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# Notice of Meeting

# Health and Wellbeing Board

## Thursday, 15th May 2014 at 9.00am

In the Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 7 May 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, Rachael Wardell (WBC - Community Services) and Councillor Quentin Webb

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

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# Agenda

## Part I

| | | | Page No. |
|---|---|---|---|
| 9.00 am | 1 | **Apologies for Absence**<br>To receive apologies for inability to attend the meeting (if any). | |
| 9.02 am | 2 | **Minutes**<br>To approve as a correct record the Minutes of the meeting of the Board held on 27th March 2014. | 1 - 12 |
| 9.08 am | 3 | **Declarations of Interest**<br>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**<br>Members of the Health and Wellbeing Board 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.)* | |

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| | 5 | **Petitions**<br>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. | |
| 9.10 am | 6 | **Quality Account proposed responses for Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust (Philip McNamara)**<br>*Purpose: The Federation of Clinical Commissioning Groups to present a summary of their comments and statement of inclusion.* | To Follow |
| 9.20 am | 7 | **Performance Framework for 2013/14 (April Peberdy)**<br>*Purpose: To agree the 13/14 performance framework and take note of how Health and Wellbeing partners worked to address the five Health and Wellbeing priorities.* | 13 - 24 |
| 9.40 am | 8 | **Health and Wellbeing Board Development session (Rachael Wardell)**<br>*Purpose: Where the Board is now and where it is going next. (Appendix to the report attached will follow)* | 25 - 38 |
| 10.10 am | 9 | **Joint Self Assessment - Learning Disabilities (Alison Love)**<br>*Purpose: To give a follow up report on the work which is now complete.* | 39 - 88 |
| 10.25 am | 10 | **The Special Education Needs and Disability Reforms (Jane Seymour)**<br>*Purpose: To raise awareness of the SEND Reforms.* | 89 - 100 |
| 10.40 am | 11 | **Quarterly update report from Healthwatch (Adrian Barker)**<br>*Purpose: To present the Healthwatch Q4 report.* | 101 - 108 |
| 10.55 am | 12 | **Forward Plan for the Health and Wellbeing Board**<br>*Purpose: For information and an opportunity for Members of the Board to place items on the Forward Plan.* | 109 - 110 |
| | 13 | **Members' Question(s)**<br>Members of the Health and Wellbeing Board 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.)* | |

14 **Future meeting dates**

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, 27 MARCH 2014

**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), Rachael Wardell (WBC - Community Services) and Dr Rupert Woolley (North and West Reading CCG)

**Also Present:** Jessica Bailiss (WBC - Executive Support), Mrs Pearl Baker (Member of the Public), Nick Carter (WBC - Chief Executive), Councillor Adrian Edwards, Jan Fowler (Director of Nursing and Quality), Jeanette Longhurst (Berkshire West Intergration), Councillor Gwen Mason, Philip McNamara (Newbury and District CCG), Councillor Graham Pask, Councillor Quentin Webb, Cathy Winfield (Berkshire West CCGs) and Lesley Wyman (WBC - Public Health & Wellbeing)

**Apologies for inability to attend the meeting:** Councillor Gordon Lundie

## PART I

### 83. Minutes

The Minutes of the meeting held on 23rd January and the special meeting on 6th February 2014 were approved as a true and correct record and signed by the Vice Chairman.

### 84. Declarations of Interest

There were no declarations of interest received.

### 85. Public Questions

#### 85(1) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of how the Health and Wellbeing Board proposed to implement the Department of Health's "Closing the Gap" priorities for essential change in mental health including physical and mental health, was answered by the Vice Chairman of the Health and Wellbeing Board.

A supplementary question on the subject of whether General Practitioners could be more proactive regarding the physical health of those with mental health issues was answered by the Vice Chairman of the Health and Wellbeing Board.

#### 85(2) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of how the Health and Wellbeing Board proposed to implement Mental Health Advocacy as described in the Care Bill, would receive a written answer from the Lead Commissioners for Mental Health Services on behalf of the Health and Wellbeing Board.

### 85(3) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of a monitoring process to ensure the implementation of Mental Health Independent Advocacy as described in the Care Bill, would receive a written answer from the Lead Commissioners for Mental Health Services on behalf of the Health and Wellbeing Board.

### 85(4) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of how the Health and Wellbeing Board would address the discharging of patients to Section 117, whilst still receiving care and treatment, would receive a written answer from the Lead Commissioners for Mental Health Services on behalf of the Health and Wellbeing Board.

### 85(5) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on whether the Health and Wellbeing Board would re-instate patients discharged from section 117 whilst still receiving care and treatment , would receive a written answer from the Lead Commissioners for Mental Health Services on behalf of the Health and Wellbeing Board.

### 85(6) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of section 117 patients being charged for 'specific' accommodation placed in by local authorities, would receive a written answer from the Lead Commissioners for Mental Health Services on behalf of the Health and Wellbeing Board.

### 85(7) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of whether the Board would address the General Practitioners role into an integrated system of care was answered by the Vice Chairman of the Health and Wellbeing Board.

### 85(8) Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board

A question standing in the name of Mrs Pearl Baker on the subject of the Health and Wellbeing Board setting up an email alert system on a number of priority topics, including mental health was answered by the Vice Chairman of the Health and Wellbeing Board.

## 86. Petitions

There were no petitions presented to the Board.

## 87. Joint Strategic Needs Assessment Report (Lesley Wyman)

Lesley Wyman introduced her report to the Board, which gave an overview of the Joint Strategic Needs Assessment (JSNA), which should be used to agree priorities for Health and Wellbeing and inform the Health and Wellbeing Strategy.

Lesley Wyman reported that the JSNA was now on the Council's website and suggested that all members of the Board take the time to have a look at it (www.westberks.gov.uk/JSNA). The aim of the JSNA was to provide analysis of data to

show the health status of different groups; identify health inequalities; highlight unmet needs; indicate recommendations and act as a useful tool for commissioning.

The process for pulling the JSNA together this time around differed to other years as Public Health now sat within the Local Authority. This made it easier to obtain input from services from across the Council for each of the sections.

The JSNA was published as a series of PDFs however, would soon become a fully interactive tool as West Berkshire Council's website was currently being redesigned and would go live in May 2014. This would make the JSNA much easier to navigate.

The JSNA was structured around the chapters:

- Starting well
- Developing well
- Living well
- Ageing well
- Wider determinants and vulnerable groups
- Demography

Lesley Wyman highlighted that as the new JSNA was web based it could be continuously updated.

Adrian Barker reminded members of the Board that producing a JSNA was a statutory duty. He emphasised the importance of Healthwatch being involved throughout the phased development process. Adrian Barker referred to an item being discussed later on the agenda regarding the management of Charters and addressing the needs of vulnerable groups and suggested that this could be tied in with the JSNA process.

Councillor Marcus Franks questioned when health would be mapped against areas of deprivation and Lesley Wyman confirmed that this was one of the next phases.

**RESOLVED that** the ward profiles be brought back to a future meeting of the Health and Wellbeing Board along with the assets serving those wards.

Graham Pask reported that Lesley Wyman had given a slightly different version of her presentation to the Local Strategic Partnership and had included ward profile information. It had been clear from the presentation that there were isolated pockets of deprivation, which needed addressing.

Lise Llewellyn reported that the next steps were to map how resources were spent across the direct. This information would be brought back to the Board however, would take time to compile and therefore timescales needed to be realistic. Regarding asset mapping, discussions would be required at a community level. It was also important to ensure that valuable work around parish planning was not duplicated.

Rachael Wardell supported the points made by Lise Llewellyn and referred to a programme she was aware of called 'Community Signature', which was a way of supporting community assets. Rachael Wardell saw the work as an opportunity for collaborative working and felt that discussions were needed with Public Health and the CCGs.

Leila Ferguson urged that the voluntary sector be involved throughout the process, particularly in asset mapping as this would highlight some of the smaller organisations working within communities.

**RESOLVED that** the Health and Wellbeing Board noted the JSNA report.

## 88. Newbury and District and North West Reading Clinical Commissioning Groups' Two Year Operational Plans (Philip Mcnamara and Dr Rupert Woolley)

Philip Mcnamara drew the Board's attention to Newbury and District Clinical Commissioning Group's (CCG) Operating Plan for 2014/16. The aim of presenting the plan was to assure the Board that it aligned with the health needs of the population and the Health and Wellbeing priorities.

The operating plan detailed a review of Newbury and District CCG's clinical aims and also achievements for 2013. The Operating Plan detailed the health needs of the population drawn from the JSNA and took account of patients' views and public opinion. A key "Call to Action" event had been held in November 2013 and over 60 members of the public had attended to contribute their views. The public would be continuously consulted on plans and listened to moving forward. Newbury and District CCG had identified three local priorities that reflected feedback from its patients and the public including:

- To better identify those who were Carers in their area, so that they could provide them with support.
- To offer Cardiovascular Health Checks to eligible patients, in order to proactively help people to remain well and healthy.
- To offer nine care processes to people identified with diabetes, so that all patients diagnosed with diabetes had the same standard of care.

The Newbury and District CCG had worked with the three other CCGs in Berkshire West to develop a five year Strategy and vision for the Berkshire West health and social care economy, which had been endorsed by the West Berkshire Health and Wellbeing Board. Through implementing their vision Newbury and District CCG were looking to secure a number of improvements in outcomes for patients and services users by 2019:

- A 3.2% reduction in the potential years of life lost from conditions which could be treated;
- An increase in the proportion of patients who said they felt supported to manage their long-term condition from 78.5% to 81%;
- A (tbc) reduction in unplanned admissions to hospital;
- A 3.6% reduction in the number of patients reporting poor experience of inpatient care;
- An (tbc) increase in the number of people reporting a positive experience of care outside hospital.

Philip Mcnamana reported that local aims outlined how the CCG wanted to join up mental and physical health. Key improvement Interventions covered the urgent care system including hospital at home and the NHS 111 service, both of which required further promotion.

Philip Mcnamara reported that close working had been demonstrated when developing the Operating Plan and it reflected both guidance from NHS England and the Area Team. Philip Mcnamara stressed that the document was just in draft form at present.

Councillor Graham Pask pleaded that agencies work together to improve discharge rates and utilise the district's greatest asset, West Berkshire Community Hospital. The access to this facility was excellent and it was hoped that the CCG would do all possible to promote its future use. Philip Mcnamara reported that this had been a key piece of

feedback from both members of the public and staff. He confirmed that they were looking to develop specific services which could be delivered from the West Berkshire Community Hospital.

Lise Llewellyn queried the aim of reducing the potential years of life lost from conditions which could be treated by 3.2% and was concerned that this figure was unrealistic. Lise Llewellyn also queried how realistic it was aiming to reduce the number of caesarean sections to less than 10%. Lise Llewellyn stated that West Berkshire was one of the healthiest places to live in the country and therefore progress was even more difficult. Philip Mcnamara reported that many of the measures were set nationally and West Berkshire was already doing well against many of them.

**RESOLVED that** Philip Mcnamara would look into the figures queried by Lise Llewellyn and confirm to the Board.

Rachael Wardell stressed that she did not want to see the number of targets dedicated to improving outcomes for children and young people diminish. It was often the case that adult issues dominated over those of children and young people. Rachael Wardell confirmed that she would be looking closely at objectives for children and young people.

Adrian Barker felt that the Operating Plan was full of innovative ideas that were aligned to the Health and Wellbeing Strategy. He felt however, that there was a lack of sense within the plan that it was part of a wider strategy, of which the Health and Wellbeing Board was one of the drivers. Further emphasis was required on prevention and this needed to be aligned with what others were doing in this area. Philip Mcnamara agreed and stated that steps could be taken to see what other information could be captured, for example from GPs as well as patients.

Cathy Winfield reported that there would eventually be an appendix to the Operating Plan which showed how the document linked to the Health and Wellbeing Strategy and other documents.

Lesley Wyman stressed that there needed to be more input from the CCGs when developing the Health and Wellbeing Strategy and this is what she hoped she would see moving forward.

Dr Rupert Woolley referred to North and West Readings draft two year Operational Plan and stated that there was much overlap with Newbury and District CCGs operating plan. The prioritise were slightly different in that they included diabetic services, end of life care, improved communications between GPs and West Call (the Out of Hours GP service) and finally the health of those living with long term conditions. Rupert Woolley reported that other areas, in particular urgent care overlapped with the Newbury and District area.

Councillor Graham Pask noted that one area that had not been mentioned was elderly dental services. It was felt that this was an area which was often forgotten however, had great repercussions.

**RESOLVED that** Jan Fowler would bring a report to a future Board meeting regarding the Dental Review.

## 89. Health and Wellbeing Performance Framework (Lesley Wyman)

Lesley Wyman gave a presentation to the Board updating them on the Health and Wellbeing Performance Management Framework. In summary:

- She had brought a paper to the November 2013 Board meeting which suggested that national performance outcome indicators were used, supported by local indicators relating to all priorities and underlying themes;

- It was felt at the Board meeting that there were too many high level indicators, which carried a risk of duplication as many were already reported on in other places.
- At the Board meeting in January it was suggested that five to eight national outcome indicators be used to monitor progress in priority areas.
- Feedback suggested that there were still too many outcomes and that a single performance framework was required for the work of the Board.
- The next steps were to agree a reduced list of national outcomes indicators and short list of local indicators based on the current Health and Wellbeing Strategy and Action Plan.
- A final report using these indicators would be brought to the Board meeting in May identifying progress made in the first year.

**RESOLVED that** an item on the Performance Framework for 2013/14 be added to the Health and Wellbeing Board's Forward Plan for the next meeting in May.

- The planning for the Performance Framework for 2014/15 would take a very different form. Priorities would be agreed from the Joint Strategic Needs Assessment (JSNA). Consultation would take place and Healthwatch would be involved in this.
- It was acknowledged that the Board did not have the capacity to focus on everything and therefore would have specific areas of focus.
- A continuum approach would be adopted that ranged from prevention and early intervention through to treatment and rehabilitation.
- There needed to be a focus on universal services as well as a targeted approach for vulnerable groups.
- As well as focusing on joint commissioning and joint working the Board needed to work to four points (taken from the Council's Strategy): Help residents to help themselves; help residents when they cannot help themselves; help residents to help one another and promote and act in the interest of the communities, people and businesses of the district.
- Areas of joint working that needed to be driven forward included public health and wellbeing, health care and social care.
- Each priority would need to be supported by a number of local indicators.
- The aim was: **one person**, supported by people acting as **one team** from organisations behaving as **one system** 'Sir John Oldham'.

Leila Ferguson reported that she had learnt from a recent course that numerous Boards had dropped the word 'health' and remained focused on 'wellbeing'. There were cases where 'wellbeing' had been placed on every council and NHS agenda. Bal Bahia confirmed that a development session for the Health and Wellbeing Board would soon be taking place where there would be an opportunity to discuss such suggestions.

Rachael Wardell stated that she supported the light touch approach to the performance management framework. However, she felt that it needed to be noted that the areas not included were still being carried out but monitored elsewhere. It was felt that it would be useful for those areas where there was a deficit, to show the gap between the deficit and where they needed to be rather than ambitions. The

Board needed to have shared objectives and identify areas where more could be done.

Adrian Barker highlighted that qualitative data was as important as quantitative data. Lesley Wyman reported that some of the information captured was based on qualitative data from self reported surveys etc. Dr Bal Bahia stated that Healthwatch gave the Board the opportunity to find out what outcomes the public wanted to see. Bal Bahia asked Adrian Barker what it was the public wanted to see and he responded that patient stories were always deemed useful. Jan Fowler suggested that the development session for the Health and Wellbeing Board might be a good place for patient experiences to be heard.

**RESOLVED that** short specific Performance Management Framework was the right direction for the Board. It was also agreed that deficits needed to be focused on.

## 90. Better Care Fund update and next submission (Rachael Wardell)

Rachael Wardell introduced her report to the Board which sought agreement on the final plan of how the Better Care Fund pooled budget would be used.

Rachael Wardell stated that the document was very similar to the first submission paper considered by the Board at their special meeting on 6th February 2014. Approval had been given at this meeting for the draft plans to be submitted to the Department of Health. Rachael Wardell stated that the report provided an update of development since the special meeting and sought approval on the final plans which would need to be submitted to the Department of Health by 4th April 2014.

A quality assurance process had taken place to ensure final plans were ready for submission. Whilst waiting for feedback on the plans from the Department of Health, discussions had taken place with the Clinical Commissioning Group (CCG) and all parties remained committed to the chosen schemes.

Rachael Wardell suggested that the Board might wish to have details of governance arrangements attached to the submission as an appendix. The Board needed to agree whether a light touch version should be submitted or a version with the governance arrangements included.

Cathy Winfield reported that the Berkshire West Partnership Board formed a layer of the governance.

Councillor Marcus Franks queried if there was a case for submitting the stages of monitoring, for example on a two monthly basis. Cathy Winfield confirmed that the standard checklist being used did not require target information at this stage.

Cathy Winfield reported that North and West Reading CCG and West Berkshire funds were being pooled together. This was detrimental to West Berkshire as North and West Reading received a larger proportion of the fund. Cathy Winfield stressed that it needed to be reflected that two CCGs made up the West Berkshire Health and Wellbeing Board.

Councillor Marcus Franks referred to page 157 of the agenda, which included information on deprivation and queried the level of detail included. Rachael Wardell confirmed that there was further detail required at this stage. Cathy Winfield reported that many of the programmes were not due to begin until 2015 and therefore West Berkshire had done particularly well to be clear on its plans at this early stage. The next year could be used to work up the remaining detail.

Councillor Franks queried the strength of the risk information detailed on pages 152, 166 and 167. Cathy Winfield concurred that the risk information could be strengthened. Phil Mcnamara confirmed that discussions had taken place with Steve Duffin (Head of ASC Efficiency Programme at West Berkshire Council) and the plan was to run the area of

work using stranded project management. The Health and Wellbeing Board would then receive reports on this. Councillor Franks stated that the detail referred to by Philip Mcnamara needed to be included in the planning document.

Councillor Franks proposed given the timings that the Health and Wellbeing Board delegate the power to Rachael Wardell and Cathy Winfield to sign off the final plans prior to them being submitted to the Department of Health. This was seconded by Dr Bal Bahia.

**RESOLVED that** Rachael Wardell and Cathy Winfield would sign of the final planning document for the BCF on behalf of the Health and Wellbeing Board.

## 91. The Urgent Care System (Cathy Winfield)

Cathy Winfield gave a presentation to the Board on Urgent Care and the Berkshire West system. In summary:

- The national review of urgent care focused on five main elements, in particular how urgent care services could connect together and work in a cohesive way.
- There was a national standard for 95% of Accident and Emergency attendances to be seen, treated, admitted or discharged within four hours. It was anticipated that more reasonable measures would be introduced in time.
- Regarding the ambulance service, a swift handover of 15 minutes between ambulance staff and the Accident and Emergency department was vital so that the ambulance service could accept a new call. If this took longer than 30 minutes an Accident and Emergency department could be fined.
- The Berkshire West urgent care system was very complex and consisted of many different components. It was expected that the complexity of the system was the reason why the public visited their Accident and Emergency department in the first instance.
- The Accident and Emergency department became the barometer of the system. Consistency was required and a system that directed people to the same places.
- The acute medical unit was for those people with more complex issues. It needed to be ensured that when entering the unit people were looked after in the most suitable part of the hospital and by the best consultant for their needs. This resulted in the best outcomes for the patient.
- There was a new service specification for NHS 111. Due to the problems with the service experienced nationally, Berkshire West opted for a phased approach to its introduction. There was realisation that members of the public were still not as aware of the 111 service as they should be. There was aspiration to have a renewed effort at raising awareness.
- There was ambition for a single health and social care hub that provided ease of access to all out of hospital services.
- The urgent care system had come under scrutiny by Monitor and NHS England and a system recovery plan would need to be implemented.
- There were a number of reasons why targets were breached including the internal discharge planning process. As a result seven day cover was being increased to help prevent patients not being discharged until after the weekend.
- Regarding what had been achieved, this included transparent whole system data, which formed an Urgent Care dashboard.

- Performance was gradually improving across the Urgent Care system. It could be seen from graphs that after a period of poor performance, recovery rates were very positive.
- Focus needed to remain on increasing discharge rates at weekends.
- Work was taking place with ECIST to help identify issues across the system. Length of stay reviews had been carried out to investigate why a bottle neck situation occurred.
- The Health and Wellbeing Board had a role to play which included taking oversight and ensuring all parts of the Urgent Care system were working to optimise flow through the system and by ensuring hr Better Care Fund was applied to develop services that would support people with urgent care needs.

Councillor Marcus Franks questioned if 999 calls made by care workers were reported on. Cathy Winfield confirmed that reports were received regarding calls from care homes however not primary carers. This was acknowledged as a useful point and further thought was required regarding communication points for carers and where they should make contact if they had concerns.

Rachael Wardell reported that the use of 111 was important when managing care pathways. If a person had real concerns then they should go to their local Accident and Emergency service, even if sound clinical advice advised them to wait until Monday.

Cathy Winfield confirmed that work also needed to take place with the voluntary sector and Children's Centres regarding the 111 service. Adrian Barker stated that this was an area where Healthwatch would be able to assist.

**RESOLVED that** the Health and Wellbeing Board noted Cathy Winfield's presentation on the Urgent Care System.

## 92. Pharmaceutical Needs assessment (Lise Llewellyn)

Lise Llewellyn introduced her report to the Board which set out the scope of the Pharmaceutical Needs Assessment (PNA). Lise Llewellyn reported that like the JSNA, the PNA was a mandatory document.

Pharmacies provided a range of services and the report considered what CCGs and Public Health could commission or add to enhance the services offered by pharmacies.

A service mapping process would take place to map existing pharmaceutical services in Berkshire against population density and rate of long term conditions. The JSNA and other relevant existing documents would be used to identify health needs of the population and to carry out a gap analysis. Consultation would also take place with the pharmacies and services users. The PNA would come back to the Health and Wellbeing Board before final sign off.

**RESOLVED that** the PNA be placed on the Forward Plan for a future meeting of the Board.

## 93. Review of Children's Public Health Commissioning Opportunities (Lise Llewellyn)

Lise Llewellyn introduced her report to the Board. Key principles in the Health and Wellbeing Strategy identified the need to focus on children. The report summarised a practical programme that would allow exploration and identification of opportunities. Lise Llewellyn reported that the report aimed to inform the Board of the national changes that would be occurring in children's commissioning for public health services and of the proposal of a local approach to support the change.

Lise Llewellyn reported that Public Health currently commissioned public health services for 5-19 year olds and Health Visitors were commissioned through the Area Team.

The new specification around Health Visiting provided universal services from ages 0 – 5. Health Visitors also provided a service to parents who's children were experiencing particular issues for example sleep issues.

In October 2015 the commissioning responsibility for these services would be brought under the Local Authority. The services needed to be aligned with services which already existed and integrated with Local Authority mainstream children's preventative services.

There would be the opportunity to look into the financial risk of health visiting services falling under the Local Authority and also the opportunity to see if there were any gaps in the allocation or transfer processes. An event would soon be organised in West Berkshire with stakeholders to look at the issues involved.

Rachael Wardell felt that there would be an opportunity to view the relationship between Health Visitors and Children's Centres. The early help hub 'help for families' fell short of thresholds and still required assistance.

Cathy Winfield questioned what would be controlled from the wider mental health and CAMHs agenda. Lise Llewellyn confirmed that the Solihull model was already being implemented and various other tools would need to be considered in the approach.

**RESOLVED that** the Health and Wellbeing Board noted the report.

## 94. Management of Charters (Lesley Wyman)

Lesley Wyman introduced the report which proposed a purpose for managing charters coming to the Health and Wellbeing Board. The Board at one of its earlier meetings had been asked to support a Charter for the Disabled Children's Trust. At the time the Board felt that there could be many other similar requests forthcoming and whilst the Board might be sympathetic to the aims and objectives of each charter, they did not feel it was appropriate to formally sign up to any one of them.

The report suggested that the Board adopted the process set out in paragraph two of the report. Lesley Wyman reported that in essence it would be her role to acknowledge receipt of a Charter and then cross reference any charter with the Health and Wellbeing Strategy.

Rachael Wardell confirmed that she was supportive of the process however, felt that another step needed adding which stated that if a charter was cross referenced with the Strategy and no link was found, the Strategy would be reviewed to ensure the area covered by the charter in question had not been missed.

**RESOLVED that** this step would be added to the process for managing charters.

## 95. Members' Question(s)

### 95(1) Question to be answered by the Health and Wellbeing Board submitted by Councillor Gwen Mason

A question standing in the name of Councillor Gwen Mason on the subject of the Health and Wellbeing Board producing a 'map' of local organisations involved in health and social care, so that it was clear where local people needed to go to seek information, advice and guidance would receive a written answer from the Health and Wellbeing Board in writing.

## 96. ITEM FOR INFORMATION - FORWARD PLAN

**RESOLVED that** all noted the Forward Plan for the Health and Wellbeing Board.

## 97. Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on 15th May 2014.

*(The meeting commenced at 9.00 am and closed at 11.05 am)*

**CHAIRMAN** …….

**Date of Signature** …….

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| **Title of Report:** | Performance Framework for 2013/14 |
| **Report to be considered by:** | The Health and Wellbeing Board |
| **Date of Meeting:** | May 15th, 2014 |

## Purpose of Report:

To recommend to the Board a finalised Health and Wellbeing Performance Framework for 2013/14
To update the Board on progress made throughout 2013/14 on each of the 5 priority areas.

## Recommended Action:

That the Board accept this performance framework for the reporting back on progress made in 2013/14 to address the priorities within the Health and Wellbeing Strategy.
That the Board also accepts this performance Framework to report back for 2014/15 progress on priorities until such time as new priorities are agreed and the Health and Wellbeing Strategy is updated.

| **Health and Wellbeing Board Chairman details** | |
|---|---|
| **Name & Telephone No.:** | Gordon Lundie (01488) 73350 |
| **E-mail Address:** | glundie@westberks.gov.uk |

| **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

1.1 Health and Wellbeing Boards were established under the Health and Social Care Act 2013 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their population and to promote integrated services. They operated on a shadow basis for the first year, and became fully operational on 1st April 2013.

1.2 The West Berkshire Health and Wellbeing Board (WB HWBB) has seen significant changes and developments in its first full year and hence the role of the Board has evolved with new responsibilities emerging, most notably those relating to the integration of health and social care services through the Better Care Fund and the Care Bill.

1.3 The overall purpose of the HWBB is to bring together bodies from the NHS, public health and local government, including Healthwatch (as the patients' voice), jointly to plan how best to meet local health and care needs. Their principle statutory duties are;

- To assess the needs of their population through a Joint Strategic Needs Assessment (JSNA);
- To set out how these needs will be addressed through a joint Health and Wellbeing Strategy that will offer a strategic framework in which Clinical Commissioning Groups, local authorities and NHS England can make their own commissioning decisions and;
- To promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets.

1.4 The H&WB Strategy, based on the JSNA, was written in the Board's shadow year (2012/13), and during 2013/14 considerable work was done on the development of a performance framework that could be used to demonstrate progress on the priority areas. At the time of the development of the strategy, the integration agenda was less apparent and therefore was not highlighted within the priorities. At the September 13/14 H&WBB meeting the first of many reports was tabled highlighting the importance of the integration of health and social care for the frail elderly. The reasons for embarking on this work in West Berkshire were:

- An 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).
- An improved patient and carer experience (A narrative for person centred (integrated) care. National Voices. 2013)
- Improved outcomes for patients (Lessons from Experience: Making integrated care happen at scale and pace. Kings Fund, March 2013).

1.5 From this point on the health and social care agenda became integral to the work of the Health and wellbeing Board. A report was brought to the Board in November 2013 setting out the progress of the Integration Programme in West Berkshire and outlining the process of transferring funds from the NHS to the LA, then known as the Integration Transformation Fund. This became the Better Care Fund (BCF).

1.6 A report was brought to the January Board meeting updating members on the Better Care Fund, describing the requirement for local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled BCF budget would 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.

1.7 A BCF plan was developed jointly by the CCG and the LA and agreed by the H&WBB at an Extraordinary H&WBB meeting on February 6th, 2014.

**The national metrics underpinning the Fund were:**

- Admissions to residential and care homes;
- Effectiveness of reablement;
- Delayed transfers of care;
- Avoidable emergency admissions; and
- Patient/service user experience.

1.8 It is apparent that the H&WB performance framework for 2014/15 must include both the priorities agreed in the 2013/14 H&WB Strategy and the outcomes of the BCF Plan for West Berkshire. However the Performance Framework for 2013/14 has only been developed to account for the priorities and outcomes set out in the original H&WB Strategy.

1.9 The attached Performance Framework for 2013/14 (Appendix a) can be utilised as a look back exercise for the first year of the H&WBB, focusing only on the priorities and outcomes listed in the Strategy. For 2014/15 an additional set of performance indicators can be added to the framework that focus on the integration of health and social care. Together this would enable reporting back to the Board both the Public Health and Wellbeing and the integration outcomes.

2.0 The five priorities in the Health and Wellbeing Strategy are:

- Supporting a vibrant district
- Giving every child and young person the best start in life
- Supporting those over 40 years old to address lifestyle choices detrimental to health
- Reducing childhood obesity in primary school children
- Promoting independence and supporting older people to manage their long term conditions

Appendix A sets out a small number of Public Health Outcomes from the Public Health Outcomes Framework, together with local indicators that show how different departments are working to achieve the overarching outcomes. The outcomes selected indicate areas of work that are undertaken in partnership. Some local indicators are still being decided by the CCG, Adult Social Care, Children's services and Environmental Health. These will be added once agreed and the metrics included.

## Appendices

Appendix A – Health and Wellbeing Board Performance Framework

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# Performance Framework for West Berkshire Health and Wellbeing Board 2013/14

## Reducing childhood obesity in primary school children

| Overarching indicator | Specific indicator | | Latest update | 'Good' is… | West Berkshire outturn | Direction of Travel on previous outturn | Benchmarks | | | Data caveats: | Frequency: | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Detail | Source | | | | | South East | England | Comparison with England value | | | |
| Prevent and reduce excess weight in children aged 4-5 and 10-11 years | 2.06i: Excess weight in children aged 4-5 years old - % of children aged 4-5 classified as overweight or obese | PHOF | 2012/13 | Low | 18.86% | Improved | | 22.23% | Significantly better | each year a different cohort of children is measured. Children are measured in the spring and summer terms and the finalised data is available 6 months later in the Dec/Jan. | Annual (2013/14 data should be available in January 2015) | |
| | 2.06ii: Excess weight in children aged 10-11 years old - % of children aged 10-11 classified as overweight or obese | PHOF | 2012/13 | Low | 29.12% | Improved | | 33.32% | Significantly better | | | |
| **Local indicators** | **baseline** | | | | | | | | | | | |
| number of additional healthy eating intiatives commisisoned in school and community settings for children | | PH Action plan | 11 | high | | improved | | | | | quarterly | AP |
| number of additional physical activity intiatives commisisoned in school and community settings for children | 7 | PH Action plan | 11 | high | | improved | | | | | quarterly | AP |
| number of children and adults taking part in physical activity projects in school and community settings | | PH Action plan | 0 | high | | improved | | | | | quarterly | AP |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| number of children and adults taking part in healthy eating projects in school and community settings | | PH Action plan | | high | | improved | | | | | quarterly | AP |
| number of additional road safety intiatives run | | PH Action plan | 3 | high | | improved | | | | | quarterly | AP |

## Supporting those over 40 to change lifestyle behaviours detrimental to health and wellbeing

| Overarching indicator | Specific indicator | | Latest update | 'Good' is… | West Berkshire outturn | Direction of Travel on previous outturn | Benchmarks | | | Data caveats: | Frequency: | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Detail | Source | | | | | South East | England | Comparison with England value | | | |
| 3.1 Decrease smoking prevalence in adults aged 18 and over | 2.14i: Prevalence of smoking among people aged 18+ | PHOF | 2012 | Low | 18.76% | Declined | 18.02% | 19.53% | Similar | | Annual (Figures will be published in Feb-15) | PH and wellbeing team |
| **local indicators** | **baseline** | | | | | | | | | | | |
| number of 4 week quitters | | local | Q1 2013/14<br>**145**<br>Q2 2013/14<br>**147**<br>Q3 2013/14<br>**225**<br>Q4 2013/14 | high | | | | | | | quarterly | FN<br>FN<br>FN<br>FN |
| number of 12 week quitters | | | Q1 2013/14<br>**90**<br>Q2 2013/14<br>**114**<br>Q3 2013/14<br>**120**<br>Q4 2013/14 | | | | | | | | quarterly | FN<br>FN<br>FN |
| 3.2 Increase the successful completion of drug treatment for opiate users | 2.15i: % of opiate drug users that left drug treatment successfully who do not re- | PHOF | 2012 | High | 12.21% | Improved | 9.16% | 8.24% | Significantly better | | This is available quarterly through NDTMS | |
| 3.6 Increase the percentage of eligible population aged 40-74 offered and receiving an NHS health check | 2.22ii: % of eligible population aged 40-74 offered an NHS Health Check who received a Health Check | PHOF/ Local | 2013/14 Q4 | High | 6.34% | Improved | | | | | Updated annually on PHOF, but we will be able to provide quarterly figures. | |
| **local indicators** | **baseline** | | | | | | | | | | | |
| number of people offered an NHS health check | | | Q1 - 2012<br>Q2 - 2429<br>Q3 - 2270<br>Q4 - 2426<br>Total = 9,137 (19.1%) | | | | 20% - 9,585 | 20% - 9,586 | Similar | | quarterly | EC<br>EC<br>EC<br>EC |
| number of NHS health checks completed | | | Q1 - 753<br>Q2 - 916<br>Q3 - 1371<br>Q4 - 787<br>Total = 3,827 (8.0%) | | | | 10% - 4,792 | 10% - 4,793 | Similar | | quarterly | EC<br>EC<br>EC<br>EC |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.7 decrease excess weight in adults | prevalence of overweight and obese adults | Active People Survey | 2012 | low | 65.50% | | 63.10% | 63.80% | similar | estimated and self reported | annual | |
| **local indicators** | **baseline** | | | | | | | | | | | |
| number of people completing a weight management course | | | 337 | | | | | | | | | LW |
| number of people completing a weight management courtse and losing 4-5% of body weight | | | | | | | | | | | | LW |

## Promoting independence and supporting older people to manage their long term conditions

| Overarching indicator | Specific indicator | | Latest update | 'Good' is… | West Berkshire outturn | Direction of Travel on previous outturn | Benchmarks | | | Data caveats: | Frequency: | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Detail | Source | | | | | South East | England | Comparison with England value | | | |
| 4.1 Decrease the under 75 mortality rate from cardiovascular diseases considered preventable | 4.01: rate of death per 100,000 of people under age 75 from CVD considered preventable | PHOF | 2009-11 | Low | 30/100,000 | | | 40.00 | Similar | three year rolling averages | Annual | CCG |
| **local indicators** | | | | | | | | | | | | |
| see indicators for smoking, physical activity and weight management | | | | | | | | | | | | |
| CCG indicators | | | | | | | | | | | | |
| 4.2 Decrease the rate of emergency admissions for fractured neck of femur in those aged 65 and over | 4.14i: Rate of emergency admissions for fractured neck of femur in those aged 65+ per 100,000 population | PHOF | 2011/12 | Low | 444.68 | Declined | | 457.16 | Similar | | Annual | CCG |
| CCG indicators | | | | | | | | | | | | |
| 4.5 Increase the proportion of people who feel supported to manage their long term condition | Directly standardised % of people who feel supported to manage their LTC | HSCIC GP Patient Survey | July 2012 - March 2013 | high | 72% | increased | | 66.70% | better | sample survey | annual | CCG ASC |
| CCG indicators | | | | | | | | | | | | |
| ASC indicators | | | | | | | | | | | | |

## Giving every child and young person the best start in life

| Overarching indicator | Specific indicator | | Latest update | 'Good' is… | West Berkshire outturn | Direction of Travel on previous outturn | Benchmarks | | | Data caveats: | Frequency: | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Detail | Source | | | | | South East | England | Comparison with England value | | | |
| Improve the emotional wellbeing of looked after children | 2.08: Emotional wellbeing of looked after children - Average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March | PHOF | 2013 | Low | 16.4% | Declined | 14.8% | 14.0% | Not compared | This indicator can be affected by the relatively low cohort of looked after children in West Berkshire. For example, March-13 figures included the 'Strengths and Difficulties' scores for 55 children in West Berkshire. | Annual (Mar-14 data will be available in December 2014). I don't know if your Children's Services Department would be able to provide you with a snapshot at the end of each quarter? | C&YP |
| **local indicators** | **baseline** | | | | | | | | | | | |
| Children and yp indicators | | | | | | | | | | | | |
| Improve breast feeding rates at 4-6 weeks after birth | 2.02ii: Breastfeeding prevalence at 6-8 weeks after birth | PHOF | 2012/13 | High | 55.60% | | 50.06% | 47.22% | Significantly better | This information is estimated using the Berkshire West PCT data, so could be an under/over representation of activity in West Berkshire. We will start to receive this information from NHS England on a quarterly basis at a CCG level. We will ask to see if this can be presented by GP, so that we can provide an estimate for West Berkshire. | We will start to receive this information from NHS England on a quarterly basis in March-14. However, this will be at a CCG level. We will ask to see if this can be presented by GP, so that we can provide an estimate for West Berkshire. | FN |
| **local indicators** | **baseline** | | | | | | | | | | | |

## Supporting a vibrant district

| Overarching indicator | Specific indicator | | Latest update | 'Good' is… | West Berkshire outturn | Direction of Travel on previous outturn | Benchmarks | | | Data caveats: | Frequency: | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Detail | Source | | | | | South East | England | Comparison with England value | | | |
| 2.5 Decrease statutory homelessness - homelessness acceptances and households in temporary accommodation | 1.15i: Homelessness acceptances per 1,000 households | PHOF | 2011/12 | Low | 1.00 | Declined | 1.53 | 2.31 | Significantly lower | | Annually updated on PHOF, although you may find that your Housing dept have monthly/quarterly stats | |
| | 1.15ii: Households in temporary accommodation per 1,000 households | PHOF | 2011/12 | Low | 0.77 | Declined | 1.23 | 2.32 | Significantly lower | | Annually updated on PHOF, although you may find that your Housing dept have monthly/quarterly stats | |
| **local indicators** | **baseline** | | | | | | | | | | | |
| Adult services indicators | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.4 Decrease the percentage of households that experience fuel poverty | 1.17: Fuel Poverty - The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology | PHOF | 2011 | Low | 6.8% | | 8.20% | 10.90% | | | Annual (2012 figures will be published in Nov-14) | |
| **local indicators** | **baseline** | | | | | | | | | | | |
| envirnoment services indicators | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.9 Reduce domestic abuse | 1.11: Rate of domestic abuse incidents reported to the police per 1,000 population | PHOF | 2011/12 | Low | 18.63 | | 16.21 | 18.15 | Not compared | | Annual (Figures will be published in Feb-15) | |
| **local indicators** | **baseline** | | | | | | | | | | | |
| community safety indicators | | | | | | | | | | | | |

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| | |
|---|---|
| **Title of Report:** | **The West Berkshire Health & Wellbeing Board – Three Years On – A Review** |
| **Report to be considered by:** | Management Board and Health & Wellbeing Board |
| **Date of Meeting:** | 15th May 2014 |
| **Forward Plan Ref:** | |

## Purpose of Report:

**To review the work of the West Berkshire Health and Wellbeing Board to date and to make recommendations with a view to strengthening its current role and providing additional support to enhance its future work programme.**

## Recommended Action:

**To approve the recommendations set out in paragraph 6.3 of the report.**

**Reason for decision to be taken:**

**A review of the West Berkshire Health and Wellbeing Board is timely, as is the potential need to strengthen its role, and accelerate progress.**

**Other options considered:**

None, although the current arrangements could be left in place.

**Key background documentation:**

Health & Wellbeing Boards, one year on (Kings Fund, 2013)
Health and Wellbeing Boards, System Leaders or talking shops? (Kings Fund, 2012)

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

- ☐ **CSP1 – Caring for and protecting the vulnerable**
- ☐ **CSP2 – Promoting a vibrant district**
- ☐ **CSP3 – Improving education**
- ☐ **CSP4 – Protecting the environment**

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

- ☐ **CSP5 - Putting people first**
- ☐ **CSP6 - Living within our means**
- ☐ **CSP7 - Empowering people and communities**
- ☐ **CSP8 - Transforming our services to remain affordable and effective**
- ☐ **CSP9 - Doing what's important well**

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

| **Portfolio Member Details** | |
|---|---|
| **Name & Telephone No.:** | Marcus Franks |
| **E-mail Address:** | mfranks@westberks.gov.uk |
| **Date Portfolio Member agreed report:** | 28th April 2014 |

| Contact Officer Details | |
|---|---|
| **Name:** | Nick Carter |
| **Job Title:** | Chief Executive |
| **Tel. No.:** | 01635 519101 |
| **E-mail Address:** | ncarter@westberks.gov.uk |

## Implications

**Policy:** This paper raises no specific policy issues but does highlight the need for the WBHWBB to review its current role and remit and in particular, whether this needs to be strengthened and if so, how this is best achieved and resourced.

**Financial:** The report does not seek additional financial resources.

**Personnel:** There are no personnel implications associated with this report. There is however, a need to marshal existing staff resources more effectively to ensure support for the Board.

**Legal/Procurement:** None

**Property:** None

**Risk Management:** If the WBHWBB does not seek to strengthen its role it could be argued that there is a risk that it will not deliver the system leadership that the Government anticipated when health and wellbeing boards were established. There is also a risk that if they are not resourced effectively to fulfil their role, then expectations will not be met. Equally there is a risk that those organisations that sit on the Board are not yet ready to jointly assume the leadership role that the Government envisaged, and that further time is needed for the relationships to mature and confidence to grow before such a role can be realistically taken on board. Further development time is also required so the Board's leadership role can be further enhanced.

**Corporate Board's Recommendation:**

| **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 | ☐ |

| **Is this item subject to call-in?** | Yes: ☐ | No: ☐ |
|---|---|---|

If not subject to call-in please put a cross in the appropriate box:

| | |
|---|---|
| The item is due to be referred to Council for final approval | ☐ |
| Delays in implementation could have serious financial implications for the Council | ☐ |
| Delays in implementation could compromise the Council's position | ☐ |
| Considered or reviewed by Overview and Scrutiny Management Commission or associated Task Groups within preceding six months | ☐ |
| Item is Urgent Key Decision | ☐ |
| Report is to note only | ☐ |

# Executive Summary

## 1. Introduction

1.1 The purpose of this report is to review the progress that has been made over the past 3 years by the West Berkshire Health and Wellbeing Board (WBHWBB). In undertaking this review evidence has been drawn from national research conducted by the Kings Fund.

## 2 Findings

2.1 The WBHWBB would seem to be in a similar position to that of many Boards nationally. It is still on a journey. Some key findings (many of which are mirrored nationally) are;

- most notably at the early stages of development a large amount of time has been devoted to governance issues and organisational updates;
- more time is spent on Public Health. Less time (if any) is spent on integration or on monitoring the local health and social care economy and the interventions that might be required to guarantee its effectiveness;
- there is no real coordination of commissioning plans. Organisational timescales conflict. This leads to problems in terms of alignment to, and recognition of, the priorities within the Health and Wellbeing Strategy;
- relationships are generally good and improving;
- resourcing is problematic and greater coordination and support is required;
- membership in terms of the size of the WBHWBB seems appropriate. There is a question as to whether the composition is correct for taking on a broader and more challenging leadership role, should this be seen as desirable.

## 3. Conclusions

3.1 In writing this review it has been assumed that the Board wants to move to a position where it develops “an executive decision making role across the whole system of health, social care and public health, with an explicit remit to oversee commissioning of all services, produce an agreed framework for integrated care and drive through the transformation of local services”. If it is to achieve this then it is recommended that;

- its scope of activity is broadened with a more balanced agenda;
- the commissioning cycle is realigned with the Health and Wellbeing Strategy at its heart;
- that resourcing and governance arrangements for the Board are overhauled and realigned to ensure the agreed role can be delivered;
- the composition of the Board is reviewed.

# Executive Report

## 1. Introduction

1.1 Health and Wellbeing Boards were established under the Health and Social Care Act 2013 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their population and to promote integrated services. They operated on a shadow basis for the first year, and became fully operational on 1st April 2013.

1.2 Given the West Berkshire Health and Wellbeing Board (WBHWBB) is now three years old (one in its fully established form) it was felt timely to take stock. The role of the Board has evolved during the course of the past year with new responsibilities emerging, most notably those relating to the Better Care Fund and the Care Bill. This paper reflects on these changes but, more importantly, seeks to assess the overall performance of the Board, its resourcing and future membership.

## 2. Background

2.1 The overall purpose of Health and Wellbeing Boards (HWBBs) is to bring together bodies from the NHS, public health and local government, including Healthwatch (as the patients' voice), jointly to plan how best to meet local health and care needs. Their principle statutory duties are;

- to assess the needs of their population through a Joint Strategic Needs Assessment (JSNA);
- to set out how these needs will be addressed through a joint Health and Wellbeing Strategy that will offer a strategic framework in which Clinical Commissioning Groups, local authorities and NHS England can make their own commissioning decisions and;
- to promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets.

2.2 The principles underlying the boards have been summarised as;

- shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations;
- a commitment to driving real action and change to improve services and outcomes;
- parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities;
- shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves;

- openness and transparency in the way that the board carries out its work;

- inclusiveness in the way it engages with patents, service users and the public.

2.3 The Kings Fund produced a report in October 2013 entitled 'Health and Wellbeing Boards – One Year on'. Their review highlighted a number of key messages;

- relationships between CCGs and local authorities were reported as being very good and getting better despite significant organisational change.

- local authorities have shown strong leadership in establishing the boards, with most being chaired by a senior elected Member. Vice chairs often came from CCGs which was seen as positive.

- most boards have produced Joint Strategic Needs Assessment (JSNAs) and health and wellbeing strategies. Progress at a local level was seen to be very patchy as was capacity for further development.

- the highest priorities in the Health and Wellbeing Strategies of most boards concern public health and health inequalities. This is seen to reflect a high priority being given to public health but concerns that boards have yet to turn their attention to the immediate and urgent strategic challenges facing their local health and care system. The report states 'unless they do, there is a real danger that they will become a side show than a source of system leadership.'

- most boards want to play a bigger role in commissioning services for their local populations.

2.4 A number of other interesting observations were also drawn from the Review;

- size of the board – between 8-12 members is seen as the optimum although many are operating with a membership between 13 and 20. Achieving a balance between inclusiveness and board effectiveness is seen to be a struggle;

- there is increasing engagement with providers which was cited as a problem when HWBBs were operating in shadow form;

- most HWBBs had agreed their priorities, many reflecting the policy objectives outlined in the Marmot Review. Health and social care integration and issues such as out of hours care, carers, quality of services and reconfiguration were rarely mentioned;

- as HWBBs move from setting strategy to implementing, it was felt board members would need to work together to wield their power of influence and persuasion over their local health and care system given their actual powers are limited;

- few HWBBs have got to the position of considering how they measure their success;

- HWBBs are keen to play a stronger role in commissioning but suggest that they may simply endorse existing programmes of work on issues such as integration and service reconfiguration instead of adopting them as new priorities. In other areas public health is seen to dominate the agenda with some HWBBs seeing health commissioning as the sole role of the CCGs.

2.5 In its conclusions the Kings Fund report highlights tensions between the boards' role in overseeing commissioning and promoting integration, between; high level strategic planning, as opposed to involvement in the operational management of pooled budgets or integrated services and between tackling population level health issues and driving forward service changes. In the context of continuing uncertainty, it concludes that the 152 boards are unlikely to be able to work through these complex issues with any great speed.

2.6 The report goes on to state, 'with all the policy indicators suggesting a stronger future role for health and wellbeing boards, whether they can deliver real change for local populations in their current form, is doubtful. The legal powers and duties of boards are largely permissive and discretionary, that is, CCGs and local authorities can do anything they wish providing that they are in agreement. In this guise, the boards are vehicles for partnership rather than executive decision making.'

2.7 The report suggests three possible scenarios for the future development of health and wellbeing boards;

- the first is that based on their current trajectory of development, most boards will default to a limited role of information sharing and high level coordination of plans and strategies. They will react to proposals and plans from partners, and some boards will make progress in overseeing specific public health programmes, but few, if any, will initiate or lead system-wide change;

- a second scenario is that in some places where there is little confidence in the board, local planning and decisions could be made in separate channels in the local authority or CCG, for example, the use of the Better Care Fund, or through urgent care boards. This would see the health and wellbeing boards by-passed and sidelined;

- a third scenario is that the boards develop an executive decision making role across the whole local system of health, social care and public health, with an explicit remit to oversee commissioning of all services, produce an agreed framework for integrated care and drive through the transformation of local services. This would be consistent with a policy thrust towards more integrated commissioning across the local NHS and local government.

## 3. The West Berkshire Health & Wellbeing Board (WBHWBB)

3.1. The West Berkshire HWBB (WBHWBB) has met 21 times since June 2011. An analysis of the agendas at these 21 meetings is reflected in Figs 1 and 2 and highlights the following;

- there is a reliance on verbal reports although this has diminished over time. In reality verbal reports should not be allowed since the Board is operating under the Executive Rules of Procedure;
- organisational updates and the most common item on the agenda. This is followed by discussions on governance. Taken together they account for half of all the agenda items brought to the Board. Again, these have become less prominent over time;
- public health and the JSNA are the next most frequent topics to appear on the agenda. Integration accounts for only 5% of the agenda discussions although its prominence has increased of late.

**Fig 1 - Delineation between verbal and written reports at the Health & Wellbeing Board (2011-2014)**

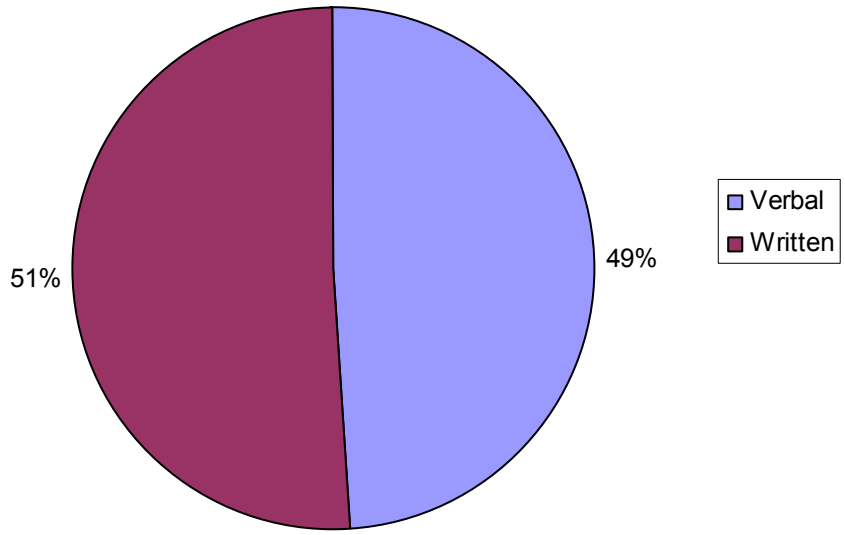
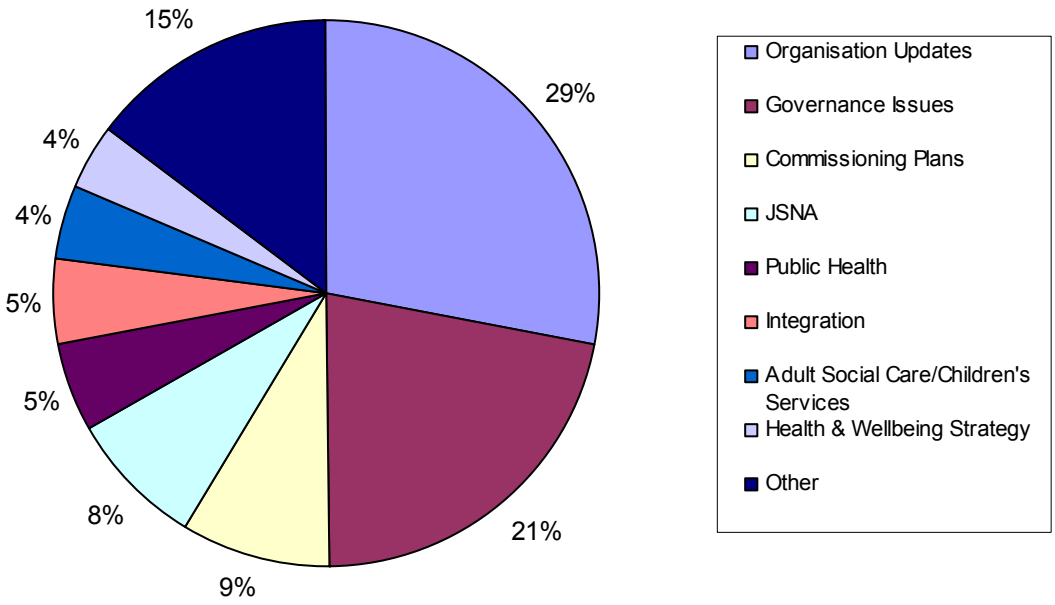


**Fig 2 - An analysis of topics placed on the West Berkshire Health & Wellbeing Board Agenda (2011-2014)**




## 4. Key issues for the WBHWBB

4.1 There are many parallels between the findings of the national Kings Fund study and the position in West Berkshire. These can perhaps be summarised as follows;

- the agendas – and therefore discussion – at the WBHWBB are more focused on public health than the wider health and social care economy. Until very recently health and social care integration has been largely absent from the debate and has only emerged to any degree by timescales associated with the need to sign off plans relating to the Better Care Fund.

- the HWBB has agreed a JSNA and Health and Wellbeing Strategy for West Berkshire. Priorities have also been agreed although these are often driven from a Public Health perspective. Whilst both commissioners and providers have brought plans to the WBHWBB these have in effect been for sign off. The Board itself has made few, if any, changes. Whilst the various timescales attached to the sign off of the various plans do not assist coordination, there is no real sense that the priorities of the Health and Wellbeing Strategy are at the heart of the planning process and a key driver in the development of commissioners' own plans;

- relationships are good and would seem to be improving;

- there remains a major issue surrounding support for the Board. At the moment individual officers from the Council and CCG provide support by way of preparing papers. If the Board wishes to move forward on a broader front and at greater pace then a fundamental rethink is required into how the Board is supported. More dedicated resource is

required preferably drawn from both the Council and CCG and if possible, other partners;

- membership – the WBHWBB currently has 9 voting members. Given the findings of the earlier research it would seem to be appropriate in terms of size but it would be timely to review the nature and scope of the membership mindful of the role that the WBHWBB wants to take, and the statutory guidance that is in place.

## 5. Moving Forward

5.1 Whilst the WBHWBB has matured and is now managing a wider work programme more aligned to its broader role, there remains a need to fundamentally consider the underlying aspirations of the Board. Looking at the three scenarios in paragraph 2.7 it is assumed that the third scenario is where the WBHWBB would wish to get to with a view that scenario 1 has already been achieved. Based on this the following would be proposed;

**(1) Scope of activity** – If the WBHWBB is to adopt a wider commissioning role and one in which there is a broader executive decision making role across the whole local system of health, social care and public health, then it would seem necessary to;

- develop a framework that allows the WBHWBB to identify key issues and pressures within the West Berkshire health and social care economy. The most practical and immediate solution to this would seem to be the adoption of some form of regular, 'overview report' which would identify the key determinants of an effective functioning health and social care economy, assess current performance against those determinants and identify where intervention is necessary/appropriate. This does not exist at present;

- the WBHWBB needs to agree its own commissioning cycle which takes priority over that of individual commissioning organisations. Commissioning activity would be driven by the priorities set out in the West Berkshire Health and Wellbeing Strategy. This is currently not in place – or at least there is no coordination;

- the Health and Wellbeing Strategy itself needs to have a wider set of priorities that are driven by more than public health outcomes, as is the case at present. The integration agenda and the issue of monitoring more closely the local health and social care economy also need to be included as priorities. Once agreed these priorities would then drive the annual work programme of the WBHWBB.

- Fig 3 seeks to demonstrate the proposed scope of activity that is being suggested and how it would be linked.

**(2) Work programme**

- review of JSNA as required if this is to influence the annual planning cycle then this will need to be done during the summer;

- review of West Berkshire Health and Wellbeing Strategy (WBHWBS) and more important the Delivery Plan annually and review of priorities to reflect the wider role of the Board (by early Autumn following the JSNA);

- alignment of all commissioners plans to WBHWBS. The Board need to agree a timescale for achieving this given organisational and statutory requirements; and the need to align this to budget cycles;

- clarify how the Integration Programme is to be programme managed. Seven individual integration projects have now been agreed at a West Berkshire level and the Board needs to have oversight of these and the means of taking corrective action should it be needed. More widely the Board also needs to retain an overview of the Integration work that is being undertaken at a Berkshire West level;

- development of a performance framework. The Board currently has no means of assessing whether it is being successful or not. There will be a number of strands to such a performance framework but it will be the main means by which the Board will be able to assess progress against its objectives and take corrective action where necessary.

**(3)** **Resourcing** – the WBHWBB does not have sufficient officer resource to achieve the role outlined in (1). Neither will a single officer or service be responsible for delivering the various elements of the proposed work programme. It is proposed to create a Health and Wellbeing Management Group which would directly support the WBHWBB. Changes would be made within West Berkshire Council to realign public health, adult social care and corporate resources to support the work of the Management Group.

**(4)** **Membership** – the HWBB currently has eight voting Members as follows;

- West Berkshire Council – (2) – the Leader of the Council or their nominated representative, the Portfolio Holder for Health and Wellbeing

- CCGs (2)

- Healthwatch (1)

- Voluntary Sector (1)

- Director of Public Health (1)

- Director of Communities (1)

There are also a further 2 non voting West Berkshire Council members and a number of supporting officers drawn from West Berkshire Council and the CCGs who attend the WBHWBB meetings. Overall the size of the Board would seem appropriate but if the scope of the

Board's activity is to be broadened then it may be worth reviewing whether the right representatives are there. In particular, representation from Adult Social Care and Children's Services may be significant given their importance to the Health and Social Care Integration agenda. This will need to be considered alongside the statutory guidance on membership.

## 6. Conclusions and Recommendations

6.1 The West Berkshire Health and Wellbeing Board is still at an early stage in its development and is continuing to evolve. Many of the current issues affecting HWBBs are reflected in the National Kings Fund survey which was undertaken last year. As with virtually all boards across the country, it would be fair to say that there is still some way to go to achieve the aspirations that the Government had for HWBBs when they were established.

6.2 In looking ahead, the first issue for the Board is to consider what role it wants to take. In setting out proposals here it has been assumed that the Board would want to adapt perhaps the most expansive role described here as "having an executive decision making role across the whole system of health, social care and public health with an explicit remit to oversee commissioning of all services, produce an agreed framework for integrated care and drive through the transformation of local services." In doing so the following would need to be attended to;

- the development of a broader agenda more attuned to the wider health and social care economy in West Berkshire;
- reflecting the above, a broader set of priorities within the Health & Wellbeing Strategy (HWBS);
- the alignment of commissioning plans around the HWBS;
- effective programme management of the Health & Social Care Integration Programme both in West Berkshire, and when developed, across Berkshire West;
- additional resourcing and stronger and more cohesive governance arrangements to support the Board.

6.3 In terms of specific recommendations the following are proposed to help take the Board's work forward. No comment is made regarding the timing of these recommendations or indeed the Board's readiness to move forward as suggested;

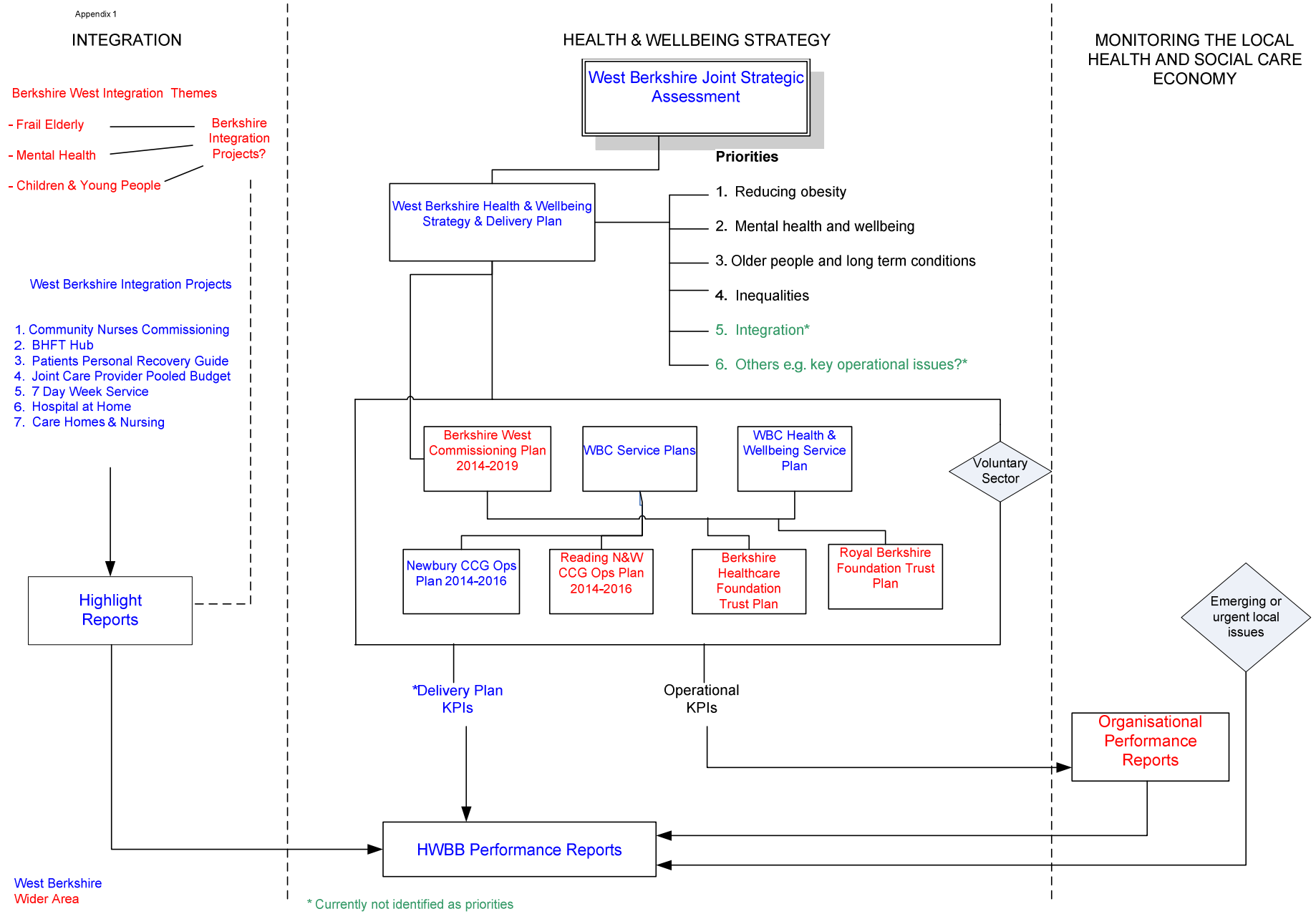
- the inclusion of a monitoring report which highlights the status of the West Berkshire health and social care economy and where necessary, areas for the Board to intervene;
- the inclusion of a programme management approach to health and social care integration following clarity as to what is to be delivered locally in West Berkshire and across Berkshire West;

- realignment of the commissioning cycle with the JSNA and Health and Wellbeing Strategy (HWBS) being agreed by the Board in January with commissioning plans following shortly after that all aligned to the HWBS and ideally, with each other;

- the Board to review its membership in light of an expanded supporting governance;

- the resourcing of the Board and associated arrangements to be agreed between WBC and the CCGs.

## Fig 3 – The proposed main strands of activity for the WBHWBB



| | |
|---|---|
| **Title of Report:** | Joint Health and Social Care Self-Assessment Framework (for People with Learning disabilities) |
| **Report to be considered by:** | The Health and Wellbeing Board |
| **Date of Meeting:** | 15th May 2014 |

**Purpose of Report:** To give a follow up report to the Health and Wellbeing Board on the work that is now complete.

**Recommended Action:** Members of the Health and Wellbeing Board to note the report.

| **Health and Wellbeing Board Chairman details** | |
|---|---|
| **Name & Telephone No.:** | Gordon Lundie (01488) 73350 |
| **E-mail Address:** | glundie@westberks.gov.uk |

| **Contact Officer Details** | |
|---|---|
| **Name:** | Alison Love |
| **Job Title:** | Service Manager – Long Term Care |
| **Tel. No.:** | 01635 519738 |
| **E-mail Address:** | alove@westberks.gov.uk |

# Executive Report

## 1. Introduction

1.1 The Joint Health and Social Care Self Assessment Framework (for People with Learning Disabilities) is a required annual report on local health and social care services for people with learning disabilities.

1.2 In 2013 the responsibility for requesting and collating this information transferred from the Government Office of South East England to Public Health England.

1.3 The requirement to collect and monitor this information was part of the Valuing People Now objectives (national strategy for people with learning disabilities 2010) and also came about because of the national enquiries into the deaths of six people with learning disabilities in hospitals. It was found that they had not had access to treatment because staff had not recognised their illnesses mainly due to their inability to communicate with these patients. The Six Lives Report and Healthcare for All were two of the enquiries that pursued this over a period years

1.4 There is also now much evidence to indicate that people with learning disabilities suffer from poorer health than the general population, often have undiagnosed physical conditions, and sometimes find it difficult to access the same treatment as other people. For this reason the Directed Enhanced Scheme of annual health checks with their GP was set up a number of years ago.

## 2. The Local Context

2.1 The local Joint Health and Social Care Self–Assessment approach was developed in conjunction with colleagues from the Commissioning Support Unit of the CCGs, and Berkshire Healthcare Trust. There was also a local consultation group with a number of service users/patients. The report was submitted in December 2013 as required.

2.2 The format of the report had changed considerably from previous years and some Colleagues struggled to get the information required. Therefore we know that there are significant gaps and inaccuracies in the health information. The local Community Team for People with Learning Disabilities has some information that gives evidence of better local health services than is portrayed in the report. However the report format clearly stipulated how and where the evidence should be gathered.

2.3 A summary of the statistical evidence is set out below and a copy of the full report is attached as an appendix. However it should be noted that some changes will have taken place since December.

## 3. The Local Information from the Report

| | **Health and Social Care Statistics for People with Learning Disabilities in West Berkshire** | |
|---|---|---|
| **Subject** | **Numbers** | **Comment** |
| Annual Health Checks by GPs 2012-13 | 237 people were noted as eligible. The actual number recorded was 138 | The Local Authority knows of over 400 people with a learning disability so the eligible number is lower than expected |
| Health Action Plans. (Can be done by a number of professionals) | 268 eligible – 159 actual | |
| GP Practices Participating in DES Health Checks | 11 out of 11 | 2 local Practices did not submit information which partly explains the low recording |
| | **Health Screening Information (over past 3 years)** | |
| Cervical Screening | 77 eligible – 22 actual | |
| Breast Cancer | 22 eligible – 8 actual | |
| Bowel Cancer | 19 eligible – 5 actual | |
| BMI | 201 recorded – 98 in obese range | |
| Known Coronary Heart Disease | 1 | |
| Known Diabetes | 16 | |
| Known Asthma | 35 | |
| Known Epilepsy | 47 | |
| | **Hospital Admissions** | |
| Acute Admission Episodes | 24 | |
| Outpatient Appointments | 51 | |
| 14. A+E Attendances | 42 | |
| | **Continuing Healthcare and Mental Health** | |
| Responsibility of CHC | 32 | |
| Section 117 of MHA | 2 | |
| Specialist MH Hospital | 4 | |
| | **Assessment and Provision of Social Care 2012-13** | |
| Number of Assessments and Re-assessments | 280 | |
| In Receipt of Community | 332 | |

| | | |
|---|---|---|
| Based Services | | |
| In Residential Care | 108 | |
| In Nursing Homes | 3 | |
| | **Employment and Work** | |
| In Paid Employment | 19 but 11 of these work less than 16 hours | |
| In Unpaid Voluntary Work | 128 | |
| | **Types of Accommodation (excluding care homes)** | |
| Night Shelter | 1 | |
| Other Temporary Accommodation | 1 | |
| Owner Occupier/Shares Ownership | 5 | |
| Tenant without Support | 40 | |
| Supported Accommodation | 116 | |
| Living with Family or Friends | 132 | |
| Adult Placement | 22 | |
| Extra Care Sheltered Housing | 2 | |
| | **Transition from Children to Adults** | |
| Total School Age Population | 25,296 | |
| Moderate Learning Disability | 69 | |
| Severe Learning Disability | 10 | |
| Profound and Multiple Disability | 20 | |
| Receiving Support in School due to Autism | 296 | |
| | **Other Significant Information** | |
| Complaints to the Local Authority | 11 | |
| Safeguarding Concerns | 100 of which 26 went to a Strategy Meeting | |
| Unannounced Visits to Local Care Homes | 100% | These are done by the Portfolio Holder for Adult Social Care and either the Director or Head of Service. This is in response to the Winterbourne View Enquiry |
| Out of Area Care Home | 16 in 2012-13. This has | This is done to specific |

| | | |
|---|---|---|
| Reviews | gone up to 48 (100%) in 2013-14 | criteria to review both the quality of the service and the needs of the service user. Again in response to Winterbourne. |

## Appendices

**Appendix A** – Joint Health and Social Care Self Assessment

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From 1 April 2013 we are part of Public Health England
We are still maintaining this website until further notice.

# Joint Health and Social Care Self-Assessment Framework

Completing survey for WEST BERKSHIRE UA. **Return to front page**

Your submission has been saved.



# 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

12

1.2 Aged 14 to 17 years old

26

1.3 Aged 18 to 34 years old

98

1.4 Aged 35 to 64 years old

148

1.5 Aged 65 years old and over

22

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

3

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

17

**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

0

2.2 Aged 14 to 17 years old

3

2.3 Aged 18 to 34 years old

10

2.4 Aged 35 to 64 years old

13

2.5 Aged 65 years old and over

5

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

2

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

1

**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

3.2 Aged 14 to 17 years old

9

3.3 Aged 18 to 34 years old

11

3.4 Aged 35 to 64 years old

7

3.5 Aged 65 years old and over

1

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

2

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

3

**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

8568

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

4456

4.3 Number of eligible population with learning disabilities

77

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

22

### 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

5452

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

3022

5.3 Number of eligible population with learning disabilities

22

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)

8

### 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

4868

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)

1679

6.3 Number of eligible population with learning disabilities

19

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)

5

## 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)?

201

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

98

**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)?**

0

**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.

1

**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.

16

**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

35

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

0

**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

47

## 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

0

15.2 Aged 14 to 17

0

15.3 Aged 18 to 34

0

15.4 Aged 35 to 64

0

15.5 Aged 65 and older

1

## 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?

237

### 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?

138

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

18.1 Total number eligible

268

18.2 Total number completed

159

## 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?

11

### 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?

11

## 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)?

Please note 21.2 has changed from "Number for people with learning disabilities as percentage of total spells". We are now asking for the denominator value as to ensure the accuracy of the information.

21.1 Number of spells for people identified as having a learning disability

24

21.2 Total number of spells

14

### 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)?

Please note this changed from "Number for people with learning disabilities as percentage of total attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

22.1 Number of attendances identified as having a learning disability

51

22.2 Total number of attendances

6

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

Please note this changed from "Number for people with learning disabilities as percentage of attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

23.1 Number of attendances involving people with learning disabilities

42

23.2 Total number of attendances

55

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

Please note this changed from "Number for people with learning disabilities as percentage of total attendances". We are now asking for the denominator value as to ensure the accuracy of the information.

24.1 Number of people with a learning disability

30

24.2 Total number of attendances

42

## 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)?

32

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

2

# 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

0

27.1.2 Age 18 or older

2

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

27.2.1 Age 0 to 17

0

27.2.2 Age 18 or older

2

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

27.3.1 Age 0 to 17

0

27.3.2 Age 18 or older

0

## 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

0

28.1.1.2 Age 18 or older

1

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

28.1.2.1 Age 0 to 17

0

28.1.2.2 Age 18 or older

0

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

28.1.3.1 Age 0 to 17

0

28.1.3.2 Age 18 or older

0

### 28.2. Located elsewhere

#### 28.2.1. Number of people placed primarily due to Challenging Behaviour

28.2.1.1 Age 0 to 17

0

28.2.2.2 Age 18 or older

1

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

28.2.2.1 Age 0 to 17

0

28.2.2.2 Age 18 or older

0

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

28.2.3.1 Age 0 to 17

0

28.2.3.2 Age 18 or older

0

## 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

3

29.2 Primarily for other reasons

3

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

5

**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

4

31.2 Primarily for other reasons

2

**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

1

32.2 Primarily for other reasons

2

## 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

6

33.2 Number NOT in hospital at index date

0

**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

5

34.2 Number NOT in hospital at index date

0

**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

8

35.2 Number NOT in hospital at index date

0

Save

# 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)

280

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

322

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

108

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

3

Save

# 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)?**

19

**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?**

11

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

8

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

2

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

128

## 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

0

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

1

42.3. Refuge

0

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

0

42.5. Acute/long stay healthcare residential facility or hospital

2

42.6. Registered Care Home

90

42.7. Registered Nursing Home

2

42.8. Prison/Young Offenders Institution/Detention Centre

0

42.9. Other temporary accommodation

1

42.10. Owner Occupier/Shared ownership scheme

5

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

37

42.12. Tenant - Private Landlord

3

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

132

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

116

42.15. Adult placement scheme

22

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

0

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

2

42.18. Mobile accommodation for Gypsy/Roma and Traveller community

0

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

412

Save

# 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?**

11

## Safeguarding

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

100

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

26

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

100

**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.

16

## 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.

4

**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?**

125

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

52.1 Percentage

26

52.2 Number

38

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

53.1 Percentage

29

53.2 Number

78

Save

# Transitions

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

25296

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

69

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

10

**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.**

20

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

296

**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.**

12

Save

# 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**

280/412 reviews were carried out last year =68%
This current yesr additional temporary staff have been appointed to specifically work on annual reviews

**Web link to further evidence**

**Real life story**

Simon has spent most of his life in long-stay hospital and long-stay residential provision. His care needs were reviewed in early 2013 and it was decided that he did not need this level of care any longer. He has now moved to a supported living service and leads a much more independent person -focussed life.

## B2. Contract compliance assurance

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

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

The supported living block contracts were all reviewed during the year. Local residential providers will also have had a quality review by the care quality monitoring officers. However it is only in the last 9 months that we have developed and used an individual and service quality review model for out of area residential placements. By September

**Web link to further evidence**

**Real life story**

During 2012 we opened a new bespoke supported living service for 4 young people with complex needs who had been placed or were in danger of being placed in out of area residential placements. Over a 6 month period all 4 moved in with individually staffed and tailored care packages. This has worked very well with no breakdowns

## 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**

These are available and monitored via the Joint Team arrangements.

**Web link to further evidence**

**Real life story**

NHS Trust staff run Health Drop-In days on a monthly basis. Wiehgt management advice, blood pressure checking and excerise classes are intended to monitor and improve the health of the people who attend.

## 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**

Learning Disability Partnership Board has made direct contact with the Safeguarding Adults Board as well as reviewing annual reporting data for people with a learning disability.
Safeguarding compliance is now part of all service quality

**Web link to further evidence**

**Real life story**

A Safeguarding investigation by Devon Council of a large residential care provider led to Mary who had been living in a residential setting coming back to West Berkshire. She has now settled in a local residential setting where it is much easier to monitor that her increasing needs are being met.

## B5. Training and Recruitment – Involvement

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

Most local LD providers do involve service users and or their families in staff recruitment.
When tendering for LD block contracts service users and families are involved in the selection process.

**Web link to further evidence**

**Real life story**

Margaret who lives in supported living was invited to be part of a provider presentation meeting during a re-tendering process for 2 large block contracts. She came prepared with a number of questions which helped the whole panel assess the ability of the providers to respond to service users

## 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**

When LD providers are being commissioned to provide a service they are specifically asked to demonstrate that their value base does demonstrate compassion dignity and respect in their recruitment and management functions. It is more difficult to evidence this in universal services

**Web link to further evidence**

**Real life story**

When Jo had to move from a residential care home that was closing to a supported living service his family specifically chose a supported living provider who they felt would respect Jo's individual wishes.

**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**

All changes to service provision and consultation about changes to services are subject to Equality Impact Assessments.

**Web link to further evidence**

**Real life story**

All such changes are changes are referred to the Disability Equality Scrutiny group whose membership is mostly service users and who are acutely aware that changes should not disadvantage disabled people. All such proposed changes are also tabled at the Learning Disability partnership Board for consultation

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

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

Most providers are responsive to complaints and whistle blowing and will work with commissioners to change and improve their service. However this seems to be difficult to sustain in a recruitment market where it is difficult to recruit and retain good quality staff.

**Web link to further evidence**

**Real life story**

After a whisltle-blowing referral and CQC visit one provider has been able to demonstrate a much improved recording system and clearer daily activity scheduels.

**B9. Mental Capacity Act & Deprivation of Liberty**

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

There is evidence of an increase in the use of MCA guidance by LD providers however this is not yet embedded in the practice of all.

**Web link to further evidence**

**Real life story**

David needed to move from his residential placement because it was closing. Opinion about the most appropriate placement was strongly divided/ Am IMCa referral was made and a Best Interest Decision making meeting held. By working through the best interest process a consensus was able to be reached by all concerned

## Section C

**C1. Effective Joint Working**

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

Partnership and joint working arrangements are in place for a growing number of health and social care activity. There are however no pooled budget arrangements

**Web link to further evidence**

**Real life story**

John had extremely challenging behaviour, mental health issues and a learning disability. He had been placed in private hospital for a number of years and work that had been done with him had moderated his challenging behaviour. He wanted to return to West Berkshire to be near

## C2. Local amenities and transport

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

The Learning Disability Partnership Board has worked with the Council's transport service to ensure that local transport providers have adjusted their vehicles and signage to make travel as easy as possible for people with disabilities. This includes talking route messages and colour coded services

**Web link to further evidence**

**Real life story**

Robert wanted to attend college when he left school but he could not use public transport on his own. A planned programme of travel training over a number of months enabled him to get by bus from Newbury to the college of his choice in Reading.

## C3. Arts and culture

- ○ Red
- ○ Amber
- ◉ Green

**Explanation for rating**

There is a good range of arts and culture facilities in West Berkshire that enable people with a learning disability to take part in drama, dance, all sorts of creative arts and craft work, and music based activities. There is also an autism cinema group.

**Web link to further evidence**

**Real life story**

Katherine has profund disabilities with little verabl communication and is confined to a wheel chair. However she is able to express herself through craft work and clearly demonstrates enjoyment of this activity through sounds and expressions.

## C4. Sport & leisure

- ○ Red
- ○ Amber
- ◉ Green

**Explanation for rating**

People in West Berkshire have access to the leisure centres that are available locally.There are also a number of specific sporting and exercise groups that are either set up specifically for people with learning disabilities or are which they can access with assistance.

**Web link to further evidence**

**Real life story**

Steven uses his personal budget to play tennis, and bowls and to work on an allotment with support.

## C5. Supporting people with learning disability into and in employment

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

West Berkshire works to ASCOF targets for employment but unfortunately paid employment has declined over the past few years due to the economic climate and the lack of support to maintain work (job coaching)

**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**

There is not a single Eductaion, Health and Care Plan in place locally yet although work is underway to develop this by April 2014. Health input into this process has been disappointing so far.
There is however work underway to improve the process of

**Web link to further evidence**

**Real life story**

Nigel had lived most of his life on a farm and wanted to continue his interest in rural pursuits when he left school. Through transition planning he was able to attend an agricultural college and to have some land based activities for the days he does not attednd college

## C7. Community inclusion and Citizenship

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

There is a user led hate crime support service in West Berkshire based with a voluntary organisation. This same organisation facilitates a peer support advocacy group which contributes to a number of wider community issues as well as promoting the needs of people with a learning disability in

**Web link to further evidence**

**Real life story**

Several members of the group above have reported being targeted by local young people and made fun of to the point that they feared going out to certain areas.
All have had the opportunity of support to report this to the police.

## 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**

There is a history of service users and families being involved in the commissioning and monitoring of voluntary sector and carers services.
There is a current consultation process for the review of the priorities for local voluntary sector services.

**Web link to further evidence**

**Real life story**

## C9. Family Carers

- ○ Red
- ◉ Amber
- ○ Green

**Explanation for rating**

There is a local carers support service with a remit to support all carers whether they are known to services or not. There is also a carers assessor within the care management service who is currently working through carers assessments and reviews.

**Web link to further evidence**

**Real life story**

Julie has been a champion for her own daughtes care for a number of years but has always generously given her time to be involved in recruitment of staff processes, consultations, service development discussions and provider selection.

Save

### 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

Save

| Question | Newbury&District |
|---|---|
| Practice population | 79112 |
| 1. How many people with any learning disability are there in your partnership board area? 0-13 | 12 |
| 14-17 | 26 |
| 18-34 | 98 |
| 35-64 | 148 |
| 65+ | 22 |
| 0-17 Ethnic Minority | 3 |
| 18+ Ethnic Minority | 17 |
| 2. How many people with complex or profound learning disability are there in your Partnership Board area? 0-13 | 0 |
| 14-17 | 3 |
| 18-34 | 10 |
| 35-64 | 13 |
| 65+ | 5 |
| 0-17 Ethnic Minority | 2 |
| 18+ Ethnic Minority | 1 |
| 3. How many people with both any learning disability and an Autistic Spectrum Disorder are there in your Partnership Board area? 0-13 | 3 |
| 14-17 | 9 |
| 18-34 | 11 |
| 35-64 | 7 |
| 65+ | 1 |
| 0-17 Ethnic Minority | 2 |
| 18+ Ethnic Minority | 3 |
| 4. How many women are there eligible for cervical cancer screening? Total Eligible Pop | 8568 |
| Smear Done L3Y | 4456 |
| LDIS Eligible | 77 |
| LD & Smear | 22 |
| 5. How many women are eligible for breast cancer screening? Total Eligible Pop | 5452 |
| Screen Done L3Y | 3022 |
| LDIS Eligible | 22 |
| LDIS & MAM L3Y | 8 |
| 6. How many people are eligible for bowel cancer screening? Total Eligible Pop | 4868 |
| Screen Done L2Y | 1679 |
| LDIS Eligible | 19 |
| LDIS & Bowel Screen | 5 |
| 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)? | 201 |
| 8. How many people with learning disabilities are there aged 18 and over who have a BMI in the obese range (30 or higher)? | 98 |
| 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)? | 0 |

| | |
|---|---|
| 10. How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease? | 1 |
| 11. How many people with learning disabilities of any age are known to their doctor to have diabetes? | 16 |
| 12. How many people with learning disabilities of any age are known to their doctor to have asthma? | 35 |
| 13. How many people with learning disabilities of any age are known to their doctor to have dysphagia? | 0 |
| 14. How many people with learning disabilities of any age are known to their doctor to have epilepsy? | 47 |
| 15. How many people with a learning disability in your Partnership Board area died between 1st April 2012 and 31st March 2013? 0-13 | 0 |
| 14-17 | 0 |
| 18-34 | 0 |
| 35-64 | 0 |
| 65+ | 1 |
| 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? | 237 |
| 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? | 138 |
| 18. How many people aged 18 and over with a learning disability have a Health Action Plan? Eligible | 268 |
| 18. How many people aged 18 and over with a learning disability have a Health Action Plan? Completed | 159 |

## Jan Evans

**From:** Wooldridge Jane [Jane.Wooldridge@royalberkshire.nhs.uk]
**Sent:** 05 December 2013 11:37
**To:** Jan Evans
**Cc:** Foster Sarah
**Subject:** IHAL figures for Newbury etc

**Newbury** as per GP practice codes ( and 25% of North and West Reading)

Q21.1 = 24

Q21.2 = 0.14%

Q22.1 = 51

Q22.2 = 0.06%

Q23.1 = 42

Q23.2 = 0.55%

Q24.1 & 24.2 = **Patients with a learning disability =** 30 patients / 42 A & E visits

Jane

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| | |
|---|---|
| **Title of Report:** | SEN & Disability Reforms |
| **Report to be considered by:** | The Health and Wellbeing Board |
| **Date of Meeting:** | 15th May 2014 |

## Purpose of Report:

- To raise awareness of the SEN & Disability reforms
- To inform the Board of work undertaken so far towards implementation of the reforms and seek approval
- To ask the Board to consider how the specific implications of the reforms for Health will be addressed

## Recommended Action:

- That the Health and Wellbeing Board approves work undertaken so far towards implementation of the SEND Reforms
- That the Health and Wellbeing Board considers how the matters outlined in Section 4 of this report will be addressed.

| **Health and Wellbeing Board Chairman details** | |
|---|---|
| **Name & Telephone No.:** | Gordon Lundie (01488) 73350 |
| **E-mail Address:** | glundie@westberks.gov.uk |

| **Contact Officer Details** | |
|---|---|
| **Name:** | Jane Seymour |
| **Job Title:** | Service Manager, SEN & Disabled Children's Team |
| **Tel. No.:** | 2783 |
| **E-mail Address:** | jseymour@westberks.gov.uk |

# Executive Report

## 1. Background

1.1 The Children and Families Act, which takes effect in September 2014, will significantly change the way in which services are provided for children with SEN and disabilities and their families.

1.2 A SEND Reform Steering Group has been in place since September 2013 to oversee implementation of the reforms. There are also sub groups working on the Local Offer and development of Education Health and Care assessment and planning processes.

1.3 All relevant stakeholder groups are represented on the Steering Group including parents, schools, the FE sector, relevant voluntary bodies, Health commissioners and providers and representatives of relevant Council teams including the SEN & Disabled Children's Team, Educational Psychology Service, Locality Teams, Adult Services, School Improvement, Sensory Consortium and Children's Centres.

1.4 A letter dated 8th April was sent by the Department for Education and the Department of Health to Lead Members for Children's Services, local authority Chief Executives, Clinical Commissioning Group Chairs and Health and Wellbeing Board Chairs. This letter outlined the reforms and encouraged recipients to ensure that their local authority is fully prepared for implementation. The letter is attached at Appendix 1.

## 2. Requirements of the Children and Families Act in respect of children with SEN and disabilities (SEND)

2.1 The existing statutory assessment and statementing process will be replaced by a much more holistic, person centred Education Health and Care (EHC) Assessment process leading to an EHC Plan setting out the child's health and care needs in addition to their special educational needs. All existing Statements will have to be converted to EHC Plans by April 2018. EHC Assessments must be completed in 20 weeks (compared to 26 weeks for a statement of special educational needs).

2.2 Every family whose child has an EHC Plan will have the right to request a Personal Budget for the education, health and / or care aspects of the EHC Plan. Currently Personal Budgets / direct payments are only allocated to meet a young person's social care needs.

2.3 Local Authorities' responsibilities will extend potentially up to the age of 25 (Statements currently lapse at age 19 years). EHC Plans can continue up to the age of 25 if a case can be made that the young person still requires an EHC Plan in order to achieve their identified outcomes.

2.4 There is a requirement to produce a comprehensive "Local Offer" setting out all services for children with SEND aged 0 to 25 and their families and how these can be accessed, including eligibility criteria. This must include services provided by education, social care, health and the private and voluntary sectors.

2.5 There are new requirements for supporting families including greater responsibility for provision of independent advice, advocacy, disagreement resolution and

mediation. These services will have to be provided in relation to health and social care issues as well as SEN related issues.

2.6 There are specific requirements for joint commissioning. These include the development of clear arrangements between Local Authorities and partner commissioning bodies for commissioning of services for children with SEND (at both a strategic and individual level), the integration of education, health and care provision for SEND where this would be beneficial ( which may include pooling of budgets) and the agreement of shared outcomes including joint analysis of intelligence about needs of the local population. In order to meet the requirement to commission services at an individual case level, Health will need to identify a Designated Medical Officer and will need to participate in multi agency panels to agree resourcing of EHC Plans for individual young people. Where there is provision which has been agreed in the health element of an EHC Plan, health commissioners must make arrangements to secure that provision.

## 3. Progress towards implementation

3.1 A process for Education Health and Care assessments has been developed and approved by the SEND Reform Steering Group. A format for the EHC Plan has been created and will be considered by the Steering Group in May. It is estimated that three new posts of Assessment Coordinator will be required. Approval has been given for recruitment and the posts are currently being advertised. The posts will be offered initially as 12 month secondments or short term contracts from September 2014. Applications are being encouraged from candidates with backgrounds in education, health or social care. Some training has already been delivered for schools, parents and professionals. There will be a series of training events between May and July for all groups likely to be affected by the reforms.

3.2 Personal Budgets are already in place for children and young people with disabilities through the Disabled Children's Team and through Adult Social Care. Processes are already in place within the Council therefore for allocation and monitoring of Personal Budgets. Work is underway to determine circumstances in which a SEN Personal Budget may be appropriate, although it is likely these will be considered on a case by case basis. Continuing Health Care have begun to develop plans for allocation of Health Personal Budgets. The Chair of the Children's CHC Panel is a member of the SEND Reform group which should help to ensure that processes for personal budgets are developed in a consistent way across the Council and Health.

3.3 The SEN Assessment Team at West Berkshire Council was restructured in September 2013 to create a post of Assistant SEN Manager for Post 16 / Transition. This has enabled the team to take on management of cases up to age 25 including young people with SEND attending FE Colleges. Discussions have been held with Adult Services about the implications of young people having EHC Plans potentially up to age 25, including the requirement for care provision to be set out in these plans. The Multi Agency Transition Protocol is in the process of being redrafted to ensure that children's and adults' teams, and other agencies, work together as effectively as possible to support young people going through transition.

3.4 A website provider for the Local Offer website has been identified and commissioned and work is currently taking place to design the website. All Berkshire Local Authorities have agreed to use the same website provider which will

help significantly with sharing of data. Questionnaires for schools (and other educational settings) and for non education providers have been designed. Schools and other service providers will be asked to submit their data on line during May and June. Guidance will be provided. The website provider (Open Objects) has met with Berkshire Healthcare Foundation Trust to discuss arrangements for "harvesting" of health data from the BHFT website. Data for the Local Offer will also be needed from the RBH Trust.

3.5 Discussions are taking place with the Council's provider of Parent Partnership Services about the extension of independent advice to young people as well as parents and about the need for independent advice to encompass health and care issues in addition to educational issues. There will also be a requirement to provide disagreement resolution and mediation in a wider range of circumstances. The current provider, Global Mediation, has agreed to absorb these additional requirements at no extra cost until April 2015 at which point the cost of the contract is likely to increase to reflect the increased usage. A service for advocacy for young people with SEND is currently being sought. It may be possible to include this within existing contracts for advocacy for young people held by the Council.

3.6 The NHS Central Southern Commissioning Support Unit, the Berkshire Healthcare Foundation Trust and the RBH Trust have all been engaged in discussions about the SEND Reforms including attendance at Steering Group and working group meetings. A Berkshire wide event for Health colleagues was held in March in order to raise awareness of the reforms. A report summarising issues for Health arising from the SEND Reforms was produced by Pranay Chakravorti of the CSU and has been considered by the Berkshire West Children's Commissioning Strategy Group and also the Children's, Maternity, Mental Health and Voluntary Programme Board. This report is attached at Appendix 2.

## 4. Specific implications for Health commissioners and providers

4.1 The report taken to the Children's, Maternity, Mental Health and Voluntary Programme Board by the CSU made the following recommendations:

- That CCGs engage in the development of personal budgets for education, health and care provision.
- That joint commissioning arrangements are established at strategic and individual child level.
- CCGs should ensure contracts with service providers include the expectation of participation in EHC Assessments and development of EHC Plans.
- Health and Wellbeing Boards should be used to promote the integration of services for children with SEND including joint arrangements and pooled budgets.
- JSNA should be used to understand levels of need and to map existing services and spend.
- Opportunities to use funding more flexibly should be explored, eg. CCG allocations to voluntary organisations could be used in a pooled arrangement with Local Authority funding.
- Potential for accessing Better Care funds should be explored (there is some indication from the Department from Health that there may be a Children's Better Care Fund)

- CCGs should develop a process with partners for resolving disputes.
- CCGs and NHSE must agree local governance arrangements which will ensure ownership and accountability around SEND commissioning, with clear lines of responsibility for both strategic and operational commissioning.
- There must be clear arrangements about what is commissioned by each CCG and by NHSE.
- CCGs need to decide how they will approve the health content of EHC Plans, eg. by allocating a Health representative to sit on local decision making panels.
- CCGs should identify a Designated Medical Officer with relevant clinical experience.
- CCGs must ensure their acute and community providers are working proactively with Local Authorities to develop, compile and publish the Local Offer.

4.2 In addition to the above recommendations, it is suggested that the following should also be considered by CCGs:

- All agencies and service providers will be expected to work in a person centred way and to offer services in as personalised a manner as possible.
- EHC Plans must be clearly outcome focused. All reports submitted as part of EHC Assessments must therefore be drafted in such a way that they lend themselves to the development of outcome focused plans.
- The deadline for completion of EHC Assessments and publication of final EHC Plans will be 20 weeks (compared to 26 weeks for a Statement) so it will be critical that all professionals contributing to EHC Assessments, including health professionals, submit their reports within the 6 weeks allowed for submission of professional reports, in order that compliance with the 20 week timescale is not compromised.
- Local Authorities will have a new duty to provide independent advice, disagreement resolution and mediation in respect of *health* issues as well as education and social care issues. There is therefore an argument for contribution to the cost of these services by Health commissioners.

## 5. Recommendations

5.1 That the Health and Wellbeing Board approves work undertaken so far towards implementation of the SEND Reforms

5.2 That the Health and Wellbeing Board considers how the matters outlined in Section 4 of this report will be addressed.

## Appendices

**Appendix A** – Letter dated 8th April 2014 from Edward Timpson MP and Dr. Dan Poulter, Parliamentary Under Secretary of State for Health.

**Appendix B** – Report to the Children's, Maternity, Mental Health and Voluntary Programme Board authored by Pranay Chakravorti, Commissioning Support Unit.

Department for Education | Department of Health

**8 April 2014**

To: Lead members for Children's Services; local authority Chief Executives; Clinical Commissioning Group Chairs; and Health and Wellbeing Board Chairs

**Dear Colleague**

**Support and aspiration: implementing the new 0-25 special needs system**

We wrote to you in December about changes to arrangements for supporting young people with special educational needs and disabilities (SEND). The Children and Families Act received Royal Assent on 13 March and implementation will commence from this September.

Thank you for the work you are doing to prepare for implementation. We know some local areas are advanced in their preparations. As well as new legal duties, the changes offer an opportunity to think widely about SEND in the context of local reform to child and adult services, for example early intervention and a life course approach. The Mandate to the NHS also highlights the importance of SEND.

In the spring, the Department for Education will publish the SEND Code of Practice for Parliamentary approval, together with transitional regulations and guidance. We are enclosing an information planning pack with this letter and want to draw your attention to three aspects in particular:

- Local offer: from 1 September 2014 local authorities will be required to consult with families and providers of services and publish a local offer of provision for children and young people who are disabled or have SEN, so that parents, carers and young people understand the range of provision available. A significant change is a 0-25 focus. Partners, including health, colleges, schools and early years, need to co-produce the local offer.

- Education, Health and Care plans: from 1 September 2014 local authorities will be required to consider new requests for an assessment of special educational needs under the new legislation, and co-ordinate services around a child or young person. No new assessments for statements of SEN or Learning Difficulty Assessments (LDAs) will be offered from 1 September 2014. Children and young people should be transferred to the new system in a phased way, prioritised at key transition points. LDAs should be phased out by September 2016, and statements should be phased out by April 2018 – although this can happen more quickly if desired. For children and young

people assessed as needing an EHC plan, they will have the right to request a personal budget so they can choose the services which are best for their family.

- Joint commissioning: from September 2014, local commissioners will be required to work together in the interests of children and young people with SEND. These arrangements must be robust enough to reach a decision in every case, and regularly reviewed. In the SEND Code of Practice, we will encourage local authorities and CCGs to agree shared outcomes, using a joint analysis of intelligence and data about the area – drawing, for example, on registers of disabled children in their area, including children with impaired hearing and sight.

**Support for implementation**

£70m has already been allocated to local authorities in 2014-15 through the SEND Reform Grant.

The Government is committed to funding new burdens on local authorities and will provide further information about additional funding shortly.

Additional funding is also being made available to support parent involvement in implementing the reforms, and to support families with the new assessment and planning processes.

A core offer of support is now available to all local authorities to help prepare for implementation of the SEND reforms with their health partners. This can be accessed through regional pathfinder champions, who have experience of implementation. Further details are in the enclosed planning pack.

We trust you will use the period between now and September to ensure your local authority is fully prepared for these fundamental reforms and, from September onwards, you will maintain the focus on a successful implementation.

This letter is copied to local authority Directors of Children's Services, Directors of Adult Services, and elected lead members for children's services.

**EDWARD TIMPSON MP**

Parliamentary Under Secretary of State for Children and Families

**DR DAN POULTER**

Parliamentary Under Secretary of State for Health

**BWCCSG - 08**

| **Name of Meeting** | **Paper Number** |
|---|---|
| Mental Health and Children Programme Board | |
| **Title of Paper** | |
| Children and Families Bill – Statutory changes to provision for children with Special Educational Needs | |
| **Date of Paper** | **Date of Meeting** |
| 28th February 2014 | 27th March 2014 |

**Purpose of Paper (For information, For discussion, For decision)**

To provide an update to the SEN implementation paper presented by Pranay Chakravorti on the 13th December 2014 outlining further implications of the reforms contained within the Children and Families Bill and the implications for Clinical Commissioning Groups

In February 2014 the Department for Education, NHS England and the Council for Disabled Children gave further direction for Local Authorities, Clinical Commissioning Groups and Provider organisations. Relevant aspects of this are covered within the recommendations' section of this paper.

**Summary**

The draft legislation was published in September 2012 with implementation in September 2014. In October 2013 the draft regulations and Code of Practice were published for consultation. The main emphasis of these reforms are to improve collaborative working across education, health and care for children and young people (CYP) 0 – 25 years and give parents more control.

**Single EHC plans**

Statutory assessments and Statements of Special Educational Need (SEN) will be replaced by Education, Health and Care joint assessments and a single Education, Health and Care Plan (EHC Plan). There is a statutory requirement for Local Authorities, CCGs and their partners to work together in Health and Wellbeing Boards to assess the health needs of local people, including those with Special Educational Need.

Local clinicians, for example community paediatricians, may participate in the development of the EHC Plan. CCGs are legally obliged to deliver the health services written in the plan. CCGs will need to determine the most appropriate person in each area to have delegated responsibility to approve EHC Plans e.g. a health professional from the provider who would need to attend the regular Panel meetings.

**Joint commissioning of provision and services**

Local Authorities and CCGs have a statutory duty to consider the extent to which Children and Young People's needs could be more effectively met through integrating services which may include pooling budgets to offer greater value for money and improved outcomes for Children and Young People (CYP) with Special Educational Needs or Disabilities (SEND).

Local Authorities and CCGs have a duty to commission services jointly for Children and Young People (age 0 to 25) with Special Educational Needs. The details of which services should be commissioned will be agreed locally but must include consideration of the following:

- education, health and social care provision reasonably required by local Children and Young People with Special Educational Needs or Disabilities;
- which education, health and social care provision will be secured and by whom;

- what advice and information is to be provided about education health and care provision, by whom and to how it is to be provided;
- how complaints about Education, Health and Care provision can be made and dealt with; and
- procedures for ensuring disputes between Local Authorities and CCGs are resolved quickly.

The joint arrangements that Local Authorities and CCGs must have for commissioning education, health and care provision for Children and Young People with Special Educational Need or Disabilities must include arrangements for considering and agreeing what information and advice is to be provided, by whom and how it is to be provided.

**Personal Budgets**

Young people and parents of children who have Education, Health and Care Plans have the right to request a personal budget, which may contain elements of education, health and social care funding. Partners are legally obliged to set out their arrangements for agreeing personal budgets.

**Local Offer**

A Local Offer must be published which provides clear, accessible and comprehensive information about the support and opportunities available locally to Children and Young People with Special Educational Needs or Disabilities and their families. The Local Offer must include information about health care provision, including speech and language and other therapies (e.g. physiotherapy and occupational therapy) and services relating to mental health, services assisting education settings for Children and Young People with medical conditions, provision and equipment, palliative and respite care for those with complex health needs, emergency care provision, continuing care arrangements and support for young people moving from child to adult healthcare services.

**Recommendations**

- That CCGs engage in the development of personal budgets for education, health and care provision specified in Education, Health and Care Plans, through the Berkshire Continuing Healthcare system given it is a legislative requirement that families are offered the option of personal budgets in Continuing Healthcare from 1st April 2014. Elizabeth Rushton is Assistant Director Lead for Berkshire.
- The need to establish joint commissioning arrangements, both at systems level and at child level. CCGs should ensure that contracts with service providers include the expectation to participate in joint assessments and the development of Education, Health and Care Plans.
- Health and Wellbeing Boards should be used to promote the integration of services for children at a strategic level – with potential for exploring Joint arrangements e.g. Section 75s and other pooled budgets – connected to each Joint Strategic Needs Assessment (JSNA)
- The JSNA, as well a tool for understanding present levels of need should also be used to assist with mapping all existing services and spend together with analysis of needs through Joint Strategic Needs Assessment process.
- Build on models of existing good practice, where funding is used flexibly. Is there potential for use of existing CCG allocations given to voluntary organisations to be used in a pooled arrangement with Local Authorities to help deliver services for children with complex needs.
- Potential for accessing Better Care funds ( some indication from DH that there may be a Children's Better Care Fund)
- Exact nature of Joint Commissioning arrangements will be left for local determination giving us necessary flexibility to commission services that meet our needs.
- Need for single process with partners for resolving complaints / disputes.

- Each CCG and NHSE has to agree local governance arrangements which ensure ownership and accountability around SEN commissioning, with clear lines of accountability around both strategic and operational commissioning

- Clear arrangements about what is commissioned by each CCG and by NHSE ( For rare conditions, Specialist Mental Health, young offenders etc.)
- CCGs consider how to approve the contents of Education, Health and Care Plans, for example delegate responsibility to a health manager for each Local Authority to sit on decision making Panels/groups. Guidance suggests it should be a designated medical or clinical officer to be identified to ensure each CCG is fulfilling its duties effectively. The person should have relevant clinical experience.
- CCGs should ensure their acute and community providers are working proactively with Local Authorities to develop, compile and publish the Local Offer.
- CCGs are also asked to consider the role of the Designated Health Officer whose role is outlined below. It is recommended that this role is facilitated by a clinician from Berkshire Healthcare Foundation Trust who are currently involved the care and assessment of this cohort of children:

*A Designated Health Officer (DHO) should be identified whose role is to ensure that the CCG is meeting its statutory responsibilities for SEN. Every CCG must help LAs identify and support children and young people with SEN. This includes:*

- *Ensuring that local health services (including primary and secondary care) are able to inform the local authority of children under compulsory school age who they think may have SEN (clause 24).*

- *The individual or individuals designated by the CCG with responsibility for fulfilling this function should provide the point of contact for LAs and schools seeking health advice on children who may have SEN.*

- *The DHO should also ensure other agencies are fully engaged with arrangements for ensuring appropriate statutory notifications are made.*

- *The DHO may also offer an advocacy role for children and young people with SEN.*

*The DHO might be an employee of a CCG, or an employee of an NHS Trust or other provider commissioned by a CCG, NHS England or a local authority. The DHO should have an appropriate level of clinical expertise to enable them to exercise these functions effectively. The DHO would not routinely be involved in assessments or planning for individuals, except in the course of their usual clinical practice, but would be responsible for ensuring that assessment, planning and health support is carried out.*

**Who has been involved from the CCGs?**

Pranay Chakravorti

**Financial implications**

Unknown at this stage. It is envisaged existing contractual arrangements with Berkshire Healthcare Trust (BHFT) will be adequate to ensure adequate input into the required assessment process. BHFT have raised concerns that capacity will be stretched but until there is robust evidence outlining additional pressures of reforms on existing workforce current contracts will remain in place.

**Has an Equality Impact Screening been undertaken? If so please attach**

Equality Impact Assessment has been undertaken by all Local Authority areas in Berkshire

| **Please list any other committees or groups where this paper has been discussed** |
|---|
| Contents of this paper have been discussed at Local Authority Steering groups leading on the SEN implementation in each locality area. |
| **NHS Outcomes Framework 2013/14** |
| Please indicate which Domain this paper sits within by highlighting or ticking below:<br>Please note there may be more than one Domain.<br>Domain 1 Preventing people from dying prematurely;<br>**Domain 2 Enhancing quality of life for people with long-term conditions**;<br>Domain 3 Helping people to recover from episodes of ill health or following injury;<br>Domain 4 Ensuring that people have a positive experience of care; and<br>Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm. |
| **Paper Author** |
| Pranay Chakravorti, Commissioning Support Manager for Children and Young People, Central Southern Commissioning Support Unit |

# Agenda Item 11

| | |
|---|---|
| **Title of Report:** | Fourth Quarter Report to the Health and Wellbeing Board by Healthwatch West Berkshire |
| **Report to be considered by:** | The Health and Wellbeing Board |
| **Date of Meeting:** | 15 May 2014 |

**Purpose of Report:** To present the Healthwatch Q4 report to the Health and Wellbeing Board.

**Recommended Action:** Members of the Health and Wellbeing Board to note the report.

| **Health and Wellbeing Board Chairman details** | |
|---|---|
| **Name & Telephone No.:** | Gordon Lundie (01488) 73350 |
| **E-mail Address:** | glundie@westberks.gov.uk |

| **Contact Officer Details** | |
|---|---|
| **Name:** | Heather Hunter |
| **Job Title:** | Lead Officer |
| **Tel. No.:** | 0800 328 9148 |
| **E-mail Address:** | heather.hunter@healthwatchwestberkshire.co.uk |

# Executive Report

## Overview

The reporting for this quarter is in two sections, a review of the main reportable information arising between January – March 2014 and an overview synopsis of the annual report for Healthwatch West Berkshire that will be published in full during this month following the Healthwatch Board meeting in mid-May. The contents of the annual overview report follows the set reporting headings of the requirement of the annual report, which runs to over a hundred pages and is therefore a distilled overview for the purposes of the Health and Wellbeing Board of the statutory points that Healthwatch are required to report upon. This report also includes the non-audited income and expenditure for the year for information.

*Heather Hunter*

## Specific reportable activity for January – March 2014

During the course of the quarter, Healthwatch has continued with outreach across West Berkshire and one-to-one engagement with the public in eight locations. The 9 – 5 telephone support service for members of the public and professionals has also grown in popularity and during the quarter we have provided information or signposted over 380 callers, the highest number in any quarter so far and reflects the growing popularity of the service which is supported by trained advice and guidance team members and a growing directory of services.

The launch of the Healthwatch West Berkshire grant fund took place and we now have four partner organisations who are working with us to provide further investigation into our identified priority areas and a special project relative to vulnerable groups.

There has been one specific investigation that has been progressed in conjunction with Healthwatch England pertaining to a complaint raised with Healthwatch England relative to care of persons in care and subject to a court of protection order under section 117 of the Mental Health Act. Specifically the matter that has been investigated has been a possible safeguarding issue relating to restrictive financial control of a detained person's assets resulting in an unnecessarily low standard of living allowance and a high levels of savings being accrued and the high level of savings resulting in loss of benefits.

Healthwatch raised specific questions with West Berkshire Council who engaged with the process and provided responses outlining the operational process and reasons for such a process. These responses have been accepted as a reasonable operational response by Healthwatch West Berkshire and have now been published on the Healthwatch website as agreed with West Berkshire Council.

However, Healthwatch West Berkshire have noted that there is a potentially wider implication of possible problematic outcome for some patients that requires further investigation on a patient by patient basis which will be pursued.

**End of year synopsis of statutory report:**

**1.** Healthwatch West Berkshire has its principal office in Hawksworth House, Headley Road East, Wokingham, Berkshire, RG5 4SE. The office contact details are telephone 01635 886210 and a website contact address of contact@healthwatchwestberkshire.co.uk

**2.** Healthwatch West Berkshire does not contract any external provider of services. The complaints service is separately contracted by West Berkshire Council who have engaged SEAP of SEAP Hastings, Breeds Place, Hastings, East Sussex, TN34 3UY.

**3.** During the financial year:

(a) Healthwatch West Berkshire has encouraged the involvement of lay persons:-

(i) in the governance of the organisation by advertising and recruiting persons to serve on the executive board of Local Healthwatch. All such persons are volunteers and engage in discussions and vote on specific decisions of governance that are made. All board papers are made accessible to members of the public via the Healthwatch West Berkshire website: www.healthwatchwestberkshire.co.uk and members of the public are invited to submit questions for discussion and may attend the board meeting.

(ii) in relevant decisions of the organisation by including local persons from local voluntary sector representative groups to input into the operational decisions of the organisation such as geographical areas for outreach, meetings and seminars, and website content. This has been achieved by Healthwatch representatives attending at local forums and committees, interaction with members of the public via social network, and specific public meetings.

(iii) in the carrying-on of the relevant section 221 activities through the recruitment of Healthwatch champions, an advisory board to the main Healthwatch board and who comprise the voluntary heads of various local networks; Healthwatch West Berkshire have no subcontractors.

It should be noted that in the foregoing, “lay person”, “volunteer” and “relevant decision” have the meaning given in the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012(**c**).

**4.** Details of the payments made to the Local Healthwatch organisation during the financial year, under the local authority arrangements pursuant to which the final annual report will be prepared is shown below. The total commissioned income was £108,000 and Healthwatch West Berkshire CIC has applied for and attracted a further independent funding via its managing arm, Family Resource Centre UK CIC bringing the total income to £122,997.

| | **12 Months to Apr-14** |
|---|---|
| **Income** | |
| Setup cost | 5997 |

| | |
|---|---|
| Annual commissioned service | 108000 |
| External grants obtained | 4000 |
| Family Resource Centre UK CIC grant | 5000 |
| **Total Income** | **122997** |
| | |
| **Expenditure** | |
| **Staff support costs** | |
| Lead Officer | 10000 |
| Development officer | 22500 |
| Marketing and development team | 20576 |
| Finance support and audit team | 4100 |
| Web and IT support team | 12950 |
| Administrative support team | 16500 |
| Healthwatch development local grants | 12500 |
| Training and meetings | 1340 |
| **Overheads** | |
| Office costs and event space rental | 9400 |
| Printing stationery | 7240 |
| Postage | 2920 |
| **Governance** | |
| Board interviews, meetings and training | 2900 |
| **Total Expenditure** | **122926** |
| | |
| **Profit (loss)** | **71** |

**5.** A synopsis of the section 221 activities that have been undertaken by the relevant persons during the financial year are outreach engagement with members of the public in 27 locations across West Berkshire, attendance at 79 local voluntary sector meetings and forums, attendance at 34 public or NHS lead meetings including Health and Wellbeing Boards, Quality Surveillance Group, various Thames Valley Health meetings, and cross border engagement with other Healthwatch in Berkshire, Wiltshire, Oxfordshire, Surrey, Hampshire, and Croydon. Enter and view training and recruitment of enter and view team. Healthwatch West Berkshire have an accredited enter and view trainer. We have also carried out engagement via the website, advertisement in magazine, and social networking. An excellent bi-annual magazine with a directory has also been well received as an engagement tool.

Healthwatch West Berkshire operate a 9 – 5 telephone support service for members of the public and this is manned by trained advice and guidance team members who offer assistance through providing information or signposting callers to other organisations. This service has been well received and is growing in popularity as people have come to recognise the existence of Healthwatch.

**6.** The impact of our activities highlighted the need for further investigation into five areas of concern identified from public and voluntary sector engagement.
These are:

1. Primary Care services including includes information into GP wait times, access to services when needed, transportation, access to referrals and more specific items;
2. Maternity services;

3. Disability. 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.

Healthwatch West Berkshire is currently funding four local investigations in conjunction with local partners relative to the above and these will be completed in the 2014/15 financial year. Local commissioners will also be asked to input into the areas of investigation and the results of these investigations will be formally reported with a view to their content impacting on new commissioning and provision and management of the care services within the meaning of section 221(6) of the Act.

**7.** During the financial year, Healthwatch West Berkshire has engaged with Healthwatch England on two matters of complaint that have been investigated. The first matter of complaint centred on patient dignity and care at the Royal Berkshire Hospital. However, the CQC overtook the initial investigation timing by releasing its own report on RBH. The second complaint is still in progress and relates to Section 117 of the Mental Health Act. The complaint centres around a possible safeguarding matter relative to persons detained under a court of protection order who have suffered a restriction in access to their income resulting in high levels of savings being generated leading to loss of housing and income support. So far, questions have been raised to West Berkshire Council who have cooperated and replied with general operational information.

The investigation will now be progressed on a more specific patient by patient investigation in West Berkshire and recommendation has been made to Healthwatch England to engage in a countrywide special investigation into the management of finances of those detained under section 117.

**8.** From the outset, Healthwatch West Berkshire embarked on a structured pattern of engagement with the public, voluntary sector, and statutory bodies. During the course of the year we have met with people of all ages and from all walks of life from across the region with the purpose of hearing their views and perspective of health and social care and also to hear the stories of those who had more in-depth experiences of such services as a patient or close associate of someone who has or is using health related services.

We have endeavoured to capture the voice of the consumer across the region to ensure Healthwatch West Berkshire became representative of what the consumer has to say on matters of health and social care. Numerically we have engaged on a one-to-one basis with almost two thousand people and have gathered almost 1000 direct written feedback as well as verbal engagement. It was a deliberate policy not to ‘lead’ comments or information gathered through targeted surveys or by visiting specific groups but rather to encourage ‘the person in the street’ to tell us their thoughts, hopes, dreams and criticisms of our health and social care services. All outreach this year has been undertaken on a like for like basis across the region, in public places and in the daytime. Therefore we are now able to say that the raft of qualitative data gathered is representative of the daytime mobile consumer voice across in West Berkshire.

The data amassed has allowed us to extract and collate information across the range of health and social care services used by the people of West Berkshire and produce statistical reports based on the number of times specific areas of concern or interest have been raised by participants. Although qualitative data is sometimes regarded as soft data, in terms of understanding the consumer voice it has been a vital way of capturing the information required to meet our desired outcome of producing an evidence based understanding of local choices, preferences and needs.

We have used this data to inform our statutory work and responsibilities during the twelve months to date particularly in relation to section 221.

We are aware that qualitative data is often regarded as soft data but it was a necessary exercise to form a basis for further investigations. In year two we will be building on the data from year one and overlaying this with new additional data from the hard to reach and seldom heard groups who are not so likely to have engaged in the street or are necessarily available in the daytime. Also in year two we will continue to offer an open reception for those who know what they wish to comment upon however we will also be conducting focussed surveys on specific subjects.

**9.** Steps were taken during the financial year to obtain the views of a wide range of local people, including:

(a) people who are aged under 21 - We have engaged in three teaching sessions in Newbury College and two local schools to date; We have particularly used social networking as an engagement tool to attract younger users.

People aged over 65 - Our outreach work has included attendance at day facilities for the older generation, care homes and forums for those who represent the older generation;

(b) people who work or volunteer in the area have been specifically targeted by Healthwatch to obtain their views and input. This has resulted in the establishment of a Healthwatch Champions Board which is staffed by local volunteers who represent specific groups of consumers and who are equipped to represent their local peers and it is they who in the future will bring matters of concern to the Healthwatch main board; The Healthwatch non-executive main board members are all unpaid volunteers who live in West Berkshire and it is they who vote on matters and are part of the decision making process. Healthwatch West Berkshire currently works with 17 main volunteers in recognised posts;

(c) people from diverse backgrounds and sectors of society, including:

(i) people of disadvantaged socio-economic status we have endeavoured to reach through engagement at children's centres and rural village halls where we have met with local low income families;

(ii) people from groups which are perceived by the West Berkshire Healthwatch as vulnerable we have reached through engagement with local forums who represent such individuals including those with physical disabilities, mental impairment, sight and hearing impairments, those living in poor housing and those living on benefits. In such cases the local

forum have taken our 'Speak out' forms and volunteers have obtained the feedback information;

(iii) we have identified and engaged with two people groups whose views we perceive, are seldom heard by persons responsible for commissioning, providing, managing or scrutinising local care services. The first group is those aged 55 – 75 who are the unrecognized 'enablers' for parents in their 80/90's and also providing child care support for grandchildren. The second group are those suffering the effects of rurality due to poor transport services, access to shops and social activities;

**10.** It was the decision of Healthwatch West Berkshire from the outset of April 2013 only to use 'enter and view' as a requirement to support a specific complaint or concern by a member of the public. Healthwatch West Berkshire has trained a small team of 'enter and view' persons and has a qualified 'trainer' on its team. To date we have had no necessity to use this function but we are fully equipped to do so.

**11.** Healthwatch West Berkshire executive directors have worked closely with Health and Wellbeing Board to ensure that the most appropriately qualified person is the Healthwatch representative. To that end, Dr Adrian Barker has been so appointed due to his wide knowledge of the health and social care sector and his experience at the board table. If Dr Barker is not available then the Lead Officer Heather Hunter represents the organisation.

**12.** The annual report will be made available via the website: www.healthwatchwestberkshire.co.uk from where it may be downloaded as a PDF file. Alternatively, printed copies may be obtained by telephoning the Healthwatch West Berkshire office. It will also be available from our social network sites.

**13.** Healthwatch West Berkshire has, during the financial year, used the trademark to which any relevant Healthwatch licence relates in relation to the carrying-on of the relevant section 221 activities.

Healthwatch West Berkshire did not engage any subcontractor during the period who would require to use the licenced logo under section 45D of the Health and Social Care Act 2008;

## Appendices

There are no Appendices to this report.

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# Health and Wellbeing Board Forward Plan 2014/15

| Reference | Item | Purpose | Action required by the H&WB | Deadline date for reports | Lead Officer/s | Those consulted | Is the item Part I or Part II? | Comments |
|---|---|---|---|---|---|---|---|---|
| **15th May 2014** | | | | | | | | |
| H&WB2.1 | Quarterly update report from Healthwatch | To present the Healthwatch Q4 report | For information | 6th May 2014 | Adrian Barker/Heather Hunter | | Part I | |
| H&WB2.2 | Joint Self Assessment - Learning Disabilities | To give a follow up report on the work which is now complete | For information | 6th May 2014 | Alison Love | Health and Wellbeing Board<br>Communities Directorate Leadership Team | Part I | |
| H&WB2.3 | SEND Reforms | To raise awareness of the Special Education Needs and Disability Reforms | For information | 6th May 2014 | Jane Seymour | Health and Wellbeing Board | Part I | |
| H&WB2.4 | Performance Framework for 2013/14 | To agree the 13/14 performance framework and take note of how Health and Wellbeing partners worked to address the five Health and Wellbeing priorities. | Discussion and Agreement | 6th May 2014 | Lesley Wyman | Health and Wellbeing Board | Part I | |
| H&WB2.5 | Quality Account proposed responses for Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust | The Federation of Clinical Commissioning Groups to present a summary of their comments and statement of inclusion. | For information | 6th May 2014 | Cathy Winfield | Health and Wellbeing Board | Part I | |
| H&WB2.6 | Health and Wellbeing Development Session | Where the Board is now and where it is going next. | To discuss and agree the way forward for the Board as as a result of the Development Session. | 6th May 2014 | Nick Carter/Rachael Wardell | Health and Wellbeing Board | Part I | |
| **24th July 2014** | | | | | | | | |
| H&WB3.1 | Quarterly update report from Healthwatch | To present the Healthwatch Q1 report | For information | 15th July | Adrian Barker/Heather Hunter | | Part I | |
| H&WB3.2 | Local account | | | 15th July | Tandra Forster | Health and Wellbeing Board<br>Communities Directorate Leadership Team | | |
| H&WB3.3 | Health and Wellbeing Strategy | To present the refreshed Strategy to the Board | tbc | 15th July | Lesley Wyman | tbc | Part I | |
| H&WB3.4 | Healthwatch: turning information into accountable items for providers | To report on how information collected by Healthwatch can be turned into accountable items for providers. | for discussion | 15th July | Heather Hunter | | Part I | |
| H&WB3.5 | JSNA: Ward profiles and Assetts | How the ward profiles can be used to identify links between deprivation and health | For information | 15th July | Lesley Wyman | Health and Wellbeing Board | Part I | Pushed back from May due to development session discussion |
| H&WB3.4 | Protocol on the working arrangements between West Berkshire LSCB, H&WB and the Munro Implementation Board | The H&WB Board to view to protocol and discuss and agree on any changes that need to be made | For discussion and agreement | 15th July | Rachael Wardell | Health and Wellbeing Board | Part I | Pushed back from May due to development session discussion |
| H&WB3.5 | Early Help | To inform the Board about the multi agency Early Help Hub | For information | 15th July | Julia Waldman | Health and Wellbeing Board<br>Communities Directorate Leadership Team | Part I | Going to Corporate Board on 13th May so was pushed back from the May H&WBB meeting. Needs to be early on the agenda. |
| **25th September 2014** | | | | | | | | |
| H&WB4.1 | Safeguarding Adults Board Annual Report | To present the SAPB annual report | For information | 16th September | Silvie Stone (independent chair) | Health and Wellbeing Board<br>Communities Directorate Leadership Team | Part I | |
| H&WB4.2 | Multi Agency Safeguarding Hub update | To give an update on MASH | For information (maybe agreement) | 16th September | June Graves | Health and Wellbeing Board<br>Communities Directorate Leadership Team | Part I | |
| H&WB4.2 | Children's Wellbeing & Anxiety Project | | | 16th September | Mark Evans | Health and Wellbeing Board<br>Communities Directorate Leadership Team | Part I | Rachael Wardell to provide further detail |
| H&WB4.3 | Pharmacetical Needs Assessment | Purpose: to present the PNA to the Board prior to final sign off. | For discussion | 16th September | Lise Llewellyn | | Part I | |
| **27th November 2014** | | | | | | | | |

# Health and Wellbeing Board Forward Plan 2014/15

| Reference | Item | Purpose | Action required by the H&WB | Deadline date for reports | Lead Officer/s | Those consulted | Is the item Part I or Part II? | Comments |
|---|---|---|---|---|---|---|---|---|
| H&WB5.1 | Quarterly update report from Healthwatch | To present the Healthwatch Q2 report | For information | 18th November | Adrian Barker/Heather Hunter | | Part I | |
| H&WB5.2 | Plan A | To provide an update on the transition programme for the communities directorate | For information | 18th November | Rachael Wardell | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| H&WB5.3 | LSCB Annual Report | To present the LSCB annual report | For information | 18th November | Stephen Barber | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| H&WB5.4 | Implementation Free School Meals for Infants | To give an update on the initiative which will be implemented in September 2014. | For information | 18th November | Caroline Corcorren | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| **22nd January 2015** | | | | | | | | |
| H&WB6.1 | Quarterly update report from Healthwatch | To present the Healthwatch Q3 report | For information | 13th January 2015 | Adrian Barker/Heather Hunter | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| H&WB6.2 | Plan A | To provide an update on the transition programme for the communities directorate | For information | 13th January 2015 | Rachael Wardell | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| **26th March 2015** | | | | | | | | |
| H&WB7.1 | Post Implementation Reflection on Special Education Needs Reforming | To report on the new way of working with Children with Educational Needs | Progress report for information | 17th March 2015 | Jane Seymour | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |
| **28th May 2015** | | | | | | | | |
| H&WB8.1 | Quarterly update report from Healthwatch | To present the Healthwatch Q4 report | For information | 19th May 2015 | Adrian Barker/Heather Hunter | | Part I | |
| H&WB8.2 | Activity and Impact report of 'Healthy School Post' | To give a report on progress | For information | 19th May 2015 | Ian Pearson | Health and Wellbeing Board Communities Directorate Leadership Team | Part I | |