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Notice of Meeting

Health and Wellbeing Board

Thursday, 23rd January 2014 at 9.00 am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 15 January 2014

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: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason, Councillor Graham Pask (Non-voting), Rachael Wardell (WBC - Community Services), Councillor Quentin Webb and Dr Rupert Woolley (North and West Reading CCG)

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

Agenda

Part I

Page No.

9.00 am 1 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

9.03 am 2 **Minutes** 1 - 10
To approve as a correct record the Minutes of the meeting of the Board held on 28th November 2013.

9.13 am 3 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.

4 **Public Questions**
Members of the Executive to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.
(Note: There were no questions submitted relating to items not included on this Agenda.)

5 **Petitions**
Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

9.15 am	6	**Forward Plan (Councillor Marcus Franks)** *Purpose: To agree the new forward plan for the Health and Wellbeing Board for the municipal year 2014/15.*	11 - 12
9.25 am	7	**Social and Emotional Wellbeing for Children and Young People (Rachael Wardell)** *Purpose: To make the Health and Wellbeing Board aware of issues around young people's emotional wellbeing and to initiate a strand of work to support improved emotional wellbeing as part of the health and social care integration.*	13 - 16
9.40 am	8	**The Better Care Fund (Formally known as the Integrated Transformation Fund) (Cathy Winfield)** *Purpose: To inform Members of the Health and Wellbeing Board about the Better Care Fund.*	17 - 28
9.55 am	9	**Commissioning Intentions (Phil McNamara)** *Purpose: To present to the Health and Wellbeing Board the process and timescales for the Clinical Commissioning Group's Commissioning Plans.*	Verbal Report
10.10 am	10	**The Clinical Commissioning Group's Five Year Strategy (Cathy Winfield)** *Purpose: To inform the Health and Wellbeing Board of the planning timetable for the CCGs five year strategy.*	29 - 30
10.25 am	11	**Performance Management Framework - Update on Progress (Lesley Wyman)** *Purpose: To present an update on progress with the Performance Management Framework.*	Verbal Report
10.35 am	12	**Quarterly Update Report from Healthwatch (Heather Hunter)** *Purpose: To report on Healthwatch West Berkshire's quarter three performance.*	31 - 34
	13	**Members' Question(s)** Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(Note: There were no questions submitted relating to items not included on this Agenda.)*	

10.45 am 14 **Future meeting dates**

27th March 2014
15th May 2014
24 July 2014
25 September 2014
27 November 2014
22 January 2015
28 May 2015

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

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, 28 NOVEMBER 2013

Present: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Rod Smith (North and West Reading CCG) and Rachael Wardell (WBC - Community Services)

Also Present: John Ashworth (WBC - Environment), Jessica Bailiss (WBC - Executive Support), Kakoli Choudhury (Public Health), Fatima Ndanusa (Public Health), April Peberdy (Public Health), Barrie Prentice (Boots and Berkshire LPC) and Lesley Wyman (WBC - Public Health & Wellbeing)

Apologies for inability to attend the meeting: Dr Rupert Woolley.

It was also noted that Andy Day and Cathy Winfield were unable to attend the meeting.

PART I

53. Appointment of Chairman

Bal Bahia asked for nominations for Chairman of the Health and Wellbeing Board. Councillor Marcus Franks nominated Councillor Gordon Lundie and this was seconded by Rachael Wardell.

RESOLVED that Gordon Lundie was appointed as Chairman of the Health and Wellbeing until the end of the Municipal Year (May 2014).

54. Minutes

It was reported that Cathy Winfield had been present at the previous meeting however, this was not reflected in the attendance record at the beginning of the previous minutes, in the also present section of the minutes.

Subject to this correction, the minutes of the meeting held on 26 September 2013 were approved as a true and correct record and signed by the Leader.

It was confirmed that the Royal Berkshire NHS Foundation Trust Five Year Integrated Business Plan item, that was deferred at the meeting was dealt with virtually.

55. Declarations of Interest

Councillor Gordon Lundie declared an interest in Health and Wellbeing, by virtue of the fact that he was the director of the pharmaceutical company UCB, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

56. Public Questions

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

57. Petitions

There were no petitions presented to the Board.

58. Flu Vaccination Update

Lesley Wyman introduced her report, which updated the Board on the flu vaccination work that had taken place and asked for suggestions on how to improve vaccination uptake in West Berkshire.

The flu plan for 2013/14 was published by the Department of Health in June 2013. One of the strategic objectives of the flu plan was to offer the flu vaccination to 100% of all those in the eligible groups. The target was to vaccinate at least 75% of those 65 and over; 75% of pregnant woman and 75% of those in a clinical risk group. In addition to this the Department of Health had brought in flu vaccinations for all two and three year old children. It was anticipated that this would be rolled out to all children in the future.

In addition to the targets stated above, the Department of Health had adopted a free voucher scheme for staff to ensure those at risk were able to receive the flu vaccination. Local Authorities would have to offer a voucher to all front facing staff. Head of Services had been tasked with providing names of those staff that would be applicable for vouchers. West Berkshire Council had 600 vouchers in total to give out however, only 300 members of staff had been designated them so far. Individuals had to formally agree and sign to receive the vaccination. Those who had received the vaccination would then be monitored for six months to see if the programme was worth while. The aim currently was to increase uptake of the voucher scheme. Emails had gone out to increase awareness from the Portfolio Member for Health and Wellbeing, Councillor Marcus Franks.

Staff at special schools were also being offered the vouchers, along with parents/carers of children at these schools. This was to help ensure all the vouchers were used. The scheme was very straight forward, once receiving a voucher, a person's details would be placed on the national website and the vaccination would be administered by a local pharmacy. Lesley Wyman confirmed that there were 18 participating pharmacies in the District.

It was stated that the rate of those contracting flu in West Berkshire was no different to that nationally. According to data provided by the CCG, the rate of uptake for the week ending 10th November 2013 was very positive. Lesley Wyman reported that the voucher scheme came to an end on 1st January 2014.

In order to increase the uptake of the flu vaccination letters had been sent out, press releases issued and social networking sites such as Twitter had been utilised.

Rachael Wardell referred to the table on page 12 of the agenda and commented that the comparison between Newbury and District and North and West Reading CCGs was very helpful. It was noted that the CCGs in some areas performed better than others and therefore Rachael Wardell stated that she would be interested to see the mechanism used by each CCG for increasing uptake. Rod Smith confirmed that both CCGs were amongst the highest performing in South Central England and stressed how demanding the national targets were. Lise Llewellyn explained that there was much inter practice variation and that individual practices would focus on targeting different groups of people from week to week, making weekly comparisons difficult.

Lise Llewellyn confirmed that pharmacies had become involved, simply to improve uptake. Councillor Graham Pask asked where the figures were collected from and it was confirmed by Lise Llewellyn that Public Health England collected the figures from weekly returns.

Councillor Marcus Franks queried whether the 18 participating pharmacies were equally spread throughout the district. Rod Smith confirmed that areas had been chosen where the uptake was lower. Only Council staff needed a voucher to claim their flu vaccination. Others had to be able to prove they were in one of the at risk groups.

Dr Bal Bahia explained that persuading people to have the vaccination in the midst of what else they had come in to a surgery to be treated for was difficult. There had also been rumours of people feeling unwell after the vaccination, which had hindered uptake.

Councillor Marcus Franks suggested that next season there might be a case for all practices to carry out the same initiatives as those practices which were high achieving, in order to increase uptake. Rod Smith highlighted that the work was also linked to deprivation.

Lesley Wyman reported that carers who were able to receive the vaccination would be identified via the carers register. The theory behind offering the vaccination to carers was that the person who they were caring for would suffer greatly if the carer became ill with flu. Carers not on the register would also be able to receive the vaccination and this would be up to the discretion of a GP Practice.

Lesley Wyman reported that there were no targets for staff uptake of the vaccination. The focus would be on key staff such as hospital staff, care home staff and front facing staff across the Council. Those who received the vaccination would then be monitored to see if illness occurred. Councillor Gordon Lundie suggested that he would raise the voucher scheme at Management Board that afternoon to help increase awareness at management level.

Councillor Lundie referred to the table under paragraph five and queried what 'good' looked like in comparison to other areas in England. Councillor Lundie asked where Officers expected to be in December with vaccination rates and where they wanted to be by the end of the programme.

RESOLVED that targets would be placed in the table by Lise Llewellyn/Lesley Wyman.

It was confirmed that Newbury Weekly News had been utilised to raise awareness. Dr Bal Bahia reported that many practices had initiated the programme at the beginning of October 2013.

59. Health and Wellbeing Board Action Plan - Performance Framework

Lesley Wyman introduced her paper, which suggested a Performance Framework that could be used to monitor progress on the Health and Wellbeing Strategy, highlighting achievement against a set of high level national outcomes and local Key Performance Indicators (KPIs). The report was proposing that the Board agree the national outcomes to be used in the performance monitoring of the Health and Wellbeing Strategy.

Lesley Wyman reported that the national outcomes were largely reported against on an annual basis. Lower level key performance indicators would be required from departments and organisations that contributed to the achievement of the outcomes.

Lesley Wyman drew the Board's attention to appendix two, which tabled the strategic objectives. A column was given, which detailed who the lead was for each objective, actions and then KPIs.

Lesley Wyman stated that it was easy to end up with too many KPIs. There were currently a lot of actions for each objective however, they had simply been lifted from the Public Health Action Plan where there were links to the objectives and she acknowledged some were not measurable. Lesley Wyman stated that she realised that some of the KPIs were process based rather than outcomes based, so therefore required further work. There were currently no performance indicators for the Clinical Commissioning

Group (CCG) shown under appendix two, or other departments within the Council. The next step was for these areas to input their own performance indicators.

Lesley Wyman stressed that the performance management framework, was in the very early stages and what she had presented to the Board was how she saw it working. It was anticipated that the Public Health Integration Programme Board would lead on ensuring comprehensive performance management was in place for the Health and Wellbeing Strategy. Lesley Wyman welcomed ideas and thoughts from the Board on the proposed performance framework.

Councillor Lundie stated that a lot of information had been presented to the Board and therefore the item should be brought back to the subsequent meeting. Rachael Wardell concurred that the information needed to come back to the Board once developed further and felt that outcomes for children were minimal as the framework currently stood. Racheal Wardell highlighted that she saw it as her role to ensure children's issues were not lost amongst the wider health agenda.

Rachael Wardell highlighted how important it was to check work required for monitoring and reporting, to ensure it was not being carried out elsewhere.

Lise Llewellyn stated that it was the role of the Board to oversee that the Council and CCGs were delivering long term health outcomes. Lise Llewellyn agreed that duplication of work needed to be avoided and therefore it was important to know exactly who would be monitoring the work on the Board's behalf. There were lots of actions but work was needed around what could be measured. Performance needed to be measurable and explanatory to the general public.

Councillor Marcus Franks acknowledged that further work was required to ensure there was not a long list of KPIs as this would become unmanageable. Dr Bal Bahia felt the work highlighted the need for integration and also the need for the Health and Wellbeing Board to be clear about what it wanted to achieve. It was also important that those presenting to the Board were also clear about its role and aims.

Lise Llewellyn explained that the performance management work could be brought back to the meeting in January however, suggested it be pushed back until March when it could be revisited in its entirety with next years work plan. Rachael Wardell stated that this would ensure the Board entered the next financial year with a clear performance framework. Leila Ferguson asked for assurance that the voluntary sector would be involved and felt that revisiting the framework in March would provide ample time to ensure they were.

RESOLVED that the performance management framework would be brought to the Board meeting in March 2014.

Councillor Lundie questioned what the next steps were to get to the point they needed to be at by the meeting in March 2014. Lesley Wyman reported that the Integration Board would be meeting in December 2013 and would begin working up the performance framework in light of discussions by the Board.

RESOLVED that a brief update should be given at the Board meeting January, where Board Members would be welcomed to feedback further comments regarding the performance framework.

60. Health and Social Care - Provider Engagement

Debbie Holdway and Caroline Bridger introduced themselves and their report which sought agreement and support from the Board to implement mandatory training criteria for long term conditions within the Service Specifications.

The purpose of the work was for Health and Social Care to work with Care Providers to raise awareness of effective management of patients with Long Term Conditions, specifically Diabetes, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease, Dementia and End of Life / Palliative Care and identify their training needs. It was recognised that in West Berkshire, there was an increasing elderly population and the focus of the project was on supporting people to remain independent within their own homes.

An increased awareness of Long Term Conditions for Care Providers would reduce the requirement for hospital admissions/crisis interventions and delay the need for residential or nursing home care. The training would address key aspects relating to the care of patients with Long Term Conditions, End of Life care, reducing avoidable admissions and supporting the integration agenda.

Caroline Bridger reported that they were looking to standardise the level of care provided through a dynamic training programme. There was already significant training available however, it was not being taken up. There was also very little training that focused on long term conditions. A pilot had been run to look at existing resources and it had identified pockets of training, some of which was provided by the voluntary sector and Social Care providers.

Caroline Bridger reported that they were continuing to network in order to develop core training needs. A meeting was taking place on 18th December 2013 to raise awareness. They welcomed suggestions from Board Members.

Councillor Gordon Lundie summarised the points made by Caroline Bridger and Debbie Holdway: Newbury and District CCG had identified a level of hospital admissions, due to a range of chronic conditions and following this had carried out an analysis to identify the gaps in training. A training specification would then be developed to cover these gaps, which in turn would reduce admissions to hospitals.

Caroline Bridger reported that a large amount of money was spent on long term care and this was mainly aimed at reducing admissions to hospital. Debbie Holding stressed that there were currently no standards on training in this area.

Lesley Wyman stressed that Public Health would very much like to be involved in future discussions, as they had specific actions around training for dementia, anxiety and depression.

Gabrielle Alford commended the positive work being carried out however, queried where the joint resources were coming from. Gabrielle Alford also asked if they were able to identify other gaps in training as a result of the scoping project. Debbie Holdway reported that they had spent a lot of time getting to know what was going on in the training remit. It was vital to utilise existing resources. The next meeting to discuss the training would also look at which organisations were able to contribute and how much. Caroline Bridger reported that West Berkshire Council were already carrying out a large amount of Social Care training. Care providers who had provided feedback had said that there were often only two to three people in attendance. Training of a standard quality, for more people would be much more beneficial and more cost effective. Training currently available was of varying quality. Caroline Bridger stressed that if all were to share information on what they provided and look at this collectively, then this could resolve some of the resource issues.

A pilot of the training programme would enable its effectiveness to be demonstrated with carers. The next step would then be to access pockets of resource. It was hoped that the outcome of the pilot would encourage others to contribute resources.

Councillor Marcus Franks referred to the Service Specification and commented that if this was carried out locally, there would be an increased risk that the local cost of care would

increase. In order to encourage involvement of the private sector, Councillor Franks suggested that Care Quality Commission (CQC) be lobbied.

Regarding driving up the local cost of care, Debbie Holdway reported that the integrated agenda for training would save money and resources whilst improving the quality of care. Caroline Bridger reported that many social care providers were keen to improve the quality of their services and therefore willing to invest in training.

Rachael Wardell felt that the programme should be health and social care led and that it would have been helpful to hear from a representative from Social Care services.

Lise Llewellyn stressed that not all training had to be face to face and suggested that e-learning and You Tube training be offered as part of the pilot.

Councillor Lundie asked for Jan Evans perspective on the area. Jan Evan's reported that the Council delivered its Social Care training in line with CQC standards. She commended the proposal and felt it gave a more robust quality framework. Jan Evans confirmed that the Council did carry out a lot of training however the service was under strain due to the way it was funded. A shared honest approach to funding was critical.

Gabrielle Alford suggested that she and Rachael Wardell have a conversation outside of the meeting to discuss the use of the Integrated Transformation Fund for training

RESOLVED that Rachael Wardell and Gabrielle Alford would meet outside of the Board meeting to discuss the Integrated Transformation Fund.

Councillor Lundie queried what action was required from the Board in terms of enabling the training project to move forward. Racheal Wardell clarified that in essence the Board were being asked if they supported the project and she did not feel it was at a stage to do so. Councillor Lundie commended the work however, concurred with Rachael Wardell and stated that in principle the Board supported the proposal; it however, needed clarity on the implications of this support before doing so.

RESOLVED that the training project be brought back to a future Board meeting.

Debbie Holdway and Caroline Bridger thanked the Board for its comments.

61. Local Safeguarding Children's Board Annual Report and SARC Protocol

Stephen Barber introduced himself as the Chairman to the Local Safeguarding Children's Board (LSCB) and drew the Board's attention to the LSCB Annual Report for 2012/13. He reported that LSCBs were established as part of the Children Act 2004 and brought together statutory partners in order to provide safeguarding and promote the welfare of children. The Annual Report was based on the latest guidance for safeguarding children and young people.

Stephen Barber highlighted some of the challenges being faced by the LSCB, one of which was General Practitioner (GP) participation. He made a plea to the Board to urge CCGs to ensure GPs contributed to child protection processes, including providing reports for those children who attended child protection conferences. Stephen Barber stressed that GPs would most likely have the longest contact with these children and therefore were well positioned to provide necessary information. A nurse had been recruited to help GPs meet this demand. Stephen Barber confirmed that ideally GPs should provide reports for 100% of children involved in child protection conferences.

Stephen Barber referred to the Identification and Referral to Improve Safety (IRIS) project. Domestic abuse was a large contributing factor to children being at put at risk and the IRIS Project was a general practice based training support and referral programme to help GPs be more aware of domestic abuse. Stephen Barber stressed that

the take up of the IRIS Project in West Berkshire was very low. He understood that GPs had little time to spare for training however, stressed that IRIS training was only two hours long.

Lise Llewellyn suggested that IRIS training be delivered as part of protected practice time. Bal Bahia reported he was aware of safeguarding training which had taken place in 2012 amongst GPs and it had been extremely successful.

Stephen Barber stated that ideally they would want 100% of GPs to carry out the IRIS training although he acknowledged that practicalities made it difficult. It was however, essential that GPs knew how to signpost patients if they suspected they were being subjected to domestic abuse.

RESOLVED that the Health and Wellbeing Board noted the challenges faced by the LSCB and would communicate these where necessary.

Stephen Barber moved onto his second item regarding Sexual Assault Referral Centres (SARCs). There were two SARCs in the Thames Valley and the most accessible from West Berkshire was the centre in Slough. SARCs were usually for adults however, the one in Slough was for children.

Stephen Barber drew the Board's attention to the Protocol on page 55 of the agenda, which was for information sharing arrangements between the Thames Valley LSCBs, NHS England and the SARCs. Largely the protocol dealt with how information on children using the SARC was passed to the relevant authorities such as the Police Force or the Local Authority. It was important that the relevant authorities were informed immediately if children were treated in the SARC. The LSCB also needed to be made aware for performance information purposes. Stephen Barber concluded that he would be taking the Protocol to a number of Boards across Berkshire to raise awareness and gain support.

RESOLVED that the Board noted the SARC Protocol.

Councillor Graham Pask stated as Chairman of the West Berkshire Partnership (WBP) that domestic abuse was a key issue that many partners were trying to address. The WBP were looking at the likely causes of domestic abuse and in particular were focusing on the theme of alcoholism. Councillor Gwen Mason commented there was a well established forum in West Berkshire called the Domestic Abuse Forum, who were next meeting that afternoon and she would raise the SARC Protocol.

62. Berkshire West Integration Programme

Rachael Wardell announced that West Berkshire had not been successful in its Pioneer bid however, the work that had taken place to form the bid was being continued and used to support the ten organisations of Berkshire West in working closer together.

The ten organisations included West Berkshire Council, Reading Borough Council Wokingham Council, the four CCGs, the Royal Berkshire Foundation Trust, Berkshire Healthcare Trust and South Central Ambulance Service Trust. The Integration Programme covered three key care groups including Frail Elderly, Mental Health and Children.

Rachael Wardell explained that the Frail Elderly work stream was the most advanced. An organisation was being recruited to take the work forward and would work across all ten organisations. The work was being funded through money previously agreed to support the Pioneer programme.

Rachael Wardell moved on to talk about the Integration Transformation Fund (ITF) that would be spent to underpin the delivery of the programme. Further guidance on this was emerging from NHS England and the Local Government Association (LGA) and the final

guidance was expected in December 2013. Rachael Wardell highlighted that the funding would only be released if the criteria were met. The Health and Wellbeing Board would therefore want to monitor the impact of ITF investments and the achievement of criteria. An event was taking place on the 6th December 2013 to look at how the ITF was being used across Berkshire. It was important that the use of the ITF in West Berkshire supported local need.

Adrian Barker expressed the importance of involving patients in the process. Rachael Wardell was able to confirm that there was little patient involvement so far in the process however, Healthwatch would be involved moving forward.

Lise Llewellyn stated that it was important that the ITF did not just consider those who required services immediately. Social isolation implications needed to be focused on too.

Councillor Gordon Lundie stated the work reminded him of the Troubled Families agenda. He was concerned that there was risk of funding something that was not sustainable. Rachael Wardell reported that 50% of the ITF would be given upfront and the second half would be rewarded against success.

Councillor Lundie noted a differential pathway cost between the two plans. Lise Llewellyn stated that this would form part of the discussions required between Gabrielle Alford and Rachael Wardell outside of the meeting. It was expected however, that services would need expanding to meet care costs.

RESOLVED that the Health and Wellbeing Board noted the progress of the Berkshire West Integration Programme.

63. Clinical Commissioning Group Planning Process

Gabrielle Alford drew the Board's attention to the report, which detailed the Strategic Planning Process for the Berkshire West CCGs for the next five years. The paper set out what was known about health economy planning processes for 2014-15 and described the key roles envisaged for Health and Wellbeing Boards. This included assuring that CCG Commissioning Plans aligned with Health and Wellbeing Strategies and their role in determining the use of the ITF.

There was a whole raft of planning guidance, some of which linked to the ITF and some to NHS planning.

Exact timescales were to be confirmed but it was likely that the CCGs would be required to submit strategic draft plans for the next five years, to the Local Area Team by the end of January 2014. It was expected that the final guidance on the ITF would be issued in November 2013.

Gabrielle Alford drew the Board's attention to the recommendations within the paper which were as follows:

- The Board was asked to note the planning requirements outlined, the timescales and the progress made to date.
- Members' attention was also drawn to the role of Health and Wellbeing Boards in agreeing a plan for the use of the ITF. This plan should encapsulate a shared vision for health and care services, which should also be articulated in each organisation's own plans, including the two and five year CCG plans which would be brought to subsequent Health and Wellbeing Board meetings for review.
- The Board was asked to endorse the Berkshire West Partnership Board's recommendation that the planning unit for CCGs' five year strategic plans should be Berkshire West.

Councillor Marcus Franks suggested that to ensure strategies were aligned the Health and Wellbeing Strategy might need reviewing. Lise Llewellyn reported that the Health and Wellbeing Strategy should be reflected in the CCGs plans. She reported that Lesley Wyman met with the CCG Board regularly and therefore the links were in place.

Adrian Barker noted that planning was being considered for Berkshire West however, questioned if there would be a prevention strategy. Gabrielle Alford confirmed that there would be. Rachael Wardell reported that there would be a need to work with Hospital Trusts outside the boundaries.

Councillor Lundie suggested that the Quality Improvement Productivity Prevention Plan (QIPP) come to the Health and Wellbeing Board once per year.

RESOLVED that the QIPP Plan be placed on the Health and Wellbeing Board's work plan once per year.

64. The Autism Strategy

Jan Evans introduced her report which aimed to update the Board on the progress with the Autism Strategy.

Autism was a lifelong development disorder that affected the way that a person communicated with and related to others and made sense of the world around them. It affected one in 100 of the UK population and there were approximately 1400 in West Berkshire with diagnosed and undiagnosed autism.

In West Berkshire only those at the top end of the Autism Spectrum received specialist support. At the other end on the Spectrum, the individual might have a very high IQ with a university degree but not necessarily be able to function normally in society without some support. They might also have mental health problems. However, because they fell outside of the criteria they were not eligible to receive support.

In February 2010 West Berkshire reviewed its service provision across adult's and children's services. The review confirmed the existence of a range of services to support adults with autism and their families, but that significant gaps did exist. In April 2010, the Department of Health launched its own Autism Strategy and West Berkshire's response to the Strategy could be viewed on page 76 of the agenda. Briefly Jan Evans highlighted that there was an Autism Partnership Board In West Berkshire, which provided strategic leadership and user and family engagement in the planning and development of services. A lot of review work had take place around developing strategic objectives.

As a result of the review Jan Evans reported that they had look at efficiencies. One key areas of need identified was the transition from Children's Services to Adult's Services and as a result Adult Social Care had established a project within the Adult Social Care Efficiency Programme to review transitions for Children's to Adult's Service to be completed by March 2014. Information services needed developing and as a result Adult Social Care had established Access For All, an Information, Advice and Signposting Service and feedback had been very positive.

There was also need for a specialist team or worker with knowledge of Autism. Currently all of the Learning Disability Team worked with those eligible for social care services as over 60 had a diagnosis of Autism and could not be supported by one practitioner. There was however scope for a lead practitioner to be identified to keep abreast of policy and practise to ensure the whole team was kept up to date and developed their own expertise.

Finally a need was identified for social groups and day activities as many fell outside of the social care criteria. Adult Social Care was reviewing how and what it commissioned with the voluntary sector and was consulting on a number of outcomes which should

extend and diversify current provision. However, the total budget for all adult social care was £1 million for a range of activities across and wide range of needs and disabilities.

In summary Jan Evans concluded that West Berkshire Council had responded to the Autism Strategy with its partners however, Adult Social Care's eligibility criteria, which enabled it to only support those at one end of the autistic spectrum, made it very difficult. Being in an environment of diminishing resources, meant there was uncertainty about how much further the aspirations and expectations of the Strategy could be progressed.

Councillor Marcus Franks questioned if universal education services were able to support those who fell under the threshold. Rachael Wardell reported that more young people than she would liked were placed outside of the authority area and it would be preferable for them to be supported at home. She reported that they strove towards improving this. There was a large drop off in services when a child became an adult, narrowing the amount of people services were able to support. Rachael Wardell stated that co-production was a method to ensuring resources went along way.

Leila Ferguson reported that Mencap received funding from the West Berkshire Council, which enabled them to provide support for adults with autism.

RESOLVED that the Health and Wellbeing Board noted the progress against the Autism Strategy 2010.

65. Quarterly update report from Healthwatch

Adrian Barker reported that Healthwatch were continuing their engagement with the community and been communicating with the public in Newbury Hospital, Supermarkets and Boots stores. There was still a lot of work to do but they were progressing well. There were currently no issues to flag up with the Board.

Rachael Wardell commended the Healthwatch report and the work that was being carried out.

Lise Llewellyn reported that Public Health would soon be seeking support from Healthwatch with work within pharmacies.

REOLVED that the Health and Wellbeing Board noted the quarterly update report from Healthwatch.

66. Members' Question(s)

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

67. Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on 23rd January 2014.

(The meeting commenced at 9.00 am and closed at 11.30 am)

CHAIRMAN …….

Date of Signature …….

Health and Wellbeing Board Forward Plan 2014/15

Reference	Item	Purpose	Action required by the H&WB	Deadline date for reports	Lead Officer(s)/ Service Area	Those consulted	Is the item Part I or Part II?	Comments
27th March 2014								
H&WB1	Health and Wellbeing Performance Framework	To present the framework in its entirety to the Board	For discussion and agreement	18th March 2014	Lesley Wyman	Health and Wellbeing Board	Part I	
H&WB2	Pharmaceutical Needs assessment	To outline the HWB board responsibilties and the programme of work to deliver these responsibilites	For discussion and agreement	18th March 2014	Lise Llewellyn	Health and Wellbeing Board	Part I	
H&WB3	Update on new childrens commissioning responsibilites	To update the board on reposnsibilites and progress to review services	For discussion and agreement	18th March 2014	Lise Llewellyn	Health and Wellbeing Board	Part I	
H&WB4	Protocol for vulnerable groups	To agree a protocol for vulneable groups	For discussion and agreement	18th March 2014	Andy Day	Health and Wellbeing Board	Part I	
15th May 2014								
H&WB5.1	Quartely update report from Healthwatch	To present the Healthwatch Q4 report	For information	6th May 2014	Adrian Barker/Heather Hunter		Part I	
24th July 2014								
H&WB5.2	Quartely update report from Healthwatch	To present the Healthwatch Q1 report	For information	15th July	Adrian Barker/Heather Hunter		Part I	
25th September 2014								
27th November 2014								
H&WB5.3	Quartely update report from Healthwatch	To present the Healthwatch Q2 report	For information	18th November	Adrian Barker/Heather Hunter		Part I	
22nd January 2015								
H&WB5.4	Quartely update report from Healthwatch	To present the Healthwatch Q3 report	For information	13th January 2015	Adrian Barker/Heather Hunter		Part I	
26th March 2015								
				17th March 2015				
28th May 2015								
H&WB5.5	Quartely update report from Healthwatch	To present the Healthwatch Q4 report	For information	19th May 2015	Adrian Barker/Heather Hunter		Part I	

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Title of Report:	Children and Young People's Emotional Wellbeing
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	23 January 2014

Purpose of Report: **To make the Health and Wellbeing Board aware of issues around young people's emotional wellbeing and to initiate a strand of work to support improved emotional wellbeing as part of the health and social care integration.**

Recommended Action: **To note the report and to agree to initiate development work to improve young people's emotional wellbeing.**

Health and Wellbeing Board Chairman details	
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Executive Report

West Berkshire focus on children and young people's emotional wellbeing.

1. Issue

1.1 Social and emotional wellbeing creates the foundations for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental health problems. That's why it is important to focus on the social and emotional wellbeing of children and young people.

1.2 Promoting social and emotional wellbeing of children and young people will help local authorities and their local partners meet objectives outlined in the public health outcomes framework for England, 2013–2016.

1.3 Social and emotional wellbeing is influenced by a range of factors, from individual make-up and family background to the community within which people live and society at large.

1.4 Evidence shows that poor social and emotional wellbeing predicts a range of negative outcomes in adolescence and adulthood. For example, negative parenting and poor quality family or school relationships place children at risk of poor mental health. Early intervention in childhood can help reduce physical and mental health problems.

1.5 The most recent official survey of mental health (2004) identified that 10% of children and young people aged 5–16 had a clinically diagnosed mental disorder. Older children (aged 11–16 years) were more likely than younger children (aged 5–10) to be diagnosed as such (12% compared with 8%).

1.6 **NICE** (the National Institute for Health and Care Excellence) recommends good practice for Health and Wellbeing Boards to assist in developing and implementing strategies to improve children and young people's emotional wellbeing locally.

2. NICE Guidelines

2.1 NICE recommends that steps are taken to ensure the following:

(1) Social and emotional wellbeing of vulnerable children features in the health and wellbeing strategy.

(2) There is integrated commissioning of universal and targeted services for children <5.

(3) Children and families with multiple needs have access to specialist services.

(4) Primary schools tackle emotional wellbeing on a whole school and targeted basis, supported by all relevant local and school policies.

(5) Secondary schools have an organisation-wide approach to tackling emotional wellbeing and have access to specialist support.

(6) Emotional wellbeing of children and young people is assessed in the Joint Strategic Needs Assessment (JSNA) and any programmes implemented are subject to review and scrutiny.

2.2 NICE makes further specific recommendations (here: http://publications.nice.org.uk/social-and-emotional-wellbeing-for-children-and-young-people-lgb12/what-nice-says) covering home visiting, early education and childcare, primary and secondary education.

3. The Children and Young People's Mental Health Coalition

3.1 In their December 2013 report "Overlooked and Forgotten", the Children and Young People's Mental Health Coalition found that:

(1) Two thirds of JSNAs did not have a section that specifically addressed children and young people's mental health needs – where there was a section it was sometimes limited to a paragraph and where there wasn't a section relevant data was placed throughout the document rather than grouped together as a comprehensive needs assessment making it difficult to find and more likely to be overlooked by professionals consulting the document.

(2) Many JSNAs and JHWSs were difficult to access and the information relevant to children and young people's mental health was difficult to find.

3.2 As a result they recommended that all JSNAs should include a section specifically about children and young people's mental health needs which uses a comprehensive range of data to estimate local levels of need for children and young people's mental health services and involve a wide range of partners in the needs assessment. They also proposed that all Joint Health and Wellbeing Strategies should include children and young people's mental health as a priority and that specific actions are included for addressing local children and young people's mental health needs which are based on evidence of need in the JSNA and that a wide range of local partners have been involved in determining.

4. West Berkshire's approach to children and young people's emotional wellbeing.

4.1 West Berkshire's JSNA does reference children and young people's emotional health and wellbeing throughout the document. It describes the issue as the "most commonly identified" and incorporates a link to the CAMHS Needs Assessment for West Berkshire estimating that up to approximately 8,700 children and young people may need support for their emotional wellbeing in West Berkshire – the majority at Tier 1 and Tier 2.

4.2 West Berkshire's Health and Wellbeing Strategy does identify the promotion of emotional wellbeing in children and young people as one of the key actions involved in **Giving every child and young person the best start in life.**

4.3 However, West Berkshire has not yet developed the kind of comprehensive, holistic and integrated strategy to support children and young people's emotional wellbeing

that is envisaged in the NICE Guidelines or in the Children and Young People's Mental Health Coalition's report.

5. Recommendation

5.1 To initiate a strand of work based on the NICE guidelines to develop the outline in the Health and Wellbeing Strategy in order to better support improved emotional wellbeing of children and young people in the District.

5.2 To propose to the West of Berkshire Children's Joint Commissioning Group that this could be a workstrand taken forward on a West of Berkshire basis and that with the agreement of that group, it should be progressed as such.

Appendices

There are no Appendices to this report.

Title of Report:	Better Care Fund Briefing – January 2014
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	23 January 2014

Purpose of Report:

To inform Members of the Health and Wellbeing Board about the Better Care Fund.

Recommended Action:

To Note

Health and Wellbeing Board Chairman details	
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1. BETTER CARE FUND OVERVIEW

The Better Care Fund (BCF) plans offer the opportunity to transform local services and provide better integrated care and support. It provides an opportunity to improve the lives of the most vulnerable providing them with better services, support and improved quality of life. It enables the integration agenda to be taken forward at scale and pace and provide a catalyst for change. It requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled BCF budget will be implemented to facilitate closer working between health and social care services. Joint plans should be agreed between CCG's and the Local Authorities and approved through the local Health and Wellbeing Boards. Local health and social care providers should also be closely involved in the development of the plans. The plan should demonstrate clearly how it meets all of the national BCF conditions, include details of the expected outcomes and benefits of the schemes involved, and confirm how the associated risks to existing NHS services will be managed. CCGs will be expected to meet the national conditions and measures and consider the quality of the impact of the BCF alongside the development of the BCF plans

CCGs and Local Authorities need to engage from the outset with all providers likely to be affected by the use of the BCF so that plans are developed in a way that achieves the best outcomes for local people. Commissioner and provider plans should have a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support service change.

2. FUNDING FOR INTEGRATED CARE

In 2014/15, a total of £1,100 million (increased from £859 million) will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will be through a Section 256 transfer. In 2015/16, this funding will be part of the pooled BCF while it will continue to be allocated to areas on the same basis as in previous years; the funding will be added to CCG allocations. CCGs will be required to pass this funding to the BCF pooled budget along with the funding from core CCG allocations. There are no additional conditions attached to the £859m transfer already announced and NHS England will only pay out the additional funding based on jointly agreed BCF two year plans.

From 2015/16, the BCF will also include a £1.9 billion contribution from core CCG funding, over and above the existing £300 million reablement funding and £130 million carers' breaks which will also be pooled in the BCF. Core CCG funding in the pooled BCF will be allocated based upon the CCG allocation formula. Additional contributions to the BCF from Local Authorities will be in the form of social care capital grants and disabled facilities grants, which will be allocated to them by central government on the same basis as for 2014/15.

The additional £241m should be used to prepare for the implementation of the pooled budgets and early progress against the national conditions and performance measures.

The BCF includes the £130m of NHS funding for carers breaks. Local plans should set out the level of resource dedicated to carer support including breaks. The BCF also included £300m of reablement funding and plans need to include this.

In 2015/16 the BCF will be a pooled budget under Section 75 governance arrangements. Funding will come through NHS England to protect the overall level of health spending. The DH will use the mandate to instruct NHS England to ring fence its contribution to the BCF. Legislation is needed to achieve this. The Disabled Facilities grant has also been included in the BCF so that planning and investment for adaptations can be included and lead to improved outcomes. The DH Adult Social care capital grant will also be included in the BCF. Relevant conditions will be attached to these grants and are in development.

The BCF will also include costs to councils resulting from care and reform. £135m revenue funding is linked to the new duties in the Care Bill which will be implemented in April 2015.The funding is not ring fenced and local plans should identify how the new duties are being met. Most of the costs result from new entitlements for carers and the introduction of national minimum eligibility thresholds.

3. Local Allocations

Council will receive their funding allocations in the normal way. NHS allocations will be two years for 2014/15.and 2015/16.The formula for distribution of the £3.8bn funds in 2015/16 will be based on the financial framework agreed by ministers.

The LA's and CCGs will receive a notification of their share of the pooled fund for 2014/15 and 2015/16.The remainder of the BCF will be allocated on the basis of CCG allocations formula. Local Authorities and CCG's will receive their share of the pooled fund based on the aggregate of the allocation mechanisms. The pay for performance will be included.

The wider powers to use the Health Act flexibilities are unaffected by the BCF requirements.

4. Agreeing a Joint BCF Plan

The Health and Wellbeing Boards will be responsible for signing off the plans. The plan must be developed as an integral part of the CCG's strategic plans.

The plans should include the following:

- Priorities and performance goals
- Ambitions set for the BCF
- Achievement of national conditions
- Understanding of the performance goals and payment regimes
- Use of agreed national template
- Shared risk register
- Engagement with providers
- Shared view of the shape of future services
- Assessment of future and capacity and workforce requirements/education and planning

5. Rewards for Meeting the Goals

Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

6. National Conditions and Metrics

What are the conditions?

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

Plans to be jointly Agreed	The Better Care Fund Plan, covering a minimum of the pooled fund Specified in the Spending Round, and potentially extending to the totality Of the health and care spend in the Health and Wellbeing Board area, Should be signed off by the Health and Well Being Board itself, and by the Constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best Outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care Services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
	Local areas are asked to confirm how their plans will provide 7-day

As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: ●● confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; ●● confirm that they are pursuing open APIs (ie. systems that speak to each other); and ●● ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the

	resolution of some Information Governance issues by DH).
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help – following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- Effectiveness of reablement;
- delayed transfers of care;
- Avoidable emergency admissions; and
- patient/service user experience.

Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential care homes	N/A	April 2014- Mar 2015
Effectiveness &reablement	N/A	April 2014- Mar 2015
Delayed transfers of care	April – Dec 2014	Jan- Jun 2015
Avoidable emergency admissions	Apr - Dec 2014	Oct 2014- Mar 2015
Patient/service user experience	N/A	Details TBC

When	Payment for performance amount	Paid for
April 2015	£250m	Progress against four of the national conditions: • protection for adult social services • providing 7- day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care will be an accountable lead professional
	£250m	Progress against the local metric and the two of the national metrics; • delayed transfer of care; and • avoidable emergency admissions
October 2015	£500m	

The metric for patient user experience and integrated care is not currently available but is in development.

In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15

A menu of possible metrics selected form the NHS, Adult Social care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long Term) condition
2.6i	Estimate diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 30/120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contract with secondary mental health services living independently with or without support
1D	Carer-related quality of life
Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24ii	Injuries due to falls in people aged 65 and over

Local areas must either select one of the metrics from this menu, or agree a local alternative.

Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- Data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- Timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

Each metric will be of equal value for the payment for performance element of the Fund.

In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to beset such that it rewards a small improvement that is purely an artefact of variation in the underlying data set.

7. How will plans be assured?

The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers.

The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).
- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA
- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.
- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG,HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.
- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.
- Ministers will give the final sign-off to plans and the release of performance related funds.

8. What will be the consequences failure to achieve improvement?

Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary

If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving

colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

9. Timescales for Submission of Plans

Health and Wellbeing Boards should provide the first cut of their completed BCF template, as an integral part of the constituent CCGs' Strategic and Operational Plans by 14 February2014,

The revised version of the BCF should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by April 2014.

10. Berkshire West CCG's and Local Authorities Joint BCF Plans Progress

The Wokingham, West Berkshire and Reading Integration Steering groups have been meeting to take forward their local joint working and integration programmes and developments.

A Berkshire West Integration workshop was held on the 6th December which outlined each organisations financial position/plans, the opportunities and barriers to integration and progress to date on the local integration plans.

Extraordinary meetings have been scheduled in January/February.

Health and Wellbeing Board sign off:

Reading	West Berkshire	Wokingham
14th February 2014	23rd January 2014	30th January 2014

Proposals include:

Reading	West Berkshire	Wokingham
Hospital @ Home	Hospital @ Home	Hospital @ Home
Nursing/Care Home Developments	Integration of Intermediate care/Reablement Services	Nursing/Care Home Developments
Intermediate Care Integration	Joint Access to the Health and Social care Hub	Integration of Reablement/Intermediate Care including two hour response for social care assessment
Time to Think Beds-Assessment beds/24hour support (Willows)	Case Coordination model	Supporting primary care developments/neighbourhood cluster tea
GP Clusters	Development of GP/community/social care clusters	Joint Access to the Health and Social care Hub
24/7 Working Plans	24/7 Working	24/7 Working
Data Sharing		

Gabrielle Alford
Director of Joint Commissioning
Berkshire West CCG's
6/01 /2014

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Title of Report:	The Clinical Commissioning Group's Five Year Strategy
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	23 January 2014

Purpose of Report: **To inform the Health and Wellbeing Board of the planning timetable for the CCGs five year strategy.**

Recommended Action: **To Note**

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PLANNING TIMETABLE

Activity	Deadline
First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	4 April 2014
Submission of final 5 year strategic plans Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Title of Report:	Quarterly Update Report from Healthwatch
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	23 January 2014

Purpose of Report: **To report on performance for Quarter three**

Recommended Action: **For information**

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Executive Report

Healthwatch West Berkshire has spent the majority of its time out in the community over a number of months. We have used outreach stands in many different locations around the area including Boots, retails parks, children's centres, educational establishments and public events. The board sought to obtain the views and concerns of the people of West Berkshire without prompting or leading those whose views we sought via surveys, or by any specific focus on particular activities, providers or user groups. We can therefore confidently say that the data we have collected and information we now provide has been collected in an open and unbiased manner and confirm that the same general form has been used throughout the process. The focus has been entirely consumer led, which enabled analysis into the findings made.

Outreach completed Third Quarter:-
Pangbourne Children's Centre – 7th October
Boots Store Newbury – 24th October
Boots Store Newbury – 21st November
Boots store Newbury – 17th December 2013
West Berkshire Community Hospital – 25–29 November

Newbury College / Youth network
Talk to Health and Social care students took place in two groups Groups: 14th and the 21st November.

- Students invited to join the new youth network called **'Your Shout' to talk about health and social care issues**
- New student group being formed for Youth which will be active from January/February

Feedback brought forward
Out of the now wealth of feedback being analysed by Healthwatch West Berkshire to be taken forward with groups in quarter 4 was around 74% positive and 26% negative.

The results of the information gathering brings the following items to the fore:

1. **Primary Care services**: This is widely commented on and includes information into GP wait times, access to services when needed, transportation, access to referrals and more specific items which are being looked into.
2. **Maternity services**: There have been many points and concerns raised, more information needed and availability of midwives raised.
3. **Disability support** now changes in funding, eligibility and access being raised. This is in terms of long term conditions, home care, family support for parents of children with additional needs.
4. **Access to information** (Youth, transition and cancer services)
5. **Mental Health:** referrals, vulnerable groups, cross communication

Following meetings with Quality Surveillance Group (QSG) and the NHS Quality Commissioning we note that the raw data has in many instances reflected the concerns of users of Primary Care services and the priorities listed above. We will therefore be seeking to assist in any way we can further investigation and working with relevant groups to support with surveys or focus groups as may assist in such work.

Now priorities are being set out by the CCG on their commissioning focus plus areas the CQC are focusing their eye, it is important that Healthwatch West Berkshire can play a

key part in supporting, inputting and representing the consumer voice of these services. During the next 2 months it will endeavor to work closely with services and raise findings and matters of concern.

All of the above matters we will be now be taking forward as projects via surveys, focus groups and with input from user groups and providers who have specific interest in the same.

However, as indicated above, more recently we have received particular concerns relative to availability of maternity care and support which is not on a lot of local agendas. Several contributors have raised a concern and therefore we are currently constructing a larger side project to investigate the actual level and details of those concerns.

Moving forward over quarter 3 into quarter 4

During the last quarter we will have been analysing the comments received to put together reports on 'Public Voice', and then making such reports available to service users, providers and commissioners in quarter 4. The focus throughout the fourth quarter will be 'raising the public voice' so that it is heard by those who can change and improve services, doing this in a transparent way.

This is currently being achieved by:

- Feedback gathered into charts and analysed. Sectioned into main groups
- Taking information forward to key groups, talks with groups underway. Gathering further information to act on feedback / current December survey.
- Presenting this feedback, inputting into how the information is being taken forward. EG. Through key charities, groups and organisations in West Berkshire.
- Publishing the feedback and findings to service users, providers and commissioners. Making sure we keep all information transparent and outward facing. Making sure that the 'Public Voice' is actively making a difference and being heard.
- Working with local providers in information sharing, raising the public voice to improve services, bringing forward the public voice into a structure which can influence commissioning and improvements of services.

Web Statistics

There were 943 unique visitors to the site during the quarter and 1,382 visits. Over 37% of the visits were from returning visitors. There were 3,401 page views averaging just under 2.46 pages per visit. Visitors to the site averaged over 3 minutes per visit. October received both the most visits for the quarter (528) and the most page views (1281).
The most popular page after the home page this quarter was Get Involved – Clinical Commissioning Groups while the News and Events posts were even more popular than any static page.

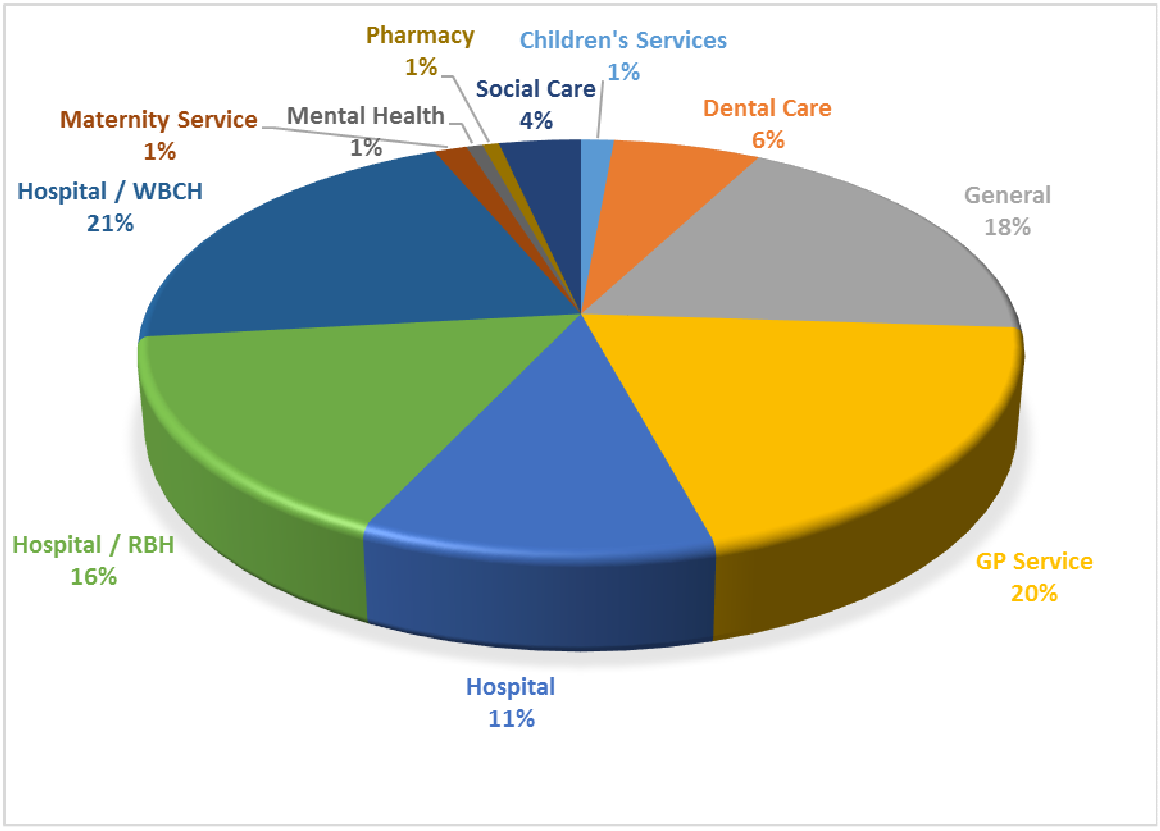
Appendices

Appendix one – Breakdown of areas of comments, issues and feedback received.

Appendix 1: Breakdown of areas of comments, issues and feedback received

Breakdown of Feedback received

Third quarter:



Year to date: