Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Bracknell Forest Council**
Clinical Commissioning Groups	**Bracknell and Ascot CCG**
Boundary Differences	**3 Ascot practices are within the boundaries of Royal Borough of Windsor and Maidenhead and these are reflected in the plans for RBWM HWBB**
Date agreed at Health and Well-Being Board:	**12/02/2014**
Date submitted:	**15/02/2014**
Minimum required value of ITF pooled budget: 2014/15	**£1.658m**
2015/16	**£6.665m**
Total agreed value of pooled budget: 2014/15	**£3.008m**
2015/16	**£6.665m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr William Tong
Position	Clinical Chair - Bracknell and Ascot CCG
Date	11/02/2014

Signed on behalf of the Council	
By	Glyn Jones
Position	Director of Adult Social Care, Health and Housing
Date	12/02/2014

Signed on behalf of the Health and Wellbeing Board	Bracknell Forest
By Chair of Health and Wellbeing Board	Cllr Dale Birch
Date	12/02/2014

c) Service provider engagement

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

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

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

Significant engagement events have included:

- Whole system workshop for the Frimley system including all commissioners and providers (acute, community, social care and voluntary sector), and HealthWatch representation
- Bracknell Forest Health and Wellbeing Board workshop attended by acute and community providers and other stakeholders
- GP Council event to engage member support and to foster changes in Primary Care
- Frimley system collaborative commissioning forum – agenda item attended by Frimley Park Hospital to discuss implications
- Joint Strategic Event – Frimley Park Hospital and CCG Managers and Clinicians to further develop the vision
- Integrated Care Teams project board with community health and social care providers – workshop discussion

Through the above forums, and building on the Joint Strategic Needs Assessment (JSNA) and Joint Health and Well Being Strategy (JHWS), local priorities and options for

further development have been identified, building on the current successful approaches. Relevant providers will be engaged in the indentified workstreams to develop the detailed plans for delivering the required outcomes.

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

- Presentations have been made at public Health and Wellbeing Board (HWB) meetings and CCG Governing Body meetings
- Discussions at Intermediate Care Partnership Board meetings, where people and carer representatives are members
- Plans for service priorities have been the subject of public engagement and consultation, examples include the Health and Well Being Strategy, joint commissioning strategy for people with dementia and the carers strategy
- The priorities for the Better Care Fund in Bracknell Forest are firmly rooted in the J JHWS which in turn is based on the JSNA and the outcomes of public consultations underpinning the full range of Joint Commissioning Strategies. The JHWS is currently the subject of a public consultation exercise to elicit local people's views on the priorities identified
- It is proposed to establish a BCF Board which will include HealthWatch

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

Document or information title	**Synopsis and links**
JSNA	http://www.bracknell-forest.gov.uk/jsna-executive-summary-2011-12.pdf
JHWS	The purpose of the strategy is to identify common goals across health and social care services and how local services might work together more closely to improve the health and wellbeing of local people. http://www.bracknell-forest.gov.uk/BF-JHWS-v10-1.pdf
Joint Commissioning Strategies • Mental Health • Dementia • Autistic Spectrum Disorders	The Joint Commissioning Strategies respond to national agenda and local priorities, as identified through JSNA, consultation and other information sources. They set out commissioning priorities for a five year period. http://www.bracknell-forest.gov.uk/Healthy-Minds-strategy.pdf http://www.bracknell-forest.gov.uk/commissioning-strategy-for-people-with-dementia-2009-to-2014.pdf http://www.bracknell-forest.gov.uk/autism-joint-commissioning-strategy.pdf

Document or information title	Synopsis and links
• Learning Disabilities • Sensory Needs • Older People • Long Term Conditions • Carers • Advocacy	http://www.bracknell-forest.gov.uk/learning-disability-commissioning-strategy-2008-to-2013.pdf http://www.bracknell-forest.gov.uk/commissioning-strategy-for-sensory-impairment-large-print-version.pdf http://www.bracknell-forest.gov.uk/Bracknell_Forest_Older_People_Strategy.pdf http://www.bracknell-forest.gov.uk/long-term-conditions-commissioning-strategy.pdf http://boris.bracknell-forest.gov.uk/sc_strat_caring_about_carers.pdf http://www.bracknell-forest.gov.uk/advocacy-commissioning-strategy.pdf
Schedule 2 to the S75 Agreement	Detailing the specification for Intermediate Care including Enhanced Intermediate Care (24/7) Document not available on the public website, however, can be made available if required.
Information sharing protocols	The Information Sharing Policy explains the circumstances under which relevant organistations may share personal information with other organisations. It also provides a mechanism for, and explanation of, ad-hoc information sharing requests. It establishes the principles, purposes and processes, for information sharing. Document not available on the public website, however, can be made available if required.
Integrated care teams • Community Team for People with a Learning Disability • Community Mental Health Team • Community Mental Health Team for Older Adults • Community Response and Reablement •	Operational policies and specifications http://www.bracknell-forest.gov.uk/healthandsocialcare
CCG 2 Year operational plan	Add link

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

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

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

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

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

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

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

the community.
g. Full consideration of both mental and physical needs.

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

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

In Bracknell Forest residents will be able to say

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

b) Aims and objectives

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

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

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

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

This will mean that

- The same total funding is spent differently to meet growing demand
- For practices – help GPs move from referring in to joining in. Mobilising clinical leadership for integration
- For social care –working with a range of organisations within and outside of Bracknell Forest boundaries
- For acute trusts – reaching out to support different pathways, which will lead to a permanent reduction in acute capacity, but at a sustainable pace

- For community trusts – putting neighbourhood needs first
- For all - breaking down of traditional organisational boundaries
- For people – seamless services which keep them well in their own home with less reliance on acute hospital or long term care home admissions.

In the 4 Key Areas of Strategy

1. <u>Protecting Social Care Services</u>

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

2. <u>Seven-Day Services</u>

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

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

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

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

3. <u>Data Sharing</u>

This is seen as a key enabler.

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

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

4. Joint Assessment and Accountable Lead Professional

People with Mental Health needs, Learning Disabilities or with a need for reablement are currently supported through multi-disciplinary teams, with a lead coordinator for each person. This enables the development of person centred holistic care and support plans. Integrated Care Teams (ICTs) have been set up to support people with complex support needs arising from long term conditions, and who are therefore at high risk of non-elective hospital admissions.

At the end of 5 years the ICTs will have expanded to support all people who would benefit from them, and the approach within the Learning Disability and Mental Health teams will be maintained for all. The specification will be designed to underpin the procurement of the support services required to keep people well, and out of hospital.

In addition to the national measures we will monitor

- the achievement of outcomes for individuals, as identified in their person-centred plan and the impact on non-elective admissions
- People and carer satisfaction with community based services
- Reduction in falls and falls-related admissions
- Improvement in number of people feeling supported to manage their own condition
- Reduction in non-elective admissions, A&E attendances, and other resources by those with a multi-disciplinary care plan
- Numbers of people supported to die at home where this is their place of choice

c) Description of planned changes

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

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

Bracknell Forest is building on strong foundations of integrated and jointly commissioned services, but there is no complacency regarding the challenges ahead.

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

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

- Further development of 7 day working, building on the existing 2 hour response by enhanced intermediate care, and the 24/7 capability of 'Forest care', and the range of crisis responses as identified in 2a above. This will include more robust hospital in-reach, robust pathways with NHS 111 and the new Bracknell Urgent Care Centre, and enhanced domiciliary responses, including use of the voluntary sector.
- Development of capacity and capability in the local care market, particularly domiciliary response, to reduce the need for hospital admissions and improve quality and equity of response

- Commissioning an integrated local falls prevention service which is accessible and tailored to local need, building on a pilot currently in place
- Understanding and acting to reduce the variation between GP practices in non-elective admissions

d) Implications for the acute sector

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

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

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

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

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

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

e) Governance

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

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

initially comprise of:

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

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

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

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

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

3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk	Risk rating	Mitigating Actions
Recruitment and retention of key skilled community staff	3/5	• Review of the reablement service to inform joint workforce strategy. • Flexible employment options to enable retention of Conditions of Service
Market capacity for good quality domiciliary care	2/5	• Increased capacity identified as a priority workstream within this programme of work. • Robust Quality Assurance Framework • Market Position Statement has been developed to inform and encourage prospective providers
Ability of acute hospitals to respond to support community based models of care	4/5	• Establishing a Health and Social Care Leaders Group to ensure alignment of strategic vision • Early development of joint care pathways supported by publicised commissioning intentions to lever change
Secondary Care activity does not reduce, thus	3/5	• Integrated services at the scale and scope necessary, as indicated by the

limiting the funds available to fund transformation		risk stratified opportunity analysis • Analysis of NEL data used to identify priority areas for community based interventions.