes:

- The removal of the existing payment for performance framework but with the introduction of two new national conditions (requiring local areas to fund NHS commissioned out of hospital services and to develop a clear, focussed action plan for managing delayed transfers of care, including locally agreed targets)

- The retention of the existing national and local performance indicators used in the current BCF submission.

5.7 The guidance states that the equivalent amount to the 2016/17 pay for performance element can be ring fence to pay for over performance in acute settings. However, this must be agreed by the HWB; in order to do this the HWB must satisfy itself that the two new national conditions will be met from the general BCF or other funding sources.

5.8 BCF plans for 2016/17 will be required to be submitted to NHS England before April 2016, when an assessment will be made on the plan quality and risks to delivery. The plans will be placed into one of three categories: "Approved", "Approved with Support" or "Not approved".

Where plans are not initially approved or are approved with support, NHS England will implement a programme of support to help areas achieve approval and / or meet relevant conditions ahead of April 2016.

5.9 Funding allocations were published in mid-February; whilst the detail is still unclear the overall BCF is broadly in line with the 2016/17 allocation.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 This report reflects the current position in relation to the development of the Better Care Fund.

Borough Treasurer

6.2 Finance will input to the Better Care Fund plan to ensure it aligns to existing budgets where relevant. There are not expected to be any budgetary pressures arising from the plan.

Equalities Impact Assessment

6.3 Equalities are considered within each scheme funded by the Better Care Fund.

Contact for further information
Zoë Johnstone, ASCHH - 01344 351609
Zoe.johnstone@bracknell-forest.gov.uk

Lynne Lidster, ASCHH - 01344 351610
Lynne.lidster@bracknell-forest.gov.uk

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 26th February 2016.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.

8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 and Q2 2015-16 submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31st March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4 - Q2. Two figures are required and one question needs to be answered:

Input actual Q3 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell O8
Input actual value of P4P payment agreed locally - Cell F19
If the actual payment locally agreed is different from the quarterly payment suggested by the automatic calculation in cell AR8 (which is based on your input to cell O8 as above) please explain in the comments box
Please confirm what any unreleased funds were used for in Q3 (if any) - Cell F34

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q3
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q3

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

6) Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q3 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Understanding support needs

This tab re-asks the questions on support needs that were first set out in the BCF Readiness Survey in March 2015. These questions were then asked again during the Q1 2015-16 data collection in August. We are keen to collect this data every six months to chart changes in support needs. This is why the questions are included again in this Q3 2015-16 collection. The information collected will be used to inform plans for ongoign national and regional support in 2016-17.

The tab asks what the key barrier to integration is locally and what support might be required in putting in meeting the six key areas of integration set out previously. . HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q3 2015/16

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q3 15/16	Actual payment locally agreed	Cumulative quarterly Actual Payments >= Cumulative suggested quarterly payments	If the actual payment locally agreed is <> suggested quarterly payment	Any unreleased funds were used for: Q3 15/16
Yes	Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
	Commentary	Yes				

6. Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care	Yes	Yes
Reablement	Yes	Yes
Local performance metric	Yes	Yes
If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes

7. Understanding support needs

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the beginning of the quarter
Yes
Number of new PHBs put in place during the quarter
Yes
Number of existing PHBs stopped during the quarter
Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)
Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?
Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?
Yes

9. Narrative

Brief Narrative	Yes

Cover

Q3 2015/16

Health and Well Being Board	**Bracknell Forest**
completed by:	Lynne Lidster Head of Joint Commissioning
E-Mail:	lynne.lidster@bracknell-forest.gov.uk
Contact Number:	01344 351610
Who has signed off the report on behalf of the Health and Well Being Board:	John Nawrockyi - Director of Adult Social Care, Health and Housing

Question Completion - when all questions have been answered and the validation

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	17
6. Metrics	9
7. Understanding support needs	13
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Bracknell Forest

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board: Bracknell Forest

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes	Yes		
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously filled in by the HWB.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Bracknell Forest

	Baseline				Plan					Actual					
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance
D. REVALIDATED: HWB version of plans to be used for future monitoring.	2,147	2,158	2,222	2,298	2,068	2,097	2,149	2,221	1,996	2,199	2,345	2,332	2,347	3.3%	290

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested quarterly payment (taken from above)*	£0	£0	£0	£0
Actual payment locally agreed	£0	£0	£0	£0

If the actual payment locally agreed is different from the suggested quarterly payment (taken from above) please explain in the comments box (max 750 characters)	

	Total Unreleased Funds			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested amount of unreleased funds**	£117,710	£90,890	£108,770	£114,730
Actual amount of locally agreed unreleased funds	£117,710	£90,890	£108,770	£114,730

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	not applicable	not applicable	not applicable	not applicable

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as of 11th December 2015.
*Suggested quarterly payment (taken from above) has been calculated using the technical guidance provided here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/. The key steps to calculating the quarterly payment are:
a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
b. multiply that by the size of the performance pot available; and
c. subtract any performance payments made for the year to date.
The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

**Unreleased funds refers to funds that are withheld by the CCG and not released into the pooled budget, due to not achieving a reduction in non-elective admissions as set out in your BCF plan. As payments are based on a cumulative quarter end value a negative (-) quarter actual value indicates the use of surplus funds from previous quarters.
HWBs should consider whether there is a need to make adjustments to Q3 payments where over or under payments may have occurred in Q4 2014/15, Q1 2015/16 or Q2 2015/16 due to changes made to NEA baselines and targets.

	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment								
Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed	Q2 Payment locally agreed
£432,100	79	140	213	290	£117,710	£90,890	£108,770	£114,730	-52	-187	-110	-49	£0	£0	£0	£0	£432,100	£1,761,000	£0	£0	£0

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Bracknell Forest

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,333,395	£2,333,395	£2,333,395	£2,333,395	£9,333,580	£8,383,000
	Forecast	£2,563,670	£2,843,950	£1,972,050	£1,972,049	£9,351,719	
	Actual*	£2,563,670	£2,843,950				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,333,395	£2,333,395	£2,333,395	£2,333,395	£9,333,580	£8,383,000
	Forecast	£2,563,670	£2,843,950	£1,233,360	£2,402,519	£9,043,499	
	Actual*	£2,563,670	£2,843,950	£1,233,360			

Please comment if there is a difference between either annual total and the pooled fund	The annual total is greater from the original plan as additional money has been ringfenced for the Better Care Fund since that plan was submitted. The annual total in Q3 differs from the annual total in Q1 as we now assume none of the performance element will be payable into the fund as A&E admissions have not reduced. It also takes into account some further income to be included in the fund identified since Q1.

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,102,000	£2,102,000	£2,102,000	£2,102,000	£8,408,000	£8,383,000
	Forecast	£870,090	£2,763,034	£2,201,026	£2,201,027	£8,035,177	
	Actual*	£870,090	£2,763,034				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,102,000	£2,102,000	£2,102,000	£2,102,000	£8,408,000	£8,383,000
	Forecast	£870,090	£2,763,034	£2,108,049	£3,302,326	£9,043,499	
	Actual*	£870,090	£2,763,034	£2,108,049			

Please comment if there is a difference between either annual total and the pooled fund	The annual total in Q3 differs from that in Q1 as we now have plans in place to utilise all funds by year end. Therefore expenditure now equals income. The annual total differs from the original plan for the same reasons set out under "income" above.

Commentary on progress against financial plan:	The pooled is expected to be fully utilised by year end. The performance element of the funding is not anticipated to be received into the fund.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Bracknell Forest

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Based on figures for the period April 15 to December 15, the full year extrapolated forecast gives a rate per 100,000 population of 688.14. The planned 15/16 figure was 596.8 so the % change is 15.3%. As reported in previous submissions, the baseline 2014/15 showed a particularly low number of admissions and demand over the year cannot necessarily be predicted by looking at the previous year's trends.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Data not available to assess progress. This data will be available after the end of March2016.

Local performance metric as described in your approved BCF plan / Q1 / Q2 return	Emergency admission due to injury, poisoning and certain consequences of external causes (ICD-10 S00 to T98X) Aged 65 and over (primary diagnosis) with external cause coded as due to falls (ICD-10 W00-W19). Crude rate per 100,000 population aged 65 and over calculated using the 2012 ONS mid-year population estimates. Source: Secondary Uses Service
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	An improvement in performance took place in Q2 when compared against the same period in 2014/15 and the trajectory has continued to show improvements for Q3 compared against the same period in 2014/15.

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Improving the health related quality of life of people with one or more LTC (Based on EQ5D Patient Survey)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	The data for EQ5D was provided in the Quarter 2 2015/16 return following publication in September 2015. The information is published annually and therefore the situation remains the same as for Q2 until the next publication date, anticipated to be September 2016.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Bracknell Forest

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	3.Developing underpinning integrated datasets and information systems

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Case studies or examples of good practice	
2. Delivering excellent on the ground care centred around the individual	No	[redacted]	
3. Developing underpinning integrated datasets and information systems	Yes	Central guidance or tools	
4. Aligning systems and sharing benefits and risks	Yes	Central guidance or tools	
5. Measuring success	No	[redacted]	
6. Developing organisations to enable effective collaborative health and social care working relationships	No		

New Integration Metrics

Selected Health and Well Being Board: Bracknell Forest

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	No	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	In development	In development	Live	In development	In development
Projected 'go-live' date (dd/mm/yy)		31/10/16	31/10/16		31/10/16	31/10/16

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the beginning of the quarter	0
Rate per 100,000 population	0

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2015)	118,496

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board: Bracknell Forest

Remaining Characters	30,149

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).
Bracknell Forest HWB has fully met the conditions for 7 day services; Joint Assessment and Care Planning; Use of the NHS number, as detailed in the previous submissions Q1 and Q2. While the overall rate of non-elective admissions has risen in Bracknell Forest, the 3 consecutive Quarters for 2015 2016 have demonstrated a step reduction in variance (13% / 9% / 6%) and there has been a noticeable decrease in the subgroup of '"Chronic ambulatory" non-elective admissions; pointing to improvement in provision of preventative services such as the Prevention and Self-Care programme within the BCF workstream, as well as the impact of other BCF schemes such as the Integrated Care Teams, where to date the Supported Discharge team have received more than 115 referrals since April 2015. In summary, the reduction in avoidable non-elective admissions is attributed to the success of the BCF projects and other areas of preventative work. The BCF projects, specifically the further development of intermediate care, are designed to directly impact on DToCs. These initiatives are supplemented by winter pressures initiatives which tackle causes of delays. The integrated care teams also support this by ensuring that advanced care plans are in place for people at high risk of admission. Through the appropriate BCF governance, further BCF funded projects are being implemented, aimed at directly or indirectly tackling DTOCs. These include providing additional capacity in the Community Intermediate Care Service, to enable the service to provide short term support for people who are either newly referred for social care support, or whose needs change, in order to: • Provide detailed information to inform assessment • Support reablement where appropriate • Provide support at the right level, at the right time and in the right place through a “right sizing” approach • Deliver cost savings through reducing or removing the need for on going support from traditional home care. As has been previously noted, the domiciliary care market is particularly challenged in this area, which impacts on DTOCs and the Better Care fund is also being used to offset the difficulties this presents. An enhancement to the Community Alarm service to provide Emergency Personal Care has been approved by the BCF Steering Group. This seeks to reduce the need to admit people to hospital who do not have sufficient emergency support at home. This service therefore contributes to the ambitions of the Better Care Fund as it potentially prevents hospital admission as well as potentially enabling safer hospital discharge.

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Department of Health

Department for Communities and Local Government

2016/17 Better Care Fund

Policy Framework

January 2016

Title: Better Care Fund, Policy Framework 2016/17
Author: SCLGCP/ SCP/ Integrated Care Policy / 11120
Document Purpose: Policy
Publication date: **01/2016**
Target audience: This document is intended for use by NHS England and those responsible for delivering the Better Care Fund at a local level (such as, clinical commissioning groups, local authorities and health and wellbeing boards).
Contact details: Edward Scully Richmond House Whitehall London SW1A 2NS Edward.scully@dh.gsi.gov.uk

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www.gov.uk/dh

2016/17 Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

Contents

Background

The Better Care Fund 2016/17 Policy Framework

The Better Care Fund is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation. In 2015-16, the Government committed £3.8 billion to the Better Care Fund with many local areas contributing an additional £1.5 billion, taking the total spending power of the Better Care Fund to £5.3 billion.

Current health and care approaches have evolved to respond reactively to changes in an individual's health or ability to look after themselves, and they often do not meet people's expectations for person-centred co-ordinated care. Greater integration is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge.

We recognise that local areas are at different points in their integration journey and in supporting them to achieve their ambitions for integrated care, we will need to prioritise progress on known barriers to change to ensure the key factors associated with successful integration are embedded and shared across the system. The Better Care Fund and other drivers of integrated care such as New Care Models pave the way for greater integration of health and social care services.

In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The local flexibility to pool more than the mandatory amount will remain. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. In looking ahead to 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

This document sets out the policy framework for the implementation of the fund in 2016-17, as agreed across the Department of Health, Department for Communities and Local Government, Local Government Association, Association of Directors of Adult Social Services, and NHS England. In developing this policy framework, the strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund has been taken on board, and we have streamlined and simplified the planning and assurance of the Better Care Fund in 2016-17, including removing the £1 billion payment for performance framework.

In place of the performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system, and to

ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

Further detailed guidance will be issued by NHS England, working with the partners above, on developing Better Care Fund plans for 2016-17. The guidance will form the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England's website. Local areas are asked to refer to and follow this guidance.

Beyond the 2016-17 Better Care Fund

The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements. Further details will be set out shortly in guidance.

1. The Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

Under the mandate to NHS England for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

Of the £3.519 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.519 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to a new national condition.

NHS England and the Government will allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2016-17, the allocation will be based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

Within the Better Care Fund allocation to Clinical Commissioning Groups is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in the Better Care Fund Planning Requirements.

Individual allocations of the Better Care Fund for 2016-17 to local areas and the detailed formulae used will be published on NHS England's website in early January.

2. Conditions of Access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17, NHS England will set the following conditions, which local areas will need to meet to access the funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

Detailed definitions of these national conditions are set out at Annex A.

Conditions of Access to the Better Care Fund

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of funding where conditions attached to the Better Care Fund are not met. The Act makes provision at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2016-17 mandate to NHS England confirms that NHS England will be required to consult Ministers before using these powers.

NHS England's power to set conditions on the Better Care Fund applies to the £3.519bn that is part of Clinical Commissioning Group allocations. For the £394m paid directly to local government, the Government will attach appropriate conditions to the funding to ensure it is included in the Better Care Fund at local level. As set out in Better Care Fund technical guidance, for 2016-17 authorities in two-tier areas will have to allocate Disabled Facilities Grant funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people.

3. The Assurance and Approval of the Local Better Care Fund Plans

Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association. For 2016-17, we have set out a more streamlined process that is better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities.

The first stage of the overall assurance of plans will be local sign-off by the relevant Health and Wellbeing Board, local authority and Clinical Commissioning Group(s). In line with the NHS operational planning assurance process, plans will then be subject to regional moderation and assurance. The key aspects of the process for the planning, assurance and approval of Better Care Fund plans are:

- Brief narrative plans will be developed locally and submitted to regional teams through a short high level template, setting out the overall aims of the plan and how it will meet the national conditions
- A reduced amount of finance and activity information relating to local Better Care Fund plans will be collected alongside Clinical Commissioning Group operational planning returns to submitted to NHS England, to ensure consistency and alignment
- Better Care Managers will work with NHS England Directors of Commissioning Operations teams to ensure they have the knowledge and capacity required to review and assure Better Care Fund plans. To support this local government regional leads for the Better Care Fund (LGA lead CEOs and ADASS chairs) or their representatives will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation)
- There may be flexibility permitted for devolution sites to submit plans over a larger footprint if appropriate
- An assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government
- These judgements on ‘plan quality’ and ‘risks to delivery’ will contribute to the placing of plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’.

A diagram of the above assurance and approval process is included in Annex B. The full details will be set out in the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England’s website.

Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an area's plan being proportionate to the perceived level of risk in a system. Recommendations of approval for Better Care Fund plans for high risk areas will be made by the regional moderation process but those decisions will be quality assured by the Integration Partnership Board (which is a senior programme leadership board comprising DH, DCLG, NHS England, Local Government Association and the Association of Directors of Adult Social Services). Final decisions on approval will be made by NHS England, based on the advice of the moderation and assurance process, in accordance with the legal framework set out in section 223 GA of the NHS Act 2006.

Where plans are not initially approved, or are approved with support, NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

NHS England has the ability to direct use of the fund where an area fails to meet one of the Better Care Fund conditions. This includes the requirement to develop a plan approved by NHS England and Ministers. If a local plan cannot be agreed, any proposal to direct use of the fund will be subject to consultation with DH and DCLG (as required under the 2016-17 mandate to NHS England).

4. National Performance Metrics

Under the 2015-16 Better Care Fund policy framework, local areas were asked to set targets against the following five key metrics:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient / service user experience
- A locally-proposed metric

In the interests of stability and consistency, areas will be expected to maintain the progress made in 2015-16. The detailed definitions of these metrics are set out in the Better Care Fund section of the NHS technical planning guidance.

5. Implementation 2016-17

The implementation of local Better Care Fund plans will formally begin from 1 April 2016. As part of its wider planning process, NHS England will require local areas to produce a multi-year strategic plan, showing how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. This will set out the actions and specific deliverables that NHS England will take forward to deliver the objectives set out in the multi-year mandate to NHS England – including those relating to the integration of health and social care and the continuation of the Better Care Fund.

In implementing the Better Care Fund in 2016-17, NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Work with partners to identify and remove barriers to service integration;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing success of the Better Care Fund – including delivery against key national performance metrics;
- Prepare as necessary for the continuation of the Better Care Fund over the next Parliament.

Annex A: Detailed Definitions of National Conditions

CONDITION	DEFINITION
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.
Maintain provision of social care services	Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16. The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund. In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process. It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14: https://www.gov.uk/government/uploads/system/uploads/attac

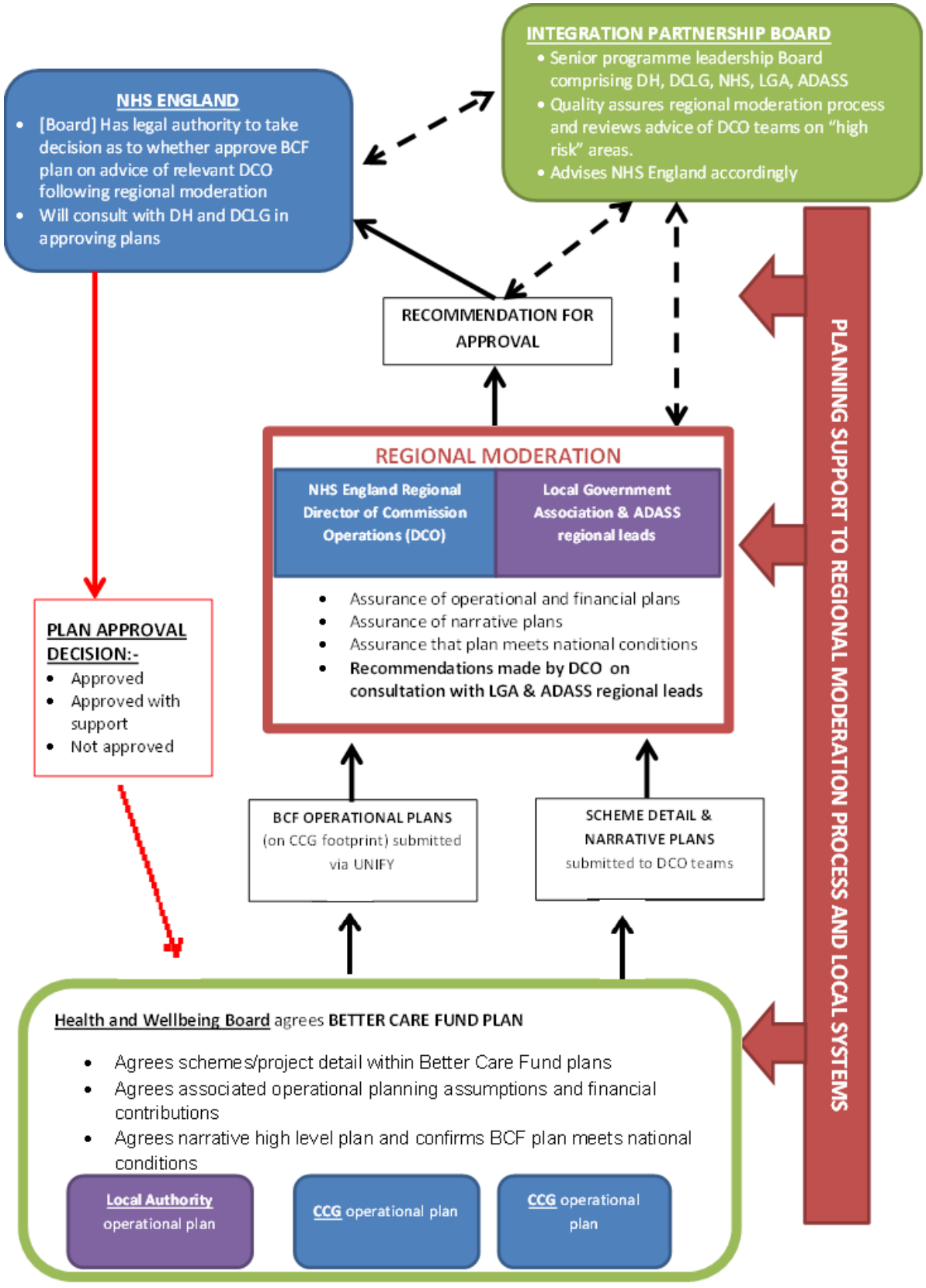
	hment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.	Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order: • To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week; • To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why. The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf). By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.
Better data sharing between health and social care, based on the NHS number	The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary

	security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and • ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place. • ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review. The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.
Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund. This should be achieved in one of the following ways: • To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better

	Care Fund plan; or • Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16); This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.
Agreement on local action plan to reduce delayed transfers of care (DTOC)	Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue. As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target. All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue. We would expect plans to: • Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring; • Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and

	best practice with regards to reducing DTOC from LGA and ADASS; • Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance; • Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity; • Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies; • Demonstrate engagement with the independent and voluntary sector providers.

Annex B: Assurance and Approval of Better Care Fund Plans



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TO: HEALTH AND WELLBEING BOARD
3 MARCH 2016

HEALTH AND WELLBEING STRATEGY – PERFORMANCE MONITORING
Director of Adult Social Care, Health and housing

1 PURPOSE OF REPORT

1.1 To agree the suite of performance indicators, and reporting mechanisms that will ensure the Health and Wellbeing Board is informed about progress on the priorities identified in the Health and Wellbeing Strategy, *"Seamless Health 2016-2020"*.

2 RECOMMENDATIONS

2.1 That the Board agree to the proposed suite of "high level" indicators (the dashboard), subject to any required amendments.

2.2 That the Board agree to receive the performance report quarterly for information (outside of meetings), with areas for concern to be agenda items for discussion and decision at Board Meetings.

3 REASONS FOR RECOMMENDATIONS

3.1 To ensure that the Board is aware of progress against the health and wellbeing priorities for Bracknell Forest, and;

3.2 Has the opportunity to consider areas of concern / poor progress, and agree what action is required.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 Not applicable.

5 SUPPORTING INFORMATION

5.1 The Board approved the Health and Wellbeing Strategy in December. At that time, a number of national indicators were not known, and it was agreed that when these were available, a "dashboard" of key indicators would be suggested for reporting to the Board.

5,2 In relation to **Priority 3: Preventing people becoming socially isolated and lonely**, work is still ongoing following the stakeholder workshop in January. Action plans and indicators will be proposed from this work.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 There are no specific legal implications arising from this report.

Borough Treasurer

6.2 There are no direct financial implications within this report for the Council.

Equalities Impact Assessment

6.3 Not required

Strategic Risk Management Issues

6.4 None

7 CONSULTATION

Principal Groups Consulted

7.1 There has been extensive public consultation in the development of the Health and Wellbeing Strategy

Method of Consultation

7.2 Public Health survey, Various consultations informing the development of local joint commissioning strategy, consultation on the 2012-2015 strategy

Background Papers

Seamless Health 2016-2020
JSNA
Joint Commissioning Strategies

Contact for further information
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SEAMLESS HEATH 2016 - 2020

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Proposed Key Indicators

Proposed Indicator Set

Priority 1: Promoting active and healthy lifestylest the

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Total emergency admissions in to hospital.	Emergency admissions to hospital are rising nationally and represent a threat to health and social care service capacity. In some cases, emergency admissions represent poor management of long term conditions,	Better Care Fund Data Reports	Better Care Fund Main Indicator	Number per 100,000 population	Quarterly	Low is good
Avoidable emergency admissions in to hospital.	Many emergency admissions are for reasons that could be avoided through prevention or adequate management in the community. These include those resulting infectious disease and poorly managed long term conditions in both children and adults.	Better Care Fund Data Reports	Better Care Fund Supplementary Indicator	Number per 100,000 population	Quarterly	Low is good
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	Measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.	UNIFY2 (NHS England) Office of National Statistics	Adult Social Care Outcomes Framework (ASCOF) 2C	Number per 100,000 population	Annual	Low is good Target: tbc

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.	SALT Hospital Episode Statistics	ASCOF 2B NHSOF 3.16(i)	%	Annual	High is good
Improving the health related quality of life of people with one or more Long Term Condition	An overarching measure of care, support, treatment and reablement of people with long-term conditions	Based on EQ5D Patient Survey	NHSOF 2	Number	Annual	High is good
Emergency hospital admissions for fractured neck of femur (hip) in persons aged 65+	Hip fractures have a significant impact on people and their families, with reduced quality of life, care needs and levels of subsequent mortality. Many hip fractures can be prevented through better falls prevention and awareness.	National Hip Fracture Database (NHFD). Hospital Episode Statistics (HES).	PHOF 4.14	Rate per 100,000 population aged 65 to 79	Annual	Low is good (target= less than 570 per 100k pop 65+)
Increase in percentage of the population taking part in sport and physical activity at least twice in the last month	Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular	Annual Sport England Active Lives Survey	Public Health Outcomes Framework (PHOF) 2.13	% increase	Annual	High is good (target TBC as new survey)

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Decrease in percentage of people physically inactive	physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year.	Annual Sport England Active Lives Survey	PHOF 2.13 (ii)	% decrease	Annual	High is good
Increase in the percentage of adults utilising outdoor space for exercise/ health reasons	Green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage, includes visits to the natural environment are defined as time spent "out of doors" e.g. in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers.	MENE survey	PHOF 1.16	% increase	Annual	High is good
Delaying and reducing the need for care and support (In development for 2015/16)	Intent to measure the effectiveness of short-term services, to understand whether there are any unintended consequences of the decision to provide no further services. To provide a more comprehensive view of the effectiveness of reablement care and support.	TBC	*Placeholder for 2015/16 (2E) Effectiveness of reablement services*	TBC	Annual	Low is good
Smoking quit rate	Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking accounts for significant burden on health and social care services. The smoking quit rate is the primary indicator of quality for the local stop smoking services.	HSCIC / Public Health Team	Tobacco Profiles for England	%	Quarterly	High is good (target = at least 60%)

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Uptake of adult weight management programmes by people who are obese.	Obesity in adults, which is recognised as a major determinant of premature mortality and avoidable ill health. Weight management services are an evidence-based way of reducing by obesity, however increasing uptake in this groups is a challenge.	Local weight management service statistics	PHOF 2.12	Number	quarterly	High is good (target = at least 150 per quarter)
Reduction in childhood obesity (Reception Year)	The probability of early childhood obesity persisting into teenage years and adulthood is high with significant health consequences. This can be addressed through education of parents and children, as well as encouraging physical activity.	National child measurement programme	PHOF 2.06i PHOF 2.06ii	%	annual	Low is good (target = less than 9%)

Priority 2: Mental Health support and services for children and young people

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Number of young people in treatment within CAMHS secondary care services	Children & Adolescent Mental Health Services at a secondary care level offer specialist mental health treatment to children and young people. They are crucial not only for the well-being of young people themselves but also for the educational attainment and family well-being.	BHFT CAMHS Service Data	Local Priority	Number of young people	Quarterly	None (will fluctuate with demand)
Expressed satisfaction with CAMHS from 1) young people, 2) parents/carers, 3) professionals	Service satisfaction is an important indicator of the quality of CAMHS Services.	BHFT CAMHS Service Data	Local Priority	Satisfaction Ratings	Annual	High is good
Time from original referral to CAMHS assessment	Young People who have sought treatment but are left waiting are vulnerable to deterioration in their mental health. It is crucial that young people are offered support in a timely way.	BHFT CAMHS Service Data	Local Priority	Number of working days	Quarterly	Low is good

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Time from assessment to start of CAMHS support or treatment, 1) within 12 weeks, 2) within 26 weeks 3) exceeding 26 weeks	Young People who have sought treatment but are left waiting are vulnerable to deterioration in their mental health. Extended waiting times beyond 12 weeks must be avoided as they leave young people particularly vulnerable to deteriorations in their mental health.	BHFT CAMHS Service Data	Local Priority	Number of working days	Quarterly	Low is good
Number of young people taking up the Public Health online mental health support (at least 115 per quarter)	Mental health support in childhood and teenage years can prevent mental illness from developing and mitigate its longer-term effects. Evidence from the literature and a review of online outcomes and alliances within text-based therapy suggests online counselling is an effective alternative to face to face counselling which is also very acceptable to young people themselves.	Local Service performance statistics	Local Priority	Number of Young People Using Service	quarterly	High is good (target = at least 115 people per quarter)
Waiting times for Public Health online mental health support (at least 95% within 24 hours)	Given the challenges in providing timely mental health support to young people in secondary care CAMHS services, it is important that an early intervention service is available, with minimal waiting times, so as to prevent deterioration and facilitate early improvement where possible.	Local service performance statistics	Local Priority	Working Days	quarterly	Low is good (target = 95% within one day)

Priority 3: Preventing people becoming socially isolated and lonely

Work is underway to develop local indicators following the Health and Wellbeing Board workshop on 27th January

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
The percentage of adult social care users who have as much social contact as they would like	There is clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care it to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. These measures will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and cares.	Social Care Survey - England	PHOF 1.18i ASCOF 1i	%	Annual	High is good
The percentage of adult carers who have as much social contact as they would like		Personal Social Services Survey of Adult Carers in England (HSCIC)	PHOF 1.18ii	%	Annual	High is good
Number of people receiving support from the local Befriending Service	Befriending is an evidence based strategy for reducing social isolation among those in most need. Befriending uses volunteers that also benefit from participation in the programme.	Local Service Data Reports	Local Priority	Number of people actively using service.	Quarterly	High is good (target = at least 75 people using service at any time)
Number of people volunteering	Evidence indicates that volunteering improves physical and mental health its positive effects on physical activity and social contact,	Data from national and local programmes	Local Priority	Number of people volunteering	Annual	High is good

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
TBC						
TBC						

Priority 4: Workforce - having enough people with the right skills, and suitable premises from which to deliver services

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
The number of Full Time Equivalent (FTE) GPs per 1,000 patients in a Practice	Measures the number of Full Time Equivalent (FTE) GPs per 1,000 patients in this Practice (FTE is based on the proportion of time staff work in a role). This information allows comparison of General Practice workforce in relation to comparable areas.	HSCIC General Practice Workforce Census		Number per 1,000 patients in a practice area	Annual	Within range compared to Similar Sized Practices (registered patients +/- 10%)
Number of Patients per GP Headcount (excl. registrars and retainers) per practice	Measure of capacity, sustainability and resilience in the primary care system and provides a comparison with other areas of similar size to give a potential range.	HSCIC General Practice Workforce Census		Number of patients per GP per practice	Annual	Within range compared to Similar Sized Practices (registered patients +/- 10%)
Number of Patients per Nurses Headcount (excl. registrars and retainers) per practice	Measure of capacity, sustainability and resilience in the primary care system and provides a comparison with other areas of similar size to give a potential range.	HSCIC General Practice Workforce Census		Number of patients per Nurse per practice	Annual	Within range compared to Similar Sized Practices (registered patients +/- 10%)

Description	Rationale	Data Source	Indicator reference	Unit of measure	Frequency	Polarity / Target
Number of Patients per Direct Patient Care Headcount per practice	Measure of capacity, sustainability and resilience in the primary care system and provides a comparison with other areas of similar size to give a potential range.	HSCIC General Practice Workforce Census		Number of patients per Direct Patient Headcount	Annual	Within range compared to Similar Sized Practices (registered patients +/- 10%)
Number of community support hours to place	Measure of capacity, sustainability and resilience in the domiciliary care market	ASCHH	Local measure	Hours per week/total hours per month / length of delay / number of people waiting	quarterly	Low is good
Number of people waiting for residential or nursing home room	Measure of capacity, sustainability and resilience in the care home market	ASCHH and CCG	Local Measure	Number of people waiting / length of wait	quarterly	Low is good
Number of agency or bank staff used per foundation trust	CQC Regulation 18 indicator of capacity stressor in social care provision	CCG contract monitoring		Number per month	Annual	Low is good
Number of posts unfilled by grade / level – NHS Trusts	CQC Regulation 18 indicator of capacity stressor in social care provision	CCG contract monitoring		Number per month	Annual	Low is good

TO: HEALTH AND WELLBEING BOARD
03 MARCH 2016

UPDATE ON THE CCG AND ADULT SOCIAL CARE FUNDED EMOTIONAL HEALTH AND WELLBEING PROJECT
DIRECTOR OF CHILDREN, YOUNG PEOPLE AND LEARNING

1 PURPOSE OF REPORT

1.1 To update the health and Wellbeing Board on the CCG Innovation Fund and Adult Social Care funded schools project.

2 RECOMMENDATION

That the Health and Wellbeing Board (HWBB):

2.1 Notes the project plans and the progress to date.

3 REASONS FOR RECOMMENDATION

3.1 To disseminate the project intentions and progress to a group of key stakeholders to ensure the work aligns with other linked development work being undertaken through the Mental Health Transformation Fund.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 This project makes a contribution to developing Tier 1 and 2 services to contribute to achieving the vision described in the Ascot, Bracknell, Maidenhead, Slough and Windsor Local Transformation Plan for Children & Young People's Mental Health and Wellbeing which aspires to ensure that

- No children and young people will have a preventable mental health issue
- If they do, they will not wait to get the help they need.

5.2 The project particularly contribute to these objectives from the Transformation Plan

- Promoting positive mental health and resilience, and developing resilience for life
- Children and young people providing support and help for each other (peer support)
- Prioritising services to meet the needs of vulnerable groups of children and young people
- To ensure professionals and the community are able to identify when children and young people are distressed and are able to support appropriately
- Everyone who comes into contact with children and young people is appropriately skilled and trained
- Increase awareness and acceptability of mental health
- Equipping professional with tools to manage risk so all feel confident to do their job.

5.3 The funding provides pump-priming to undertake five tasks which include

A/ Develop a cross organisation evidence-based Autistic Spectrum Disorder strategy which identifies a continuum of provision for children and young people in schools

B/ Sponsoring two schools to gain National Autistic Society autism friendly accreditation and become beacon schools in Autistic Spectrum Disorder to provide a community resource for other schools in Bracknell Forest and Ascot CCG area, modelling improved in-school support for children and young people pre and post diagnosis

C/ Auditing the existing panels (Early Intervention Hub, Young People at Risk Panel, Common Point of Entry) and processes through which children and young people with challenging behaviours which may be indicative of mental health difficulties and/or identified mental health difficulties are referred in order to develop greater cohesion and consistency and improving appropriate referral to tier 2 services

D/ Develop a critical mass of trained professionals and local residents to be trainers in Youth Mental Health First Aid and roll out training in the medium to long term

E/ Providing a critical analysis of emotional health and wellbeing case work, evaluating whether earlier identification and access to less specialist support could have prevented the need for this specialist service.

The activities and an update (please also see Appendix A)

5.4 **A focus on autism**

Recent data from CAMHS (autumn 2015) showed of a total waiting list of 499 young people, of which 135 were waiting 12 weeks or more for an ASD diagnosis. Nationally, there is an increase in referrals for a diagnosis of ASD from GP and other services. This links to the increase in public understanding of ASD and parents proactively seeking out diagnosis and resources for ASD. There is evidence that inappropriate referrals to CAMHS have increase waiting times. The LA is developing its ASD provision and has recently opened a specialist centre, Rise@GHC, based in Garth Hill College secondary school. This is in addition to an early years resource, Rainbow, which is based at Great Hollands primary school, the Autism Spectrum and Social Communication (ASSC) Service which provides support for pupils in their school setting, early years and primary phase and a commissioned service from Berkshire Autism Service for parents.

5.5 The CCG agreed that the benefits of developing an evidence based, multi-agency strategy were clear. The process would enable an audit of existing practice across schools, examination of the data, a consideration of the current deployment of resources, planning to strengthen provision by building on existing good practice and identifying if there is a need for new provision by a multi-disciplinary reference group.

This group has now been established and includes representation from headteachers, CAMHS and Berkshire Healthcare Trust. Three consultation events are planned between now and the summer, and a final draft strategy due July 2016.

5.6 This strand of the project will also provide specialist consultancy support to two mainstream schools to work on accreditation by the National Autistic Society as 'autism friendly' and will be used as beacons of good practice locally. A qualitative analysis of the benefits to a small number of pupils pre and post ASD diagnosis of attending an Autism Friendly School will be undertaken.

5.7 This accreditation mark is concerned with organisational development and sustainable change and therefore accreditation takes in the region of one year to obtain. Within the life-time of this project (April 2016) it is proposed to agree the action plan and key priorities and provide initial training for staff and other members of the school community. Following the final report of this project it is proposed to provide half yearly monitoring reports to key stakeholders including the CCG. This work will result in a better understanding of ASD and the principles of supporting a young person with ASD so that even if a diagnosis has not been made school staff and other agencies can confidently to support the child/YP. The participating secondary school is Garth Hill College. As there is an anticipated need to establish a primary provision similar to The Rise@Garth, a robust selection process is underway with primary schools to identify which one will benefit from this sponsorship and has the physical space to develop a resource base in future years. More information about the NAS accreditation is included in Appendix B.

5.8 **Auditing Panel processes**

The LA currently has an Early Intervention Hub and Young People at Risk Panel. These panels are used when there are concerns about a child or young person and provide an opportunity for a multi-agency group to consider the evidence and make recommendations about appropriate placement and /or additional support. Most of the cases considered have a mental health dimension, if not in the child then certainly in the family. In addition, the Fair Access Panel is used when a child or young person is at risk of being excluded from school for poor behaviour and again there is frequently known to be an underlying mental health issue.

5.9 The purpose of auditing of these mechanisms/hubs and panels is to ensure they are complementary and to assess if the client pathway through the processes is easy to navigate. A key question to address is as the Panels have been set up incrementally, do the referral systems work as a cohesive whole system to ensure children and young people can access the support they need.

5.10 **Development of Youth Mental Health First Aid capacity locally to enable the roll out training in the medium to long term**

A need for training across the community to reduce the stigma of mental health**,** upskill adults who come into contact with children and young people is appropriately skilled and trained and equip professional with tools to manage risk so all feel confident to do their job has been identified. This strand of the project will organise the delivery of training in Youth Mental Health First Aid, evidence based training

package which includes components on all the key mental health concerns. This upskilling will be of benefit in the individual's own organisation whilst providing a resource to deliver training locally in the medium to long term. The project will also sponsor three individuals to undertake a 5 day Train the trainer course.

5.11 The three sets of two day courses, each for 16 participants have been booked and these start in March, with the first course already oversubscribed.

5.12 **A critical analysis of case work, evaluating whether or not earlier identification and access to less specialist support could have prevented the need for this specialist service**

The funding has enabled the piloting of a targeted mental health post, a family systemic therapist who has been undertaking case work amongst her duties. This worker is gathering of qualitative evidence, through a critical analysis of case work, evaluating whether or not earlier identification and access to less specialist support could have prevented the need for this specialist service. This analysis will provide an insight the client journey through the various referral processes and an evidence based view on if and how the outcome could have been different and less costly in relation to service provision had identification taken place earlier.

5.13 **Project outputs**

- An ASC strategy for Bracknell Forest and Ascot schools
- Two schools (one primary and one secondary) with an action plan in place to achieve accreditation under the National Autistic Society Autism Friendly programme and a commitment to sharing good practice with other schools
- 50 members of school staff trained in Level 1 ASC awareness
- 48 professionals/active members of the community trained in Mental health First Aid and 3 staff trained as Trainers in the programme
- 15 clients supported by the Systemic Family Therapist
- A report which includes
- An audit of existing panels (Early Intervention Hub, Young People at Risk Panel, Common Point of Entry) and makes recommendations for improvement
- An analysis of cases referred to the Systemic Family Therapist identifying opportunities for earlier intervention
- An overview of project activities.

5.14 In conclusion a range of activity is being undertaken and a detailed report will be available for consideration in August 2016.

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APPENDIX A

WHAT KEY THINGS WOULD THE PROJECT HOPE TO ACHIEVE?

What are the expected benefits of implementing this idea? (e.g. cost savings, reduced activity?) **By April 2016**	**How will this be measured?** (e.g. audit, survey, change in activity levels)	**Who will benefit?** (e.g. patients, commissioners)
AUTISM FRIENDLY SCHOOLS • Two school communities will have made improvements in 'autism friendliness', raised awareness of the implications of autism across the school community and have committed to policy.	• Baseline audit completed in two schools on registration • Improvements in the schools against the baseline audit of existing • Mapping existing provision against the 8 principles of good practice of a whole school approach model to sustainable change (from Promoting children and young people's emotional health and wellbeing: A whole school and college approach, Public Health England and The Children and Young People's health Coalition, 2015). This will identify gaps and advice will be given on development work, progress will be monitored • Project plans for continuation of activity post-project support in place in both schools • Identification of benefits to children and young people pre and post ASD diagnosis identified • Cost benefit analysis of potential savings • Number of staff trained in ASC awareness (60 is the target)	• School leaders and staff in being better able to meet needs • Children and young people attend the schools, this includes those with diagnosed ASD as well as those that do not meet the threshold for diagnosis • Parents and carers through improved support of their children when in school and a higher level of expertise to work with them in providing support at home • Other schools through having modelling of good practice and opportunities for practice-based professional development
ASD STRATEGY Development of an ASC strategy for schools	• Evidence base for the strategy drawn from an audit of existing school practice and data analysis. • The success of the strategy will be measured in relation to how it addresses identified poor practice, gaps and communication • An attached action plan will be monitored and evaluated	• Schools communities • The LA through improved deployment of resources • Children and young people • Families
TRAINING THE TRAINERS A critical mass of professionals and members of the local community with a high level of knowledge and skills in how to promote mental health, forming a supportive peer group, acting as advocates in the local community to challenge stigma and create a positive	• Numbers of people trained (target is 30) • Number of session delivered • Staff and others undergoing training will demonstrate increased levels of knowledge and confidence in delivering YMHFA to others • Increased awareness of the impact of own MH, benefits to self and the setting	• Staff trained • Schools • Community • Children and young people with ASD • Possible reduction in CAMHS referrals

mental health promoting ethos, available to run training locally at minimum cost. Participants will have increased levels of knowledge and confidence in talking to young people about their emotional health and well being and increased awareness of the impact of their own mental health.		
AUDITING AND CASE WORK ANALYSIS • A deeper understanding of the strengths and weaknesses of the existing referral processes and panels • An analysis of the how the different referral systems inter-relate to each other and could be used more effectively to step down cases through referral to Tier 2 services • Evidence based recommendations for improvement • Improvements to the client journey • This work will also inform the development of a blended face-to-face and online counselling model for Bracknell Forest, as included in the CAMHS transformation plan. This model includes a 'system navigation function, early triage and help for EH&WB	• Number of cases supported by the Systemic Family Therapist and outcomes of these cases • Improvements to existing referral processes and systems • Recommendations that can result in an increase in step down of cases/referral to Tier 2 services	• Clients • LA and partners • Possible reduction in number of referrals to CAMHS

Appendix B

Autism friendly accreditation

Achieving Accreditation

The Autism Accreditation programme is a continuing accreditation process. It supports services in the interpretation of the Autism Accreditation standards and advises them on creating quality action groups to assist the process. Services carry out a self-audit process against our standards, using set criteria, until they are ready to undergo a formal review that consists of verification of the audit, observations of practice and discussions with key stakeholders by a team of professional peers.

The review team is unable to consider as evidence towards accreditation, unsolicited information provided by a third party outside of the review process. Autism Accreditation has no jurisdiction over the services that volunteer to be registered, and persons who have concerns about a service may be best advised to follow the complaints procedure of that service provider.

Key principles

The Autism Accreditation aims to set and encourage high standards of provision for autistic adults and children based on a personalised model of support. Whilst methods should be evidence-based and reflect what has been shown to have had positive outcomes for autistic people the research has also shown that there is no ‘one size fits all’ approach and therefore it is essential that approaches are tailored for the individual.

Autistic people are entitled to receive practical support if they require it to help them overcome the challenges they face in a society which very often fails to recognise or accommodate their needs. That support needs to be rooted in an understanding that autism is an integral part of who a person is, not just a disorder to be treated or suppressed so that the autistic person can present as more 'normal'. Rather, support needs to work with a person's autism rather than against it. We need to move away from a culture that assumes that professionals know best but rather values autistic people as the true experts.

Support should build upon the individual's strengths, assets, interests and talents and enhance their self-esteem and sense of self-worth. It is not about doing things for the autistic person but rather providing them with the tools, skills and confidence to enable them to take control over their own lives. This process should start from their earliest years and should be the terms of reference by which the quality and impact of support is measured.

Excellent schools and services for autistic people do not work in isolation but rather seek to share and promote good practice to ensure that the community in which the people they support live and work is more inclusive.

Criteria

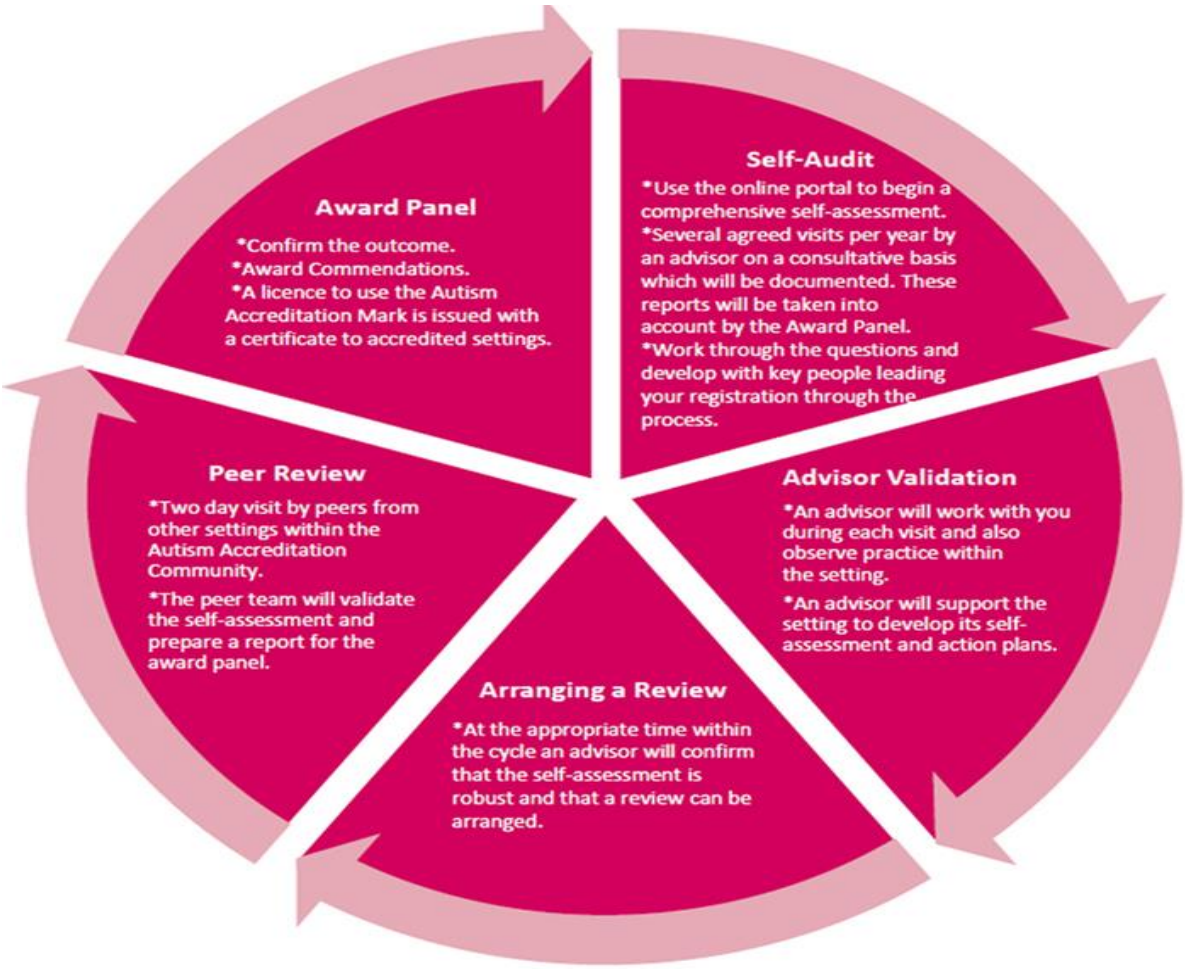
A service that meets the Autism Accreditation Standards should be able to demonstrate that:

- It is committed to providing effective support which is personal-centred and rooted in an appreciation of current knowledge and understanding of autism.
- It seeks to understand each autistic person as an individual whose autism is an integral part of who they are and who have their own unique qualities, abilities, interests, preferences and challenges.
- It enables each autistic person to carry out meaningful tasks and activities by employing a range of autism specific and personalised approaches and methods.

- It demonstrates that autistic people are supported to achieve outcomes that have a positive and significant impact on their lives.

This evidence is evaluated using autism-specific criteria, which are applied to each area of the organisation reviewed.

The accreditation process



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HEALTH & WELLBEING BOARD: FORWARD PLAN

(Scheduling of agenda items are subject to change)

June 2016

Joint Protocol for Partnership Boards - LSCB Jonathan Picken

December 2016

Thames Valley Police Mental Health Street Triage Pilot Update – Gavin Wong/Dave Gilbert

March 2017

Year of Self Care Feedback – Lisa McNally

Standing Agenda Items

Health and Wellbeing Strategy Performance Monitoring – Zoe Johnstone
Child and Adolescent Mental Health Service (CAMHS) Transformation Tracking - CCG

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