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To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

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6 June 2016

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NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 14 JUNE 2016

A meeting of the Health & Wellbeing Board will be held on **Tuesday 14 June 2016 at 6.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

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5. BERKSHIRE TRANSFORMING CARE PLAN 42

A report presenting the Berkshire Transforming Care Plan (TCP) which outlines a proposal to reduce the number of in-patient Assessment and Treatment Unit beds, for people with Learning Disabilities and/or ASD and/or Mental Health problems whose behaviour challenges others and services, and use the resulting resource to provide an intensive intervention service to support this cohort to live safely in the community and reduce admissions to Assessment & Treatment Units.

6. WEST OF BERKSHIRE, OXFORDSHIRE AND BUCKINGHAMSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN 96

A report on the development of a 5 year Sustainability and Transformation Plan (STP) for WeBOB (West of Berkshire, Oxfordshire and Buckinghamshire) for submission at the end of June 2016, to provide an opportunity to discuss the potential impact of the STP in Reading.

7. DATE OF NEXT MEETING -

Friday 15 July 2016 at 2pm

READING BOROUGH COUNCIL
REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14th June 2016**	**AGENDA ITEM:**	**4**
TITLE:	**BETTER CARE FUND – 16/17 FINAL SUBMISSION**		
LEAD COUNCILLOR:	**CLLR HOSKIN / CLLR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	**ALL**
LEAD OFFICER:	**KEVIN JOHNSON**	**TEL:**	**0118 937 4807**
JOB TITLE:	**INTEGRATION MANAGER**	**E-MAIL:**	**kevin.johnson@reading.gov.uk**

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation.

This report sets out to inform Health and Wellbeing Board members of the 2016/17 BCF submission and the changes to the mandated National Conditions that will inform spending for 2016-17. It was agreed at the March 2016 Health and Wellbeing Board meeting that delegated authority to sign off the Better Care Fund on behalf of the Board would be given to the Director of Adult and Health Care Services in consultation with the Chair and the BCF would be brought to the next meeting for retrospective approval. The Better Care Fund Vision can be found in Appendix 1.

The report goes on to explain our final submission financial details. There is still a great deal of work to be done and with an increasing financial challenge within our economy coupled with an increasing demand for services, the drive towards integration and efficiencies are stronger than ever.

The move to more integrated Health and Care services is a key national and local driver for health and social care with the BCF being one of the key policy vehicles to enable delivery. It should be noted, however, that not all elements of integration are included in the BCF, and other initiatives such as the Frail Elderly Pathway are outside the scope of this report, which relates solely to the 16/17 BCF.

2 RECOMMENDED ACTION

2.1 Acknowledgement of final submission

3 POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. In 2016-17 the Government committed £3.8 billion nationally to the BCF with many local areas collectively contributing an additional £1.5 billion, taking the total spending power of the BCF to £5.3 billion nationally.

4 CURRENT POSITION

The Better Care Fund submission for Reading is awaiting full assurance to be given by NHSE, and this is expected in the next few weeks.

The seven key areas of challenge as outlined in our Better Care Fund submission in 2016/17 are the main drivers for change in our local economy:

1. An increasing population, particularly in those over the age of 65
2. Increasing growth in non-elective admissions
3. Increasing A& E attendances, and pressure on urgent and emergency capacity
4. Delayed transfers of care, and subsequent bed days lost
5. Increasing pressures on adult social care for community packages and care homes
6. Increasing demand for planned (elective) care
7. Improving but remaining inequality of access to services across the "whole system: the whole week"

Challenge 1: An Increasing Population (particularly in those over the age of 65)

A significant amount of successful work has taken place in relation to our frail elderly pathway during 2015/16. Life expectancy, at aged 65, for men in Reading is 18.2 years, for women it is 21.0 years (PHOF, 2012-14 data). We have mapped the spend in this population cohort, establishing that we spend £187m across health and social care in Berkshire West, which represents 28% of spend from our total resources on 2% of our population. Potential new models of care are now being considered but it is clear that our largest opportunity to ensure better value for money and reduce overall spend in this group of the population needs to include an increased focus on prevention and targeting frailty in the absence of any long term condition. By focusing on prevention and well-being, we will reduce the number of elderly people escalating to a higher level of need.

The frail elderly programme sits outside of the Reading BCF but is a major piece of work within our integration agenda. Our neighbourhood cluster schemes identified areas of success and have allowed us to review our models which will be adapted during 16/17 to maximise the benefit in supporting people to live well and remain in their own homes for as long as possible.

Challenge 2: Growing Non Elective Admissions

The latest published NHS England figures for non-elective admissions (March 2016), show N & W Reading CCG and S Reading CCG with respectively the 5th and 9th lowest level of admissions in England (source NHS England MARCOM). This makes further reduction to non-elective activity extremely challenging and growth in non-electives, with a growing and ageing population, is almost inevitable.

An in-depth analysis and our local metric is currently underway to identify the causes of the rise in non-electives but headline findings show that a higher than initially anticipated proportion of activity and spend is within the 19-39 and 40-64 years age brackets and also within a number of specific wards in Reading. This analysis will help us identify and focus on a local metric to further reduce NEAs. The reductions within the BCF to the NEAs are made up of the following: i) Care Homes scheme (Reading share of this across Berkshire West Service) and ii) NEL reductions from the local schemes (Discharge to Assess and the Full Intake Model). A risk share is in place to authorise spending of the NEA which governance lies with the Reading Integration Board.

Challenge 3: Increasing A&E attendances

The Berkshire West system has a strong track record of effective partnership working with all organisations across health and social care understanding their contribution to the A&E standard and the Urgent Care Programme Board takes an oversight and scrutiny role in relation to achievement of the target. Admission avoidance services are robust with Rapid Response teams mobilising with a 2 hour response, additional investment in night sitting services in 15-16 and of note our Ambulance service (SCAS) having one of the highest non conveyance rates in the country. Whilst recognising that there is further work to do on improving delayed transfers of care performance, against a background of increasing non elective activity, the Berkshire Healthcare Foundation Trust (BHFT) Integrated Discharge Team has been successful in delivering the 'pull' model of discharge into community services (as per ECIST recommendations).

Challenge 4: Delayed Transfers of Care

Delayed Transfers of Care (DToCs) are effectively people stranded in the wrong place and behind each number is a personal story. By working in partnership to reduce DToCs we will help avoid the situation whereby people remain in an acute hospital setting when they no longer need acute care.
Across the 3 localities there has been significant improvement in 15/16 for Reading (19.4% improvement) and Wokingham (7.4% improvement) with West Berkshire remaining almost the same. These significant improvements in 2015-16 will mean that further improvement in 2016-17 will require even more effort and significant transformation The DTOC action for this year plan has been jointly devised and agreed across Berkshire West and approved by the CCGs, the 3 LAs and local Acute and Community Trusts via the Berkshire West 10 Delivery Group and the Reading Integration Board. The plan has also been discussed and approved by the Berkshire West Urgent Care Programme Board which will take an oversight and scrutiny role in relation to delivery of the plan. The target sets a realistic but ambitious approach which will be stressed tested throughout the year with a 'ramped up' approach at each quarter.

Challenge 5: Increasing Demand for Adult Social Care Community & Care Home Packages

Adult social care costs during 2015/16 have increased, resulting in significant cost pressures within Reading Borough Council. Reading also has a high level of placements into residential care and has seen escalating demand for therapy services. Additional home care packages have also placed further unsustainable demand on the local authority. However, our Better Care Fund Scheme "Discharge to Assess" has played a part in helping address this demand, but has in turn consumed more local authority resources than originally planned, at a rate which is unsustainable. During 2016/17 we will invest further and identify efficiencies to this service building on the successes seen to date.

During 2015/16 we have seen a decrease of 31% in the number of permanent admissions. However, Reading Borough Council remains outliers with higher rates of residential placements.

Challenge 6: Increased Demand for Planned Care Services

Year-on-year we have seen only a small increase in demand for planned care services, 0.4% growth across Berkshire West providers. Although elective care is outside the scope of the BCF it is important to ensure the balance between elective and non- elective work is managed across the system. High levels of non-elective demand, combined with Delayed transfers of care have the potential to reduce capacity to carry out planned procedures. Clearly a balance is important and improvements in DTOC and reduction in NEL through the Better Care Fund schemes and other initiatives will help free important capacity to carry out planned work, which in turn can reduce /address the burden of long term morbidity.

Challenge 7: Inequity in Access to Service 7 Days a Week

Key health services in the community, such as rapid response and reablement and mental health crisis teams already operate on a 7 day a week basis but uptake of these services is lower at week-ends. Using the results of our stocktake during 15/16, of which community services operate at the week-ends and how workload is profiled across the week we will use the outcomes to develop our work further for 2016/17 with our community provider. The Integrated Discharge Team does operate 7 days a week 'pulling' patients out into the community. Reading Discharge to Assess services also operate on a 7 day basis but again uptake is lower at the week-ends and joint work is needed with the hospital to smooth this flow. Further work will be undertaken with Independent Care Providers so that care packages can be started over 7 days. A robust feedback loop to the RBFT will be required so that any issues with week-end discharges can be immediately addressed. Across the Berks West system the availability of carers is a challenge and this is being addressed as part of the Berks West 10 Workforce project.

5 COMMISSIONED PROGRAMMES WITHIN 2016/17

Connected Care

Currently across the whole of Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. This high number of organisations, and the different culture, systems & technology, processes and legislation which drive them, makes it difficult to get a single view of a person at a point in time.

What our Connected Care solution is offering is the 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. The target is to achieve a shared NHS number across 17 organisations by March 2017

This supports the different integrated services in the following ways:

- The NHS number is used as the consistent patient/user identifier
- 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

Community Re-ablement Team ("CRT")

CRT provides a short term flexible service for up to 6 weeks, for patients who have been assessed as being able to benefit from a re-ablement program. The service is delivered in the clients own home. CRT is available 7 days a week, 24 hours a day.

Patient/User Focused CRT:

- More people with complex care needs are supported within the community
- People only spend the time they need in hospital
- No loss of confidence by spending too long in hospital
- More people benefit from intermediate care and re-ablement services
- People are able to recover and regain their independence

Performance and Process Focused:

- High levels of user satisfaction
- Reduced admissions into residential Care
- Reduced numbers on the 'Fit to Go' List
- Reduced delayed transfer of care (bed days lost)
- Increase in older people still at home 91 days after discharge from hospital

Discharge To Assess ("DTA")

The DTA service is part of the Willows residential care complex operated by the Council. The home consists of both residential units and self-contained assessment flats with 14 units appointed as Discharge to Assess units.

DTA is a 'step up step down' rehab and re-ablement service with the primary aims being:

- To reduce the number of patients on the fit to go list
- To reduce the length of stay for individuals who are fit to leave acute hospital care
- To reduce permanent admission to residential and nursing care

Through the provision of timely discharge from hospital and re-ablement/rehabilitation the service will enhance, in so far as possible, a residents daily living skills to enhance/maintain their independence and support them to return to or remain in their chosen place of residence (usually their own home).

The service will contribute to the following key BCF metrics:

- Patient/User satisfaction with the discharge process (local metric)
- Reducing avoidable non-elective admissions
- Reducing inappropriate admission to residential care
- Reducing delayed transfer of care/acute bed days lost

Increasing the number of patients/service users benefiting from re-ablement services

NHS Commissioned Out of Hospital Services

New to the BCF in 16/17 will be a range of Out of Hospital Services commissioned by the CCG through our community provider. These schemes , alongside other initiatives outside of the BCF, supports the overall delivery of the NEL and DTOC BCF Objectives as well as managing demand for urgent care including A & E attendances as well helping our resident remain as healthy and well as possible in the community.

The new service lines within the BCFs are as follows:

- **Adult Speech & Language:** This service supports indirectly avoidance of NELs through timely swallowing assessment in at risk individuals, hence avoiding future episodes of aspiration pneumonia and chest infections.
- **Community Geriatricians:** The community geriatricians will support the primary care teams, intermediate care teams, care homes and community hospitals within their area and provide easily accessible and speedy advice with the intention of reducing admissions to secondary care.
- **Intermediate Care** (including but not restricted to: rapid response, reablement, falls and night sitting): The aim of the Intermediate Care Services is to provide individuals who are referred to the service, with a structured goal-based action plan. This is provided by a multidisciplinary team, which is responsive to an individual's physical, psychological and social needs. This includes those who have early onset dementia, or whose needs are of a palliative nature and who wish to remain at the end of their life in their own home. In the Reading Locality the Intermediate Care Service is an integrated service provided by Berkshire Healthcare NHS Foundation Trust (BHCNHSFT) and Reading Borough Council.

- **Health hub:** The Health Hub is the single point of access for referrals from healthcare professionals to scheduled and unscheduled community services. Clinical advisors are based within the Hub providing clinical screening of referrals supporting effective prioritisation of resources to meet clinical need. This service helps facilitate patient flow (thus avoiding DTOCs) from RBFT to the community Beds or alternative community services based upon clinical need. Out-of-hours referrals are also processed and administrated through the Health Hub. Referrals are prioritised and actioned appropriately in respect of risk and urgency and forwarded to the most appropriate service in a timely manner as indicated on referral, or after triage. Access is available 24/7, 365 days a year and the Hub works with other services and teams within the Trust to ensure a smooth and seamless transition or transfer between services.

Engagement with Patients and Service Users

It is recognised that we need to improve our engagement and co-production approaches in relation to the BCF. In 2016/17 we will work with Healthwatch to ensure we gain a meaningful understanding of the personal impact of each scheme. We will also utilise a range of engagement techniques to ensure patients and users can shape our BCF programme, via dedicated task/finish user forums through to direct communications with key groups via existing private and voluntary sector partners.

Additionally, individual BCF schemes has established user feedback mechanisms to gather regular input from patients/service users in relation to their satisfaction with, and ultimate success of, the services. This feedback will be used on an on-going basis to develop individual services and the BCF programme throughout 2016/17.

6 CONTRIBUTION TO STRATEGIC AIMS

6.1 The decision contributes to the following Council's strategic aims:

- To promote equality, social inclusion and a safe and healthy environment for all
- To remain financially sustainable to deliver our priorities

6.2 Reading Borough Council is committed to:

- Ensuring that all vulnerable residents are protected and cared for;
- Enabling people to live independently, and also providing support when needed to families;
- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the council is financially sustainable and can continue to deliver services across the town;

6.3 The decision also contributes to the following:

- Equal Opportunities
- Health equality

7 RISKS

7.1 Both the CCGs and the Council are faced with significant funding issues going into 2016/17 and beyond. The BCF 16/17 Plan is for a total expenditure of £10,417k, of which £9,298k (89%) will be funded by the CCG's and £1,119k (11%) by the council. Of the total BCF budget in 16/17, £4,978k (48%) has been allocated for the Protection of Adult Social Care. Without this funding the Council could not support these services and these would have to cease, with the resulting impact on Council and NHS services.

7.2 For Berkshire West as a whole (including Reading, West Berkshire and Wokingham HWBs), the combined BCF 16/17 Plans include an additional investment of £5.1m in out-of-hospital Community Health services commissioned by the CCG from Berkshire Healthcare FT. This figure exceeds the minimum required by the national guidance. At the same time the £2.5m included in the 15/16 BCF Plan for the provision of Enhanced Access to GP services, has been removed from the BCF and will now be funded directly by the CCG from within its own budget for 16/17.

7.3 In line with national guidance, the BCF 16/17 Plan includes an amount of £542k for a risk sharing agreement related to the achievement of planned reductions in non-elective admissions. If targets are met the funds are released back into the BCF to enhance projects that are making significant improvements, this money is ring-fenced for BCF programmes.

7.4 In addition to the above, the BCF includes a contingency budget of £167k which is available to off-set unplanned additional costs incurred by the Local Authority for Adult Social Care related to BCF schemes in 16/17.

8 LEGAL IMPLICATIONS

8.1 As per 2015/16, the requirement to formally pool budgets, established under section 75 of the NHS Act 2006, with South Reading CCG and North & West Reading CCG remains.

8.2 The Section 75 pooled budget Agreements have been drafted (based on the 15/16 Agreements) and will be approved and formally executed by the appropriate council and CCG officers. The national deadline for completion and signature of the Agreements is 30 June 2016.

9 FINANCIAL IMPLICATIONS

9.1 A summary of the funding for 2016/17 is detailed below with the comparative 2015/16 figures and accompanying narrative highlighting key changes.

The planning template provides a full overview of the funding contributions for 2016/17 and has been jointly agreed by the CCG and Local Authority via the Reading integration Board and Reading Health & Wellbeing Board.

Scheme Name/Expenditure Line	16-17 Expenditure (£)	15-16 Expenditure (£)
s256/Protection of Social Care		
1. Bed based intermediate care Willows	523,000	569,000
2. Bed based intermediate care Assessment Flats	46,000	0
3. Social care intermediate care team	863,000	863,000
4. Community reablement team	1,529,000	1,529,000
5. Mental Health reablement and recovery team	200,000	200,000
6. Specialised nursing placements (to support hospital discharges)	400,000	400,000
7. Community equipment & minor adaptations	50,000	50,000
8. Care Act Monies	361,000	361,000
9. Carers Support Funding	641,000	641,000
10. Time to Decide/Discharge to Assess	556,000	456,000
11. Full Intake	398,000	398,000
12. Reablement	779,000	779,000
NHS Out Of Hospital Commissioned Services		
13. Speech and Language Therapy	44,000	0
14. Community Geriatrician	87,000	0
15. Intermediate Care	92,000	0
16. Health Hub	742,000	0
17. Intermediate Care night sitting, rapid response, reablement and falls	341,000	0
18. Care Homes in reach	244,000	0
19. Support to residential and nursing care homes (Enhanced Care in Care Homes)	158,000	
20. Rapid Response and Treatment to Care Homes – RRAT	280,000	175,000
21. Hospital at Home	0	827,000
22. Health & Social Care Hub	0	72,000
23. Health and Social Care ICT (Interoperability)	300,000	256,000
24. GP 7 Day Access	0	902,000
25. Programme Management	209,000	0
26. Disabled Facilities Grant	815,000	500,000
27. Social Care Capital Grant (16/17 combined with DFG)	0	317,000
28. Contingency (inc £167k in 16/17 for Adult Social Care)	217,000	182,000
29. Risk Share Agreement	542,000	0
30. Performance Fund	0	719,000
	10,417,000	**10,196,000**

10 DECISIONS/ACTIONS REQUIRED

10.1 Delegated authority was given to the Director of Adult and Health Services in consultation with the Chair and members of the Board to submit our proposal. Due to timings of submission set by NHS England and Board meetings the Health and Wellbeing Board need to acknowledge the final submission of the Better Care Fund 2016/17.

11 BACKGROUND PAPERS

11.1 Final Better Care Fund submission 2016/17 – this will be available after full assurance is given by NHS England.

12 NEXT STEPS

12.1 The BCF is a standing item on the HWB agenda. The BCF programme manager will update the Board on progress to date and performance measures at the next meeting.

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS

Reading Borough Council
Working better with you

Our Vision:
A Healthier Reading

Better Care Fund Plan 2016/17

Our Local Vision

"Communities and agencies working together to make the most efficient use of available resources to improve life expectancy, reduced health inequalities and improve the health and wellbeing across the life course"

Contents

Introduction

In line with our local health and Wellbeing Strategy, by 2019 our vision is for Reading residents to be empowered to live well for longer at home. In order for this to become a reality, it will require health and social care to work together, with families and carers as experts partners. (See Better Care Fund Plan 2014 page 8 for further detail on patient outcomes.)

Since we wrote our Better Care Fund Plan in 2014, the population of Reading continues to grow. Census data from 2001 and 2011 indicate an increase of 11,300 people in the population of Reading borough in that time period and annual estimates indicated continued population growth. There has been an 11% increase in the past 10 years to the most recently available population figure of 160,825[1] in 2014. There has been an increase in the population across all age bands with the greatest increase seen in the 0-5 year old population (43% increases in 10 years). Recent population projections show that this increase in overall population is likely to continue to increase over the next 10 years though the increase is now no longer predicted to be greatest in the 0-5 year old population. However, it should be noted that these projections do not take into account planned housing developments in the area with these and other developments affecting the local area such as Crossrail being likely to attract new residents. We continue to see extremes of wealth and although poverty and deprivation have improved in some areas, there are areas of Reading that have seen further deterioration in their level of deprivation when compared to the England average. We have, however, also made some good progress in the last year:

- In North & West Reading , life expectancy for men has improved
- A reduction in the number of adults smoking
- A reduction in the number of under 16 year olds who are obese
- Reduced inactivity in adults
- Hip fractures have been reducing, in the main, over recent years
- Under 75 mortality from cancers considered preventable continues to reduce
- In South Reading, there has been a reduction in Alcohol binge drinking and alcohol related hospital admissions and the number of people under 75 years dying from liver disease continues to fall.
- Fewer pre-school children are estimated to have a mental health disorder
- Increasing numbers assessed and cared for in their own home. With declining numbers in residential care
- Increasing satisfaction with social care support , helping people to achieve positive outcomes
- A 32% reduction in delayed discharges from hospital

There is still a great deal of work to be done and with an increasing financial challenge within our economy coupled with an increasing demand for services, the drive towards integration and efficiencies are stronger than ever.

[1] This is the Reading borough population only. Reading CCGs and GPs cover a broader catchment area thus the higher population figure used elsewhere within this document and the BCF Narrative template.

Evidence base: The Challenges and the Case for Change

The seven key areas of challenge as outlined in our Better Care Fund submission in 2014 (page 16) remain the main drivers for change in our local economy:

- ✓ An increasing population, particularly in those over the age of 65
- ✓ Increasing growth in non-elective care.
- ✓ Increasing A& E attendances, and pressure on urgent and emergency capacity (particularly in the under 5's)
- ✓ Delayed transfers of care, and subsequent bed days lost
- ✓ Increasing pressures on adult social care for community packages and care homes
- ✓ Increasing demand for planned (elective) care
- ✓ Improving but remaining inequality of access to services across the "whole system: the whole week"

In addition the pressure has heightened in recent months with all organisations within our economy, including acute & community providers, CCGs, ambulance trust and the local Authority experiencing significant financial challenge.

Challenge 1: An Increasing Population (Particularly in those over the age of 65)

A significant amount of successful work has taken place in relation to our frail elderly pathway during 2015/16. Life expectancy, at aged 65, for men in Reading is 18.2 years, for women it is 21.0 years (PHOF, 2012-14 data). We have mapped the spend in this population cohort, establishing that we spend £187m across health and social care in Berkshire West, which represents 28% of spend from our total resources on 2% of our population. Potential new models of care are now being considered but it is clear that our largest opportunity to ensure better value for money and reduce overall spend in this group of the population needs to include an increased focus on prevention and targeting frailty in the absence of any long term condition. By focusing on prevention and well-being, we will reduce the number of elderly people escalating to a higher level of need.

The frail elderly programme sits outside of the Reading BCF but is a major piece of work within our integration agenda. Our neighbourhood cluster schemes identified areas of success and have allowed us to review our models which will be adapted during 16/17 to maximise the benefit in supporting people to live well and remain in their own homes for as long as possible.

Challenge 2: Growing Non Elective Admissions

The two Reading CCGs remain in the lowest 5 CCGs in England for non-elective admission numbers. This makes further reduction to non-elective activity extremely challenging and growth in non-electives, with a growing and ageing population, is almost inevitable.

Significant programmes of work are already in place to help manage the non-elective demand and sit outside of the Better care Fund. However, during 2015/16 we have seen a 14.4% growth for South Reading and 11.4% for North & West Reading in non-elective admissions against a plan of 3.3% (based on raw SUS data i.e. before any data challenge).

	North & West Reading CCG	South Reading CCG
Base line total NEA activity 14/15	6409	7765
Actual 15/16	7142	8885
% growth in NEA	11.4%	14.4%

This has also resulted in subsequent pressure on adult social care provision. As is illustrated below under rising A & E attendances, we have seen a high conversion rate to admission alongside subsequently high referral to adult social care.

An in-depth analysis is currently underway to identify the causes of the rise in non-electives but headline findings show that a higher than initially anticipated proportion of activity and spend is within the 40-64 years age brackets, as demonstrated on the data extract below:

Age Group	BW Registered Population as at January 2016	% of BW Registered Population as at January 2016	NEL Spells	% NEL spells	NEL Spend	% NEL spend
0 - 18	119,893	23%	4,657	17%	£5,182,571	9%
19 - 39	156,468	30%	4,473	17%	£6,033,364	11%
40 - 64	171,767	33%	6,471	24%	£12,576,475	23%
65 - 74	43,822	8%	3,272	12%	£8,598,109	16%
75+	35,062	7%	8,177	30%	£22,472,636	41%

The outputs of this further analysis will help further inform service planning and provide an evidence base for further work required by system partners outside the BCF to support a reduction in these numbers. In order to meet our Better Care Fund objectives of reducing non-elective admissions and delayed transfers of care we need better understanding of:

- NELs and A&E attendances by age band <18, 19-64, >65, >75
- A breakdown of type sub-chapters by age band
- A breakdown of spend by age band
- Associated pressure of rising non electives on adult social care demands

The BCF template submitted on 03 May 2016, alongside this narrative, pulls through the non-elective activity plan from the CCG operating plan template (18TH April submission data) by apportioning the figures to the appropriate health and well-being board. This was populated by NHSE, using a baseline figure for non-elective actual activity for the CCGs. The CCG then applied a factor of growth to this plan based on a national tool called the Indicative Hospital Activity Model which gives the CCGs a guide of what growth levels should be expected. **This equated to 2.2% across the 4 CCGs in Berkshire West.** It is noted however that the rate may be further reviewed based on the outcome of contractual negotiations with the acute providers.

The CCG has not applied the transformational change projects (QIPPs) that are expected to deliver reductions in non-elective admissions. The reductions within the BCF to the NEL expected plan are made up of the following: i) Care Homes scheme (Reading Share of this across Berkshire West Service) and ii) NEL reductions from the local schemes , Discharge to Assess and the full intake model.

To date, within the Better care Fund, specific work carried out, particularly focusing on care homes (BCF Scheme 02) during 2015/16 has delivered training and education, has seen a reduction of 72 (20%) non elective admissions (from the targeted care homes) when compared to baseline at 2014/15, but which is lower than the original plan for a 50% reduction for this scheme. There has however been a reduction in 999 calls with a 48% conversion rate to non-elective admission, but with 70% of the short stay admissions identified as could potentially have been avoidable. There has been a review of full medication carried out on 815 (34%) of patients in 25 (48%) of our care homes with a saving of £106,997.

A full review of the scheme has been carried out and our learning has allowed us to refocus this scheme during 2015/16 and into 2016/17 by linking it with the Hospital at Home programme (BCF Scheme 01) to establish a new service providing rapid response and assessment in care homes through a dedicated geriatrician led team. Our intention would be to look to expand this to support all residents in the community to further support admission avoidance. This has started to produce early positive results and outcomes to date have included a 23% (14) reduction in non-elective admissions in its first phase of operation covering 15 care homes. Anecdotally all calls to the new service were appropriate and would have resulted in a call to 999 and an A &E attendance. We therefore plan to build on our successes and further enhance and expand during 16/17 within the refreshed BCF. We plan to further focus on improving skills and knowledge within care homes helping them to better support individuals in times of crisis and in developing synergy with the Local Authority Quality Assurance and Safeguarding systems. We will recruit a second care home pharmacist to expand the medication reviews across all care homes and to all residents. We plan to focus on avoidable admissions due to respiratory disorders, urinary tract infections and trauma. Combined these disorders account for 45% of hospital admissions year on year within our care homes across Berkshire West.

The main aims of the refreshed scheme for 16/17 will be to:

- Reduce avoidable admissions or readmissions or A &E attendances from care homes.
- Reduce non-emergency ambulance dispositions and conveyances from care homes.
- Reduce 999 calls from care homes.
- Reduce the number of on the day unplanned visits by GPs to care homes.
- Increase the number of patients going back to care homes on the same day after attendance at A&E.
- Increase use of the single point of access hub (BCF 05a) to access timely community services for admission avoidance for those in care homes and in supported living accommodation.
- Increased use of near patient testing and telehealth to support delivery of care within the home care setting.
- Improve access to a dedicated 24/7 support for end of life care.
- Establish MDT in reach teams within care homes according to need, providing training, urgent clinical care and regular medication and care panning reviews.
- Proactive support to ensure they are able to work within the Care Quality Commission (CQC) and safeguarding requirements outlined within their contract with Local Authorities (LA)
- Achieve greater resilience and consistency to care home performance monitoring and review across the care quality system, through improved health and social care collaboration

- Proactive targeting by joint health and social care MDT teams, to homes where quality, safeguarding, elevated non elective and A & E /NHS 111 activity or calls to primary care are higher than anticipated.

As part of the 2016/17 project a programme of work will be established for 2017/18 - 2020/21 continuing on the themes already established that ensure Health and Social Care together meet the objectives set out in the supporting documents for those people in our society that are reliant on care and extra support to help them lead better more comfortable lives. This will include looking outside the care home setting at care options delivered within an individual's home, supported living and where required use of step up and down facilities.

Challenge 3: Increasing A&E attendances

High levels of A & E attendances have remained a challenge within 15/16. More people are been recorded has having injuries due to falls (this will predominantly be older people) however hip fractures have been reducing, in the main, over recent years (though rates have increased for men and reduced for women). In addition we are seeing higher conversion rates, with nearly 1/3 of attendees requiring a non-elective admission. Many of these are short stay but many are also more complex presentations, which in turn impacts on lengths of stay and increased difficulties for timely discharge.

The Berkshire West system has a strong track record of effective partnership working with all organisations across health and social care understanding their contribution to the A&E standard and the Urgent Care Programme Board takes an oversight and scrutiny role in relation to achievement of the target. Admission avoidance services are robust with Rapid Response teams mobilising with a 2 hour response, additional investment in night sitting services in 15-16 and of note our Ambulance service (SCAS) having one of the highest non conveyance rates in the country. However, we will continue to review capacity within the service on a monthly basis, to ensure it addresses any increased demand. Whilst recognising that there is further work to do on improving delayed transfers of care performance, against a background of increasing non elective activity, the Berkshire Healthcare Foundation Trust (BHFT) Integrated Discharge Team has been successful in delivering the 'pull' model of discharge into community services (as per ECIST recommendations). Health have also been working in partnership with Local Authorities to deliver new integrated models of care to support patients requiring onward care post-acute discharge. The approach varies in each locality but all approaches are built on the principles of referral to an integrated health and social care team via a Single Point of Access, discharge to assess and a full intake model. All these initiatives are specifically aimed at improving flow through the hospital, supporting achievement of the A&E target, which acts as a barometer of patient flow. Other models of delivery will also be considered by the CCG during 16/17 to further support reduced admissions.

Despite the rise in A&E activity levels performance against the 4 hour standard has been strong through the majority of 15-16 with the target achieved in quarters 1, 2 and 3. Performance has been challenged in quarter 4 but the system remains one of the best performing in the South Central region.

Challenge 4: Delayed Transfers of Care

We welcome the Better Care planning requirement to agree a local action plan to reduce delayed transfers of care (DToCs) and improve flow and took this opportunity to work with our partner CCGs and LAs in Berkshire West to agree a system wide approach to the development of our local action plans.

The Berkshire West urgent care system has a history of strong effective partnership working. Managing the "Fit List" and DTOC is an integral part of its work so partners agreed that the Berkshire West Urgent Care Programme Board should have an oversight role in the development of the action plan and the monitoring of its impact.

Delayed Transfers of Care (DToCs) are effectively people stranded in the wrong place and behind each number is a personal story. By working in partnership to reduce DToCs we will help avoid the situation whereby people remain in an acute hospital setting when they no longer need acute care.

10 days in hospital is equivalent to 10 years ageing if you are over 80 years old

AND

A patient is defined as 'safe to discharge' when:

- A clinical decision has been made that the patient no longer needs acute care AND
- An MDT decision has been made that the patients is ready for transfer AND
- The patient is safe to discharge.

Situation Analysis

The first part of this work involved an analysis of current DTOC performance across the three localities as reported for BCF purposes and also an analysis of current "health performance" in relation to the national ambition to have no more than 3.5% bed days lost as proportion of total occupied bed days at acute trust provider level each month. This highlighted the need to ensure that all partners understood these differences when considering what a proportionate plan to improve DTOC performance should be.

Royal Berkshire NHS FT *(Oct 2014 to Sep 2015)*

Reason for Delay	NHS Patients	NHS DTOC Days	Social Care Patients	Social Care DTOC Days
A Completion Assessment	2	26	13	304
B Public Funding	0	0	0	26
C Further Non Acute Nhs	99	3,667	0	0
Di Residential Home	8	272	21	741
Dii Nursing Home	33	1,232	34	1,248
E Care Package In Home	0	11	56	1,908
F Community Equip Adapt	1	30	1	44
G Patient Family Choice	19	711	1	8
H Disputes	75	2,570	1	19
I Housing	4	131	0	0
Grand Total	**241**	**8,650**	**127**	**4,298**

Highest reasons for delay are further NHS care, nursing homes and disputes.

Berkshire Healthcare NHS FT *(Oct 2014 to Sep 2015)*

Reason for Delay	NHS Patients	NHS DTOC Days	Social Care Patients	Social Care DTOC Days
A Completion Assessment	2	47	6	142
B Public Funding	2	9	8	83
C Further Non Acute Nhs	28	1,004	0	0
Di Residential Home	5	204	34	1,044
Dii Nursing Home	16	537	31	957
E Care Package In Home	13	395	33	1,057
F Community Equip Adapt	2	44	1	62
G Patient Family Choice	7	181	9	250
H Disputes	0	0	0	9
I Housing	2	75	0	0
Grand Total	**77**	**2,496**	**122**	**3,604**

The highest reasons for delay are further NHS care, residential homes and care packages in the community.

Performance between 2014/15 and 2015/16

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Berkshire West delayed days					3,239	3,821	3,725	2,878	3,425	2,829	3,026
Annual moving average					3,239	3,530	3,595	3,416	3,462	3,214	3,040
							15/16 Change:		**-9.4%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Reading delayed days	865	806	1,040	1,202	901	1,444	1,879	1,035	1,217	959	1,005
Annual moving average				978	987	1,147	1,357	1,315	1,394	1,273	1,054
			14/15 Change:		**34.4%**		***15/16 Change:***		**-19.4%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
West Berkshire delayed days					1,099	1,061	1,028	951	1,163	923	1,052
Annual moving average					1,099	1,080	1,063	1,035	1,051	1,016	1,022
							15/16 Change:		**1.1%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
okingham Berkshire delayed days					1,239	1,316	818	892	1,045	947	969
Annual moving average					1,239	1,278	1,124	1,066	1,018	926	963
							15/16 Change:		**-7.4%**		

Across the 3 localities there has been significant improvement for Reading (19.4% improvement) and Wokingham (7.4% improvement) with West Berkshire remaining almost the same. These significant improvements in 2015-16 will mean that further improvement in 2016-17 will require even more effort and significant transformation.

Royal Berkshire NHS Foundation Trust Delays 2015

Delay Transfer of Care		*Beds:*	627			
Month	**Reading**	**West Berks**	**Wokingham**	**Oxford**	**Other**	**Total**
Jan-15	202	93	105	196	174	**770**
Feb-15	185	154	169	153	84	**745**
Mar-15	250	113	160	189	135	**847**
Apr-15	181	148	111	249	87	**776**
May-15	320	99	190	227	75	**911**
Jun-15	315	247	304	127	78	**1,071**
Jul-15	219	136	166	173	59	**753**
Aug-15	189	31	119	214	132	**685**
Sep-15	217	75	173	158	204	**827**
Oct-15	195	117	154	147	184	**797**
Nov-15	216	250	142	229	91	**928**
Dec-15	166	173	205	339	50	**933**
Annual Total	**2655**	**1636**	**1998**	**2401**	**1353**	**10043**
Share Proportion	26.4%	16.3%	19.9%	23.9%	13.5%	

Oxfordshire and Reading are the largest contributors to delayed days at the Royal Berkshire Hospital. West Berkshire, Wokingham and other localities make up about half of the remaining delayed days. The overall delayed day percentage is 4.4% which is above the 3.5% national target.

Berkshire Healthcare NHS FT Delayed Transfers of Care 2015

Delay Transfer of Care		*Total Beds:*	140	
Beds per Locality/Site	35	*59*	46	
Month	**Reading**	**West Berks**	**Wokingham**	**Total**
Jan-15	174	39	178	**391**
Feb-15	115	5	73	**193**
Mar-15	96	35	113	**244**
Apr-15	99	20	70	**189**
May-15	109	62	108	**279**
Jun-15	188	65	208	**461**
Jul-15				
Aug-15	122	9	186	**317**
Sep-15	142	16	193	**351**
Oct-15	87	19	91	**197**
Nov-15	72	32	123	**227**
Dec-15	149	29	62	**240**
Annual Total*	**1353**	**331**	**1405**	**3089**
Share Proportion	43.8%	10.7%	45.5%	
**Annual total only includes 11 months - original data missing July 2015 data*				

Data only includes beds commissioned by Berkshire West CCGs (Oakwood Unit Reading, West Berkshire Community Hospital and Wokingham Hospital).

Reading and Wokingham together contribute approximately 90% of the delays at Berkshire Healthcare sites. In terms of number of delayed days, BHFT has almost 30% of delayed days as RBFT indicating that 2016-17 schemes will also need to target discharge planning in community sites.

Overall BHFT is operating at 6.6%, with Reading and Wokingham operating at over that average.

Annually the percentage by site is as follows;

- Reading – 11.5%
- Wokingham – 9.1%
- West Berkshire – 1.7%

Challenge 5: Increasing Demand for Adult Social Care Community & Care Home Packages

Adult social care costs during 2015/16 have increased, resulting in significant cost pressures within Reading Borough Council. Reading also has a high level of placements into residential care and has seen escalating demand for therapy services. Additional home care packages have also placed further unsustainable demand on the local authority. However, our Better Care Fund Scheme 04 "Discharge to Assess" has played a part in helping address this demand, but has in turn consumed more local authority resources than originally planned, at a rate which is unsustainable. We plan during 2016/17 to further invest and expand this service building to the successes seen to date.

During 2015/16 we have seen the number of permanent admissions to care from April to December 2015 decreased by 57 admissions from 2014. However, Reading Borough Council remains outliers with higher rates of residential placements.

Challenge 6: Increased Demand for Planned Care Services

Year on year we have only seen a small increase in demand for planned care services, 0.4% growth across Berkshire West providers. Although elective care is outside the scope of the BCF it is important to ensure the balance between elective and non- elective work is managed across the system. High levels of non-elective demand, combined with Delayed transfers of care have the potential to reduce capacity to carry out planned procedures. Clearly a balance is important and improvements in DTOC and reduction in NEL through the better care fund schemes and other initiatives will help free important capacity to carry out planned work, which in turn can reduce /address the burden of long term morbidity.

Challenge 7: Inequity in Access to Service 7 Days a Week

During 2015/16, (BCF 05c) we increased service provision within our GP practices to provide routine care in the evenings and on Saturday mornings. In addition pre-bookable resilience appointments are available at peak times over the winter period to support the reduction in A & E attendees. 97% (28) of our eligible GP practices in the two Reading CCGs have offered these extend services since Sept 2015. Further consideration now needs to be given to provide enhanced access cover for the remaining 3% and to consider extending to Sundays.

Within social care and across our providers, we have worked to identify and realign those services seen as essential to provide a robust whole system: whole week approach. This has included a Reading Borough Council Social Worker presence in the hospital at weekends, funded from resilience monies and increased Occupational Therapy time to ensure assessments can be carried out in a timely way over 7 days. We continue to focus on discharge planning and offering access to social work support for relatives considering care home placements, including individuals who will be funding their own care. We continue to monitor progress and identify gaps in service provision that impact on delayed transfers of care or increase pressures during Monday to Friday. Our connected care and integrated hub schemes (BCF05a & BCF03) continue to be important enablers in allowing care to be provided seamlessly and consistently throughout the whole week.

The Local Authority has a duty to provide an Approved Mental Health Practitioner (AMHP) service to its population. Over a 24 hour period this is covered across the Community Mental Health Team (Monday – Friday, 9-5) and by the Emergency Duty Service run by Bracknell Forest Council who run their service from 5pm – 9 am weekdays and throughout the weekend. This does create some challenges in terms of work not being started and delayed until the next 'shift' which lends to a delay in the assessment process for individuals.

We are in the process of reviewing the AMHP service to ensure that we can provide a seamless and timely offer to people with mental health needs who required an AMHP assessment.

This work commenced in March 2016 and is expected to be concluded by June 2016.

SDIPs are in place within the acute and community/mental health provider contract around 7 day working for 16/17.

See page 15 of this narrative for further detail on our plans to develop 7 day working for 16/17.

2015/16 Better Care Fund Scheme Review

A workshop to reflect on the Better Care Fund (BCF) progress over 2015/16 and to evaluate the local Reading BCF schemes was held in Dec 2015. We utilised the national self-assessment toolkit as an opportunity to critique existing schemes and to help inform our plans for 16/.17. This review workshop had representation from key stakeholders across health, social care, Healthwatch Reading, Berkshire Healthcare Foundation trust, Royal Berkshire Hospital and Reading Voluntary Action.

Our key findings were:

- Although 2015/16 has seen significant progress towards improving integration , much more is still required to be done to fully ensure we are working as efficiently as possible across the whole system , involving all key stakeholders
- Many schemes highlight the potential to become more fully integrated and we have been able to demonstrate varying degrees of integration within our existing projects along with some important next steps to build on learning this year.
- We identified across all schemes the need to improve and better define outcomes allowing more meaningful data collection
- It was identified that there was a need to urgently review the resources available from a workforce perspective to ensure adequate support is available to drive projects forward more efficiently in 16/17.
- We identified the importance of co-production of schemes with clearly defined shared aims and outcomes
- It was evident that we need to improve collection of patient experience feedback which is both consistent and informs future project/service developments.
- We recognised the complexity of the governance arrangements at both local and Berkshire West level, with some projects appearing to be outside of local control.
- Scheme accountability requires further definition and clarification if we are to be more successful in 16/17
- Further clarification is sought to define existing core resources and how these fit with and local scheme requirements
- Duplication in commissioning arrangements could be further refined.
- We reaffirmation the ultimate aims of the BCF to reduce non elective admissions and reduced delayed transfers of care.
- We need to increase prevention, maximise independence and self-management within our population, as a means of helping contain future costs.

A) BCF Scheme 04: Discharge to Assess

All members present supported the carry forward, with modifications and improvements, into the BCF for 16/17 of the most successful of our two local work streams, the "Discharge To Assess" scheme.

This Scheme consists of **two elements:**

1. The Full Intake Model element aims to increase community reablement team capacity offering admission avoidance, reablement and support to the "discharge to assess bed base".

2. The "Discharge to Asses" service consisted initially of 10 beds in the Willows residential home. A further 2 beds were funded in year , following identification of a gap in service provision and increasing demand, specifically for older people with mental health including dementia at a cost to RBC outside of the scope of the original BCF)

The total cost of these services provided jointly by RBC and BFHT is currently £854k p.a. (£456k for Discharge to Assess and £398k for Full Intake).

The Full intake model element achieved the highest score of all the schemes reviewed, closely followed by the Discharge to Assess bed based element.

The lowest individual scores within the scoring matrix for both reflected the need for improved patient/user satisfaction assessments. It is planned to introduce the Friends and family test to this service for 16/17. Both elements of this scheme, on reflection, had delivered and exceeded against the intended outcomes, reducing delayed transfers of care and length of stay in an acute hospital. This however, now needs to be refreshed to address changes seen in the patient cohort and model of care, since the original BCF was produced and to address capacity issues where activity has been far higher and of higher acuity than originally planned. Both elements of the scheme need improved data collection to provide solid evidence of value for money in the longer term e.g. costing of the impact on reduction in requirements for residential care. Further opportunities exist for improved integrated working e.g. single service manager across health and social care as well as further pathway improvements.

Next Steps:

It was agreed to urgently set up a task and finish working group during 16/17 with all key stakeholders early in Jan 2016 to refresh and refocus the scheme and prepare a Project initiation document (PID) which addresses the issues highlighted during the review process. The 16/17 BCF plan should be strengthened to better describe the Full intake model and to further analysis the impact of these two elements on DTOC and NEL. The staff mix of the services will also be reviewed with a possible reduction in Health staff (Nurse, Pysio etc.) replaced with additional care staff/assistances in line with patient/users needs. The budget split between the Council and BHFT (local community health provider) will be adjusted accordingly.

B) BCF Scheme 05b Neighbourhood Clusters Initiatives

This scheme during 2015/16 has consisted of four phased pilots which have been running independently of each other using existing resources (outside of the BCF). Each pilot was scored separately during the evaluation process but a number of themes emerged which

allowed us to make recommendations for a more integrated approach going forward into 16/17.

Pilot 1: Social Prescribing

This pilot commenced in June 2015 and is funded currently through CCG Partnership development funds (£29k) and is provided by Reading Voluntary Action. This pilot has received 22 referrals in the first 9 months. Although the service is valued by users and has seen improvements in wellbeing outcomes and offers a valuable function in signposting and supporting individuals within the community, the greatest challenge has been to receive large enough numbers of referrals from GP practices into the service. This project is not currently integrated with the other pilots nor into social services and may duplicate some of the work currently already commissioned elsewhere, e.g. the citizen's advice bureau. Plans to roll the pilot out across the whole of Reading are currently being reviewed within the PDF process and were therefore felt to be outside of the BCF.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly around the source of referrals and could link into the other pilots in a fully integrated manner but would be better placed outside of the BCF, due to the different funding stream and recognition that, although important integration work streams, they do not **all** impact directly on DTOC nor Non Elective admissions.

Pilot 2: Living Well

This pilot also commenced in June 2015 and is operating across the 10 practices in North & West Reading, funded from Quality premium money £79k. The pilot has seen 91 people in the first 8 months and some good early outcomes and clear deliverables in reduced GP appointments, 99 calls, A & E attendances as well as a 50% reduction in unplanned admissions in the patient cohort. Patient wellbeing scores had also seen improvements and although patient satisfaction data had been collected it has yet to be analysed. The greatest challenge, as with the social prescribing pilot has been the low numbers of referrals seen from within GP practices.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly around the source of referrals and as with the social prescribing pilot, could link into the other 4 pilots in a fully integrated manner, but outside of the main BCF.

Pilot 3: Case Co-Ordinators

This pilot commenced in July 2015 and utilises existing BFHT resource funded by the CCGs of 1 w.t.e Case Coordinators at a cost of approximately £44k p.a. The pilot, through the use of the ACG tool and local knowledge had identified large numbers easily identifiable clients suitable for early intervention and community support. In the first 4 months, 70 people were reviewed. Results from quarter 1 show a 30% reduction in GP contacts, 64% less calls to NHS 111, a reduction of 69% in A & E attendance and a 85% reduced unplanned admissions for this cohort of patient before and after the interventions. The lessons learnt from this pilot where it is possible to identify a specific cohort of frequent flyer clients could be further developed and integrated with the other neighbourhood pilots to maximise future value for money. Introduction of the Friends and family test would help strengthen and inform this pilot going into 16/17.

The Reading Integration Board in principle felt this scheme would be worth linking, particularly around its ability to identify suitable clients, with other 3 pilots in a more fully integrated manner, again outside of the BCF.

Pilot 4: Right 4 U

This pilot commenced in Nov 2015 and is provided by Reading Borough council through a different way of working using existing staff. It currently only offers support to approximately 300 RG2 postcode residents and first contacts, but there are plans to extend across reading going forward. It should be noted that this pilot was only commenced in Nov 2015 and it has not yet been possible to evaluate it fully. The early indications are that the pilot has identified large numbers of clients suitable for early prevention and community support. There has been a low conversion rate to requiring with over 60% of contacts being offered timely personalised help , without the need for long term social care or short term social care services. This project is not currently integrated with the other pilots nor into health.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly by linking into the other pilots in a fully integrated manner, in a separate work stream outside of the BCF.

Next Steps:

We have identified strengths and weaknesses in all four schemes. By bringing those successful elements of the schemes together we could significantly improve the offer to the Reading population in relation to prevention and early community support. We now need to re-establish a neighbourhood cluster working group as a task and finish working group with all key stakeholders to refresh and refocus the scheme and prepare a Project initiation document (PID) which addresses the issues highlighted during the review process. This particular work stream will due to difference in funding streams remain run outside of the main BCF, but remain a key work stream for Integration in Reading.

C) BCF Scheme 01 & 02: Hospital @ Home & Care Homes

In 2015/16 a CCG investment of £387,000 in a Care Homes project moved to the Better Care Fund (BCF) and a total of £2,981,000 (FYE) investment was provided to also support the Hospital at Home (H@H) project. Following monitoring and learning early during the implementation phase, The H@H project was rebranded in September 2015 and was replaced by the Rapid Response and Treatment Service (RRAT) for Care Homes. RRAT is a new service provided by the locality community teams which will respond within 2 hours of receipt of a referral or within 2 hours of a patient returning home from A&E. The RRAT provides increased and targeted Community Geriatrician input, including active treatment interventions including crisis support and the use of telehealth to support those at risk of admission. The enhanced rapid response pathway provides crisis response and treatment for patients in care homes. The service is available 8am – 8pm, 7 days a week with a proposed length of stay of up to 5 days on the pathway.

In April 2015 the GP CES was incorporated into and moved to the Anticipatory Care CES and funding adjusted.

The aim of the project to date has been to provide a common and consistent approach to improving outcomes for those people living in Nursing and Care Homes in Berkshire West through training and education of care home staff, medication review of all residents and anticipatory care planning and since October 2015 enhanced through the introduction of RRAT.

Full review of each of these elements has been carried out and the learning has concluded:

- Training & Education: The KPIs need to be more reliably measurable. It is proposed that going forward, further training options are considered especially to ensure we are able to better target the key four diagnoses that have the greatest impact on NEL admissions: UTI, Pneumonia, Falls and Dementia. In addition a focus on reducing

calls to 999 through empowering staff in their decision making and ensuring all homes are aware of the alternative care options

- Reduction in Non- Electives: The planned gross savings £292k across Berkshire West anticipated in the 2015/16 project will not be realised, however we have seen a reduction in non-elective activity in this cohort of patients of 72 unplanned admissions (20%) against a target of 50% reduction and an associated saving of £215k. 999 calls have not shown a decrease and with a 48% conversion to admission, there is still further work to be done to fully address this problem. There appears to be potential to further reduce the 0-1 length of stay admissions, of which 70% are considered potentially avoidable.
- Medication review: further investment is required to maximise the savings on investment and to increase from 1 to 2 w.t.e pharmacists (1 w.t.e. in 2015/16 has released £107k of savings.)
- Whilst the RRAT service data is only very recent, and therefore limited, it does demonstrate an effective impact on the numbers of NEL admissions from the first phase of 15 Care Homes and this is demonstrated in both the QIPP and Care Home report. For phase 1, 15 NEL admissions have been avoided in the first 2 months of the scheme: a 23% reduction in NEL admissions for this cohort of care homes. Anecdotally all calls attended by the clinical staff were felt to be appropriate and all would have resulted in calls to SCAS and attendances at A&E in their opinion had the RRAT service not been in place. For 2016/17 the project will recommend continued investment in this service and roll out as planned across all 4 phases to cover all nursing and residential homes in Berkshire West.

The Reading Integration board has agreed to carry forward the revised care Home Scheme into the 16/17 Better care fund, in line with our findings and learning to date. It is felt locally that this scheme has the greatest potential to impact on the care home Non Elective Admissions.

In addition for 2016/17 a review of the reporting mechanisms and savings options across the pathway will be undertaken. Following review of the data the following savings for 2016/17 is recommended:

- South Central Ambulance Service (SCAS) – Hear and Treat is reduced by 90%
- SCAS Calls - See and Treat is reduced 50% reduction.
- SCAS - See, Treat and Convey is reduced by 50%
- Secondary care 0-1 day Length of stay (LOS) is reduced by 75%
- Secondary Care 2+ days LOS is reduced by 30% in line with national evidence of similar project outcomes.

The Reading board also supported the continuation of the Rapid Treatment for care homes project within an overarching Care Home Project for 16/17 which bridges Health and Social Care.

D) BCF Scheme 03: Connected Care

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. This high number of organisations, and the different culture, systems & technology, processes and legislation which drive them, makes it difficult to get a single view of a person at a point in time.

What our Connected Care solution is offering is the 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:

- The NHS number is used as the consistent patient/user identifier
- 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

Please See Narrative Template for further information.

E) BCF Scheme 5c: 7 Day Working

We have made good progress on achieving 7 day services access across a range of primary, local authority, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 2015/16 (a core part of the 2015/16 planning guidance). Further detail is provided in our Berkshire West CCGs Operating Plan 2016/17. *(Ref Berkshire West CCGs Operating Plan 2016/17 section 6.2 7 day services).*

Primary care: In addition to investments made via the BCF, through systems resilience and into MH services all of which directly support 7 day access we have invested in an Enhanced Access CES for Primary Care. Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number.

Acute Care: In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met their agreed actions on standards 7 and 9.

Across Berkshire West , We are in the process of finalising the requirements with RBFT (acute provider) for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the self-assessment tool on 7 days as required by the end of April 2016 and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards.

The key milestones and timelines proposed will require by the end of quarter 1 (end of June 2016) for baseline positons and trajectories to be agreed for implementation in 16/17 against four priority clinical standards as well as for several new agreed priority clinical standard areas to ensure full coverage of the 10 clinical standards by the end of March 2017. Following agreement of the baseline and trajectory values at the end of quarter 1 , implementation and delivery will then be monitored at the end of quarters 3 (End of Dec 2016) and quarters 4 (end of March 2017) for each clinical standard area.

Community Care: Berkshire Healthcare Foundation Trust (BHFT), our community provider, also had an SDIP in 2015/16 which covered the respective elements of standard 7(MH on

acute admission, Psychological medicines services (PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning.

Key health services in the community, such as rapid response and reablement, home care and reablement as well as the mental health crisis teams already operate on a 7 day a week basis but uptake of these services is lower at week-ends. Using the results of our stocktake during 15/16, of which community services operate at the week-ends and how workload is profiled across the week we will use the outcomes to develop our work further for 2016/17 with our community provider. The Integrated Discharge Team does operate 7 days a week 'pulling' patients out into the community.

Mirroring our acute provider, our community and mental health provider (BFHT) will be required to build and develop a 16/17 SDIP to cover standards relating any consultant led care e.g. mental health and community inpatients and geriatrician services. The trust will be required to complete a self–assessment tool and quarter by quarter through 2016/17 have specific milestones to deliver the appropriate standards. The key milestones and timelines proposed will require by the end of quarter 1 (end of June 2016) for baseline positons and trajectories to be agreed for implementation in 16/17 in priority clinical standards to ensure full coverage of the applicable clinical standards by the end of March 2017. Following agreement of the baseline and trajectory values at the end of quarter 1, implementation and delivery will then be monitored at the end of quarters 3 (end of Dec 2016) and quarters 4 (end of March 2017) for each clinical standard area.

Social Care: Reading Discharge to Assess services operate on a 7 day basis but again uptake is lower at the week-ends and joint work is needed with the hospital to smooth this flow.

Reading Council have new contracts and rotas in place to achieve a social worker presence at the Royal Berkshire Hospitals 7 days a week in 2016/17 to ensure that assessments and placement can take place consistently across the week. Further work will be undertaken with Independent Care Providers so that care packages can be started over 7 days. A robust feedback loop to the RBFT will be required so that any issues with week-end discharges can be immediately addressed.

For 16/17 our focus on 7/7 services will continue, however with the move to full delegation from April 2016 for primary care services, the GP element of the 7 day funding will transfer from the BCF to the Primary care budgets held by the Berkshire West CCGs. This will then be managed through the primary care commissioning committee which has representation form NHSE, CGGs as well as local authority representation.

For 16/17 our focus on 7/7 services will continue, however with the move to full delegation (where CCG will see the transfer of responsibility and funds move from NHSE to the CCGs, who will have fully delegated authority to manage the budget and commission primary health care from GP practices)from 1st April 2016. The decision was taken to avoid splitting the budget resource for access to primary care that the GP element of the 7 day funding will transfer from the BCF to the Primary care budgets held by the Berkshire West CCGs. This will then be managed through the primary care commissioning committee which has representation form NHSE, CGGs as well as local authority representation.

F) BCF Scheme 5a Health & Social Care Hub

A review report was considered by the Berkshire West 10 delivery group in Jan 2016. This outlined the progress to date with the Wokingham Hub. The main of this scheme is to provide a single point of access that ensures patients/users only tell their 'story' once; that has an overview of all local suitable/available support resources and has the authority to commission said resources directly.

West Berkshire local authority area are currently committed to their access model as the first step towards an integrated hub, but recognised that there must be learning from both systems and that it the models are not directly comparable and therefore once both models have been sufficiently evaluated that the learning be brought back to enable optimisation of the benefits of both models to the system as a whole.

Reading had recently launched through their partners for change program “Right 4 U“ model which is showing early sings of success. (see review above B) BCF scheme 5b). Although this will sit outside of the BCF in 16/17, it is important that the findings coming from the Frail Elderly Pathway programme highlights the aspirations for a streamlined access for users to both health and social care which reduces handoffs and promotes integration. Reading will continue to work with partners on future options and expansion of their model to ensure it is fully integrated across health and social care.

2016/17 Revised Better Care Fund Plan: What has changed?

A summary of the funding for 2016/17 is detailed below with the comparative 2015/16 figures and accompanying narrative highlighting key changes.

The planning template provides a full overview of the funding contributions for 2016/17 and has been jointly agreed by the CCG and Local Authority via the Reading integration Board and Reading Health & Wellbeing Board.

Scheme Name/Expenditure Line	16-17 Expenditure (£)	15-16 Expenditure (£)
s256/Protection of Social Care		
1. Bed based intermediate care Willows	523,000	379,000
2. Bed based intermediate care Assessment Flats	46,000	0
3. Social care intermediate care team	863,000	374,000
4. Additional intermediate care and re-ablement resources to support H@H, delayed discharges	0	368,000
5. Community reablement team	1,529,000	1,066,000
6. Mental Health reablement and recovery team	200,000	150,000
7. Specialised nursing placements (to support hospital discharges)	400,000	139,000
8. Community equipment & minor adaptations	50,000	35,000
9. Protection of Social Care	0	1,100,000
10. Care Act Monies	361,000	361,000
11. Carers Support Funding	641,000	641,000
12. Time to Decide/Discharge to Assess	556,000	456,000
13. Full Intake	398,000	0
14. Reablement	779,000	779,000
NHS Out Of Hospital Commissioned Services		
15. Speech and Language Therapy	44,000	0
16. Community Geriatrician	87,000	0
17. Intermediate Care	92,000	0
18. Health Hub	742,000	0
19. Intermediate Care night sitting, rapid response, reablement and falls	341,000	0
20. Care Homes in reach	244,000	0
21. Support to residential and nursing care homes (Enhanced Care in Care Homes)	158,000	175,000
22. Rapid Response and Treatment to Care Homes – RRAT	280,000	0
23. Hospital at Home	0	827,000
24. Health and Social Care ICT (Interoperability)	300,000	256,000
25. Seven day Integrated Health and Social Care Teams (Inc. GP 7 Day Access and Full Intake)	0	1,372,000
26. Programme Management	209,000	0
27. Disabled Facilities Grant	815,000	500,000

28. Social Care Capital Grant	0	317,000
29. Contingency	217,000	182,000
30. Risk Share Agreement	542,000	719,000
	10,417,000	**10,196,000**

Summary of changes

S256/Protection of Social Care (lines 1 – 9)

Lines updated to reflect actual expenditure and to enable consistent financial reporting. Please see 'Maintaining the provision of social care' in the narrative document for more detail.

Time to Decide/Discharge to Assess (line 12)

Following our programme evaluation we are continuing with the Discharge to Assess 'step down/step up' beds at the Willows residential home and expanding the service with two additional units/beds at a cost of £100k pa. The budget split between health and social staffing is being reviewed inline with patient/user needs and is subject to change from the figures reported in the Planning Template. Please see page 11 above for further details. This also applies to the Full Intake Model funding and staff mix.

Seven day Integrated Health and Social Care Teams (Inc. GP 7 Day Access and Full Intake) (lines 13 & 25)

Improving access to General Practice element of 7 day services removed and now funded outside of the BCF to allow alignment with other primary care budgets under full delegation responsibilities.

The Full Intake model continues to be funded with the remaining balance invested into NHS Commissioned out of Hospital Services.

Hospital at Home/ Rapid Response and Treatment to Care Homes (lines 22-23)

Hospital at Home project redesigned in September 2015 and replaced by the Rapid Response and Treatment Service (RRAT) for Care Homes.

Programme Management (line 26)

Dedicated resource has been included for both local and pan Berkshire BCF/Integration programme management.

Disabled Facilities Grant/Social Care Capital (lines 27-28)

In lieu of final determination correspondence it is assumed the DFG allocation includes the Social Care Capital thus figures have been combined for 16/17.

NHS Commissioned Out of Hospital Services (lines 15-20)

New to the BCF in 16/17 will be a range of Out of Hospital Services commissioned by the CCG through our community provider. These schemes , alongside other initiatives outside of the BCF, supports the overall delivery of the NEL and DTOC BCF Objectives as well as managing demand for urgent care including A & E attendances as well helping our resident remain as healthy and well as possible in the community.

The new service lines within the BCFs are as follows:

- **Adult Speech & Language:** This service supports indirectly avoidance of NELs through timely swallowing assessment in at risk individuals, hence avoiding future episodes of aspiration pneumonia and chest infections.
- **Care Home Support Services**: This is in addition to the new investment included in BCF within 16/17.
- **Community Geriatricians:** The community geriatricians will support the primary care teams, intermediate care teams, care homes and community hospitals within their area and provide easily accessible and speedy advice with the intention of reducing admissions to secondary care.
- **Intermediate Care** (including but not restricted to: rapid response, reablement, falls and night sitting): The aim of the Intermediate Care Services is to provide individuals who are referred to the service, with a structured gaol based action plan. This is provided by a multidisciplinary team, which is responsive to an individual's physical, psychological and social needs. This includes those who have early onset dementia, or whose needs are of a palliative nature and who wish to remain at the end of their life in their own home. In the Reading Locality the Intermediate Care Service is an integrated service provided by Berkshire Healthcare NHS Foundation Trust (BHCNHSFT) and Reading Borough Council.
- **Health hub:** The Health Hub is the single point of access for referrals from healthcare professionals to scheduled and unscheduled community services. Clinical advisors are based within the Hub providing clinical screening of referrals supporting effective prioritisation of resources to meet clinical need. This service helps facilitate patient flow (thus avoiding DTOCs) from RBFT to the community Beds or alternative community services based upon clinical need. Out Of hours referrals are also processed and administrated through the Health Hub. Referrals are prioritised and actioned appropriately in respect of risk and urgency and forwarded to the most appropriate service in a timely manner as indicated on referral or after triage. Access is available 24/7, 365 days a year and the Hub works with other services and teams within the Trust to ensure a smooth and seamless transition or transfer between services.

Supporting Metrics and Targets for 2016/17

Non-elective admissions

Please see Page 5 of this document for detail regards how our NEA target for 16/17 has been set. Further details are also enclosed on our BCF Planning Template.

Delayed Transfers of Care

At a meeting on 21 April 2016 the Reading Integration Board considered the DTOC situation analysis (summary at page 7 above and at annex 3) and the following three scenarios for what the overall DToC target should be (acute and community beds):

Scenario 1: Ambitious

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	697	670	649	615	567
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	813	736	706	658	625
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	871	837	811	769	711

Scenario 2: Moderate

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	767	740	720	687	636
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	831	772	759	729	696
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	959	925	900	858	798

Scenario 3: Conservative

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	792	784	765	731	680
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	837	789	787	768	740
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	990	980	956	914	853

It was agreed that the Reading target should be based on the ***Conservative scenario 3*** and these figures/targets have been entered onto the attached BCF Planning Template. The Board also agreed an action plan (annex 3) which contains a set of clear actions to deliver improvement and that builds on both the success of local initiatives and on nationally agreed best practice interventions.

Reduction in the numbers of people over the age of 65 in residential care

Reading Borough council have made significant progress on this in 15/16 but still benchmarks higher than neighbouring Local authorities. Continued focus is therefore to ensure only those who need intensive support, live in residential care settings. This focus is required in relation to patient flow/pathways and the front line culture of practice to ensure our strategies to support people in their own home are fully embedded.

At present health and social care teams are supported through improved decision making processes, e.g. R4U, integrated working and work-streams such as positive risk taking the RRAT and care home programme will continue within 2016/17. The proposed target within 2015/6 was to reduce admissions by 58%. The forecast target is a reduction of 31%. This

achievement will see a plateau within 2016/17 and further work with regards to length of stay will need to be addressed within the KPI metrics.

The planned target for 2016/17 is a further reduction of 8%. This is based on financial resources, national targets and statistical neighbour analysis.

Increase in the number of people at home 91 days post discharge

Focus and prioritisation continue in this area to ensure we have robust preventative and crisis management services in the community, in particular effective reablement services that support people post-discharge and help them to achieve their full potential recovery. In order to support patient flow the reablement service is currently prioritising hospital discharges – this will need to be regularly monitored to ensure the service can effectively support people in the community to prevent admission in the first place.

Performance improved during the year, but due to the unforeseen increase in demand, the target will not be achieved, based on the current upward trend early indication is that Reading should achieve the next year's target. This is due to the fact that within 2015/16 the stretch target of 95.5% still at home 91 days after discharge from hospital (community or acute) was too great and within 2016/17 although a stretch target has been implemented this is significantly less. The reduction within 2015/16 could be associated with the increase of NELs and the pressures placed within the system to discharge clients from the acute trust, as well as the higher acuity of the older people leaving the acute sector.

The planned target for 2016/17 is 82.7% and the stretch target will be 86.7%. This is based on a change in care services within the Willows Residential Care Home (DTA beds).

Local Metric - draft proposal

Within Reading, following a recent analysis of NEA activity the largest numbers of individuals (44%), by age group, contributing to the NEAs at the Royal Berkshire Hospital is 19-64 years. This group also represented 37% of the total NEA spend.

The BCF local metric is to plan and devise an analytical system that enables a greater integrated approach to gain a better understanding of this system pattern and identify any contributing factors. Working with Public Health/Housing and Drugs and Alcohol teams we plan to further align preventative work and tackle issues identified that are amenable to change.

Metric 5: Total non-elective admissions in to hospital (general & acute), age 19-64, per 100,000 population /month?	Effective joint working of hospital services (acute, mental health and non-acute) and community-based prevention services to analyse non-elective activity for residents aged between 19-64 years.
Rationale	With a particularly young population within Reading, it is important we focus our integration efforts not only towards the elderly population but also in a preventative manner at our younger age groups, to help support them remain well for longer and able to self-manage. There is a need for a series of comprehensive systematic reviews

	that will identify interventions to address the organisation of care and access for the purpose of reducing non-elective admissions (NEA in this patient cohort).This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the integration between health and social care services. Minimising non-elective admissions enabling people to be treated in the community or at home is one of the desired outcomes of the Better Care programme.
Definition	Total number of non-elective admissions for 19-64 year olds per 100,000 population. A non-elective admission occurs when an Admission that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. **Numerator:** The total number of non-elective admissions for patients (aged 19-64) for all months of baseline period by local authority of residence **Denominator:** ONS mid-year population estimate (mid-year projection for population) A literature review on the effectiveness of system programmes that have been implemented in Reading will consider emerging best practice in reducing NEAs. The evidence based support for BCF programmes has been considered in this review. The review highlights the effectiveness of emerging models of integrated care compared to usual care.
Source	This systematic review will be carried out across a wide range of electronic databases (ALAMAC, Mosaic and Rio) to identify NEA activity and a review of interventions used to reduce unplanned hospital admissions in 19-64 year olds.
Reporting schedule for data source	• Milestone plan production • NEA analysis 19-64 years

	• Quarterly highlight reporting • Programme analysis • Monthly at Reading Integration Board
Historic	April 2016

Patient experience

As a sector, we need to understand more about how services are affecting people's lives, rather than simply what outputs services are providing. If users are to be at the heart of care planning and provision within Reading, then user experience information will be critical for understanding the impact and outcomes achieved - enabling choice and informing service development.

The development of the BCF local User Metric based on user experience will be used:

- To provide assured, consistent and benchmarked local data on care outcomes. It is the most significant pool of personal outcome information for people receiving adult social care.
- To support transparency and accountability, enabling people to make better choices about their care.
- To help local services identify areas where outcomes can be improved in a very challenging financial climate, and support their own initiatives with an assured vehicle for obtaining outcome information.
- To populate outcome measures in the Adult Social Care Outcomes Framework

When care is not joined up it affects both patients and carers adversely, but currently there are few robust and tested instruments for assessing how well users of health and social care services feel their care is being coordinated.

The proposal is for feedback from patients/service users to be gathered through semi-structured interviews carried out in a number of settings spanning the services funded by the Better Care Fund and those that form part of the work plan of the Integration Programme Board. The same survey will be used in all settings and highlight results will be reported on monthly with a fuller quarterly report.

The survey will be carried out face-to-face, via an internal team or by a third sector provider, to ensure both statistical and qualitative feedback can be gathered. Research into how people answer questions about integrated care and health and social care services working together, shows there is sometimes a danger of people 'averaging out' their responses e.g. giving an average score to balance a good experience with a health professional with a bad experience with a social worker or vice versa. This stresses the importance of giving examples and explanations, this is one of the reasons a face-to-face interview is favoured, in terms of understanding and recording the person's own context and descriptions, to add greatest value to local intelligence on integration.

To date a patient service experience measure has been established across care providers and will be reported on within the first quarter. This quarter will also see the proposed service user experience plans built and signed off by Reading Integration Board. The full implementation date for this metric will be 1st July 2016.

Programme Governance

In Reading, we have a history of pooling health and social care budgets to deliver improved outcomes, and have developed governance arrangements appropriate for integrated care. These have been refreshed to establish joint governance arrangements covering both our Better Care Fund and Care Act implementation programmes.

The primary accountable board for the Better Care Fund schemes across Reading is the Reading Integration Board. This is chaired jointly by the Head of Adult Social Care at Reading Borough Council and the Operations Directors for the Berkshire West Clinical Commissioning Groups.

Reading's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the Borough.

As many of our Better Care Fund schemes span all three unitary authorities and all four CCGs across Berkshire West, as well as local projects specific to particular unitary authority areas, we have established robust governance structures for working across the sub-region.

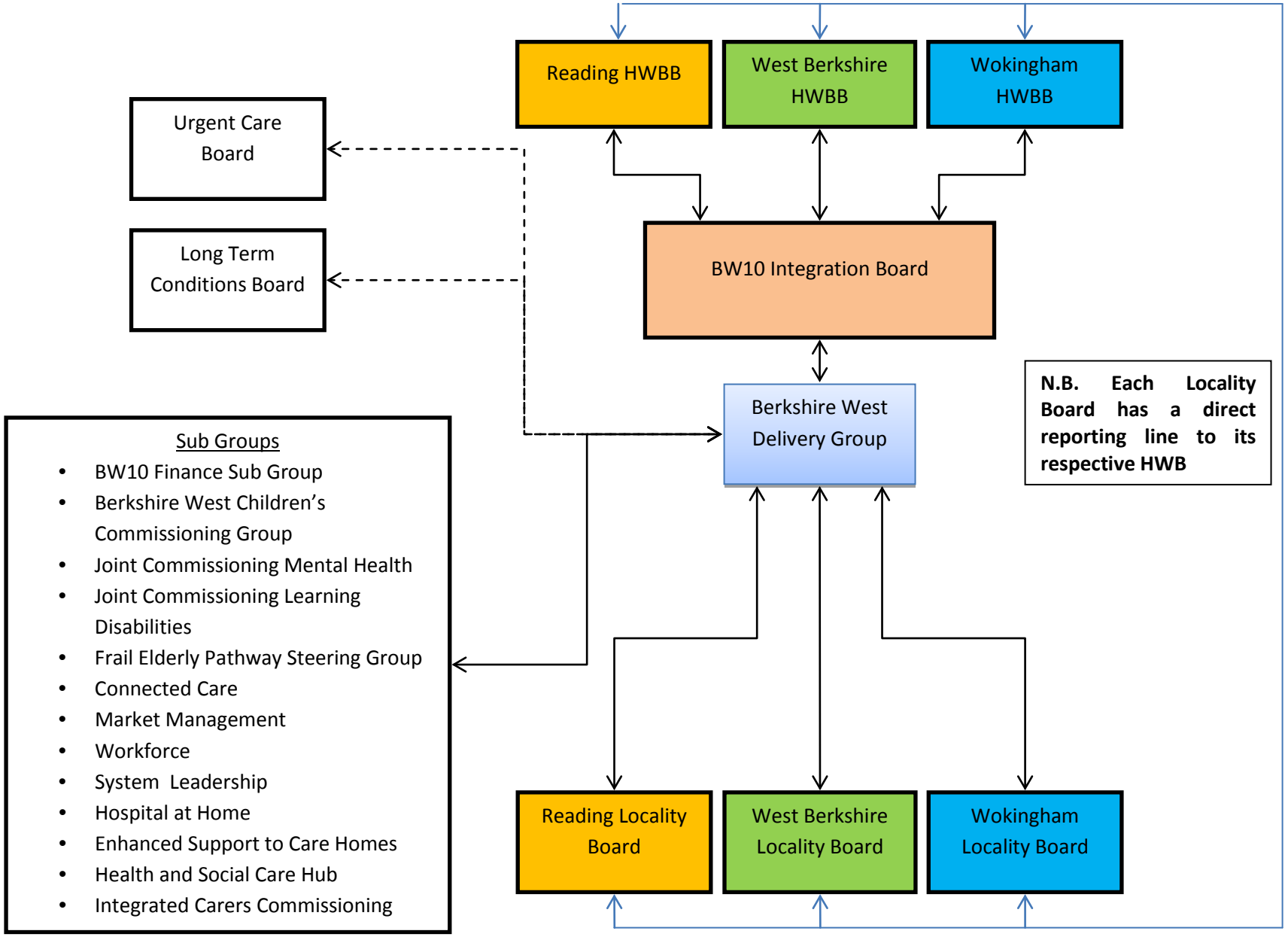
The diagram below shows the key structures across Berkshire West. The Reading Locality Board is the Reading Integration Board.

For projects that span all three unitary authorities in Berkshire West (Wokingham Borough Council and West Berkshire Council as well as Reading Borough Council), accountability is held with the Berkshire West Integration Board, with the Berkshire West 10 Delivery Group acting as the programme board on their behalf.

An additional group, the Berkshire West 10 Finance Sub Group, provides financial support and analysis to the 3 local and the pan Berkshire Integration Boards

Terms of References for the Reading Integration Board are attached at Annex 5.

Berkshire West 10 Integration Programme Governance Map



2016/17 Integration & Beyond: Our plans for New Models of Care and Sustainability

Berkshire West Accountable Care System (ACS)

As outlined previously, the Berkshire West "Health and Social Care Economy" has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign.

To meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and to operate as an ACS. The ACS is a collective enterprise that will unite its members and bind them to the goals of the health and Care system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West.

The key characteristics of our ACS will be:

- We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live.
- We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy
- We will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system
- Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system.
- Finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism.
- We will develop and use long term contracts to promote financial stability of the providers
- It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations.

References

- **Reading Better Care Fund Plan 2014** - https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/fast-track/
- **Berkshire West CCGs Operating Plan 2016/17 (attached at Annex 10)**
- **Reading Market Position Statement -** http://old.reading.gov.uk/marketpositionstatement

Annex

Annex 1 – BCF Programme Plan

Annex 2 – BCF Programme Risk Log

Annex 3 – DTOC Reduction/Management Plan

Annex 4 – Risk Share Mechanism

Annex 5 – Reading Integration Board Terms of Reference

Annex 6 – Joint Assessment/Referral From

Annex 7a – Connected Care - Full Business Case

Annex 7b – Connected Care – Project Communications Plan

Annex 7c – Connected Care – IG Principles and Data Sharing

Annex 7d – Connected Care – Consent to Share Data

Annex 7e – Connected Care – IG Improvement Group – Terms of Reference

Annex 7f – Connected Care – IG Improvement plan/checklist

Annex 8 – 2015/16 BCF Scheme Review

Annex 9 – HWBB minutes delegating joint authority for plan approval to the CCG Chief Officer and Reading Borough Council Director of Adult Social Care and Health

Annex 10 – Berkshire West CCG Operational Plan

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**Health and Well Being Board**		
DATE:	**14 June 2016**	**AGENDA ITEM:**	**5**
TITLE:	**Berkshire Transforming Care Plan**		
LEAD COUNCILLOR:	**Rachel Eden**	**PORTFOLIO:**	**Adult Social Care**
SERVICE:	**Adult Disability/Commissioning**	**WARDS:**	**All**
LEAD OFFICER:	**Jenny Miller**	**TEL:**	**x72471**
JOB TITLE:	**Commissioning Manager**	**E-MAIL:**	**Jennifer.miller@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1.1 NHS England has set up a set of boards across the country to oversee the reforms required by the Review post-Winterbourne "Transforming Care for People with Learning Disabilities and/or ASD and/or Mental Health problems whose behaviour challenges others and services". The Berkshire Transforming Care Board consists of all the CCGs and Local Authorities in Berkshire. It has drafted The Berkshire Transforming Care Plan which was submitted by the CCGs to NHS England on 16th May 2016. The plan outlines the proposal to reduce the number of in-patient Assessment and Treatment Unit beds for this cohort of people and use the resulting resource to provide an intensive intervention service to support this cohort to live safely in the community and reduce admissions to A&T Units.

1.1.2 This change will require better specialised care provision in the community and affordable accommodation for a small increase of very high needs individuals.

1.2 Appendix: Berkshire Transforming Care Joint Health and Social Care Plan.

2. RECOMMENDED ACTION

2.1 To support Berkshire's vision to close down 50% of the in-patient service and developing an intensive intervention service in the community thus reducing the reliance on Assessment and Treatment units to support people with a learning disability and/or autism and mental health conditions.

2.2 To work with the West of Berks and Wokingham Health and Well Being Boards to identify resource and budget to ensure the transformation takes place by March 2019.

3. POLICY CONTEXT

NHS England has set up a Berkshire Transforming Care Board to lead the governance of this plan. There is a representative on this board for the Directors of Adult Social Care but each Local Authority area needs to agree the plan through its Health and Well Being Board.

4. THE PROPOSAL

4.1 Current Position: A central part of the action plan resulting from the National review post Winterbourne View was "to ensure that people with challenging behaviour only go into hospital if hospital care is genuinely the best option and only remain in hospital for as long as it remains the best option". By June 2014 it was expected that all individuals should have been receiving personalised support and care in their community and that when hospital based care is necessary the aim should always be that of recovery, improvement and returning to the community as soon as feasible.

More recently CCGs have been urged to avoid reliance on inappropriate or over extended hospital placements and are requested to "work with providers of specialist services to ensure that CTPLD's have the additional, intensive support they need to keep people out of hospital, including in crisis".

The Berkshire Transforming Care Plan (TCP) brings together work undertaken by a range of key stakeholders: Local Authority Commissioning Managers and operational leads, Carers, Berkshire Health Care Foundation Trust Clinical teams and Managers, 7 CCGs and NHS England, to articulate a proposed way forward to deliver high quality, needs led intervention to people with Learning Disabilities and/or ASD and/or Mental Health problems whose behaviour challenges others and services.

4.2 Options Proposed

The appended Transforming Care Plan (TCP) has been jointly developed with the 6 local authorities and the 7 CCGs and shows how services will be transformed for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

The Berkshire Transforming Care Plan is aligned to the national plan 'Building the Right Support –to develop community services and close 50% of the inpatient facilities by March 2019. The vision is to improve the pathway for people with learning disabilities and challenging behaviour by reducing reliance on in-patient beds and increasing access to intensive specialist community services.

The Berkshire plan is built on agreed values and principles, and identifies specific actions to ensure that all services are planned through clinical engagement and accountability, commissioned and provided in line with national plan and the regional 'Positive Living Model' for people whose behavior may challenge.

The Positive Living Model will aim to support:-

1) Person Lead Planning
2) Advocacy
3) Carer support & Respite
4) Positive Behaviour Support
5) Specialist Social Care
6) Intensive Intervention Service

Some in-patient beds will be retained to provide therapeutic Inpatient support for planned and emergency day and overnight services to individuals for whom it is clinically indicated. A specialist multi- disciplinary team will assess needs, design and implement therapeutic programmes of care that require the physical environment a building based unit can offer. A therapeutic inpatient unit will also act as a resource hub for the intensive intervention service and sessional activity, such as Sensory Integration can be provided.

This cohort of people usually require intensive support in the community and high cost packages of care. There is high risk of breakdown of care package and it is difficult for this cohort to acquire and maintain tenancies.

The Plan aims to close 50% of the inpatient beds by March 2019 and use the same staff resource to provide an intensive support service in the community to prevent further admissions and support on discharge. Therefore, suitable affordable accommodation in the community must be identified and either specialist care providers need to be brought into the area or existing providers need specialist training to be able to meet the needs of these people. The specialist providers could be third sector or commercial. We will publish a public request for Expressions of Interest which we hope will attract a good range of providers to work with to develop the specification.

5. CONTRIBUTION TO STRATEGIC AIMS

- RBC Corporate Plan 2016-19.
  Safeguarding and protecting those that are most vulnerable:
  - Our commissioning of care services needs to be better aligned to the future needs of people and the Care Act.
- RBC Learning Disability Strategy published March 2016.
- NHS England have a national requirement aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015).

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Berkshire Transforming Care delivery plan will be co-produced with people with lived experience and support from the 6 Learning Disability Partnership Boards.

7. EQUALITY IMPACT ASSESSMENT

7.1 Once the plans for the proposed new services are developed in more detail it will be necessary to carry out an Equalities Impact Assessment on the possible impact on people with disabilities.

8. LEGAL IMPLICATIONS

- The services will be compliant with The Care Act 2014
- The procurement of new community provision will be subject to the Contract Procedure Rules of the participating partner local authorities.

9. FINANCIAL IMPLICATIONS

This plan covers a very small cohort of people. Over the last 18 months there have been 10 Reading patients discharged: seven of these have current social care packages with a total annual cost of £397k. At the end of March 2016 there were eight Reading in-patients, two have existing packages with RBC of £107,000 and £125,000. If beds are reduced by 50%, at any one time, there will be about 4 people living in the Reading community who would previously have been in hospital. These people average over £1000 per week so the potential pressure on the RBC revenue budget is over £200k per year.

The financial implications arising from the proposals set out in this report are set out below:-

1. Revenue Implications

	2016/17 £000	2017/18 £000	2018/19 £000
Other running costs – Adult Social Care external supported living		Up to £100	£200
Joint cost across 3 West of Berks Local authorities to procure and/or train specialist external provision	£10	£20	
Expenditure			
Income from: Continuing Health Care and Section 117 Mental Health		Potential sharing of placement costs	Potential sharing of placement costs
Total Income			
Net Cost(+)/saving (-)			

2. Risk Assessment.

The West of Berkshire Project Group that has met regularly for two years and this group has an aspiration that there will be joint commissioning across the 3 authorities and the CGGs for these community services for this high needs cohort. Each authority on its own has too few of this cohort to be able to attract cost effective specialist provision or training. This joint commissioning has failed to get started due the lack of capacity of the three local authority commissioning teams to meet and develop the new services.

There needs to be a budget to ensure the new community provision is in place prior to the closure of the beds. No money has been identified for this step-change.

10. BACKGROUND PAPERS

10.1 Berkshire Transforming Care Joint Health and Social Care Plan

NHS
Newbury and District
Clinical Commissioning Group

NHS
North and West Reading
Clinical Commissioning Group

NHS
South Reading
Clinical Commissioning Group

NHS
Wokingham
Clinical Commissioning Group

NHS
Bracknell and Ascot
Clinical Commissioning Group

NHS
Windsor, Ascot and Maidenhead
Clinical Commissioning Group

NHS
Slough
Clinical Commissioning Group

Berkshire Transforming Care Joint Health and Social Care Plan

Reading Borough Council
Working better with you

West Berkshire Council

WOKINGHAM BOROUGH COUNCIL

www.slough.gov.uk
Slough
Borough Council

Bracknell Forest Council
The borough of opportunity

THE ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

May 2016

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NHS Berkshire Transforming Care Joint Health and Social Care Plan to transform services for people with Learning Disabilities and/or Autism or with a Mental Health condition who display challenging behaviour.

8. Proposed work streams - What we need to work on

Work Stream	Description
• Joint commissioning and integration	To align financial processes between health and social care in local authority/CCG areas. To explore joint commissioning across Berkshire for people with exceptionally complex needs. To share best practice and jointly management market across the County where possible
• Communication and Engagement	To design a comprehensive list of stakeholders and how best to engage them To create a Berkshire wide TCP communication plan To consistently and effectively communicate and engage all key stakeholders
• Workforce Development and Culture	To undertake a cultural audit within each local LDPB areas To create and deliver a workforce development programme for staff To grow a cultural change programme with people with lived experience at the centre
• Children and Young People	To engage children and young people services fully To develop new joint ways of working To ensure people using services have person lead plans that sees them through their life course
• Autism	To engage fully with local people with Autism and the services that support them To include people with Autism in all relevant developments To enhance current support for people with Autism
• Service Reconfiguration	To deliver the intensive Intervention Service and redesigned specialist beds To reduce the reliance on bed based services by enhancing local community provision To grow more robust housing and support solutions To further develop meaningful day occupation and employment opportunities To enhance services to effectively meet the needs of children and young people in transition To reconfigure services to further support people with Autism
• Risk Management –	To create a shared Financial, Quality and Relational risk plan with effective mitigation To mitigate risks through a robust Programme Management Approach and a Programme Management Office

A full proposal will be presented to the Transforming Care Partnership Board that will be fully worked up through engaging people with lived experience as a blue print for delivering the Transforming Care Plan locally. The board will engage programme management support to coordinate the delivery of this process with leadership at Director level to head up each work stream. A co-production group will be an integral part of the each of the work streams to plan and support the delivery of the main objectives to deliver the vision for supporting people to lead meaningful lives.
Each of the 6 local authorities will retain local autonomy to deliver the main objectives through developing shared Berkshire wide principles that will be centred on empowering people with a learning disability and/or autism and their families to live the lives they want and choose.

The Programme Management Approach will be across agencies, geographical and organisational boundaries and focus on strengths within the system. People with a learning disability and or autism will be meaningfully represented at every level of the decision making process.

The Berkshire Transforming Care Partnership

The Berkshire Transforming Care Partnership Board and all stakeholders hold a shared vision and commitment to support the implementation of the national service model to ensure that children, young people and adults with learning disabilities, behaviour that challenges and those with Mental health and Autism receive services to lead meaningful lives through tailored care plans and subsequent bespoke services to meet individual needs.

The 6 Local Authorities in Berkshire already have well established Learning Disability Strategies or Plans, this joint Transforming Care Plan will be aligned to services that are already commissioned and the Board will ensure that the implementation plan is co-produced through collaborating with people with lived experience and their Carers.

BFC joint-autism-commissi

BFC LD-strategy-2014-19.p

Slough's Learning Disability Plan FINAL.p

http://www.reading.gov.uk/media/4847/Support-for-People-with-Learning-Disabilities-Strategy/pdf/LD_Strategy_(Part_1-3).pdf

http://info.westberks.gov.uk/CHttpHandler.ashx?id=33954&p=0

The map below shows the areas that form the key partnerships in Berkshire who will jointly implement the "Positive Living Model" and recognise that those with a learning disability and/or autism and challenging behaviours are not best served by long-term hospitalisation.

The Transforming Care Partnership Board and operational groups recognise that there are challenges ahead due to the geographical spread, the mix of some good but inconsistent provision of choice and the complexity of having 7 CCGs and 6 Local Authorities to work together to deliver a shared vision. The CCGs and Local Authorities recognise that significant change is required in the way that services are commissioned and provided across Berkshire.

Governance and stakeholder arrangements

Berkshire CCGs and Local Authorities were part of the NHS England Thames Valley Network to develop a commissioning framework and model that enables, empowers and supports people with learning disabilities with or without autism whose behaviour may be challenging. This programme of work spanned six months and included meaningful involvement of people with learning disabilities and or autism in every aspect of the work. This also included a significant amount of collaboration with family carers and other support groups in a variety of sectors.

Whilst this programme was underway, Berkshire West system created a strategic plan for the delivery of the Transforming care agenda using a collaborative and systemic approach.

The Berkshire East system worked in a more iterative way across agencies and the system to enhance local provision and enable local people to live ordinary lives.

Both the East and West of Berkshire hold monthly multi-agency meetings, which include Local

Authority, CCG and Provider representatives. These meetings have focussed on Transforming Care and acted as the project delivery groups.
Berkshire CCGs commissioned external project support and subject-matter expertise to facilitate the change process and a formal governance structure was put in place that reported up through all represented organisations at tactical and strategic levels.

Since the most recent changes creating Transforming Care Partnerships has seen the advent of Senior Responsible Officers (SROs), there has been a joining up of resources between the West and the East and there is now a governance structure covering all key stakeholders across the whole of Berkshire.

The specialist service is provided for adults with a learning disability over the age of 18. The nursing staff and members of the MDT work closely with the six locality-based Community Teams for People with Learning Disabilities (CTLD's). Staff liaise with Community Mental Health Teams (CMHT), Out of hour's mental health services and acute mental health in-patient services. Staff work closely with independent sector providers of support to people with learning disabilities to enable safe and supportive transfers of care.

The service model is underpinned by a whole system approach to admission only when necessary, providing proactive community support and returning people to the community in a timely way with ongoing support strategies to maintain health and wellbeing.

Blocks and Barriers

Berkshire is a complex area with 6 local authorities and 7 CCGs, however, there is a shared vision to commission appropriate community based support to reduce the reliance on in-patient beds. This will be achieved primarily through the Berkshire CCGs de-investing resources from a block contract with the main provider for Mental health and Learning Disability services and re-investing this resource to support the redesign of services; this will be in the form of an 'Intensive Intervention service in the community and enhanced support within the community teams. Ensuring the wider community support across health and social care will also be key to delivering this.

One of the key risks and barriers for commissioning an Intensive Intervention Service through diverting health resources to support people in the community is the increase in financial pressures for the 6 local authorities to house people appropriately with the right supports. Some of these pressures will be met through capital funding from NHS England for adaptions to improve people's living space.

The TCP is cognisant of the risks to social care and the need for these risks to be better understood given the increasing pressures and demand. The move to reducing inpatient provision especially for those people who have been in services for some time will inevitably impact the Local Authorities however to what extent is largely unknown. Work will be undertaken to understand the fuller impact for health and social care.

The Berkshire Transforming Care Partnership Board recognises that the CCGs and the local authorities will need to work together to develop a processes for joint commissioning with a vision to agree pooled budgets to overcome budget pressures and support people out of hospital.

Improving Support Planning and Delivering Outcomes

The Transforming Care Partnership Board will agree systems to ensure that everyone has a person-centred support plan with clear outcomes that can be monitored and are based around the principles set out in the Model of Care below on page 7 which was created by people with lived experience, family carers, providers and commissioners. The Positive Living Model is person-centred; housing and support will focus on achieving the best outcomes for the individual thus

reducing the reliance on in-patient beds to sustain people's lives in the community.

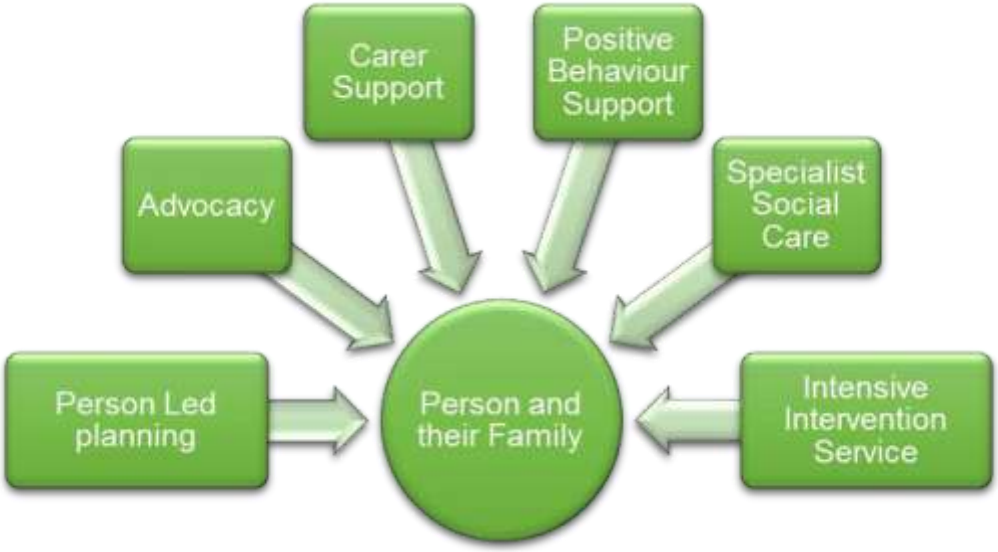
The support planning and outcomes will be linked into ensuring that there are housing options and money available to adapt properties for people to live safely within their own communities.

The CCGs and Local Authorities will develop plans to ensure that there is access to improved use of data and information to inform remodelling and commissioning for people that are currently using in-patient services as well as children transitioning into adult services to plan for the coming years.

Positive Behavioural Support Model

Positive behavioural support is a multi-component framework for;

(a) Developing an understanding of the challenging behaviour displayed by an individual, based on an assessment of the social and physical environment and broader context within which it occurs;
(b) with the inclusion of stakeholder perspectives and involvement;
(c) using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support; and
(d) that enhances quality of life outcomes for the focal person and other stakeholders.



The Transforming Care plan will link to the 6 Local Authority Learning Disability Strategies/ Plans to ensure a system wide approach is applied through utilising resources that are already available to people delivered through the community teams for people with learning disabilities (CTPLDs).

An Intensive Support Service will be developed and delivered through working with existing learning disability teams of trained staff to provide outreach services to people that are discharged from hospital and to ensure only those that require an admission are admitted. The Care and Treatment Review process led by CCG commissioners will further support this process and ensure that recommendations derived from the CTRs are delivered through robust communication. Good levels of communication will ensure that people can continue to live safely with the right support in their community.

Improving Services
The Transforming Care Partnership Board will aim to ensure that specialist support for people with learning disabilities and behaviour that challenges is improved through seeking opportunities for increasing behavioural specialism. The Transforming Care Programme Board will work towards developing integrated care pathways to ensure people receive the right services at the right time from the right people and this will include agreeing a set of standards and principles for all future commissioning of learning disability services. There will be close working with the CAMHs Transformation Boards – in Berkshire west this is the multiagency Future In Mind group and in the east of Berkshire this is via the East Berkshire Transforming Children's Health Board.

Improving Commissioning
Identifying needs early is an important aspect of commissioning the right services. Commissioning services for younger people transitioning to adult services offers a prime opportunity for this. We will also work to establish joint commissioning pathways to ensure we have the right services in place. Out of area placements will be reviewed to ensure that where appropriate people are supported to move back to the area. We will consider how we can use Section 75 (lead commissioning and pooled budgets) to develop a continuum of care between health and social care.

Improving Funding Arrangements and Value for Money
Social Care and NHS agencies will work together to ensure that we share a common understanding of health and social care funding criteria. We will also look at using pooled budgets to deliver better integrated care. High-cost placements will also be reviewed to ensure they provide value for money by delivering high quality outcomes.

Improving Support for Carers and Providers
People caring for a family member who has challenging behaviour are a vital and valued part of the support available. We will ensure that carers are properly supported. We also explore how better to support providers and customers. In this respect workforce development initiatives through training, advice and peer support networks will be developed.

Describe the health and care economy covered by the plan
The Berkshire health and care economy is diverse with 6 Local Authorities and 7 CCGs (outline below). Whilst the CCGs are co-terminus with the Berkshire boundary, not all individual CCGs are co-terminus with the Local Authorities.

Local Authorities	CCGs
Bracknell Forest Council	Bracknell and Ascot CCG
Slough Borough Council	Slough CCG
Royal Borough of Windsor & Maidenhead	Windsor Ascot and Maidenhead CCG
West Berkshire Council	Newbury and District CCG
Reading Borough Council	South Reading CCG
	North West Reading CCG
Wokingham Borough Council	Wokingham CCG

The CCGs commission health care provision on a collaborative basis with a single contract with Berkshire Healthcare Foundation Trust on a block contract (BHFT). The commissioned service consists of:-

1. Assessment and Treatment Units; Little House in Bracknell with 7 beds and the Campion Unit in Reading with 9 beds
2. Health component to community team for people with a learning disability. There are 6 CTPLDs who are all co-located within the Local Authority and therefore work together. The

service leads for the CTPLDs are jointly funded by health and social care, however, are separately supervised by BHFT

A range of advocacy services are also commissioned by the local authorities.

Berkshire West CGGs and the Local Authorities commission voluntary and the independent sector to provide advocacy and support services e.g. Mencap.

Across Berkshire, in and out of area providers are commissioned on a spot-purchase basis to provide support packages or placements for individuals requiring additional support post-discharge.

Currently health and social care commission separately with no collaborative commissioning or pooled budgets.

Provider relationships; CCGs and Providers review and keep up to date on performance through monthly meetings. Additionally service and commissioner meetings take place regularly to keep up to date on performance, in-patient activity, CTRs, discharges plans. BHFT is a key partner in the Transforming Care Partnership both in terms of planning and delivery. Residential care services are commissioned by the local authorities from a wide range of local, regional and national specialist providers. Placements are made out of the area where local provision is not available to support individual needs but our aim is to place locally wherever possible.

Describe governance arrangements for this transformation programme

Prior to the establishment of the TCPB governance arrangements have been separate for each half of the county and are now unified under the new Senior Responsible Officer (SRO) role. All parties have signed up to the structure and meetings are underway. The Tactical pan Berkshire workshops commenced in April 2016.

Accountability

The TCPB is accountable to the Chief Accountable Officers in East and West Berkshire and Chief Executives of the 6 Local Authorities and the Health and Well-Being Boards. Progress reports are shared with the Berkshire West Partnership Board that has Director-level representation from Reading, Wokingham and West Berkshire Councils. In the East of the County, meeting minutes and updates are reported in to the Joint Strategy, Planning and Development Committee.

Meeting	Chair	Membership	Frequency
Transforming Care Partnership Project Board	Gabrielle Alford – Director for Joint Commissioning Berkshire West CCG and Senior Responsible Officer for Transforming Care in Berkshire	Lead CCG Commissioning Managers Local Director/s for Adult Social Care Programme Director Berkshire East CCG Head of Learning Disability services – BHFT Director of Finance, Performance & Information BHFT (This board will be extended to include Children's Commissioning Director)	Monthly/Bi Monthly
Pan Berkshire Tactical workshops	Gabrielle Alford	Members of the Operational groups Direct Health and Social Care Staff and Third Sector People with Lived experience and Carers	Quarterly
East TCP Operational Group	Nadia Barakat	Local Authority representatives CCGs representatives BHFT representatives The Wellbeing Collective	Monthly
West TCP Operational Group	Sarita Rakhra	Local Authority representatives CCGs representatives BHFT representatives The Wellbeing Collective (This operational group will extend membership to include Children's commissioners, safeguarding leads to support the Transforming Care Plans)	Monthly

East TCP Operational Group

Name	Job Designation
Nadia Barakat	Head of Mental Health and Learning Disabilities Commissioning , CCGs
Hannah Doherty	Head of Service, Bracknell CTPLD
Louise Kerfoot	Head of Service, RBWM CTPLD
Simon Broad	Head of Service, Slough CTPLD
Colin Archer	Head of Learning Disabilities –Berkshire Healthcare Foundation Trust
Alan Sinclair	Interim Director of Adult Social Services, Slough Borough Council
Niki Cartwright	Interim Head of Strategy and Commissioning, CCGs

West TCP Operational Group

Name	Job Designation
Gabrielle Alford	Director for Joint Commissioning, Berkshire West CCGs

Jackeline Weise	Senior Commissioning Manager, RBC, ASC
Jenny Miller	Senior Commissioner, Adults Commissioning Team | Directorate of Adult Care and Health Services
Roz Haines	Business Manager – Adult Social Care West Berkshire Council
Paul Coe	Service Manager West Berkshire Council
Karen Felgate	Service Manager Contracts and Commissioning West Berkshire Council
Colin Archer	Head of Learning Disabilities –Berkshire Healthcare Foundation Trust
Isla Middleton	Consultant Psychiatrist , Learning Disability Specialist Services –BHFT
Mike Stillman	Market Development Manager – Wokingham Borough Council
Julie Stevens	Operational Commissioning Manager – Wokingham Borough Council

Autism Services

The 6 Local Authorities in Berkshire commission autism services and the CCGs commission an Autism Assessment and Diagnosis service for adults.

The diagnosis of autism in children and young people is provided through the CAMHs service with additional support from paediatricians for younger children. Additional support has been commissioned into provide family support pre and post diagnosis through the voluntary sector and children's integrated therapy service.

Programme Interfaces

This is an area of development and the Transforming Care Partnership board will look to ensure that plans are appropriately embedded into the health and social care system, to include Children's commissioning, CHC, MH services, Housing and Autism Partnership Boards.

The TCP interfaces with a number of existing programmes and Boards including:

- Learning Disabilities Partnership Boards
- Autism Partnership Boards
- CAMHs Transformation Future in Mind (East & West Berkshire)
- Transition Groups within the LAs

The Programme will link in with housing and children's services further to ensure that this programme of work is fully embedded.

Describe stakeholder engagement arrangements

The Transforming Care Programme Board specifically commissioned an independent consultant with considerable experience in mental health and learning disability care to lead a customer voice project.

The aim of the customer voice exercise was to identify people's experiences of the care that is provided in Berkshire for those with a learning disability and/or autism that have behaviours that challenge.
This was delivered through reviewing hospital care and for people with lived experience and their carers to identify a range of suitable and different types of services in community settings. It was important to hear that whatever services are provided or will be commissioned in the future are able to meet a broad range of needs particularly in a time of real difficulty or crisis. These engagement events were also to communicate Berkshire's vision of developing a Positive Living Model and Intensive Support Service in the community.

The list below details people's experiences and the implementation plan will address each area in a systematic manner through involving people with lived experience to co-design their vision in areas that they would like to be improved. This will be achieved through improved communication and consistent engagement with the 6 Learning Disability Partnership Boards, development of a co-produced Charter and opening membership to people with lived experience on the Transforming Care Board to shape the care pathway.

Hospital Care

Generally people felt that hospital care was **too long** and **centred around contracts and not the person** and people are **unsure about how to navigate through a complex system.**

Positive Behavioural Support (PBS)

PBS approaches need to be **more robust** with a **stronger mandate to train, educate and deliver** across a range of services.

Intensive Support Service (ISS)

Most carers felt **very positive** about a new ISS and think it will **offer hope** and a **fewer and reduce length of stay** or **avoid hospital admissions** altogether.

The big message is that staff, carers and people with lived experience want to be engaged in the development and testing out of a new service.

What People with Lived Experience Required

Feeling safe, 'liking the staff', being close to important things like the shops, town and friends,
having someone who 'understands people's feelings', 'helping to understand how to react to feelings'

The CCGs have presented high level Transforming Care plans to the Learning Disability Partnership Boards.

Berkshire East CCGs have commissioned service user/ family feedback to understand the end to end experiences and impact of services. This information will be used to shape the range of services and provide a platform for co-production across Berkshire.

Berkshire West CCG organised a specific event for Carers to provide in-put to develop key elements of the 'Positive Living Model'

- People with lived experience of learning disabilities and or Autism - The main engagement routes for this wider group have been through LD Partnership Boards and LIGs. There has been number of info graphics and presentations delivered as well as an accessible newsletter. People have given their views and ideas through

the regional work, pan Berkshire and in smaller localities and communities.

- People with learning disabilities and or autism who have used services because of behaviour that challenges - This specific group are currently being supported to share journeys and their views on what has worked well and what could be improved and how. This work is being undertaken by an independent third party organisation all the feedback used to design and test the model.
- Family Carers – Family carers have been involved in the work from the start with two carer engagement workshops as well as range of activities to keep people informed and listened to. Family carers have been interviewed and the information has been used to design the new model. There is now a local Carers Champion who is directly involved in the development process.
- Health and Social Care Support providers – The main health and Local Authority providers are an integral part of the overall programme and have a seat on all meetings and are part of every aspect of redesign. The main health provider is the second half of the coproduction partnership that is redesigning the pathway, increasing community support and reducing the reliance on beds. Operational staff from the specialist health and social care teams has been directly involved in a number of workshops over the past ear redesigning the pathway. Independent social care support providers have been involved in a carer workshop to engage them in this work.
- Local Authorities – Local Authority commissioners are on every relevant board and meeting. This work is fully multi-agency and the 6 local authorities are all signed up to this work operationally and strategically.
- CCGs – The CCGs have been leading and directing this work and have been offering support and leadership for this programme.
- Services for children and young people – This is the area of stakeholder engagement is the least developed within Berkshire and will be prioritised over the next 6 months.
- Third sector – The voluntary sector have been engaged predominantly through the LD partnership boards and LIGS although several third sector organisations have been involved in the engagement workshops throughout this process.

An Experience Based Co-Design (EBCD) project has been launched in Berkshire; this involves service users, family members and staff working together to redesign learning disability services. The learning from this will inform our local services and subsequently rolled out other areas. EBCD in Berkshire will run for 12 months, beginning with a 6-month 'discovery' phase, in which local patients and staff will be interviewed about their experiences of a service. The patient narratives are video-recorded, and from these a 'trigger film' will be developed to stimulate discussion between staff and patients about potential quality improvements (and the film becomes a resource that can be used by other organisations). An important characteristic of the EBCD discovery phase is that it draws on rigorous, narrative-based research with a broad sample of users, rather than relying on a single representative on a committee or a few anecdotes.

Equally important will be the subsequent co-design phase, in which patients, families and staff will come together as equal partners in small change working groups to set priorities for quality improvement, and design and implement change.

It is recognised that more engagement is required with children and young people to ensure their views are reflected in service development.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The programme has included people with lived experience at every stage and step of the way; this has been mainly in a consultative way although Berkshire has designed the new service model directly based on the input of people with lived experience, the Learning disability Carer Champion has been part of staff workshops and development sessions.
The new model is designed in a way that people with learning disabilities will be part of the leadership team in a formal way running, evaluating and developing operational support for people with complex needs. Using the co-production reflective tool Berkshire has 'got the basics right' comprehensively, and is 'really getting there' in its design for the future model of support. This reflective model will be useful in marking progress over the journey of the Transforming Care partnership.

There is a real desire within Berkshire to grow a collaborative culture and create a system based on co-production with people with lived experience. This aspiration is articulated in the strategy and includes enhancing personalised budgets, self-directed support and people with lived experience being actively and meaningfully involved in enhancing the lives of people with learning disabilities and or autism.

The Berkshire Transforming Care Partnership Board recognises that co-production with children and young people with a learning disability and/or autism is an area of development and will engage a board member from Children's commissioning to support this area of work. In additional in the future children and young people with learning disabilities and/ or autism will be invited to support project planning and implementation of the Positive Living Model

A learning disabilities Champion with an interest in or lived experience will be identified to engage with local people, feed in views and develop the model.

Baseline assessment of needs and services

Provide detail of the population / demographics

A commitment of this plan, and those mentioned within it, is to collect data in relation to the following groups. This will form part of our next Joint Strategic Needs Assessment (JSNA).

1) Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.

2) Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.

3) Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

4) Children, young people or adults with a learning disability and/or autism, often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.

5) Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed**.**

Improving Information

The CCGs and local authorities recognise that a greater understanding of the needs of people with challenging behaviour is required and commissioners will address gaps through working with public health to provide more robust information through the local Joint Strategic Needs Assessments.

Table 1: Projecting Adult Needs and Service Information (PANSI) projections for people aged 18-64 with challenging behaviour for the six authorities is as follows.

Local Authority Area	2014	2015	2020	2025	2030
Reading	47	47	47	48	49
West Berkshire	42	42	42	42	42
Wokingham	44	43	44	45	45
Bracknell Forest	33	34	35	35	35
Slough	42	42	44	46	48
Royal Borough of Windsor and Maidenhead	39	40	40	41	42
Total	**247**	**248**	**252**	**257**	**261**

Although the numbers of people are relatively small and are not predicted to grow significantly we know that services for people with challenging behaviour can be difficult to commission in the immediate locality and that if we are to achieve our aim of enabling more people with challenging behaviour to be supported in the community we will need to improve our understanding of the needs of the individuals affected and extend and enhance services in a number of key ways.

2015	Bracknell	Reading	Slough	W&M	West Berks	Wokingham
Predicted LD prevalence 18-64	1,816	2,583	2,287	2,137	2,259	2,339
Predicted LD prevalence 64+	341	403	289	564	577	580
Children (2014 data)	467	120	1026	467	391	462
Total	2,624	3,106	3,602	3,168	3,227	3,381

2030	Bracknell	Reading	Slough	W&M	West Berks	Wokingham
	1,912	2,672	2598	2,246	2,244	2,435
	539	558	446	770	854	838
	490	124	1166	491	387	481
	2,941	3,354	4,210	3,507	3,485	3,754
% change	11.21	10.80	11.69	11.07	10.80	11.10

LD with challenging behaviour 18+

Local Authority Area	2014	2015	2020	2025	2030
Reading	47	47	47	48	49
West Berkshire	42	42	42	42	42
Wokingham	44	43	44	45	45

Bracknell Forest	33	34	35	35	35
Slough	42	42	44	46	48
Royal Borough of Windsor and Maidenhead	39	40	40	41	42
Total	**247**	**248**	**252**	**257**	**261**

Year 2014	**Bracknell**	**Reading**	**Slough**	**RBWM**	**West Berkshire**	**Wokingham**
Children with moderate LD known to schools	450	*	907	581	346	364
Children with severe LD known to schools	*	105	92	39	*	75
Children with profound and multiple LD known to schools	17	15	27	*	45	23
Children with autistic spectrum disorders known to schools	237	322	316	321	663	526
Children with LD known to schools	**467**	**120**	**1026**	**620**	**391**	**462**
Children likely with challenging behaviour (severe/ profound LD)	**17**	**120**	**119**	**39**	**45**	**98**

Autism

Data obtained from http://www.poppi.org.uk and http://www.pansi.org.uk/ predicts that in Berkshire 2015:

- 5527 people of 18-64 will have an autism spectrum disorder
- 1238 people over the age of 64 will have an autism spectrum disorder

The CCGs and Local Authorities will establish further detailed analysis of this data to inform our future plans.

Analysis of inpatient usage by people from Transforming Care Partnership

The CCGs commission 16 in-patient beds within Berkshire; these beds and learning disability services are commissioned through a block contract with Berkshire Healthcare Foundation Trust. This includes the community teams for people with learning disabilities.

In addition currently a further 12 beds are commissioned out of area which are funded either by the CCG or from within the block contract.

The 2 Assessment and Treatment Units within Berkshire:

Campion Unit

- The service is delivered from the West of the county. There is an agreed pathway between the service and the Community Teams for People with Learning disabilities (CTPLDs), most admissions are planned with the individual service user/ family/ carer.
- The Care and Treatment Review process provides the platform to ensure that key recommendations are followed up in the best interest of the person in the unit. Unplanned out of hours requests for admission are channelled through the emergency duty teams and the BHFT urgent care service.
- The service will operate within the 18 week; referral to treatment milestone as laid out by regulation and subsequent additions within contract year.
- Progress of referrals is reviewed at CTLD team meetings and at the monthly LD forum.

Little House

- The service is delivered from a single stand-alone unit based in the East of the county and operates with same principles as the Campion unit.

Below outlines the inpatient use in Berkshire in Q1 – Q3 2015/16 across Berkshire which highlights a difference between the East and West of the patch both in terms of numbers and admissions.

The Berkshire plan includes retaining the commissioning of 11 beds for specialist health provision. This is to ensure that when people with learning disabilities are in need of this level of specialist care, they get the right care in the right place, provided locally in a timely manner, with their admission being for the shortest possible time. We will use our existing community teams, supported by the new Intensive Intervention Service to avoid and reduce admissions where ever possible. However some people will require specialist services and where these are necessary our teams will work to ensure these admissions have a clearly defined reason for the admission and planning for discharge will begin from the point of admission - to ensure people are only within inpatient services for the period required therapeutically.

	Newbury & District	Reading North & West	Reading South	Wokingham	Q1 15-16 (Berks West)	Bracknell	Slough	WAM	Q1 15-16 (Berks East)	Total
Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder (including Asperger's Syndrome)	7	3	7	6	23	2	3	5	10	**33**
Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder Asperger's Syndrome)	1	1	4	0	6	1	1	2	4	**10**
Numbers of patients discharged to community settings	2	1	2	1	6	0	1	1	2	**8**

	Newbury & District	Reading North & West	Reading South	Wokingham	Q2 15-16 (Berks West)	Bracknell	Slough	WAM	Q2 15-16 (Berks East)	Total
Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder (including Asperger's Syndrome)	8	3	5	5	21	2	3	5	10	**31**
Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder Asperger's Syndrome)	3	1	0	0	4	0	1	1	2	**6**
Numbers of patients discharged to community settings	2	0	2	0	4	2	0	0	2	**6**

	Newbury & District	Reading North & West	Reading South	Wokingham	Q3 15-16 (Berks West)	Bracknell	Slough	WAM	Q3 15-16 (Berks East)	Total
Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder (including Asperger's Syndrome)	7	3	6	5	21	1	3	5	9	**30**

Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder Asperger's Syndrome)	3	0	2	2	7	1	0	0	1	**8**
Numbers of patients discharged to community settings	0	0	2	1	3	1	1	1	3	**6**

The chart below highlights the number of people in CCG commissioned hospital/health beds which are currently out of area.

	Newbury & District	**Reading North & West**	**Reading South**	**Wokingham**	**Q3 15-16 (Berks West)**	**Bracknell**	**Slough**	**WAM**	**Q3 15-16 (Berks East)**	**Total**
Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder (including Asperger's Syndrome)	2	1	2	2	7	0	1	1	2	**9**
Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and /or autistic spectrum disorder Asperger's Syndrome)	0	0	0	0	0	0	0	0	0	**0**
Numbers of patients discharged to community settings	0	0	0	0	0	0	0	0	0	**0**

Of the 9 people identified in the table above – there have been 8 CTR's (for 1 person it was not considered in their Best Interest due to plans for discharge in place at the time).

Of these 9 people:-

- 1 person has now been discharged back into Berkshire into a supported living service
- 2 people were identified as being ready for discharge in 6 months – suitable community services are being identified and responsible commissioner issues being addressed
- 1 person has had a period of leave under section to a community based service in Berkshire but had to return to the hospital placement due to concerns for their wellbeing at the time
- 1 person had discharged plans in place however the identified placement withdrew the offer of a community placement due to behaviour displayed early in the transition – alternatives being identified
- 1 person was not ready for discharge at the time of the CTR but is now ready and a community based service has been identified pending agreement of funding between CCG/LA
- 1 person is subject to restrictions due to the Ministry of Justice and remains in their current placement
- 1 person remains not ready for discharge and suitably supported in the current placement – alternative local provision is also being explored
- 1 person remains appropriately placed in a step-down/rehabilitation service following discharge from a long period of detention in secure services

The assessment and treatment units within the TCP area of Berkshire is only accessed by those registered with a Berkshire GP. On occasion there are requests out of county to admit a patient in to either Little House or the Campion Units however no patients have ever been admitted from out of county. Individuals are either discharged into the community (with/ without package) or in some cases places in independent hospitals out of the county. This is due to the longer term needs of individuals which would not be best served by the assessment and treatment units.

There are instances where individuals who have not previously been resident in Berkshire are placed by either CCGs or LAs out of the area in a supported living/ residential environment. Subsequently these individuals once registered with a local GP become the responsibility of the CCGs and would then be able to access the assessment and treatment unit if at risk.

Individuals who are repatriated back by either LA or CCGs from out of area (placements) will also be able to access the assessment and treatment units.

Individuals who are placed out of area by Berkshire LAs whose placement subsequently breaks down are often refused admission to assessment and treatment units within that placement area which leads to pressure on the Berkshire system to admit. This will be improved through mapping the current use of in- patient beds and scoping the development of joined up health and social care strategies to secure better accommodation, systems and services to support people to remain in their own home.

The current housing provision will be strengthened through developing the provider market through a joint health and social care procurement framework. The Capital investment from NHS England will be utilised to adapt properties so that people can be placed into appropriate accommodation.

<u>NHS England Specialist Commissioned Services</u>

There are currently 16 Berkshire patients in out of area NHS England specialist Commissioning beds. The Board will seek to ensure that there are robust transition plans through mapping where people in this care pathway to plan future services that are sustainable and conducive to the person's wellbeing.

Describe the current system

The CCGs commission health care provision on a collaborative basis with a single contract with

Berkshire Healthcare Foundation Trust on a block contract (BHFT). The commissioned service consists of:-

1. Assessment and Treatment Units; Little House in Bracknell with 7 beds and The Campion Unit in Reading with 9 beds
2. Health component to community team or people with a learning disability. There are 6 CTPLDs who are all co-located within the Local Authority and therefore work together. The service leads for the CTPLDs are jointly funded by health and social care however are separately supervised by BHFT.
3. Tier 4 CAMHs services are commissioned by NHS England.

Berkshire Local Authority Learning Disability Commissioning

The six Local Authorities commission learning disability services separately for their own residents to meet their Care Act responsibilities through a range of methods including spot and block purchase arrangements to meet eligible needs. The Local Authorities are focussed on personalisation which is delivered through personalised budgets and direct payments.

Services commissioned include supported living, care home placements, day services, community support, and respite. Social care services provision is based on person centred planning to ensure that people receive quality services that meet their needs.

The Local Authorities in Berkshire also support individuals in transition from Children's services and employ specialist workers to support young adults with a learning disability reaching the age of 18.

All Local Authorities with social services responsibilities assess the care needs of any person who requires community care services and to provide or arrange services to meet their eligible care needs. The local authorities in Berkshire ensure that people are supported to live as independently as possible and in housing rather than institutional care. Support packages are implemented to maximise independence including supported living arrangements.

The CCGs and local authorities employ joint community teams for people with learning disabilities who are required to support adults with learning disabilities to be as healthy as possible and have the same rights, independence, choice and inclusion as those adults without learning disability. This is provided through a multi-disciplinary, integrated health and social care service for adults with learning disabilities resident in the Berkshire area and with a Berkshire GP.

These joint teams are contracted to ensure that they provide health and social care to adults with Learning Disabilities through an integrated interdisciplinary team. This includes a range of health and social care professionals, e.g. community nurses, occupational therapists, health care assistants, speech & language therapists, primary care liaison nurse and dieticians.

The CCGs and local authorities are committed to ensure that providers deliver high quality, evidence based services, which promote good, measurable outcomes for service users and their family carers to continuously improve these services through access to joint information systems. This involves working collaboratively with primary and secondary care services to raise their awareness of LD specific issues.

Berkshire Healthcare Foundation Trust is commissioned to provide a Children and Young People's Integrated therapy Team (CYPIT). This service is now developing to further integrate emotional health and wellbeing (CAMHs) services with physical health. A children's toolkit is available online for families and this is being expanded to incorporate strategies to support mental health and behaviour. An online support platform for parents and carers is due to open in Summer 2016.

Berkshire Healthcare Foundation Trust has a specialist nursing service that supports children with profound learning disabilities and provides much of the physical and nursing support to children.

The service will also provide support to parents and behaviour support is delivered through schools (mainstream and specialist).

Across Berkshire in and out of area providers are commissioned on a spot purchase basis to provide support packages or placements for individuals requiring additional support post admission.

The CCGs and local authorities have developed plans for 'Future in Mind for improving the mental health and wellbeing of children and the main objective is to integrate and build resources within the local community so that emotional health and wellbeing support is offered at the earliest opportunity thereby reducing the number of children and mothers at the perinatal stage whose needs escalate to require a specialist intervention, a crisis response or admission to an in-patient facility. This means that:-

- Good emotional health and wellbeing is promoted from the earliest age
- Children, young people and their families are emotionally resilient
- The whole children's workforce including teachers, early years providers and GPs are able to identify issues early, enable families to find solutions, provide advice and access help
- Help is provided in a coordinated, easy to access way. All services in the local area work together so that children and young people get the best possible help at the right time and in the right place. The help provided takes account of the family's circumstances and the child or young person's views.
- Women with emerging perinatal mental health problems access help quickly and effectively
- Vulnerable children access the help that they need easily. This includes developing Liaison and Diversion services and better links with SARCs.
- Fewer children and young people escalate into crisis. Fewer children and young people require in patient admission.
- If a child or young person's needs escalate into crisis, good quality care will be available quickly and will be delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible, as close to home as possible.
- When young a person requires residential, secure or in patient care, this is provided as close to home as possible. Local services support timely transition back into the local area.
- More young people and families report a positive experience of transition.

The neurodevelopmental pathway (ADHD and ASD) is being developed within the main provider Trust in Berkshire and with partners with the following objectives for 16/17:-

- Enhance provision across the system for children and young people with ASD and Learning Difficulties.
- Review current Common Point of Entry and access arrangements into CAMHs services, ensuring access for the most vulnerable (includes step down from in-patient units, links to SARCs, Looked After Children's services, emerging Liaison and Diversion services for under 18's, forensic services, provision for children and young people with LD and ASD)

When asked to process map and draw the current system staff and carers confirmed the following;
The SWOT analysis below was derived from health and social care adult services engagement events. The Berkshire Transforming Care Implementation Plan will address the issues detailed below through looking at areas that work well and strengthening areas that require improvement. This work will be co-designed by putting the person at the centre of future planning.

Strengths	Weaknesses
Evidence of good clinical practice. Clinical expertise around Challenging behaviour exists. Examples of joint working across the County. All teams have a Proact Scip trainer. Clinical expertise around Challenging behaviour exists. 1 definite Head of Service. A universal desire to provide high quality provision. People with Challenging Behaviour are prioritised. PBS experts within the service.	An example of too many clinical hands offs in some teams. Significantly more unplanned admissions that planned. Multiple routes through the system for users. Many different sources of clinical guidance. Highly complex services. Many examples of duplications and gaps. Limited formal clinical leadership. Limited client and carer leadership of services. Very flat management structure with little definition
Opportunities	**Threats**
6 Community Teams for people with Challenging Behaviour exist 6 Local Authorities. 7 Health Commissioners. Clinical expertise around Challenging behaviour exists. 16 beds in 2 units. PBS is already in place but not consistently used. Even more examples of opportunities and possibilities.	6 Community Teams for people with Challenging Behaviour exist 6 Local Authorities. 7 Health Commissioners Few examples of talent management or role development. Some confusion around pathways, processes and ways of working. Individual professional waiting lists in some areas. Some professional groups outside the service budget. Communication issues between teams and professionals.

Voluntary Sector Commissioning:

Autism Berkshire is commissioned by CCGs to provide support for families and children with autism. We will link this organisation in to developing future plans. Parenting Special Children is commissioned in Berkshire to support families particularly in the post diagnostic period.

Berks West CGGs commission voluntary and independent sector to provide information, advice, advocacy and support services e.g. Mencap, ASD Family Help, A range of statutory and non-statutory advocacy services, including self-advocacy are commissioned by the local authorities.

CAMHS

CAMHS Tier 3 services are commissioned Berkshire wide; this includes the provision of an Autism diagnosis service, autistic spectrum disorder as well as specialist mental health pathways.
An eating disorders service is in operation for those with complex needs and in 2016/17 the provision of a full community based eating disorders service will be available in line with the nation standards.

Tier 2 CAMHs services are commissioned by the local authorities. Berkshire West CCGs jointly commission youth counselling services.

The CAMHs Transformation Plans have funded additional behaviour support to children and families pre and post diagnosis of autism as well as blending counselling services.

Local CAMHS Transformation Plans


Transformation plan-Reading Borough Cou


Transformation plan-West Berkshire Counc


Transformation plan-Wokingham Borough (


East Berkshire Local Transformation Plan F

The local transformation plans are also available on CCG websites in easy read formats with Frequently Asked Question sections. The website content has been developed in partnership with service users.
For example:
http://www.southreadingccg.nhs.uk/mental-health/camhs-transformation
http://jsna.bracknell-forest.gov.uk/news/mental-health-services-children-young-people-transformation-plan

NHS England Specialist Commissioned Services

The specialist commissioner in NHSE currently commission Tier 4 in-patient facilities for children and young people with mental health problems and/or learning disabilities.

The fundamental challenge in delivering care in its current format is the number of partners involved in commissioning and delivering the services.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Berkshire will strengthen its local provision through working with people with lived experience to review the current provider market to develop bespoke and accessible accommodation to sustain people's wellbeing in their local community. One of the key challenges is that Berkshire does not have a single procurement strategy to support housing needs.

The Berkshire Transforming Programme has applied for capital funding to utilise this money to redesign and develop existing estate for supported living tailored to meet individual needs.

Estates and housing providers	
NHS Estate – owned by BHFT	Campion Unit with 9 beds, fit for current purpose The Little House with 7 beds, fit for current purpose
Bracknell Forest Council	Currently 5 properties owned by the council 4 x housing providers 5 bed respite unit and a day service unit
Slough Borough Council	3 x day centre. All fit for purpose (max 35 people p/day) 1 x Respite 8 bedded respite unit which is fit for purpose 1 x 8 bedded residential unit SBC currently commission 12 Supported housing providers
Royal Borough of Windsor and Maidenhead	1 x 4 bed property used for short breaks (property owned by NHS) 2 x 8 bed residential care homes (property owned by Housing Solutions – housing association) 2 x day centres, one owned by RBWM, one owned by Housing Solutions – day centre in Maidenhead purpose built, includes public library and café. 5 x care homes (4 x 6 bed, 1 x 4) bed, owned by NHS but transferred to Housing Solutions with a capital charge agreement. (hospital re-provision) 2 x supported living services in Maidenhead, owned by Housing Solutions (16 one bed flats) – good quality purpose built 1 x supported living service in Old Windsor, owned by Radian Housing – housing association (11 one bed flats) – good quality purpose built 9 x supported living service in Windsor, owed by Radian Housing – housing association (9 one bed flats) – good quality purpose built
Wokingham Borough Council	Council owned properties where support for people with a learning disability is provided. Acorn day centre (purpose built and equipped day centre). Hillside Park LD Supported living consisting of 9 self-contained flats The Council owns a number of supported living dwellings across the borough 1 x 4 units 1 x 3 units 1 x 2 units 10 x 1 unit In addition the Council works with 17 independent housing providers/housing associations providing 171 units across 47 sites. Support to residents is commissioned from a range of support providers. The Council also commissions a 8 bed respite unit for overnight and sessional day respite.
Reading Borough Council	1 x 6 bed LD respite unit for adults (RBC owned) 1 x 6 bed respite unit for LDD Children (RBC Owned) 8 x shared houses for supported living 2-5 beds each (RBC owned) 1 block of 6 one bed flats for supported living (RBC owned) 28 shared houses and flats owned by RSLs or private landlords currently used for LD supported accommodation. Landlords include Radian, Trinity Housing, Sovereign, Dimensions.
West Berkshire Council	Purley Park Trust 16 units of supported living Hillview House supported living and residential care Advance UK 21 units of shared accommodation – supported living across West Berkshire Sovereign Housing 3 houses for supported living – support delivered by Creative Support

	A2Dominion – Pelham House – Supported Housing for 16 residents. Support provided by Dimensions. Golden Lane Housing 12 units of Supported Housing in 2 houses West Berkshire Mencap – Heffernan House West Berkshire Sovereign - Blagden House Supported living for 5 adults WBC also owns 3 Day Centres Hungerford Resource Centre – 20 places (Pan-Disability), currently 4 LD users in rotation Greenfield House Resource Centre – 20 places (Pan-Disability), currently 9 LD users in rotation Phoenix Resource Centre – 20 places (Pan-Disability), currently 31 LD users in rotation

There is significant volume of estate within the county both LA and health owned. Further work will be undertaken to ensure that bespoke personalised service in appropriate services are provided through capital investment from NHS England.

Vision, strategy and outcomes

Our Vision
By 2019, people in Berkshire with a learning disability and or autism will be fully supported to live good lives in their communities, with the right support from the right people at the right time.
Our strategy

- Strengthen the role of the community teams for people with learning disabilities and/or autism and develop a workforce strategy that provides consistency across services regardless of where people live, delivers equality and promote a positive culture.
- Promote greater support to Carers and families of people with learning disabilities and/ or autism.
- Offering people with learning disabilities and/ or autism a choice of where and who they choose to live with to lead everyday lives.
- Developing a provider market that will support people to realise their aspirations and maintain wellbeing.
- Collaborate and strengthen the role of the LD Partnership Boards to access engagement with people with lived experience to plan the 7 workstreams listed on page 4.
- Utilise existing beds differently and creatively to offer respite and short term interventions with robust plans for discharging people back into the community with the support from well-developed community teams for people with learning disabilities, the voluntary sector, housing and day care facilities.
- Promote greater access to advocacy to support choice and a voice for people with lived experience.
- Strengthen the role of Primary Care to support health and wellbeing.

The Berkshire Transforming Care plan will dovetail with the local learning disability and autism strategies to deliver the vision.

People will have a positive experience regardless of where care is provided, with access to good housing options, to live safely exercising their right to choice to achieve the following outcomes:-

- Focus on improving quality of life and support to reduce behaviours that pose a risk to self and others through a robust workforce development to improve standards of care through increased knowledge and experience to support people to live meaningful lives.
- To reduce the reliance of referrals to hospital and avoid hospital admissions through increasing life opportunities in the community. This will be achieved through developing an 'Intensive Intervention service in the community, specialist interventions and Positive

Behavioural Support as well as personalised care and support.

Housing that is right

Support from community (teams & providers)

Describe your aspirations for 2016/17 - 2018/19

The Programme Board will ensure that people have the best opportunity to lead ordinary lives through the right support system to meet their individual needs. The Board will ensure that the vision for the future is further articulated through involving people with lived experience to co-design services to support people out of hospital and into appropriate community placements.

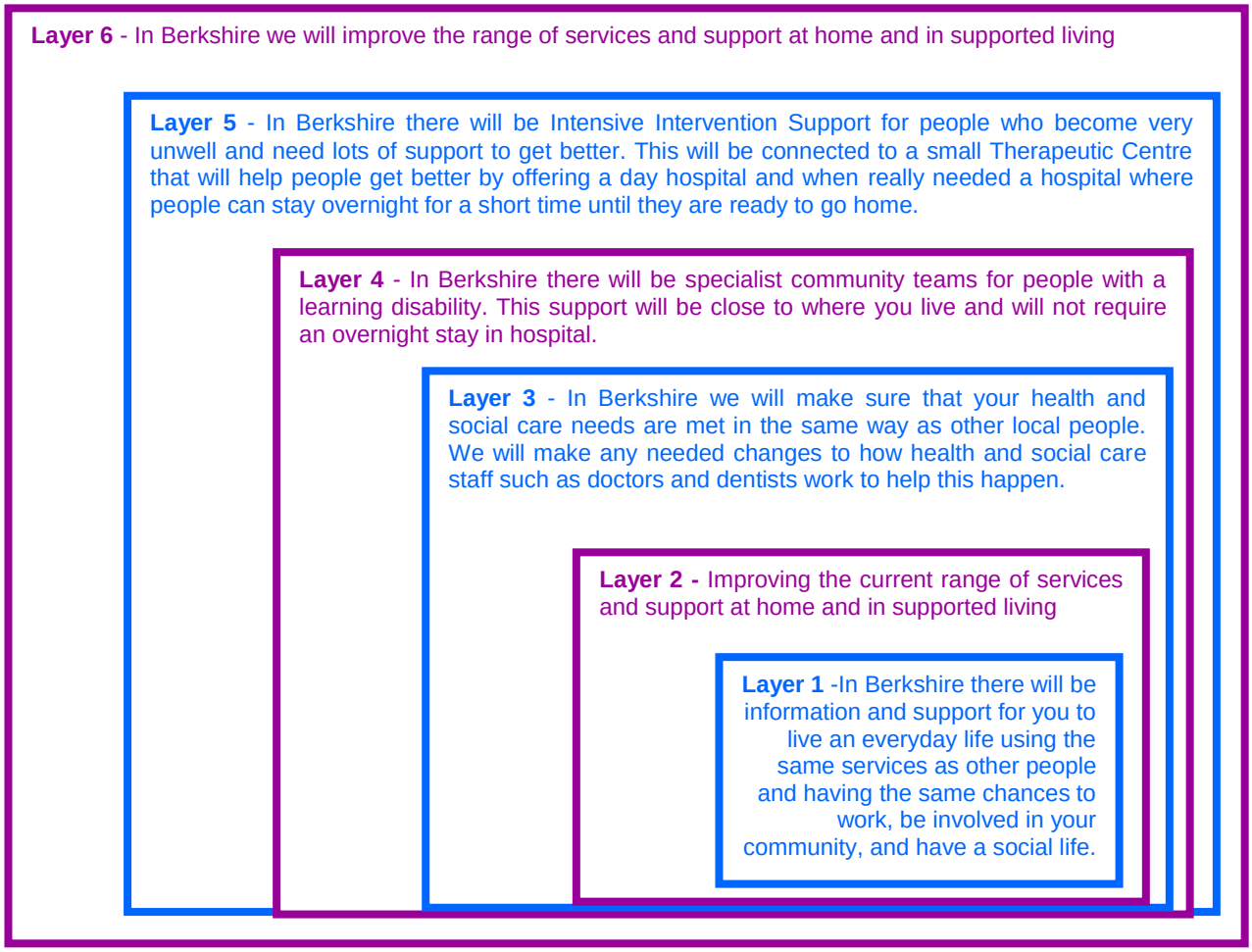
This will mean working closely with Health and Social Care to support people to lead meaningful lives through access to:-

1) Individualised tailored care plans
2) Personal Health Budgets
3) A safe environment designed to meet the person's holistic needs
4) Meaningful easy read information to navigate through to services
5) Well trained staff regardless of people receive services
6) Choice to design own services
7) Personal Health Plans

8) Carers Information, Advice and Support
9) Positive Behaviour Support
10) Education, Support and Housing
11) Timely and meaningful diagnostic support

What support will look like in the future?
In order for us to deliver this vision, Berkshire will ensure that it has the following in place:-

There are going to be 6 layers of support for people:



Intended Benefits for People with Lived Experience

People with learning disabilities, family carers, clinical staff and local authority managers have identified the benefits to people. The benefits relate specifically to 5 cohorts outlined. The benefits will be measured through audit, evaluation and formal Periodic Service Review of the redesigned service.

Berkshire has committed to supporting and empowering people with Learning Disabilities to ensure that they can say;

"I get to take positive risks and be fulfilled"

"People who support me use positive approaches"

"My life changes because of my needs and wants and not because of how services are designed"

Benefits to Performance

- Reduced numbers of unplanned admissions.
- Reduced length of stay.
- Reduce overall admissions.
- Increase number having their needs met in the community.
- Reduce readmission within 12 months.
- Increase number treated in the community.
- Extend out of hours capability per day.
- Extend days of community working per week per week.

Benefits to Quality

- Least restrictive environments for individuals.
- Admissions only when absolutely necessary.
- Lengths of stay determined by clinical need.
- Improved communication throughout pathway.
- Improved joined up nature of service.
- Improved Customer experience.
- Increased range and intensity of specialist community interventions.
- Increased Support and capacity within Community Teams for people with Challenging behaviour and for those with other needs.

Benefits to Cost

- Reduction in out of area placements by 75%.
- Reduction in Local Authority costs relating to placement breakdown.
- Management of efficiency targets within BHFT.
- No additional recurring investment required from CCGs.
- No additional recurring investment required from BHFT.
- Reduction of costs related to avoidable admissions and readmissions.

How will improvement against each of these domains be measured?

- A bespoke balanced scorecard approach developed using key metrics based on each of the agreed benefits above.
- Increased personalised budgets.
- Experience feedback from people using services.
- Coordinated and collaborative commissioning across health and social care.
- Local people, People with lived experience and other stakeholders will be engaged in evaluating improvement against each domain using, Citizens Juries, Periodic Service review and learning events.

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Positive Behaviour Support is the central principle around which services are developed. It is a multi- layered framework for improving the quality of life of people with learning disabilities and or autism whose behaviour challenges services. The focus is upon the person and others with whom the person has a close and significant relationship.

- All staff working directly with people with Learning Disabilities and or autism have sufficient knowledge, training and support to promote their psychological wellbeing and to identify early indicators of behavioural difficulty.
- Health promotion widely available for people whose challenging behaviour may be caused by a physical issue.
- Mental Health Promotion widely available for people whose challenging behaviour may be caused by psychological distress.
- People with Learning Disabilities with behaviour that challenges are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day.
- Positive Behaviour Support is the methodology of choice for all practitioners and there is sufficient skill, knowledge and delivery of intervention using Positive Behaviour support approach.
- People receive help outside 9-5 Monday to Friday and carers get help needed with other tasks such as house maintenance and shopping, including respite and preventative support via Mencap, ASD family help.
- Support gradually increases when needed and can be stepped up and down at any time.
- The tiered approach is used to offer a spectrum of care from prevention through to emergency intervention.
- The model is based on building blocks that people can use to build a bespoke service for each individual.
- Individuals are empowered to be in control of their lives, making choices and gaining increased independence.
- The Positive Living Model works for people through their life course and “becoming an adult will be about the party not the cliff edge!”
- Case coordinators and radical person centered planning are in place and effective.
- Community teams include dedicated specialist expertise in challenging behaviour using Positive Behaviour Support and manage the risks associated with this particular group.
- Direct support and intervention for staff in social care agencies and organisations from Intensive intervention practitioners is widely available.
- Multi agency Positive Behaviour Intensive intervention teams that provide direct training and intervention to individuals, carers and families are present in each county.
- Creative Housing solutions are in place for people with very complex needs and behaviour that challenges.

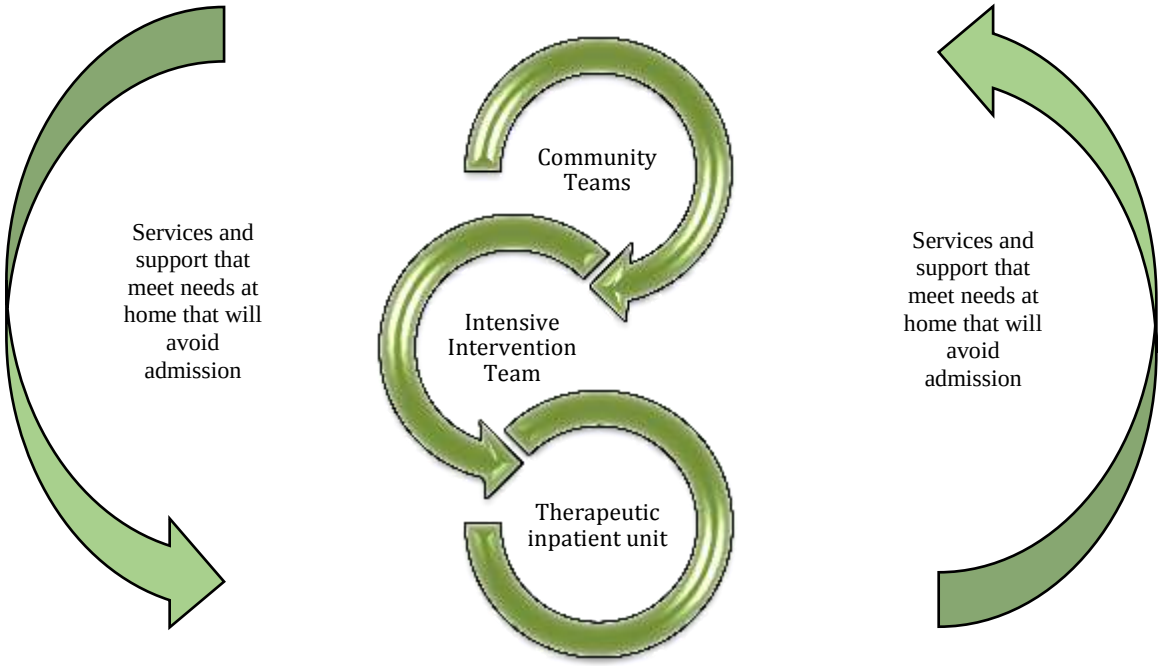
- Comprehensive and robustly funded Advocacy and Carer Support is in place and accessible.
- Periodic Service Reviews run by People with Learning Disabilities and or autism, Carers and Professionals.

Overview of your new model of care

The Proposed redesigned service

A process of triangulation of all the local information, national drivers, Positive Living Model, customer voice work and commissioning intentions was undertaken this was then compared against the financial resource available and the following proposal was created.

There will be four core elements of the redesigned service, community teams for people with learning disabilities (CTPLD), an intensive intervention team (IIT), Supports and Services that will meet people's needs at home (SSH) and a therapeutic Inpatient Unit (TIU).



The community teams will be strengthened through increased resource and a reduction of pressure from the work currently associated with supporting people with behaviour that challenges that are in crisis. The teams will be able to respond more proactively and preventatively to people whose behaviour that is challenging as well as those needs of people whose behaviour is not challenging as a result of increased capacity.

The Intensive Intervention team will offer support and consultation to the community teams, will work in partnership with them as people's behavioural needs become more intense, will pick up direct case work for people who require that level of intensity and specialism, enable people to access the therapeutic inpatient unit as and when required in a planned way, speed up discharge as a result of working alongside communities to ensure a state of discharge readiness and reduce the rate of readmission by working with people post discharge for 12 weeks.

The Therapeutic Inpatient Unit will provide planned and emergency day and overnight services to individuals for whom it is clinically indicated. The specialist multi-disciplinary team will assess needs,

design and implement therapeutic programmes of care that require the physical environment a building based unit can offer. The therapeutic inpatient unit will also act as a resource hub for the intensive intervention service and sessional activity such as Sensory Integration can be provided.

McKinsey 7S Framework in relation to the redesigned service

The framework was developed in the early 1980s by Tom Peters and Robert Waterman, two consultants working at the McKinsey & Company consulting firm, the basic premise of the framework is that there are seven internal aspects of an organisation or service model that need to be aligned if it is to be successful. This framework has been used within the project workshops with staff and will be the basis of the internal implementation once the redesign has been agreed.

Strategy - The plan devised to maintain and build high quality provision, excellent customer experience and cost efficiency.

The learning Disability services in Berkshire have created a vision that everyone locally has signed up to.

'Developing excellent services in local communities with people and families, improving their health, wellbeing and independence. – The best care in the right Place for people with Learning Disabilities'

Style - The style of leadership adopted and embedded within the service and wider organisation

Conscious Leadership is the model of leadership identified as most aligned to the service model and the culture of the provider as an organisation.

A conscious leader is someone who leads by serving and thereby inspires their followers to do the same. Someone who empowers people to make decisions and take controlled risks with the responsibility and awareness for the consequences for all. Someone who recognises how we are all connected and therefore every action we take has a consequence beyond ourselves.

This is what is meant by conscious leadership and it offers a powerful and sustainable approach to all areas of life and sits very comfortably within a context where people who use services are empowered and enabled to live aspirational lives however complex their support needs may be.

Being aware and responsible for our own actions - and responses to the actions of others - is having the power to change the future and make a difference in our organisation and the wider system. The major implication of this is that leadership is not restricted to a few but that everyone has the ability - and indeed the responsibility - to lead.

Shared Values - These are the core values of the service that are evidenced in the culture and the general work ethic.

The values assumed within this proposal and those at the core of the people who have worked together across professions, boundaries and agencies on this project are the three that BHFT have identified for their organisation as a whole:

- **Caring** for and about you is our top priority.
- We are **Committed** to providing you with good quality, safe services.
- Working **Together** with you to develop innovative solutions.

These Values effectively articulate the foundations that the new service model has been built on

and they work in harmony with the CCGs Values.

Systems - The daily activities and procedures that staff members engage in the redesigned service

The Intensive Intervention team will work alongside the local CTPLDs to meet the needs of individuals with learning disabilities and challenging behaviour (with or without autism and mental health needs) who require a period of intensive, focussed assessment and intervention that is beyond the capacity of the CTPLD. It will also work closely with the inpatient service to deliver care in the least restrictive environment, and to avoid inappropriate or unnecessarily long admissions.

The key objectives of the proposed Intensive intervention model are:

- To provide a flexible, proportionate and timely response to crises so that service users receive care in the least restrictive environment, consistent with their clinical and safety needs and with the minimum of disruption to their lives.
- To develop preventative input in order to avoid future crises.
- To actively encourage continued and meaningful involvement of the service user, family and carers.
- To add value to the lives of all adults displaying significantly challenging behaviour. IIT members will work in partnership with other stakeholders to commission, create, and strengthen capable and resilient environments.
- IIT will contribute to the planning and support of local services in order to facilitate the return of people currently in out of area placements.
- To work closely with generic mental health services to ensure people with learning disabilities can access their specialist skills during crisis.

Staff - The workforce plan including Human Resources issues.

The service is modelled on three core staff groups, leadership, specialist skills and direct behavioural support. Within those three will be a number of sub sections of staff groups and grades. The staff will be located in three teams and will all have dedicated time within the Core Intensive Intervention team.

As part of the implementation phase a full workforce plan will be created with details of the numbers as well as the training and development requirements. The Tiered model of service will underpin the workforce plan and enable the service to plan for skills and expertise needed to sustain the service in the long term.

The table below outlines the types of professionals required to work within the new Intensive Intervention Team and how some of the professionals would remain within other teams and offer expertise to the Challenging behavior service. It is crucial that the Community Learning Disability Teams are supported and empowered and that a culture is developed that encourages equality and equal status across the whole pathway.

What new services will you commission?

The commissioning section outlines Berkshires Clinical Commissioning Groups intention to redesign the current service specification that forms part of the contract with Berkshire Foundation NHS Trust

to deliver health services to people with learning disabilities.

It is the intention to disaggregate the existing specification in order to commission a more defined provision for people with learning disabilities and or autism whose behaviour may challenge.

This work is part of the system wide Berkshire Transforming Care Partnership.

The section of the plan sets out a high level narrative that indicates to the system an intention to work collaboratively and in co-production with the existing provider to remodel services in line with the national Model.

There is a truly compelling vision for the redesign of services, reducing inpatient beds and investing in bespoke community intensive support services. Berkshire intends to maintain the high quality of services currently offered and enhance them further by redesigning aspects of the provision to better meet the needs of this discrete but incredibly vulnerable group of people and their families.

Commissioning Intentions Summary

Segment	**Covering:**	**Supported by:**
1. New specialist health pathway for people with a learning disability and or autism whose behaviour challenges	Individuals will have robust and effective community support In the form of a challenging behaviour pathway that will enable them to live supported lives in the community and receive intensive intervention as and when required to prevent hospital admission. If a short stay in a health resource is clinically indicated this will be offered locally and the whole process will be orientated around returning the person to their chosen life in the community	Stakeholder sign up Individual organisation vision JSNA Regional Positive living model National winterbourne Concordat NTDI JIP Partnership Boards
2. Improving quality and outcomes	A) Reduction in numbers of people requiring in patient beds B) Reduction in length of stay C) Enhancement of individuals lives through increased choices, better care, better communication and more control thus reducing challenging behaviour D) Reduction in the impact of challenging behaviour on individuals lives and their carers lives E) Increased alignment with other key plans around, carers, continuing care, specialist social care, mental health, access to physical care	Detailed metrics to be provided in the commissioning specification Sign up from key stakeholders such as Health and Wellbeing Boards and learning disability partnership board
3. Sustainability	In five years, the numbers of people in Berkshire requiring a specialist health bed per year should be reduced by 50% and that the default position for almost everyone is robust personalised planning, positive behaviour support, a comprehensive pathway of care that	Detailed metrics to be supplied in the financial plan to be produced in 2016/17

	increases in intensity as and when required and an integrated specialist health offering that enables people who may display challenging behaviour to live in a community setting of choice.	
4. Improvements to Housing, Care and Support	To increase life opportunities for people to live in their community through commissioning appropriate housing and support services to sustain people's wellbeing through personalised care plans and a trained workforce aligning personal health and social care budgets and increasing access to direct payments to increase choice.	Mapping current provision within Berkshire and market development in 2016/17.
5. Improvement interventions	To achieve the desired state the key improvement interventions planned are a meaningful pathway between the community team and a highly specialist behavioural resource centre. A new intensive intervention service to support individuals and their carers whenever needed and the building based resource centre able to provide positive behavioural support to individuals and their circle of support around them throughout their life course.	Contract expectations included in the financial plan to be produced in 2016/17

Segment	**Key Line of Enquiry**	**Response**
a) System vision	What are the specialist health commissioning intentions for people with Learning Disabilities and or Autism and behaviour that challenges?	To implement the national model For Berkshire Foundation NHS Trust to work in co production with CCCGs to redesign existing services and to reduce bed numbers in order to deliver Intensive intervention service and Positive Behavioural support. For individuals and their carers to be central to all planning throughout their life course.
	How does the vision include the six Cs of compassionate care and meet the Winterbourne Concordat deliverables?	**Care** - These commissioning intentions focus on delivering high quality care in peoples local communities offering an increasing intensity of intervention as and when required **Compassion** - The Positive Living Model has been built on stories from individuals with learning disabilities, experiences of people using assessment and treatment services, carers and other stakeholders. All messages from these people have strongly indicated that a compassionate community model is what they want **Competence** – The commissioning intentions outline a community support model that requires highly trained competent staff **Communication** – The model is designed as a pathway and effective communication will be essential to the success of the services **Courage** – Taking the steps towards reducing bed numbers and reinvesting in community intensive support requires a belief in the vision and a courageous leap of

		faith from the system **Commitment** – These commissioning intentions will require time and effort from key stakeholders and a true commitment to the improvement of health and wellbeing of this vulnerable group of individuals These commissioning intentions meet the winterbourne deliverables by significantly reducing ATU beds, enabling individuals to receive tailor made community intensive intervention, keeping the individual and their family at the centre of the planning and delivery of care and the whole model being underpinned by positive behavioral support approaches.
	How do the commissioning intentions address the following aims: a) Improving health outcomes for this specific group? b) Reducing Health inequalities for this specific group? c) Increase quality of experience for individuals and their families?	The improving health and lives learning disability observatory. Health Inequalities in people in the UK by Professor Eric Emerson state that people with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable. The health inequalities result, to an extent, from barriers they face in accessing timely, appropriate and effective health care.
		Individuals with lived experience of using assessment and treatment units and their carers were interviewed as part of developing the Thames valley 'Positive Living Model' and all of them strongly indicated that they believed they could have been more effectively supported in their communities and that moving away from home into a hospital setting had been a detrimental transition for them. The specialist health elements within the Berkshire plan that are outlined in these commissioning intentions focus on improving health outcomes, reducing inequalities and enhancing the experience of users and carers by; • Enabling the person to be at the centre of all care planning and delivery • The circle of support around an individual being trained and using positive behavioural support methodologies • Clinicians with significant expertise in positive behavioural support being present in the community teams • There being an intensive support service available to intervene in a flexible way in and out of hours as and when required to wrap around an individual offering tailor made support • A small number of beds that are available locally to people as part of a pathway that can be accessed in a short term way if and when individuals require them

		• The specialist health interventions in this document being part of the 6 elements within the Berkshire plan
	Who has signed up to the strategic vision? How have the health and wellbeing boards and the Partnership boards been involved in developing and signing off the plan?	The Health and Wellbeing Boards and Learning disability Partnership Boards have signed up to the Berkshire Plan and were part of developing the Berkshire Transforming Care' report that initiated this programme of work. The specific commissioning intentions will require formal sign off prior to co-production work with the key provider.
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	There is a clear 'You said, we did' document for the creation of the regional 'positive living model' which included individuals and carers from Berkshire and further local listening exercises have been completed during 2015, some focussed on individuals with learning disabilities and two for Carers. A Customer voice exercise is being undertaken currently and a large scale event is being planned for April 2016
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed?	Yes, an assessment of the current state has been undertaken and forms part of the Berkshire Transforming Care report. There is also work underway to include increased data around this service user group in the JSNA
	Do the interventions identified below take into consideration the current state?	The interventions are designed around all the information gathered regarding the current state and the desired future state.
	Does the two year detailed commissioning intentions document provide the necessary foundations to deliver the strategic vision described here?	The two year detailed commissioning document is in train and would be the next step of the programme and completed
	How have the community and clinician views been considered when developing plans for improving outcomes?	Community and clinician involvement has been extensive in the production of the 'Berkshire plan and these specific specialist health elements would require additional Berkshire stakeholder engagement during the planning phase
	What data, intelligence and local analysis were explored to support the development of these commissioning intentions?	Current contracts and specifications, JSNA, admission and treatment data for Berkshire and local trend analysis over the past 3 years. Learning disability annual reporting data. Public health data and national prevalence information all supports these commissioning intentions

	How are the plans for improving outcomes aligned to local JSNAs?	The new services will improve a range of inequalities in the JSNA including individuals receiving health care close to home, enhanced engagement with primary care, reduced incidents of untreated mental ill health and reduction in challenging behaviour attributed to a health or psycho social need
The transformational interventions required to move from the current state and deliver the commissioning vision for people with a learning disability and or autism with behaviour that may challenge.	**Intervention One** To reduce the number of purchased assessment and treatment beds by 50% by 2019 Expected Outcome • For significantly less people to find themselves in bed based specialist health services • For the system to respond by increasing the type and availability of specialist social care housing for this group • For intensive support in the community to be commissioned as a viable alternative to hospital assessment and treatment beds • For specialist skills and knowledge to be transferred to community support settings • For the remaining beds to be redesigned as part of a challenging behaviour pathway. • For cost savings to be released and available for investment into community intensive support Investment costs • Financial costs will be minimal as the beds will be decommissioned and savings released for reinvestment • Non-Financial costs include collaboration and co-production with the provider and the risk of the community provision not being in place in advance of beds being decommissioned. Implementation timeline 50% of contractual value of current bed based spend to be reduced between 2016 and 2019 releasing investment at that point for intensive support service Enablers required Intervention two needs to be planned and in place in advance of July 2016. Senior sign up from provider and operational project management of transition by provider. Remaining elements of the national model need to be in place to ensure success i.e. specialist social care and carer support/respite. Potential risks • Beds still required after reduction this causing clinical risk to individuals • Damage to provider relationship • Destabilise provider • Duplicated spend if out of area spend increases at the same time as decommissioned spend into intensive support	
	Intervention Two To commission a challenging behaviour intensive service to be operational in 2016 Expected Outcome	

	• Reduced need for bed based provision • Increased support in local communities • Reduction of challenging behaviour in people's lives • Increased Carer support • Individuals living in their housing of choice • Intensive support when and where people need it • Increased skills and knowledge in the community <u>Investment costs</u> • Financial costs To be confirmed, the investment will be almost the same as the decommissioned bed savings released from intervention one. There will be project costs and pump priming required to mobilise the new service in advance of the bed reduction <u>Implementation timeline</u> Creation of service during 2015 with a 'go live' date of July 2016 <u>Enablers required</u> Intervention two needs to be planned and in place in advance of July 2016. Senior sign up from provider and operational project management of transition by provider. Remaining elements from the positive living model need to be in place to ensure success i.e. specialist social care and carer support/respite. <u>Potential risks</u> • Beds still required after new service in place causing clinical risk to individuals • Damage to provider relationship • Destabilise provider • Duplicated spend if out of area spend increases at the same time as decommissioned spend into intensive support
	Intervention Three <u>Commission a model that ensures all users and carers are at the centre of all care planning</u> <u>Expected Outcome</u> • Individuals at the centre of all planning for them, no action without their involvement\ • Robust and independent advocacy in place for all individuals • Life course planning not just for childhood transitions • Individuals significant others supported to be actively part of planning and evaluating care • Individuals empowered and supported to challenge care decisions not in their best interests <u>Investment costs</u> • Financial costs Low levels of financial investment required, part of the national model implementation project – transforming care partnership <u>Implementation timeline</u> For this to be in early implementation stage by April 2015 and fully embedded by

	December 2015 in advance of bed reduction and new service model being on line. Enablers required This is a key element from the Berkshire plan and will be implemented as part of the transformation project. This intervention will be enabled by cultural change across the system and building on pockets of local best practice and learning from national examples of good practice. Potential risks • If this intervention isn't successfully implemented then the success of the other interventions will be at risk • The achievement of this intervention rests on a large number of stakeholders being committed to a sustained cultural change across the system • Circumstances around individuals can be complex leading to challenging conversations and dynamics. Skills and confidence in empowering people and in mediation will need to be in workforce plan
	Intervention Four Commission a positive behavioural support approach and training Expected Outcome • All staff and supporters in the lives of individuals with learning disabilities will have positive behavioural support training. This group to include GPs teachers, dentists and wider networks • People with a key relationship with an individual will have enhanced training specifically orientated around supporting that person. This group to include family members, support staff and health/social care staff • There will be professionals in community teams with advanced skills and knowledge in Positive behaviour support • The culture will shift to supporting people consistently in a different and positive way with confidence and compassion. Investment costs • Financial costs to be assessed fully and national funding opportunities to be explored. • Non-Financial costs There is a time cost from all involved in supporting people with learning disabilities so that the whole system has a basic awareness of the model and how to positively support people Implementation timeline Preparation and implementation once commissioned will take 6 months and so this model would be in place by October 2015 and operational by July 2016 Enablers required Sign up from Local system Support from main provider Commissioning and funding of the model National support and potentially funding Risks • This element is crucial to the success of the whole model

	• Not having access to necessary training to ensure adequate numbers of psychology staff are fully skilled • Destabilising existing psychology teams

The outcomes of the above interventions aim to deliver:

- Enhanced Advocacy and Self Advocacy services
- More flexible support for carers and families
- Positive Behaviour Training
- An Intensive Intervention service to support people and their families when things become more challenging, to eliminate avoidable admissions and to support people when they are discharged from hospital bed based care.
- Bespoke support packages using personalised health budgets

What services will you stop commissioning, or commission less of?

- There is an aim of reducing the reliance on bed based hospital care by 50% with the funding being diverted to community support from the newly designed Intensive Intervention Team

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What existing services will change or operate in a different way?

- The Community Teams for People with a Learning Disability (CTPLDs) will be working in a new way and will be undertaking a piece of workforce redesign to build the necessary skills that are required to meet people's needs in a new and innovative way focussing on; Health facilitation, Positive Behavioural Support and strengths based approaches for independent Living
- Redesign the local Inpatient Services and divert resources into the community through individualised support planning and identifying those people that are at a risk of admission.
- The local Inpatient Services will be redesigned to offer a wider range of therapeutic interventions in a resource centre approach. This may include, sessional interventions, peer workers, day assessments and therapeutic programmes and core inpatient programmes and may see people admitted to hospital for short periods when necessary.
- The CTPLDs to provide outreach support in people's homes.
- Strengthen the Care and Treatment Review process to ensure that there information available on people at risk of an admission and support people out of hospital into appropriate community placements.

Describe how areas will encourage the uptake of more personalised support packages

We will work with the existing mechanisms for using personal health budgets to support people with complex needs. This will be particularly focussed on those individuals for whom a solution has not been successfully sought.

The Berkshire CCG's are committed to further rolling out Personal Health Budgets (PHBs) across

our area for all patients who would benefit from them. In time this will include those with a learning disability, autism, as well as those in maternity, end-of-life and elective care. Our next step is to take what we have learned from offering PHBs to those with Continuing Health Care needs (CHC) and apply this in a new offer to people with learning disabilities. In doing so we confidently expect to further develop our processes and practice to facilitate the further roll out of PHBs to other patient groups.

We will develop this work jointly with appropriate local partners and with the relevant Local Authorities (LAs) in particular. The 6 local authorities that cover Berkshire have already taking part in an engagement exercise to launch this work and signed up to being involved in joint delivery and sharing of resources where appropriate and practical.

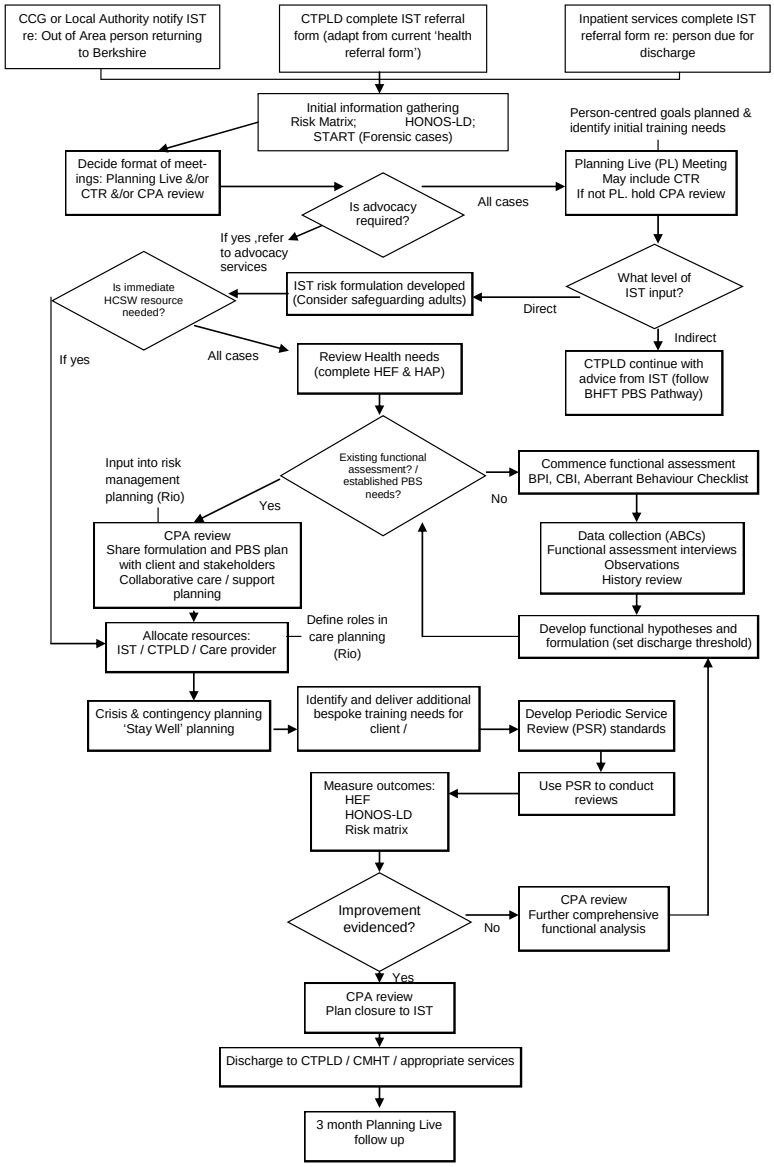
What will care pathways look like?

See table below on Page 40 and in addition:

- People will have access to timely assessment and access to the Intensive Intervention Service.
- Access to technology to lead independent lives
- Well trained accessible staff to navigate through services from the point of referral to the end point
- Mental Health staff to have access to training to support people in community placements in during hospital stay
- Link into the local Crisis Care Concordat to have access to system wide support
- Access to Personal Health Budgets to support discharge planning
- Access to an Assessment and treatment Unit beds where this is clinically appropriate
- Timely access to community staff

<u>Areas that will need further development</u>

- Pooled Health and Social Care budgets
- An at risk register that would provide an opportunity for early identification and support to avoid a hospital admission – the current CTR process supports people at risk but a more formal process and register will need to be developed
- A Forensic pathway will be developed with specialist commissioning for people detailed under a home office section
- Link and align the TCP to the local joint Learning Disability Strategies
- Develop closer links with Continuing Health Care, Education and Children's commissioning to strengthen the care pathway.
- Alignment with specialist NHS commissioning



How will people be fully supported to make the transition from children's services to adult services?

In Berkshire West the SEND Joint Implementation Group meets regularly and is attended by the SEND leads in each of the 3 Local Authorities, the CCG Head of Children's Commissioning (who is also the Designated Clinical Officer), provider leads from RBFT and BHFT, parent /carer representatives and voluntary sector representatives.

A key focus is transition into adult services and the implementation of Ready Steady Go. A workshop to improve transition is scheduled for 27 April and this workshop aims to better align EHCPs and Ready Steady Go principles so that ideally families have a single plan.
Thames Valley Strategic Clinical Network has provided support in the development of transition arrangements in the area.

Partners have jointly completed a self-evaluation focussing on two questions:

1. How effectively does the local area identify children and young people who are disabled and /or have special educational needs?
2. How effectively does the local area meet the needs and improve the outcomes of children and young people who are disabled and/or have special educational needs?
The above includes CYP with and without an EHCP

A comprehensive Local Offer has been published on websites in each area and this information is updated regularly.

A Joint Agreement between the Berkshire West CCG Federation, the Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospital Trust, West Berkshire Council, Reading Borough Council and Wokingham Borough Council, in respect of operational arrangements for children and young people with Special Educational Needs and Disabilities (SEND) aged 0 to 25 years is in place. This document covers joint arrangements for individual children and young people with SEN and disabilities.

Work is underway to improve arrangements for EHCP health reports for young people over the age of 16 years.

The Designated Clinical Officer undertakes strategic duties relating to the Children and Families Act. Discussions are underway with BHFT and RBFT to ensure that structures are in place to assure the quality and timeliness of EHCP reports. The service specifications for the provider services are being updated to reflect the requirements of the Act and to understand any changes in activity flows.

A funding panel is in place to consider requests to commission services that are in addition to those that are ordinarily available in the area. This includes requests for out of area placements/ treatments.

How will you commission services differently?

The Board will lead a process for engaging people with lived experience to redesign the current care pathway.

The Board will also lead a process to develop joint Health and Social Care processes to ensure that people are not delayed in hospital due to budgets. In the future Berkshire TCPB will look to develop:

- Pooled budgets
- Personalised Budgets
- Co-production with providers to redesign and improve quality
- Outcomes based contracting across a pathway rather than traditional methods of counting activity
- Individuals and their circle of support will be directly and meaningfully involved and often in charge of creating bespoke specifications of care and then selecting the right people to provide that specified support

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How will your local estate/housing base need to change?

The Transforming Care Board will carry out a mapping exercise to identify current and predicted needs to develop the local housing market use the capital investment from NHS England will

be used to adapt properties e.g. sounding proofing and water proofing

- Reduction of existing bed based estate
- Creation of new inpatient service
- Increased numbers of supported living properties and RSLs

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

Berkshire will strengthen the CTR process to keep people out of hospital and provide access to greater community support through the Intensive Intervention Services and embed the Positive Living model in the community

Berkshire TCPB will seek to improve opportunities to develop the housing and care market to meet the needs of resettling people and greater involvement of the voluntary sector to promote choice and independence.

The following area will also be strengthened:-

- Co-production between the CCGs and The specialist Health provider
- Planned and in progress 'resettling' programme
- The new intensive Intervention Service and redesigned bed based service will be supporting the successful resettling process
- Housing and care options

How does this transformation plan fit with other plans and models to form a collective system response?

This plan has been developed in collaboration with the 6 local authorities and 7 CCGs. Carers of people with a Learning Disability have been instrumental in supporting the development of the 6 key elements of the Positive Living Model and the pathway re-design that will support [people to remain well in the community.

We recognise that the vast majority of peopled aged 14 to 25 years of age have an Educational Health Care Plan (EHCP). Locally it is recognised that the vast majority of this group will also have mental health needs and for those under the age of 18 will be known to CAMHS. Therefore, the Future in Mind local Transformation Plans will address the needs of this cohort. Currently it is known that there is an overlap of transformation planning related to future in mind, SEND reforms (Children and Families Act and the Care Act), we are working together with local authorities to streamline this development.

- CAMHS – this will fit together and be part of the young People with learning disabilities project commencing 2016
- Children With disabilities programme – As above
- Adult mental health – this is dove tailed already and the new service will be directly linked to MH services
- Autism – This is already linked in and there are synergies between both strategies
- Dementia – This work needs further development and is being planned
- Carers Strategy – This is strongly linked and is referenced in both strategies and work plans

What are the programmes of change/work streams needed to implement this plan?

The TCP Board will develop detailed implementation plans in collaboration with people with lived experience and agree processes with the 6 local authorities to support the development and strengthen:-

- Preventative strategies
- Carers support & Training
- Strengthen access to primary care
- Person centred care plans that meet the holistic needs of people
- Intensive Intervention in the community
- Pooled budgets
- Joint Health and Social Care Funding Panels
- Local housing provision
- Skilled workforce

There have been a range of work streams covering the 6 elements of the Positive living model and these are now being expanded to achieve the wider programmes of change that fit within the National model such as children and young people (Please refer to CAHMS Transformation Plans).

Who is leading the delivery of each of these programmes, and what is the supporting team.

Positive Living Model Element	***Lead***	***Support***
Person Centred Planning	Local Authorities	Children Services
Advocacy	Local Authorities	Mainstream advocacy services
PBS	BHFT	Independent Psychologist
Specialist Social Care, Housing and Support	TBC	The TCP Operational Groups
Intensive Intervention Team	BHFT and CCGs	Independent consultants
Respite and carer support	CCGS	Carer Champion

What are the key milestones – including milestones for when particular services will open/close?

Milestone	**Date**	**Lead**
Stakeholder Engagement	On-going	CCGs and LAs
Customer Voice Exercise	February 2016	Independent consultant
Co-Production to deliver the plan through developing an implementation plan.	May 2016	Programme Manager
Workforce Development within Community LD teams	March 2016	Programme Manager
Remodel in patient offering	April 2016	Berkshire Transforming Care Programme Board
Confirm detailed pathway and Operational Policy	February 2016	BHT and CCGs
Workforce plan created	March 2016	BHFT
Share HR consultation document	April 2016	BHFT
Commence HR change process	April 2016	BHFT
Recruitment new team	June 2016	BHFT
Change management within services	Ongoing	BHFT
Commence reduction of bed usage	September 2016	CCGs
Commencement of Intensive	September 2016	CCGs

community provision		
Evaluation of redesign	January 2017	CCGs and LAs

What are the risks, assumptions, issues and dependencies?

Risk	Grade	Mitigation
That the programme will not dove tail effectively the needs of children and adults and there will be gaps in provision	*Red*	• *Board sponsors to directly engage and unblock* • *A phase 4 plan to be created to develop this work*
Risk to local authority budgets for increased supports and housing	*Red*	• There may be new revenue costs and work will be undertaken to understand the full risks and plans to mitigate
Potential risk to quality and safety of clients and staff through transition period and mobilisation	*Amber*	• Double running or pump priming will be required and a contingency plan is being produced
Risk of insufficient Internal Engagement	*Green*	• Workshops, newsletter, engagement events, focus groups, planning groups
Risk of insufficient External Engagement	*Amber*	• *News Letters, Presentations, listening events, conversations and the governance structure*
Risk of co-production with people with lived experience not being as radical as the local vision	*Red*	• *Carer Champion role* • *LD partnership Boards* • *Self-advocacy groups* • *People with lived experience on the new leadership team*

What risk mitigations do you have in place?

See above

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[1]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

2 Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

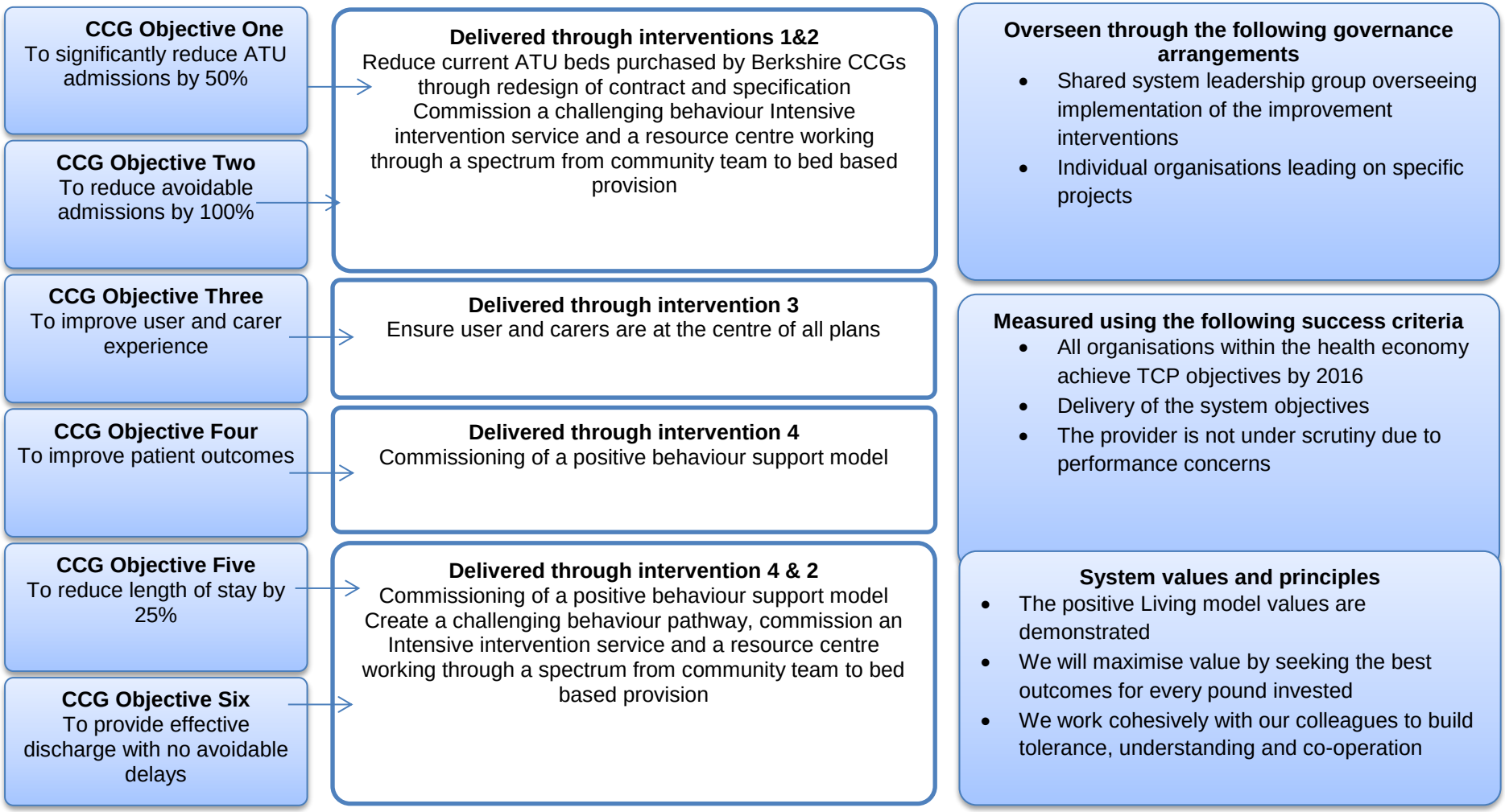
Indicator No.	Indicator	Source	Measurement[2]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - Psychiatry of	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period The consultation took 90 days as the specified period for readmission. We would recommend that this period should be

[2] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

		Learning Disabilities or diagnosis of a learning disability or autism.	reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring GP Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
6	Proportion of looked after people with learning disability or autism for	MHSDS. (This is identifiable in	Method – average census. • Denominator: person-days for patients in current spell of

	whom there is a crisis plan	MHMDS returns from the fields CRISISCREATE and CRISISUPDATE)	care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan

A: Learning Disability specialist health commissioning intentions for people whose behaviour may challenge



READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14 JUNE 2016**	**AGENDA ITEM:**	**6**
TITLE:	**West of Berks, Oxfordshire and Buckinghamshire Sustainability and Transformation Plan**		
LEAD COUNCILLOR:	**CLLR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	
LEAD OFFICER:	**WENDY FABBRO**	**TEL:**	**0118 937 2072**
JOB TITLE:	**DIRECTOR OF DACHS**	**E-MAIL:**	**Wendy.fabbro@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The NHS England Planning Guidance, December 2015, asked all health and care systems to develop a 5 year Sustainability and Transformation Plan (STP) for submission at the end of June 2016. Over the following months a footprint emerged which comprised the West of Berkshire Local authorities, Oxfordshire and Buckinghamshire (WeBOB). This STP footprint will encompass a population of 1.8m people, with a £2.5bn 'place based' budget for spending on local services. Within the footprint there are the following organisations:

- 7 NHS Clinical Commissioning Groups
- 6 NHS Hospital Provider Trusts
- 5 Local Authorities

The footprint does not encompass the East Berkshire area.

Council debated the NHSE decision to define the footprint in this manner and relayed concerns to decision makers in DH, NHSE, LGA, and local MPs and CCGs. The Council motion which was agreed is attached for ease of reference at Appendix 1 (Minute 60 refers).

A Plan was submitted to NHSE by WeBOB at the end of April (Appendix 2) with the following emerging priorities:

- Tackling inefficiencies and reducing variation between organisations and geographical areas
- Urgent and emergency care

- Mental health
- Improving outcomes in cancer and maternity services
- Focus on developing the workforce, particularly with regard to General Practice

It has been communicated from NHSE that the WeBOB April submission is Low risk within the overall national context. However it is also clear that all organisations are facing significant budget deficit and financial challenge (£150m for Berks West, £511m for WeBOB). It is anticipated that there could be opportunities for financial reconciliation across the WeBOB Health community footprint, ie any underspends could be contributed to tackle overspends elsewhere although this does not have a direct impact on Local Authorities.

Financial allocations from NHSE to carry through implementation of the STP were announced at the end of May, with the WeBOB support being in the region of £2.4m

A further submission containing a revised draft of the STP is due to be submitted to NHS England at the end of June.

This week Sustainability and Transformation Plan (STP) leads received further guidance on what to include in their 30 June submissions. This guidance included a template that asks how each footprint will achieve financial balance by 2020/21. The template covers most CCG and NHS England commissioning activity, as well as Better Care Fund income and expenditure and asks for voluntary information on additional impacts arising from social care or non-NHS providers where it has been modelled.

For end of June the submission is to cover:

- 3-5 critical decisions which will be required to implement the strategic priorities identified
- An explanation of the anticipated benefits, with a focus on specific outcomes against health, quality and finance (Five Year Forward View triple aim)
- The proposed activities to be undertaken by specific geographic / organisational members
- Detailed modelling of the local activity, workforce and finance
- An early calculation of how the 2021 funding allocation will be spent within the footprint

This report is being presented to provide an opportunity to discuss the potential impact of the STP in Reading.

1.2 Appendices

Motion agreed at Council
April submission to NHSE

2. RECOMMENDED ACTION

2.1 Members are asked to consider what criteria they wish to be used to evaluate, approve or challenge the WeBOB STP submission due by the end of June; and to delegate authority to Director Adult Care and Health, Chief Exec of the CCG and Chair of the HWB to provide any approval or challenge on behalf of the HWB

2.2 Members are asked to consider how they wish to be engaged in the future governance of the STP implementation

3. POLICY CONTEXT

3.1 The HWB duty under Health and Social Care Act 2012 is to improve integration between practitioners in local health care, social care, public health and related public services so that patients and other service-users experience more "joined up" care, particularly in transitions between health care and social care. The boards are also responsible for leading locally on reducing health inequalities.

3.2 Health and wellbeing boards have no statutory obligation to become directly involved in the commissioning process, but they do have powers to influence commissioning decisions made by CCGs. However, CCGs and local authorities may delegate commissioning powers to health and wellbeing boards so that they can lead on joint commissioning.

4. CURRENT POSITION/THE PROPOSAL

4.1 Current Position and issues:

- The East of Berkshire does not reside within the footprint of the WEBOB STP and it is not yet understood what challenges this may present to the West of Berkshire particularly in respect of Berkshire wide services.
- The impact on emerging models of shared financial governance for the acute, community, primary care in West of Berkshire through an Accountable Care System (ACS) and how this is presented within the STP is not yet clear.
- Changes in the organisation of acute services with respect to operational and financial sustainability, improvements in outcome, networks, outreach etc could potentially impact on Reading residents
- Any changes to the provision of Specialised Services (which are commissioned by NHS England rather than local CCGs) have not yet been fully scoped and may operate over even larger footprint.
- Mental health has a significant spend (over £100m) out of area, and several Trusts operate within WeBOB, which will require further work to understand.
- Although in principle all areas integration plans include stimulating and facilitating more individual accountability for health and sustainable resilient communities, it is currently unclear what the full extent of these initiatives

may be. However driving change via prevention services at the scale of WeBOB may not facilitate a community co production model.

- Releasing the level of financial savings required for all organisations with the footprint will continue to be extremely challenging, and could well include organisational change.
- There is an ongoing requirement to ensure that the governance of the STP takes into account the statutory functions of all member organisations; with particular reference to democratic accountability and compliance with the Health and Social Care Act 2012. It is not yet clear how Health and Wellbeing Boards will be engaged in forming plan and polices, approving, and monitoring progress.

4.2 **Options Proposed**

The WeBOB Sustainability and Transformation plan is not complete at the date of drafting this report, and further information will be shared at the HWB Meeting on 14th June. Ahead of that discussion, it is proposed that:

- All the stakeholders in the system need to have a clear understanding of the drivers for new care models that have the potential to deliver a better user experience, higher quality and the potential to lower costs.
- All partner organisations need to support the vision and direction of travel.
- Consideration is needed of each member organisation's statutory functions and the role of its local residents.
- Partner organisations should consider how services can be delivered closer to home and community.
- There is a greater understanding and clarity around the resourcing and funding implications for each organisation of the STP process

Members may wish to receive regular and frequent briefings on progress, and to agree the criteria that will underpin Board approval.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 It is not yet clear how the plan will be consulted.

6. EQUALITY IMPACT ASSESSMENT

6.1 It is not yet clear what issues will arise.

7. LEGAL IMPLICATIONS

7.1 There are issues arising from the 2012 Health and Social Care Act to be resolved.

8. FINANCIAL IMPLICATIONS

8.1 There are funds identified to resource transformation but plans on expenditure are not yet available.

9. BACKGROUND PAPERS

COUNCIL MEETING 22 MARCH 2016

ITEM NO 13 – LOCAL NHS REORGANISATION

This Council notes that:

- On 10 March 2016 NHS England recorded its worst ever performance as the NHS missed almost all of its key waiting time targets in January
- NHS England faces a projected financial deficit of between £2.3 billion and £2.8 billion for this financial year
- Our local hospital, the Royal Berkshire Hospital, has missed its A&E four hour waiting target again in January, is consistently missing cancer referral to treatment waiting time targets and is currently for the first three quarters of this financial year running at a loss of £10.4 million
- The Berkshire NHS Healthcare Trust, which provides mental health and community health services is projected to finish this financial year £2.4 million in deficit whilst five Reading GP practices have been rated by CQC as inadequate and placed in special measures since the start of 2015
- The NHS in England is currently developing local Sustainability and Transformation Plans in order to deliver the NHS Five Year Forward View with the aim of delivering financial sustainability, improved outcomes and better integration with local authority services
- That the NHS planning guidance says that "local authorities should be engaged with these proposals."

Council believes that:

- It is fundamentally flawed for NHS England to propose, without any consultation with local authorities or local people, that the area of planning and organisation of our STP should not be the established working area of Berkshire West (Reading, West Berkshire and Wokingham) but Berkshire West, Oxfordshire and Buckinghamshire
- In order to achieve the £270 million savings at the heart of the business case for this huge NHS administrative area it will be necessary to bring together planning and management into one single operation
- That residents benefit from health and social care decisions being made locally and in close partnership with residents and communities
- That a 'one size fits all' approach to planning health services across Berkshire, Buckinghamshire and Oxfordshire will significantly harm the

ability of local health and care to integrate around local needs, and actively involve local people, communities and the voluntary sector

- That another top down reorganisation of the NHS, so soon after the last disastrous shake up of the 2012 Health and Social Care Act, will reduce the capacity of the NHS to work with the Council and partners to deal with the crisis of demand and funding for healthcare in Reading

- An overriding priority to balance budgets within the new larger planning area without full consideration of the greater needs of Reading could be to the detriment of our health services.

This Council agrees to:

- request that the Managing Director write to the chief executive of NHS England and the Secretary of State for Health detailing the Council's objections to these proposals

- instruct the Managing Director and senior officers to continue with their dialogue with local NHS partners to propose measures to protect the position of locally driven and responsive health and care services by:

    1. securing an absolute commitment to maintain local integration plans based on local needs and priorities

    2. exploring how Reading health resources can be ring-fenced and protected for Reading residents

    3. securing a commitment that Reading Borough Council will have a role and be consulted on developing NHS Sustainability and Transformation Plans

    4. continuing to impress on health partners that social care is an essential part of providing better care for our residents and is central to delivering the NHS Five Year Plan.

Workstream (the narrative below is from slides 4,5,6 of the 15 April submission)	**Lead**
Improving the health of people in our area	**Jonathan McWilliam,** Oxfordshire DPH is co-ordinating this work with the other DsPH.
Tackling inefficiencies in patient experience of care will drive increased quality and productivity Digital interoperability	Acute Trusts work co-ordinated by **Bruno Holthof**; plus AHSN support **Lois Leer**, Berkshire West CCGs
Urgent and emergency care	This is being progressed through the UECN chaired by **Annet Gamell**
Mental Health	**Stuart and Julian** plus CCG leads, **Ian Bottomley** from Oxfordshire CCG; **Debbie Richards,** Bucks CCGs; **clinical lead** from Berks West
Improving outcomes in: Cancer Maternity	Part of Acute Trusts work co-ordinated by **Bruno Holthof** Clinical Senate review due to be published. **We need someone to take a lead on this and work with the clinical senate and the report authors.**
The GP workforce is at significant risk of becoming unsustainable, putting at risk our out of hospital services development	**Graham Jackson and Joe McManners**
Significantly reducing variation will drive efficiencies	Spec comm – **David Smith** as chair of TV collaborative commissioning group TV Priorities – **Lou Patten**
The BOB footprint has unique workforce challenges; expensive living costs with a national pay scale for service providers and local high levels of employment mean low numbers of available health and social care professionals	Support to come from HEE - **David Smith** and **Neil Dardis** to oversee
Safety Improvement Methodology	**NHS Trusts plus Gary Ford**

Buckinghamshire, Oxfordshire and Berkshire West

Sustainability and Transformation Plan

15th April submission

1.8m population
£2.5bn place based allocation
7 CCGs
6 Foundation and NHS Trusts
14 local authorities

Key information details
Name of footprint and no: Buckinghamshire, Oxfordshire and Berkshire West – No: 44 **Region: South** **Nominated lead of the footprint including organisation/function: David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group** **Contact details (email and phone): david.smith@oxfordshireccg.nhs.uk 01865 336795** **Organisations within the BOB footprint: See next slide**

Section 1: Organisations within the BOB footprint

- The BOB footprint consists of 3 distinct local health and care economies. Total population for the BOB footprint is 1.8m. Total place based NHS allocation for 2016/17 is £2.547bn.
- The BOB footprint borders 9 other STP footprints.
- Other key partners are the Oxford AHSN, Health Education Thames Valley, Thames Valley Clinical Senate, Strategic Clinical Networks, Thames Valley Urgent and Emergency Care Network, Thames Valley and Wessex Leadership Academy, CLAHRC. Most of these also cover other footprints.

Local Health and Care Economy	Clinical Commissioning Groups (x 7)	Acute Trusts (x 3)	Community Services Providers (x 3)	Mental Health Services Providers (x 2)	Other significant NHS Providers (x 1)	Local Authorities (x 13)
Buckinghamshire (pop: 549,000)	Aylesbury Vale CCG Chiltern CCG	Buckinghamshire Healthcare NHS Trust	Buckinghamshire Healthcare NHS Trust	Oxford Health NHS Foundation Trust	South Central Ambulance Service NHS Foundation Trust GP Federations under development	Buckinghamshire County Council South Bucks District Council Aylesbury Vale District Council Chiltern District Council Wycombe District Council
Oxfordshire (pop: 730,000)	Oxfordshire CCG	Oxford University Hospitals NHS Foundation Trust	Oxford Health NHS Foundation Trust	Oxford Health NHS Foundation Trust	South Central Ambulance Service NHS Foundation Trust 4 GP Federations	Oxfordshire County Council Oxford City Council West Oxfordshire District Council Cherwell District Council Vale of White Horse District Council South Oxfordshire District Council Note: Oxfordshire councils are developing proposals to create 1-4 unitary councils
Berkshire West (pop: 528,000)	South Reading CCG North and West Reading CCG Wokingham CCG Newbury & District CCG	Royal Berkshire NHS Foundation Trust	Berkshire Healthcare NHS Foundation Trust	Berkshire Healthcare NHS Foundation Trust	South Central Ambulance Service NHS Foundation Trust GP Federations under development	Reading Borough Council Wokingham Borough Council West Berkshire Council Note: these are unitary councils

Section 2: Leadership, governance & engagement

- The 3 local health and care economies have long standing arrangements, set out below, which form the foundations of our working across the BOB footprint. Our aim as a BOB footprint is to build on not duplicate these arrangements, using the collective strength of all organisations to drive change. In developing the STP, our approach is to identify those big ticket issues where working at the larger scale of the BOB footprint will deliver change faster.
- We have established a BOB Leadership Group which includes Chief Executives of all the NHS organisations, local authority representatives and representatives from our key partners. The roles, functions and membership will be kept under constant review as our plans are developed and then implemented. This group will ensure delivery of the key workstreams across the footprint.

Local Health and Care Economy	Governance	Involvement of patients and the public	Local Government involvement	Involvement of NHS staff and clinicians
Buckinghamshire	**Healthy Bucks Leaders Alliance** – CCGs, NHS Providers, County Council CEO and ASC Director, Director of Children's Services, NHSE, DPH	STP proposal and updates have been to 2 HWB, BHT Board and both CCG GB meetings in public. Further and wider involvement planned as STP takes shape with tangible areas of STP wide work	Buckinghamshire County Council are members of the HBL Alliance. Reports are provided to the Health and Well Being Board .	Clinical Leads are being assigned to the seven STP workstreams. NHS Clinicians – commissioner and provider – are involved throughout all local transformation projects
Oxfordshire	**Oxfordshire Transformation Board** – includes senior managers and clinicians from OCCG, OUHFT, OHFT, OCC, GP federations	Regular updates are provided to HWB and HOSC. One of the Locality Forum Chairs will be joining the Transformation Board. Further involvement will take place as firmer proposals are developed.	Oxfordshire County Council are members of the Transformation Board. Reports on the Transformation Programme are provided to the Health and Well Being Board and the Health Overview and Scrutiny Committee.	The Medical Directors of OUHFT and OHFT are members of the Transformation Board. Clinicians are also involved in specific service reviews.
Berkshire West	**Berkshire West Integration Board** (CCGs x 4, NHS providers x 3 and LAs x 3) BW Delivery Group Health and Well Being Boards x 3 Locality Integration Boards x 3 Berkshire West Accountable Care System	PPI jointly run at locality level between CCGs and Council. All service redesign programme boards have patient representation. Embedded PPI strategy Quarterly health watch and 3rd sector meetings	The 3 LAs are members of the Berkshire West Integration Board. Reports on the Integration Programme are provided to the Health and Well Being Board.	All service redesign programmes have clinical/professional leadership. The Berkshire West Accountable Care System has a clinical reference group.

Section 3: Improving the health of people in our area

Local Health and Care Economy	Significant health and wellbeing gaps	Actions to be implemented
BOB	Health and Wellbeing Gaps identified jointly between the NHS and Local Government using local and national data, JSNAs, NAO standards, National Outcomes Frameworks , FYFV and Right Care analysis show commonalities across the BOB area. These are: 1) The need to tackle lifestyle factors as the core business of all organisations, especially inactivity, obesity, alcohol, smoking and mental wellbeing across the life course. This will reduce disease and deaths across the board, but particularly CVD and cancers. 2) The need to target all services at those most in need and differentiate the service offered accordingly so as to level up inequalities. 3) The need to coordinate all services around a 'better start in life' so as to reduce inequalities from the outset and reduce childhood obesity.	All NHS and social care services must see prevention as their 'core business' and shift from providing a 'sickness service' to providing a health and wellbeing service. DsPH have a role in coordinating this action in their 3 local areas for primary prevention, but leadership and investment will also be required from NHS organisations for primary, secondary and tertiary prevention and for reducing health inequalities. Because needs vary across the geography and service configurations differ, this work will be led through 3 local plans coordinated at BOB level. DsPH have agreed to work closely with colleagues in NHS England and PHE to develop consistent datasets helping to define improvements in outcomes/ROI. DsPH within the BOB footprint will support the NHS by working together on the following 4 topics: 1) Diabetes prevention – to disseminate best practice as it emerges from BOB national pilot sites 2) Alcohol- to develop evidence-based plans in partnership with the SE PH Network 3) NHS staff health and wellbeing - to mainstream best practice in the BOB area using the national Workplace Wellbeing Charter and CQINs 4) To review inequalities in the uptake of cancer screening by people with a learning disability and implement emerging improvements.
Buckinghamshire	Inequalities – health and life expectancy gap Preventable long term conditions Maternity and early years outcomes Mental wellbeing throughout the life course	Address via place, communities & individual focus across Bucks system. Using community development and asset based approaches & co-design/co-production.
Oxfordshire	Inequalities – health and life expectancy gap Preventable long term conditions Ensuring a better start in life Parity of esteem re mental health and mental wellbeing for all ages.	Address via each organisation contributing to the coordinated planning of prevention, reduction of inequalities , better start in life and parity of esteem. Focus on coordinating and re-shaping existing services to fill gaps.
Berkshire West	Inequalities - health and life expectancy gap. Action using NAO identified framework . 5 lifestyle risk behaviours plus mental well being across the life course .	Action as part of the Berkshire West 10 programme and as part of the accountable care organisation delivery . Development of a strengths based approach to social care, extending the reach to help/prevent the need for long term services.

Section 4a: Improving care and quality of services: emerging priorities

Identified Care and Quality Gap	Emerging Priorities for transformation at scale
Tackling inefficiencies in patient experience of care will drive increased quality and productivity	Reducing overlap and inefficiencies in access to diagnostics and supporting services along cancer pathways and specialist referral routes Developing a digital operational strategy that puts patients at the centre of ownership of all their information, enables sharing of information across services and enhances mobile access to advice and support
Urgent and emergency care	Developing a whole system integrated model to manage the ebbs and flows of urgent care demand across all providers, including virtual support from one unit to another. Building a predictive UC model across the entire 1.8m population in order to reduce variation and maintain high quality services. Re-thinking urgent care models to reserve hospital attendances and admission for only instances when primary/out of hospital care models are not appropriate. Developing consistent triage across primary and secondary care, supported by access to patient information and comprehensive instructions regarding self management post discharge.
Mental Health	**The Healthcare Challenge** .The capacity and breadth of the full range of mental health services detailed in the NHSE Mental Health Taskforce Five Year Forward View is unacceptably limited, variable and inconsistent across the footprint, and investment is strikingly low against weighted per capita national benchmarks, even though services benchmark well on efficiency. **Emerging Priority**: Implement the recommendations of the MH taskforce (also known as the 5 Year Forward View for mental Health) and increase the range and quantity of mental health services available to the BOB population. **Enabler** : Map the gap between current provision and that outlined in the Taskforce. Prioritise the identified service improvements with reference to the economic report accompanying the Mental Health Taskforce which identifies where the largest system wide benefits can be achieved (for example reduction in costs in physical healthcare expenditure and also relieving pressure on primary care to help release time for complex case management of frail older people) **The Healthcare Challenge.** The current provision and commissioning of specialist mental health services (tertiary) and out of area placements is fragmented and poorly co-ordinated. This has an adverse impact on both cost and quality. **Emerging Priority :** Develop a comprehensive strategy for the provision of all specialist Mental Health services in the region. In order to provide the necessary scale this is likely to involve working with neighbouring footprints (Frimley and Wessex). **Enabler**: Identify current spend by all agencies (providers and commissioners) on specialist Mental Health services and review against current pattern of provision. Identify opportunities to provide alternative services closer to home which would provide demonstrable financial and quality benefits.

Section 4a: Improving care and quality of services: emerging priorities

Identified Care & Quality Gap	Emerging Priorities for transformation at scale
Improving outcomes in: • Cancer • Maternity	 Review of cancer care pathways to increase productivity and enhance patient experience; access to diagnostics and reducing follow-ups in accordance with best clinical practice; cancer recovery package as per 'commissioning person-centred care for people affected by cancer'; Community- based chemotherapy administration (home, Community facility, mobile bus, GP practice) ; End of life care To review the maternity provider landscape across the footprint in order to maximise networked clinical support opportunities and reduce maternity unit diversions. (Clinical Senate report being finalised). To work with the Strategic Clinical Network to improve maternity care by reviewing the induction pathway and reducing C-section rates.
The GP workforce is at significant risk of becoming unsustainable, putting at risk our out of hospital services development	Supporting primary care providers to improve efficiency and effectiveness, including development of new at-scale provider entities. Using headroom created by increased self-care to enable new ways of supporting people with frailty and/or multiple long-term conditions. Tapping the potential within the wider primary care landscape including social care, voluntary sectors; developing a consistent approach to primary care services access and the enablers specifically estates, IT..
Significantly reducing variation will drive efficiencies	Standardising services in terms of clinical thresholds. Developing consistent access to specialised services, for all, as appropriate Developing a consistent approach to Procedures of Lower Clinical Value and Clinical Priorities across the South Region. Reducing admissions and length of stay for patients with frailty.
The BOB footprint has unique workforce challenges; expensive living costs with a national pay scale for service providers and local high levels of employment mean low numbers of available health and social care professionals	Focusing on the potential for back to work staff already within the Thames Valley area. Aligning workforce strategies across health and social care. Development of different roles to support new models of care and to provide new routes into areas of current scarcity, for example by creating a pathway from Healthcare Assistant into nursing.
Safety Improvement Methodology	To develop a consistent approach to improving quality and safety, collaborating on delivery of large-scale improvement programmes and a relentless focus on quality and safety at every level across the footprint.

Section 5a: Improving productivity and closing the local financial gap - 2016/17 plans

- The latest 2016/17 positions, subject to plans and contracts being finalised, for each of the organisations in BOB are as follows:

Local Health and Care Economy	CCGs	NHS FTs and Trusts
Buckinghamshire	Chiltern 1% surplus £3.6m Aylesbury Vale 1% surplus £2.3m	Bucks Healthcare £8m deficit
Oxfordshire	1% surplus £7.5m	OUHFT £33.9m surplus (after receiving £20.4m STF funding) OHFT £2.4m deficit (after £0.2m STF)
Berkshire West	0.5% surplus £2.7m	Royal Berks FT £4.8m surplus (after £9.9m STF) Berks Healthcare FT £2.3m deficit
All CCGs		SCAS FT £0.9m deficit

Section 5b: Improving productivity and closing the local financial gap – 2020/21 challenge

- Work is in progress to identify the financial challenge for 2020/21, supported by Rubicon Health Consulting and the South, Central and West CSU.
- Under a do-nothing scenario, the cumulative financial gaps, based on the work to date, are as follows:

Local Health and Care Economy	Financial Gap
Buckinghamshire	£185m
Oxfordshire	£176m
Berkshire West	£150m

Section 6a: Big decisions

Local Health and Care Economy	Big Decisions
BOB footprint	Potential changes in acute services and specialised services which arise from the work which the acute trusts have started. Award of the contract for the new 111 system and integrated clinical hub
Buckinghamshire	The target activity reductions in secondary care and local provider competition may result in some services being provided by alternative providers through networks – will need public engagement. Consultation on community hubs may affect historic services at community hospitals.
Oxfordshire	Public consultation to be launched later in 2016 which will consult on changes to community hospitals, Horton Hospital, closure of acute beds
Berkshire West	Implementation of Frail Elderly pathway consulted on in 15/16. Establishment of an Accountable Care System, operating to a new financial framework. Emerging priorities are prevention, urgent care, planned care, cancer, LTC/elderly, implementation of the Berkshire West primary care strategy.

Section 6b: Potential service changes which we have in common with other footprints

Local Health and Care Economy	Issue	Footprint
BOB	Changes which may arise from the review of specialised acute services provided by OUHFT	Northamptonshire (No: 20); Bath, Swindon and Wiltshire (No: 40); Milton Keynes, Bedfordshire and Luton (No: 24)
	Changes which may arise from the discussions that the acute trusts have started	Northamptonshire (No: 20); Bath, Swindon and Wiltshire (No: 40); Milton Keynes, Bedfordshire and Luton (No: 24)
	Specialised Mental Health Services provided by OHFT	Bath, Swindon and Wiltshire (No:40); Milton Keynes, Bedfordshire and Luton (No: 24); Wales
	Urgent and emergency Care Network and 111 integrated urgent care re-procurement	Frimley (No: 34)
Buckinghamshire	LD Services – Change of provider from Southern Health to Hertfordshire Healthcare	Hertfordshire and West Essex (No: 25) Hampshire (No:42)
	Local but out of county Provider (Frimley) challenging historic patient flows to BHT	Frimley (East Berks, Surrey CCGs)
	Future services reconfigurations in Midlands and East region will affect local provision and patient flows and tertiary flows, specifically: (i) Milton Keynes FT & Bedford Hospitals; (ii) the future of West Herts Hospitals Trust; (iii) potential siting of HASU in the lower Midlands and East region.	Need for liaison with STPs footprints in Midlands and East region
Oxfordshire	Future provision of services at the Horton Hospital in Banbury (part of OUHFT)	Northamptonshire (No: 20) and Coventry/Warwickshire (No: 18)
	LD Services – change of provider from Southern Health FT to Oxford Health FT	Hampshire (No: 42)
Berkshire West	MH and community services are provided by BHFT who have a Berkshire wide footprint.	Frimley (No: 34)

Section 7: Support we would like

Our emerging thinking is:

- **Areas where we would like regional or national support as we develop our plans**.
    - The STP to be submitted to NHSE in June should be kept as light as possible and focussed on the actions that are to be taken not on descriptions of the problems.
    - Support to assist us in determining the scale of the financial challenge we have and to confirm that the actions we are taking will deliver this.
    - Central support and air cover as we transition to new ways of working; develop new contractual models
- **National barriers or actions we think need to be taken in support of our STP**.
    - A need for greater flexibility to enable us to develop new models in primary care and new financial models which align incentives to the ambitions of the whole system.
    - Role of regulators needs to be aligned to supporting us with implementing transformational change.
    - We need to consider options for joining up the work of the BOB organisations with the local offices of the national bodies.
- **Areas where we could share good practice or where we would like to access expertise or best practice from other footprints.**
    - Emerging best practice from the vanguards that is particularly relevant to helping us address our local issues needs to be shared with us.
- **Other key risks that may affect our ability to develop and/or implement a good STP**.
    - Public consultation will be needed on a large number of service changes. Many of these will not be popular with patients and politicians.
    - Addressing the workforce challenges that we have across all parts of our health and care system.

Annex 1: Populations and financial allocations

- Figures from the Financial Allocations for 2016/17 issued by NHSE

LHEs and CCGs	2016/17 Population	2016/17 place based allocation
Buckinghamshire Aylesbury Vale CCG Chiltern CCG	 209,667 339,657	 306,075 484,486
Oxfordshire CCG	729,830	1,029,306
Berkshire West Newbury CCG North & West Reading CCG South Reading CCG Wokingham CCG	 118,043 110,197 138,635 161,251	 169,189 160,476 181,403 216,709
TOTALS	**1,807,280**	**2,547,644**