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Notice of Meeting

Health and Wellbeing Board

Thursday, 26th September, 2013 at 9.00 am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 18 September 2013

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss on (01635) 503124
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Mr Bal Bahia (Newbury and District CCG), Leila Ferguson (Empowering West Berkshire), Councillor Graham Jones, Dr Catherine Kelly (Reading and West CCG), Dr Lise Llewellyn (Public Health), Councillor Graham Pask, Lady Emma Stevens (Healthwatch) and Rachael Wardell (WBC - Community Services)

Also to: John Ashworth (WBC - Environment), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Councillor Gwen Mason, Matthew Tait (NHS Commissioning Board), Councillor Quentin Webb, Cathy Winfield (Berkshire West CCGs) and Lesley Wyman (WBC - Public Health & Wellbeing)

Agenda

Part I

			Page No.
9.00 am	1	**Election of Vice-Chairman** To elect a Vice-Chairman for the Health and Wellbeing Board for the 2013/14	
9.03 am	2	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	
9.05 am	3	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 25 July 2013.	1 - 8
9.08 am	4	**Declarations of Interest** To receive any Declarations of Interest from Members.	
	5	**Public Questions** There were no public questions submitted relating to items on this agenda.	
9.10 am	6	**Royal Berkshire NHS Foundation Trust Draft Five Year Integrated Business Plan (Royal Berkshire NHS Foundation Trust)** *Purpose: The Royal Berkshire NHS Foundation Trust has completed its draft five year Integrated Business Plan (IBP) and are now seeking views and feedback from stakeholders.*	9 - 28

9.40 am	7	**Funding Transfer From NHS England to Social Care (Jan Evans)** *Purpose: To inform the Health and Wellbeing Board of how the 2013-14 funding transfer from the NHS is being used by West Berkshire Council.*	29 - 44
9.50 am	8	**Public Health - Immunisations Update (Lesley Wyman)** *An update on behalf of Kakoli Choudhury (Health Protection Consultant, Bracknell).*	45 - 56
10.00 am	9	**Joint Assessment Framework for Learning Disability (Rachael Wardell)** *Purpose: To draw to the attention of the Health and Wellbeing Board a new requirement to undertake a Joint Health and Social Care Assessment for Learning Disability.*	57 - 130
10.05 am	10	**Frail Elderly Pathway (Rachael Wardell)** *Purpose: To make the Health and Wellbeing Board aware of an early strand of Health and Social Care integration being undertaken in the West of Berkshire.*	131 - 134
10.15 am	11	**Turnaround Families Programme (Julia Waldman)** *Purpose: To provide information on the local implementation of the Department for Communities and Local Government's Troubled Families Programme: 2012-2013.*	135 - 172
10.35 am	12	**Call to Action (Cathy Winfield)** *Purpose: To inform the Health and Well Being Board of the national Call To Action that will engage stakeholders in the design of a renewed and revitalised NHS. To advise the Board of its role in this process.*	173 - 202
	13	**Members' Question(s)** There were no Member questions submitted relating to items on this agenda.	
10.45 am	14	**Future meeting dates** 28 November 2013 – Committee Room 1 23 January 2014 – Committee Room 1 27 March 2014 – Committee Room 1 22 May 2014 – Committee Room 1	

Andy Day
Head of Strategic Support

West Berkshire Council is committed to equality of opportunity. We will treat everyone with respect, regardless of race, disability, gender, age, religion or sexual orientation.

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 25 JULY 2013

Dr Alex Anderson (Newbury and District CCG) *(Vice-Chairman)*, Leila Ferguson (Empowering West Berkshire), Heather Hunter (Healthwatch (substitute)) Dr Lise Llewellyn (Public Health), Councillor Graham Pask and Dr Rupert Woolley (Reading and West CCG (substitute)

Also Present: Lesley Wyman (WBC - Public Health and Wellbeing), Andy Day (WBC - Strategic Support), Janet Meek (NHS), Adrian Barker (Healthwatch), Paul Batchelor (Dental Public Health), Jan Evans (WBC - Adult Social Care) (Cathy Winfield (Berkshire West CCGs), Chris Washbrook, Barrie Prentice and Jessica Bailiss (WBC - Executive Support)

PART I

27. Minutes

The Minutes of the meeting held on 23 May 2013 were approved as a true and correct record and signed by the Vice Chairman.

28. Declarations of Interest

No Declarations of Interest were received.

29. Public Questions

29(1) Question submitted to the Board by Mr Chris Horner

A question standing in the name of Mr Chris Horner on the subject of plans to shift care into the home, supported by assistive technologies would receive a written answer from Jan Evans on behalf of the Health and Wellbeing Board.

30. Health & Wellbeing Action Plan (Lesley Wyman)

Lesley Wyman introduced her report to the Board which detailed progress with the Health and Wellbeing Strategy Action Plan, which was still in draft form. The action plan underpinned the Health and Wellbeing Strategy which contained five priority areas. Actions were set out to show that they were either lead by the Public Health team or in partnership with the Local Authority, Clinical Commissioning Group (CCG) or third sector organisations.

Lesley Wyman referred to page 45, which was an outline summary of the Public Health budget for 2013/14. Core team staffing costs referred to staff in Bracknell, including a knowledge and information team, working on the Joint Strategic Needs Assessment (JSNA) the Director of Public Health for Berkshire and a Health Protection Consultant.

School nursing, sexual health, tobacco control and substance misuse were joint agreement contracts and were agreed at the outset when Public Health transitioned from the NHS. Sexual health services were under review in order to get a better sense of the true cost of these services specific to West Berkshire. This review was progressing well with the Royal Berkshire Hospital.

Work on tackling obesity and increasing physical activity; NHS health checks; work targeting the Gypsy, Roma, Traveller and Black and Minority Ethnic communities and finally crime and disorder had been rolled over from 2012/13.

Any money remaining would be available for providers to bid for who could contribute to achieving Public Health outcomes in the priority areas.

Lesley Wyman referred to page 47 of the agenda, which detailed the process for identifying providers who could contribute to the action plan. It was noted that the timescale was tight, however, it was important that the application process was completed as quickly as possible. Expressions of interest could be submitted by any West Berkshire Council department; Newbury and District CCG, North and West Reading CCG or any voluntary/community group.

From the expressions of interest a list of projects would be drawn up by a panel consisting of the West Berkshire Chief Executive, Strategic Director of Public Health and the Head of Public Health and Wellbeing.

Lesley Wyman reported that she would distribute the action plan more widely to third sector organisations via Empowering West Berkshire. Work had already taken place via the Public Health Integration Board to look at the Action Plan in more detail and to assist with identifying possible projects from West Berkshire Council.

Proposals put forward needed to have measurable outcomes and there was a set of assessment criteria that needed to be considered in order to be successful. Any projects proposed needed to be realistic in terms of meeting objectives within the set timescale (March 2015). If a project included appointing to a post, then there would have to be explanation included on the sustainability of the work post March 2015.

Lesley Wyman stated that projects that promoted joint working would be viewed favourably along with those that addressed health inequality. Projects would also be assessed on the extent to which they aimed to prevent deterioration in health and thereby reduce demand on services.

Leila Ferguson asked how the application documents would be accessed and Lesley Wyman reported that they would be placed on the website and it was vital that they were clearly identifiable.

Jan Evans felt that it was important that analysis work was used by Public Health to give an indication of where the gaps where. This would help prevent an inundation of unsuitable applications.

Councillor Graham Pask praised the Action Plan document although was fearful it might raise expectations due to the size of the document. Councillor Pask expressed how important it was to link to Parish Plans when delivering the Action Plan.

Dr Rupert Woolley questioned whether the CCGs would be involved in considering the bids. Lesley Wyman confirmed that both CCGs would be consulted.

RESOLVED that: Lesley Wyman would organise a meeting with Dr Rupert Woolley and Dr Catherine Kelly.

It was confirmed that the formal decision process would involve both the Local Authority and the CCGs and as a result would have to go through the Health and Wellbeing Board before being approved.

Dr Alex Anderson asked if projects emerging throughout the year would be considered or those in 12 months time. Lesley Wyman confirmed that there would be further opportunities as there would be growth in the budget in 2014. It was important to note that this year they would not be interested in projects that would involve a long period of planning. New projects would need to start in 2013.

Dr Anderson questioned how the funding would be governed and how this would link to the Health and Wellbeing Board. Lesley Wyman reported that the Health and Wellbeing Integration Board, performance managed the Action Plan. This group then reported into the Health and Wellbeing Board. Dr Lise Llewellyn stated that Lesley Wyman would act as the link to the CCG Board as she attended these meetings.

Councillor Graham Pask asked who was responsible for monitoring the Public Health budget. Dr Llewellyn confirmed that herself and Nick Carter were responsible for the Local Authority Public Health Budget. Updates on the budget had to be reported to the Health and Wellbeing Board and via the Councils budget monitoring process.

31. Public Health Advisory Board Feedback (Lise Llewellyn)

Dr Lise Llewellyn drew the Boards attention to Nick Carter's report, which gave an update of the work of the Berkshire Public Health Advisory Board. In essence the aim of the Board was to ensure contracts were progressing through monitoring their performance. The Board would then identify opportunities and re-commission in order to meet local need. The Board had a streamlined way of procuring the services.

The Public Health Advisory Board also played a key role in ensuring Public Health was delivering against its mandate.

Dr Llewellyn highlighted the Boards Terms of Reference and reported that the Board's Membership was formed from the six Berkshire Unitaries.

Dr Llewellyn added that the Advisory Board was also taking an overview of health protection and infectious diseases in Berkshire, which involved close liaison with each Local Authority's Emergency Planning Team.

32. Winterbourne View (Jan Evans)

Jan Evans introduced her report which aimed to update the Board on the outcome of the Serious Case Review of Winterbourne View Hospital and local actions with respect to the Department of Health recommendations.

Minister Norman Lamb had led on the Winterbourne View Review. Recommendations and actions from the Department of Health were very clear and involved NHS and Social Care organisations working in collaboration to review the way they worked.

Locally a Berkshire wide Winterbourne Project Group consisting of the six local Authorities would be established to ensure the delivery of actions and recommendations deriving from the Winterbourne View Review. This group would be chaired by the Director of Joint Commissioning for Berkshire West CCGs and would report to the Health and Wellbeing Board. This group would carry out a stock take of progress as requested by the Department of Health, which was in essence a self assessment of work taking place. The self assessment process would indicate areas that required focus.

There had been a Serious Case Review carried out since the Winterbourne Review by Devon County Council. In October 2011 three safeguarding alerts had been raised in Devon regarding "Atlas" LD care homes run by Atlas Project Team Limited (APTL). APTL went into administration and all placing Local Authorities were given notice to move individuals by 30 July 2012. West Berkshire had one individual in a Devon APTL care home for whom alternative care was found immediately.

This situation had flagged the need for there to be an advocate representing the West Berkshire Council present, when individuals were placed in long distance homes and had no family who could take responsibility.

33. Funding Transfer from NHS England to Social Care (Janet Meek)

Janet Meek drew the Boards attention to her report on the funding transfer from NHS England to Social funding, which detailed arrangements and amounts to be transferred from the NHS to Local Authorities during 2013/14 – 2015/16.

In late June, two Gateway letters from NHS England had been sent referring to the transfer of funding from the NHS to Local Authorities.

The first letter looked at the Funding Transfer from NHS England to social care. Funding for Berkshire West Authorities would come directly from the Thames Valley Area Team and the Health and Wellbeing Board would be the forum for discussions between the Area Teams, CCGs and Local Authorities on how the money should be spent.

The funding allocated to West Berkshire was almost £1.8 million. Funding would be passed over to the Local Authority once a Section 256 Agreement was signed. However, before the agreement was signed certain conditions needed to be satisfied which were set out in Janet Meek's report.

The second letter concerned the Spending Round Health Settlement, which proposed the establishment of a £3.8bn Integrated Care Fund (Integrated Transformation Fund) of which the NHS would contribute £3.4bn. Most of the Transformation Fund would be a pooled budget for the integration of health and social care. It was stated that much of this was not new money and previously fell under NHS England. Some new money would be available as described in a further Bill from the Department of Health.

The pooled funding would sit with the Local Authority however, would be subject to plans being agreed by local Health and Wellbeing Boards and signed off by CCGs and Council Leaders. Plans would be subject to assurance at a national level and would need to include the protection of social care services.

Janet Meek reported that her paper was for discussion and for all to note the conditions. Janet Meek proposed that a sub task group of LA and CCG representation be established to recommend how funding was allocated in 2013/14.

Jan Evans stated that she had received the first Gateway letter however had not seen the second letter concerning the Spending Round Health Settlement. Jan Evans proposed that she would speak to finance colleagues and bring a report to the next Board meeting which outlined how the 13/14 funding was being spent.

RESOLVED that: Jan Evans put together a report for the next meeting of the Health and Wellbeing Board in September, outlining the current budget and how funding had been spent to date.

Dr Lise Llewellyn noted how well the discussion fitted in with those that had previously taken place on the Action Plan. Dr Llewellyn felt that more focus was required regarding preventative care. Dr Llewellyn highlighted that there would be risk in trying to add NHS Number to data as this would be extremely challenging. There was also a risk regarding seven day working.

Councillor Pask noted that they were already three months in to the 2013 virtual funding and questioned what the procedure was with this in mind. Jan Evans stated that this money had been accounted for against items outlined in Janet Meek's report (page 79). Next year there would be a formal plan put in place for spending the money, which would be agreed in advance with the NHS.

Councillor Pask felt strongly that a mechanism was required to support how the funding was allocated. Jan Evans suggested in the first instance a smaller group meet including finance colleagues.

RESOLVED that: Jan Evans would set up a one off meeting with finance and CCG colleagues, to look at funding for 2013/14 in preparation for the next Board meeting in September.

Regarding NHS Numbers, Jan Evans reported that Social Care used the system RAISE. In two to five years this would need replacing. It was possible that the NHS system RIO might be suitable for the Council to use. It was asked whether this would also affect Children's Services and Jan Evans confirmed that there was a strong argument for Adults and Children's Services going forward with a similar system.

Dr Alex Anderson highlighted that there were two decisions that were required. Firstly to agree a sub task group and then secondly, a timescale for this group to be set up in.

RESOLVED that: coordinated by Jan Evans: a Sub Task Group would be set up to recommend how the funding should be allocated in 2013/14 and associated KPI's by the next meeting of the Health and Wellbeing Board on 26 September.

34. JSNA Update (Lesley Wyman)

Lesley Wyman referred to her report which gave an update on progress with the JSNA process.

Work with the new style JSNA was progressing well, moving from PDF to a web based tool. There was good representation from the six Berkshire Authorities and groups were moving the project forward in each locality. Jason Teal was representing West Berkshire and was looking at how to link the JSNA to the areas current District Profile. The plan was to establish a web based tool, then create ward profiles and CCG profiles.

Each Local Authority would be given a template and a small team tasked with taking the work forward. In West Berkshire this team consisted of Jason Teal, Jenny Legge (Research and Consultation Team), Lesley Wyman and Phil Rumens (Web Development). Jason Teal had already created ward profiles for West Berkshire and was using these to show other Local Authorities. It was hoped that the wad profiles would be completed by the end of August and the JSNA published by mid November 2013. Any data was required by the end of August.

Councillor Graham Pask commended the ward profiles and asked if the health authority could provide health data to the same broken down level. Lesley Wyman stated that it was more difficult to break down health data due to such small numbers. Dr Lise Llewellyn explained that they had to be careful not to make it possible to identify individuals. Dr Llewellyn reported that by December 2013 the JSNA would be in an easily accessible format and then the next stage would be to look at particular health issues in more detail.

35. Integrated Health and Social Care Management including the Pioneer Programme (Cathy Winfield)

Cathy Winfield referred to page 89 of the agenda which featured the Berkshire West Application to become an integration pioneer. The document set out the direction of travel. It looked at what an area would want to move away from, what to retain and what to move towards. The model used to illustrate this within the bid document, was modelled on Frail Elderly Services.

Cathy Winfield referred to the part of the bid application document (page 96), which detailed options for integration. These included developing a Social Care Hub which would provide access to both community and social care services; changing the way of working; encouraging independent living though working with care homes and using risk stratification across health and local authority services.

The Health and Wellbeing Board would have a leading role in demonstrating strong governance arrangements. A Chief Officers group would consist of representatives from the ten Berkshire West Areas. The Berkshire West Partnership Board were formed to monitor the approach to integration.

Cathy Winfield reported that a decision would be made as to whether Berkshire West was a pioneer in December 2013. However, as a result of the spending review the piece of work would need to be carried out regardless of whether pioneer status was achieved.

Paul Bathchelor noted that there was no reference to dental care. More doctors were receiving visits from oral patients due to the service being free and he questioned how the existing workforce was being trained to deal with this. Dr Lise Llewellyn noted Paul Bathchelor's point and confirmed that reviewing the skill mix was a key priority for the area.

Dr Llewellyn felt that it was important that changes in services needed to be communicated to the public and it was noted that Healthwatch played a vital role in capturing the voice of the general public.

Dr Alex Anderson referred to Cathy Winfield's point that work was required regardless of the Pioneer Programme. It was felt that the body of work required a name and needed to be reported on to the Health and Wellbeing Board.

Jan Evans felt that if the Local Integration Steering Group took responsibility for the Pioneer Programme it would need its terms of reference reviewed. Much of the detail regarding integration that had been touched on had not been consolidated as areas of work and therefore required further focus.

RESOLVED that: Jan Evans to ensure the Local Integration Steering Group review its terms of reference to take on this wider remit.

36. Review of West Berkshire Council's Eligibility Criteria (Jan Evans)

Jan Evan's referred to David Lowe's report, which advised the Board of the Scrutiny review into adult social care eligibility criteria.

Following legal action, the Council's Executive Member for Community Care supported by Officers, requested that the Health Scrutiny Panel conduct a review into the way the Council provided adult care services. This was to ensure that they continued to be statutorily compliant and did not disadvantage the very vulnerable of West Berkshire.

In 2003 West Berkshire Council set a policy of 'critical' only (4 levels include low, moderate, substantial and critical). Therefore if a person's assessed care needs were critical they would receive personal care services. A Scrutiny led exercise supported by Council Officers commissioned a consultation, including with local residents. A report had been drawn up from the results and Jan Evans was meeting with David Lowe to discuss the response. The report would go to Overview and Scrutiny Management Commission and then the Executive.

Jan Evans reported that other areas had tried to change to 'critical' but had been challenged by the consultation process. The aim of the Scrutiny exercise was to look into the cost of West Berkshire moving to 'substantial'.

Dr Alex Anderson was concerned about the impact the change could have and questioned whether the impact would be assessed. Jan Evans confirmed that there would be a substantial equality impact assessment carried out.

REOLVED that: Jan Evans would circulate the equality impact assessment once it was publically available.

Jan Evans confirmed that if the Care Bill was endorsed, all 1000 individuals in West Berkshire would need re-assessing anyway. This would have a profound affect of Adult Social Care. The Government had given re-assurances that this would not significantly affect Council care budgets.

Councillor Graham Pask stressed that this issue should come back to the Health and Wellbeing Board, as it was important all were aware of the potential impact this could have on the already stretched Council budget.

37. Healthwatch (Heather Hunter)

Heather Hunter introduced the first quarter progress report for Healthwatch West Berkshire. In summary:

- The progress report included a basic project development implementation plan (page 116).
- The report aimed to give transparency, without confusing people with too much detail.
- West Berkshire Healthwatch was the first Healthwatch to begin and was set up by 1 April 2013.
- Healthwatch was a standalone community interest company;
- Two members of staff were from the Family Resource Centre;
- There were a Board of non-executive directors.
- Lady Emma Stevens was the Healthwatch representative on the Health and Wellbeing Board and Heather Hunter would attend meetings on a quarterly basis.
- The operation side of Healthwatch was run by the Family Resource Centre.
- Healthwatch England had given minimal guidance on the purpose of Healthwatch, so each area was able to interpret this for themselves depending on what was needed in a particular area
- West Berkshire Healthwatch had consulted the public on their views about the NHS and generally they had been positive.
- West Berkshire Healthwatch had its own website, which was admired and used as a template by other areas. As a result of this an extra £6k had been raised.
- A board of Healthwatch Champions had been formed, they were due to meet in three weeks time.
- The main West Berkshire Healthwatch Board meetings would link to the Health and Wellbeing Board. They would also feed into the Champions Board.

Councillor Graham Pask congratulated Healthwatch on the work that had taken place in a short period of time however, questioned how Healthwatch could be found by members of the public. It would be challenging to capture the voice of the general public and not just become a contact point for those who had complaints. Heather Hunter stated that work was taking place to become established with the public. They had set up pods in Boots, Tescos, libraries and Children's Centres.

It was highlighted that the Health and Wellbeing Board needed to utilise Healthwatch for any survey work required. The Healthwatch website was also there for the Board to use to communicate any key messages to the public.

38. Members' Question(s)

There were no Member questions submitted relating to items on this agenda.

39. Date of the next meeting

The date of the next meeting was 26 September 2013 in the Council Chamber (Market Street Offices).

(The meeting commenced at 9am and closed at 10.35am)

CHAIRMAN …….

Date of Signature …….





Royal Berkshire NHS Foundation Trust

Integrated Business Plan
2013 – 2018

Stakeholder Summary: August 2013
(Draft version for discussion purposes)






Executive summary

Introduction

As a foundation trust, the Royal Berkshire NHS Foundation Trust (RBFT) needs to ensure a solid financial base so that we are able to continue to invest in services for our patients, deliver high quality care with the best outcomes and an exemplary patient experience. Our Integrated Business Plan (IBP) sets out our challenges for the next five years, namely: to continue to deliver safe and high quality patient care in tandem with identifying further efficiency challenges.

Quality of care remains our top priority and is at the heart of our strategy, which seeks to build on and continuously improve the quality of our services, clinical outcomes and clinical productivity. Our services are already amongst the safest in the country with low mortality and infection rates an improving patient experience and good operational performance. This is supported by our historically strong financial performance, with earnings before interest, tax, depreciation and amortisation (EBITDA) of above 6% and track record of delivery of Cost Improvement Plans (CIPS). Although some of our estate is modern there is a significant capital programme of £100m over the next 10 years to ensure that all our facilities meet our current and future needs.

Market Assessment

The context in which we operate is changing and will impact significantly on the configuration of our services over the next five years. These changes are likely to see a shift in a large number of outpatient attendances into the community as we harness new technology and also improve the range of diagnostics at our community sites. We have analysed the impact of the growing population (particularly the growing numbers of elderly people) and lifestyle factors for our catchment population over the next five years and have reflected these in our planning. Overall a residual growth rate of approximately 5% and 11% has been assumed for elective and outpatient activity in the most likely growth scenario over the next 5 years.

Strategic and service delivery options

The future organisational form of RBFT is uncertain but the likelihood, and our preferred option is that we will remain as a stand-alone organisation, vertically integrated with community providers to deliver seamless care to patients. We recognise that any option will take time to be implemented and that we will need to be a stand alone organisation in the short term. We will continue to strengthen our position by addressing the cost of financing with increasing emphasis on being part of healthcare groups, clinical networks and delivering integrated care with our partners. However our assessment is that we will reach a point where this arrangement will no longer be viable and we anticipate that this will probably be in the next 3 years. The impact of the anticipated growth in demand alongside the relocation of appropriate activity into the community means that we will need to develop services that can deliver the anticipated requirements of our patients over the next five years, whilst ensuring that our income grows sufficiently to support our plans. The impact of our service developments and the increasing demands have been converted into activity projections.

Financial Plans

We have a track record of significant cost improvement programmes, totalling £49m over the last three years. We need to continue to deliver further savings of between 3-5% over the next five years and we have identified Quality, Innovation, Productivity and Prevention (QIPP) Programme opportunities of £46m over this period. Of major concern to the Trust is the current penalty regime around non elective threshold and readmissions, resulting in lower payments for this unavoidable growth in non elective work which is predicted to grow to £8.4m in 2013/14: the equivalent of treating 4000 patients for free. Based on projected high growth activity assumptions, we have modelled our income growing by £44m to £381m with a surplus of £6.5m. However, this is based on assumptions regarding service development and growth in activity. In our limited growth activity model, we would actually see our income reduce from 2012/13, representing a £49.5m reduction from our high growth model and final year deficit of £1.9m.

Demand management and activity growth

The general trend in activity over the last few years has been of significant growth, particularly in emergency and non-elective care. We are therefore committed to supporting commissioners in the successful implementation of demand management, including shifting activity from day case to outpatient procedures and ensuring reductions in the number of follow up appointments. The Trust continues to be a top performer in day case rates and reductions in outpatient follow up activity, resulting in financial savings and avoidance of unnecessary hospital stays. Our implementation of admission avoidance schemes for non-electives have been successful but are currently not keeping up with the pace of increase of non-elective admissions and there is predicted to be continued growth in referrals year on year which is leading to a growth in our waiting lists.

Limited growth activity models are predicated on the assumption that commissioners plan to introduce effective demand management schemes. If these schemes are fully embedded the medium and high growth in activity we have projected may be avoided. As we have not yet seen significant impact of these schemes in reducing activity, we have set out the required increase in capacity across the health economy to match demand. This increase in capacity may be mitigated by the corresponding success of demand avoidance through reducing lengths of stay, delayed discharges and readmissions in addition to developing alternative and more efficient and effective treatment pathways or locations.

Activity growth projection

We have modelled three scenarios:

- Limited growth – assumes income will remain flat.
- Medium growth – our most likely estimate of future activity.
- High growth - a higher rate of growth based on specific assumptions around market share and service developments.

Both our medium and high growth scenarios are below the historical trends in activity increase that we have seen in recent years

	Medium growth over 5 years	High growth over 5 years
A&E	20%	33%
Outpatients	11%	17%
Day cases	26%	28%
Non Elective	10%	26%
Elective	5%	8%
Direct Access	4%	4%

We therefore expect to see the following shift based on activity between now and 2017/18:

- Potentially 125-196 extra inpatient beds required (based on our medium to high growth analysis and an assumption of 87% occupancy.)
- Shift from Inpatient to day case and outpatient activity, with predicted growth of between 12-17% for outpatient slots.
- Potential increase in Berkshire West market share to 80%.
- Income will increase to circa £360-380m.
- Increase of our usage of community sites.
- Estate reconfiguration and investment of £10m per annum.
- Expansion of specialist centre.

Conclusion

RBFT is a strong acute Trust with a large A&E and maternity unit, a good reputation, excellent clinical performance and a sound operational record. The quality of the services we provide is our top priority. The hospital is valued for its core services and our vision is to strengthen these, continuously improving quality whilst shifting appropriate work out of the hospital and integrating our services across the community.

We are a healthcare provider committed to doing better through teamwork. We recognise that far from being independent we are interdependent, working within a broader health system with an emphasis on lasting relationships with our partners to make a difference for our patients and their families. We pursue continuous improvement with the passion and perseverance to become one of the country's best healthcare providers. It is vital that each aspect of our work in future drives better value by seeking to enhance the outcomes of care and through the redesign of clinical pathways to reduce the costs of those outcomes. We will seek to do this by working together in partnership.

Summary of our strategic vision

Where we are

The Royal Berkshire NHS Foundation Trust

- Large DGH Plus.
- Services to local people across Berkshire and Oxfordshire.
- Hyperacute and specialist services
- Significant emergency pressures crowding out activity.

Clinical operating model – Care groups

- Patient-centred clinical operating model, organised around patient needs: Networked; Urgent; and Planned.

Our estate

- Some facilities not matching the patients' expectations.
- Significant expenditure to maintain at an acceptable level.

Financial position

- Current funding not fully following the patient, therefore required non-recurring funding.
- High costs of historic investments.
- Savings of £49m in last three years.

The challenge

Ensure ***safe, high quality care*** for all, with improving patent experience and operational performance. The population of older people is increasing higher than the national average, increasing admissions, length of stay and pressure on non elective beds.

Matching demand with capacity and skills: Increasing levels of non-elective demand are not fully reimbursed, reducing margins and impacting on elective activity. Capacity constraints continue to increase waiting lists and reduced market share of commissioned activity.

Competition to provide ***healthcare across our entire community:*** responsive to the needs of the patient and the health economy. Independent sector pose a threat to our elective and ambulatory services. The new outpatient and elective markets have grown in recent years with the single largest determinant of competition being waiting times.

Deliver ***financial stability***, ensuring appropriate funding for all the work that we do. Medium growth model delivers financial stability through service development and growth in activity. Downside model would result in a potential deficit and a reduction in cash.

Developing an ***estate that can deliver rationalised and integrated services*** reflecting our clinical services strategy, delivery of high priority maintenance backlog; and those developments of highest priority e.g. ICU Emergency Department.

Our strategic options

Vision

- Vertically integrated DGH Plus.
- Top decile performer for quality, including patient experience and outcomes.

Activity and capacity plan

- Capacity to match growth in population and service developments.
- Additional system capacity to be provided to address forecast 125 extra beds for mid-case scenario.

Estates

- Range of options: Best use of RBH and community facilities to deliver clinical services strategy.

Our financial plan

- Financial plan (medium growth) is based on activity below historic trends.
- If limited growth activity scenarios are correct then this will lead to a reduction in income and 'stranded' costs.
- The RBFT will need to be appropriately paid for the activity delivered.

About us

Our services are primarily commissioned by the newly formed Clinical Commissioning Groups (CCGs) in Berkshire. However, our services also draw in patients from neighbouring areas, most significantly South East Oxfordshire. Our catchment population is approximately 500,000 and we provide specialist care, including cancer services, bariatric care and hyperacute stroke and heart attack services to a wider population of approximately one million. We are one of the largest district general hospitals in the country with an annual turnover of circa £320m and we employ nearly 5,000 staff across a wide variety of clinical and non-clinical roles.

Our locations

Our staff deliver a wide range of care and treatment at a range of locations across Berkshire and South Oxfordshire.

Our specialist centre is the Royal Berkshire Hospital in Reading, a large district general hospital with the expertise available to treat patients requiring urgent or hyper-acute care.

Additionally we have a number of community sites where we deliver ambulatory care and diagnostics. A key part of our strategy will be developing the range of services offered in the community to take a greater proportion and range of care nearer to, or at, patient's homes. Our major community sites include:

- West Berkshire Community Hospital (day case surgery also provided);
- Prince Charles Eye Unit (day case surgery also provided);
- Royal Berkshire Bracknell Clinic; and
- Townlands Community Hospital.

Clinical operating model – Care groups

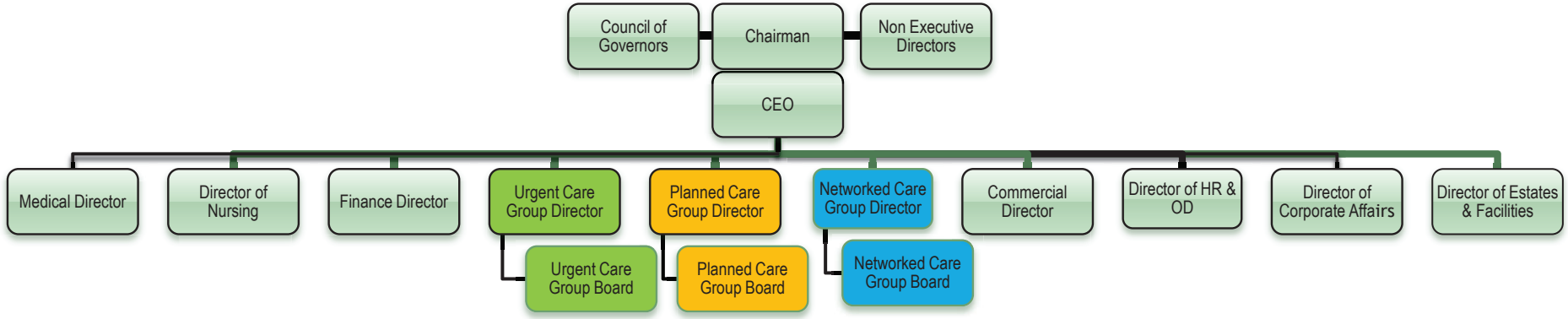
Our clinical operating model puts patients at the centre of everything we do. The Trust's services are organised around patient needs through the establishment of the Networked (long term conditions), Urgent (emergency) and Planned (elective) care groups. Our strategy is to develop zones of care on our sites so that our built environment supports our clinical operating model. We will also deliver a greater volume and range of care closer to patients homes. Clinical teams are at the heart of running the Trust, working in partnership to serve the best interests of patients and our communities.

The concept of the ***Networked*** Care group is driven by the need for new sustainable models of care to accommodate the growing number of patients with long term conditions (LTCs), the ageing population and the growth of the frail elderly in particular. The care group aims to take a whole system approach operating end to end across the health economy with all stakeholders:- patients, carers, general practice, community services, social and voluntary sectors.

The ***Planned*** Care group is the core elective part of the Trust's business. The care group provides high quality seamless care for patients which can be planned in advance in an inpatient or day case environment. Services include a wide range of elective services and cancer care.

The ***Urgent*** Care group is the core emergency part of the Trusts business. A key aspect of high quality urgent and emergency care is bringing the right clinician to the right patient at the right time, first time. Getting the right decisions and diagnosis early in the pathway of care as possible reduces length of stay and errors whilst improving safety and quality of care.

Our structure



Our population and community

A population of around 880,000 people live within approximately 30 minutes of the central Royal Berkshire Hospital site covering most of Berkshire as well as border areas of Oxfordshire, Buckinghamshire and Hampshire. Not all of these are in our core catchment areas. A further population of 85,000 residents within the Newbury CCG (Clinical Commissioning Group) area live within 40 minutes of the Royal Berkshire Hospital site but are much closer to West Berkshire Community Hospital. This gives a total catchment population of approximately one million and provides a strong platform for us to build and consolidate a secure future.

By 2018, the population in our core catchment area is forecast to increase by nearly 25,000 people. However this growth will not be equal across age groups and localities: the growth in the elderly and infant population in Wokingham and West Berkshire being more significant than elsewhere.

The health of our population

Generally the majority of our population is healthier than the England average. However there are significant pockets of deprivation and life expectancy gaps, particularly in Reading and West Berkshire. Each of our key areas has distinct health needs and the health promotion programme 'Staying Healthy' is a key priority across each area.

The table of changes in disease trends demonstrates the upward trend in disease incidence that is predicted as our population grows and becomes older. The rate of increase of disease prevalence is beyond that which can be explained by population growth alone. This suggests that our population is getting unhealthier and is likely to place growing demands on healthcare services.

Disease	2011	2015	2020	Vulnerable population
Coronary heart disease	19,500	20,400	21,345	West Berkshire and Wokingham
Stroke	9000	9500	9900	West Berkshire and Wokingham
Cardio-vascular disease	47,000	49,500	52,000	West Berkshire and Wokingham
Chronic obstructive pulmonary disease	13,700	14,500	15,000	All
Dementia	32,500	34,000	35,500	West Berkshire and Wokingham
HIV	663	687	710	Reading
All cancers (new diagnoses)	1700	1800	1900	All

Source: Joint Strategic Needs Assessment, Berkshire West

Past and current performance

Over the past two years we have consistently performed well against the range of targets we are measured on externally. When benchmarked against trusts in our peer group we perform highly across key targets.

However, like other trusts across England and particularly in the South East we recognise that continuing to meet these targets against a background of increasing patient demand will be very difficult.

Work carried out by both Capita and The Kings Fund suggest that the emergency access target is particularly fragile. When benchmarked against other trusts in our region we find that our admission rates from A&E are lower and our length of stay for non-elective patients are higher reflecting the acuity of the patients we admit. This suggests we are admitting appropriately and our readmission rate is low suggesting we do not discharge prematurely.

We have the lowest bed base per 100,000 population in the country and this leaves us vulnerable to fluctuations in demand and hold-ups in the discharge process.

Benchmarked emergency care metrics

Trust	Length of stay 0-1 days (%)	Readmits (%)	Conversion to admission (%)
Royal Berkshire NHS FT	44.3	12.7	24
Heatherwood and Wexham Park NHS FT	56.0	14.3	29
Hampshire Hospitals NHS FT	54.7	12.4	23
Frimley Park Hospital NHS FT	52.5	14.7	27
Buckinghamshire Healthcare Trust	51.7	12.2	29
Oxford University Hospitals NHS Trust	51.7	14.1	16

Source: The Kings Fund

Past and current financial summary

We have an EBITDA of above 6% and a healthy cash balance of £20m. We do however have historically high costs of financing including impairments of circa £30m in the last two years for major investments made. We have a track record of significant CIP delivery, totalling £49m (both income and cost) over the last three years and will seek to drive this important element through our newly launched QIPP Programme with a focus on quality.

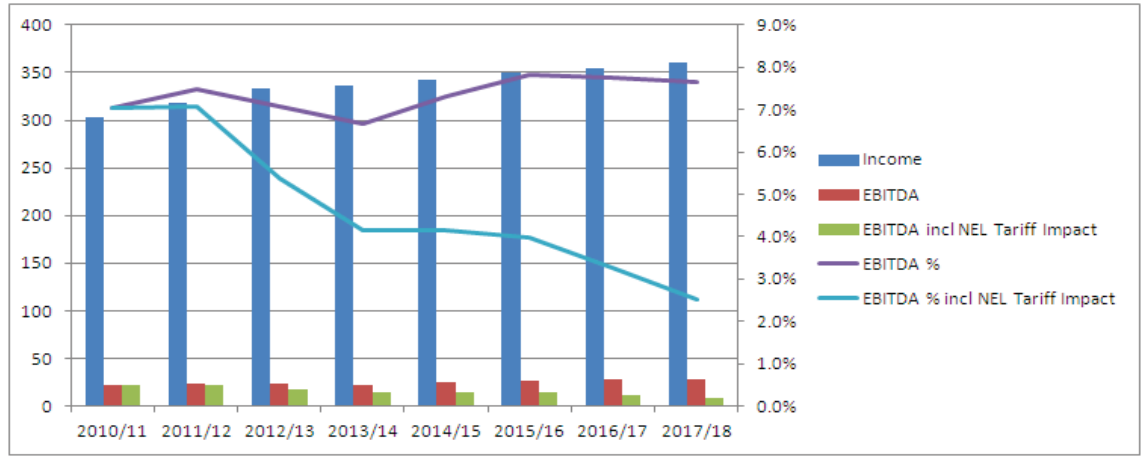
However our expenditure growth has outstripped income growth leading to weakening overall margins. This is a result of a combination of factors which include the impact of the cost of historical investments and lower payments for unavoidable growth in non-elective work.

Of major concern to the Trust is the current penalty regime around non-elective threshold and readmissions. Given current growth rates in non-elective admissions this penalty has the potential to grow to £8.4m in 2013/14, which is the equivalent of treating 4,000 patients for free.

Income and Expenditure £m	2010/11	2011/12	2012/13
Total income	303.1	317.4	333.4
Pay costs	(180.7)	(183.6)	(190.0)
Other direct costs	(101.1)	(110.1)	(119.8)
Total direct costs	(281.8)	(293.7)	(309.8)
EBITDA	21.3	23.7	23.6
EBITDA Margin	7.0%	7.5%	7.1%
Depreciation	(12.2)	(13.6)	(16.5)
PDC	(6.5)	(6.1)	(5.2)
Other	(0.6)	(2.8)	(1.4)
Surplus/ (Deficit)	2.0	1.2	0.5

Source: Royal Berkshire NHS Foundation Trust

Income and EBITDA Trends (incl NEL Tariff Impact & Readmission Penalties)



Source: Royal Berkshire NHS Foundation Trust

Past and current activity levels

There have been changes in the way we code and count activity over recent years but the general trend has been for growth, particularly in emergency and non-elective care where increases in activity have been consistent and sustained.

We are committed to providing 'Better Value Better Care' for our patients and commissioners and therefore there has been a shift in activity from day case to outpatient procedures and reductions in the number of follow up appointments. The Trust is a top decile performer for day case rates and for reductions in outpatient follow up activity. The reduction in follow up appointments achieved since 2010/11 translates into cash savings of circa £8.4m to our commissioners. The high day case rate benefits both our commissioners and our patients who avoid an unnecessary hospital stay.

We have also implemented admission avoidance schemes for non-electives which have generated significant savings for our commissioners (£10m-£14m). However the number of non-elective admissions continues to grow at an unrelenting pace. Despite commissioner demand management schemes we are still seeing a growth in referrals year on year which is leading to a growth in our waiting lists. The increasing demand for non-elective care is having an impact on our ability to deliver elective targets.

'More of the same' is not enough and we must take an innovative approach in delivering care in the future. Our ethos is to work differently to ensure we provide quality care to all our patients.

Demand management - working together to keep well and out of hospital

Our future activity projections are broadly aligned with a review of future demand commissioned by NHS Berkshire West. It is clear that over the next five years there will be a growth in demand across all types of activity but with particular pressures on emergency attendances and non-elective admissions of children and people aged over 65 years.

No single element of the health economy can deal with this increased demand alone. We already work with our partners including local GPs, Berkshire Healthcare NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust, local authorities and the third sector to manage demand. We need to continue to work in an integrated way with our health and social care partners to ensure that there are appropriate and effective demand management schemes to ensure that admission is avoided where possible and that patients are cared for at the right time, in the right place by the right person. We have a strong foundation of integrated working on which to build upon.

Our approach to demand management recognises reducing demand and increasing capacity. We have been successful in reducing demand through a number of admission avoidance schemes, which have realised significant savings for the health economy. However, we know that to avoid increases in activity over the next five years, additional demand reduction initiatives are required if the health economy is to avoid the additional costs of increased bed capacity.

Initiatives already in place

Frail elderly admission avoidance

Over recent years we have worked closely with partners to set up working parties to look at the pathways of care for frail elderly patients and how these might be improved. These working parties include the Long Term Conditions Board, the Clinical Summit and the Capacity Planning Group and it is through these means that we will continue to work collaboratively to drive through improvements for this vulnerable patient group. We employ Community Geriatricians who work across community hospitals, nursing homes and in patients own homes to ensure that patients can receive the right level of care and the appropriate care packages outside of an acute hospital setting. Working together in this way has prevented between 240 and 360 admissions per month saving the commissioner circa £7.7m-£11.6m over an 18 month period.

Paediatric admission avoidance

We have worked with GPs in Reading to develop pathways for common reasons children attend the emergency department. These protocol based pathways aim to give GPs and parents the confidence to manage these common conditions in the community and explain when it is appropriate to seek secondary care help.

Demand management for elective care

Our Orthopaedic team have worked collaboratively with commissioners to develop referral pathways for Orthopaedics. These pathways set out the steps that GPs need to take before referring a patient and ensures that surgery is not considered as the first treatment option. We have seen an increase in our conversion rate for Orthopaedic new appointments to surgery which suggests that this approach is effective. We have worked with our commissioners to ensure that procedures of low clinical value are not carried out without special permission.

Demand management initiatives in place and delivering savings	Benefit
Frail elderly admission avoidance 240 – 360 p.c.m. (per annum savings over 18 mths)	£7.7-11.6m
Excess bed days (per annum savings over last 2 years)	£1.1m
New to follow up ratio (reduction in 0.79 FU over 3 years – average)	c.£6m

Source: Royal Berkshire NHS Foundation Trust

Market assessment

To inform our integrated business plan we carried out a detailed assessment of:

- predicated changes in population size;
- predicted changes in population structure;
- local health needs;
- changes in disease prevalence, particularly long term conditions;
- the needs of our commissioners;
- our competitors and the threat they pose; and
- our own internal strengths and weaknesses as well as the external opportunities and threats.

Our findings and our response to those findings are detailed below :

Population growth

Growth is predicated across all sections of the population and this will lead to an increase in demand. In response, we are planning to increase our theatre, endoscopy, ICU and emergency department capacity as well as increasing both the elective and non-elective bed base. We will refurbish our maternity unit to ensure we have sufficient capacity to deal with the sustained high birth rate and to ensure we are well positioned to respond should there be the need for a high volume birth centre in our region.

Demand for care closer to home

Our commissioners and our patients both wish to have more services provided closer to home. We plan to maximise the use of our community sites by increasing the range and volume of services we provide at these sites. Key to this will be ensuring that appropriate diagnostics are provided so that patients can have a one-stop assessment and do not have to travel to the RBH site for diagnostics.

Growth in the elderly population and increasing long term conditions

The increased demand from the >65's and particularly the >85's will require a health and social network approach. Existing admission avoidance schemes will be built upon in order to keep people well enough to be cared for at home. We will also work with partners to improve the discharge process, particularly for patients who will require on-going care. We are already working in an integrated way in some specialities e.g. diabetes and rheumatology and we will build on this.

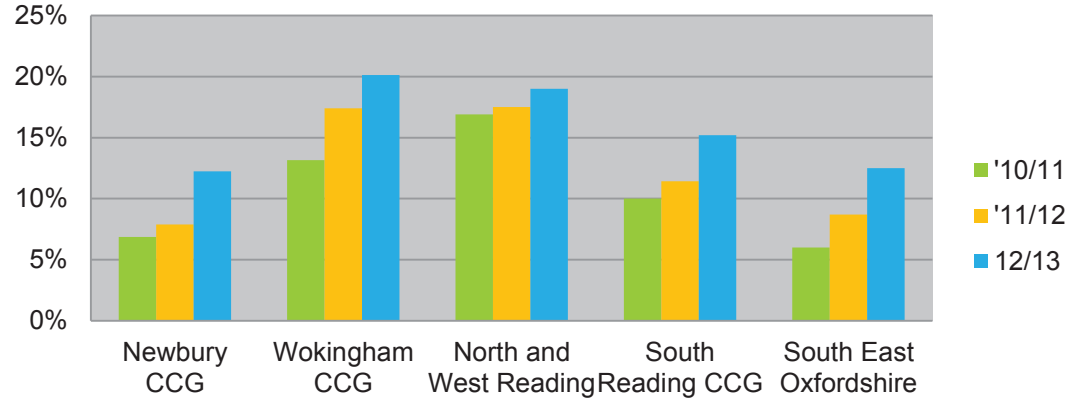
Harnessing our strengths

We have identified key areas where we have proven strength and we aim to develop these services and promote them to increase our market share at our boundaries and win back lost market share from within our key catchment area. We will develop to be centres of excellence for a range of specialities or procedures e.g. cardiology, oncology (brachytherapy and IMRT) and elective surgery (particularly spinal surgery).

Competition

We face increased competition from both NHS and independent sector providers. Our competitive strengths lie in our trusted position in the local community, our ability to manage the most acute patients and the breadth of services provided. Our weaknesses are the comparatively poor condition of parts of our estate and our waiting times which are longer than those of our competitors. A detailed market assessment plan has been developed which will address the competitive threat we face. Key facets of our response to competition include reducing waiting times for outpatient appointments to less than 6 weeks and improving our estate, including the creation of an elective orthopaedic centre and refurbishment of planned care wards.

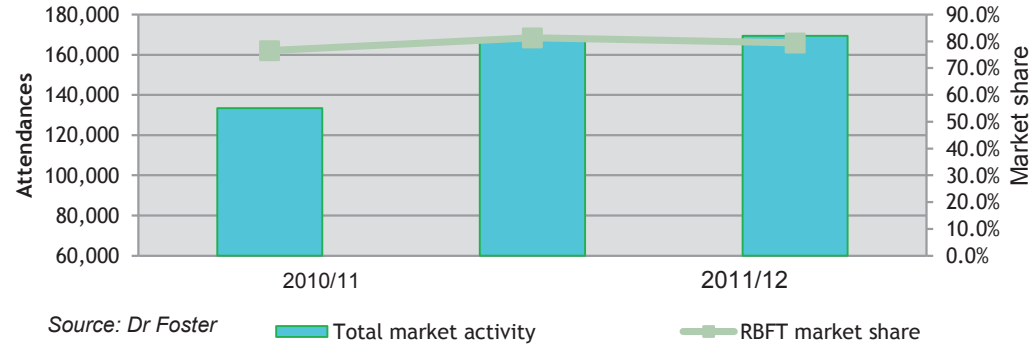
Private Providers Share of Orthopaedic Elective Activity



Source: Dr Foster

New outpatient appointment activity has risen significantly since 2010/11. This is partly due to shift in activity from day case to outpatient. RBFT has maintained overall market share over this period although has lost its share in some key areas.

Market Trends for New Outpatient Appointments



Source: Dr Foster

Service developments

Each of the Care Groups has reviewed its market share and has assessed its own strengths and weaknesses. They have identified key service developments that they will focus on during the next five years to ensure that they continue to provide high quality safe care and an exemplary patient experience.

Key quality priorities driving service developments:

- **Improve outcomes for patients**
- **Improve patient safety**
- **Improve the patient experience**

Networked Care

- Further development of integrated services with our partners. This will require the development of new funding models which are yet to be formalised but may include pooled budgets or programmed budgets for some services.
- Providing care closer to home for patients using innovative techniques.
- Integrated frail elderly care: the Care Group is actively working with the CCGs, Berkshire Health Care FT, Unitary Authorities and the voluntary sector to re-engineer the frail elderly pathway. The focus will be on re-ablement, case coordination/management, prevention and support. In doing so there is a recognition that services need to be brought together.
- Consolidation of pathology services.

Planned Care

- Improve the outcomes following complex surgery by creating a surgical High Dependency Unit.
- Become a Centre of Excellence for spinal surgery, hip arthroscopy and urology and develop a benign upper GI centre.
- Establishment of a dedicated and fully integrated elective orthopaedic centre.
- Deliver radiotherapy and chemotherapy using innovative techniques.
- Provision of dedicated planned care beds with adequate capacity co-located with pre-operative assessment and the admissions suite in line with the estates zoning strategy.
- One-stop outpatient appointments with short waiting times.
- Develop an integrated eye service.

Urgent Care

- Development of Urgent care floor with capacity to provide seamless patient flow in ED, ICU and CDU.
- Establishment of further teams to provide 24/7 specialist services.
- Development of a maternity service to meet the increasing demand and growth in population and birth rates.
- Working with our community partners on supporting patients being cared for in the most appropriate environment either through admission avoidance or effective discharge schemes.
- Ensure our equipment is fit to meet the future developments in delivery of care in all specialties.
- Hyperacute centre for cardiology and stroke.

Activity projections

The impact of our service developments and the increasing demands we face from the growing population and increasing disease prevalence have been converted into high level activity projections as detailed below.

Activity type	2012/13 activity	Projected activity change from 2012/13 to 2017/18					
		Medium		High		Limited	
		2017/18 activity	Change	2017/18 activity	Change	2017/18 activity	Change
Elective inpatient	8,148	8,656	508	8,952	804	8502	354
Day case	32,348	40,917	8,569	41,697	9,349	34,734	2,386
New outpatient	163,523	181,916	18,393	188,043	24,520	179,369	15,839
Follow-up outpatient	305,139	340,546	35,407	363,059	57,920	327,794	22,665
Outpatient procedure	27,300	30,903	3,603	31,621	4,321	30,330	3,030
Other outpatient	19, 904	22,327	2,423	22,393	2,489	20,794	890
Non-elective	45,870	50,232	4,362	57,787	11,917	49,031	3,161
Direct access	3,020,490	3,063,629	43,139	3,236,974	216,484	3,025,260	4,568
A&E attendances	101,642	122,181	20,539	134,908	33,266	112,137	10,495
Chemotherapy /Radiotherapy	22,692	33,121	10,429	33,485	10,793	29,764	7,072
Renal attendances	75,131	94,288	19,157	94,288	19,157	78,492	3,361

Source: Royal Berkshire NHS Foundation Trust

Limited growth

- assumes income will remain flat
- Modelled on the assumption of limited growth in all areas except non-elective. Application of the tariff deflator (modelled at 1.1%) results in flat income growth
- Note that this scenario does not include key service developments in haematology and audiology that reduce activity (included in high and medium growth scenarios)

Our key assumptions are as follows:

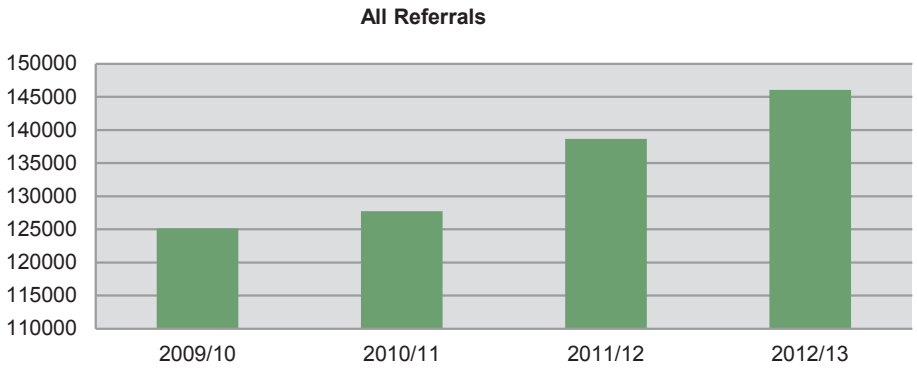
Medium growth

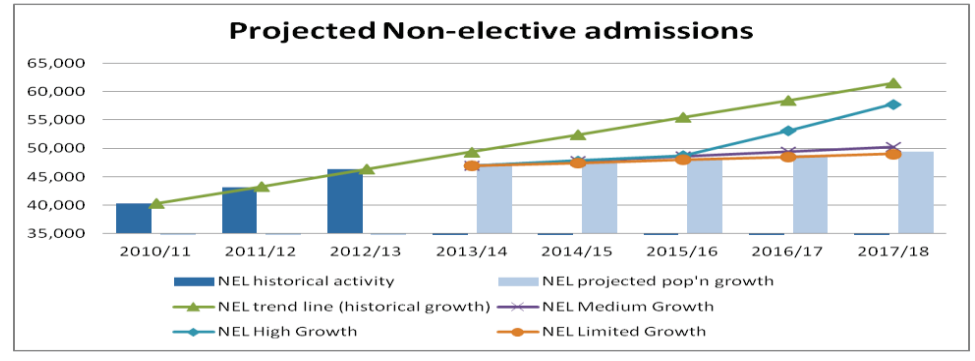
- Our most likely estimate of future activity
- Impact of growing population as per ONS estimates (all years)
- Market share growth as per 2013/14 activity plan (in year 1: 2013/14)
- Launch of haematology DAWN service (year 2)
- Additional market share growth in orthopaedics, general surgery and plastic surgery of 2% over years 2-5 related to the elective orthopaedic centre service development
- Increase in endoscopy demand as per DoH estimate (years 2-5)
- Flexible sigmoidoscopy screening programme (years 4-5)
- Increase in IMRT (from year 2)
- Lucentis treatment for diabetic macular oedema (from year 2)
- Reduction in outpatient waiting times to 6 weeks (in year 1)
- 4% Growth in adult A&E attendances and 8% growth in paediatric A&E attendance (years 2-5)
- ICNARC predictions for ICU bed need (year 2-5)
- Growth in birth rate beyond ONS predictions (years 2-5) – impact on both maternity and paediatrics

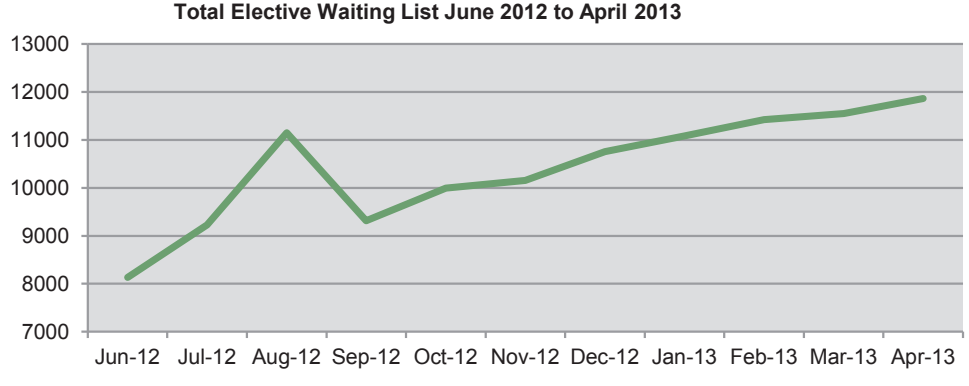
High growth

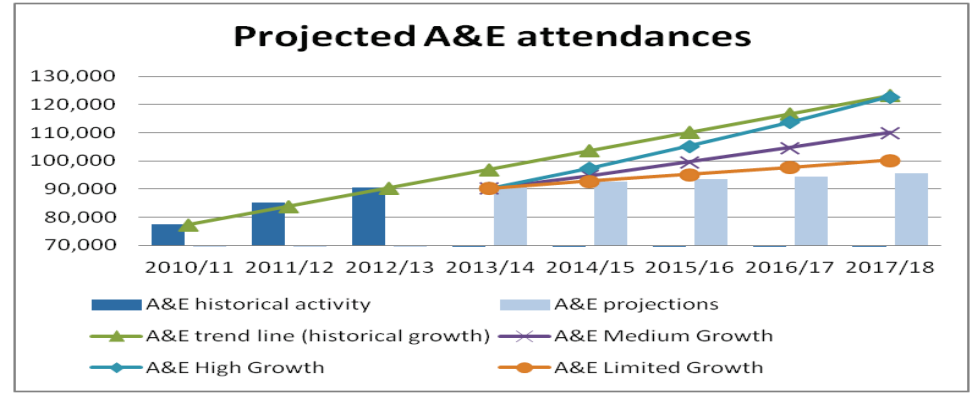
- a higher growth based on specific assumptions around market share and service developments
- Includes the assumptions in the medium growth model, with additional growth
- Growth in renal activity
- Increase in obesity referrals for NICE guidelines
- Additional market share growth in orthopaedics, general surgery and plastic surgery of 7% over years 2-5 related to the elective orthopaedic centre service development
- Additional market share growth 2% over years 2-5 in ENT, gynaecology, oncology, ophthalmology, rheumatology, haematology, paediatrics, cardiology and respiratory
- Impact of 8000 birth centre on gynaecology activity (year 5)
- 8% growth in adult A&E attendances
- Designation as an 8000 birth unit (year 5) – impact on both maternity and paediatrics
- Designation as a paediatric inpatient centre for Berkshire

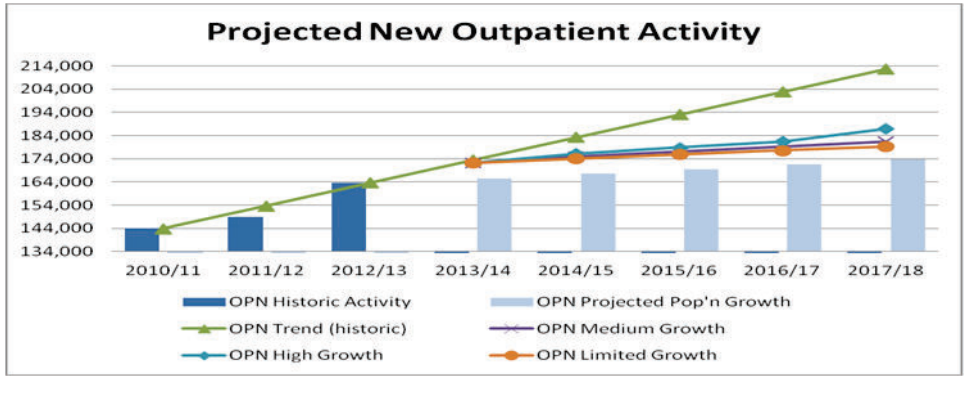
Past, current and forecast demand











Cumulative activity growth projection

	Medium growth over 5 years	High growth over 5 years
A&E	20%	33%
Outpatients	11%	17%
Day cases	26%	28%
Non Elective	10%	26%
Elective	5%	8%
Direct Access	4%	4%

All data source: Joint Strategic Needs Assessment Berkshire West; Royal Berkshire NHS Foundation Trust

Impact of service developments: Capacity analysis

The table below details the additional bed requirement across the whole health economy based on our bed base (as at Q4 2012/13) and the bed base that would be required to deliver our medium and higher growth scenarios, assuming our model of care delivery remains the same. It is recognised that a reasonable proportion of this capacity would be provided by RBFT.

- A 93% bed occupancy rate is considered a realistic estimate of current utilisation. The corresponding bed requirement is matched by our capital investment programme which includes funded plans for the Heygroves SHDU (8 beds 2013/14), the Redland Orthopaedic Centre (11 beds 2013/14) and the Pre-operative Assessment Unit (28 beds 2014/15). Our work with Newton on analysis of length of stay has identified expected savings enabling a reduction in the bed base of approximately 28 beds from 2013/14 which, combined with the additional bed capacity, would ensure adequate capacity if this level of occupancy were to continue.
- A bed occupancy rate of 85% is considered to be an optimum level to offer a high quality service without compromising safety and patient experience. Although our quality performance and careful management of activity demonstrates that we have never compromised safety, the current occupancy rate of 93% is not ideal in the long term.
- Ideally we would be seeking to achieve 87% occupancy rate over time and the attainment of this reduced occupancy rate will put additional pressure on capacity.
- If capacity can be released through innovations in caring for non-elective patients, availability of beds in the community and effective demand management, such as, reducing length of stay and delayed discharges this will reduce the number of beds predicted. In the absence of significant impact of these schemes in reducing activity, the following analysis represents the required increase in capacity offered by the local health economy to match activity.

	Bed type (Occupancy Rate)	2013/14 Net growth	2014/15 Net growth	2015/16 Net growth	2016/17 Net growth	2017/18 Net growth	Five year: cumulative growth
Medium growth scenario	Inpatient beds (87%)	+68	+12	+15	+15	+15	**+125**
	Inpatient beds (93%)	*+32*	*+12*	*+13*	*+15*	*+14*	***+87***
	Day beds (87%)	-	-	-	+13	+6	**+19**
	Day beds (93%)	-	-	-	*+4*	*+5*	***+9***
High growth scenario	Inpatient beds (87%)	+68	+14	+16	+52	+46	**+196**
	Inpatient beds (93%)	*+32*	*+13*	*+15*	*+50*	*+45*	***+155***
	Day beds (87%)	-	-	-	+15	+6	**+21**
	Day beds (93%)	-	-	-	*+5*	*+6*	***+11***

The table on the right details the increase in outpatient activity projected across the 5 year period and the projected percentage increase in slot capacity that will be required to meet this. As well as traditional outpatient clinics part of this increase in capacity may be met by other innovative ways of delivering outpatient care such as virtual clinics and the harnessing of telemedicine.

	Outpatient activity	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Medium growth scenario	Projected activity	515,988	540,200	549,786	558,644	566,923	575,839
	% change in required slots from 2012/13		5%	7%	8%	10%	12%
High growth scenario	Projected activity	515,988	540,200	556,675	566,867	576,481	605,263
	% change in required slots from 2012/13		5%	8%	10%	12%	17%

Key strategic investments

Royal Berkshire Bracknell Clinic

We opened the Royal Berkshire Bracknell Clinic, our £28m 'state of the art' renal and cancer clinic in July 2011. The clinic offers the most advanced radiotherapy cancer treatment available in a community setting. For the first time local patients needing chemotherapy and renal patient requiring dialysis are able to receive their treatment in a modern setting close to where they live.

As income has grown from renal, cancer and general outpatient activity, the Bracknell Clinic realised an operating surplus in 2012/13. Incremental cash receipts from Primary Care Trusts in March 2013 enabled us to reduce loans by £7.5m.

Discussions with other healthcare providers have identified some potential rental activity but this provides a lower return than an activity model. Increasing outpatient activity can deliver breakeven by 2014/15 and reverse the cash outflow by 2017/18. This will require an increase of 8,200 and 19,600 appointments, representing 15-30% of patients currently seen at the Royal Berkshire Hospital from Bracknell and Wokingham. The second floor remains available for future development.

Electronic Patient Record

As a Trust we are committed to delivering an Electronic Patient Record (EPR) and our investment into the Cerner Millennium system in 2012, was our first step towards delivering the Electronic Patient Record by 2018. Since the implementation, the Trust has experienced a number of operational issues with the system, which stem from the design and the complexity in the configuration of the system.

We have undertaken significant activity to ensure the system remains safe for patients, and allows us to maintain data integrity. However, as a consequence of these issues the Trust has faced significant operating costs. We are continuously reviewing our approach to minimise the costs with the system and a number of these actions have helped significantly to reduce the monthly operating costs. Typically in most industries operating costs of IT is circa four per cent of total income. In our environment clinical systems should represent less than one per cent of income.

The Trust and Cerner (the supplier of the system) are committed to rectifying the operational issues faced with the system. Both organisations remain committed to delivering an Electronic Patient Record and we strongly believe we will have the operational issues addressed

Looking towards the next 5 years, we are in the process of developing our detailed plans to support our IM&T strategy towards the delivery the Electronic Patient Record by 2018. These actions will involve a number of activities: strong EHR foundation; health information exchange; data management and analytics; care management and patient engagement. We also have to be mindful to have a strategy which is adaptive and one which will operate in different organisational configurations that may materialise to allow us to be financially viable in the long term.

Our estate and facilities

Our real estates strategy has been developed to support the clinical services strategy and help to meet our clinical objectives to be a local healthcare provider of choice providing safe and clinical effective services. The Trust has considered in detail the clinical services priorities and the condition of its real estate portfolio, and reviewed the available options and their affordability. A transformational approach and a new build on a green field site were both considered to be financially unviable whilst doing nothing is unviable from both a clinical perspective and a patient experience perspective. Our preferred option therefore is to adopt a 'make best use approach' where the cost of developments is phased over 10 years and zones of care are created to support our clinical operating model. There is a key decision required around the future use and retention or reinvestment for the North Block. Mobilising this Real Estate Strategy will still require significant investment by the Trust, and this is anticipated to be some £100m over 10 years, based on current day costings. The disposal of Craven Road properties, Battle site and other underused buildings reduces our backlog expenses.

Emerging strategic options - next five years

Having considered the challenges and pressures on rising demand, the opportunities identified in the Capita report, decreasing margins and increasing capital investment requirements, we recognise that our organisational form may need to change to ensure our long term future. In our view there are a number of strategic configurations that RBFT could adopt, or play a part in, going forward in order to remain clinically and financially viable. Given the challenging and uncertain wider NHS environment it is difficult to predict our exact organisational form in five years time.

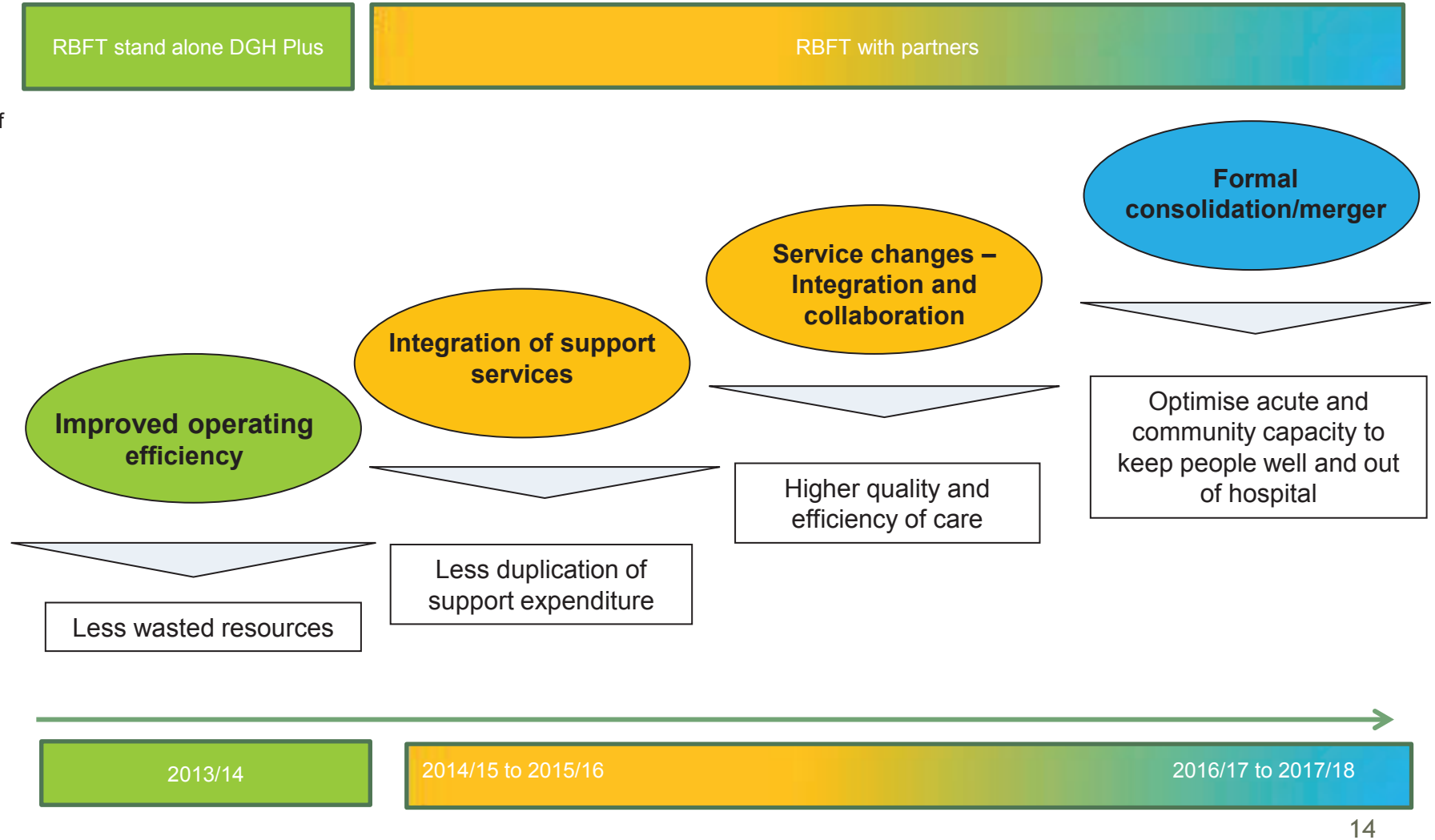
We recognise that any option will take time to be implemented and we will need to be a stand alone organisation in the short term. We will continue to strengthen our services by addressing the cost of financing with increasing emphasis on healthcare groups (clinical networks) and delivering integrated care with our partners. However our assessment is that we will reach a point whereby these arrangements are no longer viable. We anticipate this will probably be by 2016/17 and during the intervening period we will continue to assess and evaluate the strategic options available to us. As our strategy develops the preferred strategic configuration that is necessary will become clearer.

First phase

- Stand alone DGH Plus
- Clinical network, rationalisation of cancer surgery, low volume elective, children and maternity services
- Vertical integration of healthcare through partnership

Second phase

- West Berkshire Integrated Care Organisation



Our vision and strategic objectives

We have developed our strategy in response to our assessment of the likely needs of our population over the next five years and a detailed assessment of the market in which we operate. In developing our strategy we have taken into account the views of our staff and our patients. We have also examined our internal strengths and weaknesses and the external opportunities and threats. A summary of our vision and strategic objectives is shown below.

"Providing the best healthcare in the UK for our patients in our community"

Patients first choice of provider of quality healthcare	• Healthcare provider serving our local population (Berkshire West, Bracknell & South East Oxfordshire). • >90% of the local market within a 30 minute drive time of RBFT by providing care closer to home. • A robust approach to quality of care aimed at improving patient safety, clinical outcomes and a first class patient experience. • Diversified income streams.
Financially viable and sustainable in the long term through the delivery of economic, efficient and effective services	• Develop a robust QIPP programme and deliver cash savings of £40m. • Maintain a liquidity ratio of at least 15 days. Maintain an FRR of 3. • Achieve optimal economic utilisation of our estates. • Increase our revenue streams. • Receive full payment for activity delivered.
Hyperacute and specialist centre of excellence	• Continuous review of performance indicators. • Status as hyperacute centre. • Training and education budget increasing by £1m over 5 years.
Key partner in the development and delivery of integrated health and social care	• Develop and maintain health, social and clinical networks across stakeholders. • Ensure collaborative working and leveraging our network to bring to benefit our staff and patients today and tomorrow.
Excellence in education, innovation, research and development	• Develop our research and development facilities. • Achieve a 100% recommendation rate from staff as a place to work and a place where their friends and family would be treated.

Long term financial model scenarios

We have seen consistent growth in activity over the last few years and a key challenge will be to work with commissioners to both manage this growth and affordability whilst ensuring we have the necessary capacity to meet this demand. A key challenge for us is ensuring that we are appropriately funded for all the work that we do and in this context the current penalty regime on non-elective tariffs, which sees potential unfunded cost of some £8.5m and growing, is simply not financially sustainable.

The Trust remains focussed on driving plans which mitigate the cost of historical investments.

£m	2013/14 (Budget)	2014/15 (Medium growth scenario)	2017/18 (Medium growth scenario)		2014/15 (High growth scenario)	2017/18 (High growth scenario)		2014/15 (Limited growth scenario)	2017/18 (Limited growth scenario)
Income	336.4	342.9	359.8		345.2	380.9		335.8	331.4
EBITDA	22.4	25.1	27.5		25.2	29.2		23.6	20.8
EBITDA Margin %	6.7%	7.3%	7.6%		7.3%	7.7%		7.0%	6.3%
Surplus	0.5	2.4	4.8		2.5	6.5		0.9	(1.9)
Surplus Margin %	0.1%	0.7%	1.3%		0.7%	1.7%		0.3%	-0.6%
Closing Cash	20.1	19.1	22.5		19.3	27.0		17.7	8.8

NB; All scenarios assume that the non-elective penalties are zero. If not all scenarios would show significant deficit and FRR of 2 in all years.

We have run scenarios around income with a "high growth scenario" of 3.0% growth per annum and "limited growth scenario" with minimal change to activity with tariff deflator resulting in reduced income.

The "high growth scenario" has income growing to £381m, EBITDA to 7.7%, surpluses to £6.5m and an ending cash balance of £27.0m.

Our "limited growth scenario" has income reducing to £331m, EBITDA falling to 6.3%, a final year deficit of £1.9m, and an ending cash balance of £8.8m and would result in an FRR of 2, most likely in the early years.

This scenario would require significant further cost reductions to return us to financial stability.

Quality, Innovation, Productivity and Prevention (QIPP) Programme

The Trust has delivered efficiencies of nearly £49m over the past 3 years (both cost and income). However, the on going challenge of delivering major efficiency savings whilst delivering key service targets and coping with operational pressures means that it is becoming increasingly difficult to identify savings without impacting on the quality of patient care. The Trust believes that the emphasis now needs to change to medium / long term large scale change to deliver top decile efficiency and quality, which both national and international evidence demonstrates will also reduce waste and deliver cost efficiencies.
With full support from both the Trust Board and Care Groups, we have developed a QIPP Programme under the 4 work streams of Quality, Innovation, Productivity and Prevention (Safety). A dedicated Quality Improvement team, led by a senior medical consultant, has been created to work with operational staff using a range of quality and service improvement tools to improve the patient experience, safety, efficiency and productivity of patient care which will deliver ongoing financial and non financial efficiencies.

Key risks to delivery

Our integrated business plan sets out our ambition to deliver high quality care that meets the needs of patients and commissioners and is affordable for the local health economy. There are inherent risks to the realisation of the IBP and to the continued viability of the Trust. These risks, and the mitigating actions we will take are summarised below.

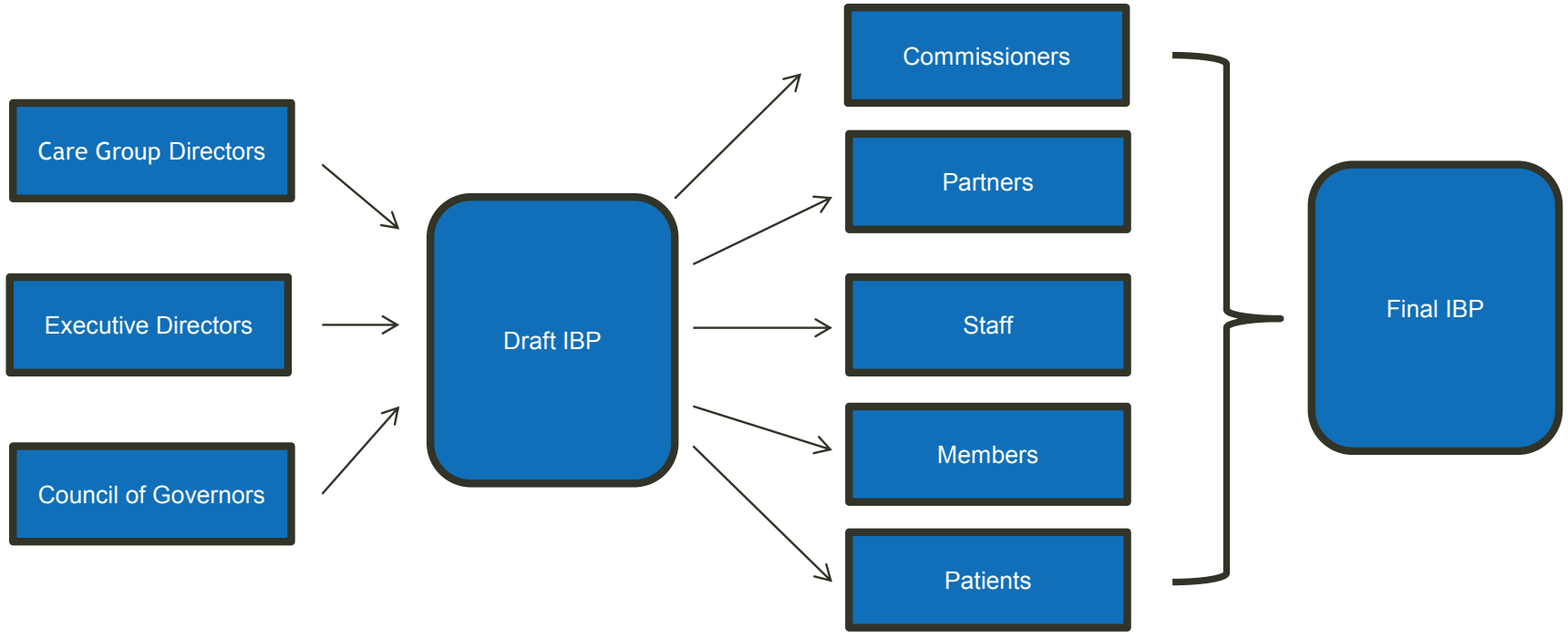
Strategic Risk	Principal Indicators	Mitigations
Failure to maintain quality of patient services	Patient experience indicators show a decline in quality. Potential breach of Care Quality Commission (CQC) regulations. Trust Quality Strategy goals are not met. Quality aspects of contracts with Clinical Commissioning Groups (CCGs) are not met. CIPs impact on patient safety or unacceptably impact on service quality. Failure to meet NHS constitution standards.	Focus on patient safety, outcomes and patient experience through delivery of Quality Strategy and Trust Values. Staff engagement and awareness of required standards. Strengthened quality governance. Use of benchmarks to inform analysis of progress. On-going quality impact review of CIP schemes. Close liaison with NHSLA and CQC.
Failure to maintain financial sustainability	Required levels of QIPP not delivered. Pay costs not adequately controlled. Expected levels of income exceed CCGs affordability. Commercial opportunities not exploited. Lack of capital resources to meet investment requirements. Escalation of EPR implementation costs.	Rolling cost improvement programme with contingencies. Care Group ownership. Estates strategy. EPR stabilisation programme.
Expected increase in demand not funded by commissioners	Activity levels unaffordable for health economy. Lack of robust plans across the healthcare system. Inability to respond to requirements to flex capacity.	Internal performance controls. Effective liaison with commissioners. Strengthened links with commissioners through new partnerships.
Loss of share of current and potential market	Loss of existing market share. Failure to gain share of new markets. Lack of support for business cases or tenders.	Strategy developed with commissioners. Agree assumptions and financial approach with key commissioners. Maintain ability to be nimble in flexing capacity. Contingency plans for withdrawal from services.

Our workforce vision and plan

As a Trust, we recognise our staff as our most valuable asset and as such, our workforce and its leadership and management is at the heart of the successful delivery of our strategic objectives over the next 5 years. Our workforce vision is to be the best place to work, learn and train. This workforce vision lends itself to a 'high commitment' based workforce strategy, a strategy based on developing the commitment of staff so that efficiency and quality of performance is driven by motivated and engaged employees who are committed to the delivery of outstanding patient care.

Staff Group	WTE Staff in Post as at 31/3/13	WTE Staff in Post as at 31/3/14	WTE Staff in Post as at 31/3/15	WTE Staff in Post as at 31/3/16	WTE Staff in Post as at 31/3/17	WTE Staff in Post as at 31/3/18
Medical and Dental (Previous)		579.10	599.36	597.33	594.64	592.53
Medical and Dental Staff (Activity/Business Cases)	579.10	20.26	15.89	15.15	15.67	13.77
Medical and Dental Staff (QIPP 3%)	0.00	0.00	(17.92)	(17.84)	(17.78)	(17.66)
Medical and Dental Staff Total	**579.10**	**599.36**	**597.33**	**594.64**	**592.53**	**588.64**
Registered Nursing and Midwifery Staff (Previous)		1465.64	1676.78	1671.12	1663.57	1657.68
Registered Nursing and Midwifery Staff (Activity)	1465.64	211.14	44.47	42.36	43.84	38.52
Registered Nursing and Midwifery Staff (QIPP 3%)	0.00	0.00	(50.13)	(49.91)	(49.73)	(49.40)
Registered Nursing and Midwifery Staff Total	**1465.64**	**1676.78**	**1671.12**	**1663.57**	**1657.68**	**1646.80**
All Scientific, Therapeutic and Technical Staff (Previous)		517.00	542.10	539.70	536.40	533.80
All Scientific, Therapeutic and Technical Staff (Activity)	517.00	25.10	13.79	12.79	13.41	11.17
All Scientific, Therapeutic and Technical Staff (QIPP 3%)	0.00	0.00	(16.19)	(16.09)	(16.01)	(15.87)
All Scientific, Therapeutic and Technical Staff Total	**517.00**	**542.10**	**539.70**	**536.40**	**533.80**	**529.10**
Support to Clinical Staff (Previous)		1213.07	1271.93	1266.17	1258.50	1252.52
Support to Clinical Staff (Activity)	1213.07	58.86	32.23	30.09	31.60	26.20
Support to Clinical Staff (QIPP 3%)	0.00	0.00	(37.99)	(37.76)	(37.58)	(37.24)
Support to Clinical Staff Total	**1213.07**	**1271.93**	**1266.17**	**1258.50**	**1252.52**	**1241.48**
Infrastructure Staff (Previous)		612.86	614.86	614.86	614.86	614.86
Infrastructure Staff (Activity)	612.86	2.00	18.45	18.45	18.45	18.45
Infrastructure Staff (QIPP 3%)	0.00	0.00	(18.45)	(18.45)	(18.45)	(18.45)
Infrastructure Staff Total	**612.86**	**614.86**	**614.86**	**614.86**	**614.86**	**614.86**
Total Staff (Previous)		4387.67	4705.03	4689.18	4667.97	4651.39
Total Staff (Activity)	4387.67	317.36	124.83	118.83	122.96	108.12
Total Staff (QIPP 3%)	0.00	0.00	(140.68)	(140.04)	(139.54)	(138.63)
Total Staff Total	**4387.67**	**4705.03**	**4689.18**	**4667.97**	**4651.39**	**4620.88**

Engagement process



The IBP has been developed collaboratively between the care groups and corporate directorates and throughout the process the views of the Board and the Council of Governors have been taken into account. Our draft IBP will now be shared with stakeholders including our commissioners, partner organisations, staff and patients. We have a detailed engagement plan to ensure that stakeholder feedback is taken on board before our final IBP is presented to the Trust Board in November 2013.

The engagement exercise identifies different groups of stakeholders who have different perspectives of the needs and aspirations of the local populations. The groups range from the staff who provide the services and the partners who support us, the patients who receive the services and the commissioners who pay for the services. Our engagement approach will maximise the opportunity to encourage 'conversations' amongst stakeholders and to ensure that all views are heard.

The feedback from the various cohorts of stakeholders in the engagement process will be taken into account in developing the final iteration of the IBP.
The Trust will revise the draft IBP by incorporating elements of the feedback that have the potential to enhance the quality and efficiency of the care that it provides, are consistent with commissioners' intentions and affordable. All stakeholder feedback will be responded to directly prior to finalisation of the IBP.

Review process

The IBP will be reviewed on an annual basis as part of the Monitor Forward Planning process. It will form part of the Trust's on-going performance management cycle, with Care Group annual plans and monitoring being aligned to the IBP and updated based on actual activity levels. Subsequent IBPs will be updated on the same basis.

Title of Report:	**Funding Transfer from NHS England 2013-14**
Report to be considered by:	Health and Well Being Board
Date of Meeting:	26th September 2013
Forward Plan Ref:	N/a

Purpose of Report: To inform the Health and Wellbeing Board of how the 2013-14 funding transfer from the NHS is being used by West Berkshire Council.

Recommended Action: The Health and Wellbeing Board to approve the use of the 2013/14 transferred monies.

Reason for decision to be taken: To allow for the planned transfer of NHS funds to the Council to be completed.

Other options considered: None

Key background documentation: Report 'Funding transfer from NHS to Social Care 2013/14 to 2015/16' to the HWBB meeting on 25th July 2013

The proposals contained in this report will help to achieve the following Council Strategy priority:

☒ **CSP1 – Caring for and protecting the vulnerable**

The proposals will also help achieve the following Council Strategy principle:

☒ **CSP5 - Putting people first**

The proposals contained in this report will help to achieve the above Council Strategy priority and principle by:

Portfolio Member Details	
Name & Telephone No.:	Councillor Joe Mooney - Tel (0118) 9412649
E-mail Address:	jmooney@westberks.gov.uk
Date Portfolio Member agreed report:	

Contact Officer Details	
Name:	Jan Evans
Job Title:	Head of Adult Social Care
Tel. No.:	01635 519736
E-mail Address:	jevans@westberks.gov.uk

Implications

Policy:	None
Financial:	The NHS funding plays an essential role in enabling existing health related social care services to be maintained. Had agreement not been reached on their use then significant cuts in non-statutory areas would have had to be made within the resulting negative impact on all stakeholders.
Personnel:	None
Legal/Procurement:	None
Property:	None
Risk Management:	None
Corporate Board's Recommendation:	n/a.

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☒
• Is it a major policy, significantly affecting how functions are delivered?	☐	☒
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☒
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☒
• Does the policy relate to an area with known inequalities?	☐	☒
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia		☐
Not relevant to equality		☒

Executive Summary

1. Introduction

1.1 For 2013-14 an additional £0.519m was provided to West Berkshire Council by the NHS. This increased the total NHS funding level to £1.782m in 2013/14.

1.2 In order to secure the release of these funds agreement needs to be reached between the Council and NHS England (via the Thames Valley Area Team and the CCGs in Berkshire West) on how they are being used. The Health and Well Being Board has been agreed as the forum for discussions and agreement between the parties.

2. Proposal

2.1 This report explains the financial background in which the Council is operating and how the total NHS funding has been used to support Adult Social Care.

2.2 Agreement has been reached between the NHS England Area Team and the Council and this report, along with the appended S256 agreement, identifies those areas of spend which have been protected as a result of this funding.

3. Conclusion

3.1 The additional NHS funding has been most welcome and has been used to protect care services at a time when total funding for councils has been significantly reduced.

1. Introduction

1.1 In 2012-13 West Berkshire Council received £1.263m of Health and Social Care Funding from the Department of Health. This was non ringfenced and, whilst not directly added to the Adult Social Care (ASC) budget, it did enable the Council to build a degree of protection into the ASC budget. This money was spent as follows:-

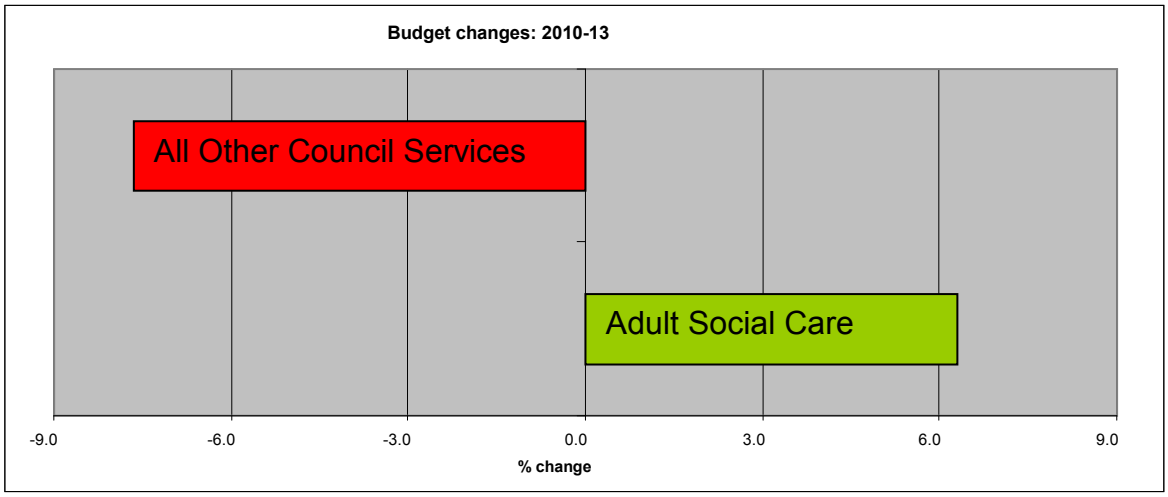
£150,000 – Enhancement of WBC Reablement Service
£ 20,000 – Additional night warden for crisis work
£518,000 – Increased care home bed capacity
£ 575,000 – Demography; domiciliary care

1.2 For 2013-14 an additional £0.519m was provided, bringing the total funding to £1.782m. Whilst this additional funding was most welcome, it does have to be seen in the context of the year on year budget reductions faced by this and other councils. Local Authorities have been subject to significant spending cuts as part of the Comprehensive Spending Review, 28% over four years.

1.3 Even with this additional NHS funding, in 2013-14 the Council has less money to spend on services than it had in the previous year.

2. Use of Transferred Funds in 2013-14

2.1 As evidenced by the following table, protecting the most vulnerable of our citizens remains a Council priority and therefore this additional funding from the NHS has been used to protect ASC, as far as is possible, from the full level of cuts faced by all other Council services. The additional NHS England funding in both 12-13 and 13-14 has been an important factor in allowing the Council to take this approach.



2.2 Whilst, in line with all other Council services, ASC has been required to deliver efficiency savings, 2013-14 is the first year where the net budget has reduced. In all previous years the net budget provided to ASC has been increased due to significant Council investment. The following table shows the level of investment in ASC in comparison with the total investment in all of the other Council services.

Service Investments Financial Years 12-13 and 13-14

	12-13	13-14
Adult Social Care	3,408,140	551,000
All Other Council Services	1,768,460	1,414,580
	5,176,600	1,965,580

2.3 The 2012-13 investment was required to reflect the pressures that had been building on most ASC activities. In excess of £550k of investment was made in financial year 13-14 towards the additional costs of care for young adults with learning disabilities as they transitioned from Children's Services

2.4 In order to ensure councils are making appropriate use of the transferred funds, NHS England has requested that the spend is classified under the categories set out in the table below. These sums have been allocated against each row on the basis of these are the likely areas where cuts have been avoided as a result of this funding. Using the transferred funds to support existing services was a recognised option for councils (further details of the services protected are provided in Section D of the attached S256 agreement).

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***£***	***Subjective code***
Community equipment and adaptations	80,000	52131015
Telecare		52131016
Integrated crisis and rapid response services	425,000	52131017
Maintaining eligibility criteria		52131018
Re-ablement services	425,000	52131019
Bed-based intermediate care services		52131020
Early supported hospital discharge schemes	275,000	52131021
Mental health services	74,000	52131022
Other preventative services	504,000	52131023
Other social care (please specify)		52131024
Total	**1,783,000**	

2.5 Whilst ASC would have had no desire to make cuts in these areas it has to be recognised that with reduced overall funding and an ageing population it would be these non-statutory functions (preventative services, early hospital discharge schemes, reablement etc.) that would have had to be scaled back.

3. Transfer Process

3.1 The monies will only be passed over to the Council once the Section 256 agreement has been signed by both the Council and the NHS England Area Team. The agreement document is provided as Appendix 1 to this report and will be signed following the approval of this report by the Health and Wellbeing Board.

4. Future Years Funding

4.1 As detailed in the report 'Funding transfer from NHS to Social Care 2013/14 to 2015/16' that was considered by this Board at its meeting on 25th July 2013, significant changes are being made to the funding arrangements between the NHS and Local Authorities. Some additional funding (£200m nationally) will transfer in 2014/15 to assist in the preparation for a planned major transfer of funds (£3.8bn from the NHS nationally) in 2015/16. Details of the sums transferring to each council are not yet available.

4.2 Overseen by the Health and Well Being Board, the Council and the NHS jointly need to develop plans that cover how this funding should be best utilised within the health and social care economy. These plans must demonstrate how care and support services will be protected and how a number of new significant additional responsibilities will be met which include, but are not limited to;

- 7-day working in health and social care, to support patients being discharged and prevent unnecessary admissions to hospital at the weekend
- better data sharing, including universal use of the NHS number as a unique identifier
- a joint approach to assessment and care planning

4.3 Further meetings between senior staff from the Council and their NHS colleagues are planned for the coming months in order to move this work forward.

4.4 One note of caution is that in a recent joint communication from the Local Government Association and the NHS there is reference made to this additional funding also being used to cover some of the costs associated with the Care Bill. Whilst there remains a lack of detail in major areas, the work done to model the financial impact of the Care Bill on this Council does suggest that it will result in major additional costs. The Government has previously stated that it would fully fund the costs arising from the Care Bill but we need to be cautious that the same funding is not spent more than once.

5. Conclusion and recommendations

5.1 The additional funding from the NHS in 2013-14 has been used to minimise the substantial cuts to Adult Social Care that would have otherwise been required. This approach has largely avoided any negative impact on service users and has allowed Adult Social Care to continue to invest in preventative services, maintain its crisis and rapid response services, continue to develop its 'Home Safe' service (early hospital discharge) and make positive changes to its re-ablement function.

5.2 It is recommended that the Health and Well Being Board note the contents of this report and approve the 2013/14 spend and the associated draft S256 Transfer Agreement.

Appendices

Appendix A – S256 Transfer Agreement

Consultees

Local Stakeholders:	n/a
Officers Consulted:	Steve Duffin - Head of Service (ASC Efficiency Programme)
	Andy Walker – Head of Finance
Trade Union:	Not applicable

Appendix A

MEMORANDUM OF AGREEMENT FOR TRANSFER OF ALLOCATION FOR SOCIAL CARE FOR 2013/14

Between

NHS England (Thames Valley) and West Berkshire District Council together referred to as "the Parties"

Giving effect to a transfer of monies from NHS England to the West Berkshire District Council pursuant to Section 256 of the NHS Act 2006.

Section A: Background and Principles

1. The purpose of this Memorandum of Agreement is to provide a framework within which the Parties will enable transfers of funding pursuant to Section 256 of the NHS Act 2006 and in line with the National Health Service (Conditions relating to payments by NHS Bodies to Local Authorities) Directions 2013, to enable those funds transferred to be invested by social care for the benefit of health and to improve overall health gain.

2. Gateway reference 00186 states that NHS England will transfer £859m from the 2013/14 mandate to local authorities.

3. The funding must be used to support adult social care services in each local authority, which also has a health benefit.

4.NHS England Thames Valley, on the recommendation of NHS Newbury and District CCG, North and West Reading CCG and the West Berkshire Health and Wellbeing Board ("through approval of s256 paper at its meeting on 26th September 2013 and is satisfied that:

- the transfer of this funding is consistent with their Strategic Plan that it is likely to secure a more effective use of public funds than if the funds were used for solely NHS purposes, in line with the conditions relating to Section 256 payments the Act.
- The transfer of these funds has had regard to the Joint Strategic Needs Assessment, the draft Health and Wellbeing Strategy and the commissioning plans of both the Clinical Commissioning Group and Local Authority.
- The funding transfer will make a positive difference to social care services, and outcomes for users, compared to service plans in the absence of a funding transfer

Section B: Purpose of this Memorandum of Agreement

5. This Memorandum of Understanding gives effect to those arrangements to benefit the population of West Berkshire through the use of these monies the partners intend to secure more efficient and effective provision of services across the health and social care interface as outlined in Schedule 1.

6. Monies defined in Section C below will be transferred to the Local Authority under Section 256 and used in accordance with the terms of this agreement. If this subsequently changes, the memorandum must be amended and re-signed, as a variation to the original.

7. This Memorandum of Understanding governs the transfer, monitoring and governance arrangements for the monies and the projects associated with delivering the objectives.

Section C: Terms of Agreement – The sums of money

8. The money, which shall be transferred from NHS England to Social Care, is shown below:

	2013/14
Allocations for social care	**£**1.793

9. Payments will be made quarterly based on invoices issued by the Local Authority. The invoices must quote the relevant purchase order number.

10 Where a payment is made under this Agreement, the Council will provide an annual voucher in the form set out in Schedule 3 to Agreement. This voucher must be authenticated and certified by the Director of Finance or responsible officer of the recipient.

11. Recipients must send completed vouchers to their external auditor by no later than 30th September following the end of the financial year in question and arrange for these to be certified and submitted to the paying authority by no later than 31st December of that year. A Certificate of Independent Auditor opinion is set out in Schedule 3 to the Agreement.

Section D: Terms of Agreement – The uses of money

12. Uses of this funding will be as follows and will be subject to review as part of the joint governance arrangements set out in Section E below:

Detail	**Budget £s**	**Outcome**
Community Equipment and Adaptations	80,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer. Equipment provided enables safe hospital discharge, falls prevention and greater independence e from health and social care services.

Integrated care and rapid response services	425,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer. Service works jointly with surgeries and BHFT Intermediate Care Services to enable timely hospital discharge and the prevention of inappropriate hospital/care home admission
Reablement Services	425,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer... WBC Home Care Improvement Service works with service users for up to 6 weeks, led by OTs to promote independence and a reduction of demand for health and social care community services.
Early supported discharge Schemes	275,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer. Service redesign to provide a Home Safe service supporting first 48hrs following hospital discharge, preventing DTOCs and ensuring safe, timely hospital discharge.
Mental health services	74,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer. Funding has supported placements of service users on S117 reducing DTOC at Prospect Park Hospital.
Other preventative services – (financial support to the voluntary sector and other organisations currently providing a range of preventative services)	504,000	The funding transfer will enable current service levels to be maintained. A situation that would not have been possible in the absence of a funding transfer. Carers support; range of commissioned services and individual grants to support Carers to continue caring; respite, day opportunities; education, support groups, contingency planning. Preventative services; range of commissioned services to support independence, self sufficiency and reduce

		dependency on statutory services; day opportunities, family support, home from hospital, handyman, befriending.
Total	**1,792,796**	

Section E: Terms of Agreement - Governance, Reporting and Monitoring

13. In West Berkshire District Council the Agreement shall be held by Director of Communities and appointed nominees to manage, monitor and deliver.

14. In NHS England the Agreement shall be held by the NHS England (Thames Valley) Director and appointed nominees to manage, monitor and deliver NHS interests.

15. In Newbury and District and North and West Reading CCG the appointed nominee for governance and monitoring purposes will be the CFO.

16. The Integrated Partnership Board shall monitor and review the programme of work monthly and ensure corrective action where required. At least one officer of the CCG shall be a member of this Board. West Berkshire Wellbeing board will receive quarterly reports on the progress of the programme of work from the Integrated Partnership Board and ensure the programme supports the delivery of the Health and Wellbeing Strategy and Joint Strategic Needs Assessment. NHS England will be represented on the West Berkshire Wellbeing Board. The Wellbeing Board will review the annual expenditure of the allocation.

17. Any underspend on the transfer money will be discussed by West Berkshire District council and Newbury and District and North and West Reading CCGs via the Integrated Partnership Board and agreement reached as to how the underspend should be dealt with. This may or may not include retention of the underspend with West Berkshire District Council for use on additional activity for the benefit of health or an alternative arrangement.

18. The Council will report expenditure plans on a monthly basis to NHS England (Thames Valley) categorised into the following service areas (Table 1) as agreed with the Department of Health.

Table 1: **Analysis of the adult social care funding in 2013-14 for transfer to local authorities**
Service Areas- 'Purchase of social care'

Community equipment and adaptations
Telecare
Integrated crisis and rapid response services
Maintaining eligibility criteria
Re-ablement services
Bed-based intermediate care services
Early supported hospital discharge schemes
Mental health services
Other preventative services
Other social care (please specify)

Section F: Terms of Agreement - Renewal, Disputes, Variation and Alteration

19. The agreement may be altered by mutual consent by an exchange of letters.
20. In relation to continuation beyond 1st April 2014, such provisions as shall be directed by the Secretary of State on continuation and transferal of agreements shall apply.

21. Disputes shall be resolved by informal means wherever possible and thence by formal meeting of the Integrated care governance group and referral to the Health and Wellbeing Board if agreement cannot be reached.

Section G: Signatures

In respect whereof, the parties to this agreement have caused to be affixed their hands and seals.

Signature_____

Name_____

Position _____

Date _____

FOR AND ON BEHALF OF West Berkshire District Council

Signature_____

Name_____

Position _____

Date _____

FOR AND ON BEHALF NHS ENGLAND

SCHEDULE 3

Section 256 Voucher

West Berkshire District Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2014 (YEAR)

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

Scheme Reference Number
Revenue Expenditure
Capital Total
Title of Expenditure

Project £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS
OF TRANSFER

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

Signed: ……

Date: ……

Director of Finance

Certificate of independent auditor

I/We have:

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

(Except for the matters raised in the attached qualification letter dated)* I/we have concluded that

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

Signature ……. Name (block capitals) ……. Company/Firm

……. Date …….. * Delete as necessary

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Title of Report:	MMR immunisation update
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	September 26th 2013

Purpose of Report: **To update the Board on the status of MMR immunisations**

Recommended Action: **For information**

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	
E-mail Address:	

Contact Officer Details	
Name:	Lesley Wyman
Job Title:	Head of Public Health and Wellbeing
Tel. No.:	01635 503434
E-mail Address:	lwyman@westberks.gov.uk

Executive Report

1. The purpose of this paper is to brief the board on the Measles Mumps and Rubella (MMR) vaccination catch up programme and the progress that the Thames Valley area team are making in delivering the national target.

2. Attached is a paper from the area team describing the range of national initiatives being undertaken to increase the uptake of the MMR vaccine to 95%.

3. Immunisations are a highly effective way of maintaining the health of the population by reducing the occurrence of infectious disease.

4. Immunisations are commissioned by NHS England are team from a range of providers, with a focus on General practice. The role of local Public Health is to monitor the delivery of the vaccination programmes and give assurance to the HWB board on the effectiveness of these programmes on delivery to the local communities.

5. We have been meeting with the area team to support the local delivery of the national work. However the impact of the programmes has been limited both nationally and locally and so a second set of actions is now being planned. However at this point I cannot assure the board that the national 95% MMR target will be delivered, though Berkshire has not seen any increase in measles cases and so there is no immediate risk . At the meeting I will give a verbal update on the extra actions planned to improve the local performance.

Measles, mumps and rubella (MMR) Immunisation Update for Berkshire

5.1 Background

In April 2013 The Department of Health, Public Health England and NHS England jointly launched a campaign aiming to drive up demand for MMR vaccination. This was in response to an increase in the number of measles cases in England over the last two years with an annual total of 1,920 confirmed cases in 2012, the highest annual figure since 1994. This was sustained into 2013. There is a high rate of cases in teenagers, which has not been experienced in previous years. The 10 to 16 year old age group is the one most affected by the adverse publicity relating to MMR vaccine between 1998 and 2003 and therefore there are larger numbers of children of this age unimmunised or partially immunised against measles. This creates the potential for school based outbreaks as seen in Swansea and the north east of England. Although there has not been an increase in confirmed cases in Thames Valley there is still the potential for outbreaks particularly in those areas where coverage of MMR immunisation has been low in the past.

One dose on MMR vaccine is 90-95% effective at protecting against measles infection. Two doses will protect 99% of those immunised. There is a national target to immunise 95% of children with one dose of vaccine by the age of 2 years and 2 doses of vaccine by the age of 5 years.

This report provides an update on Phase 1 of the MMR catch up campaign, an outline of the approach for Phase 2 and

5.2 MMR catch up campaign Phase One (April to August 2013)

The first phase of the catch-up campaign consists of the following elements running concurrently:

- An urgent communication to encourage parents or guardians of unvaccinated (highest priority) and partially vaccinated young people 10 to 16 years to be vaccinated at their General Practice.
- A rapid programme of identification and invitation of unvaccinated and partially vaccinated young people by General Practice in liaison with Child Health Information System Services.
- Targeting of vulnerable groups such as Gypsy, Roma, traveller families; there are still disproportionate number of cases within this community.
- Sustained intervention over longer term that will strengthen current routine approaches.
- Ensuring there is continued improvement in the routine immunisation programme for under 5's.

The proposed outcome is that 95% of young people aged 10 to 16 years to have received at least one dose of MMR by September 2013.

(1) Phase 1 actions and outcomes in Berkshire

A Thames Valley steering group led by NHS England screening and immunisation team planned and co-ordinated the catch up campaign supported by the Director of Public Health and local authority colleagues.

- Local press releases were produced to coincide with the national release of measles data in early May and June with the Director of Public Health providing the local voice for these. This generated radio and newspaper coverage of the MMR catch up campaign.
- The Director of Public Health facilitated the circulation of letters through schools to students and their parents highlighting the importance of MMR immunisation and signposting them to their GP for immunisation.
- This was done at the start of the campaign with a second communication linking the need for MMR vaccination to travel to areas of Europe with a high incidence of measles being sent out to coincide with the start of the school holiday.
- All local GPs, except one, signed up in May to the Enhanced Service requiring them to identify unimmunised and partially immunised 10 to 16 year olds in their registered populations and invite them for immunisation.
- Working with the practice that opted out NHS England Thames Valley area team have identified and invited children registered with this practice for immunisation
- All GPs are commissioned to provide MMR immunisation to children up to the age of 15 years. The Enhanced Service also included provision for the immunisation of young people and adults aged 16 years and over.
- As a longer term sustainable intervention the NHS England Thames Valley Area Team are looking to commission the school nursing service to offer MMR catch up immunisation in secondary schools at the same time as other immunisations that are offered in school. (Human papilloma virus immunisation to Year 8 girls and the diphtheria, tetanus and polio booster in Year9 or 10)
- The routine immunisation of under 5's is discussed in a later section.

5.3 Measuring the impact of Phase 1

Data on the numbers of children identified and invited will not be available until after the end of August when a new national data collection system goes live.
Nationally it is estimated that as a result of the campaign the number of 10-16 year olds immunised against measles has increased by 1%. This data is not available at local level. Since the beginning of July coverage information on children up to the age of 18 years has been collected by Public Health England through the Immform weekly and monthly sentinel surveys. This system extracts information directly from a number of GP clinical systems.

It has been recognised nationally that obtaining accurate information on the coverage of MMR immunisation in 10-16 year olds is very difficult. Data on both General Practice clinical systems and Child Health Information systems becomes less accurate as children get older. As families move around the country or move in from abroad immunisation histories are less likely to be entered onto computer systems once a child is beyond the age of the routine immunisation programme.

Audits of records, including some work carried out locally by the public health team have estimated that 30- 50% of 10-16 year olds whose electronic records identify them as unimmunised have actually had MMR immunisation. A national audit is about to start sampling records 24 upper local authorities across England to estimate the magnitude of under recording. The results of this audit will be available in the autumn.

Table 1 presents the immunisation coverage in 10-16 year olds by CCG from Immform sentinel survey week ending 27th July 2013. For each CCG between 45 and 70% of practices are included in the Survey. This shows the proportion of children unprotected against measles to range from less than 9% in Newbury and District to over 14% in Slough and South Reading. These figures have not been adjusted to reflect the under-recording of immunisation discussed above.
Even allowing for under-recording most areas would still be below the target of 95% children having at least one does of MMR. The coverage in Slough and South Reading is of particular concern and these will be priority areas for action in Phase 2 of the catch up campaign.

Table 1: MMR immunisation coverage in 10 to 16 year olds taken from Immform sentinel survey week ending 27th July 2013

CCG	Children aged 10-16 years Doses MMR vaccine received		
	zero	only one dose	two doses
	%	%	%
Bracknell and Ascot CCG	10.9	10.6	78.5
Slough CCG	14.1	17.9	68.0
WAM CCG	10.8	14.8	74.4
Newbury and District CCG	8.6	9.3	82.1
N&W Reading CCG	9.3	9.8	80.9
South Reading CCG	14.2	15.4	70.4
Wokingham CCG	9.6	12.3	78.1

(1)

5.4 Phase 2 of the catch up campaign

Coverage data collected in July 2013 suggested that the aspiration of 95% coverage in the target age group is unlikely to be met by September. As a result Phase 2 plans are being developed nationally; although the final version has not yet been published the likely elements are set out below. The following actions are proposed before the end of August

1. Undertake a further push with general practice to encourage those practices who have not yet taken part in the catch-up to do so.
2. Encourage all practices that have not already done so to 'clean' their data ensuring that vaccinations are properly recorded as this is fundamental to the success of the programme.
3. Consider further communication to GPs regarding the need to identify and re-invite any remaining unvaccinated children in the target age-range.

Planned developments for the autumn may include:

1. Additional publicity to raise awareness of the need to get vaccinated.
2. Activate a sustainable service checking status and providing MMR vaccine for those
   - Moving from primary to secondary school at start of next year
   - Having HPV vaccine in Year 8
   - Having the teenage booster of diphtheria, tetanus and polio (dT/IPV)
3. In areas which have not reached the 95% target plan to offer school-based vaccine sessions for catch-up vaccination early in the autumn term of next academic year.
4. Audit of a sample of vaccination records for children with no record of MMR in a range of areas to estimate the likely under-estimation of true vaccination coverage.
5. Specific outreach to vulnerable and underserved groups e.g. traveller communities

Implementation of Phase 2 in Berkshire

There will be a meeting of the Thames Valley steering group including Directors of Public Health to agree the actions that will be taken locally to deliver the Phase 2 recommendations in Thames Valley. Proposal will include plans to

- Improve the quality of local data so a true picture of MMR coverage can be obtained
- Deliver school based immunisations in Berkshire in the 2013-14 academic year; possibly an initial focus in Slough and South Reading with wider roll out over the autumn and spring terms
- Ensuring the gypsy, Roma, traveller community in our area have good immunisation uptake.
- Continue work to increase uptake of MMR in under 5's

(1) Current coverage in children 5 years and under

Table 2 shows the coverage of MMR immunisation in 2 year olds and 5 year olds in Berkshire 2012-13 by local authority.
Three from six unitary authorities have achieved or almost achieved the 95% target for the first MMR immunisation and all apart from Slough are at or above 90%. Coverage of two MMR immunisations by 5 years old is much lower in all areas and is not at 95% in any area. Slough is the area of greatest concern as uptake is only 81% in this borough. Appendix 1 shows the upward trend in MMR coverage in Reading, West Berkshire and Wokingham over the last 5 years. (Similar data is not available for other unitary authorities)

A plan is currently being developed by NHS England Thames Valley working with local stakeholders to improve immunisation coverage in Slough in under 5's. This includes initial work to ensure that the coverage data is robust and accurately reflects the actual coverage. A change in the Child Health Information System used and disruption resulting from the protracted consultation prior to the merger of child health teams across Berkshire may have had an impact on data quality affecting Slough, Bracknell and Windsor and Maidenhead.

Work continues in all areas to increase the uptake of the second MMR injections. The NHS England Thames Valley screening and immunisation team regularly identify those children late for immunisation and supply this information to practices to ensure these children are followed up.

Table 2 MMR immunisation coverage 2012-13
(Cover data)

Unitary Authority	1st MMR by 2 years (%)	2nd MMR by 5 years (%)
Reading BC	94.7	91.5
West Berkshire Council	96.0	92.6
Wokingham BC	95.5	93.3
Bracknell Forest Council	90.0	88.0
Royal Borough of	92.1	86.7

Windsor and Maidenhead		
Slough BC	89.3	81.0

5.5 Appendix 1

Trend in MMR immunisation in Reading, West Berkshire and Wokingham

Reading	**1st MMR by 2 years**	**2nd MMR by 5 years**
2008-2009	**81.01**	**66.69**
2009-2010	**87.29**	**75.75**
2010-2011	**89.29**	**81.22**
2011-2012	**93.17**	**86.09**
2012-2013	**94.69**	**91.50**
Target	**95.00**	**95.00**

West Berks	**1st MMR by 2 years**	**2nd MMR by 5 years**
2008-2009	**85.3**	**77.5**
2009-2010	**92.54**	**81.97**
2010-2011	**91.66**	**89.39**
2011-2012	**94.51**	**90.35**
2012-2013	**95.99**	**92.62**
Target	**95.00**	**95.00**

Wokingham	**1st MMR by 2 years**	**2nd MMR by 5 years**
2008-2009	**86.1**	**72.2**
2009-2010	**92.66**	**77.75**
2010-2011	**93.27**	**87.20**
2011-2012	**95.16**	**91.30**
2012-2013	**95.52**	**93.27**
Target	**95.00**	**95.00**

Appendices

There are no Appendices to this report.

Title of Report:	Routine immunisation schedule
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	September 26th, 2013

Purpose of Report:

The purpose of this paper is to brief the West Berkshire Health and Wellbeing Board about the routine immunisation schedule and the schedule for immunising those in clinical risk groups.

Recommended Action:

For information

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	
E-mail Address:	

Contact Officer Details	
Name:	Lesley Wyman
Job Title:	Head of Public Health and Wellbeing
Tel. No.:	01635 503434
E-mail Address:	lwyman@westberks.gov.uk

Executive Report

Immunisation schedule for routine immunisation and for those in clinical risk groups

The purpose of this paper is to brief the West Berkshire Health and Wellbeing Board about the routine immunisation schedule and the schedule for immunising those in clinical risk groups.

Immunisations are a highly effective way of maintaining the health of the population by reducing the occurrence of infectious disease.

Immunisations are commissioned by NHS England are team from a range of providers, with a focus on General practice. The role of local Public Health is to monitor the delivery of the vaccination programmes and give assurance to the HWB board on the effectiveness of these programmes on delivery to the local communities.

Table 1 shows the routine immunisation schedule.

Table 1 Routine immunisation schedule

Age	Diseases protected against	Delivered in Berkshire by
2 month old	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae (Hib)	GP/ Practice nurse
	Pneumococcal disease	
	Rota virus	
3 month old	Diphtheria, tetanus, pertussis, polio, Hib	GP /Practice Nurse
	Meningococcal group C (Men C)	
	Rota virus	
4 month old	Diphtheria, tetanus, pertussis, polio, Hib	GP /Practice Nurse
	Pneumococcal disease	
Between 12 and 13 month old	Hib, Men C	GP /Practice Nurse
	Pneumococcal disease	
	MMR	
2 and 3 years old	Influenza (from Sept'13)	GP /Practice Nurse
3 years 4 months old	Diphtheria, tetanus, pertussis, polio	GP / Practice Nurse
Girls aged 12-13 year old	HPV	School nurse
Around 14 year old	Tetanus, diphtheria, polio	School nurse
	Men C (from Sept'13)	
65 year old	Pneumococcal disease	GP /Practice Nurse
65 years and older	Influenza	GP /Practice Nurse
70 years old	Shingles (from Sept'13)	GP /Practice Nurse

79 year olds (for 2013)	Shingles (catch-up programme)	GP / Practice Nurse

Source: Department of Health

Table 2 shows the immunisation schedule for those in clinical risk groups

Table 2 Immunisation schedule for those in clinical risk groups

Age	Disease protected against	Delivered in Berkshire by
At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	1st dose - Maternity service Remaining doses – GP/ Practice Nurse
At birth	TB	Maternity service or TB service (if not given at birth)
6 months – under 65 years	Influenza	GP / Practice Nurse
2 years – under 65 years	Pneumococcal disease	GP /Practice Nurse
Pregnant women	Influenza	GP / Practice Nurse
From 28 weeks of pregnancy	Pertussis	GP /Practice Nurse

Source: Department of Health

Appendices

There are no Appendices to this report.

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Title of Report:	Joint Health and Social Care Assessment for Learning Disability
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26 September 2013

Purpose of Report:

To draw to the attention of the Health and Wellbeing Board a new requirement to undertake a Joint Health and Social Care Assessment for Learning Disability.

Recommended Action:

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Graham Jones (01235) 762744
E-mail Address:	gjones@westberks.gov.uk

Contact Officer Details	
Name:	Rachael Wardell
Job Title:	Corporate Director - Communities
Tel. No.:	01635 519722
E-mail Address:	rwardell@westberks.gov.uk

Executive Report

1. Introduction

1.1 This paper presents the new Joint Health and Social Care Learning Disability Self Assessment Framework. All Local Authority Areas have been asked to complete the self-assessment working with local partners including CCGs to a deadline of end November 2013.

1.2 The assessment framework replaces the "Valuing People Now" Self Assessment and the Learning Disability Self Assessment.

1.3 The purpose of bringing this paper to the Health and Wellbeing Board is to alert partners to the requirement to engage in this piece of work and to secure commitment to assist in its completion by the deadline.

2. Self Assessment - Conduct

2.1 The Self Assessment is to be carried out in accordance with the guidance contained in the Guidance Toolkit at Appendix 1.

2.2 The return outline itself appears at Appendix 2 indicating key information which will need to be collated via CCGs.

2.3 Easy-to-read guidance which explains the return is at Appendix 3.

2.4 More detailed and comprehensive information can be found at Public Health England's website: http://www.improvinghealthandlives.org.uk/projects/hscldsaf

3. Conclusion

3.1 The Health and Wellbeing Board is advised that the Self Assessment activity will be taking place this autumn, led by the Local Authority. Relevant partners are invited to engage with the process to ensure a completed return on time.

Appendices

Appendix 1 - Guidance Toolkit
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_18782_130806%20JHSCSAF%202013%20Guidance%20FINAL.pdf
Appendix 2 – HealthCare Information Requirements for the Return
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_18951_2013%20Joint%20Health%20and%20Social%20Care%20Learning%20Disability%20Self-Assessment%20Framework%20v2.pdf
Appendix 3 – Easy to read guidance:
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_18702_What's%20it%20all%20about....pdf

directors of adass adult social services

NHS England

Gateway reference 00312

Joint Health & Social Care Self-Assessment Framework 2013 - 2014

Guidance and Resource toolkit

getting it right when treating people with a learning disability

Contents

Overview

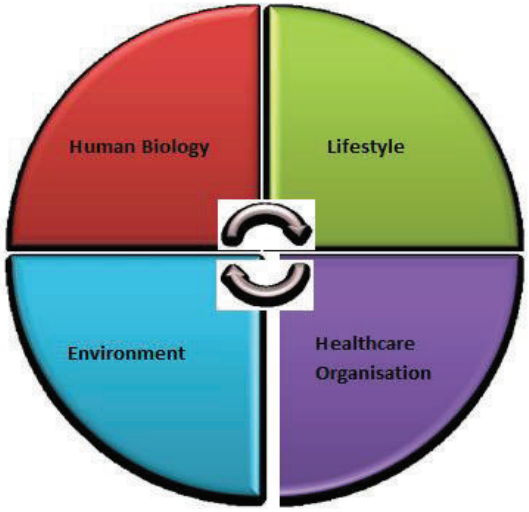
The Joint Health and Social Care Learning Disability Self - Assessment Framework is a single delivery and monitoring tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, Department of Health and the Association of Directors of Adult Social Services on the following:

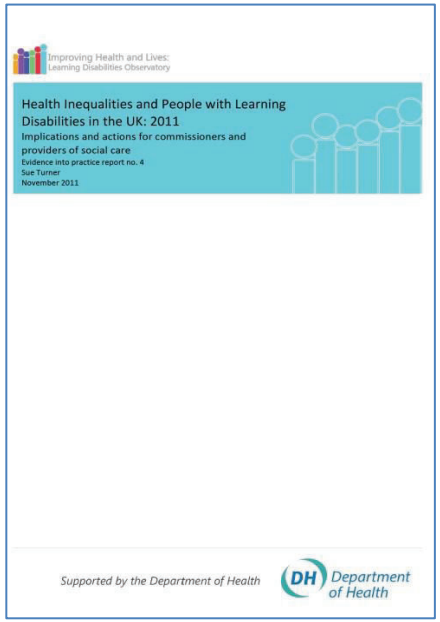
1. **Key priorities** in the:
    - Winterbourne View Final Report Annex B (WBV)
    - Adult Social Care Outcomes Framework 2013-14 (ASCOF)
    - Public Health Outcomes Framework 2013-2016 (PHOF)
    - National Health Service Outcomes Framework 2013-14 (NHSOF)
    - Health Equalities Framework

2. **Key levers** for the improvement of health & social care services for people with learning disabilities;
    - Equality Delivery System
    - Safeguarding Adults at Risks requirements
    - Health & Wellbeing Boards
    - Consultation and co-production with people with learning disability and family carers

3. **Progress Report** on Six Lives and the provision of public services for people with learning disabilities.

Rationale





The Joint Health and Social Care Learning Disability Self - Assessment Framework (JHSCSAF) and subsequent improvement plans will ensure a targeted approach to improving health inequalities and achieving equal and fulfilling citizenship helping commissioners and local people assess how well people with a learning disability are supported to STAY HEALTHY, BE SAFE and LIVE WELL.

A simple public health model (Lalonde's health field 1994) highlights that people with learning disabilities are disadvantaged in all four domains and experiencing poorer health than the non-disabled population, because of:

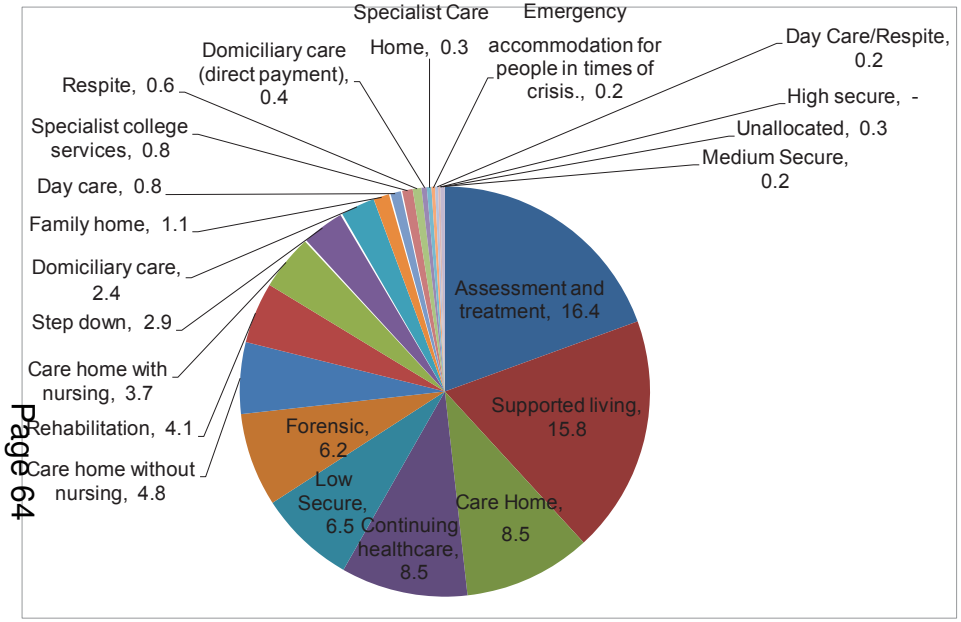
1. Greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.
2. Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities.
3. Communication difficulties and reduced health literacy.
4. Personal health risks and behaviours such as poor diet and lack of exercise.
5. Deficiencies relating to access to healthcare provision.

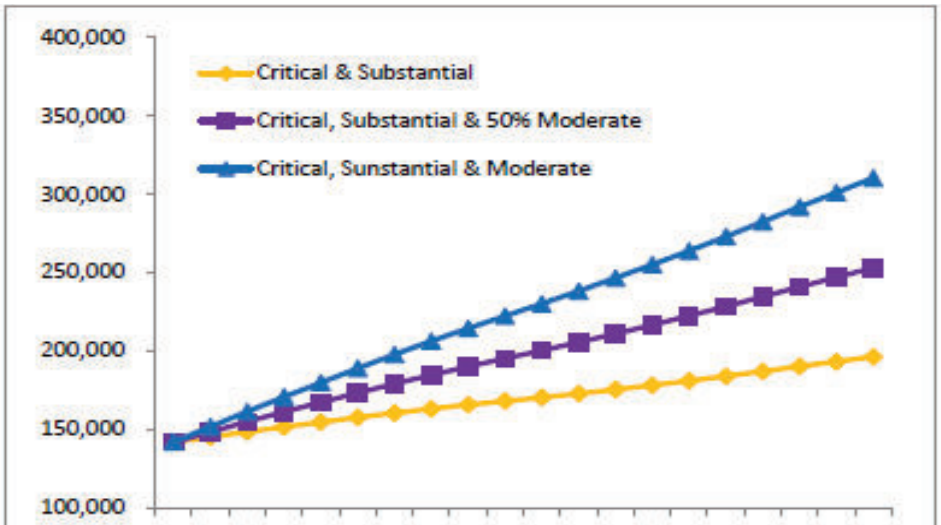
People with learning disabilities are 58 times more likely to die before the age of 50 than the general population (Hollins et al 1999)

There are numerous reports on the Improving Health and Lives (IHAL) website about the health and wellbeing of people with learning disabilities.

IHAL:
http://www.improvinghealthandlives.org.uk/publications/year/2011

Rationale





Examples below of the benefits in terms of outcomes in understanding and using the data as part of the self – assessment process:

The NHS in London spend over £85 Million on individual care packages for people with learning disabilities. Some of these services do not deliver high quality care leading to poor outcomes. 57 % of 946 NHS care packages are provided in out of area Placements. Often there are legitimate reasons for placing someone out of the local area, but often this is due to the lack of capacity and capability of the local health and social care system to support local solutions.

Work undertaken in Lincolnshire demonstrated that people with learning disabilities, although a small percentage of the population (0.3%), accounted for 6% of the Accident and Emergency budget (Eccles 2011).

Over the next 20 years we will see an increase in the number of people with learning disabilities, it is forecasted that there will be twice as many people with a learning disability. By 2030 there will also be an increase in complexity of needs, with young people with learning disability with extremely complex needs now living well into adulthood. This is of course good news, but will be a significant challenge for the NHS in terms of cost and resources.

National Enablers

There are a number of national enablers in place to improve the health & social care of people with learning disabilities and whenever possible the self-assessment framework is aligned with these.

Safeguarding and Equality Delivery System

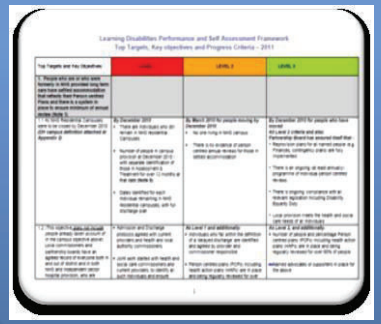
- Monitor Compliance Framework: Foundation Trust Pipeline
- Data from the Public Health Observatory
- Direct Enhances Service for Annual Health Checks
- Quality Outcomes Framework (QOF) register for Learning Disabilities
- QOF register for Down Syndrome
- Care Quality Commission (CQC) inspection of assessment and treatment units
- CQC Essential Standards for Care
- Winterbourne View Final Report Annex B (WBV)
- Adult Social Care Outcomes Framework 2013-14 (ASCOF)
- Public Health Outcomes Framework 2013-2016 (PHOF)
- National Health Service Outcomes Framework 2013-14 (NHSOF)
- Statutory Adult Safeguarding Boards- Law Commission outlined legislative framework
- ‘No Secrets’ remains policy driver: Making Safeguarding everybody’s business
- Quality Governance Framework including QIPP and CQUIN

The benchmark also assesses the underlying Legislative Framework and tests how this work for people with learning disabilities.

- Mental Capacity Act including Deprivation of Liberty 2007
- Vulnerable People's Act 2006
- Equality Act 2010
- Human Rights Act 1998
- Autism Act 2009
- Health and Social Care Act 2012
- Carers Services and Recognitions Act 1995

There are 3 tools to support local implementation:

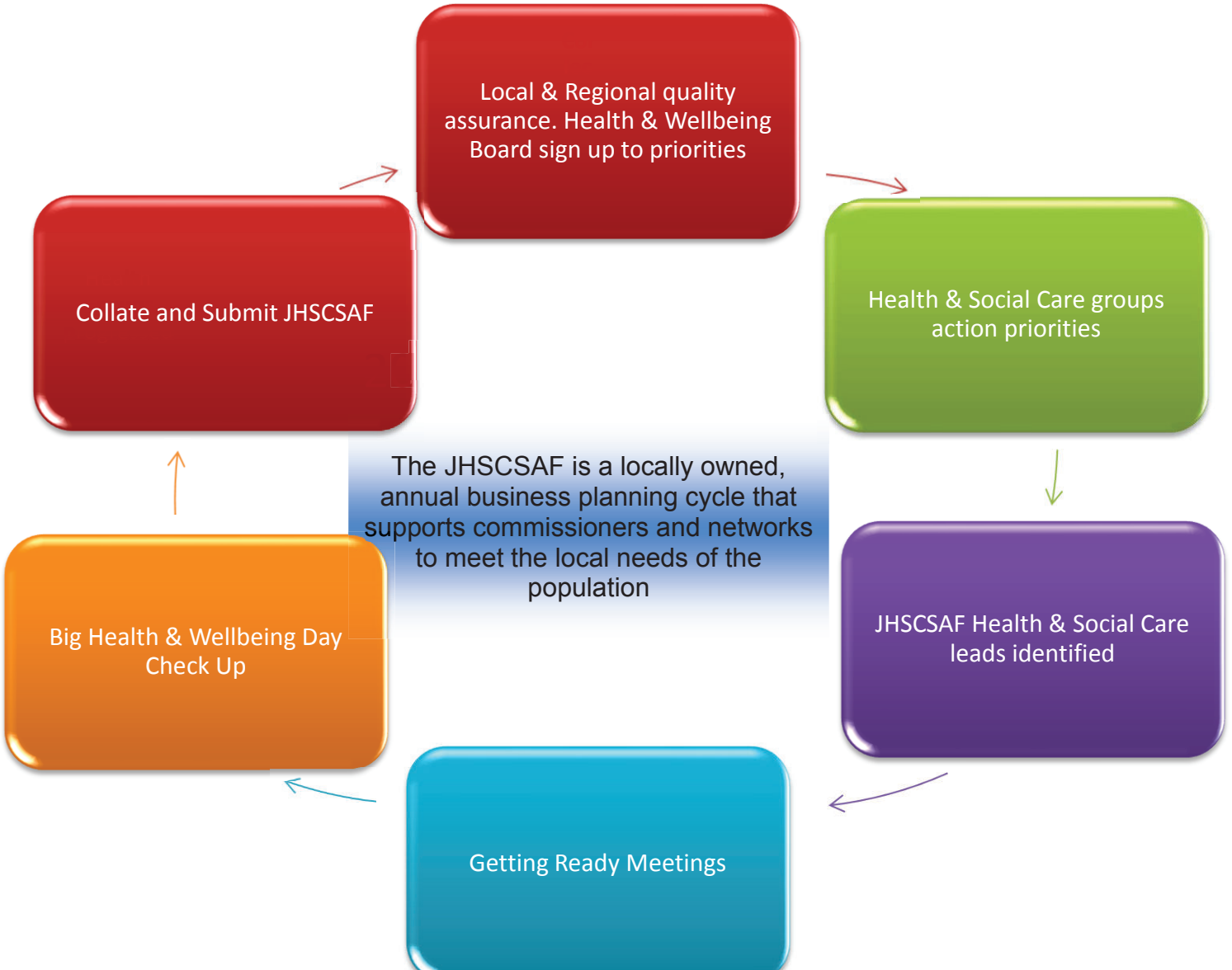
1. **Guidance pack:** This explains the rational and the processes. It tells localities what needs to be done, by whom and the local timeframes for completing the self-assessment framework.



2. **The Benchmark – Measures & Data:** This revised tool provides each local area with a nationally agreed benchmark to help assess their progress. The advantage of a national tool is that it makes regions and localities comparable and allows the Public Health Observatory (Improving Health and Lives) to analyse national data. The tool has been developed in partnership and consultation with all regions, commissioners and people with learning disabilities.

3. The evidence tool: Following consultation in 2012 – 2013, we have requested that the Improving Health and Lives (IHaL) create an online feedback form which will allow easier and coordinated submission of responses and evidence.

The Self-Assessment Framework Annual Cycle



The process in more detail

1. **Nominated Leads:**

   A lead should be identified in both the Clinical Commissioning Group(s) and the Local Authority(s).

   Your leads will have a good knowledge of the mainstream health & social care agendas, and have sufficient seniority to influence their provider and commissioner partners. The nominated leads are not expected to have all the answers but they have a crucial role in coordinating the responses.

2. **Getting Ready Meetings:**

   These are crucial so everybody has a clear understanding of their role and provide information and evidence for Big Health & Well-Being Check Up Day. Ideally, you should use existing meetings and networks and link into these. They will enable people with learning disabilities and family carers to have time together to think through some of the targets and objectives. They should be coordinated by the nominated leads. It would be useful to get a good written record of what people have said. People should bring that with them to the Big Health & Well-Being Check Up Day, and it should also be handed in so that it can be used in the feedback report. The JHSCSAF this year wants to hear positive and negative real life stories of experience that explain why a locality thinks particular areas are strong or need improvement. The ultimate quality assurance is the experience people with learning disability and family carers have. The different targets often involve very different people, so it may be useful to hold 'target specific' meetings.

3. **Big Health & Wellbeing Check Up Days:**

   The aim of this day is to discuss and vote on the targets in the JHSCSAF and identify actions to progress. This step is key in fulfilling the vision laid out in the White Paper '*Local Democratic Legitimacy in Health'*

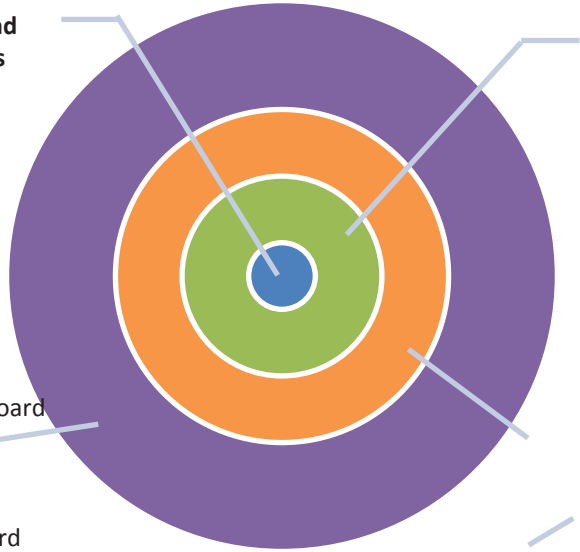
The process in more detail

4. GOVERNANCE

This year there is a huge change in the health and local authority structures nationally. Here is how quality assurance will be undertaken.

People with learning disabilities and family carers

LOCAL
Reporting, planning & action
Partnership Board / Function
Health and Wellbeing Board
Local Government Cabinet
Clinical Commissioning Groups



NATIONAL
Reporting & received
Learning Disability Programme Board
National ADASS
NHS England
Winterbourne View Joint Improvement Programme Board

SUB-REGIONAL
Quality assurance function
NHS England Area Teams and Regional ADASS

6. **Collecting Evidence and Submission**: the process followed should now enable the health & social care leads to complete the JHSCSAF with qualitative and quantitative information. The leads will benchmark their local progress against the national framework. This is then submitted online and received by the Area Team lead and the regional ADASS lead for learning disabilities.

SUBMISSION

Quality Assurance: Clinical Commissioning Group(s) and the local authority(s) will work together on the JHSCSAF. The results are their work will be published by IHaL.

NHS England Area Teams and regional ADASS leads will receive the completed JHSCSAF from each local area for whom they have responsibility. As part of the assurance process they will want to consider the approach to be taken locally to:

- seek views from people with learning disability, family carers and the 3rd sector
- identifying areas of best practice and areas of concern where a deep dive or sector led improvement may need to be undertaken
- provide joint feedback to local areas including people with learning disability and family carers.

Health & Wellbeing Boards

Health and Wellbeing boards should hold localities to account firstly for completing/publishing it then for the quality or their results. A script to support Health and Wellbeing Boards that wish to validate the returns in their localities will be developed and published on the IHaL website.

Guidance

General Overview

Staying Healthy: As with the general population, people with learning disabilities should have their primary healthcare met through Primary Care services whenever possible. Healthcare for All (2008) highlighted the need for systems to be developed in primary and secondary care services so that the journey of people with learning disabilities in traceable.

The standard assesses how the Primary Care Enablers (Direct Enhanced Scheme, Quality and Outcome Framework registers for people with learning disabilities and Down Syndrome) are implemented in primary care. Hence Primary Care Commissioning has an essential role in completing this section.

Valuing People Now reiterated that all people with learning disabilities should have a Health Action Plan that is integrated with their annual health check. The aim of integrated primary and community services providing person centered care is to avoid unnecessary hospital admissions.

Six Lives, the report by the Health and Parliamentary Ombudsman and Healthcare for All required the regulators (CQC and Monitor) and secondary care services to adjust their healthcare and make reasonable adjustments to avoid future failings of the healthcare system as described by the Six Lives Report and the more recent 74 Deaths and Counting Report (2012).

You can use the table to identify the relevant lead for each standard descriptor.

Guidance

Standard Description	Guidance Notes	Identify lead for each area
A1	There is concern that many people with learning disability are unknown to services and do not subsequently get access to the healthcare that they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disability. Using available prevalence data will allow some indicative benchmarking around whether numbers of people on registers are likely to be accurate. All people with learning disability are not being identified via the QOF and therefore local data needs to be scrutinised and systems put in place within primary care to ensure that all people are put onto the QOF register irrespective of if they are known to social services, or not.	
A2	Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability.	

Standard Description	Guidance Notes	Identify lead for each area
A3	Whilst many practices sign up to the LD DES there is significant variability in the numbers of annual health checks that are actually completed. Underlying health conditions continue to be missed leading to poor health, sometimes death and long term costly interventions. Annual health checks have been shown to effectively reduce health inequality and improve health outcomes. Therefore a population wide 'roll out' at a local level is an essential action required to secure long term and consistent improvement in the health of this vulnerable group.	
A4	The LD DES guidance puts the onus on GPs to generate meaningful health action plans at the time of the annual health check to address health priorities. Integrated annual health checks and health action plans will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which can support reduction inappropriate secondary care referrals. It also provides the person with a learning disability (and their Carer, if appropriate) with a clear understanding of 'what needs to happen' over the next 12 months.	

Standard Description	Guidance Notes	Identify lead for each area
A5	Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability.	
A6	Healthcare providers frequently state that having no prior warning of somebody's learning disability and specific needs resulting from their disability, prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be made trackable as identified within primary and secondary care. By including LD status in your referral you will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will lead to a potential reduction in DNA's, length of stay and inappropriate repeat attendances.	

Standard Description	Guidance Notes	Identify lead for each area
A7	In Healthcare for All (recommendation 10) the value of advocacy, including learning disability liaison is clearly described, as well as a clear call for Trust Boards to publicly report that they have effective systems to deliver reasonably adjusted health services. Many Trusts have appointed learning disability liaison nurses though there is more than one way in which the learning disability liaison function can be delivered. This indicator seeks to explore the full extent of the learning disability liaison function in acute settings within the localities in England. Of particular importance is whether providers and commissioners are gathering and using HES data to inform decisions on where the greatest need for an LD function may be given trends and evidenced need.	
A8	Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator will capture examples of where this is happening well in the wider primary care community. In order for reasonable adjustments to occur routinely services need a way to both record patients' learning disability status and describe the required reasonable adjustments. This measure is about universal services **NOT** those services specifically commissioned for people with a learning disability.	
A9	Evidence suggests 7% of the prison population - and greater number in the criminal justice system, have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform Provision, regarding: •what is available including prevention, •development required and •ensuring health services are accessible.	

Guidance

General Overview

Being Safe: Making sure that we design, commission and provide services which give people the support they need close to home, and which are in line with well-established best practice. This is something the Winterbourne Review highlighted.

We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.

This section looks at safeguarding and quality.

You can use the table to identify the relevant lead for each standard descriptor.

Guidance with complex needs

Standard Description	Guidance Notes	Identify lead for each area
B1	Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way.	
B2	This measure asks localities to demonstrate how thorough their contracting processes are. This is important as contract monitoring is one of the first methods of scrutiny and assurance.	
B3	Following the publication of Healthcare for All in 2008 (Sir Jonathan Michael) the CQC developed a number of essential standards for healthcare providers to meet in order to assure a minimum standard of care, to be offered to people with learning disability. Subsequently MONITOR (the independent regulator of Foundation Trusts) adopted the same standards into their compliance framework. As these are minimal quality standards it would be expected that all FTs should be meeting these. This indicator not only seeks confirmation that this is the case but expects commissioners to demonstrate the evidence gathered from providers to confirm this and the evidence that where trusts strive to achieve foundation status, commissioners support the attainment of monitor standards.	

Standard Description	Guidance Notes	Identify lead for each area
B4	Governance, safety, quality and monitoring. Learning from Winterbourne View Review and good commissioning practice have identified failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safety and safeguarding for people with learning disability in all provided services and support.	
B5	This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training.	
B6	Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the confidential enquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this.	
B7	This measure is about how effectively your locality assesses and addresses the needs and support requirements of people with learning disabilities through local authority strategies with clear reference to current and future demand.	

Standard Description	Guidance Notes	Identify lead for each area
B8	This standard requires evidence of a learning organisation that integrates, learning from complaints, incidents, patient, carer and staff feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities. Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements	
B9	Mental Capacity Act (MCA). MENCAP's report Death by Indifference: 74 Deaths and Counting, highlighted the inconsistent application of the MCA 2005. This standard requires evidence that the five principles of the MCA are understood and consistently embedded within and across organisations to ensure safe, equal and high quality healthcare people with learning disability. Organisations are asked to demonstrate that there is evidence of routine monitoring across the whole organisation of implementation of MCA principles.	

Guidance

Standard one: Access to Health, Governance, Assurance and Quality

General Overview

LIVING WELL: People with learning disabilities and their family carers deserve an equal opportunity with the rest of the population to fulfill their lives as equal citizens of our nation safe from crime and intolerance

This section is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives.

You can use the table to identify the relevant lead for each standard descriptor.

Standard Description	Guidance Notes	Identify lead for each area
C1	This measure looks for the evidence that formal arrangements are in pace that foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented.	
C2	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.	
C3	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.	
C4	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.	
C5	This measure is about the importance of occupation and the equity that needs to be shown for people with a learning disability. Evidence of initiatives, data of the actual local picture are important.	

Standard Description	Guidance Notes	Identify lead for each area
C6	Delivering effective transitions for young people is recognized as a way of addressing the difficulties confronted by young people with learning difficulties and their families at transition. Previous research has demonstrated that information is a key need at this time. Information relates to co-production of local services driven by parent and user involvement as well as having a sound knowledge base of future need to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health services needed to support young people approaching adulthood - and their families. This measure touches upon the national Single Education, Health and Care Plan for people with learning disability. This policy is one of your key ways of evidencing success in this area.	
C7	Community inclusion and Citizenship are core to the need for people with a learning disability to be equal members of our community. This measure asks you to evidence that you have asked what inclusion and citizenship means to your local population, evidence that you are responding to such consultation and evidence that people actually feel part of the local community.	
C8	People with learning disability and family carer involvement in service planning and decision making including personal budgets This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice.	

Standard Description	Guidance Notes	Identify lead for each area
C9	Family Carers – Consultation on the JHSCSAF raised a strong call for family carers to be given a place to specifically contribute about their needs in the measures. This measure asks for evidence that family carers are involved not only in service design and commissioning, but in wider strategies as not all people with learning disabilities and family carers are known to or use services but need a voice in the shaping of the community.	

General Overview

The DATA: This section is self-explanatory and, in result of the consultation, we have tried to include where you might find the information and what other statutory returns or priorities collation of the data will help in completing.

It may seem more extensive than in previous years however it also includes information that replaces some of the Learning Disability Partnership Board reporting requirements and gives you a very broad set of information to help you assess the environment for people with a learning disability locally.

TIMESCALES:

Early August 2013	IHaL Website open for JHSCSAF collation and input	
30th November 2013	Deadline to submit completed JHSCSAF	
December - Feb 2014	Quality assurance and regional reporting	
March 2014	Presentation to Health & Wellbeing Boards	National Reporting

GUIDANCE - web-links

Useful Web links

QOF Registers
http://www.gpcontract.co.uk/timeline/ENG/LD%201#childorgs
(this can be further interrogated by Practices in Download- you will need the practice codes)

QOF Guidance:
http://www.nhsemployers.org/SiteCollectionDocuments/QOFguidanceGMScontract_2011_12_FL%2013042011.pdf

Prevalence Rates and Annual Health Check Data:
http://www.improvinghealthandlives.org.uk/numbers/

Healthcare For All
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Learningdisabilities/DH_077213

Direct Enhanced Scheme for 2013/14
http://www.google.co.uk/url?q=http://bma.org.uk/-/media/Files/PDFs/Practical%2520advice%2520at%2520work/Contracts/gpenhancedservicesguidance201314nhse.pdf&sa=U&ei=yqP_UebUIpKzhAfxkoDgDQ&ved=0CBsQFjAA&usg=AFQjCNFEccP1Allx1v6cKJCm1bveRKHhfg

Information Centre: National Collection of Annual Health check Data
http://www.ic.nhs.uk/services/omnibus-survey/using-the-service/data-collections/ld-health-checks

Useful Resources relating to Primary Care Contracting
http://www.pcc.nhs.uk/search.php?q=learning+disabilities

Useful Web links

Equality Delivery System
http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm

PCT profiles : Health inequalities and people with learning disabilities
http://www.improvinghealthandlives.org.uk/profiles/index.php?pdf=E09000002

RCN statement and recommended resources
http://www.rcn.org.uk/ data/assets/pdf_file/0004/78691/003024.pdf
http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities/guidance

GMC website on learning disabilities
http://www.gmc-uk.org/learningdisabilities/default.aspx

Royal College of GP
http://www.rcgp.org.uk/clinical_and_research/circ/innovation evaluation/learning_disabilities_resource.aspx

Mental health nursing of adults with learning disabilities,
http://www.rcn.org.uk/ data/assets/pdf_file/0006/78765/003184.pdf

Compliance Framework 2012/13
http://www.monitornhsft.gov.uk/sites/default/files/Compliance%20Framework%2030%20March%202012%20FINALv1.1_0.pdf

MENCAP Getting it Right Campaign
http://www.mencap.org.uk/campaigns/take-action/getting-it-right

Joint Strategic Needs Assessment Core Dataset
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf

Local Profiles:
http://www.improvinghealthandlives.org.uk/profiles/index.php?pdf=E09000002

Valuing People Now
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

Services for Challenging Behaviour or mental health needs
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080128.pdf

Outcomes Framework for NHS in England 2013/14
https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

Adult Social Care Outcomes Framework 2013/14
https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

Public Health Outcomes Framework 2013/16
https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

People with profound disabilities
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

Autism
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369

Royal College of Psychiatry:
http://www.rcpsych.ac.uk/mentalhealthinfo/problems/learningdisabilities.aspx
http://www.rcpsych.ac.uk/specialties/faculties/intellectualdisability.aspx

No Health without Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Social Care Institute for Excellence;
http://www.scie.org.uk/topic/people/olderpeople/olderpeoplewithlearningdisabilities/adultswithlearningdisabilities

Older People
http://www.dhsspsni.gov.uk/auditlearningdisabilitychpt8.pdf

Dementia and Learning Disabilities
http://www.rcpsych.ac.uk/files/pdfversion/cr155.pdf

Transition Planning
http://www.scie.org.uk/publications/tra/index.asp

Support and Aspiration
http://www.education.gov.uk/schools/pupilsupport/sen/a0075339/sengreenpaper

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

Prison Reform Trust Resources
http://www.prisonreformtrust.org.uk/SearchResults/tabid/41/Default.aspx?Search=learning+disabilities

Positive Practice Positive Outcome
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124743

Health and Parliamentary Ombudsman
http://www.ombudsman.org.uk/search?queries_keyword_query=six+lives
http://www.ombudsman.org.uk/care-and-compassion/

Six Lives Progress Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_120251

Healthcare For All
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Learningdisabilities/DH_077213

Winterbourne View Review
http://www.dh.gov.uk/health/2012/02/review-of-winterbourne-view-hospital/

Equality Delivery System
http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm

Safeguarding Adults at Risk
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

Mental Capacity Act
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/mental-health-act/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england--second-report-on-annual-data-2010-11

74 Deaths and Counting
http://www.mencap.org.uk/74deaths

National Framework for Continuing Healthcare
http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_076334

CQC Inspection of Assessment and Treatment Units
http://www.cqc.org.uk/public/our-action-winterbourne-view/review-learning-disability-services/learning-disability-reports

Useful Weblinks

Commissioning Learning Disability Health Services
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109088
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079987

Equity and Excellence Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Carers Strategy
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

Responsible Commissioner Guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

CQC
http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf
http://www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final.pdf

Out of Area Protocol

Easyhealtth is a simple-to use, easy-to-understand website that makes it straightforward for people to find health information:
www.easyhealth.org.uk

Self Assessment Framework Overview
http://www.improvinghealthandlives.org.uk/projects/self_assessment/regions/

Easy Read Tools for Big Health Check Up Day

Good Healthcare for All Resource for Family Carers and people with learning disabilities
http://www.learningdisabilities.org.uk/publications/176171/

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Joint Health and Social Care Self-Assessment Framework

Healthcare

Demographics

You should obtain this information from general practices. You can do this directly either by the Clinical Commissioning Group (CCG) or Commissioning Support Unit (CSU) using MiQuest queries, or by direct liaison with practices. Primary Care Trusts and GP practices may also know this information from routine liaison in relation to Health Checks. In some areas, primary care contracting requires information flows to support this.

You should aim to provide this data broken down by **age bands** and **ethnicity**. However, if you are unable to provide an age breakdown at this level then **either** report the data by the number of people of aged **0 to 17** years old and aged **18 and over**, **Or** the numbers for **all ages**. These are the last three options in questions 1 to 3.

Please note recorded as being from an ethnic minority means that a person's ethnic category (if declared) is different from the English ethnic majority. That is to say they are not 'British (White)'. This refers to the term as defined for the NHS data dictionary.

1. How many people with any learning disability are there in your Partnership Board area?

1.1 Aged 0 to 13 years old

1.2 Aged 14 to 17 years old

1.3 Aged 18 to 34 years old

1.4 Aged 35 to 64 years old

1.5 Aged 65 years old and over

1.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

1.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 1.8 and 1.9, question OR 1.10.

1.8 Aged 0 to 17 years old

1.9 Aged 18 years old and over

1.10 All ages

2. How many people with complex or profound learning disability are there in your Partnership Board area?

Complex or profound learning disability here means learning disability complicated by severe problems of continence, mobility or behaviour, or severe repetitive behaviour with no effective speech (i.e. representing severe autism) (Institute of Public Care, (2009) Estimating the prevalence of severe learning disability in adults. IPC working paper).

2.1 Aged 0 to 13 years old

2.2 Aged 14 to 17 years old

2.3 Aged 18 to 34 years old

2.4 Aged 35 to 64 years old

2.5 Aged 65 years old and over

2.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

2.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 2.8 and 2.9, question OR 2.10.

2.8 Aged 0 to 17 years old

2.9 Aged 18 years old and over

2.10 All ages

3. How many people with both any learning disability and an Autistic Spectrum Disorder are there in your Partnership Board area?

3.1 Aged 0 to 13 years old

3.2 Aged 14 to 17 years old

3.3 Aged 18 to 34 years old

3.4 Aged 35 to 64 years old

3.5 Aged 65 years old and over

3.6 Aged 0 to 17 years old and recorded as being from an ethnic minority

3.7 Aged 18 years old and over and recorded as being from an ethnic minority

If you are unable to provide an age breakdown at this level of detail then complete either questions 3.8 and 3.9, question OR 3.10.

3.8 Aged 0 to 17 years old

3.9 Aged 18 years old and over

3.10 All ages

Screening

This information should be obtained from GP practices. This may either be done directly by the CCG or CSU using MiQuest queries, or by direct liaison with practices. Directors of Public Health should be monitoring this routinely as an equalities issue.

The total eligible population includes people with and without learning disabilities unless otherwise stated.

4. How many women are there eligible for cervical cancer screening?

- The eligible population are women aged 25 to 64 years old inclusive and who have not had a hysterectomy.
- The population who had a cervical smear test in the last three years (1st April 2010 to 31st March 2013 inclusive) if aged 25 to 49 years old or else in the last five years (1st April 2008 to 31st March 2013 inclusive) if aged 50 to 64 years old

4.1 Number of total eligible population

4.2 Number of total eligible population who had a cervical smear test

4.3 Number of eligible population with learning disabilities

4.4 Number of eligible population with learning disabilities who had a cervical smear test

5. How many women are eligible for breast cancer screening?

- Eligible population are women aged 50 to 69 years old, inclusive.

5.1 Number of total eligible population

5.2 Number of total eligible population who had mammographic screening in the last three years (1st April 2010 to 31st March 2013)

5.3 Number of eligible population with learning disabilities

5.4 Number of eligible population with learning disabilities who had mammographic screening in the last three years (1st April 2010 to 31st March 2013)

6. How many people are eligible for bowel cancer screening?

- Eligible population are people aged 60 to 69 years old, inclusive.

6.1 Number of total eligible population

6.2 Number of total eligible population who satisfactorily completed bowel cancer screening in the last two years (1st April 2011 to 31st March 2013)

6.3 Number of eligible population with learning disabilities

6.4 Number of eligible population with learning disabilities who satisfactorily completed bowel cancer screening in the last two years (1st April 2011 to 31st March 2013)

Wider Health

This information should be obtained from GP practices. This may either be done directly by the CCG or CSU using MiQuest queries, or by direct liaison with practices. These are routinely available measures of major health issues that should be monitored by Directors of Public Health.

Report how many people there were on the **31st March 2013**.

7. How many people with learning disabilities are there aged 18 and over who have a record of their body mass index (BMI) recorded during the last two years (1st April 2011 to 31st March 2013)?

8. How many people with learning disabilities are there aged 18 and over who have a BMI in the obese range (30 or higher)?

9. How many people with learning disabilities are there aged 18 and over who have a BMI in the underweight range (where BMI is less than 15 as per Health Equalities Framework indicator 4C)?

10. How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease?

As per the Quality and Outcomes Framework (QOF) Established Cardiovascular Disease Primary Prevention Indicator Set.

11. How many people with learning disabilities of any age are known to their doctor to have diabetes?

As per the QOF Established Diabetes Indicator Set and include both type I and type II diabetes here.

12. How many people with learning disabilities of any age are known to their doctor to have asthma?

As per the QOF Established Asthma Indicator Set

13. How many people with learning disabilities of any age are known to their doctor to have dysphagia?

14. How many people with learning disabilities of any age are known to their doctor to have epilepsy?

As per the QOF Established Epilepsy Indicator Set

Mortality

Following the publication of the Confidential Inquiry, Directors of Public Health will want to set up mechanisms to monitor this. Relatively few are likely to be able to answer this question this year. In the longer term this will be produced as part of the NHS Outcomes Framework.

15. How many people with a learning disability resident in your Partnership Board area died between 1st April 2012 and 31 March 2013?

15.1 Aged 0 to 13 inclusive

15.2 Aged 14 to 17

15.3 Aged 18 to 34

15.4 Aged 35 to 64

15.5 Aged 65 and older

Annual Health Check & Health Action Plans

16. How many people with a learning disability aged 18 and over were agreed as eligible for an Annual Health Check under the Directed Enhanced Scheme between 01 April 2012 and 31 March 2013?

17. How many people with a learning disability aged 18 and over had an Annual Health Check under the Directed Enhanced Scheme between 01 April 2012 and 31 March 2013?

18. How many people aged 18 and over with a learning disability have a Health Action Plan?

18.1 Total number eligible

18.2 Total number completed

Practices participating in Health Checks

Report how many general practices there were on the **31st March 2013**.

19. How many GP practices are there in your Partnership Board area?

20. How many GP practices in your Partnership Board area signed up to a Locally Enhanced Services or Directed Enhanced Service for the learning disability annual health check in the year 2012-2013?

Acute & Specialist Care

Providers should know this as a result of the Compliance Framework.

Report the numbers between **1st April 2012 and 31st March 2013**.

21. How many spells of INPATIENT Secondary Care were received by people identified by the provider as having a learning disability under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715)?

21.1 Number of spells

21.2 Number for people with learning disabilities as percentage of total spells

22. How many OUTPATIENT Secondary Care Attendances were received by people identified by the provider as having a learning disability under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715)?

22.1 Number of attendances

22.2 Number for people with learning disabilities as percentage of total attendances

23. How many attendances at Accident & Emergency involved a person with learning disabilities as the patient?

23.1 Number of attendances

23.2 Number for people with learning disabilities as percentage of attendances

24. How many people with a learning disability have attended Accident & Emergency more than 3 times?

24.1 Number of people

24.2 Number for people with learning disabilities as percentage of total attendances

Continuing Health Care and Aftercare

Your Local CCG or CSU/Function should have this information.

Report the numbers on the **31st March 2013**.

25. How many people with a learning disability are in receipt of Continuing Health Care (CHC)?

26. How many people with a learning disability are in receipt of care funded through the Section 117 arrangement of the Mental Health Act?

Location of mental health and learning disability in-patient care

In most cases, this should be known by CCG and possibly through CSU. Your Local CCG or CSU should have this information.

Report the numbers on the **31st March 2013**.

27. How many people with learning disability were in-patients in mental health or learning disability in-patient units (HES speciality function codes 700 to 715) run by providers that provide the normal psychiatric in-patient and community services for the CCGs in your Partnership Board area.

Note: the impact of this question is likely to be the 'missing figures' that relate to those placed out of area and this will be compared with the Winterbourne View data collection/registers.

27.1. Number of people placed primarily due to Challenging Behaviour

27.1.1 Age 0 to 17

27.1.2 Age 18 or older

27.2. Number of people placed primarily due to Mental Health Problems

27.2.1 Age 0 to 17

27.2.2 Age 18 or older

27.3. Number of people placed primarily due to complex physical health needs

27.3.1 Age 0 to 17

27.3.2 Age 18 or older

28. How many people with learning disability were in-patients in mental health or learning disability in-patient units commissioned by NHS England (specialised commissioning)?

Note: this question has been changed to clarify what is requested.

28.1. Located in your Partnership area or a CCG area bordering it

28.1.1. Number of people placed primarily due to Challenging Behaviour

28.1.1.1 Age 0 to 17

28.1.1.2 Age 18 or older

28.1.2. Number of people placed primarily due to Mental Health Problems

28.1.2.1 Age 0 to 17

28.1.2.2 Age 18 or older

28.1.3. Number of people placed primarily due to complex physical health needs

28.1.3.1 Age 0 to 17

28.1.3.2 Age 18 or older

28.2. Located elsewhere

28.2.1. Number of people placed primarily due to Challenging Behaviour

28.2.1.1 Age 0 to 17

28.2.2.2 Age 18 or older

28.2.2. Number of people placed primarily due to Mental Health Problems

28.2.2.1 Age 0 to 17

28.2.2.2 Age 18 or older

28.2.3. The Number of people placed primarily due to complex physical health needs

28.2.3.1 Age 0 to 17

28.2.3.2 Age 18 or older

Reasons for mental health and learning disability in-patient placements

CCG or CSU should have this information. In some cases where commissioning for this group has been partly subcontracted to providers, this may require their input too.

29. How many people with a learning disability have been admitted once or more often to both in-patient mental health and learning disability care (HES specialty function codes 700-715) at least once between 01 April 2012 and 31 March 2013?

Count each individual once only.

29.1 Primarily for management of challenging behaviour

29.2 Primarily for other reasons

29.3 Total number of individuals (One individual may in the year have had admissions for both reasons)

30. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013?

30.1 Primarily for management of challenging behaviour

30.2 Primarily for other reasons

31. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013 who had been in-patients continuously in this or other placements for more than 90 days.

31.1 Primarily for management of challenging behaviour

31.2 Primarily for other reasons

32. How many people with a learning disability were in both in-patient mental health and learning disability care (HES specialty function codes 700-715) on 31 March 2013 who had been in-patients continuously in this or other placements for more than 730 days (two years).

32.1 Primarily for management of challenging behaviour

32.2 Primarily for other reasons

Challenging Behaviour

CCG or CSU should have this information.

Report all NHS funded hospital care.

33. Number of people with a learning disability or autism, with challenging behaviour in NHS funded care on the PCT register handed over to the CCG at 31st March 2013.

33.1 Number in hospital at index date

33.2 Number NOT in hospital at index date

34. Number of people with a learning disability or autism, with challenging behaviour in NHS funded care on the CCG register at 30th June 2013.

34.1 Number in hospital at index date

34.2 Number NOT in hospital at index date

35. Number of people in learning disability or autism in-patient beds at 1st December 2012 (Publication of Transforming Care) and number of these whose care has been reviewed in line with the Ian Dalton Letter between the beginning of December and 1st June 2013.

35.1 Number in hospital at index date

35.2 Number NOT in hospital at index date

Assessment and provision of social care

You should refer to your Local Authority Referrals, Assessments and Packages of Care (RAP) Return data.

Report the numbers between 01 April 2012 and 31 March 2013.

36. How many people with learning disabilities received the following between 01 April 2012 and 31 March 2013?

36.1 Received a statutory assessment or reassessment of their social care need whose primary client type was learning disability. (A1 and assumedly knowable from sources capable of producing A6 and A7)

36.2 Received community-based services whose primary client type was learning disabilities (P1)

36.3 Received residential care whose primary client type was learning disabilities (P1)

36.4 Received nursing care whose primary client type was learning disabilities (P1)

Inclusion & Where I Live

Social services statistics unit should have this information. Please note, these are data you should have reported to the Health & Social Care Information Centre (HSCIC) earlier in the year. They are included here so they can be seen in the context of the other data. They will not be published by HSCIC until March 2014.

Report the number of people with learning disability as primary client type.

Employment & Voluntary Work

Refer to Adult Social Care Combined Activity Returns data L1.

37. How many people with learning disabilities in paid employment (including self-employed known to Local Authorities)?

38. How many people with learning disabilities as a paid employee or self-employed (less than 16 hours per week) and not in unpaid voluntary work?

39. How many people with learning disabilities as a paid employee or self-employed (16 hours + per week) and not in unpaid voluntary work?

40. How many people with learning disabilities as a paid employee or self-employed and in unpaid voluntary work?

41. How many people with learning disabilities in unpaid voluntary work only?

Accommodation

Refer to Adult Social Care Combined Activity Returns data L2

Please note, the National Adult Social Care Intelligence Service rounds these numbers to nearest five prior to publication. As such, we will take similar precautions when publishing these data.

42. How many people with a learning disability live in or are registered as:

42.1. Rough sleeper/Squatting

42.2. Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self-referrals)

42.3. Refuge

42.4. Placed in temporary accommodation by Local Authority (including Homelessness resettlement)

42.5. Acute/long stay healthcare residential facility or hospital

42.6. Registered Care Home

42.7. Registered Nursing Home

42.8. Prison/Young Offenders Institution/Detention Centre

42.9. Other temporary accommodation

42.10. Owner Occupier/Shared ownership scheme

42.11. Tenant - Local Authority/Arm's Length Management Organisation/Registered Social Landlord/Housing Association

42.12. Tenant - Private Landlord

42.13. Settled mainstream housing with family/friends (including flat-sharing)

42.14. Supported accommodation/Supported lodgings/Supported group home (accommodation supported by staff or resident caretaker)

42.15. Adult placement scheme

42.16. Approved premises for offenders released from prison or under probation supervision (e.g., Probation Hostel)

42.17. Sheltered Housing/Extra care sheltered housing/Other sheltered housing

42.18. Mobile accommodation for Gypsy/Roma and Traveller community

42.19. What is the total number of people with a learning disability known to the Local Authority?

Quality

For Health Commissioning Deprivation of Liberty Safeguards refer to Omnibus data collection
http://www.hscic.gov.uk/dols

Training

43. How many of Health & Social Care commissioned services implement mandatory learning disabilities awareness training? - We have withdrawn this question.

Complaints

44. How many complaints have directly led to service change or improvement in learning disabilities services?

Safeguarding

45. How many adult safeguarding concerns have there been in the year to 31st March 2013 concerning adults with learning disabilities?

46. How many adult safeguarding concerns have been raised in relation to people with learning disabilities that required escalation?

47. What percentage of commissioned accommodation, residential or nursing placements "in borough" have had unannounced visits in the past 12 months?

48. How many commissioned accommodation, residential or nursing placements "out of borough" have had unannounced visits in the past 12 months?

Note: this question has been changed. Please provide the total figure, not the percentage.

Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interest referrals

49. How many Deprivation of Liberty Safeguards referrals were made by local authorities in 2012-13?

Note: this question has been changed to clarify what is requested.

50. How many Deprivation of Liberty Safeguards referrals were made by CCGs (formerly PCTs) in 2012-13?

Note: this question has been changed to clarify what is requested.

51. How many Best Interest Decisions referrals have been made in 2012-13?

52. What percentage and number of staff in commissioned services have undertaken DOLS training in the last 3 years?

52.1 Percentage

52.2 Number

53. What percentage and number of staff in commissioned services have undertaken Mental Capacity Act training in the last 3 years?

53.1 Percentage

53.2 Number

Transitions

54. The total school age population in your Partnership Board area

55. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of moderate learning disability.

56. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of severe learning disability.

57. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of profound or multiple learning disability.

58. The number of people receiving additional assistance in school because of Special Educational Needs, with a primary need category of autistic spectrum disorder.

59. The number of people with a learning disability aged 14 to 17 years old who are in receipt of a co-produced transition plan.

Self-Assessment Framework

This section allows you to rate each measure of the self-assessment framework green, amber or red. You should continually refer to the guidance in order to decide the ratings. The guidance can be downloaded here.

In addition, you can click on each measure which will take to the definition of the measure and the RAG ratings.

In order to rate yourself RED, you must meet the criteria described under this heading In order to rate yourself AMBER, you must meet the criteria described under BOTH the RED and AMBER headings In order to rate yourself GREEN, you must meet the criteria described under the RED, AMBER and GREEN headings

For each indicator, you should provide an explanation as to why you rated it green, amber or red and a link to a webpage containing further evidence to support this rating.

In addition, you can also provide a positive or negative real life stories of experience that explains why you think that indicator is strong or needs improvement.

Please note, we would like you to keep these explanations and stories concise. As such please limit these to 1,000 characters (including spaces). There is a counter underneath each comment box indicating how many characters out of the 1,000 you have used.

Section A

A1. LD QOF register in primary care

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for this rating

Web link to further evidence

Real life story

A2. Screening

People with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for this rating

Web link to further evidence

Real life story

A3. Annual Health Checks and Annual Health Check Registers

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation to rating

Web link to further evidence

Real life story

A4. Health Action Plans

Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care and these include a small number of health improving activities. Refer to RCG guidance around health action plans.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation to rating

Web link to further evidence

Real life story

A5. Screening

Comparative data of people with learning disability vs. similar age cohort of non-learning disabled population in each health screening area for:

a) Cervical screening

b) Breast screening

c) Bowel Screening (as applicable)

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

A6. Primary care communication of learning disability status to other healthcare providers

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

A7. Learning disability liaison function or equivalent process in acute setting

For example, lead for Learning disabilities.

Known learning disability refers to data collated within Trusts regarding admission - HES data.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

A8. NHS commissioned primary and community care

* Dentistry

* Optometry

* Community Pharmacy

* Podiatry

* Community nursing and midwifery

This measure is about universal services NOT those services specifically commissioned for people with a learning disability.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

A9. Offender Health & the Criminal Justice System

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

Section B

B1. Regular Care Review

Commissioners know of all funded individual health and social care packages for people with learning disability across all life stages and have mechanisms in place for on-going placement monitoring and individual reviews.

Evidence should describe the type (face to face or telephone etc.)

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

B2. Contract compliance assurance

For services primarily commissioned for people with a learning disability and their family carers

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

B3. Assurance of Monitor Compliance Framework for Foundation Trusts

Supporting organisations aspiring towards Foundation Trust Status

Governance Indicators (learning disability) per trust within the locality

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

B4. Assurance of safeguarding for people with learning disability in all provided services and support

This measure must be read in the context of an expectation that ALL sectors, Private, Public and Voluntary / Community are delivering equal safety and assurance.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

B5. Training and Recruitment - Involvement

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

B6. Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture.

This is a challenging measure but it is felt to be vital that all areas consider this.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation to rating

Web link to further evidence

Real life story

B7. Local Authority Strategies in relation to the provision of support, care and housing are the subject of Equality Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities.

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

B8. Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

B9. Mental Capacity Act & Deprivation of Liberty

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

Section C

C1. Effective Joint Working

- ◯ Red
- ◯ Amber
- ◯ Green

Explanation for rating

Web link to further evidence

Real life story

C2. Local amenities and transport

- ◯ Red
- ◯ Amber
- ◯ Green

Explanation for rating

Web link to further evidence

Real life story

C3. Arts and culture

- ◯ Red
- ◯ Amber
- ◯ Green

Explanation for rating

Web link to further evidence

Real life story

C4. Sport & leisure

- ◯ Red
- ◯ Amber
- ◯ Green

Explanation for rating

Web link to further evidence

Real life story

C5. Supporting people with learning disability into and in employment

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

C6. Effective Transitions for young people

A Single Education, Health and Care Plan for people with learning disability

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

C7. Community inclusion and Citizenship

- Red
- Amber
- Green

Explanation for rating

Web link to further evidence

Real life story

C8. People with learning disability and family carer involvement in service planning and decision making including personal budgets

This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice.

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

C9. Family Carers

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Explanation for rating

Web link to further evidence

Real life story

Have you looked at the PDF output and agree that all the answers as they appear on it are correct?

To do this, click Return to front page then click on 'View' under **Start Questionnaire**.

This marks the end of principal data collection and at the closing date (currently set as 30th November) we will lock the questions in the principal entry against further change.

- ☐ *Yes*

The Joint Self-Assessment

What's it all about?- Easier Read Guidence

The Joint Self- Assessment is a way of checking how good services are working for people with learning disabilities and their family members and family carers. It helps us think about lots of different services. This includes things like:

- Housing
- Going to the doctors or the hospital
- If the local swimming baths or libraries are accessible
- Wether personal budgets are working for people

In the past we did this in two ways. These were the:

- Health Self-Assessment Framework
- The Learning Disability Partnership Board Report

Everybody thought it would be a good idea to bring the two together.

The big idea is that EVERYBODY should be involved in checking and planning services. There are four big parts to the assessment. This sheet tells you about the four parts.

Compliance

Every area should be able to show that they have things written down in polices or that they are following rules. These things help us check they are following the law and good decisions are being made. This includes things

like:

- Policies to make sure people are safe
- Ways of working that make sure people are using the Mental Capacity Act

Data

This is about asking areas to get information about numbers. This includes things like:

- How many people have paid jobs
- How many people are having an annual health checks
- How many people are from black and minority ethnic communities

Numbers are important but we need to get the thoughts and feelings of people too.

Measures

The measures are three things that people have said we need to get right for people with learning disabilities and family carers. The Framework tests how good areas are doing about these three things:

Section A - Staying Healthy

This includes lots of things such as getting a good service from the doctors, chemist, dentists or when going to hospital.

Section B – Being Safe

This is about people being safe when using health services such as being in hospital or getting support from

social services such as where people live. It also means people are safe when out and about where they live such as going to the swimming baths or being on the bus.

Section C – Living Well

This is about people with learning disabilities and their families having a say about how services should work. It is also about making sure that they are thought about when planning and buying services

It also about inclusion and making sure that people with learning disabilities are welcomed and valued in their community.

The way we test how areas are doing is called the RAG rating. This uses the same colours as traffic lights. This means:

Red…This means that things are not good and there is lots of work to be done

Amber…This means there are some plans or work in place but still lots to do

Green…This means that your area is doing really well on something

Sharing Stories

This is the real tester for areas to check how things are working. The Sharing Stories part is a chance for everybody to share stories of:

- Good ways of working
- Bad ways of working

This could include stories about getting extra time at your doctors for your appointment or choosing who supports you where you live and getting a job.

We should all be able to learn from these stories about how to do things better. They should also help people who plan and buy services use the money in the best way possible.

There is a sheet that comes with this information called the ‘Sharing Stories Sheet’ that people will use to collect information. We hope that everybody will use these including:

- People with learning disabilities and families
- Direct support workers
- Advocates
- Doctors/Nurses
- And more

There will be somebody in your area that is collecting these stories that you can send yours too. The details are on the sharing stories sheet.

Big ideas about how to make the framework happen

The people in charge of making the Framework happen where you live are:

- Clinical Commissioning Groups
- Health and Wellbeing Boards
- Learning Disability Partnership Boards

We think that areas know how to involve people in the best way locally but we do think that areas should:

- Make sure everybody gets a chance to talk in a room together about what is happening and how things are going. Questionnaires are not a good way to do this

- Decide together how well they think their area is doing and decide scores together

- Make sure people are working together to plan and buy services

All the information from the framework will be given to the government to help them decide what they should be doing for people with learning disabilities and their families.

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Title of Report:	Frail Elderly Pathway Project
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26 September 2013

Purpose of Report: **To make the Health and Wellbeing Board aware of an early strand of Health and Social Care integration being undertaken in the West of Berkshire.**

Recommended Action: **To note the report.**

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Graham Jones (01235) 762744
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Executive Report

Berkshire West Frail Elderly Pathway: Proposed Purpose, Methodology and Support Requirements

Purpose

Berkshire West Health and Social Care partners have committed to working more closely together to ensure effective provision of quality services to our population, using our collective resources to achieve the best outcomes we can for service users and their families. We have also agreed that we want to focus on our response to people that are referred to as "elderly frail" in recognition of the fact that the majority of health and social care resources are used in meeting the needs of this group. Understanding our current pathway, the gaps in it, and how we could improve it, forms the essential groundwork for future consideration of potential structural or financial models of service provision.

We have already established locality groups in each Council area, where health and social care partners are working together on the integration of services. This cross-locality initiative will build on locality focussed planning, enabling consideration of the whole pathway through the inclusion of services which are provided across more than one locality.

Benefits

The reasons for embarking on this work fall into 3 main groups:

- Enhanced ability to deal with demand growth and income reduction across health and social care services (Norman Lamb at the Kings Fund Integrated Care Summit. 24.05.2013).
- Improved patient and carer experience (A narrative for person centred (integrated) care. National Voices. 2013)
- Improved outcomes (Lessons from Experience: Making integrated care happen at scale and pace. Kings Fund, March 2013).

Proposed Methodology and Outputs

The pathway project will include:

- The base pathway (which will describe "what does good look like?") which will be informed by both service-user need and best practice evidence. This will be developed by a core group of representatives of social care, primary care, voluntary sector and NHS provider Trusts – who will be a combination of people with direct knowledge of the "front line" work done by their organisation, as well as people with the leadership authority to influence change. This is expected to involve 6 half days with a facilitator and project lead. It is anticipated that this will lead to several smaller work streams, which will be determined by specific parts of the pathway and the relevant organisational interfaces.

- Identification of required outcomes for service users at each stage of the pathway, along with proposed service standards.

- An analysis of current service provision and capacity from all social care and health providers will be required. N.B. the assumption is that this will be supported by partners to avoid requirement for commissioning additional external capacity.

- All of the above will generate a gap analysis, which will inform;

- Recommendations for required service changes, which will include removing unnecessary duplication, delays and transactions; providing or re-providing new elements of care; workforce implications including skill mix and non-clinical staff training and development.

Governance

It is proposed that governance for this project is undertaken through existing forums as far as possible, minimising additional meetings and duplication of effort.

1. Project Team: Including project sponsors (Director leads from Wokingham Borough Council and the two Foundation Trusts) and project manager. Links to locality integration groups and accountable to the Berkshire West Partnership.

2. Steering Group: Berkshire West Partnership.

Support Requirements and Costs

We propose to engage independent support to the project – both to ensure we have the required capacity to undertake the work and also to ensure that there is a sense of equity and lack of bias, which could compromise our work if the workshop facilitation and project support were to come from any of the partner organisations

1. Workshop Facilitator: to lead/ prepare and write up 6workshops to identify the components described above. Estimated 6 days to run 6 half day workshops with required preparation and write up. Approx. £6k.

2. Project Management: to lead the pathway development process using workshop outputs, capita and other information analysis, meetings with key stakeholders and taking responsibility for production of project documentation and a final report with recommendations for approval by partners. Estimated 1 day a week for 3 months. 13 days@ £650 + expenses = approx. 10k.

Total Costs (including venue hire): £16,560 (estimate only)

Appendices

There are no Appendices to this report.

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Turnaround Families Programme

www.westberks.gov.uk/turnaroundfamilies

Year One Report

May 2013

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West Berkshire Council

Contents

***Thanks**: to all those who have been involved in developing, supporting and implementing the Programme in Year 1.*

Section 1: Introduction and Background

1.1 Report Introduction

This report looks at the progress made in the first year of West Berkshire Council's Turnaround Families Programme, the name for the Council's local delivery of the national Troubled Families Programme.

The report starts with background information, moves on to the activities undertaken as part of the programme then presents an analysis of families we aimed to work with and have worked with. Stemming from that, we look at early outcomes and findings. In the final section, we look at what we have learnt from the activities of the Programme's first year and draw from this any priorities for the second year of the delivery.

1.2 National Context

In April 2012 West Berkshire Council confirmed its participation in the England-wide Troubled Families Programme, launched by the Prime Minister in late 2011 and directed by the Troubled Families team, based in Department for Communities and Local Government (DCLG). All local authorities in England signed up to the Programme.

The Programme aims to ensure that 120,000 troubled families in England are 'turned around' by the end of the current Parliament. The Government says that 'troubled' families are those with:

- no adult in the family working
- children not in school when they should be
- young people committing crime
- family members involved in anti-social behaviour.

Other problems such as domestic abuse, relationship breakdown, child protection concerns, mental and physical health problems, housing issues, debt, poverty and isolation make it incredibly hard for families to start sorting out their problems.

A key aim of the Programme is to incentivise and encourage local authorities and their partners to develop new ways of working with families that focus on lasting change.

In West Berkshire we have a number of multi-agency initiatives aimed at reducing the risk factors and behaviours within high need families and this is reflected in district-wide strategic activity through to face to face practice interventions. Links to many of these initiatives are referenced through this report. When we embarked on the Programme we wanted to develop an approach that valued and extended this existing experience, resources and expertise.

1.3 Set-up and implementation

Each authority received funding to appoint a Troubled Families Co-ordinator, with recommendations for how this funding would be used. In West Berkshire 0.2fte of a manager's time was allocated as a dedicated resource to get the Programme up and running from April 2012. A small set-up group of key service managers supported the planning work in the first two months.

A development officer was also appointed to undertake the complex work related to monitoring, evaluation and reporting as well as communications and administrative

activities. An apprentice was also recruited as it was important that the Programme set an example in relation to supporting employment opportunities for potentially NEET young people. These two post holders started in September 2012.

The local programme was named the Turnaround Families Programme (TFP).
The delivery model is different in each authority but the DCLG promoted the use of intensive, assertive and persistent family-based interventions.

1.4 Local Programme Ambitions

The main ambitions set out for the Turnaround Families Programme are:

- to turnaround:
  - service delivery to better meet the needs of local families with high needs, including through help at an earlier stage
  - the lives of 145 families who engage with the Programme in a positive way
  - strategic funding and partnership working to develop new finance models for how we can pay for and deliver effective services with less money
- to offer both challenge (to do better) and support (to carry out a difficult task) to service providers and families

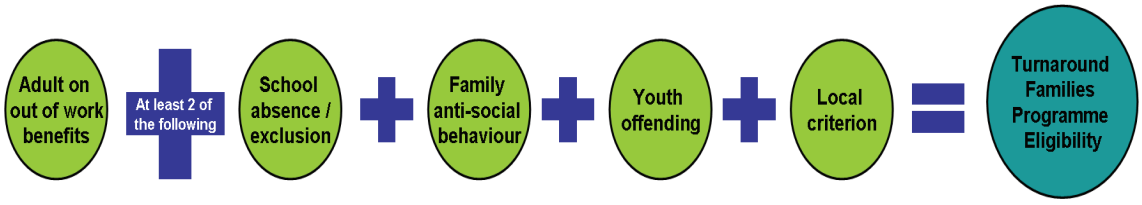
1.5 Results required

There is a very specific definition of results associated with the Programme which is determined by the DCLG and which directly impacts on the payments received by the Council for the Programme. These relate to improvements in:

- School attendance
- Reductions in unauthorised school absences
- Reductions in youth offending
- Higher employment levels, and associated reductions in unemployment benefit dependency
- Reductions in family anti-social behaviour.[1]

In West Berkshire to ensure the Programme reaches the families for whom results payments could be achieved, the criteria in Figure 1 were agreed to move families into education, work or training.

Figure 1: West Berkshire Turnaround Family Programme access criteria



[1] Please see Appendix 2: for the full detail of the Troubled Families Programme criterion.

1.6 First Year Activities[2]

Activity	Summary	Dates
Start up	■ Established an implementation and action group ■ Agreed Project Initiation and governance arrangements ■ Agreed a high level vision and plan for the programme ■ Formulated a budget ■ Development of a communications plan to inform and engage local stakeholders ■ Recruitment of support staff	April-June
Identification of local cohort	Mapping of family information using local data sources and DWP employment-related benefit data to understand volume of families meeting criteria and how this relates to target assigned by DCLG – at local level YOT, Education, Safer Communities and Police data involved.	April-June 2012
Service mapping	In order to understand current local provision and how to enhance this and avoid duplication a service directory was produced.	June – August 2012 (but refresh will be ongoing
Service consultation	Consultation with services, and schools via School Forums to explore opportunities and gap analyse that could be addressed by the Programme. This informed the commissioning plan. Findings of a peer-led parent consultation undertaken in March 2012.	June-Sept 2012
Workforce development	With a potential change in ways of working with families a piece of work to explore workforce development issues was undertaken. This included identifying relevant training and exploring potential workforce development needs associated family-focused work with high need families.	June – September 2013
Development and processing of commission-ing plan	A commissioning plan with associated expenditure was produced in consultation with key service managers.	June 2012 then ongoing
Work with families	Phased approach to work with families due to delays in appointing intensive intervention staff	Late October 2012
Partnership activity	A range of work was undertaken to support wider systems change activity	April 2012 onwards

[2] Appendix 1: provides details of the Governance arrangements for the Programme.

1.7 Funding

The DCLG has adopted a payment by results model of funding to help incentivise success in authorities and has assigned specific numbers to each local authority to work with over three years. In West Berkshire the number is **145 families**.

The DCLG set out the rules for the Troubled Families in its Financial Framework for results and payments. This included details of the proportion of money to be received up front (attachment fees) and the payment levels available for each type of result (payment by results) for each of the three years of the national Programme. (A summary of the key information is included in Appendix 2:).

Funding is for 121 of these families as DCLG has assumed that we are working with and receiving funding for at least 1/6th of the families already through other schemes. Appendix 3 has details of the projected income modelling. In relative terms the direct funding for the Programme is not substantial, less than £300,000 per year, with the projected Year 2 level decreasing significantly in Year 3.

The DCLG has also indicated it expects local authorities to match their potential maximum funding of £4000 per annum with a further £6000 but no stipulation is made on how this should be done or requirement to evidence this.

1.8 Distinctive features of the Programme

Certain aspects of this Programme set it apart from other initiatives; some of its distinguishing features can be described as follows:

- Firmly whole family-focused addressing the needs of both adults and children, reflected in the results payment model
- Age range of children that is linked directly to results is four (Year 1 at school) to 17 years
- Participation by families and individuals in the Programme is voluntary
- Focused on moving families towards economic independence through addressing the issues that impact family members' ability and aspirations to work and engage in learning
- The number of potential stakeholders involved and the reach of influence required by the Programme to make a difference is wide and crosses children's and adults' services; therefore a broad range of agencies and services contribute to achievement of results
- The scope of family level data collection, collation and reporting is both broad and very detailed, and includes Department for Work and Pensions data
- Very prescriptive payment by results model set by DCLG, which means income levels for each year of the Programme are different, which affects delivery design.

Section 2: Programme activities (2012-2013)

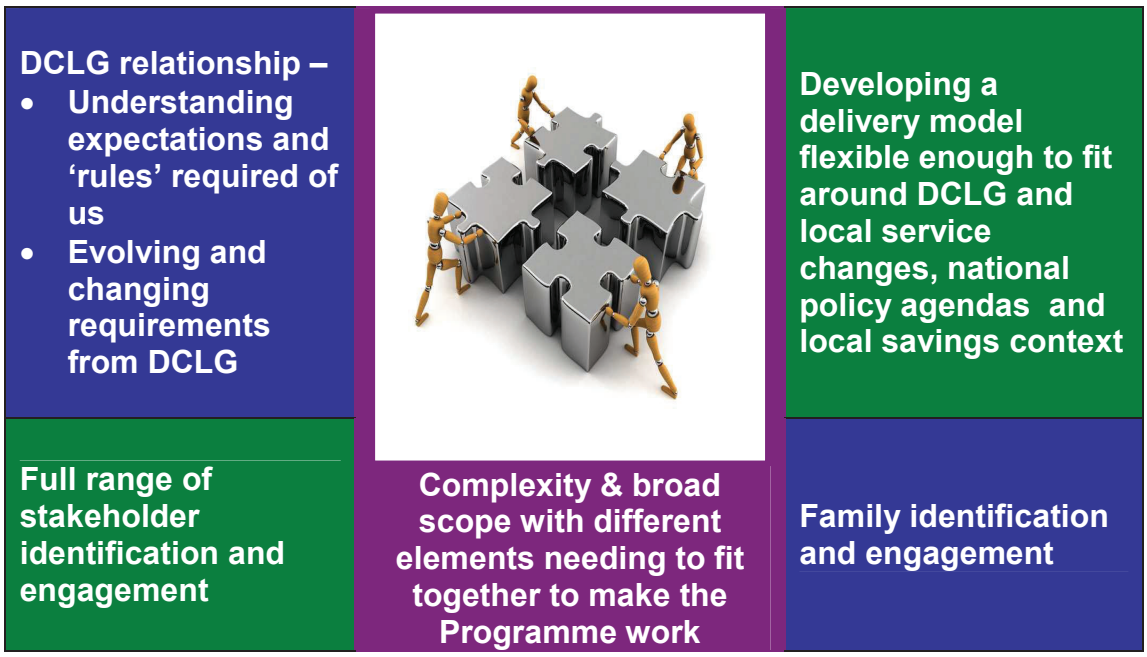
This section details Programme activities undertaken in Year 1 and associated timelines.

2.1 Programme scope

The Programme has a number of features, shown in Figure 2, which affected our approach to:

- meeting the implementation pace required by DCLG
- the local need for flexibility in the context of changing local services, and
- local financial risk management associated with the Payment by Results model.

Figure 2: Key elements of the Programme affecting pace and change



These features have inter-dependencies. For example, during the year the DCLG refined the results claims criteria and this had an impact on family identification and engagement. Furthermore, the payment rules for attachment fees also changed towards the end of the 2012-13 financial year to affect potential income in 2013-14. This in turn will have an effect on service delivery.

2.2 Commissioning

The following principles informed development and commissioning activity. These were:

- Build on the strengthening families approach used in children's services that recognises all families have assets and strengths with which to build resilience, self-reliance and a healthy and happy family life
- Enhance and add value to the wide range of work the Council and partners deliver currently to families targeted by this Programme
- Create a mix of provision in terms of delivery partners including third sector and community providers, and a variety of provision. Provision mix refers to a balance of:
    - Existing interventions that have evidence of success

- Development of evidence-based programmes locally, initially through a pilot approach

- Innovation through supporting creative initiatives that are underpinned by a sound theoretical base

Whilst work is focused on high need families we also supported activity in recognition that families are members of different communities (both place and people) and that to achieve sustainable change we need to attend to these wider dimensions of family life. Figure 3 helps illustrate this approach.

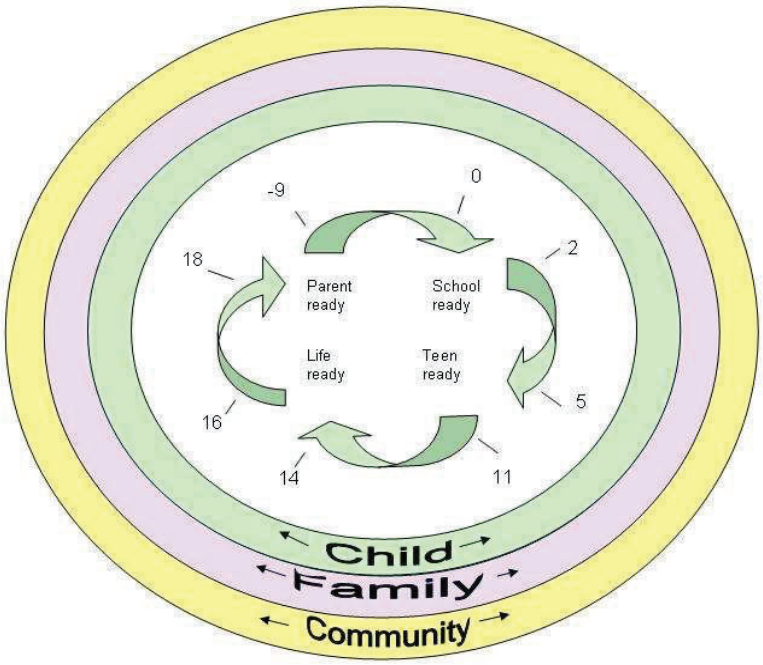


Figure 3: Different dimensions of family work

The commissioning plan included both internal services and external provision. Early consultation with key services, national research evidence, local intelligence and feedback from a parent consultation on early intervention undertaken in the spring of 2012 informed the commissioning plan, which has the following key elements:

- Grant funding to develop a range of new or adapted provision
- Extension of our intensive family support (Family Intervention Project or FIP) focusing on children on the edge of being permanently excluded from or disengaging fully from school
- Development of workforce and activity, for example for substance misusing families – a group who the FIP had consistently found it difficult to 'turn'.
- Topping up existing internal provision – e.g. YOT literacy and numeracy mentoring
- Support for community provision

Each strand of activity in the commissioning plan is described and evaluated in Section 3: Family analysis[3]. Different activities were undertaken in year to support wider change and these are discussed also in Section 4: Outputs and Outcomes.

2.3 Access routes for families to TFP provision

The referral and assessment process agreed for start the of April 2013 is shown in Figure 4 and Figure 5.

Figure 4

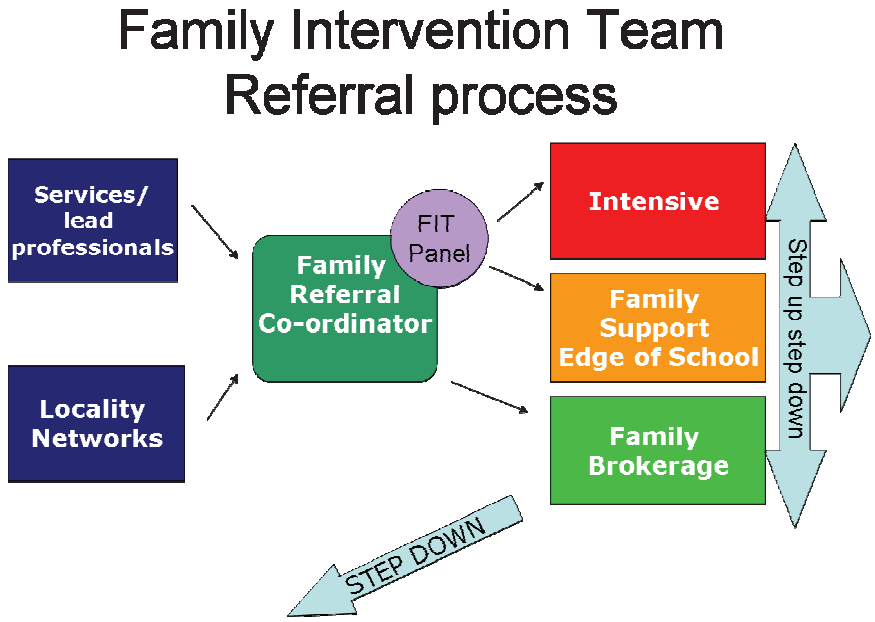
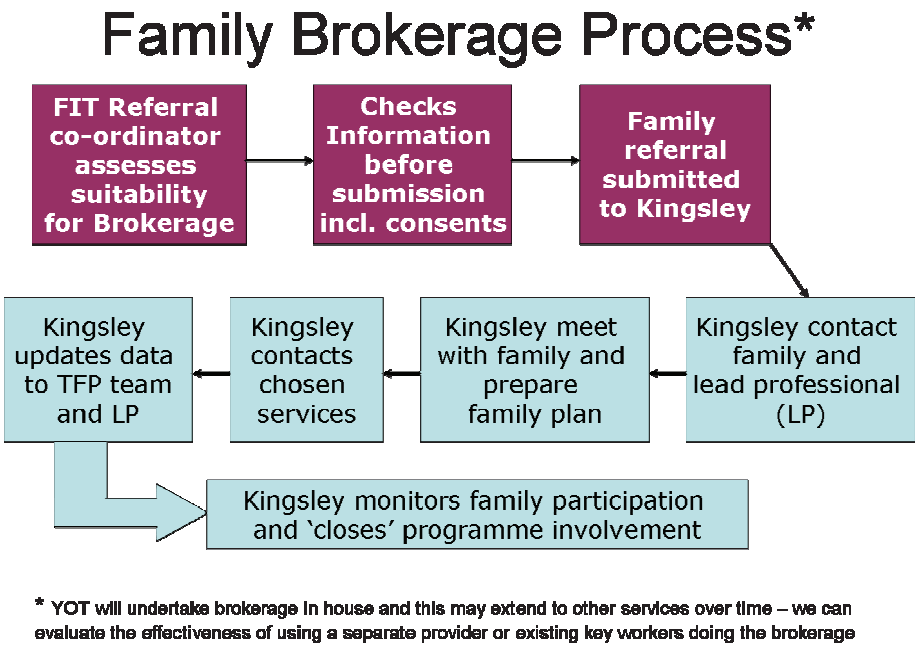


Figure 5



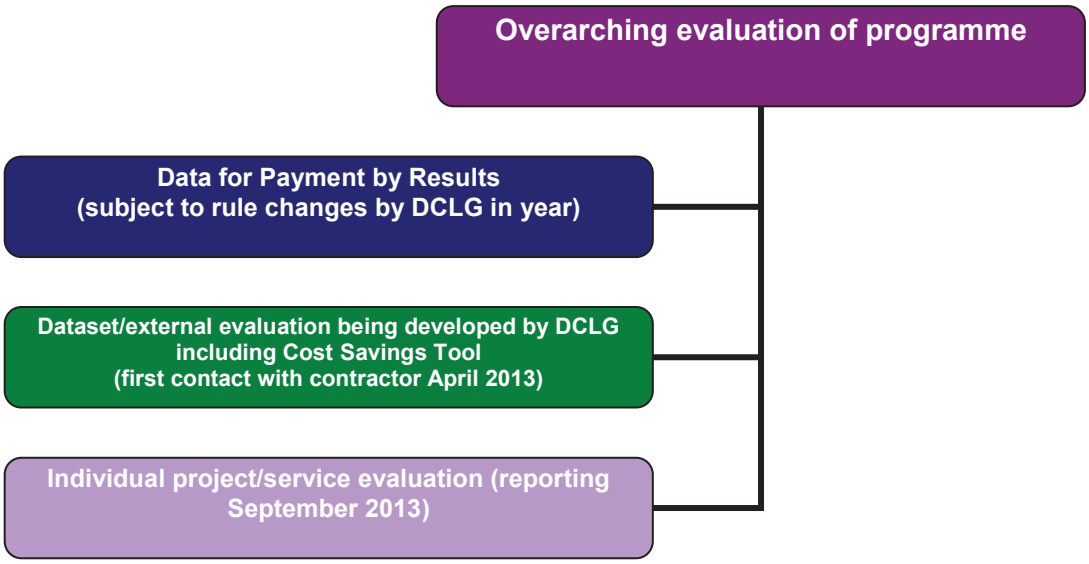
* YOT will undertake brokerage in house and this may extend to other services over time – we can evaluate the effectiveness of using a separate provider or existing key workers doing the brokerage

[3] Read the full commissioning plan online on the following webpage: http://www.westberks.gov.uk/turnaroundfamilies

2.4 Monitoring and evaluation activity

An overarching framework was designed for the Programme, shown in Figure 6.

Figure 6: Representation of monitoring and evaluation activity strands



Based on the requirements set out by DCLG, the following types of data are being collected on those families involved in the Turnaround Families Programme in West Berkshire:[4]

1. Number of fixed exclusions per child per family, including dates when exclusions occurred (to satisfy requirement 1).
2. Number and duration of unauthorised absences per child per family, including dates when the absences occurred (to satisfy requirement 1).
3. Occurrences of anti-social behaviour per family, including dates of when this occurred (to satisfy requirement 2).
4. Offences committed per child per family, including dates of when those offences were committed (to satisfy requirement 3).
5. Adults who have volunteered for the Work Programme, and dates of when this occurred (to satisfy requirement 4.a).
6. Adults who have been attached to the European Social Fund/DWP families Programme (locally called Progress!) and dates of when this occurred (to satisfy requirement 4.a).
7. Adults who are receiving out-of-work benefits with dates of receipt (to check satisfaction of requirement 4.b)
8. Adults who have entered continuous employment, with dates of when the employment started and (if applicable) ended (to satisfy requirement 4.b)
9. Feedback from professionals who worked with families on the Programme

At the time of writing this report the DCLG had indicated that a broader set of indicators would need to be monitored for 10% of Programme participants as part of the national evaluation and these will be explored further in Year 2. In addition a broader process, economic and impact evaluation will be part of the national evaluation and we will need to understand the implications for us in Year 2.

All organisations funded through the Turnaround Families Programme are required to produce quarterly reports and routine data generated by services will feed into our interventions evaluation. Data may include baseline, ongoing and closing qualitative

[4] A detailed breakdown of these requirements can be found in DCLG's 'Financial Framework for the Troubled Families Programme's payment-by-results scheme for local authorities (March 2012).

and quantitative assessments from families of used as part of the Programme delivery.

Reference group members were surveyed on their views on the early impact of the programme and in Year 2 a wider and deeper stakeholder feedback process, particularly with families, will be undertaken.

The DCLG also requires our activities to be subject to internal audit and audit activity is planned for 2013, with a focus on the processes associated with results submission to DCLG.

We were not able to implement all the elements, for example cost benefit analysis due to the delays in DCLG being clear about the national requirements for monitoring and evaluation. We need to align our work with this in order to avoid establishing twin track approaches. The national evaluation, which requires data to be supplied by all local authorities, got underway in April 2013.

2.5 Communications

Due to the scope of the Programme, communications were identified as a vital component of project implementation. The appointment of a Communications apprentice supported communications activities within the Programme. These include:

- Developing a recognisable name and 'brand' for the Programme
- Production of quarterly bulletins updating on Programme progress (called Turn Bulletins – each edition indicating progress in degrees)
- Production of short videos and audio clips by service providers, young people and parents – to provide a more user-friendly way of describing programme activities to families, supported by a You tube channel for the Programme
- Attending meetings and groups to inform people about the Programme in West Berkshire
- Producing an image gallery with photographs relevant to the Programme
- Developing web pages with information on the Programme
- Providing annual reports and presenting these within the Council and to key local groups.

Section 3: Family analysis

3.1 Initial Data Collation Exercise

One of the requirements at the beginning of the Programme in March 2012 was to conduct a data collation exercise which involved identifying which families meet the national Troubled Families criteria. This was done to inform local development of the Programme and to enable the DCLG to better understand how well its target numbers for local authorities are aligned with local levels of need. Data was derived from a variety of sources, including:

- Youth Offending Team system
- Education Management system
- Thames Valley Police system
- Sovereign database
- Department for Work and Pensions
- RAISE children's information system.

Table 1 provides a breakdown of children by school who met either the absence or exclusion criteria (n=384) before the criteria were cross-referenced with the other criteria. 84 individuals met the youth offending or anti-social behaviour criteria.

Table 1: Children per school based on initial data collation exercise.

Schools with fewer than 5 children meeting criteria	Schools with 10-20 children	Schools with more than 30 children
Aldermaston C.E. Primary School Beedon C.E. (Controlled) Primary School Bucklebury C.E. Primary School Burghfield St Mary's C.E. Primary School Falkland Primary School Fir Tree Primary School and Nursery Garland Junior School Hermitage Primary School John Rankin Junior School Mortimer St Mary's C.E. Junior School Parsons Down Junior School Speenhamland Primary School Spurcroft Primary School St Finian's Catholic Primary School St John the Evangelist C.E. Nursery and Infant School Sulhamstead and Ufton Nervet School The Willows Primary School The Winchcombe School Theale C.E. Primary School Westwood Farm Infant School Whitelands Park Primary School Brookfields Special School The Castle School Alternative Curriculum 14-19	John O'Gaunt Community Technology College Kennet School St Bartholomew's School Trinity School The Downs School	Denefield School Little Heath School Park House School The Willink School Theale Green Community School Reintegration Service Pupil Referral Units

When matched with unemployment related information from the Department from Work and Pensions it was found that **119 households with 141 children** met the full Troubled Families criteria (see Appendix 2:).

With such an emphasis on working with family level data the information sharing issues associated with the Programme have been very challenging and advice and guidance from DCLG has not been clear. This has had an impact of Programme delivery pace.

One outcome as reported in Section 4: was a refresh of the local multi-agency information sharing protocol.

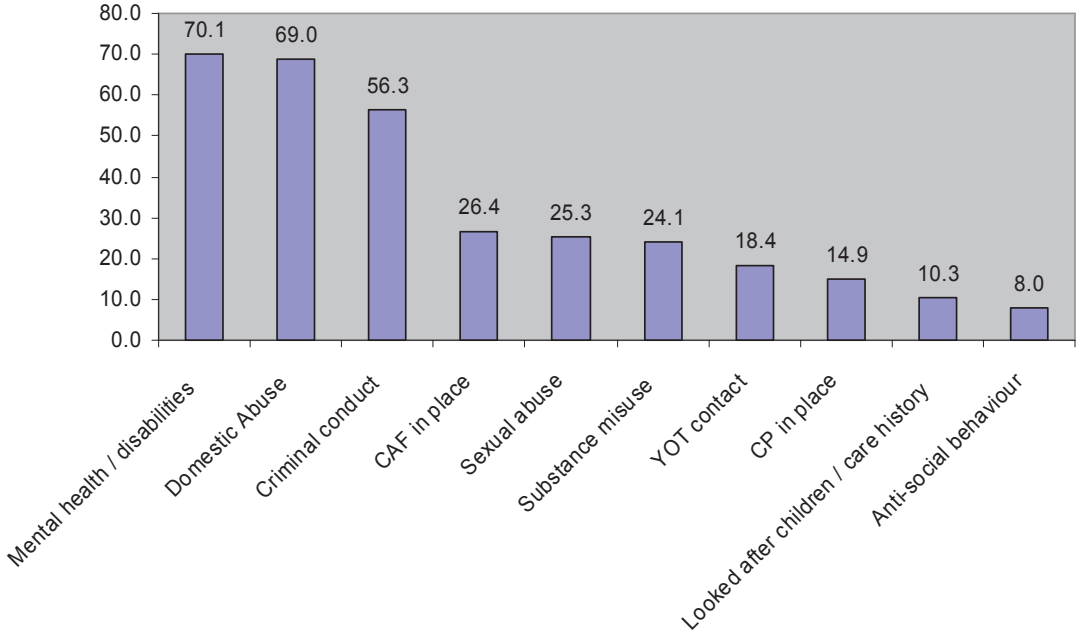
3.2 RAISE analysis of family information from initial data collation

Following the initial data collation, an in-depth analysis of the 87 cases in the family sample was conducted using West Berkshire's children's information system 'RAISE'.

Key findings

Mental health and disabilities is the most prevalent characteristic found amongst the families, effecting over 70%, (see Figure 7).

Figure 7: Family characteristics from RAISE review



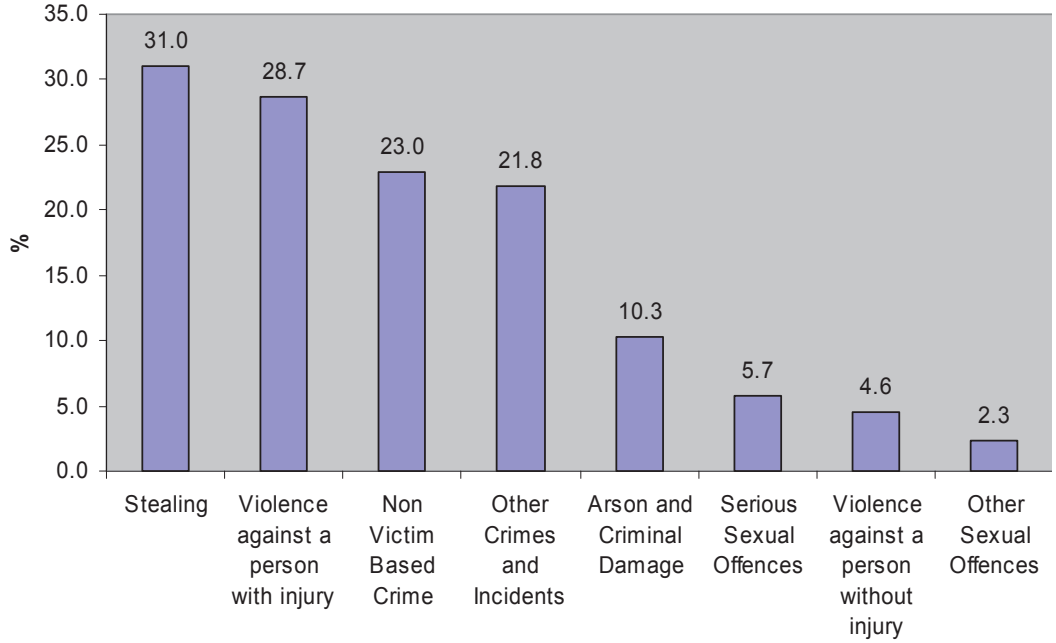
86% of the families had been involved with Children and Adolescent Mental Health Services. 18% had had contact with the Youth Offending Team.

High proportions of the families had experienced domestic abuse (69%) or are involved in some kind of criminal activity at 56% (see Figure 7).

38% of the families have a history of domestic abuse 23% of families involving a male perpetrator and 6% female. For 29% of the families, domestic abuse tends to be perpetrated by one or both parents, whereas for 14%, the perpetrators are the children.

The most common forms of criminal activity found amongst families are shown in Figure 8.

Figure 8: Criminal activity found amongst families from RAISE review based on ONS categories



Additional issues of note include experience of sexual abuse (25%) and those involved in substance misuse including alcohol, (24%) (see Figure 7).

A majority of individuals in the families had received multi-agency support (48%) but these individuals only came from 16% of the families. 31% were separated or lone parent families, with children living with their mother.

In 26% of families there was a CAF in place. We wanted to understand if families had a history of recurring social care involvement. Whilst the coding process was rather subjective, broadly it appears that approximately half had recurring and complex problems, whilst slightly fewer were first time entrants to the system due to a specific incident or set of needs. This helps us to understand whether families fit the idea of inter-generational problems promoted through the national Programme.

In terms of the services used by individuals in the families, the top 15 are shown in Table 2. These are all public sector services except Sovereign Housing.

Table 2: Top 15 services used by individual members of families (not mutually exclusive)[5]

Services received	No. Individuals
Education	124
Family Resource Service	78
Children and Adolescent Mental Health Services	70
Family Intervention Partnership	53
Education Welfare Service	48
Housing	44
Police	40
Health Visitor	37
Early Intervention Service	34
Sovereign Housing	33
Youth Offending Team	32
Family Group Conferencing	24
Young Carers	10

[5] A full version of this analysis will be available on the Turnaround Families webpages.

Findings from the RAISE analysis

The analysis shows that within the sample presenting two or more of the national Troubled Families criteria there was **a strong association at local level with the family risk factors identified by the DCLG** in its initial and later research[6], with mental health, domestic abuse and criminal activity being the most prevalent. So applying the local criteria *will* reach families with multiple needs.

The review attempted to capture a picture of whether families met the profile of 'Troubled Family' characterised by DCLG as being part of an inter-generational, workless culture. A report by Joseph Rowntree Foundation on this topic, published in December 2012[7], found that *'cultures of worklessness' was not a good explanation for unemployment* and that the **evidence did not support inter-generational transmission of a non-working culture as being a common reality.**

Almost half of the families in the analysis appear to be first time users of children's social care, suggesting there is a **gap between high need families accessing social care on a repeat basis and those for who an incident triggers involvement** that may not lead to recurring involvement. This supports our approach to offering different levels of intervention within the Programme.

For first time entrants to social care, robust, needs-led intervention may divert them from further involvement. However, it may also **support the case for sustaining and working more closely with early help services**. Mention of use of community, universal and early help provision was limited in the case samples.

In turn this suggests the **need for professionals to have access to good, current information** on such services, which supports the decision to produce a service map as one of the first activities undertaken through the Turnaround Families Programme.

The review also supports the **need for wide inter-agency involvement in the Programme to address education, employment and training activity** and engagement by families who meet the criteria locally. It also shows why it may be difficult to achieve the required results. A report by DWP (2008:18[8]) states that *those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).*

With conditions such as depression, ASD, ADHD and anxiety being most prevalent, it may be appropriate to explore with local mental health services the sufficiency and effectiveness of current provision.

The findings appear to **support the decision to align and extend provision within the Family Intervention Team** (formerly the Family Intervention Project) to provide more resource for intensive, whole-family, multi-agency interventions. Involving mental health services more centrally in joint working with existing partners within the Programme appears to be crucial. The evidence from local YOT delivery backs up the **benefits of greater integration of mental health specialism in case work.** Domestic abuse, adult offending and substance misuse are other key service areas requiring engagement in the Programme based on the results of this review.

[6] Specifically, Louise Casey's report to the Department for Communities and Local Government, 'Listening to Troubled Families', July 2012.
[7] Shildrick, T et al (2012) *Are cultures of worklessness passed down through the generations,* JRF
[8] DWP (2008) *Mental Health and Work report – welfare reform impact assessments*

Section 4: Outputs and Outcomes

This section examines some of the early findings resulting from the work of the Turnaround Families Programme in West Berkshire based on the different types of activities in the commissioning plan.

4.1 Delivery volumes

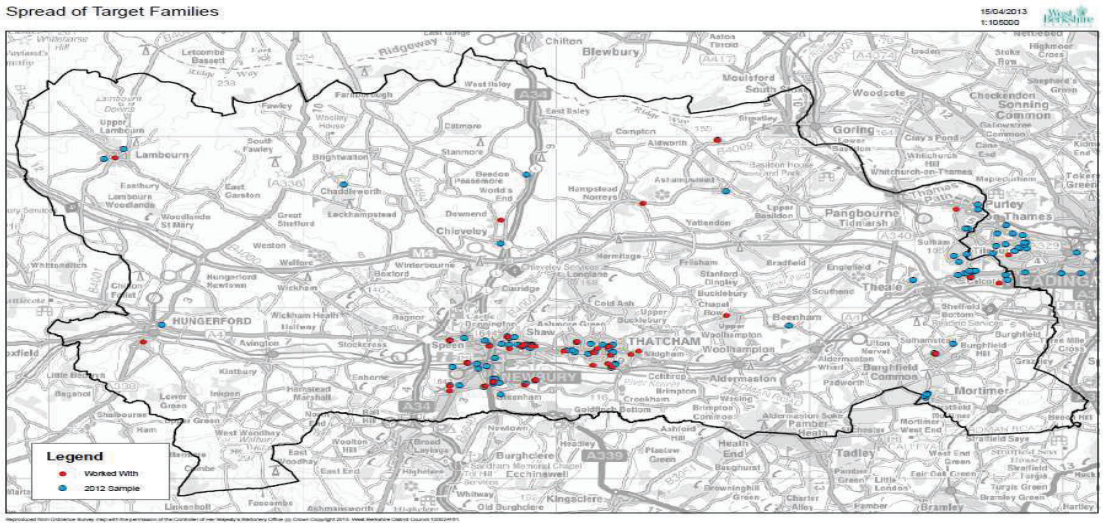
We aimed to work with 50 families in Year 1 and had started work with 42 (84%) by late March 2013 when we submitted monitoring information to DCLG. This ensures our eligibility for 100% attachment fees in Year 2. Data in Table 3 is for mid April 2013.

Table 3

<table>
<tr><th>Numbers[9]</th><th>Characteristics</th><th>Targeting effectiveness</th></tr>
<tr><td>46 families</td><td>Large majority reside in areas of high socio-economic deprivation (see map in Figure 10)</td><td>All families met at least two TFP criteria – this needs to rise to 3 in 13-14. Referral sources are appropriate but need to extend in 2013-14, including to relevant adult services and children's social care.
<table>
<tr><th>Referral Source</th><th>No.</th></tr>
<tr><td>PRU (Bridgeway)</td><td>12</td></tr>
<tr><td>PRU (Badgers Hill)</td><td>10</td></tr>
<tr><td>Riverside Community Centre (for Lions Quest)</td><td>9</td></tr>
<tr><td>PRU (The Porch)</td><td>8</td></tr>
<tr><td>Early Intervention Team</td><td>7</td></tr>
<tr><td>Family Resource Service</td><td>4</td></tr>
<tr><td>Domestic Abuse Referral Team</td><td>3</td></tr>
<tr><td>Turning Point</td><td>3</td></tr>
<tr><td>Family Intervention Project</td><td>2</td></tr>
<tr><td>John O'Gaunt School</td><td>1</td></tr>
<tr><td>Youth Offending Team</td><td>1</td></tr>
</table></td></tr>
<tr><td>62 individuals</td><td>49 children and young people
13 adult family members.
23 girls and 26 boys
Age range 9 to 70 years old</td><td>15 individuals from the original cohort of families identified through the initial data collation exercise undertaken.
46 = from families who meet unemployment criteria
29 = offending or ASB criteria
46 = school absence or exclusion related criteria</td></tr>
</table>

[9] The figures in this section are based on data available as at 16th April 2013.

Figure9



4.2 Projects extending or adding value to existing good practice

Intensive Family Support Work – Children on the Edge of Education

Description	Extending intensive family support to families in which at least one child is at risk of permanent exclusion or disengagement.
Target activity	• Work to begin in September 2012 • Work with 15 families per year • Minimum contact of three times per week for up to six months
Outputs	• First casual worker started in December 2012. • Casual co-ordinator started in February 2013. This post is now being advertised as full-time. • Work has begun with three families
Case Study 1[10] Jo is a mother of two teenagers who refuse to go to school. She wants to return to work but feels she can't until the children are sorted. The family support worker is providing practical support to get the children to school, linking with other education services whilst also provide information, support and strategies for the mother to set and maintain rules, routines and boundaries. She will focus on the employment issues when the school situation is stabilised.	
Case Study 2 Annie and Chris are parents of Laura and Mia, both under 8. Chris has substance misuse issues and lost his job towards the end of last year and Annie has mental health issues. Both children are in primary school and their attendance is improving but has been very poor. Annie finds it difficult to manage the home and the worker helps with independent living skills. The worker is also helping the family access the correct services and the children to attend school. Parenting support and help with finances and benefits issues is being sought. The parents will be referred to the mindfulness course that will be running at the Children's Centre and the aim will be to focus on steps to employment when the current issues have been tackled.	

Youth Offending Team's Education Support Service (annual report September)

Description	Individual mentoring for young people involved with the YOT.
Target activity	• To begin work in April 2013. • Have a minimum contact with young people of once per week based on individual need. • Number of target participants based on service needs.

[10] All names are fictional and case studies adapted to ensure anonymity is maintained

Outputs	• Extension of hours of existing YOT worker. • Worked with two young people.

Feedback about one young person's progress:

Willink School - "Rachel has consistently supported Pete through his final year at the Willink. I believe we would have lost Pete's commitment to education had Rachel's support not been there."

Pete's Mother - "I wanted to write to you regarding the mentoring my son received from the YOT. The help and support he received from both Rachel Caine and Hilary Hutchins was fantastic, both were very supportive and regularly kept me informed of my son's progress. I have seen a massive change in my son, his attitude has changed and he is now a much better person than he was before the mentoring started. Rachel worked closely with Pete at school and helped him prepare for his GSCEs. Even when the order had finished both continued to help my son. I am so grateful and appreciate everything they have both done for Pete and he feels the same."

Other feedback:

"Rachel has provided Jenny with superb support which has had a direct impact on the excellent progress Jenny has made. Rachel's work with Jenny has really supported and complemented the work of the teaching staff."

- Lead teacher at a PRU

Professionals on the Turnaround Families Management Group have spoken very positively of the YOT mentoring programme and are currently discussing extensions to this support.

4.3 Projects supporting new evidence-based activities

Parenting and family support for families with substance misuse issues

Description	Development and delivery of evidence-based programmes for families with substance misuse issues, with staff development enhanced by an action learning set.
Target activity	To deliver at least one Baby Incredible Years and one M-Pact Programme
Outputs	• In January 2013, Baby Incredible Years began targeted work with 4 substance misusing parents at North Thatcham. Children's Centre and working with Turning Point. 2 families completed the Programme. • M-PACT train the trainer courses have been delivered to 2 people. • M-PACT has begun to work with 4 families. • Action Learning Set has been delivered to 8 staff.

Parent Feedback for Baby Incredible Years – what worked:

- It hasn't been about drug issues
- The Children's Centre has been a good place.
- Partners were welcome and we were able to talk to them about what we were doing as they understood
- Information about brain development was interesting, the attachment and how brains develop differently in boys and girls. Small bits of information such on the babies' development were useful and The safety quiz
- It needs to have a Turning Point Worker who was qualified to recognise

whether someone was fit to attend – the worker should know the person as everyone presents differently

Parents' suggestions for improvement include:

- There weren't enough people, a bigger group of about 10 would be better
- Other people from other walks of life should be allowed to attend with varied experiences – not necessarily families just from Turning Point
- The Turning Point worker changed and it was assumed that the parents knew them but we didn't
- There should be honesty about why the Turning Point worker is involved
- Some of the content was too basic

Parents gave the following feedback in relation to early M-PACT sessions they attended:

"I enjoy my groups very much. I have got a lot from the group in how to deal with my alcoholism and control situations that may occur and deal with things that have happened"

"I think that these groups are good because it has given me a chance to talk things out with people if I am upset, and the activities make you look in deep at what it's about"

"I find our group very welcoming and friendly. It's very helpful and useful to know people are there for support for me and my daughter, and our communication is getting so much better".

Feedback in relation to the Action Learning Set identified the following issues:

- For specialist programmes with narrow age ranges it can be hard to reach required number of referrals
- Staff turnover is unhelpful (Turning Point)
- Managing different working cultures in children's' centres, family support with Turning Point was a challenge – the former being very structured and directive

And solutions:

- Clear links to wider referral process is needed
- Build relationships with referrers and find a way around issues with health visitors' emails
- Felt that critical to the project had been facilitators with experience with substance misuse problems emphasising the importance of MPACT working with local providers.
- Joint working led to greater awareness and accommodation of different professional and agency styles
- Ensure good written and verbal communication – the group adapted the M-Pact leaflet and this may now been adopted nationally

4.4 Evidence-informed local innovation

Adventure Family Training (residential [RAFT] and local [LAFT])

Activity	
Targets	• To deliver one first RAFT in August 2012 • Have 2 RAFTs and 3 LAFTs per annum • Work with 12 families altogether, 4 with RAFT and 6 with

	LAFT
Outputs	One RAFT was delivered in summer 2012 with 3 families. Could not identify a therapist to support the further development of the programme at that time though links were made with Wilderness Adventure in Essex - Adventure Dolphin staff visit now planned in May. Second RAFT in planning.

Case Study 1

In August 2012 a pilot Residential Adventure Family Training (RAFT) experience in Wales was provided for 3 families. This was run by Adventure Dolphin and the Family Resource Centre as a pilot for the development of a local and residential family-based adventure therapy programme. The lessons learned will contribute to design of the new programme, which will also use specialist expertise on adventure therapy programmes. For one mother who attended the benefits were clear:

One mother said of her experience *Absolutely brilliant, my child has now seen me in a different light and recognises we have some thing in common especially rock climbing. We had the opportunity to talk about feelings and memories which has made us closer. Our improved relationship has helped us to maintain boundaries and rules.*

4.5 Innovations Fund Projects

A grant call invited organisations to submit bids enhance or develop new activities targeted at families meeting the Turnaround Families Programme criteria. A number of creative projects were funded. These will not report until September 2013 but interim results are presented, for the period up to mid April 2013. The target numbers are up to September.

Start	Activity	Target Nos	Actual nos.
Jan	Berkshire Youth Berkshire Lions	10-12, Years 6 and 7	10 families

Case Study: Crafty Craft Race and involving the whole family

This is the first Lions Quest Programme to run in the UK. It is year-long structured programme and activities to engage and involve the whole family are part of it

We have entered the group in the Crafty Craft Race. At one session members were invited to bring their younger siblings and we used arts work to get them working together banners for them to wave on the day in support of the boat.

Parents were then invited to help build the craft and get involved with organisation, doing food and drinks for these sessions.

So using a community activity like this has been a great way to engage all family members and to show support for and interest in what the young people are doing.

Feedback from young people and parents via feedback forms.

The programme is at an early stage but early feedback from young people is positive *"Its fun", "like the snacks, "could be longer" "I like everything".*

Parents reported that they were positive about the Programme, though most felt it was too early to see any behaviour changes.

Activity	Body Rocks Course by Creativity in Sport
Targets	16 families / 40 individuals
Outputs	• 3 families / 5 individuals completed work • PRU group of 8

	• work with group of up to 12 girls and 6 boys and their families in Thatcham starting in May. • support for unemployed group in Calcot under discussion with Calcot project

Activity	Creative Mindfulness workshops, East-West Detox Using practical, art and meditation based techniques the courses give children and adults a range of practical helping techniques they can use to understand, manage and change their behaviours in social situations.
Targets	2 school groups per term
Outputs	3rd group underway (all PRUs), 4th in Planning at Hungerford primary School and another with a Children's Centre 17 children involved

Feedback from young people on Creative Mindfulness:

"I enjoy meditation with Mike because he's a really caring person. He understands and he brings candles and different oils to chill and relax us which makes us focus on ourselves and our problems. Mike is really helpful because he used to take drugs so he knows what it is like. He makes you realise that you only have one life so make it good. The fact drugs ruin all opportunities for you is not the way to go about things."

"I enjoy doing these lessons because I've been one of those people who have been on weed and suffered a massive consequence from doing so and it was the biggest mistake I ever made. …I want is a chance to talk to other people and tell them the horrible effects it has on them, because I've never had that chance before. I think it would be a good experience for me to be able to talk to people and help them. Also I really like to do drama and with the help of Mike I might be able to teach other people those skills and get their life back on track and find them a new hobby apart from drugs".

"I enjoy Mike's sessions because he is calm and relaxing and I'm thinking about his methods and practicing them. His lessons are interesting and different to any other lesson."

Case study: Badger's Hill PRU staff member on Mindfulness Course
Through sharing personal experience the facilitator, Mike, was quickly able to build a relationship with the group who engaged with the sessions.

The students were fully engaged in the discussions on Drug use and misuse, addiction and treatment. At the end of each session Mike demonstrated how meditation was very much part of the treatment and how it helped with allsorts of personality traits like anger and anxiety.

Mike's warm personality helped him to engage with the group. They showed him respect and always welcomed him. However sustaining the techniques shown by Mike was difficult for many of them.

Start	Activity	Target Nos	Actual nos.
Oct	Newbury Community Resource Centre	30 families / 40 individuals	13 families / 13 individuals

Case study: Bridgeway PRU on the Newbury Community Resource Centre
Chris attending the Community Resource Centre (CRC) has allowed him to have positive role modelling and an opportunity to achieve his potential to a very high standard. Students like him find education a very difficult environment and this can lead to long term negative attitudes towards learning, with the support from Joe at

CRC we have been able to discuss with Chris' future plans. The partnership working between CRC and Bridgeway has been the stable factor in his education and allowed him the opportunity to have a positive experience whilst in education.

Case study: Newbury Community Resource Centre

Jamie was initially unsure as to what he could offer as a volunteer but when he visited the project for the first time he was very drawn to the bicycle workshop. So far, Jamie has learnt new skills culminating in him building his own bicycle from scratch using re-cycled parts. Initially Jamie was uncertain due to lack of confidence however his confidence has developed enormously and he is seen as very much part of the team. Jamie's volunteer mentor said: 'Jamie has come on in leaps and bounds and if we were employing a trainee bicycle technician then Jamie would definitely be a worthy candidate'. Other users of the Slater Centre have commented to me on Jamie's politeness and helpfulness. Jamie said 'I think the project is amazing. I like meeting new people and getting on with other volunteers. I want to carry on as a volunteer as I am learning new skills too'.

Start	Activity	Target	Actual nos.
Jan 12	FRC UK Family Finance Roadshows	6 roadshows delivered by mid May	All 6 confirmed. (starting April 2013)
District wide roadshows: Calcot, Thatcham, Newbury Greenham, Newbury Clayhill, Lambourn and Hungerford. Brought together 9 organisations providing information, advice to families on benefits advice, savings, courses, etc. including Newbury College, CAB, Job centre Plus, Sovereign Housing, Credit Union, Family Information Service			
Feb 12	FRC UK Family Buddies Pilot	4 family matches by July	• 1 volunteer trained, and matched in April. • 2 more volunteers to be trained by mid May.

Start	Activity	Target Nos	Actual nos.
Oct 12	Adviza, Enhancing Chances	30	11

Case study: Enhancing Chances with Adviza[11]

Aidan had very low self esteem and motivation. He had a difficult home life, with both parents unemployed, and Aidan being a primary carer for one when not in school.

Aidan did not see progressing to college or further training and just wanted to "get a job or something". His timetable was around 4 hours per day in school, and he avoided being inside at home wherever possible due to the environment.

Through engaging with Enhancing Chances, Aidan was exposed to a series of experiences which drew out his strengths – he reflected on his work experience at a farm– one of the key things in his life which he felt fully engaged with and that he was making progress with. From this the Adviser was able to work with him and identify potential entry routes into post 16 education – and has now applied for Sparsholt College, with a backup plan in place with the Youth Contract and BIONIC support to engage him in agriculture and land based engineering – both of which will provide sustained training and satisfy the requirements of the Raising of Participation Age.

[11] Taken from the Enhancing Chances Mid-Year Report.

Having this safety net in place has given Aidan confidence in moving forwards and he is aware that he is not alone moving forwards and will be able to use this safety net – and the broader Adviza services – as they need it moving forwards into a post-16 environment. Additionally, the Adviser is working with Aidan to identify possible work experience placements in the future. Using the existing placement as a referee – and through using his own networking – we have been able to speak with a number of local farmers and agricultural contractors to nurture potential work placements to keep him engaged in positive activities on "non college days", to build up his skills and experiences, and to offer him potential routes into apprenticeships when he feels ready for full time employment.

With trust built with Aidan we can look at possibilities of exploring wider family issues.

Start	Activity	Target nos by end July	Actual nos.
April 13	Family Support Brokerage, Kingsley	Up to 30	1 (started April 2013)

4.6 Workforce development

Outputs

1. Funded Kwango online domestic abuse awareness programme which launched in January 2013; 105 had accessed this training as at April 2013.
2. Specialist work with substance misusing families using conferences; two families have accessed this support.
3. Two places were funded on an NVQ level 4 course for complex families; two families accessed this support.

4.7 Activities not delivered for which funding was allocated

Provision	Reason for non delivery
Family Group Conferences and Individual Systemic or Family Therapy	General demand across Children's Services for FGC reduced in 12-13 so no additional funding required. Unable to identify local therapists to support development of local adventure family training.
Adult and Family Learning	Discussions held but further funding not required in year. Plans agreed for 13-14.
Action research on poverty affecting children's attainment	Funding was allocated to a joint Educational Psychology & School Improvement Service Project. Lack of school interest was cited as the reason the project did not start.
Place-based initiative	Discussions were held with the Calcot Project about contributory funding but not agreement reached. Further discussions are underway to hopefully agree a contribution for 13-14. However locality based support has been funded for activities in Clay Hill area and the finance roadshows. Across the district

4.8 Feedback from Innovations Fund project providers.

Some of the aspects of projects which were described as effective included:

- Working intensively with participants.
- Working closely with other professionals to ensuring the attendance of participants.
- Spending time outside of activities engaging participants informally and building trust.

Some of the techniques used to overcome barriers included:

- Leveraging community connections to identify families.
- Being persistent with schools and participants in order to achieve engagement.
- Running activities for a longer period to allow more time or participants to accept support and engage.
- Using PRU staff to help enforce discipline.

4.9 Outcomes as results submitted to DCLG

In January 2013, the first set of results to the Department for Communities and Local Government's (DCLG) as part of the payment by results model for the Troubled Families Programme. West Berkshire submitted results for 3 families, who showed the following progress:

- All families showed reduced exclusions and improved attendance to above 85% in the last 3 school terms.
- In one family, all minors showed more than a 60% reduction in offending over the last 6 months.
- In one family, there was more than a 60% reduction in anti-social behaviour over the last 6 months.

Families receive support and intervention from a wide range of agencies and interventions and the results claims show what positive changes have happened within families but not *how* these have come about. At this stage it is very unlikely that Programme activities can make any claim to making a difference as the first results submitted in January 2013 relate to periods of twelve or 6 months, before the Programme started. TFP activities will always contribute to only a part of the services received by families so any results will always be based on the contributions of many services and individuals. However in addition to the DCLG results Programme interventions will hopefully contribute to a range of hard and soft outcomes for families.

The DCLG rules about claim periods have also changed so subsequent claims will again show what has changed, but not what has caused these changes.

This is why we are trying to generate data at intervention level so that we can at least determine what difference small-scale activity can make.

It also reminds us why a partnership approach is so vital for this Programme – for understanding and tackling issues in families that so many agencies play a part in addressing.

The Government estimates that the cost to the public purse of families it wants to target through the Troubled Families Programme to be approximately £9 billion a year. Most of this is estimated to be spent on reacting to problems rather than providing lasting results and changing lives. So understanding the potential cost savings arising from Programme results is important.

Whilst we await the cost savings tool that will be adopted for the National Evaluation, we have produced an exemplar cost avoidance sum based on the above results submitted to DCLG. Table 4 illustrates some of these potential savings.

Table 4: Illustration of potential costs avoided from results achieved with families[12]

Type of cost – examples related to results above	To who	How much	Indicative TFP cost avoidance on first results
Single Arrest	Police	1,930 x 1 minor	1,930
YOT order	YOT	1,102 x 1 minor	1,102
School absence	Society	3,753 pa x 3	11,259
Anti-social behaviour warning letter	Safer Communities Partnership	66 x 1 family	66
Police call out	Police	33 per hour x 2 hours	66
Eviction for anti-social behaviour (example of ASB)	Social Housing provider	6,500 for 1 property	6,500
		Total for one year	20,923

Table 5 looks at the progress of comparator and neighbouring authorities to West Berkshire in relation to the Troubled Families Programme. Of the 14 authorities, West Berkshire comes third in terms of percentage of families worked with for which results were achieved and fourth in terms of the number of families results were submitted for. We aimed to work with 51 families in the first year and actually provided provision to 46 families (90%).

As mentioned at the start of the report each authority can determine its own approach to working with families. Table 5 shows that the top two claimants are somewhat outliers in relation to all other authorities in the table, which must raise questions for DCLG about what is happening 'on the ground' and the extent to which any kind of national tracking can lead to comparative data presentation.

Table 5: Results submitted by comparator authorities in January 2013

Area	Total number of families	Number of families as identified as at Dec '12	Number of families worked with as at Dec '12	Number of families for which results achieved as at Jan '13	% of families worked with for which results achieved
Slough	330	172	99	80	81
Wiltshire	510	277	277	122	44
West Berkshire	145	119	35	3	9
Windsor & Maidenhead	140	140	38	2	5
Oxfordshire	810	516	262	9	3
Reading	345	341	59	0	0
Bracknell Forest	115	36	26	0	0
Wokingham	110	46	37	0	0
Hampshire	1590	489	236	0	0
Southampton	685	615	51	0	0
Surrey	1050	771	163	0	0
Portsmouth	555	175	51	0	0
Buckinghamshire	545	417	60	0	0
Hertfordshire	1350	1211	194	0	0

[12] These calculations were made using C4EO/DfE Family Cost Savings Calculator which is available at the following location: http://www.c4eo.org.uk/costeffectiveness/

In terms of meeting the matched funding criteria, West Berkshire contributed to this in year one by:

- Revenue funding into the Programme budget via a carry forward for 2012-13
- Extensive partner time in planning and servicing groups
- Collaborative delivery models with some interventions for example the M-Pact programme has involved staff from the Family Resource Service, the Edge and Turning Point as well as the Family Support Worker Edge of Care. Similarly the Baby Incredible Years has been delivered with Children's Centre and Turning Point staff with clinical supervision support from the Parenting Support Co-ordinator.
- The Family Finance Roadshows have involved Newbury College, Sovereign Housing, Job Centre Plus, Citizen's Advice Bureau and Newbury Credit Union
- Development of the Family Buddy scheme has involved members of the community giving them time voluntarily to be buddies.
- YOT mentoring support was given to the Programme without charge

We hope we can link contributions to amounts in 2013-14 with the aid of the national costing tool.

4.10 Impact

TFP provision should contribute to making a positive difference to the following high level outcomes prioritised by the Children and Young People's Partnership and these will be data areas we can track more closely from Year 2 now we have the RAISE information.

Children[13] grow up in families without experiencing domestic violence
Children living in low-income families attain and achieve in school to the same level as their better off peers
Children have good mental and emotional well-being

4.11 Systems change

In the final part of this section we report on specific early outcomes that may inform systems level change.

Opportunities

A main opportunity that was taken in relation to service adaptation was to use the Family Intervention Project in-house transfer to create a single team and referral pathway for the TFP. Due to the transition issues, this delayed full implementation of the referral route.

The savings agenda within the Council requires us to think differently about how we can improve services to families whilst also having to reduce some aspects of provision. This gave us the chance to link the change aims of the Programme to internal developments. In particular work related to early help for families and support pathways for children.

We have been able to use the development of a set of questions related to children in adult social care assessments to build in TFP criteria to support identification of families. This will be tested from May 2013.

[13] Children = from pre birth to 19 or 25 for those with a learning disability

During the year, closer working opportunities have arisen with Job Centre Plus, the Progress Programme (funded by Department for Work and Pensions and European Social Fund) and other adult-focused services including Turning Point and the Probation Services. These can be developed further in Year 2 to enable access to the Programme via both children's and adults' routes.

Identifying and sharing learning from the Programme is critical. Activities like the action learning set for those working with families with substance misuse and the family finance road shows has promoted and encouraged learning from inter-agency working. The latter were intended to bring agencies together working on the impact of benefit reforms to support joint working. Finding different ways to generate individual and organisation learning from the Programme is very important.

Some of the issues related to the information sharing challenges led to the decision to update the Multi-agency Information Sharing Protocol and discussions to produce a single Protocol relevant to both the Children and Young People's Partnership and Safer Communities Partnership. This has been done.

Creative space

To agitate systems thinking it was hoped that the Innovations Fund projects would bring a breath of 'fresh air' into a scenario where many services have been working a long time with families and invite us to consider new questions and to explore what might and does work with which families in which contexts.

The bids that were submitted enabled us to fund new and interesting projects including:

- Development of M-Pact Programme for families with substance misuse issues
- Delivery of the first Lions Quest Programme in the UK, a highly structured year-long community-based international programme. The stage we are funding is for young people at transition between primary and secondary school and is being delivered in the area of highest child poverty in the district.
- A Body Rocks Programme that integrates discussion, physical activity, motivational training, accredited training opportunities and a peer training model.

Stakeholder engagement

Having a core engaged and committed group of service managers helped considerably in taking the Programme forward and side-stepping some of the basic challenges of having a Programme that is called 'Troubled Families' and how to take it forward in a way that does not label families.

As shows from the service map produced below the criteria for the Programme required engagement with a very broad range of services and the need to find points to connect and to work together for mutual benefit. In year a piece of work was done to understand the 14-19 landscape as there seemed to be a number of national and local initiatives targeting the same NEET and at risk of NEET group. A workshop was run for the relevant agencies and prospectus type document was produced with information on these to share with professionals.

Figure 10: Turnaround Families Programme Service Map – many of these services cover more than one area

Implementation Group member views

A survey of Implementation Group members with regard to progress against the Programme ambitions elicited eight responses**.**

To turnaround service delivery to better meet the needs of local families with high needs, including through help at an 'earlier stage', respondents felt that this started through good relationships with key partners and existing services within West Berkshire. This also helped target the right families. Some of the barriers put forward include lack of clarity from Central Government, difficulties with obtaining information to identify families and the complexity of the Programme.

To turnaround the lives of 145 families who engage with the programme in a positive way, good partnership working and leadership helped towards this. Also local services helped engage target families whilst new services strengthened existing initiatives. Some of the barriers to achieving this ambition included lack of resource and capacity creating delays in programme start-up; issues with identifying families rather than individuals, the complexity of the programme, lack of clarity from Central Government and professional's lack of awareness about the Programme. Another barrier was key services, such as schools, not being involved to the level required in order to move ahead with the Programme.

One of the main factors that helped West Berkshire Council to offer both challenge (to do better) and support (to carry out a difficult task) to service providers and families was that many existing related services were already working well. Also the determination to make the Programme a success by those involved. Some of the suggested barriers to this ambition were lack of understanding of family education and learning needs and of the referral process. Also, lack of articulation about what

the Programme looked like in practice. Working through PRUs limited the Programme from working in a more family focussed manner, but also helped delivery to get up and running.

Delays in staff recruitment and decisions about where to 'host' Programme operations impacted negatively on service delivery to families, take up of Innovations Fund Projects and confidence in the Programme referral pathways by some potential referrers. A lot of work was done in the first part of the year talking to people about the Programme and engaging people and the delayed start meant momentum from this work was lost.

Section 5: Conclusions

The first year has seen mixed success, with direct family contact happening through a phased start up process. Some summary conclusions are presented next.

- **Using the Programme funding to support different types of provision** has brought funding opportunities for voluntary and third sector providers and enabled the development of new forms of support and intervention for families.

- **Indicative findings from different projects are positive** but in Year 2 more data on outcomes and impacts will be obtained, as well as family experiences. In terms of commissioning activity more attention needs to be given to a focus on early age, earlier stage help, particularly as the 'marketplace' of provision in the NEET 15-18 year old space is a relatively crowded one.

- **Taking the opportunity to integrate the Family Intervention Partnership team** with the Turnaround referral and intervention work to become a single Family Intervention Team appears to be a positive step. This has provided with a single referral entry point and a more streamlined and coherent offer to families and professionals. It also has resulted in three levels of intervention that align with the model favoured by DCLG.

- **Including a community focus** allows for local capacity building and helps to identify and grow local support for families. Further locality effort and coordination is needed to achieve this.

- **The contributions of a wide range of individuals and agencies** to the thinking and development of the Programme have ensured that the Programme gained momentum and a focus in the early days, though delivery delays offset some of these benefits.

- **The Programme has involved a heavy investment of partners' time** relative to the level of funding. It is important therefore that in Year 2 and thereafter we achieve a good return on this investment.

- **The combination of DCLG rules, which have changed over time, along with the Programme complexity** made understanding the Programme and communicating this to others a challenge.

- **Issues related to information sharing and data collation** for both national and local activity took a lot of time to understand and work through and remain complex.

- **The multi-stranded approach to Programme activity** makes it hard to see the whole picture of Programme delivery. Activity and reporting timelines for different projects mean that it will not be until the Year 2 report that this picture can be presented fully.

- **Holding the line on the referral criteria and fidelity** in relation to whole family work requires strong gate keeping and monitoring. The phased approach working through the Pupil Referral Units helped get services to young people but diluted action related to whole family economic activity.

Section 6: Priority actions for Year 2

The Implementation Group members who responded to the survey identified the following priority areas for action in Year 2 (n=8).

- Make best use of collective resources, including building on use of joint resources/knowledge to target the right families
- Increase family participation in Programme design and evaluation
- Establish the main referral and delivery route, and ensure it is
    - well promoted
    - simple
    - accessible
    - low on bureaucracy
    - co-ordinated with other relevant referral processes.
- Get a prompt, quick start to allow full year of impact
- Broaden understanding of Programme goals
- Start looking at ways in which other services can learn from the programme's work
- Closer monitoring of contact with families, looking at outcomes and impact
- Co-ordination of services and effort across a wide range of provision including services for adults such as Adult Social Care, Probation Service, Job Centre Plus and Work Programme providers and build community based networks and provision.
- Link to wider children's services pathways project.
- Greater involvement/awareness in schools – joining up with the Pupil Premium activity in schools
- Ensure learning from Programme feeds up and down
- Demonstrate front line delivery benefits.
- Undertake further needs analysis
- Assess impact and effectiveness of the various strands of the Programme
- Commission work based on learning from Year 1
- Make sure that everyone (internally and externally) is clear of their role
- Be prepared to challenge service providers for either not using the service or not adapting their practice around the programme principles and values
- Use the referral process and Family Intervention Team panel as a means of monitoring, challenging and supporting providers which will thus help them challenge and support families better.
- To set and monitor targets for referral levels from different service providers

These will be translated into action plans by the Management Group but will include the following:

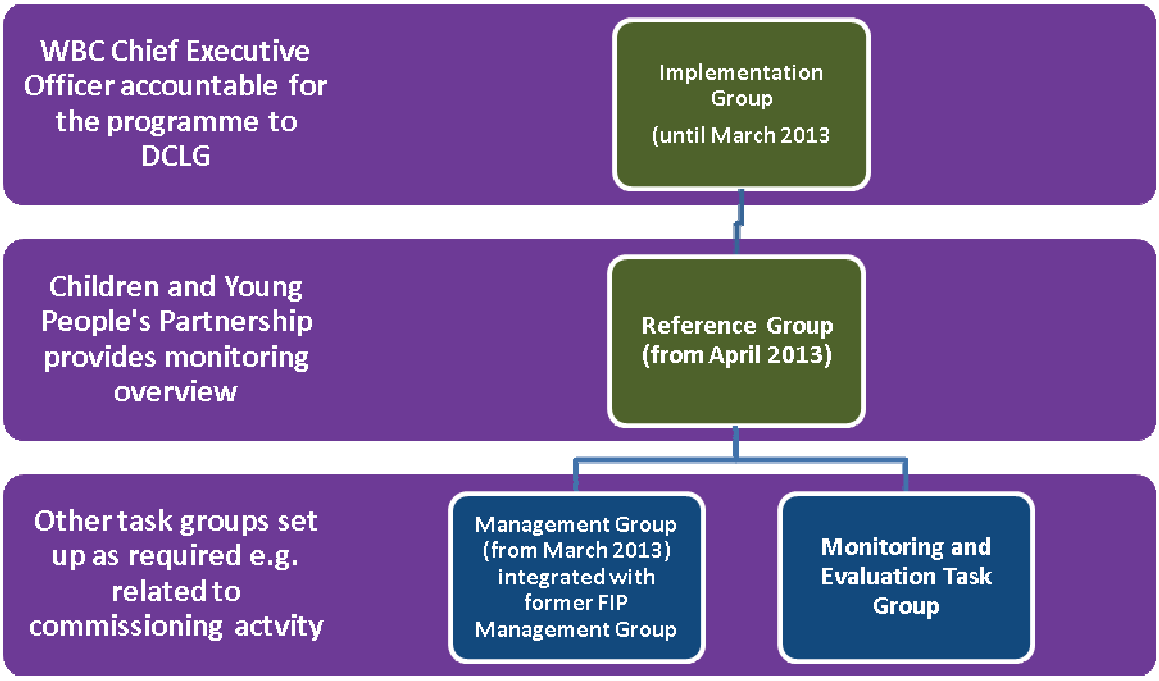
Next steps

Commissioning Plan to be agreed by Management Group when funding confirmed by DCLG	May 2013
Implementation of commissioning plan	May-July 2013
Promotion of referral pathway to relevant services and agencies	April-May 2013
Proactive work to generate referrals setting targets for YOT, Education Welfare Service, Children's Social Care and Adult Services	Mat 2012
Links with Job Centre Plus and other adult employment services to be clarified and agreed in writing and through operational activity	May 2013

Appendix 1:

Governance

Groups Membership



Reference Group Membership

Alex O'Connor	ASB Coordinator
Andrea Griffiths	Headteacher Hungerford Primary School
Angie Creed	Education Data Management Assessor
Angie Palmer	Team Leader, The Key
Cathy Burnham	Principal education Psychologist
Cathy Hunter	Family Intervention Team Lead
Davy Pearson	YOT Manager
Geoff Bush	Jobcentre Plus
Irene Neill	Portfolio Holder Children and Young People's Services
Jacquie Davies	Head of PRU
Janet Scott	Service Manager (Adult & Community)
Julia Waldman	Commissioning, Strategy and Partnerships Manager (CYP)
Mark Evans	Head of Children's Services
Natalie Upton	Leaning and Services Information Manager, Newbury College
Pamela Bale	Council Member for Pangbourne Ward and Deputy Leader of the Council
Robin Rickard	Local Police Area Commander
Satdeep Grewal	Development Officer, Turnaround Families Programme

Management Group Membership

Alex O'Connor	ASB Coordinator
Carolyn Waterhouse	FRS Manager
Cathy Hunter	FIP Manager
Davy Pearson	YOT Manager
Julia Waldman	Commissioning, Strategy & Partnerships Manager
Juliet Penley	Children's Service Manager

Karen Pottinger	Principal Education Welfare Officer
Rebecca Horne	Sovereign Housing
Satdeep Grewal	Development Officer, Turnaround Families Programme
Vacant	Family Referral Coordinator
Kazem Bholah	CAMHS Service Manager Newbury

Monitoring and Evaluation Task Group

Alison Roe	Research & Information Manager
Julia Waldman	Commissioning, Strategy and Partnerships Manager (Children and Young People)
Satdeep Grewal	Development Officer, Turnaround Families Programme
Angie Creed	Education Data Management Assessor
Alison Berry	Information Officer, Children's Services

Innovations Fund Assessment Group

Cathy Burnham	Principal Education Psychologist
Alex O'Connor	ASB Coordinator
Julia Waldman	Commissioning, Strategy and Partnerships Manager (CYP)
Irene Neill	Council Member for Aldermaston Ward
Andrea Griffiths	Headteacher, Hungerford Primary School

Appendix 2:

National Troubled families criterion and payment-by-results measures[14]

	National Troubled Families Criteria (more than one criterion may apply per person)
1	**Involvement in crime and anti-social behaviour (ASB)**
1a	Households with 1 or more under 18 year old with a proven offence in the last 12 months
1b	Households where 1 or more member has an ASBO, ASB injunction, anti□social behaviour contract (ABC), or where the family has been subject to a housing□related ASB intervention in the last 12 months (such as a notice of seeking possession on ASB grounds, a housing□related injunction, a demotion order, eviction from social housing on ASB grounds).
2	**Have children who have not in school (due to unauthorised absence or exclusion)**
2a	Has been subject to permanent exclusion
2b	Three or more fixed school exclusions across the last 3 consecutive terms
2c	Is in a Pupil Referral Unit or alternative provision because they have previously been excluded
2d	Not on a school roll
2e	A child has had 15% unauthorised absences or more from school across the last 3 consecutive terms
3a	**Households which also have an adult on DWP out of work benefits** (Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support and/or Jobseekers Allowance, Severe Disablement Allowance).

Result	Attachment fee	Results payment	Total
They achieve all 3 of the education and crime/ASB measures set out below where relevant: 1. Each child in the family has had fewer than 3 fixed exclusions and less than 15% of unauthorised absences in the last 3 school terms; **and** 2. A 60% reduction in anti-social behaviour across the family in the last 6 months; **and** 3. Offending rate by all minors in the family reduced by at least a 33% in the last 6 months.	£3,200 per family	£700 per family	£4,000 per family
If they do not enter work, but achieve the 'progress to work' (one adult in the family has either volunteered for the Work Programme or attached to the ESF provision in the last 6 months).		£100 per family	
OR			
At least one adult in the family has moved off out-of-work benefits into continuous employment in the last 6 months (and is not on the ESF Provision or Work Programme to avoid double-payment).	£3,200 per family	£800 per family	£4,000 per family

[14] Taken from DCLG's 'Financial Framework for the Troubled Families Programme's payment-by-results scheme for local authorities (March 2012), p.10.

Appendix 3:

Income modelling for Turnaround Families Programme in West Berkshire

2012-15 Income	Year 1	Year 2	Year 3	
Data collation carry forward (staff costs)	20000	0	0	
Co-ordinator fee (staff costs)	75000	75000	75000	
Attachment fee for year	160000	122400	32000	
Grant carry forward		58500		
Anticipated results payment based on 40% success rate*	0	16000	32640	
Total	255000	271900	139640	
Calculations				
Attachment fee as a percentage of £4000	80%	60%	40%	
No. of families engaged	50	51	20	**121**
Results payment as a percentage of £4000	0	20%	40%	
Minimum no. of families likely to achieve successful results for whom results payment will be received	0	20	21	**49**

*This level set to provide appropriate level of challenge whilst minimising financial risk to Council of not meeting results for all families

Appendix 4:

Glossary of Terms

Acronym	Definition
ADHD	Attention Deficit Hyperactivity Disorder
ASB	Anti-social Behaviour
ASBO	Anti-social Behaviour Order
ASD	Autistic Spectrum Disorder
CAF	Common Assessment Framework
CAMHS	Children and Adult Mental Heath Service
CRC	Community Resource Centre
CYP	Children and Young People
DCLG	Department of Communities and Local Government
DWP	Department for Work and Pensions
FGC	Family Group Conference
FIP	Family Intervention Partnership
FIT	Family Intervention Team
FRC UK	Family Resource Centre UK
FRS	Family Resource Service
LAFT	Local Adventure Family Training
M-PACT	Moving Parents and Children Together
NEET	Not in Employment, Education or Training
ONS	Office for National Statistics
PBR Model	Payment by Results model
PRU	Pupil Referral Unit
RAFT	Residential Adventure Family Training
RAISE	West Berkshire's children's information system
TFP	Turnaround Families Programme
YOT	Youth Offending Team

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Title of Report:	The NHS belongs to the people: A Call to Action
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26 September 2013

Purpose of Report:

To inform the Health and Well Being Board of the national Call To Action that will engage stakeholders in the design of a renewed and revitalised NHS. To advise the Board of its role in this process.

Recommended Action:

The Board is asked to:

- Note the challenges faced by the NHS.
- Consider the opportunities for addressing these challenges and the extent to which these are in line with current local strategy
- Agree how the Health and Well Being Board will fulfil their role in this process

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NHS England has published the attached Call to Action document to engage NHS staff, stakeholders, patients and the public about the future of the NHS in the light of challenges the service faces. It aims to:

- Build a common understanding of the need for change
- Provide the opportunity for people to describe how the values that underpin the NHS can be maintained
- Gather ideas and potential solutions that enable CCGs to develop 3-5 year commissioning plans
- Gather ideas and solutions to develop national plans, levers and incentives

Three options have already been ruled out:

- Do nothing
- Assume increased NHS funding
- Cut or charge for fundamental services or “privatise” the NHS.

The pressures the NHS faces are associated with the changing demand for services and the challenge of supplying services.

Key drivers of demand are the ageing population, the increase in people with Long Term Conditions and rising patient expectations. People understandably want to have more information and be more involved in decision making about their care. Increasingly they expect to access services 24/7 as close to home as possible. They also expect health and social care services to be well co-ordinated and tailored to their needs. This means that we need to rethink how services are provided.

The challenges of supplying services relates to the increasing cost of provision, limited financial resources and diminishing opportunities for productivity improvements.

The costs of provision are driven by the expansion of treatments and procedures now available to treat conditions that were previously undiagnosed or untreated. These new innovations cure disease and prolong life but are invariably more expensive than previous management.

Whilst the NHS has been protected in recent public sector spending reviews, it is expected its budget will remain flat in real terms for the next decade. In addition local government has faced much greater financial challenge which has impacted on spending on social care. The document suggests that reduced social care can drive up demand for health services and therefore we need to consider how health and social care spending is allocated in the round to provide integrated, cost effective services.

A number of strategies such as reducing length of stay in hospital, pay freezes, and national pricing mechanisms have delivered an annual 4% efficiency saving in recent years. However, there is a limit as to how much more can be achieved without damaging the quality or safety of patient care.

The document identifies some of the possible opportunities for meeting these challenges:

- A renewed emphasis on prevention with much closer working between public health, local authorities, Health and Well Being Boards and the NHS.
- Giving patients more control: self management, personalised care planning and shared decision making have been shown to produce better clinical outcomes, reduce hospital admissions, increase compliance with drug treatment and avoid over treatment
- Using technology: access to health records on line, getting test results, booking appointments, email consultations with doctors
- New models of care based on an understanding of an individual's risk.

Following the overarching Call to Action a supplementary document has been published which focuses on Improving General Practice. In addition to the challenges already identified, national data shows patients are concerned about access to GP services in hours and out of hours. There is an increasing workforce pressure with large number of GPs and practice nurses heading towards retirement, fewer doctors entering general practice and more part time workers. New views are merging about how general practice should develop to meet these challenges:

- Practices operating at greater scale through networks, federations or mergers
- BUT preserving relationship continuity that comes from individual practice units
- General practice at the heart of a wider system of integrated care outside hospital working with comm7unity health services, pharmacy, social care and the third sector
- Shifting resources from hospital care to out of hospital services

The four CCGs in Berkshire West have planned a workshop on 7th November for the 56 GP practices in the area to consider new models for the future and will report back to the Health and Well Being Board on emerging thinking

CCGs and Health and Well Being Boards have specific responsibilities in relation to this important engagement. CCGs will run local engagement events during the Autumn to inform the development of Commissioning Plans. People can also respond on line via the CCGs' websites.

The Health and Well Being Board should consider how it can support this engagement process with the local community; ensure that public health, CCG and local government plans are aligned and agree how the new integrated budget will contribute towards joint strategic plans.

Appendices

The NHS belongs to the people: A Call To Action

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NHS England

The NHS belongs to the people

A CALL TO ACTION

Index

Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

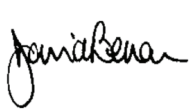
If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.



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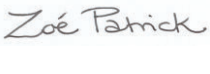

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The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.

"DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE."

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre
http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

> "Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

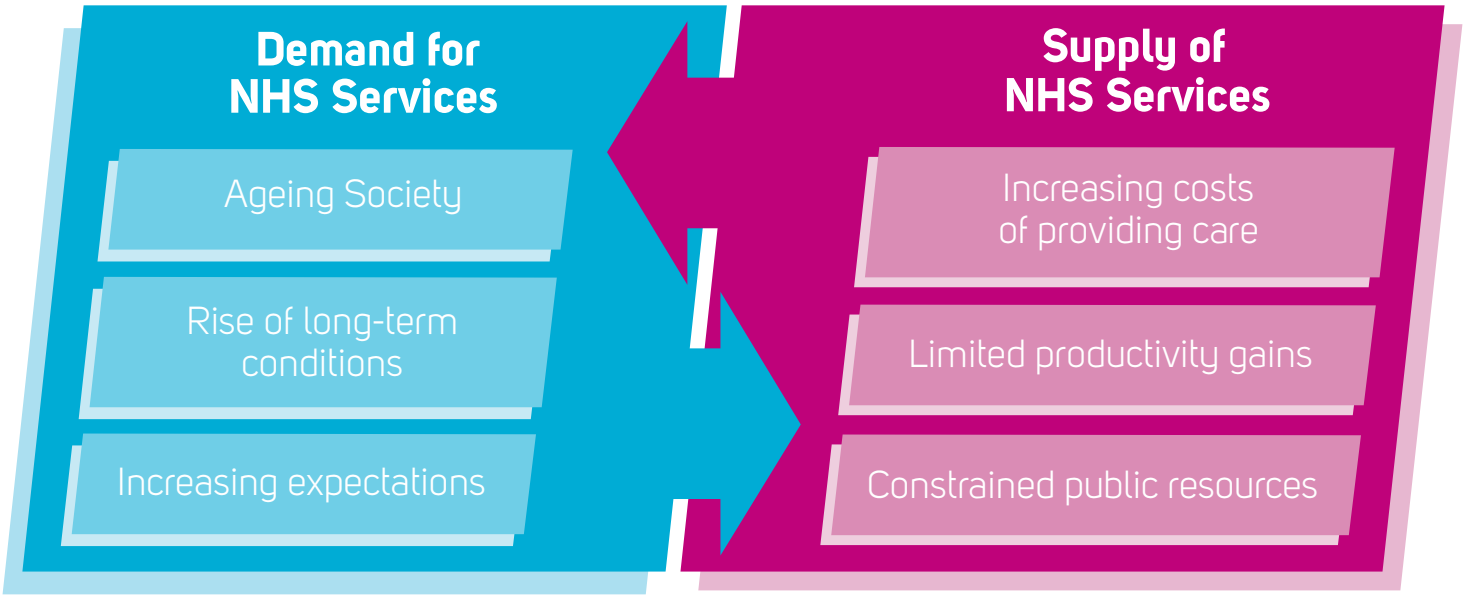
The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.
[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153
[13] The Marmot Review (2010), "Fair Society Healthy Lives"
[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]

> "STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

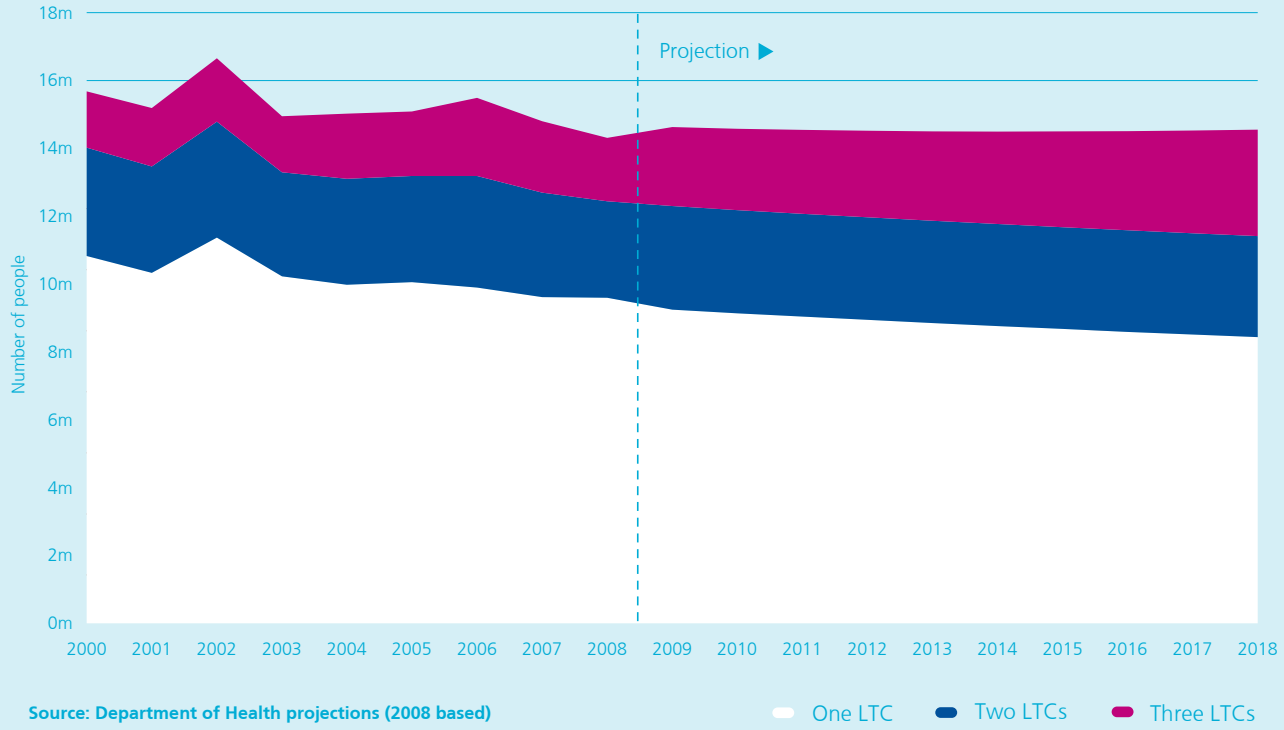
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

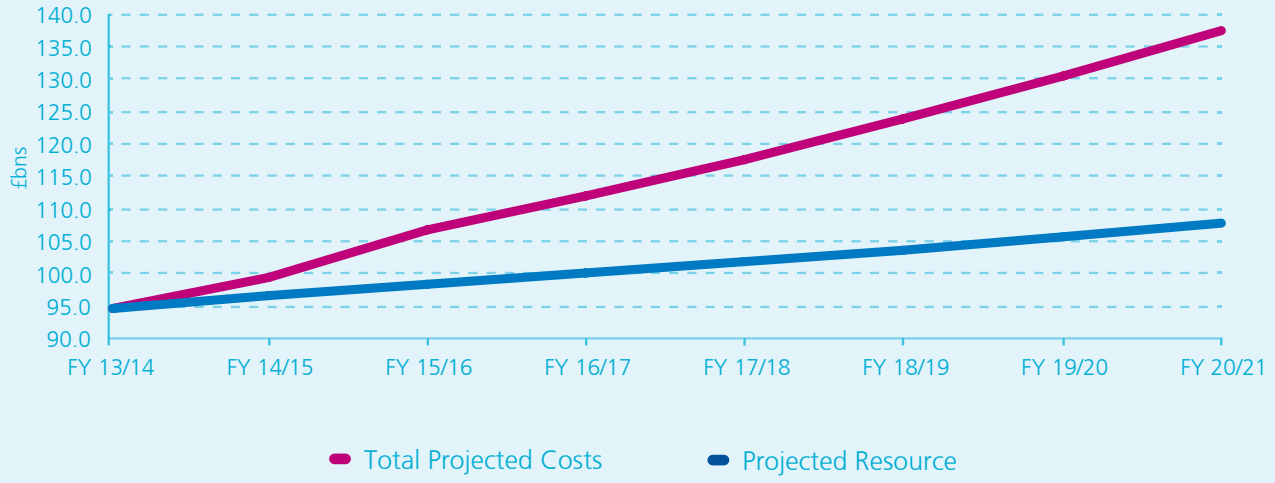
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

"THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England"

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.

[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".

[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".

[36] https://www.phbe.org.uk/

[37] NHS England (2013), "Catalogue of Potential Innovation".

[38] Office for National Statistics (2009), "e-society" (Social Trends 41).

[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

Clinical Commissioning Groups

- The CCGs have an important role in:
  - Leading and/or working in partnership with other CCGs to run local engagement events (potentially with health and wellbeing boards)
  - Incorporating the 'Call to Action' as a complementary strand to existing engagement work over the autumn
  - Building momentum with local partners – e.g. health and wellbeing boards, patients' groups
  - Liaising with Area Teams for shared development of engagement work, in order for ATs to consolidate area engagement
  - Providing feedback on the progress of the 'Call to Action' in their localities
- There is not a single mandated approach to the CCG activity, as this would run contrary to the principles of the new commissioning system. CCGs have flexibility to join with ATs and neighbouring areas (providing that does not diminish the opportunities for local communities to participate) and to use the services of CSUs to manage this locally.
- The 'Call to Action' will lead to 5 year commissioning plans owned by each CCG, with the first 2 years covering hard edged commitments. The engagement phase should provide a key channel through which CCGs can test ideas and gather feedback to inform their strategic plans.
- The Commissioning Assembly will continue to be key partners in co-producing this going forward.

Health and wellbeing boards

- The health and wellbeing boards (HWWBs) have an important role in:
  - Understanding the specific communities to engage during the campaign
  - Agreeing how the £3.8bn integrated budgets will contribute towards the strategic plans
  - Ensuring community needs and requirements are covered in the plan development at a local health economy level
- There is an opportunity for health and wellbeing boards to be critical partners in the design and delivery of the call to action, in supporting the alignment of plans and encouraging the wider participation of local stakeholders.
- There is not a single approach to how this could work, but area teams and clinical commissioning groups are asked to consider how their HWWBs can be integral to this process, there is joint ownership where possible, and to ensure this is part of the dialogue with HWWBs around identifying and meeting local priorities.
- The Strategy Unit will refine further the roles and working models as we discuss with colleagues in regions and area teams, and with the Commissioning Assembly.