NHS South of England

BCF Plan 2016/17 - Cover Sheet

Health & Wellbeing Board Name	Slough
Date of submission	Tuesday 3 May 2016
Has the plan been signed by CCG(s)?	Yes the plan has been circulated and discussed between Slough Borough Council and Slough CCG as well as partners in the Joint Commissioning Board. This plan has now been agreed for submission.
Date the plan was Signed off by HWB	Slough Wellbeing Board discussed the plan on Wed 23 March 2016 together with the Q3 update. The SWB agreed a delegated decision over the sign off of the final version on 3 May to the voting members of the JCB. The SWB will also review and discuss the plan at the meeting on 11 May 2016.
Are the minutes of the HWB at which the plan was agreed attached to this submission?	Minutes of the Slough Wellbeing Board meeting can be found here. Final plan not available at the time papers dispatched for a decision in advance of the final deadline of 3 May. Delegated authority given to Joint Commissioning Board to sign off the plan and SWB will receive on 11 May.

Section 1 – Confirmation of funding contributions

Requirement	Response
Describe how your BCF Plan meets the minimum contributions for: • CCG minimum contributions • DFG • Care Act monies • Formers 'Carers Breaks' funding • Re-ablement funding	The Slough BCF programme for 2016/17 builds and develops that written, submitted and assured through the 2015/16 planning process. The financial plan includes the CCG minimum contribution of £8.259m together with the full Disabled Facilities Grant allocation of £775k (see Tab 4 of submission template) giving a total of £9,034,554 into the Pooled Budget for this year.
Is any additional funding from the LA or CCG(s) included?	No
Please confirm if this narrative plan, and the planning return template, has been signed by all parties and include the name, role, organisation and contact details of the authorising officer(s)	The narrative has been shared and discussed at the Slough Wellbeing Board meeting on 23 March 2016 and the outline agreed. It was noted that some of the detail and content will be subject to change between that point and the final submission on 3 May 2016.The Health and Wellbeing Board agreed to delegate approval of the final version to the Joint Commissioning Board which met and discussed the plan on 25 April 2016. All voting members of the JCB were present. These are: Alan Sinclair – Interim Director of Adult Social Services, Slough Borough Council Sangeeta Saran – Head of Operations, Slough CCG George Grant – Departmental Finance Officer, Slough Borough Council Nigel Foster – Chief Finance Officer, East of Berks CCGs
Your plan should provide a full overview of the funding contributions for 16/17 and set out any changes from 15/16. Please summarise here any changes from 15/16 and how these	The overview of the funding contributions and changes since 2015/16 are included in the planning template. Overall the expenditure plan has not changed significantly from that of 2015/16. Where they have been changes within year these have been agreed through the

Requirement	Response
have been agreed.	Joint Commissioning Board and a contract variation signed to the s75 Pooled Budget agreement. Towards the end of 2015 the BCF Delivery Group used the BCF self-assessment tool to help reflect on 2015/16 and help plan towards 2016/17. We also looked at return on investment in terms of impact on reducing non-elective activity where this was possible and whether the schemes aligned with New Vision of Care. Through this process the group identified: i) areas of activity that are performing well and how we want to build and develop these ii) projects that have been slower to get off the ground and what might help in terms of resource and/or linking and scheduling with other planned project activity and iii) areas which aren't performing so well and taking steps to further review, evaluate or redesign Together with the commissioning support unit we were able to do some detailed analysis of several of our BCF schemes and projects which tracked specific cohorts of people and their A&E attendances, outpatient's appointments and admissions. There was positive impact demonstrated in relation to: Children's Community Respiratory service, Telehealth, Care Homes, Complex Case Management and Intensive Community Team. Following feedback on the first submission of the narrative plan Slough is now adopting a revised position and is not planning any additional reductions through the BCF this year. Our ambitions for reducing NEA are now encompassed within our Operational Plan for 2016/17. We have outlined our planned gains through our QIPP programme with BCF providing the investment from which to achieve those gains. Our Operational Plan is proposing to achieve delivery of 2% increase in NEL in 2016/17 against IHAM. There will be a risk share agreement in place against this 2% of activity. Based on last year's forecast outturn this will be £542k. Details of how the risk share arrangement will operate in 2016/17 will be included in the s75 pooled budget agreement but will include a performance related element so that if improved performance is attained in 2016/17

Requirement	Response
	(under 2%) additional funding will be released in to pooled fund. There is new funding in 2016/17 for delivery of our Out of Hospital Transformation project (which will also form part of our plan for reducing DToCs), an integrated cardio prevention project and investment towards integration within local community wellbeing hubs. There is then also additional funding going into Telehealth, Care Homes, Equipment and to maintaining social care.
Please summarise the impact assessment of any changes you have made	There are no significant changes to the Slough BCF plan for 2016/17. Broadly our programme will continue in the work stream areas outlined in the original submission. Projects within the programme started at different stages and are being monitored and reported on monthly though the PMO software (Verto) to track progress. New areas of focus for our BCF integration programme in this year are the Single Point of Access (termed as an 'Integrated Health and Social Care Hub') and the Integrated Care Services (our 'Out of Hospital' transformation programme) both of which have been planned developments in our ambitions for integration locally but have been delayed mostly due to the size and complexity of these projects and capacity to take these forward in year one. In drawing up our draft expenditure plan for 2016/17 has been some additional investment into the protection of adult social care in order to meet requirements (maintaining provision of services and ensuring that local social and health care systems as a whole is not destabilised). All new projects and schemes within BCF go through Equality Impact Assessment process as part of the development of full business cases.

Section 2 – Narrative overview

Please describe the local vision for health and social care services, including changes to patient and service user experience and outcomes.	The vision for the Slough BCF still the same as that described in the 2015/16 submission. Slough Better Care Fund plan The overarching vision is that: *"Slough health and social care services will join together to provide consistent, high quality personalised support for me and the people who support me when I'm ill, keeping me well and acting early to enable me to stay happy and healthy at home."* Our vision seeks to preserve the values that underpin a universal health service, free at the point of use, alongside a social care system which continues to be subject to financial assessments and contribution. However we envisage fundamental changes to how we deliver and use health and care services. Through working together, we will enable people living in Slough to live longer, be healthier, and have a better quality of life, especially in the communities with the poorest health. We will join our systems and processes together to ensure that we effectively and proactively identify and support residents at an early stage and provide support to those who need it the most. We will simplify and offer to all our residents' ready access to a comprehensive range of generic and specialist services to support their needs. Our vision will see us increasingly delivering services through integrated care teams including locality based teams clustered around GP practices and we already have shared plans for two sites where this will happen as part of new building development. We will also bring together a wider range of health and social intermediate care and reablement services. In the medium term we are also making strong progress towards strengthening community resilience so as to enable our residents and diverse communities to start well, live well, and age well in their homes, schools and communities. The delivery of the BCF programme is aimed at delivering the following outcomes: • Reduce avoidable emergency admissions to hospital *(this is monitored overall but also within specific projects by tracking at individual level via NHS no. to ascertain impact of intervention. The target is to manage and hold growth to 2% increase).*

	• Improve patient and user experience of health and social care services *(this is monitored overall via GP and service user (ASCOF) survey but also within projects e.g. telehealth)* • Encourage independence and self- reliance by building community capacity *(forms part of our proactive care and strengthening community capacity worksteams and impact measured through complex case management impact and activity and our community navigator project. Our revised local indicator will also measure and report on people's confidence in managing their own health)* • Reduce the proportion of patients falling into crisis and needing admission to hospital or a care home *(this is monitored through our complex case management project but will also form part of our Out of Hospital Tranformation programme).* • Increase the proportion of patients who feel supported to manage their long term conditions *(this is measured though the GP survey and reported through public health locality profile. We will also be measuring and reporting on patients confidence to manage their own health).* • Improve mortality and morbidity statistics for CVD, respiratory, stroke and heart failure *(this is monitored through service and project reporting activity)* • Reduce permanent admission to nursing and residential care for over 65s *(target set within BCF metrics and monitored on BCF dashboard and through ASCOF reporting to Slough DMT).* • Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement *(as above)* • Reduce delayed transfers of care *(as above)* • Reduce avoidable hospital admissions for children and adults (*NEA of children monitored*

	and reported in BCF dashboard) • Increase number of people with a health and social care personal budget *(no targets set for people with health personal budgets social care PB target set and monitored through SBC ASCOF)* • Increase number of people (aged 65+) offered reablement following discharge from hospital *(no targets set but measured and monitored through the RRR service reporting).* • Ensure all patients have a choice of place of death *(performance being baselined and improvements driven through the East Berkshire End of Life strategy).* • Provide more support within the community for self-care and prevention initiatives for children and young people *(this has started with asthma management with additional investment identified to extend in year two)* • Increase access to self-care for people with mental and physical health problems *(through the 'Talk before you Walk' CCG campaign, the joint Information and Advice Strategy in development and the Community Navigators in the newly commissioned SPACE consortium)* • Safeguard and support vulnerable adults and children in our communities *(Monitored and reported through the respective Children and Adults Safeguarding Boards)* **What difference will it make to patients and service users?** If we are successful in our delivery we will hear the following positive messages from those people who use our services: "We have access to a range of support that helps us to choose to live the life we want" "We are supported to achieve our goals and take control of our care and support needs" "If we have questions about our care we know who to contact" "We have information and support to remain as independent as possible" "We take responsibility for our health and our care"

	"We have support for any carer(s) involved in our care" "We are involved in discussions and decisions about our care and treatment" "We have someone we trust so that we can get help at an early stage to avoid crisis" Our workstreams for the BCF remain the same for 2016/17. These are • Proactive Care • Single Point of Access ('integrated point of referral' for short term services) • Integrated Care Services (our 'Out of Hospital' Transformation programme) • Strengthening Community Capacity As we take forward our programme for this next year it is also increasingly important that we ensure that BCF aligns with the New Vision of Care programme which has been working to develop the design model for the care of people across our area. This programme has brought together a wide range of people from different organisations involved in care of people with complex needs along with public, patients and carers. The New Vision of Care hypothesis is attached here together with a presentation made to an Integration workshop hosted in Slough in Feb 2016. Appendix 1. Model of New Vision of Care East Berkshire Hypothesis Appendix 2. New Vision of Care and BCF presentation The programme of change within the BCF is also closely aligned together with the changes taking place within the social care reform programme in the local authority. In our approach to working both with communities (through our new voluntary sector contract) and with individuals are moving away from a model of assessment of need towards an asset based approach. This is a 'three tier' approach which can be described by: i) an 'early help' function whereby people are provided with personalised information and advice with call-backs ii) tailored short term support at times of crisis when people need additional care and help, and iii) long term care where required (but incorporating I&A and short-term too). This 3 tier approach also complements and mirrors the approach of the CCG to patients access to GP and primary care where firstly they have access to good information and advice

	('Walk before you Talk'), then for those people who need it they have access to same day appointments and at the third tier there is complex case management whereby people have proactive support with their long term conditions to help stabilise and gain confidence in managing their own care. The CCG and Council together will build on the strengths of the Community Hubs in Slough and work has already started for the adult social care teams in the neighbourhoods that we serve in order to strengthen the relationships that we have with people, communities, the voluntary sector and partners. By creating a circle of support for people in the heart of our communities the Council and partners will be able to better support the citizens of Slough so that they can to have an independent life for as long as possible. This vision for the community hubs will see local centres becoming a collaborative work place for community facing professionals and communities, so that our staff can apply the "3 tier asset based conversations" in a diverse multidisciplinary environment and maximise earlier preventative, outreach and close signposting solutions for the citizens of Slough. The programme is in three phases and is actively pursuing opportunities to build a whole community based model together with CCG where we have joint working space, practices and multi-disciplinary working with General Practitioners and Community Health colleagues. We are also looking to develop integrated care within neighbourhood sites, or 'clusters', at a very local level. We know that our community centres provide a focal point and facilities to foster greater level of local communal activity and bring residents, the local business, neighbourhoods, and smaller organisations together to improve the quality of life in their areas. Slough Borough Council has started on development of both i) an Information and Advice strategy and ii) a Prevention strategy with workshops already held together in partnership with CCG, public health, community and voluntary sector and other stakeholders. There has been a pilot patient navigator project run over the past 12 months with three local voluntary sector organisations each working with a different GP practice. The learning from these pilots is now been evaluated and taken forward with a transition to a community navigator function across the borough being co-ordinated through SPACE in voluntary sector consortium. This has now started and several of the volunteers participating in the pilot are

	continuing to develop their role and a first training session being run on 22 April and being ready to commence by 1 May 2016. Links to the existing pilot practices will continue but will develop a more targeted support though a social prescription scheme where GPs will complete and make a referral. This will then be rolled out to all 16 GP practices as volunteers are recruited and trained, as well as to other community based points of access.
Supporting documents which contribute to the local vision for health and social care services	Slough Joint Strategic Needs Assessment is used to assess the current and future healthcare and wellbeing of residents of Slough. The JSNA informs the development of the Joint Wellbeing Strategy. Slough Joint Wellbeing Strategy (2013-16) has following priorities identified: • Health • Economy and Skills • Housing • Regeneration and Environment • Safer Communities Our ambition for health is that by 2028 Slough will be healthier with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives. **Slough Clinical Commissioning Group locality profile (2015)** Provides a detailed profile and analysis of Slough's population including demographics, lifestyle and health behaviours, children and adults health profiles, and an analysis of the GP survey results. Appendix 3. Slough CCG Locality Profile 2015 **CCG operating plan 2016/17** Appendix 4. CCG Operating Plan Slough Borough Council – 5 year plan The plan is a key driver outlining the priority outcomes for the Council by 2020 which

	includes: • More people will take responsibility and manage their own health, care and support needs. • Children and young people in Slough will be healthy, resilient and have positive life chances. **Joint Carers Strategy 2016-2021** This strategy outlines Slough vision and commissioning intentions in relation to carers, updating to meet requirements within the Care Act and aligning local priorities with the four national priorities for carers: • Identification and recognition • Realising and releasing potential • A life outside of caring • Supporting carers to stay healthy Appendix 4. Slough Carers Strategy 2016-2021 **Promoting and supporting the wellbeing of residents with the voluntary sector** This strategy outlines the partnership approach between Slough Borough Council and the CCG to working with the voluntary sector. This is an outcomes approach to commissioning which aligns activity in the sector with the shared ambitions and improve outcomes being sought for Slough residents. The re-commissioning of the voluntary sector was a large commissioning project within 2015-16 resulting in the award of a contract to the new 'SPACE' consortium (Slough Prevention Alliance Community Engagement) which started in January 2016. **New Vision of Care** During 2015/16 the East Berks CCGs together with Chiltern CCG have been working with Frimley Health FT, Berkshire Healthcare FT, Local Authorities, voluntary Sector and the public to develop a new and transformed model of care to commission health and social care services for people with complex needs. Though the project partners have developed a new and transformational vision of care to help avoid unnecessary admissions to hospitals and care homes and the loss of independence. This will be for adults but the vast majority of intensive uses will be people with more complex conditions. Key project areas for delivery

	are: • Workforce Development • Communication and engagement • Collaborative leadership • Aligning incentives • Share Your Care • System governance
Describe how the BCF contributes to the local implementation of the vision of the FYFV and the move towards fully integrated health and social care by 2020; and the aspects of the change the local area is intending to deliver using the BCF.	The East Berkshire Clinical Commissioning Groups draft Operating Plan for 2016/17 sets out the responses to the nine 'must do's' for our system as laid out in "NHS "Delivering the Forward View" (see appendix 4)Strategically the BCF programme contributes to delivery of strategic themes of: - Self management and prevention - Primary Care - Person centred co-ordinated care - Urgent Care Discussions are at an early stage around our plans for integration for 2020. A workshop was held in February bringing together representatives from across the East of Berkshire. The session was very positive and generated a lot of discussion around elements of integration but generally there was a recognition of our shared the same goals and outcomes for our communities and a commitment from those present to doing this together. A brief summary report for the Systems Leaders Group is attached in appendix 6. Appendix 6. Integration workshop Feb16 – SLG briefing
Please list the issues that the BCF will be used to address in the local area	The case for change in the 2015/16 submission continues but an updated picture which includes the following: • An aging population, with more people needing more care. Over the next 5 years the number of people aged 85 and over is expected to increase by 27.3%;

	• Higher levels of long term conditions particularly circulatory diseases, respiratory disease and tuberculosis (incidence of cancer lower than national and SE average). • Increasing rates of diabetes, dementia, strokes, and mental health problems. • An inadequate primary care base - amongst the lowest number of GPs in England • Ongoing and increasing demand on A&E attendances and on acute hospital beds to deal with urgent care admissions, exacerbated in winter • A rising birth rate - the highest crude birth rate in England, placing increasing demand upon services • An overreliance on acute admissions for children- some 20% of all non elective admissions- for Slough this equating to a £3.12m spend in acute hospital care • Rising citizen expectations around the quality and location of care • Financial constraints as health and social care see significant decreases in their budgets • Saving requirements for adult social care of approximately 5% per annum over the next three years, which has led to fundamental review of the social care offer
Explain how the BCF will address quality and reduce costs based on segmented risk stratification. (Reference local issues and how integration will be used to drive improvement). If relevant please provide supplementary data to support the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery.	Proactive Care is one of the four workstreams within our BCF programme through which we are taking a systematic identification approach to identifying patients who are at risk and making targeted interventions. Within our Complex Case Management project we are using a risk stratification tool (ACG) to identify those patients who require more intensive support and targeting intervention through period of regular appointments with GPs (integrating the running of the complex case finding process together with the targeted use of extended access within the Prime Ministers Challenge programme). We are now monitoring activity of this cohort of patients month to month and although at early stages there are signs of significant reduction on admissions and A&E attendances though this approach. There are currently 568 patients proactively case managed through this project who see their GP once every 3 weeks for a 20 minute appointment. Within this cohort there has to date been a 28% reduction in both non-elective admissions and A&E attendances as well as 37% reduction in outpatients first appointments. We will be commissioning a new integrated cardiac prevention programme in 2016/17 which will also be using proactive case finding methodology of people at risk and who will benefit

	from a range of early interventions to improve cardiovascular health. In response to the high number of non-elective admissions of Children for asthma and respiratory difficulties in October 2015 we started running a community respiratory service in Slough which is led by the acute hospital. There are two nurses who follow up in the community those who have attended or been admitted to hospital for additional education, training and support to the children and their families. They also work together with practices to provide support to GPs and practice nurses with guidance and support about managing respiratory conditions. In the last quarter there have been 50 home visits and 3 nurse led clinics and 14 GP clinics. We are looking to extend our complex case management approach in primary care further to identify children and young people (under 18s) who would benefit in a similar way. We will also link the process to identify those people suitable for support through the PCICT (Primary Care Intensive Community Treatment service) and our Telehealth scheme. Risk Stratification is also in use for the Directed Enhanced Service (DES) for identifying the top 2% of the population most at risk of admission / re-admission to hospital, with multiple co-morbidities. Further opportunities for risk stratification being explored are around identification of people towards the End of Life Care to identify earlier and support advanced care planning so that people can be given appropriate health and social care support, services and intervention in their own home and a choice in their place of death. In support of the above we have developed an End of Life Care Strategy led by our East Berkshire End of Life commissioners steering group and in conjunction with the EOLC providers steering group, which outlines the 'ideal' end of life care service model improving outcomes for people towards the end of life, including people's experience and quality of care through greater service coordination and increased out of hours provision and as a result a reduction in unplanned admissions. The ambitions for palliative and End of Life care follow those of the national framework for local action 2015 -2020, published September 2015. This East Berks Commissioners group is also working with Social Finance to test the practical

	feasibility of making improvements to the EOLC model: · Understand our local population need and current service provision · delivery the key principles on improvements to the end of life care service model, in particular through preventative and community based services · Test and develop the operating and financial model assumptions to build on both the investment case for the EOLC Incubator and the business case for the CCG Appendix 7. Social Finance – EoL incubator model presentation

Please provide a description of the specifics of the overarching governance and accountability structures in place locally to support integrated care, including:
 	
• A description of the specifics of the management and oversight in place to support the delivery of the BCF plan?
 	
• An articulation of the arrangements in place to support joint working?
 	
• Key milestones associated with the delivery of the plan of action in 2016-17?
 	
• A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally including:
  • A quantified pooled funding amount that is 'at risk'
  • Demonstration that this has been calculated
	The BCF Programme for Slough has strong governance arrangements in place which have worked effectively in the first year of running the programme through a pooled budget s75 agreement. The governance arrangements are described in the 2015/16 plan.
	
	The Slough Wellbeing Board is the statutory committee with responsibility for overseeing the BCF programme in Slough. It is the decision making body and receives quarterly updates on progress and developments.
	In support of the SWB there is then a BCF Joint Commissioning Board which provides the strategic direction for the BCF programme and also meeting quarterly Appendix 8. Joint Commissioning Board Terms of Reference
	
	A Better Care Fund Delivery group is then the 'engine room' for driving forward the programme and this group meets approximately twice a month. These meetings alternate between:
	i) Performance, Finance and risk monitoring (with attendance of finance officers)
	ii) Business case development and service review
	Appendix 9. BCF Delivery Group Terms of Reference
	
	There are then various task and finish project groups which meet to take forward discrete project work and scheme development within the BCF programme. As well as feeding into the delivery group for progress and management they report monthly into the PMO function

using clear analytics and modelling • An articulation of any other risks associated with not meeting BCF targets in 2016-17 • An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements	within Slough Borough Council and monthly into the CCGs project management software (for reporting on progress on QIPP and BCF projects to the Senior Leadership Team). There is a risk log kept for the BCF programme overall reviewed by the BCFDG and the Joint Commissioning Board (JCB) Appendix 10. BCF Programme Risk Register – March 2016 There are also monthly reporting and overview of the BCF dashboard to: - Slough CCG QIPP and performance committee - monthly - Slough Operational Leadership team - quarterly (or more frequently as required) - Locality meetings (with representatives from GP practices across the borough) The dashboard for Month 10 of the BCF programme is included in appendix 11. Appendix 11. BCF Performance Dashboard Milestones for delivery of the 2016/17 BCF programme Q1 • Development of full business case and PID for the Integrated Hub (Single Point of Access for professional referrals with agreement to the target operating model for Slough. Project Board established. • Data collation and analysis for the Out of Hospital Transformation programme. Outline business case developed for agreement and sign up of partners • Commence procurement of Care Home enhanced GP support service • Develop specification for integrated cardiac prevention service Q2 • Project implementation of workstream activity to establish Integrated Hub • Development of full business case for the Out of Hospital Transformation programme for agreement of partners. Governance agreed and established. • Procurement process for integrated cardiac prevention services Q3

	• Integrated Hub comes into operation • Out of Hours Transformation programme starts

Section 3 - National Conditions

Plans Jointly Agreed Does the BCF Plan cover a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, and is it signed off by the HWB itself, and by the constituent Councils and CCGs? Explain how, in agreeing the plan, have you engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. Please illustrate: • There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan • This includes an assessment of future capacity and workforce requirements across the system • The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences?	Yes the BCF plan is a jointly agree programme of work supported through a minimum pooled budget as specified. The plan for 2016/17 has not at this time been agreed by the Slough Wellbeing Board although they are regularly appraised of developments and a report was presented at 23 March summarising Q3 progress and outlining the expenditure plan and activity for 2016/17. Appendix 12. Slough Wellbeing Board BCF Report 23 March 2016 Health and social care providers are represented and engaged throughout the BCF programme through the Joint Commissioning Board (see terms of reference for membership) but also many are also involved directly within individual project planning / steering groups. Workforce development has been identified as a key risk to the successful implementation of BCF activity. Gaps in effective ways of working, skills and capacity - in care homes and domiciliary care markets in particular - are a common challenge across the area. Nursing and Occupational therapist capacity is stretched with competition of staff between acute providers and private organisation community services and GP practices. Within our BCF we will be joining with WAM and Bracknell colleagues in order to take a proactive and collaborative approach to addressing these shared workforce issues together with a other key workforce development opportunities. It is agreed that in Q1 2016/17 a task and finish group will jointly identify with WAM and Bracknell BCF colleagues the skills shortages relating to our immediate priorities and current BCF projects. Terms of Reference have been developed and highlight the commitment to an overall timeline for progress as follows:

As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, please confirm that local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.	Q1 - Scoping opportunities and current areas of progress/excellence Q2 - sharing and engagement with other to develop agreed plan Q3/4 - Implementation We will develop a joint draft action plan with key milestones by end June 2016 relating to BCF challenges that we can actively progress within available resources. Sharing of the good practice between areas and organisations that is currently in place will enable some immediate, tactical progress. However, we recognise that this working group will need to extend its engagement, influence and collaboration with the wider CCG and regional and national agencies to align our local need within other collective approach eg: South East ADASS programme, recruitment and retention programme in BHFT, homecare and care home staff including that of registered managers through our Provider engagement forum, developing reablement and intermediate care capacity through our Out of Hospital Transformation programme, the voluntary sector community navigator support developing through our SPACE consortia, and Primary care staff. The New Vision of Care programme may have a valuable role to play in taking this forward, but no assumptions are made presently until our analysis is complete and resourcing a forward plan can be scoped.
Maintaining the Provision of Social Care Please specify the total amount from the Better Care Fund that has been allocated for supporting of adult social care services and confirm: • That at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified • The amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Overall there is around £5.742m of the Better Care Fund going into social care or related activity. This compares to £5.127m of planned spend within the 2015/16 BCF plan. Details are contained in tab4 of the Planning template. Social care covers areas of: - Telehealth - Telecare - Disabled Facilities Grant - RRR services (intermediate care and reablement) - Joint Equipment - Nursing Care placements - Domiciliary Care

Please describe how the local adult social care services will continue to be supported in a manner consistent with 2015-16. Has this support been agreed locally and, as a minimum, does the funding and services maintain in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16? In setting the level of protection for social care in your local area, please describe how you have ensured that any change does not destabilise the local social and health care system as a whole? Please include a comparison to the approach and figures set out in 2015-16 plans and confirm this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14.	- Intensive Community Rehabilitation - Responder Service - Carers - Community Capacity - Additional Social Care Protection Within the expenditure plan there is £296k allocated as the local proportion for implementation of Care Act duties and £210k that is dedicated to carer-specific support. In 2016/17 some of the underspend that has arisen from BCF projects that have either ended or started later than planned has been invested back into social care. £300k was invested into provision of additional equipment across health and social care and approximately £300k additional funding directly into front line services. This is now sustained investment that is being carried forward into our plan for 2016/17 with an additional £260k of funding for equipment across health and social care services, £25k increased investment in Telehealth and additional £117k for additional social care protection.
7-Day Services Please detail your plans to deliver 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care, and how your approach to 7-day services will: • prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week • support the timely discharge of patients, from	**Social Care**: Slough residents already have 7-day access to intermediate care with a 2 hour response time for urgent need, from a multi-disciplinary team 7 days a week between 8am and 10pm. This part of the service is aimed at preventing unnecessary hospital admissions and supporting discharge. There are also social care practitioners based on site at Frimley North hospital site to facilitate discharge. Use of SRG funding has also supported the establishing of working practices for seven day services across the Slough health and social care economy. **Mental Health** Slough has a 24/7 response for Mental Health through Berkshire Healthcare NHS Foundation

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 • is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17	Trust (BHFT) out-of-hours crisis response team to respond to people with mental health needs. The Home Treatment team provides a 24/7 service, preventing inappropriate admission and facilitating discharge for people with non-acute needs arising from Dementia. **Acute** Through our collaborative commissioning arrangements we will be reviewing the 7-day working arrangements in our acute provider and putting in plans to ensure these are comprehensive so that no person is admitted to, or stays in hospital longer than necessary. Schemes to strengthen 7 day working around the acute trust (Frimley Health NHS Foundation Trust) have been piloted using winter pressures (SRG) monies. Following evaluation, successful pilots will be extended further. **Community** Slough offers a walk-in centre open 7 days a week, 8am till 8pm, for all minor injuries and illnesses. This is primary care led, and also provides for integrated pathways into intermediate care, and social care support as well as the existing Primary Care (GMS) and GP Out of Hours service. **Primary Care** Practices in Slough have been operating extended access to GP supported through the Prime Ministers Challenge funding to meet the challenges for patients who find it hard to access primary care during core hours Monday to Friday. This offers appointments into the evening Monday to Friday (6.30pm – 8pm) and offering booked and on-the-day appointments on Saturday and Sunday. It also proactively uses opportunity for regular or extended appointments for those people at risk who have been identified though the complex case management process. Further information on our position on seven day working is appended to the CCG 2 year Operating Plan 2016/17 Appendix 13 – CCG Operating Plan – 7 day services
Data Sharing on the NHS Number	

Please use this section to demonstrate that the right cultures, behaviours and leadership exists locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. In your response please confirm if: • you are using the NHS Number as the consistent identifier for health and care services, and if not, your plan to do so • you are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls • you have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when you plan for it to be in place • you have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review) Please also describe how these changes will impact upon the integration of services.	Currently across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different culture, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time. What the Connected Care solution is offering the is ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways: • No need for multiple laptops to access health and social care data separately • Access to real time data reducing the need for phone calls to various organisations to collate pieces of information • Reduce the amount of time required to contact the relevant organisations in relation to a person. • More accurate data • The ability to streamline the integrated services better by creating true single assessments The ability to streamline the transfer of a person from one service to another by developing health and social care pathways As part of the procurement there were a number of technical requirement s which the preferred bidder has signed up to in relation to Open APIs. The benefit to the use of APIs. The APIs will define what data is shared between the various systems and is what will support the real time access to data. Open APIs will then future proof going forward data exchanges between the multiple systems any changes in technology and legislation. The Connected Care Implementation team consists of an Information Governance Group across Berkshire made up of the Caldicott Guardians, business representatives and technical people to ensure that the appropriate controls are put in place in the new solution. For Slough this includes the Slough BCF Programme Manager, the Transformation Manager (SBC) and the IT Strategy Manager (SBC). The guiding principles and development of the group were defined around the principles developed by Dame Fiona Caldicott, the Information Governance Oversight Panel and Information Governance Alliance. Copies of the ToR and the IG Principles are in appendices 14 and 15 for reference.

	Appendix 14. Connected Care IG Principles Appendix 15. Connected Care IG Steering Group ToR All organisations are obliged to ask for consent to share and disclose information to other organisations and inform the person how and what data they will be sharing with what organisation. The Connected Care projected has an overarching Communication Work stream which is chaired through the NHS and made up of representatives from each of the organisations and members of various patient groups. Depending on the organisation there will be different points of consent models and again part of the IG work stream have developed a consent model which will be adopted by all organisations. Once the Connected Care projected is implemented all organisations who are involved will be updating their websites to direct the person to the guidance around the consent to share model and the opting out process. Attached for reference is the consent model and the communication plan. Appendix 16. Connected Care Communication Plan Appendix 17. Connected Care Consent Model The ways in the which the changes will impact and support integrated services will be as follows: . Streamline and align business processes . Reduce duplication of information and data entry across multiple systems . Allow access to real time data for health and social care practitioners . Reduce the amount of time contacting multiple organisations for the appropriate information or the correct point of contact . The ability to create joint care plans across health and social care by using structured data across multiple systems . The ability to work mobile and more effectively with real time access to data . The roles and responsibilities will define that the appropriate teams will have access to the information they require to enable them to do their job rather than inundate them with lots of information they do not require.

	Currently the NHS number is not used as unique identifier across health and social care services. For Social Care in Slough the NHS numbers are collected for all new entrants to services and we are in the process of updating historical records through our review processes. We will also be implementing a tool to enable us to routinely check and match NHS numbers safely and securely pending completion of the IG toolkit to enable us to move towards getting an N3 connection which is required in order to implement. Currently the implementation is also limited by the support the HSCIC can give to authorities to provide this matching service and we not able to give a firm date by which this will be complete. The timeline for Slough BC being connected to the Connected Care interoperability interface with the NHS number is by March 2017. Appendix 17. Connected Care implementation plan
Joint Approach to Assessment Please identify which proportion of the local population will be receiving case management and named care coordinator and which proportion of the local population will be receiving self-management help - following the principles of person-centred care planning. Please demonstrate if you plan to identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors). Please include a description of plans for health and social care teams to use a joint process to assess risk and plan care, and agreed milestones demonstrating how and when this condition will be fully complied with.	There is active complex case management of that cohort of people who are identified as being at risk of an admission to hospital (through risk analysis and case finding activity). These are currently offered time limited (3 month) regular GP appointments to proactive support in managing their long term complex conditions. The move towards having a named care co-ordinator is captured and described within the New Vision of Care model which each area across the East of Berkshire is signed up to. Within our planned approach to integrating short term services ('Out of Hospital transformation') we are describing within our deliverables to have adopted a joint and trusted assessor approach through this process. The BCF supported a Dementia Care Advisor in last year and had been built into the expenditure plan to continue funding through 2016/17. The advisor provides advice and support for people diagnosed with dementia, their carers, family and friends. This information includes: • local support services • getting a break • legal planning • support for carers • living well with dementia

	• national support services • money matters Slough also has a dementia action plan for delivering improvements to diagnosis and support and the experience of people with dementia in care homes. Appendix 18. Slough Dementia Strategy – key actions 2014-16 Appendix 19. Slough Dementia JSNA 2015
Agreement on the Consequential Impact of Change Please describe how the impact of local plans has been agreed with relevant health and social care providers and whether there been public and patient and service user engagement in this planning, as well as plans for political buy-in. Your response should demonstrate that these align to provider plans and the longer term vision for sustainable services. Please also articulate how mental and physical health are considered equal, and that your plans aim to ensure these are better integrated with one another, as well as with other services such as social care. You should also demonstrate clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans.	Please refer to 2015/16 BCF plan for public and patient engagement and involvement in developing our programme of change. In terms of overseeing the development of our BCF and engagement in delivery our acute trust provider has representation at our BCF Joint Commissioning Board. BCF Planning also forms part of discussions that take place at the Systems Leaders Group to ensure alignment across the system. In respect of provider plans, the Frimley Health operational plan for 2014-2016[1] states that "The impact of the Better Care fund and other National initiatives to reduce Hospital care will be felt through reduced patient volumes and associated income. Should these reductions exceed underlying growth (i.e. present a net reduction in activity for the Trust) then there will be a net reduction in income. There will however also be a reduction in associated cost, thus mitigating the financial impact of the change. The key task for the Trust will be firstly to continue to grow catchment to minimise any net reduction in income, and secondly to drive out as much associated cost as possible should there be a net reduction in activity." The Frimley Operational plan aligns with many of the key drivers for the BCF, including the development of a consultant delivered 7 day a week service, reducing delays in discharging patients through improved communication and discussion with social care teams. Previous sections explain how there is alignment between the overarching BCF plan, CCG operating plans and provider plans.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338357/FRIMLEY_Operational_Plan_14-16_1_.pdf

Agreement to invest in NHS out of hospital commissioned services Please detail your agreed plan for using your share of the £1 billion that had previously been used to create the payment for performance element of the fund, in line with the national condition guidance, linking back to the summary and expenditure plan tabs of your BCF planning return template. Please describe if you have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance. Please make reference to the consideration of the long term trend in admissions, and the success of schemes implemented to date. If a risk sharing arrangement has been agreed please explain how the decision was arrived at, and illustrate the conditions are appropriate and consistent with guidance. For NHS commissioned out-of-hospital services, and services that were previously paid for from funding made available as a result of achieving your non-elective ambition, please confirm if these continue in a manner consistent with 15-16 and provide evidence to support any changes to service provision from 15-16 plan.	There is £1.649m within the 2016/17 plan for NHS commissioned out of hospital services (Tab 2 on summary template). Investment has been identified in this year for our 'Out of Hospital Transformation' programme which will see further integration of our local short term services and is a major workstream for our 2016/17 plan. Currently Slough community care services are provided by both Slough Adult Social Care and Berkshire Health Foundation Trust, providing a range of bed based, community based and home based services. These are: 1. Slough Borough Council: Recovery, Rehabilitation and Reablement Services: • Occupational Therapy and Physiotherapy • Rehabilitation (home based) • Reablement (home based) • Recovery & Reablement (bed based) • End of Life 2. Berkshire HealthCare Foundation Trust • Intensive Community Rehabilitation (2 weeks- community) • Assessment Rehabilitation Centre (community) • Recovery & Rehabilitation (bed based with nursing) The core objectives from both services are to : - Manage increased patient complexity in the community - Offer step up and down responses, to prevent hospital/residential admissions, - To facilitate timely discharge - Decrease the levels of ongoing reliance upon statuary services, through promoting independence - Improve patient choice and control, and satisfaction of what and how services are delivered to meet their outcomes - Delivering services closer to home - Support to patients to remain in their own home during a period of rehabilitation and assessment; increasing the opportunity to maximise independence and reduce the numbers of long term care

	Within our original 2015/16 BCF plan Slough committed to achieving a 3.5% reduction in NEL admissions through its BCF. There has been encouraging signs of positive impact through delivery of our first year's programme although we did fall short of our target overall. For 2016/17 we have aligned our NEL activity with that of the CCG Operational Plan (see page 3-4) and identified a risk share of £542k within the BCF against a 2% increase in NEL activity. Further detail is to be agreed on use of the risk share should BCF successfully impact and contain an increase to under 2% . This will be included in our s75 Pooled Budget agreement. Throughout the development of the 16/17 BCF planning and submission processes, there has been close dialogue and liaison with the parallel development of the CCGs' operating plans and supporting financial models. This collaborative approach has taken into account a number of new and historical considerations including: • National requirements of the 2015/16 funding streams, particularly those associated with the NEA admission targets. These established the parameters of each local contingency fund relating to the 3.5% NEA targeted improvement for the 15/16 period • New 16/17 national CCG planning assumptions reflecting the Integrated Hospital Activity Model data (IHAMS) • Impact on NEA data recoded using SUS data sources rather than MARCOM • Impact of local population data which is reflected in the HWB/BCF footprint and overlay with CCG data sources It is recognised that all these changes create a complex platform on which to establish a clear year on year position and basis for monitoring the future delivery of both operating plan objectives and BCF targets. There is an expectation that continuing pressure from 15/16 will be carried forward into 16/17, particularly on NEAs. The plans reflect joint working to mitigate and manage increased demand for services within a common financial envelope. Meeting both QIPP objectives and individual BCF plans and work streams is recognised as being key to the success of all stakeholders. Each Better Care Fund will continue to reflect a tailored contingency arrangement which has

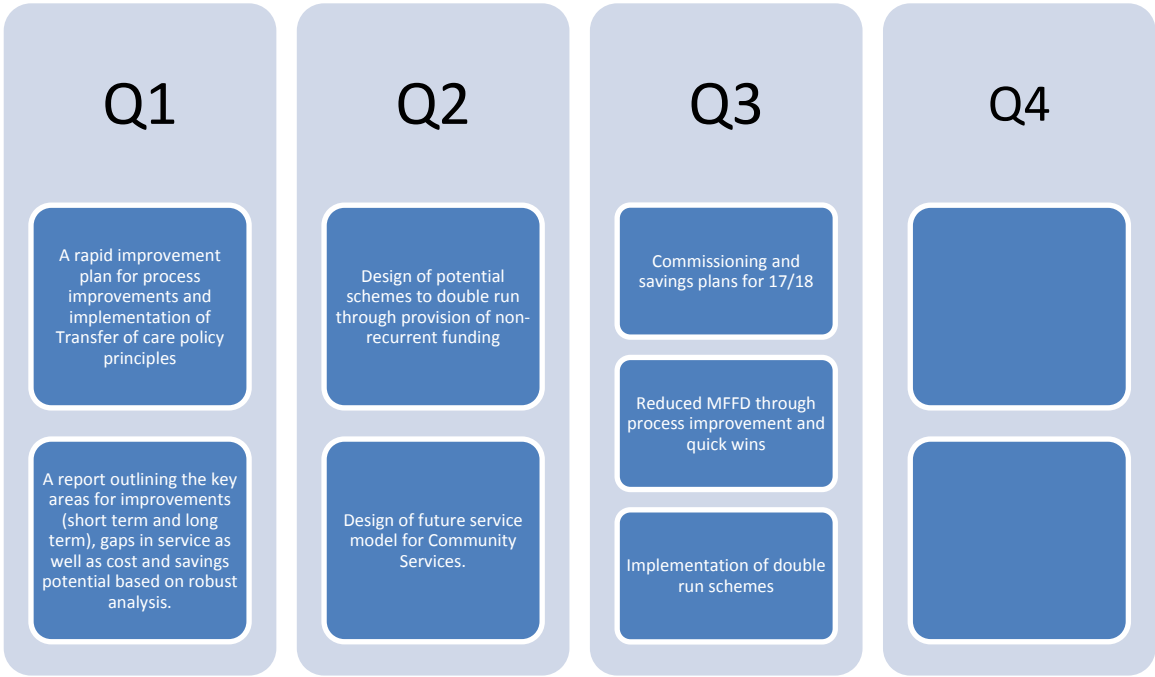
	been reviewed and aligned to the new reporting requirements and data gathering processes. Substantial Improvement to the data monitoring mechanisms is in hand to ensure that improvements to performance are captured, analysed and understood at a level of detail not previously provided. This will enable individual BCF and the partner CCGs to recognise the impact of improvement programmes, their sustainability and the platform of progress/baseline from which the improvement measures are being gauged. This will promote opportunities to enhance: • piloting of innovative projects and subsequent upscaling to maximise benefits • benchmarking performance between areas and • access to best practice • reconciliation with other measures that will reflect consequence of change • contract management discussion with key providers As 16/17 unfolds, the performance will be mapped and decisions can be made at individual BCF level to manage its local contingency arrangements within the context of the local and regional context.
Agreement on Local DToC Plan Please provide assurance, with supporting evidence that you have established a stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. Please describe how your plan sits within the context of an overall plan across the health and care system to improve patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge)? Please confirm your target is reflected in the relevant CCG(s) operational plan, and that you have considered	DTOC plan for 2016 – a whole system approach An East Berkshire wide transformation programme to improve performance on DTOC and transform our 'Out of Hospital' services and care pathways is being developed together with providers partners and other stakeholders. This will that ensure a coherent narrative be adopted between acute trust providers and all 3 CCGs. More information will be available on this as the project develops during this year. Within the our project for the development of our DToCs improvement plan there are three main objectives: 1. Comprehensive Berkshire East review of short term services which prevent admission and support appropriate early discharge form an acute setting 2. Reduction in Medically Fit patients waiting for discharge within Frimley Health (WPH).

the use of local risk sharing agreements with respect to DToC, with clear reference to existing guidance and flexibilities and with reference to the track record of current performance In agreeing the plan, please detail you methods of engagement with the relevant acute and community trusts and confirm that the plan has been agreed with your providers. Please also detail any engagement with the independent and voluntary sector Please demonstrate clear lines of responsibility, accountabilities, and measures of assurance and monitoring, taking into account national guidance and best practice (as set out in technical guidance)	3. Re defining services required to sustainably manage flow through the wider health and social care system Re-basing 'medical fit for discharge' to 'medically fit for transfer' will benefit the wider health and social care system as long as joint community services are able to provide the ongoing care and support; proactively and rapidly respond to individual patients; move from 'assess to discharge' to a model of 'discharge to assess'. The opportunity is clear. As acuity of patients increases, the flow through the system will continue to be challenged. This will lead to disrupted patient flow, with people not receiving the right care in the most appropriate environment. Failure to address potential capacity issues within the community outside of the hospital will also lead to continued blockages and affect the quality of care received across health and social care. **Baselining** The programme will be undertaking a robust analysis of the health and social care system; along with the wider provider market which includes understanding patient flow within care with nursing; residential and the homecare providers; along with housing. This analysis will describe the market; current process; the reasons for admissions, tipping points into care (included LA funded support), delays in system -wide patient flow and activity levels, gaps and opportunities. In order to achieve the objectives and outcomes based on firm evidence, rapid analysis and information gathering will need to take place. This will include but not be limited to: – MFFD analysis for East Berkshire (All hospitals) – Analysis of WPH /FPH data (also need to include all other areas including A+E) – Admissions data/ including the 'tipping' point into statutory services – Occupancy rate – Dependency levels (if we can) – Readmission Data – DTOC data – Service Reviews – Review of BCF arrangements across east Berkshire – Review of contract arrangements – both health and social care – Analysis of Discharge policy against current practice (Gap Analysis) – Pathway process mapping, which includes discharges from A+E. – Clinical audit input

- System Workshops
  - Issue Identification
  - Solution Generation

From the analysis, it is expected that short term solutions and process improvements should be achievable as immediate actions. These will start the process of reductions in MFFD. For more complex discharge issues, a more robust Root Cause Analysis work will be required.
The main aim for the end of the first quarter to re configure the hospital; creating a step down nurse led ward with the associated tariff. This ward will accept at point of discussion to transfer and then complete discharge arrangements eg TTA's ; transport; nursing home assessment etc.

Appendix 20.Slough DTOC Plan 2016



Scheme Level Spending Plan Please confirm if your scheme level spending plan, submitted as part of the BCF Planning Return template, accounts for the use of the full value of the budgets pooled through the BCF.	Yes. The scheme level spending plan has been completed in planning return template and accounts for the full value of the minimum pooled budget required.
National Conditions If you have not already done so, please include here an explanation of how the targets against the National Conditions have been set, and your plans for how these targets will be met, and whether they represent a realistic assessment of the impact of BCF initiatives on performance in 2016-17.	Targets reflect the performance of our BCF in year one and our ambition in year two to continue improving our performance against the BCF metrics whilst delivering transformational change in the way in which services are delivered in Slough. Metrics and target performance activity against these has been discussed and agreed through both the BCF Delivery Group and the Joint Commissioning Board meeting on 25 April. **NEL ambition** has been covered above (pages 3-4). Whilst we will continued to track and monitor performance against NEL admissions there is no target for reduction in BCF as it is now aligned with the CCG Operational Plan. **Residential Admissions** Sloughs forecast outturn for 2015/16 for residential admissions has been slightly lower than target (72 against a planned 77). We are committed to improvement in the rate of admissions against our plan for 2015/16. Numbers of admissions for Slough are low and small changes in activity can make marked difference to the annual rate. Historically Slough has been high on this indicator but has improved in successfully reducing admissions to care homes since 2012/13. Our ambition is to maintain this good performance against an increasing population and an increase in those who present with complex needs. We will support more people at home through DFGs, equipment and reablement support, providing short term support when

	required and not making decisions about long term when in acute hospital. **Reablement** Slough has been high performing in terms of its reablement activity for older people in recent years. It was our ambition in 2015/16 expand the reach of the service and offer reablement to a greater number of older people discharged from hospital. We acknowledged that our success rate would drop against a larger cohort of patients but the denominator increased significantly more than anticipated. Our 91 day indicator has reduced further as a result to 88%. For 2016/17 we plan to maintain our higher level of activity but with this regain a higher success rate of 90%. **Delayed Transfers of Care** Our DTOC activity in 2015/16 has seen significant variation between quarters. We aim to reduce this variation and reduced our average rate per quarter over the year from 555 to 429. This requires achieving actual target activity of 470 reduced bed days per quarter (per 100,000 of people 65+) or better. **Local Metric** We have chosen to change our local metric in this year from 'Average EQ-5D (health related quality of life) score for people reporting having one or more long-term conditions' to 'Confidence in managing own health'. Both of these are metric related to the GP patient survey but following discussion at the Delivery Group and the Joint Commissioning Board it is agreed that the confidence indicator is a better indicator of the outcome we are aiming to achieve for people in terms of having access to good access to primary care, good quality information and advice when needed and being proactively supported to manage health conditions. There are a number of BCF and other related activity that support improvements against this measure which includes: • Early Help • Complex Case Management • Telehealth and telecare • Information and advice • Community navigators

Metric : GPS33 Confidence in managing own health - confident (total)	Effective proactive management of people with long term and complex health conditions. Evidence of impact of a move to self care, complex case management, access to information and advice, innovative and flexible ways of support.
Rationale	This is an important marker of the effective shift towards people being empowered and supported to better manage their own health. It fits with the Slough BCF workstream of Proactive Care
Definition	The percentage of patients who respond to their GP survey question 33. "How confident are you that you can manage your own health?". It includes all patients who answer the question and responds as either 'very confident' or 'fairly confident'.
Source	GP Patient Survey
Reporting schedule for data source	Frequency:

		GP Survey every six months Timing: 6 month lag Baseline: January 2016 baseline rate of 90%