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Notice of Meeting

Health and Wellbeing Board

Thursday, 27th November 2014 at 9.00am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 19 November 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), Dr Barbara Barrie (North and West Reading CCG), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Portfolio Holder for Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Portfolio Holder for Children and Young People), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Nikki Luffingham (NHS England Thames Valley) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also to: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Lesley Wyman (WBC - Public Health & Wellbeing), Councillor Graham Pask, Councillor Quentin Webb, Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG) and Matthew Tait (NHS Commissioning Board)

Agenda

Part I

			Page No.
9.00 am	1	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	
9.01 am	2	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 18th and 25th September 2014.	1 - 16
9.05 am	3	**Health and Wellbeing Board Forward Plan** For information.	17 - 20
9.07 am	4	**Actions arising from previous meeting(s)** For information.	21 - 22
9.10 am	5	**Declarations of Interest** To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.	

6 **Public Questions**
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.)*

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

Items for discussion

Systems Resilience

9.15 am	8	**Health and Social Care Dashboard (Tandra Forster/Shairoz Claridge/Jessica Bailiss)** Purpose: To present the Dashboard and highlight any emerging issues.	23 - 26

Health and Wellbeing Strategy/Joint Strategic Needs Assessment

9.25 am	9	**JSNA Ward Profiles (Lesley Wyman)** Purpose: To report on how the ward profiles can be used to identify links between deprivation and health.	27 - 32
9.35 am	10	**Themes for Health and Wellbeing Board meetings (Lesley Wyman)** Purpose: To propose three priorities from the Health and Wellbeing Strategy that the Board will focus on over the next twelve months.	33 - 38

Governance and Performance

9.50 am	11	**Health and Wellbeing Strategy Performance Report (Lesley Wyman)** Purpose: to present a performance report against the current Health and Wellbeing Strategy.	39 - 52
10.00 am	12	**Health and Wellbeing Board Governance (Councillor Marcus Franks)** Purpose: to give clarity on the constitution for the Health and Wellbeing Board.	53 - 58

Development Plan

10.10 am	13	**Health and Wellbeing Board Development Session (Nick Carter)** Purpose: for the Board to view the draft objectives and agenda for the next development session taking place on 4th December 2014, which will be facilitated by the Local Government Association.	59 - 60

Integration Programme

10.20 am	14	**Update report on the Better Care Fund (Tandra Forster)** Purpose: To give an update on the BCF following on from the Special Meeting of the Health and Wellbeing Board that took place 18 September 2014.	61 - 166
10.35 am	15	**Better Care Fund Project Management Report (Tandra Forster)** Purpose: To update the Board on progression with the Better Care Fund projects.	167 - 174

Other issues for discussion

10.50 am	16	**Safeguarding Adults Partnership Board Annual Report (Sylvia Stone)** Purpose: To present the SAPB annual report to the Health and Wellbeing Board.	175 - 200
11.00 am	17	**Pharmaceutical Needs Assessment Briefing (Lise Llewellyn)** Purpose: To present PNAs that belong to other areas to the Board for comment.	201 - 212
11.10 am	18	**NHS Five Year Forward View (Cathy Winfield)** Purpose: To note the Five Year Forward View and discuss the implications for West Berkshire health and well being system and Better Care plan.	213 - 254
	19	**Members' Questions** 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.	

Other Information not for discussion

20	**Local Safeguarding Children's Board Annual Report** The LSCB annual report for information.	255 - 294
21	**Mental Health Crisis Concordat** The Mental Health Crisis Concordat for information *(Please note that although this is only for information at this stage, a follow up report will come to the Health and Wellbeing Board for discussion in January 2015).*	295 - 296
22	**Future meeting dates** 22 January 2015 26 March 2015 4 June 2015 30 July 2015 (provisional) 24 September 2015 (provisional) 26 November 2015 (provisional) 28 January 2016 (provisional) 24 March 2016 (provisional) 26 May 2016 (provisional)	

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.

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

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 18 SEPTEMBER 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), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Joe Mooney (Community Care, Insurance), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs) and Nikki Luffingham (NHS England Thames Valley).

Also Present: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Tandra Forster (WBC - Adult Social Care), Steve Duffin (Head of Adult Social Care Change Programme), Fiona Slevin-Brown (Berkshire West CCGs) and David Holling (Head of Legal Services).

Apologies for inability to attend the meeting: Dr Barbara Barrie, Councillor Irene Neill and Lesley Wyman.

PART I

31. Declarations of Interest

There were no declarations of interest received.

32. Better Care Fund - Submission of Plans to NHS

Councillor Marcus Franks introduced the item to Members of the Health and Wellbeing Board. He explained that the same report had previously been considered by Members of the Council's Management Board due to the substantial financial risk to the Local Authority. Members of the Executive had concluded that they could not sign up to the Better Care Fund (BCF), which could leave the Local Authority facing the risk of a £3.8 million shortfall although this position would need to be formalised by the Executive itself. Councillor Franks invited Rachael Wardell to give further background to the item.

Rachael Wardell explained that Members of the Health and Wellbeing Board had considered a detailed report on the planned use for the BCF on the 6th February 2014 and approval had been given for the draft plans to be submitted to the Department of Health (DoH). BCF Plans had been developed in collaboration with the Clinical Commissioning Groups (CCGs).

The BCF took existing money and redirected it into Adult Social Care and integration, focusing it on a number of issues. The CCGs and Local Authority had worked together to develop and prepare plans for the BCF. Rachael Wardell confirmed that there was still full commitment to the seven schemes presented to the Board in February 2014 subject to the funding situation being clarified by the Department of Health.

In July 2014 a ministerial announcement significantly changed the funding and performance arrangements and the DoH had set a new template requiring further detail on planned use for the BCF in line with this. The submission deadline for the new

template was 12 noon on 19th September 2014. Rachael Wardell stated that there was no intention to step away from any of the areas of work detailed in the original BCF plans. This was still considered crucial work across the West of Berkshire.

Rachael Wardell explained that Central Government had not allocated an overall sum of money solely for the implementation of the Care Act and this was now included within BCF. The CCGs and Local Authority had negotiated a proportion of the funding, which would fund the Care Act obligations however, this amount did not come close to what was required as outlined in guidance. West Berkshire was one of just three authorities in England operating at 'critical only' and therefore faced significant new costs arising from the change to a new minimum eligibility criteria. The BCF did not include any additional funding to meet these costs.

Councillor Gwen Mason reported that she had only recently become a Member of the Board and therefore had not been able to vote at the meeting in February. She was concerned about agreeing to a 3.5% improvement target. Councillor Mason was in support of a 1.1% local improvement target, which would put £250k of the BCF funding into a performance pot rather than £550k. Councillor Mason also felt that a £3.8 million shortfall was too large a risk for the Local Authority to take.

Steve Duffin confirmed that the risk arrangements had been discussed with the CCGs. If the 1.1% improvement target was met then the money would be released. Councillor Franks queried if the 1.1% target could be rejected. Cathy Winfield confirmed that this had been agreed by the CCGs and as a consequence, this had been incorporated into the National Assessment Programme. Feedback on the plans would be available on 10th October 2014.

Dr Lise Llewellyn raised two questions, firstly she asked if the Health and Wellbeing Board did not sign of the BCF, how would the programme be taken forward. Secondly she asked with West Berkshire being one of three authorities operating at 'critical only' what the other two authorities were doing. Dr Llewellyn felt that if only West Berkshire were refusing to sign up to BCF plans then this would put them in a difficult position.

Rachael Wardell confirmed that the other two authorities were Northumberland and Wokingham. Northumberland were showing little interest in receiving the money and Wokingham were in a similar position to West Berkshire. Wokingham were not, however, facing as big a financial risk as West Berkshire and were proposing to submit their BCF plans by the deadline. They were however, proposing to attach conditions stating they would withdraw from the agreement if these were not met by the DoH.

Cathy Winfield stated that there would be difficulty funding the schemes if the BCF plans were not signed up to and submitted. Some of the schemes were already in the implementation stages and therefore this would impose a large risk to the CCG.

Dr Rod Smith stated that a large proportion of the Berkshire West population would benefit from the plans being submitted. He suggested that West Berkshire sign up to the BCF plans but with caveats attached which would allow both the Council and the CCGs to pull back from the plans at a later date if the Care Act financial issues were not resolved.

Cathy Winfield reported that she understood the Council's reluctance to sign up the BCF plans given the change in financial circumstances. She stated that the issues had been exacerbated by the late change of thinking around funding for the Care Act, as it had been implied that would be centrally funded. Cathy Winfield stated that they would be expected to deliver the seven schemes within the BCF. Reading was part of the National Exemplar Programme. If West Berkshire did not sign up to the plans, a third of the

schemes could be placed at risk and therefore this could place the National Exemplar Scheme at risk.

Cathy Winfield stated that the CCGs were of the view that it was better to submit the plans with caveats as this would place the Board in a stronger position for leverage.

Councillor Gordon Lundie thanked Cathy Winfield and Rachael Wardell for their comments and stated that he was not in disagreement with them. The situation they found themselves in had been caused by a mistake made by the Local Government Association. Councillor Lundie stated that this would not prevent the Local Authority in moving forward with the important health agenda. Councillor Lundie stated that it was difficult for the Local Authority to sign up to something it did not agree with. It was hoped that by not signing the plans this would give some short term leverage through bringing the DoH back to the table for discussion. It was felt that it could weaken the Local Authority's position in terms of future legal cases if it was to sign up to the plans. Councillor Lundie confirmed that the Local Authority did not want this position to impact on the good working relationship it had with Health.

Cathy Winfield commented that she did not see the risk as a Local Authority pressure alone, but rather a whole system risk. Services would precipitate into a higher level of need if they had to address liabilities. It was therefore a joint CCG and Local Authority risk/responsibility (whilst working closely with Wokingham). She stated that it would be extremely difficult for the CCGs not to sign up to the BCF.

Nikki Luffington stated that it was part of NHS England Local Team Framework to support the submission of plans going forward. Nikki Luffington commended West Berkshire's plans. She reported that the NHS England Local Team would be fully supportive of the plans being submitted with a caveat if necessary. Concerns about vulnerability were understood however, Nikki Luffington felt that if the plans were not submitted it would leave West Berkshire at risk.

Dr Bal Bahia felt that the Board was in the same position it was in during February. Dr Bahia supported the view that it was a larger system risk rather than a risk to a single organisation.

Rachael Wardell explained that the risk was not a new risk however, it had not previously been quantified. The plans had been submitted on the basis of goodwill in February 2014 and with an expectation that the information would be provided.

Adrian Barker asked what would happen next if the plans were not signed and submitted. Councillor Franks stated that the outcome of this course of action was currently unknown.

Steve Duffin explained that the key issue was around the impact assessment. The methodology used was divided over 133 social care authorities rather than the three operating a 'critical' only. Fundamentally he felt that funding for the eligibility criteria had been placed into the wrong pot.

Dr Llewellyn acknowledged that short term clarity was required and suggested that a possible way forward would be to sign up to the BCF and then add a condition stating that if the funding issues were not resolved to the satisfaction of the Board within six weeks the Board would pull back from the agreement. Clear caveats would be required to ensure any judicial review process was not compromised in the future.

Cathy Winfield stated that CCGs plans spanned over five years and that the transfer detailed was recurrent, with the first transfer planned for 2015.

Councillor Lundie summarised that there were two possible proposals on the table: the Health and Wellbeing Board could refuse to sign the BCF Plans or alternatively the Board could sign the plans with the financial caveats clearly articulated.

Dr Smith confirmed that West Berkshire would be aligned to Reading and Wokingham if they signed their plans. Dr Bahia noted that Wokingham had signed their plans before the risk had crystallised. Cathy Winfield reported that she understood that Wokingham were submitting their plans with conditions and if these were not met they would withdraw their submission.

Councillor Franks invited Nick Carter to speak to the Board on the matter. Nick Carter felt that the position would be enhanced by a unified Board response as opposed to the Council alone voting to sign up to the plans. He suggested that a date could be inserted as part of the caveat and if assurance was not given by this data that the Care Act money would come from Government, then the Board could pull away as one from the BCF plan. Agreement from Wokingham should also be sought on taking a similar position. Nick Carter reported that he could confirm from conversations with the Chief Executive for Wokingham Borough Council that they were fully aligned with West Berkshire's position.

Cathy Winfield felt that it was reasonable for the Health and Wellbeing Board as a partnership to submit the conditions referred to and that this would represent a partnership response not a single organisation response.

(Meeting adjourned at 5pm and recommended 5.03pm)

Councillor Lundie noted that the Health and Wellbeing Board were facing a very challenging issue, which was importantly recognised as a system risk by all.

Councillor Lundie proposed that the BCF plans should be signed off subject to a clear caveat stating that if a resolution to funding the Care Act centrally was not found by 31st October 2014 the Board would exercise its right to withdraw from the commitments set out in the plans.

Councillor Lundie added that his recommendation was based on receiving the full support from the bodies on the Health and Wellbeing Board, as this would present a much stronger case.

Councillor Mooney seconded Councillor Lundie's proposal.

RESOLVED that:

(i) The Better Care Fund Plan be approved and submitted to the DoH subject the DoH confirming, by the 31 October 2014, that the full cost of funding the new minimum eligibility criteria under the Care Act would be met centrally

(ii) If assurance was not received the Board would withdraw its support for the BCF Plan.

(With the exception of one abstention, the above resolutions received the full support of the Board).

(The meeting commenced at 4.10 pm and closed at 5.10 pm)

CHAIRMAN …….

Date of Signature …….

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

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 25 SEPTEMBER 2014

Present: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Dr Barbara Barrie (North and West Reading CCG), 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 (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Children and Young People, Youth Service, Education), Rachael Wardell (WBC - Community Services) and Nikki Luffingham (NHS England Thames Valley)

Also Present: Councillor Geoff Mayes, Jessica Bailiss (WBC - Executive Support), Andy Day (WBC - Strategic Support), Lesley Wyman (WBC - Public Health & Wellbeing), June Graves (WBC - Housing), Heather Hunter (Healthwatch), Tandra Forster (WBC - Adult Social Care), Fiona Slevin-Brown (Berkshire West CCGs), Fatima Ndanusa (Public Health), April Peberdy (Public Health), Susan Powell and Sylvia Stone (Safeguarding Adults Partnership Board)

Apologies for inability to attend the meeting: Cathy Winfield and Councillor Joe Mooney

PART I

33. Minutes

The Minutes of the meeting held on 24 July 2014 were approved as a true and correct record and signed by the Chairman.

Councillor Marcus Franks asked Rachael Wardell for a brief update on the Better Care Fund (BCF), which had been the subject of an extraordinary meeting which had taken place the previous week.

Rachael Wardell reported that Health and Wellbeing Board had agreed at the extraordinary meeting that the BCF be approved and submitted to the Department of Health (DH) subject the DH confirming by the 31 October 2014, that the full cost of funding the new minimum eligibility criteria under the Care Act would be met centrally.

Wokingham had submitted their BCF plan with a caveat aligned to that submitted by West Berkshire. West Berkshire and Wokinghman had written a joint letter to the DH. Concerns had also been submitted to respective Members of Parliament so that they could lobby the DH on behalf of both West Berkshire and Wokinghman.

34. Health and Wellbeing Board Forward Plan

Councillor Marcus Franks drew the Board's attention to the Forward Plan, which was included for their information.

Adrian Barker recalled that at the last Board meeting in July, the possibility of inviting interest groups along to speak to the Board had been discussed. He queried what groups the Board would want to hear from and which issues it might be interested in. Councillor Franks reported that he had given this some thought and suggested that once the Health and Wellbeing Strategy (HWBS) was agreed, the Board should pick out three priorities it

wished to focus on. Groups could be invited to come along based on the chosen priorities.

35. Actions arising from previous meeting(s)

All were happy with the actions that had been completed since the last Board meeting in July.

36. Declarations of Interest

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

Dr Bal Bahia declared an interest in all matters pertaining to Primary Care, by virtue of the fact that he was a General Practitioner, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

Dr Barbara Barrie declared an interest in all matters pertaining to Primary Care, by virtue of the fact that she was a General Practitioner, but reported that, as her interest was not personal, prejudicial or a disclosable pecuniary interest, she determined to remain to take part in the debate and vote on the matters where appropriate.

37. Public Questions

Councillor Marcus Franks reported that a number of questions had been submitted by Mrs Pearl Baker. However, as Mrs Baker was unable to attend the meeting a written response would be sent to her.

38. Petitions

There were no petitions presented to the Board.

39. Health and Social Care Dashboard (Tandra Forster/Jessica Bailiss)

Councillor Marcus Franks introduced the Dashboard to Members of the Health and Wellbeing Board. Tandra Forster highlighted that it was still very much a work in progress.

Rachael Wardell raised her concern about the use of the word ‘target’ in relation to the Children’s Services section. Some of the metrics gave volume, for example the number of Looked After Children. This type of information could not be targeted as they did not want to drive numbers down but rather benchmark against what was considered the normal range.

RESOLVED that the wording for the Children’s Social Care section of the dashboard be reviewed to include ‘normal range’ rather than ‘target’ where necessary.

Tandra Forster explained that some of the data came from the national performance framework and some detailed volume. The dashboard had two elements; the number of people receiving services and then targets around the work being carried out by these services.

Dr Lise Llewellyn felt that dashboard only reflected a part of what the Health and Wellbeing Board covered and issues like early intervention and school readiness were not included. Tandra Forster reported that it was just a snapshot of the Health and Social

Care economy and that prevention work would be fed into the Board as part of the Health and Wellbeing Strategy (HWBS).

Rachael Wardell commended the dashboard for showing the whole range of hospitals servicing West Berkshire.

Councillor Marcus Franks referred to ASC7 regarding the Proportion of 111 calls converted to 999 and queried if it was lower or higher number the CCG were seeking on this metric. Fiona Slevin-Brown stated that lower numbers were positive for this target. Rachael Wardell felt that this metric might just reflect the nature of calls and therefore suggested that the steps taken in deciding a call should be converted to 999 should be included within the narrative for the dashboard.

Councillor Gordon Lundie asked if there was an indicator that could be included around accessibility to General Practitioners (GPs). Fiona Selvin-Brown explained that work was being carried our by the NHS Local Area Team on Primary Care demand. They were currently trialling an IT system with practices in the Oxford area and would be linking in with West Berkshire going forward. It was difficult to apply a single metric due to the way Primary Care was managed in that each practice had its individual processes.

Dr Barbara Barrie stated that end of life support by services could be used as a measure for integration.

RESOLVED that a measure indicating performance of end of life services to be added to the Dashboard.

Councillor Lundie asked Dr Bal Bahia to give his perspective on how practices were monitored. Dr Bahia stated that each practice was set up individually. If the demand was not being met then actions were taken to increase nursing and medical staff. There were lots of ways practices were measured including national metrics and patient consultations. A lot of work had taken place with practices in West Berkshire to increase capacity using the Call to Action Fund. Dr Bahia stated that more people in West Berkshire used West Call Out of Hours GP service because they lived further away from Accident and Emergency services.

Lise Llewellyn noted that there were a range of metrics within the BCF. She suggested that the CCG/NHS England should be asked to carry out a baseline assessment to give the ability to measure the impact over winter on primary care services.

RESOLVED that NHS England and the CCG would look into carrying out a baseline assessment to show the impact on Primary Care Services over the winter.

Councillor Franks stated that a baseline would help in identifying where the problems were going forward and if the Board was able to help with any of these. Councillor Franks referred to a survey he was aware of elsewhere that collected information on access to GPs. Adrian Barker stated that access to GP information was collected through Healthwatch consultations.

RESOLVED that Adrian Barker would send access to GP information to Jess Bailiss to circulate prior to the next Health and Wellbeing Board.

Councillor Marcus Franks referred to the four hour Accident and Emergency indicator and noted that the Royal Berkshire Hospital was improving. Tandra Forster confirmed that this was correct however, they were still under pressure and work was ongoing.

RESOLVED that a completed version of the dashboard would be brought back to the next Health and Wellbeing Board in November.

40. A update report on the Better Care Fund (Tandra Forster)

Tandra Forster introduced the item to Members of the Health and Wellbeing Board. Within the paperwork there was a highlight report for each of the five projects, which supported the seven schemes of the Better Care fund (BCF).

Dr Bal Bahia referred to the Enhanced Care and Nursing Home Support Project and stated that all practices who were linked to a Care Home had signed up to the plans.

Rachael Wardell noted that two of the projects were rated as red under their project budget status. Tandra Forster confirmed that red meant that funding had been identified through the Call to Action funding however, had not yet been received. The aim was to improve outcomes from people accessing services. It was noted that this should be rated green by the time of the next board meeting in November.

Dr Lise Llewellyn asked where performance for the BCF was being reported and queried if this would be done through the Health and Social Care Dashboard.

Lise Llewellyn stressed that a subset of performance metrics were required for the BCF that could be reported to the Health and Wellbeing Board at each meeting

RESOLVED that Tandra Foster and Fiona-Slevin Brown would identify a subset of performance metrics for the Better Care Fund that could be reported to the Health and Wellbeing Board at each meeting.

Councillor Marcus Franks noted that the budget section was blank on some of the highlight reports. Tandra Forster stated that a new programme for management across the West of Berkshire was being set up.

Nikki Luffington reported that Key Performance Indicators were being monitored and therefore missing information was expected imminently.

Councillor Franks praised the format of the highlight reports in helping the Board keep an overview of the BCF projects.

41. Draft Health and Wellbeing Strategy available for consultation (Lesley Wyman/Adrian Barker)

Lesley Wyman drew Members attention to her report on the Health and Wellbeing Strategy (HWBS). A lot of changes had been made since the Board meeting in September to incorporate the health and social care agenda. Priorities were based on the Joint Strategic Needs Assessment and there had not been any major changes over the past two years. The aim had been to narrow down the number of priorities compared to the original strategy.

Lesley Wyman reported that another area for the Board to discuss was how the HWBS sat with the Sustainable Community Strategy (SCS). The previous HWBS had touched on the wider determinants of health however, these had largely been covered in the SCS. Lesley Wyman asked if the Board were of the view that the wider determinants of health should be included within the HWBS or if they should be addressed in a separate strategy. She had included them within the priorities for the time being however, the Board needed to decide where they should be included. It was reported that this item largely linked to item 12 regarding the merger of the Local Strategic Partnership and Health and Wellbeing Board.

The rest of the Strategy was relatively self explanatory. It gave a picture of health and wellbeing in West Berkshire, the challenges faced and what the priorities were for the district. A section on the integration agenda was currently awaited. Tandra Forster confirmed that this section would be produced based on the Better Care Fund.

Lesley Wyman stated that the next step was to take the HWBS out to consultation. A consultation plan could be seen in appendix one.

Racheal Wardell stated that she had attended a meeting where there had been a really good discussion on integration on a West of Berkshire basis. There had been representatives from Wokingham and Reading local authorities as well as the CCGs, Hospital Trusts and Ambulance Trusts. There had been a shared ambition in the room for joint social care commissioning however, there had also been acknowledgement that they were still in the early days of the integration agenda. Rachael Wardell was in full support of plans for integration being included within the HWBS. She was also in support of slimming down the number of boards and strategies.

Rachael Wardell felt that information on carers should not just sit under the older people section within the strategy, as those requiring carers also included adults with learning disabilities, children and children who were carers themselves.

Dr Lise Llewellyn felt that the wider determinants of health needed to be included within the HWBS as they were crucial to the health and wellbeing of the population. Dr Llewellyn suggested that the priority on blood pressure be broadened out to cardiovascular disease.

Councillor Gwen Mason was concerned that Children's issues were not being adequately reported on within the HWBS in its current draft. She could not identify where ordinary children's views were being listened to. There used to be a Children and Young People's Partnership however, this had been disbanded.

Rachael Wardell reported that she was not concerned to the same extent as Councillor Mason as focus was being given to tackling inequalities and supporting vulnerable children and young people. Capacity within the system was limited which was why focus was being given to these areas. The Children and Young People's Partnership had become unsustainable as there had been little scope to act on matters it was discussing due to resourcing pressures. Rachael Wardell stated that she would be happy to revisit the possibility of the children's group once resources allowed.

Councillor Marcus Franks stated that although wider children's issues were not covered by priorities within the HWBS, they were covered by individual services plans. Adrian Barker confirmed that Healtwatch were also listening to the views of children and young people in schools.

Adrian Barker reported that there were a number of areas where he would like to see more emphasis within the strategy. He wanted to see the public treated as equal partners; more detail on how the priorities and objectives would be delivered and how the different sectors would need to work together to do so, for example around obesity. Adrian Barker felt that the draft HWBS was largely focused on public health at the moment and if it was to drive partner commissioning plans this needed to be broadened out. Finally Adrian Barker felt that the wider determinants of health were extremely important and needed to be included. Although issues such as the environment should not be priorities within the strategy, there should be reference to how important these issues were to health and wellbeing. Adrian Barker felt that to ensure there was buy in into the priorities, task and finish groups should be formed to look at detailed aspects of the strategy.

Leila Ferguson highlighted that there was still a Children and Young People's Forum, which was led on by Rosemary Lily from the voluntary sector.

Dr Barbara Barrie felt that the HWBS needed to embrace the Board's commitment to patient choice at the end of life. Councillor Gordon Lundie supported this point.

Councillor Franks stated that going forward if agreed, the new Community Sub-Partnership would carry out a lot of the work around the wider determinants of health. Housing also needed broadening out to include the amount of housing and the sustainability of housing.

Lesley Wyman asked if the Board would like the wider determinants of health included within the main body of the HWBS or as a separate section. Dr Llwelleyn felt that they should be included within the overall HWBS to ensure they were not overlooked.

Dr Bal Bahia felt that the HWBS needed to reflect the current health and social care economy, if the Board were expecting partners to use the HWBS as a basis for their commissioning plans.

RESOLVED that Lesley Wyman would speak to Dr Bahia outside of the meeting.

Cllr Marcus Franks suggested that once the HWBS was agreed, the Board could choose three priorities that it would focus on over the following year. The aim of this was to ensure the Board took ownership and drove its own Strategy.

RESOLED that Councillor Franks' suggestion for the Board to focus on a select number of priorities, be explored once the HWBS was agreed and placed on the forward plan.

Heather Hunter from Healtwatch was leading on the delivery plan for the HWBS and therefore Councillor Franks invited her to make any comments.

Heather Hunter reported that they had produced a timeline for consultation on the HWBS and were currently on track. However, she suggested that the four proposed public engagement meetings be replaced with a simple online presentation. This would also be supported by a paper version. It was felt that four public engagement meetings would be very restrictive and the online presentation would increase engagement with a wider audience and ensure people were not excluded.

Heather Hunter reported that the presentation would be taken out to the Healthwatch outreach stations. There were 27 outreach stations in 21 areas.

Rachael Wardell reported that she was in support of broadening consultation methods. She felt that rather having the online presentation instead on the public engagement meetings, it should be carried out in addition to it.

Heather Hunter stressed that the consultation was very time limited with little opportunity for advertisement and therefore they risked being criticised if they held the public engagement meetings.

Tandra Forster stated that she also supported the online presentation being carried out in addition to the public meetings.

Lesley Wyman confirmed that the final version of the HWBS was due to come to the next Board meeting on the 27th November. Dr Llewellyn concurred with earlier comments of having both the online presentation and the public engagement meetings however, questioned what timescale was realistic for doing this. Heather Hunter felt that they would need a further two to three weeks.

Rachael Wardell noted that the HWBS was for delivery in the next municipal year and therefore suggested the final version go to the board meeting in January 2015 rather than November.

RESOLVED that the final version of the Health and Wellbeing Strategy would be brought to the Board meeting in January 2015 for sign off rather than November, to allow for a more thorough consultation phase. A new consultation timetable to be drawn up to reflect this.

42. Development Plan for the Health and Wellbeing Board (Nick Carter/Marcus Franks)

Councillor Marcus Franks drew the Members' attention to his report, which included a development plan for the Health and Wellbeing Board. The development plan detailed the steps the Board needed to take in becoming an executive decision making body that understood, drove and pushed to improve the health and social care economy of West Berkshire.

Ideas for the development plan had come from the development sessions which had taken place earlier in the year for the Board. It had been decided through these sessions that the Board wanted to move towards a form of integration that involved pooling budgets.

Adrian Barker praised the report and development plan however, suggested moving forward it would need to incorporate how the Board would use the sub-partnerships to progress work. Councillor Franks suggested that this could be included once these sub-groups had been agreed. It was also felt that there could be additional column added at a later date which detailed how each stage was going be achieved.

43. Proposal to merge the Local Strategic Partnership Management group and Health and Wellbeing Board (Nick Carter)

Andy Day introduced the report, which aimed to enable the Board to consider the proposal to merge the Health and Wellbeing Board with the Local Strategic Partnership (LSP).

Andy Day reported that in the year 2000 legislation had requested that Local Authorities set up LSPs. Part of their role was to develop the Sustainable Community Strategy (SCS). If the Board decided to agree to the recommendations set out within the report there was potential to join the Health and Wellbeing Strategy (HWBS) and SCS together.

The LSP had twelve members and the membership was split up equally between the public, private and voluntary sectors. The real motivation for having LSPs was to drive the Local Area Agreements (LAAs) under the former Labour Government. The aim of the LAA was to identify what areas within the district required improvement. There had been a large amount of funding attached to the LAA.

Since the demise of the LAA the purpose of the Board was less clear. There were three sub-partnerships that sat underneath the LSP and of these only the safer Communities Partnership was statutory. The Skills and Enterprise Sub-Partnership was leading on the City Deal and largely focused on getting young people into work or education. The Greener Sub-Partnership was largely self sustaining. The LSP had also led on the two locality projects in the district, which had been very successful.

Andy Day referred to the report, which was suggesting that the LSP be discontinued. If the Board was minded to agree the proposal then the sub groups that were working well as part of the LSP would be retained. The report also suggested that a new Communities Sub-Partnership be set up, which would lead on community focused work that had been successful under the LSP including the locality projects. The terms of reference for this group needed to be agreed.

Leila Ferguson reported that she had no problem with the principles of the report however, was concerned that children and young people's issues were being overlooked. She was also concerned that the private sector representation would be lost if the new plans were agreed. Andy Day stated that if the Board felt that the private sector should sit on the Communities Sub-Partnership then this could be arranged.

Lesley Wyman felt that the Communities Sub-Partnership needed broadening out to include all vulnerable groups and tackling inequalities. She felt that these issues were missing from the subgroups as they currently stood.

Councillor Marcus Franks referred back to his suggestion for the Board to focus on three priorities from the HWBS once agreed. He felt that the Communities Sub-Partnership could support this work. Councillor Franks felt that the governance structure on page 70 of the report was flat. He asked for clarity on what the Board's purpose was in overseeing the work of the sub-partnerships as some did not fit in with the Health and Wellbeing Board's agenda. Councillor Franks suggested that the sub-partnerships feed into the Communities Sub-Partnership and then this group feed into the Health and Wellbeing Board.

Andy Day referred to the report which suggested that two additional meetings a year be set up to focus on the wider wellbeing agenda. These events would also help to inform the refresh of the HWBS. He suggested that the sub-partnerships report into the Board every six months at one meeting.

Rachael Wardell expressed her support for discontinuing the LSP however, felt that more work was required to agree the terms of reference for the Communities Sub-Partnership. Rachael Wardell suggested that the Board agree to the recommendations within the report in principle subject to the terms of reference being firmed up in time for when the Board next met in November.

Andy Day stated that he did not expect the membership of the Communities Sub-Partnership to be static as it would need to change depending on the issues being discussed.

Councillor Marcus Franks suggested that the links between Parish Planning and those the Communities Sub-Partnership would deal with should be mapped .

Dr Lise Llewellyn felt that it was important that vulnerable groups and tackling inequalities were issues that fell within the remit of the Communities Sub-Partnership and that the Head of Public Health and Wellbeing should be a standing member of the group. She also felt that it was important that the Sub-Partnerships did not report ongoing work to the Board and that they only reported issues where they needed Board's support. Otherwise the Board would be at risk of being inundated with information.

Andy Day reported that he would ensure that the Board were only alerted to issues needing support from the Board. The work plans of the sub-partnerships would be shaped to support the HWBS and Joint Strategic Needs Assessment.

RESOLVED that:

1. The Terms of Reference for the Communities Sub-Partnership to be firmed up in time for the next Health and Wellbeing Board in November
2. The recommendations as set out in section 5 of the report (Proposal to merge the LSP and HWBB) were agreed subject to the Terms of the Reference for the Communities Sub-Partnership being amended.

44. Risk to the CCG if providers do not meet the NHS Constitution rights or pledges for patients (Cathy Winfield)

Fiona Slevin-Brown introduced Phil McNamara's report to the Health and Wellbeing Board. The aim of the report was to address a query received following approval of the Newbury and District CCG Quality Premium at the July Board meeting.

Fiona Slevin Brown explained that the report emphasised what was said in the original paper brought to the Board in July and highlighted the risk if numerous rights and pledges were not achieved. In essence, if targets were not met then no payment would be received. A pot of money had been divided over four targets and 25% of the money would be released when each target was met. The CCGs were working with the Royal Berkshire Hospital and other providers to achieve the targets.

Rachael Wardell recalled that at the last meeting she had highlighted the process as unhelpful as it was driven predominately by bureaucratic processes.

Fiona Slevin-Brown reported that the CCGs were required to undertake the work. Dr Lise Llewellyn highlighted that NHS rights and pledges were driven by national policy. It was hoped that local targets were chosen based on local need. Adrian Barker stated that the aim was to support the system and not to chase targets. Fiona Slevin-Brown stated that the aim of the work was to enable them to achieve better outcomes for patients.

45. Protocol Agreement between the Health and Wellbeing Board and the Safeguarding Adults Partnership Board (Sylvia Stone)

Sylvia Stone introduced the Protocol Agreement between the West Berkshire Health and Wellbeing Board and the West of Berkshire Safeguarding Adult Partnership Board (SAPB).

In essence the protocol aimed to improve communication between the two Boards, particularly around the Care Act. It would strengthen the governance to ensure joint working took place as much as possible.

Sylvia Stone reported that Healthwatch had recently joined the SAPB and therefore was a link between the two boards. It was also important that the Health and Wellbeing Board had sight of the SAPBs Annual Report as well as receiving feedback on other issues such as the Care Act.

Rachael Wardell expressed her support for the protocol and stated that the Board had signed up to a similar protocol with the Local Safeguarding Children's Board (LSCB). She was also in support of the SAPB presenting their Annual Report to the Board, to mirror what was brought to the Board by the LSCB.

Dr Lise Llewellyn felt hat the protocol was unclear around expectations of the Health and Wellbeing Board and highlighted that it was not responsible for delivery. Sylvia Stone reported that delivery would sit with the subgroups of the SAPB. The role of the Health and Wellbeing Board was to keep an overview and be aware of key findings and learning areas.

It was suggested that the word 'ensure' be used throughout the protocol when referring the Health and Wellbeing Board.

Dr Llewellyn reported that she would like to see the Health and Wellbeing Board taking a role in unblocking barriers for the SAPB. Dr Bal Bahia concurred and asked if the SAPB currently held providers to account on safeguarding issues. Sylvia Stone reported that the SAPB was a non statutory body and would not become statutory until April 2015. The SAPB currently took a negotiating role rather than a challenging one however, it was hoped that this would change after April 2015.

Rachael Wardell suggested that the Safeguarding Adults Partnership Board (SAPB) Protocol be amended so that the word 'Board' was not used alone. This would avoid confusion to whether it was the SAPB or HWBB being referred to.

Councillor Marcus Franks proposed that the Health and Wellbeing Board sign up to the protocol agreement between the Health and Wellbeing Board and the SAPB.

RESOLVED that:

1. Sylvia Stone would send the amended version of the protocol to Jess Bailiss.
2. The SAPB Annual Report to be placed on the HWBB Forward Plan for November.
3. The Health and Wellbeing Board signed up to the protocol agreement with the SAPB.

46. Pharmaceutical Needs Assessment (Lise Llewellyn)

Dr Lise Llewellyn introduced her report to the Board which presented the draft Pharmacy Needs Assessment (PNA) for West Berkshire. Once the document had been agreed by the Health and Wellbeing Board the PNA would go out for public consultation.

The Health and Wellbeing Board were required to support the NHS Area Team in delivering the PNA. A new pharmacy could only be opened if a need was demonstrated. The West Berkshire PNA was one of six for the whole of Berkshire. Surveys had taken place with pharmacies, dispensing surgeries and users.

In West Berkshire there was generally a high level of satisfaction with pharmaceutical services. The PNA was not recommending that West Berkshire needed a further pharmacy.

Pharmacies played a key role in delivering wider primary care services and signposting to services. In 2013 they had carried out work around drink awareness. Further focus was required to explore how pharmacies could be used as a sign posting service for older people, for example to winter warming services and flu vaccinations. Their role in giving professional advice needed to be built upon.

Dr Llewellyn explained that the next step was to take the PNA out to public consultation, which would take place over three months. Dr Llewellyn reported that she would also be bringing PNAs from other authorities to the Health and Wellbeing Board for their comments. She was happy to summarise the PNAs rather than bring them to the Board in their entirety.

Councillor Irene Neill referred to page 119 of the report and stated that just over the border, there was a pharmacy in Tadley. Dr Llewellyn stated that she would ensure this was noted.

Fiona Slevin-Brown queried how the CCGs should best link in with the PNA. Lise Llewellyn reported that CCGs were a statutory consultee.

Councillor Marcus Franks queried to what extent the Health and Wellbeing Board had leverage to request existing services extend their services. Dr Llewellyn stated that the services currently sat with the area team. Offering advanced services was a voluntary choice and therefore pharmacies could not be forced to extend their services.

Tandra Forster queried how many pharmacies carried out home delivery services. Dr Llewellyn reported that this was a voluntary service however, there was a high percentage of pharmacies offering this service.

Nikki Luffington explained that although the Area Team held the core contract and were responsible for monitoring services, pharmacies could work with others on a voluntary basis for example the Local Authority or CCG.

Adrian Barker asked if the Council or CCG were currently commissioning pharmacies to deliver services. Dr Llewellyn reported that they were and examples included supervised consumption of methadone, needle exchange service and Chlamydia screening.

Councillor Franks proposed that the Health and Wellbeing Board agree that the West Berkshire PNA go out for public consultation.

RESOLVED that the West Berkshire PNA would go out for public consultation.

47. Thames Valley Quality Surveillance - Dental Review

The Health and Wellbeing Board noted the report regarding the Thames Valley Quality Surveillance – Dental Review.

48. Members' Question(s)

49. Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on 27 November 2014.

(The meeting commenced at 9.00 am and closed at 11.25 am)

CHAIRMAN …….

Date of Signature …….

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Health and Wellbeing Board Forward Plan 2014/15

Ref.	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
27th November 2014								
	Items for Discussion							
	System Resilience							
H&WB5.1	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	30th October	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
H&WB5.2	Update report on the Better Care Fund	To give an update on the BCF following on from the Special Meeting of the Health and Wellbeing Board that took place 18 September 2014.	For Information and discussion	30th October	Tandra Forster	Health and Wellbeing Management Group	Part I	
H&WB5.3	Better Care Fund Project Management Report	To update the Board on progression with the Better Care Fund projects.	For Information	30th October	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
H&WB5.4	JSNA Ward Profiles	To report on how the ward profiles can be used to identify links between deprivation and health.	For Information and discussion	30th October	Lesley Wyman	Health and Wellbeing Management Group	Part I	
H&WB5.5	Themes for Health and Wellbeing Board meetings	To update the Board on progression with the Better Care Fund projects.	For discussion and agreement	30th October	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Commissioning Plans							
	No items for discussion							
	Public Engagement							
	No items for discussion							
	Finance							
	No items for discussion							
	Governance and Performance							
H&WB5.6	Health and Wellbeing Strategy Performance Report	To present a performance report against the current Health and Wellbeing Strategy.	For Information and discussion	30th October	Lesley Wyman	Health and Wellbeing Management Group	Part I	
H&WB5.7	Health and Wellbeing Board - Governance	To give clarity on the constitution for the Health and Wellbeing Board.	For Information and discussion	30th October	Andy Day	Health and Wellbeing Management Group	Part I	
	Development Plan							
H&WB5.8	Health and Wellbeing Board Development Session	To brief the Board on the objectives for the next development session taking place on 4th December 2014, which will be facilitated by the Local Government Association.	For Information and discussion	30th October	Nick Carter	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
H&WB5.9	Pharmaceutical Needs Assessment Briefing	To present PNAs that belong to other areas to the Board for comment.	For discussion and comment	30th October	Dr Lise Llewellyn		Part I	
H&WB5.10	Safeguarding Adults Partnership Board Annual Report	To present the SAPB annual report	For information	30th October	Sylvia Stone /Natalie Madden	Health and Wellbeing Board Communities Directorate Leadership Team	Part I	
H&WB5.11	NHS Five Year Forward View	To note the Five Year Forwards View and discuss the implications for West Berkshire health and well being system and Better Care plan.	For information and discussion	30th October	Cathy Winfield	Health and Wellbeing Management Group	Part I	
	Other information not for discussion							
H&WB5.12	Local Safeguarding Children's Board Annual Report	The LSCB annual report for information	For information	30th October	N/A	LSCB	Part I	
H&WB5.13	Mental Health Crisis Concordat	The Mental Health Crisis Concordat for information.	For information	30th October	Dr Bal Bahia	Health and Wellbeing Management Group	Part I	A follow up report will come to the Health and Wellbeing Board for discussion in January 2015.
22nd January 2015								
	Items for Discussion							
	System Resilience							
H&WB6.1	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	11th December	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
H&WB6.2	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	11th December	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
H&WB6.6	The Care Act	To give feedback on the consultation.	For Information and discussion	11th December	Tandra Forster	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
H&WB6.3	Finalisation and agreement of the new Health and Wellbeing Strategy	The Board to finalise and agree the Strategy post the consultation period.	For Agreement	11th December	Lesley Wyman	Health and Wellbeing Board, key stakeholders and the public	Part I	
	Finance							
H&WB6.4	The Council Budget 2015/16	To give an overview of the budget for the coming year	For Information and discussion	11th December	Nick Carter		Part I	
	Governance and Performance							

Health and Wellbeing Board Forward Plan 2014/15

Ref.	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&WB6.5	Health and Wellbeing Performance Report	To give a report to the Board on performance against the current Health and Wellbeing Strategy.	For Information and discussion	11th December	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
H&WB6.6	Dementia Alliance	To inform the Board about this national programme of work, which has time limited funding	For information and discussion	11th December	Tandra Forster	Health and Wellbeing Management Group	Part I	
H&WB6.7	LSCB Business Plan	To present the LSCB Business Plan to the Board.	For Information and discussion	11th December	Fran Gosling-Thomas	LSCB	Part I	
H&WB6.10	Mental Health Crisis Concordat	The Mental Health Crisis Concordat for information.	For information	11th December	Dr Bal Bahia	Health and Wellbeing Management Group	Part I	
26th March 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	26th February	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	26th February	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	The Health and Wellbeing Annual Conference	To discuss ideas for the conference, which will help shape the refresh of the Health and Wellbeing Strategy.	For information and discussion	26th February	Lesley Wyman	Health and Wellbeing Board, key stakeholders and the public	Part I	
	Health and Wellbeing Strategy Hot Focus: Looked After Children	To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.	For information and discussion	26th February	Lesley Wyman/Mark Evans			
	Commissioning Plans							
	Alignment of Commissioning Plans	To timetable/forward plan the alignment of commissioning plans	For Information and discussion	26th February	Tandra Forster	Health and Wellbeing Management Group	Part I	
	Public Engagement							
	Draft Strategy for community engagement	To present the draft strategy to the Board for comment.	For discussion	26th February	Adrian Barker	Health and Wellbeing Management Group	Part I	
	Development Plan							
	Development Plan for the Health and Wellbeing Board	To keep an overview of the Boards progression	For Information and discussion	26th February	Nick Carter/Marcus Franks	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	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	26th February	Jane Seymour	Health and Wellbeing Board Communities Directorate Leadership Team	Part I	
4th June 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	7th May	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	7th May	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	Joint Strategic Needs Assessment	To present the JSNA to Health and Wellbeing Board	For information	7th May	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Governance and Performance							
	Community Sub-Partnership Terms of Reference	To present the Terms of Reference for this group to the Health and Wellbeing Board.	For discussion and comment	7th May	Andy Day/Nick Carter	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	Child Sexual Exploitation	To advise on the extent of the issues in West Berkshire.	For information	7th May	Mark Evans	Health and Wellbeing Management Group	Part I	
30th July 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	2nd July	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	2nd July	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							

Health and Wellbeing Board Forward Plan 2014/15

Ref.	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
	Feedback on the Health and Wellbeing Strategy Hot Focus: Looked After Children	To feedback on activity that has taken place over the last three months.	For information and discussion	2nd July	Lesley Wyman/Mark Evans	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Hot Topic: Mental Health and Wellbeing in Adults	To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.	For information and discussion	2nd July	Lesley Wyman/TBC	Health and Wellbeing Management Group	Part I	
24th September 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	27th August	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	27th August	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Governance and Performance							
	Health and Wellbeing Strategy Performance Reporting	To present a performance report against the performance framework for the Health and Wellbeing Strategy.	For Information and discussion	27th August	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Development Plan							
	Development Plan for the Health and Wellbeing Board	To keep an overview of the Boards progression	For Information and discussion	27th August	Nick Carter/Marcus Franks	Health and Wellbeing Management Group	Part I	

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RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
19	25-Sep-14	A measure indicating performance of end of life services to be added to the Dashboard.	Jess Bailiss	CCG	Health and Social Care Dashboard	This was discussed at the last Management Group and it was suggested that a measure around end of life services should sit underneath the performance framework for the HWBS rather than the resilience dashboard. Dr Barbara Barrie has suggested an indicator.
20		NHS England/the CCG to carry out a baseline assessment to show the impact on Primary Care Services over the winter.	Fiona Slevin-Brown/Nikki Luffington	CCG	Health and Social Care Dashboard	Discussions are taking place between the CCG and NHS England to identify the best way forward.
21		Access to GP's' was an issue often raised through consultations carried out by Healthwatch. Adrian Barker would send this information to Jess Bailiss to circulate prior to the next Health and Wellbeing Board.	Adrian Barker/Jess Bailiss	Healthwatch	Health and Social Care Dashboard	This information has been circulated to the Board.
22		A completed version of the dashboard would be brought back to the next Health and Wellbeing Board in November.	Jess Bailiss/Fiona Slevin-Brown/Tandra Forster	West Berkshire Council/CCG	Health and Social Care Dashboard	On the forward plan/agenda for 27th November 2014
23		Tandra Foster and Fiona-Slevin Brown to identify a subset of performance metrics for the Better Care Fund that could be reported to the Health and Wellbeing Board at each meeting.	Tandra Forster/Fiona Slevin-Brown	West Berkshire Council/CCG	An update report on the Better Care Fund	This will be covered under the Integration Section of the next agenda - 27th November 2014.
24		Dr Bal Bahia felt that the Health and Wellbeing Strategy needed to reflect the current health and social care economy, if the Board were expecting partners to use the Strategy as a basis for their commissioning plans. Lesley Wyman would speak to Dr Bahia outside of the meeting.	Lesley Wyman/Dr Bal Bahia	West Berkshire Council/Newbury and District CCG	Draft Health and Wellbeing Strategy available for consultation	Dr Bahia and Lesley Wyman are discussing this outside of the meeting and any comments on the Stratetgy will be fed back through the formal consultation process.
25		Cllr Marcus Franks suggested that once the Health and Wellbeing Strategy was agreed, the Board could choose three priorities that it would focus on over the following year. The aim of this was to ensure the Board took ownership and drove its own Strategy.	Councillor Marcus Franks/Health and Wellbeing Board	Health and Wellbeing Board	Draft Health and Wellbeing Strategy available for consultation	Report including three proposed priorities will be brought to the meeting on 27th November 2014.
26		The final version of the Health and Wellbeing Strategy would be brought to the HWBB in January for sign off rather than November, to allow for a more thorough consultation phase. A new consultation timetable to be drawn up to reflect this.	Heather Hunter/Lesley Wyman	Healthwatch/West Berkshire Council	Draft Health and Wellbeing Strategy available for consultation	Placed on the forward plan for January 2015.
27		It was resolved that the Health and Wellbeing Strategy should go out to consultation.	Heather Hunter/Lesley Wyman	Healthwatch/West Berkshire Council	Draft Health and Wellbeing Strategy available for consultation	The Health and Wellbeing Strategy will go out to consultation on 20th October 2014.
28		Rachael Wardell suggested that the Safeguarding Adults Partnership Board (SAPB) Protocol be amended so that the word 'board' was not used alone. This would avoid confusion to whether it was the SAPB or HWBB being referred to. The amended version would be forwarded to Jess Bailiss.	Sylvia Stone	SAPB	Protocol Agreement between the Health and Wellbeing Board and the Safeguarding Adults Partnership Board	Updated version of Protocol has been received and signed accordingly.
29		The SAPB Annual Report to be placed on the HWBB Forward Plan for November.	Jess Bailiss	West Berkshire Council	Protocol Agreement between the Health and Wellbeing Board and the Safeguarding Adults Partnership Board	On the forward plan/agenda for 27th November 2014
30		The Terms of Reference for the Communities Sub-Partnership to be firmed up in time for the next Health and Wellbeing Board in November	Andy Day/Nick Carter	West Berkshire Council	Proposal to merge the Local Strategic Partnership Management Group and Health and Wellbeing Board	Further consideration is required regarding the Terms of Reference for this group and therefore it has been placed on the forward plan for June 2015.

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System Resilience - Health and Social Care Dashboard

Adult Social Care

Ref.	Indicator	Basis	Frequency	2014/15 Benchmark	2014/15 Target	Positive or negative trend (see key)	Latest data
ASC1	Average number of Delayed Transfers of Care which area attributable to social care per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**1.2 (in Q2)**
		Great Western Hospitals NHS Foundation Trust				↔	**0 (in Q2)**
		Hampshire Hospitals NHS Foundation Trust				↑	**2.5 (in Q2)**
		Oxford University Hospitals NHS Trust				↑	**0.2 (in Q2)**
		Royal Berks NHS Foundation Trust				↓	**1.5 (in Q2)**
		Total West Berkshire			4	↑	**6.1 (in Q2)**
ASC2	Proportion of older people (65+) who were still at home 91 days after discharge from hospital to reablement/rehabilitation service	West Berkshire Council Adult Social Care	Quarterly		90%	↓	**88% (in Q2)**
ASC3	Number of assessments completed in last 12 months leading to a provision of a Long term service (excludes Carers)	West Berkshire Council Adult Social Care	Quarterly		Target data not yet available		**Data not available (in Q2)**
ASC4	Proportion of clients with Long Term Service receiving a review in the past 12 months	West Berkshire Council Adult Social Care	Quarterly		Target data not yet available	↑	**0.63 (in Q2)**

Arrow key	
↑	Latest data is positive compared to the last quarter
↓	Latest data is negative compared to the last quarter
↔	Latest data is the same as the last quarter

Children's Social Care

Ref.	Indicator	Basis	Frequency	Normal Range	2014/15 Target	Positive or negative trend (see key)	Latest data
CSC1	The number of looked after children per 10,000 population	West Berkshire Children's Services	Quarterly	Between 38 and 46 per 10,000		↑	**48 (in Q2)**
CSC2	The number of child protection plans per 10,000 population	West Berkshire Children's Services	Quarterly	Between 28 and 34 per 10,000		↑	**33 (in Q2)**
CSC3	The number of Section 47 enquiries per 10,000 population	West Berkshire Children's Services	Quarterly	Between 20 and 25 per 10,000.		↑	**24 (in Q2)**
CSC4	To maintain a high percentage of (single) assessments being completed within 45 working days	West Berkshire Children's Services	Quarterly		70%	↓	**73% (in Q2)**
CSC5	Looked after children cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↑	**99% (in Q2)**
CSC6	Child Protection cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↓	**91% (in Q2)**

Acute Sector

Ref.	Indicator	Basis	Frequency	2014/15 Benchmark	2014/15 Target	Positive or negative trend (see key)	Latest data
AS1	**4-hour A&E target - total time spent in the A&E Department** (% is less than 4 hours) [standard is 95% of patients seen within 4 hours]	Royal Berks NHS Foundation Trust	Monthly		95%	↓	**94.7% (in Q2)**
		Hampshire Hospitals NHS Foundation Trust				↓	**94.6% (in Q2)**
		Great Western Hospitals NHS Foundation Trust				↑	**96.6% (in Q2)**
AS2	Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↓	**2.5 (in August)**
		Great Western Hospitals NHS Foundation Trust				↑	**0 (in August)**
		Hampshire Hospitals NHS Foundation Trust				↑	**1.6 (in August)**
		Oxford University Hospitals NHS Trust				↑	**0.8 (in August)**
		Royal Berks NHS Foundation Trust				↓	**6.6 (in August)**
		Total West Berkshire		14.7 (2012/2013 data)		↓	**11.5 (in August)**

Acute Sector (continued)							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
AS3	**Ambulance Clinical Quality - Category A 8 Minute Response Time - Red 2** [Category A Red 2 incidents: presenting conditions that maybe life threatening but less time critical than Red1 and receive an emergency responses irrespective of location in 75% of cases]	Berkshire West	Monthly		75%	↑	**78.6% (in August)**
AS4	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West			TBC	↑	**1167 (in August)**
		Hampshire Hospital Foundation Trust for Berkshire West			TBC	↑	**369 (in August)**
		Great Western Hospital for Berkshire West			TBC	↑	**183 (in August)**
AS5	Number of non elective admissions	Royal Berkshire Foundation Trust for Berkshire West	Monthly		No target information available	↑	**466 (in August)**
		Hampshire Hospital Foundation Trust for Berkshire West				↑	**133 (in August)**
		Great Western Hospital for Berkshire West				↑	**81 (in August)**
AS6	Total number of 111 calls	Berkshire wide	Monthly		No target information available	↓	**47670 (in Q2)**
AS7	Proportion of 111 calls converted to 999	Berkshire wide			No target information available	↑	**9.7% (in Q2)**
AS8	Friends and Family test - in - patient score	Royal Berks NHS Foundation Trust	Monthly		No target information	↑	**82 (in August)**
		Hampshire Hospitals NHS Foundation Trust			No target information available	↑	**75 (in August)**
		Great Western Hospitals NHS Foundation Trust			No target information available	↓	**71 (in August)**
AS9	Friends and Family test - A&E score	Royal Berks NHS Foundation Trust	Monthly		No target information available	↑	**68 (in August)**
		Hampshire Hospitals NHS Foundation Trust			No target information available	↓	**64 (in August)**
		Great Western Hospitals NHS Foundation Trust			No target information available	↑	**67 (in August)**

Arrow key	
↑	Latest data is positive compared to the last quarter
↓	compared to the last quarter
↔	Latest data is the same as the last quarter

Primary Care							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**Quarter 1 Benchmark**	**Positive or negative trend (see key)**	**Latest data**
PC1(a)	GP referrals to secondary Care	Newbury & District CCG	Quarterly		3,863	N/A	**3579 (in Q2)**
PC1(b)	GP referrals to secondary Care	North & West Reading CCG	Quarterly		4,536	N/A	**3858 (in Q2)**
PC2	Friends and Family Test	TBC	TBC		TBC	TBC	TBC
PC3	Access metric to be defined	TBC	TBC		TBC	TBC	TBC

Community Services							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
CS1	Mental Health - Crisis response % of responses witih 4 hours	Berkshire West	quarterly from Q2		85% Q2, 90% Q3 and 95% Q4		Data will be available from Q2
CS2	Average number of Delayed Transfers of Care (all delays)	Berkshire Healthcare Trust as a provider	monthly		No target information available	↑	**15.5 (in Q2)**
CS3	Rapid access to Community Services: 2 hour crisis reponse by Community Nursing and Rapid Response	Berkshire West	quarterly from Q2		90%		Data will be available from Q2

Appendices

Appendix 1 - Indicator/Target Narrative

Appendix 1

Adult Social Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
ASC1	**(Adult Social Care Framework 2C Part 2)** This data is sourced from NHS England and is a monthly snapshot of delays taken on the last Thursday of the month at midnight. The Total West Berkshire figure is reported on nationally. Quarter two data is provisional. Data for September will be released in October.	This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. This is a two-part measure that reflects both the overall number of delayed transfers of care per 100,000 population aged 18 and over (part 1 - see acute section AS2) and, as a subset, the number of these delays which are attributable to social care services and to both (health and social services) (part 2).
ASC2	**(Adult Social Care Framework 2B Part 1)** Small cohort that may fluctuate quarter to quarter due to unexpected deaths, health alerts or severe weather i.e. extremely cold winter - events which are outside of our control. In Q2, 8 clients started placements in res/nursing care rather than remaining at home. Data based on 3 monthly reporting of hospital discharges to rehabilitation/enablement and outcome at 91 days after discharge.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This measures the effectiveness of reablement services.
ASC3	**(Service Plan Performance Indicator)** The data will be available for the board in January 2015. The use of data from the previous year is not appropriate for setting a baseline due to the new statutory reporting framework (SALT). The reports to extract relevant data aligned to statutory reporting are still to be completed. Therefore there is no national data or comparator group data or England average to measure against at this point.	
ASC4	Figures are expected to increase for this indicator in Q3 due to data recording issues that are being addressed. In previous years, the denominator included clients with electrical equipment services, respite and short term services but excluded professional support. The denominator is now based on Long Term Service clients in the year so now includes Community Mental Health Team, professional support but excludes all short term services and low level support. The use of data from the previous year is not appropriate for setting a baseline due to the new statutory reporting framework (SALT). The reports to extract relevant data aligned to statutory reporting are still to be completed. Therefore there is no national data or comparator group data or England average to measure against at this point.	

Children's Social Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
CSC1	Target numbers for CSC 1, 2 and 3 have been set by Children's Services and are set on the basis of the level that the service aspire to get the figures back to. Target numbers are what are considered as more manageable for the service. Trend data is based on the last quarter.	Looked after child: These are children who are looked after by the authority
CSC2		Child Protection Plan: A detailed inter-agency plan setting out what must be done to protect a child from further harm, to promote the child's health and development and if it is in the best interests of the child, to support the family to promote the child's welfare.
CSC3		Section 47 Enquiry: Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.
CSC4	Target Numbers come from those set in Children's Services' Service Plan. Trend data is based on the last quarter.	Single Assessments: The single assessment is a new assessment document. It is gradually replacing the initial and core assessments by combining both within one document.
CSC5		
CSC6		There are ongoing recording issues in relation to Child Protection Conferences on RAISE and therefore the true performance is likely to be higher that that presented.

(Appendix 1 continued)

Acute Sector		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
AS1	Data is based on provider as a whole	
AS2	**(Adult Social Care Framework 2C Part 1 See ASC1)** Data is based on Provider figures for West Berkshire residents only.	See ASC1
AS3	Data is based on Berkshire West as a whole.	Category A Red 1 incidents: Presenting conditions that may be immediately life threatening and the most time critical and should receive an emergency response irrespective of location in 75% of cases. Category A Red 2 incidents: Presenting conditions that may be life threatening but less time critical than Red1 and receive an emergency response irrespective of location in 75% of cases.
AS4	Data is based on Provider figures for Berkshire West.	
AS5	Data is based on Provider figures for Berkshire West.	An elective admission is one that has been arranged in advance. It is a non emergency admission, a maternity admission or a transfer from a hospital bed
AS6	Data is based on Berkshire as a whole	NHS 111 is a new service that was introduced to mae it easier for people to access local NHS Services in England. 111 can be called when medical help is required quickly however, it's not a 999 emergency.
AS7	Data is based on Berkshire as a whole	People phoning 111 are asked a number of questions. Whether the call is converted to a 999 call depends on the answers to these questions. This process takes account of local services available in the area.
AS8	Data is based on each provider as a whole	The NHS friends and family test (FFT) is an opportunity for service users to provide feedback on their care and treatment received, with the aim of improving services. It was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed a similar care or treatment.
AS9	Data is based on each provider as a whole	

Primary Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
PC1(a)	No target can be provided because an increase or decrease in appropriate referrals is neither good or bad.	Secondary (or 'acute') care is the healthcare that people receive in hospital. It may be unplanned emergency care or surgery, or planned specialist medical care or surgery
PC1(b)	No target can be provided because an increase or decrease in appropriate referral is neither good or bad.	
PC2		
PC3		

Community Services		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
CS1		
CS2		
CS3		

Title of Report:	**West Berkshire Ward Profiles and assessing health and wellbeing needs across the district.**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27th November 2014

Purpose of Report:

To make the Board aware of the West Berkshire Ward profiles and demonstrate how they could be used to identify health and wellbeing needs at the ward level, in order to address inequalities across the district.

Recommended Action:

The Board will become familiar with the ward profiles and will advocate a programme of targeting activities and resources to the most deprived communities in order to address inequalities in health and wellbeing.

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1. Background

The Joint Strategic Needs Assessment (JSNA) Electoral Ward profiles have been produced by Public Health Services for Berkshire on behalf of the local councils. The purpose of the ward profiles is to identify areas for further investigation and to provoke discussion with commissioners and elected members.

The profiles display a range of indicators which should be considered as a whole picture of the Ward rather than focusing on individual indicators in isolation.

Information about the age structure and deprivation of the Ward is provided at the beginning of the profiles and this context is essential for interpreting the rest of the profiles, in particular when comparing the Ward to other areas in the district.

The profiles should be used as a guide to provoke further discussion and investigation. The data cannot be used in isolation and should be supplemented with further data to delve deeper into any issues of interest.

2. The ward profiles structure

The demographic data in the profiles provides the contextual information about the Ward. It tells us something of the basic characteristics of the people living in the Ward and should be considered when looking at the rest of the profiles. This data is all taken from the Census 2011.

The population pyramid shows how the age/gender structure of the Ward population compares, on average, to the rest of the local authority.

The index of multiple deprivation (IMD) (including access to services (access to GP, food shops, primary school etc)) is a measure of relative deprivation which ranks each area in the country on a number of measures of deprivation including but not limited to income deprivation. These are:

- Income,
- employment,
- health deprivation and disability,
- educations skills and training
- barriers to housing and services
- crime and disorder
- living environment
- income deprivation affecting children
- income deprivation affecting older people

The Ward profiles show where each ward ranks within the local authority.

Child poverty figures show the percentage of 0 to 19 year olds living in households in receipt of Child Tax Credits where income is below 60% of median income or in households in receipt of Income Support/Job Seekers Allowance.

Benefit data is shown as at November 2013. It is important to note that the numbers of benefit claimants may be alter based on the month of the data. All further data included in the economy and enterprise section is sourced from the Census 2011.

Education data was requested at Ward level from each local authority. Where the authority was able to provide this data then this appears in the profiles. This data will only show children who are resident within the Authority and are educated in State maintained schools located within the Authority.

West Berkshire was unable to provide this data so published Department for Education small area data was used. This data is based on the residence of the child and includes all State Maintained schools. This data is published at Lower Super Output Area level and was aggregated to Electoral Ward. Lower Super Output Area (LSOA) is an average of roughly 1,500 residents and 650 households. Measures of proximity (to give a reasonably compact shape) and social homogeneity (to encourage areas of similar social background) are also included.

3. Health data

The first section shows health outcome data such as hospital admissions and deaths. Due to the large differences in these outcomes based on age and gender, these factors have been taken into account using a process call ‘indirect standardisation’. This takes data for a particular indicator (for example, deaths) from a reference population (England) split by age and gender. These figures are then applied to the population of the Ward in order to calculate what we would expect the death rates to be in the Ward. We can then compare the actual Ward value against the expected Ward value.

The second section looks at lifestyle data (obesity, binge drinking, and healthy eating). There were three stages to calculating Ward level data.

The original source is the individual level Health Survey for England data.

The results of the survey have then been calculated to MSOA (Middle Super Output Area) level by the Association of Public Health Observatories (now under Public Health England). MSOAs have a minimum size of 5,000 residents and 3,000 households with an average population size of 7,500. They fit within local authority boundaries. The Health Survey data was modeled to the local population using a number of variables such as age, ethnicity, gender, deprivation etc.

These MSOA level estimates were then calculated to ward level for the Public Health England Local Health tool. They used weighted-populations to disaggregate from MSOA to ward level.

- Housing
- All housing data was sourced from the Census 2011.
- Community safety

All data was sourced from Thames Valley Police and is shown as a rate per 1,000 all age population.

- Environment

The urban/rural classification of an area is provided by the Office for National Statistics (ONS).

There are six urban/rural classifications; defined as follows:

- Major Urban: districts with either 100,000 people or 50 per cent of their population in urban areas with a population of more than 750,000
- Large Urban: districts with either 50,000 people or 50 per cent of their population in one of 17 urban areas with a population between 250,000 and 750,000
- Other Urban: districts with fewer than 37,000 people or less than 26 per cent of their population in rural settlements and larger market towns
- Significant Rural: districts with more than 37,000 people or more than 26 per cent of their population in rural settlements and larger market towns
- Rural-50: districts with at least 50 per cent but less than 80 per cent of their population in rural settlements and larger market towns
- Rural-80: districts with at least 80 per cent of their population in rural settlements and larger market towns

Land use statistics are provided from the General Land Use Database in square metres.

Domestic energy consumption is sourced from Office for National Statistics Neighbourhood Profiles and is shown in total megawatt hours over three years.

The aim of this presentation is to show how the ward profiles can be utilised to highlight key health and wellbeing needs at ward level. Elected Members and commissioners will gain a better understanding of local needs and will be able to work in partnership, targeting resources and initiatives to better meet these needs and tackle inequalities in health.

On occasions particular data may not be available for a Ward. This will be indicated by a missing bar on a chart or will be indicated in the text. This is due to the data containing numbers of less than five. To comply with data protection, these numbers cannot be included due to the risk of identifying individuals who may not wish to be identified.

Appendices

Appendix 1 - Small area statistics

Consultees

Local Stakeholders:

Officers Consulted:

Trade Union:

Appendix 1

Using small area statistics

We need to be cautious when drawing conclusions from data which has come from a small sample. This is because the data is less reliable in that it is more easily affected by chance variation which is not due to any measurable cause.

We can measure this chance variation using confidence intervals which are calculated using the size of the sample and a chosen level of confidence (usually 95%). This is illustrated in the table and chart below (data is fictional).

Although the percentage achieving 5 GCSEs for all areas is the same (50%) the confidence intervals show us that we can be more confident in the figures for Berkshire and for the local authority than we can be for the Ward level figure. For Berkshire we can be 95% confident that, allowing for chance variation, between 49% and 51% of children achieve 5 GCSEs. Within a Berkshire Electoral Ward, this range increases and we can be 95% confident that, allowing for chance variation, between 37% and 63% of children achieve 5 GCSEs.

Area	Percentage achieving 5 GCSE	Lower confidence interval	Upper confidence interval
Berkshire	50%	49%	51%
Berkshire Local Authority	50%	48%	52%
Berkshire Electoral Ward	50%	37%	63%

This becomes important when comparing two areas or two time periods as illustrated below. At first glance we would say that performance in the Ward (30%) is worse than the Berkshire average (50%). However, the range in which we can be confident the Ward value falls when allowing for chance variation is between 22% and 55%. The upper range is actually higher than the Berkshire average. Therefore, we would have to interpret this as the percentage of children in the Ward achieving 5 GCSEs being no different to the Berkshire average.

Area	Percentage achieving 5 GCSE	Lower confidence interval	Upper confidence interval
Berkshire	50%	49%	51%
Berkshire Local Authority	40%	37%	42%
Berkshire Electoral Ward	30%	22%	55%

Title of Report:	**Health and Wellbeing Priority Themes for 2015/16**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	November 27th 2014

Purpose of Report:

To propose three priority areas that will be brought to the Health and Wellbeing Board for update, discussion and development

Recommended Action:

That the Health and Wellbeing Board agree to focus on the three priorities suggested and that individual Board members will participate in Board presentations and facilitating improvement in these areas of work outside of the Board meetings as required.

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Executive Report

The updated Health and Wellbeing Strategy to be agreed following a full consultation at the January 2015 Health and Wellbeing Board meeting will have a set of approved priorities drawn from the Joint Strategy Needs Assessment. Currently there are 11 priorities which range across the life course covering children, adults and older adults. These priorities indicate health and wellbeing issues where West Berkshire Council and CCGs face particular challenges or are not performing as well as they might be when benchmarked against other comparable areas.

At the November H&WB Board meeting it was agreed that three priorities be selected from the total each year and that these would be the focus for the Board for a prescribed period of time – 14/14 Hot Focus 1, Hot Focus 2, Hot Focus 3. This will enable a detailed presentation to be made to the Board and give an opportunity for the appropriate commissioners, providers and partners to discuss their work, including successes and barriers that they face in addressing this particular priority. Integrated models of care will be highlighted wherever possible.

A first presentation will be made to the H&WB Board and Board members will have time to ask questions, clarify outcomes, budgets and relationships. Barriers and blocks to achieving outcomes can then be discussed and possible solutions developed. Board members should be able to commit resources where needed, including budget, people, information etc. A multiagency plan of action will be suggested with individual leads for specific actions and timescales where possible. Innovative solutions will be generated and integrated services that provide a synergy.

Following the H&WB Board meeting a small task and finish group will come together to execute the action plan, calling on partner organisations where required. This work will be rapid and focused and will require all partners to play their part. At the following W&WB Board meeting a progress report will be presented to outline what actions have been taken in this priority area and what improvements are ensuing. Work will then continue alongside progress on all the other priorities that are reported back through the performance framework on a quarterly basis.

The following priorities are suggested for 2015/16

Hot Focus 1 (April 2015- July 2015) - We will improve the health and educational outcomes of looked after children through high quality health, and social care support

Hot Focus 2 (August 2015 – November 2015) - We will promote mental health and wellbeing in all adults through prevention, early identification and provision of appropriate services

Hot Focus 3 (December 2015 – March 2016) - We will maximise independence in older people by preventing falls, reducing preventable hospital admissions due to falls and improving rehabilitation services.

Hot Focus 1 supporting information

Children who have become looked after as a result of a legal order or who have been accommodated on a voluntary basis in agreement with their parents/carers, are one of the most vulnerable groups in society. Children enter care for a range of reasons including

physical, sexual or emotional abuse, neglect, or family breakdown. Children in care generally have significantly higher levels of health needs than children and young people from comparable socio-economic backgrounds who have not been looked after. Their life opportunities and long term outcomes are also often much poorer and poor health is a factor in this. Past experiences, including a poor start in life, removal from family, placement location and transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist. Promoting the health and wellbeing of these looked after children are therefore paramount.

What is the picture in West Berkshire?

- At March 2013, West Berkshire Council was responsible for 144 looked after children. This was a rate of 40.0 looked after children per 10,000 population under 18 – a rate lower than the England average (60 per 10,000). By October 2013, this had increased to 158 children.
- The number of unaccompanied asylum seeking children looked after by West Berkshire Council is fairly stable, and was 10 as at March 2013.
- There are more boys than girls in care in West Berkshire, and this is also true of unaccompanied asylum seeking children.
- The majority of looked after children are placed in family settings with foster carers or adoptive carers (82% at the 31st March 2013) with the rest placed in other settings according to their individual needs (children's homes, specialist homes or nursing establishments or independent living).
- All children in care are subject to a health plan. Health assessments must be undertaken twice a year for children under 5 years, and annually for children and young people aged 5 years and over. The proportion of looked after children who receive an annual health assessment and regular dental checks is quite high (74% for medicals and 83% for dental checks as at October 2013).

Hot Focus 2 – supporting information

Mental health and wellbeing consists of how we think and feel (our emotions and satisfaction with life) and how function (good relationships with others, having a purpose in life). We all have mental health and anyone can experience good or poor mental health and wellbeing. In any given year, one in four adults in the UK will experience a diagnosable mental health problem, with mixed anxiety and depression being the most common. There are a variety of risk factors for poor mental health and wellbeing which include; poverty, discrimination, violence, abuse, peer rejection and isolation, stressful life events (such as bereavement and relationship problems) and poor physical health. Conversely, there are also factors that can positively affect mental health and wellbeing. These include; economic security, empowerment, feelings of security, positive interactions with others, physical activity, stable and supportive family environments and a healthy diet and lifestyle.

Poor mental health can impact on physical health in the same way that poor physical health can impact on mental health. For example, poor mental health can increase the risk of cancer, back pain and irritable bowel and reduce life expectancy. National research has shown that around 30% of people with a long term condition also have a mental health problem. Some unhealthy behaviours (such as smoking, excess alcohol consumption, overeating etc) are used to control stress or boast mood.

It is important that we work to; understand and prevent mental health problems, to ensure that we achieve a parity of esteem (by ensuring that we value mental health equally with physical health) and that we promote positive mental health and wellbeing among those living with or recovering from a diagnosable mental health problem and the general population.

The New Economics Foundation (NEF) identifies research that promotes five actions (known as the five ways to wellbeing) that encourage action to improve our mental health and wellbeing; connect, keep learning, give, take notice, and be active. Positive mental wellbeing is associated with good physical health, good resilience, reduced mental ill health, improved education attainment and reduced risky health behaviours.

What is the picture in West Berkshire?

- Around 125 people in every 100,000 people living in West Berkshire are admitted to hospital due to mental ill health. This is lower than the national and regional average. In West Berkshire, about 7 people in every 100,000 commit suicide (or injury of undetermined intent).
- An estimated 4,467 (9%) people with depression and/or anxiety in Berkshire West (across Reading, Wokingham and West Berkshire) are receiving treatment through Increasing Access to Psychological Therapies (IAPT). The national rate is 6% of people receiving treatment. Uptake of psychological therapies is higher than the national and regional average, 70% of adults (aged 16+) who are referred for psychological therapy enter into psychological therapies.
- The rate of people recovering from psychological therapy treatment is also higher than the national and regional average. Around 55 people out of every 1,000 people who have completed a psychological therapy treatment were moving towards recovery in 2011/12.
- Significantly more people registered with GP Practices in West Berkshire LA are recorded as having depression than the national, regional, and Berkshire West average.
- 14,718 people registered with GP Practices in West Berkshire LA are on clinical registers recorded as having depression. This equates to 13% of the GP list size population.
- Around 2,150 people aged 65 and over living in West Berkshire are estimated to have depression. By 2020, an estimated 2,672 people aged 65 and over are predicted to have depression.
- Nationally published data for 2010/11 suggests that, in West Berkshire LA, significantly fewer (2.5%, count = 5) of adults in contact with secondary mental health services are in employment than the national (9.5%) and regional (7.9%) averages. However, we know that this is likely due to a change in the system used for recording this national data. Locally produced figures suggest that closer to 15% of adults in contact with secondary mental health services in West Berkshire LA are in employment. It is expected that the national figure will return to previous levels in 2012/13 once recording issues are resolved.

Hot Focus 3 – supporting information

Older people are more vulnerable to slips, trips and falls which could lead to broken bones, admissions to hospital as a result of falls, admissions to a residential/nursing home as a result of falls and a reduction of discharges to residential/nursing homes following a hospital admission as a result of a fall. Having a fall may reduce the confidence of

someone who has fallen, possibly making them afraid to leave their homes resulting in social isolation and reduced independence.

Many of the risks of falling can be prevented and may help to reduce the fear of falling, as well as improving balance, strength and stamina. Investing in falls prevention can to reduce the financial burden on the NHS by preventing fractures and reducing avoidable hospital and/or residential/nursing home admissions.

What is the picture in West Berkshire?

- The rates of injuries due to falls in people aged 65 and over living in West Berkshire are better than the national average. In 2012/13, there were 1,381 emergency hospital admissions for falls in persons aged 65 and over per 100,000 population.
- There were 142 emergency admissions for hip fractures in every 100,000 people aged 65+ in 2012/13.
- In 2012/13 the rate of emergency admissions for injuries due to falls in persons aged 80+ was 3,541 per 100,000 population which is better than the regional average.
- The number of hip replacements being undertaken for people in West Berkshire has increased slightly over the last five years. Around 50% of patients from West Berkshire go home from hospital within 28 days of an emergency admission to hospital with a hip fracture. This is slightly lower than the proportions seen nationally and regionally.

Different priorities will require a variety of partners to lead the task and finish group but in each case the Public Health and Wellbeing team will provide support in the form of needs analysis and relevant data, models of best practice, NICE guidance and other national strategies, plus evidence of effectiveness and cost effectiveness.

This work, if agreed could begin in January 2015 depending on the need to alter any of the current priorities in the amended Strategy. The Board should make that decision.

It is important to note that work on all the priorities will continue and progress will be reported to the H&WB Board on a quarterly basis.

Appendices

There are no Appendices to this report.

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Title of Report:	**Health and Wellbeing Strategy Performance Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27 November 2014

Purpose of Report: Purpose: to present a performance report against the current Health and Wellbeing Strategy.

Recommended Action: For the Health and Wellbeing Board to be alerted of any of the existing priorities where progress has not been made and to make decisions as to how this should be addressed

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Marcus Franks (01635) 841552
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Contact Officer Details	
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Executive Report

The performance framework template was brought to the Health and Wellbeing Board in May 2014. This contained a number of high level indicators for each of the current priorities:

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

It was acknowledged at this meeting that some of the high level indicators were possibly not the most informative due to low numbers e.g. homelessness. In addition many local indicators were not included at the time. The number of local indicators that could have been included was largely due to the inclusion of a total of 30 priority areas for action in the H&WB Strategy. This has instigated a revision of the Health and Wellbeing Strategy to include a smaller number of priorities.

There was a suggestion at the May meeting that a task and finish group should be set up in order to improve and complete the 13/14 performance framework. Unfortunately this was not done, since the focus became the development of the new strategy.

Appendix 1 shows progress on as many of the high level indicators as possible where new data is available. In addition some of the Public Health and Wellbeing local indicators are reported on for 2013/14.

The following points can be made on the 2013/14 data:

Addressing childhood obesity in primary school children

The data presented remains the data for the academic year 2012/13. The data for 2013/14 has been collected and uploaded to the health and Social Care Information Centre and will be available in Dec/Jan. Our rates of obesity in reception year and year 6 children is better than the national average. Much activity has taken place during 2013/4 around healthy eating and physical activity, both in community and school settings, commissioned by Public Health and Wellbeing. Activities have been made available to children in areas of relative deprivation, including free swimming lessons and free half term activities.

Supporting those over 40 years old to address lifestyle choices detrimental choices detrimental to health

It is important to note that the most up to date prevalence data for smoking in adults is 2012 and this increased slightly from 2011. Although below the national prevalence, when compared to other authorities in the same deprivation decile West Berkshire ranks highest, ie we have the highest prevalence of smoking compared to other authorities who have similar levels of deprivation. In addition and more concerning is that we did not reach

our targets for numbers of people giving up smoking for 4 weeks and for 12 weeks. This has improved in Q1 of 2014/15 where we are on track.
The prevalence of overweight and obesity as a combined figure has been estimated from the Active People Survey, which is a change from previous estimates that used Health Survey for England data. In this case we cannot compare levels of obesity previously used. The levels of excess weight show that 2/3rds of our adult population are overweight or obese. We are higher than the national figure plus rank 4th highest compared to the localities with similar deprivation levels.
The local indicators used are the number of residents attending weight management interventions in West Berkshire and losing weight. Unfortunately due to the tendering out of this service the data is not robust enough to give us a reliable figure for West Berkshire alone. Now that the main weight management service Eat4Health has been commissioned out to the third sector we will have this data for most of 2014/15.
Public Health has also invested in a physical activity co-ordinator who is building up the Health walks programme locally.
The number of NHS health checks offered in 2013/14 was just over 9,000, representing 19.1% of the eligible population. This is higher than the national figure and about mid table compared to areas in the same deprivation decile. The number of people who then received a health check was 8%. We aim for a 50% uptake so need to improve on this figure.
The percentage of residents who are opiate users who successful complete drug treatment and do not represent within 6 months rose from 7.2% in 2011 to 12.2% in 2012.

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

The overarching indicator used for this priority is mortality rates in the under 75s age group from cardiovascular disease which is considered preventable (includes heart disease and strokes). The data is presented as three year rolling averages in order to iron out annual fluctuations. The 2009/11 rate in West Berkshire was 40.6 per 100,000 population and this increased to 43.3 per 100,000.

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. This shows the importance of preventative services as well as high quality treatment services.

The indicator showing the rate of emergency admissions due to hip fractures in the over 65 year age group is an important indicator for falls prevention. West Berkshire has a lower rate than the England rate and the local rate has dropped slightly for 12/13. Due to the increase in the population however this represents an increase from 137 to 142 emergency admissions for hip fractures.

The final high level indicator shows that the percentage of people who feel supported to manage their long term condition in Newbury and District CCG is 70%, higher than the national average. (no data available for NWR CCG).

Giving every child and young person the best start in life

The first high level indicator used here relates to the emotional wellbeing of looked after children. Due to the relatively small number of looked after children in the 12/13 data set (N=55) this data cannot be compared directly to other localities. The score is an average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March. There was a small improvement from 2011/12 to 2012/13. New data is due in December 2014.

The second PHOF indicator is breast feeding prevalence at 6-8 weeks. This was 55% for 2012/13 which is better than the national average and very similar to most of the other LAs in the same deprivation decile. NHS England was due to supply this data to LAs on a CCG basis by March 2014, but this has yet to happen. This is still a very valid indicator of giving every child the best start in life (see PHOF definitions http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000008/are/E06000037)

Supporting a vibrant district.

The percentage of households experiencing fuel poverty show that West Berkshire is better than the national average. The percentage in 2012/13 was only 6.6 but this represents just over 4000 households.

The rate of domestic abuse reported to the police per 1000 population shows a small rise from 18.7 to 19.4 per 1000 pop. This is similar to the national rate. It is difficult to obtain reliable information on the extent of domestic abuse as there is a degree of under-reporting of these incidents. Changes in the level of domestic abuse incidents reported to the police are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation (PHOF definitions).

The homelessness numbers are considered too small to be of value in this performance framework.

It is evident that for the most part the local indicators have not been added to the 2013/14 performance framework. Since the high level indicators are usually available only on an annual basis and represent 1 or 2 years prior to the year being reported on, it will be necessary to have robust local indicators that relate to activities being commissioned and delivered in the reporting year. These will contribute to addressing the selected priorities.

The new H&WB Strategy will have an accompanying performance framework and partners involved in addressing the health and wellbeing priorities will be required to supply appropriate, measureable, robust local indicators that can be reported back to the Board on a quarterly or 6 monthly basis. The Public Health and Wellbeing team will support others in the development of their indicators in addition to developing their own.

Appendices

Appendix 1a to 1e – Health and Wellbeing Performance Framework for 2013/14

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

Reducing childhood obesity in primary school children

Overarching indicator	Specific indicator		West Berkshire outturn	2013/14	'Good' is…		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 18.86%		Low		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 29.12%		Low		Improved		33.32%	Significantly better			
Local indicators	**Target**												
number of additional healthy eating intiatives commisisoned in school and community settings for children	11	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 PH physical activity projects in school and community settings		PH Action plan	tbc		high		improved					quarterly	AP
number of children and adults taking part in healthy eating projects in school and community settings		PH Action plan	tbc		high		improved					quarterly	AP
number of additional road safety intiatives run		PH Action plan	tbc		high		improved					quarterly	AP

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

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	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	2011 18.6%	2012 18.76%	Low	↑	18.02%	19.53%	Similar		Annual (Figures will be published in Feb-15)	PH and wellbeing team
local indicators	**Target**											
number of 4 week quitters				**2013/14**								
		local	Not Available	Q1 144	high						quarterly	FN
				Q2 **149**								FN
				Q3 **157**								FN
				Q4 291								FN
	Total Target	840		741								
number of 12 week quitters			Not Available	**2013/14**								
				Q1 **90**								
				Q2 **114**							quarterly	FN
				Q3 **120**								FN
				Q4 155								FN
	Total Target	588		479								
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-present to treatment within 6 months	PHOF	2011 7.2%	2012 12.21%	High	↑	9.16%	8.24%	Significantly better		This is available quarterly through NDTMS	
3.6 Increase the percentage of eligible population aged 40-74 offered an NHS health check	2.22ii: % of eligible population aged 40-74 offered an NHS Health Check	PHOF/	N/A	2013/14 19.1%	High	N/A	17.10%	18.40%			Updated annually on PHOF, but we will be able to provide quarterly figures.	
3.6 Increase the percentage of eligible population aged 40-74 receiving an NHS health check	2.22ii: % of eligible population aged 40-74 who received a Health Check	PHOF/	N/A	2013/14 8.0%	High	N/A	6.60%	9.00%				
local indicators				2013/14								
number of people offered an NHS health check				Q1 **2012**							quarterly	EC
				Q2 **2429**			20% - 9,585	20% - 9,586	Similar			EC
				Q3 **2270**								EC
				Q4 **2426**								
	Total Target			**9,137 (19.1%)**								EC
number of NHS health checks completed				Q1 **753**								EC

				Q2 **916**			10% - 4,792	10% - 4,793	Similar		quarterly	EC
				Q3 **1371**								EC
				Q4 **787**								EC
	Total Target			**3,827 (8.0%)**								
3.7 decrease excess weight in adults	prevalence of overweight and obese adults	Active People Survey		2012 65.5%	low		63.10%	63.80%	similar	estimated and self reported	annual	
local indicators	**Total Target**											
number of people completing a weight management course	337			NA								LW
number of people completing a weight management courtse and losing 4-5% of body weight				NA								LW

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

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline				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 40.6/100,000	2010-1212 43.3/100,000	Low	↑		53.5/100,000	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	2011/12 577.3	2012/13 552.4	Low	↓		568.1/100,000	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	N/A	July 2012 - March 2013 70%	high	↑		67%	better	sample survey	annual	CCG ASC
CCG indicators												
ASC indicators												

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Giving every child and young person the best start in life

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline				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	2010/11 15.8%	2012/13 16.4%	Low	↑	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 6 8 weeks after birth	2.02ii: Breastfeeding prevalence at 6-8 weeks after birth	PHOF	Not available	2012/13 55.6%	High	↑	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**											

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Supporting a vibrant district

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline				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 1.00/1000	2012/13 1.00/1000	Low	↓	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	0.8/1000	2011/12 0.77/1000	Low	↓	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 6.8%	2012/13 6.6%	Low	↓	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 18.63	2012/13 19.4	Low	?	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:	**Health and Wellbeing Board - Governance**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	27th November 2014
Forward Plan Ref:	N/a

Purpose of Report:

To provide an update on the governance arrangements in relation to the Health and Wellbeing Board with particular reference to voting, deputies and referencing certain matters up to the Executive.

Recommended Action:

To note the report.

Reason for decision to be taken: To ensure that the governance arrangements relating to the Board and clear and transparent to both the Board and the public.

Other options considered: N/A

Key background documentation: Health and Social Care Act 2012

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

X CSP5 - Putting people first

The proposals contained in this report will help to achieve the above Council Strategy principle by:
ensuring that the appropriate governance arrangements are in place for the Health and Wellbeing Board

Portfolio Member Details	
Name & Telephone No.:	Councillor Marcus Franks
E-mail Address:	mfranks@westberks.gov.uk
Date Portfolio Member agreed report:	

Contact Officer Details	
Name:	Andy Day
Job Title:	Head of Strategic Support
Tel. No.:	01635 519459
E-mail Address:	ada@westberks.gov.uk

Implications

Policy:	N/A
Financial:	N/A
Personnel:	N/A
Legal/Procurement:	This report is in accordance with the Local Government Act 2000 and Health and Social Care Act 2012.
Property:	N/A
Risk Management:	N/A

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	X
• Is it a major policy, significantly affecting how functions are delivered?	☐	X
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	X
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	X
• Does the policy relate to an area with known inequalities?	☐	X
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: X
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	X	

Executive Summary and Report

1. Introduction

1.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system could work together to improve the health and wellbeing of their local population and reduce health inequalities.

1.2 The Health and Wellbeing Board's primary role is to provide strategic leadership to improve the health and wellbeing of West Berkshire's population (both adults and children) and to reduce the inequalities in health experienced by some communities. It aims to:

(i.) ensure delivery of improved outcomes for the people of West Berkshire bringing together national health and social care policy in conjunction with local priorities.

(ii.) achieve democratic legitimacy and accountability, and empower local people to take part in decision-making about local health and wellbeing.

2.0 Purpose

2.1 The purpose of the Board is to improve the health and wellbeing of people of all ages resident in West Berkshire and to reduce health inequalities in the District.

The underlying principles that the Board works to are as follows:

(i.) shared leadership of a strategic approach to the health and wellbeing of our local communities.

(ii.) a commitment to driving real action and change to improve services and outcomes.

(iii.) shared ownership of the Board by all the members (with commitment from their nominating organisations) and accountability to the communities it serves.

(iv.) openness and transparency in the way that the Board carries out its work

(v.) inclusiveness in the way it engages with patients, service users and the public.

3.0 Key responsibilities

3.1 The key responsibilities of the Board are;

(i) To provide collective leadership, set strategic direction, prioritise local activity and present comprehensive plans of what will be done locally, where possible and deemed appropriate by the Board, to address needs and improve health and wellbeing in alignment with West Berkshire's priorities, outcomes and principles.

(ii) To prepare the West Berkshire Joint Strategic Needs Assessment which identifies the local health and wellbeing needs of the District's

Population ensuring effective and meaningful engagement and dialogue with local communities and service users.

(iii) To prepare the West Berkshire's Joint Health and Wellbeing Strategy

(iv) To promote partnership and integration of commissioning and service delivery across health, social care, public health and other service areas in conjunction with the Health and Wellbeing Strategy.

(v) To ensure that the plans of local and regional commissioners, including the NHS West Berkshire's Clinical Commissioning Group's commissioning plan, promote the delivery of the West Berkshire's Joint Health and Wellbeing Strategy wherever appropriate.

(vi) To measure progress against local plans including West Berkshire's Clinical Commissioning Groups Plans, the Joint Health and Wellbeing Strategy and other supporting plans and request action is taken to improve outcomes when monitoring indicators show plans or initiatives are not working.

(vii) Board members are accountable to each other for mobilising and co-ordinating partners and identifying available resources to deliver agreed priorities.

4.0 Role of the Board

4.1 The Board will do the following:

Coordinate partnership working

(i) Bring together NHS, public health and social care leaders with members of the local population and democratically elected representatives.

(ii) Promote integration of business action plans of partner organisations where appropriate.

(iii) Coordinate information sharing across partners.

(iv) Coordinate commissioning decisions to reflect the priorities identified by the Board including the use of joint commissioning and pooled budgets where appropriate.

(v) Consult with service users and carers about service developments which will affect them.

(vi) Work with the Local Safeguarding Children and Adult Boards to ensure all partners promote the safety and welfare of children, young people and vulnerable adults.

(vii) Maximise effective and efficient working to avoid partner organisations duplicating each others' work.

(viii) Link with the voluntary and community sector.

Identify local needs

(i) Lead the development of the Joint Strategic Needs Assessment, which identifies local health and wellbeing needs and priorities.

Set strategic direction and priorities and communicate actions

(i) Prioritise actions, based on the agreed strategic direction, joint commissioning strategies and Joint Strategic Needs Assessment, to meet the needs of the current population and avoid compromising the wellbeing of future generations.

· (ii) Communicate actions in publically available action plans.

Performance monitor

(i) Evaluate performance against locally agreed priorities.

(ii) Evaluate performance against nationally set outcomes frameworks for the NHS, public health and social care.

(iii) Produce annual reports of progress in relation to above action plans, in order that the Board is publically accountable for delivery of these actions.

5.0 Membership

5.1 The Membership of the Board shall consist of the following:

- Leader of the Council (or other designated Portfolio Holder)
- Portfolio Holder for Public Health and Wellbeing
- Portfolio Holder for Children and Young People
- Portfolio Holder for Adult Social Care
- Shadow Portfolio Holder for Health and Wellbeing
- *Director of Public Health*
- *Director for Communities (WBC)*
- *3 nominated representatives (in total) from the two Clinical Commissioning Groups*
- A nominated representative from the Voluntary and Community Sector
- *A nominated representative from Local Healthwatch*
- A nominated representative from NHS England Local Area Team

5.2 Those members denoted in italics are Statutory Members of the Board.

6.0 Quorum and Voting

6.1 A quorum shall be four members (which must include at least one member from the Clinical Commissioning Groups and one from West Berkshire Council). Board members are able to nominate a deputy who can attend and vote in their absence but must have delegated authority to make decisions. Nominated deputies will form part of the quorum.

6.2 The Board will operate in accordance with the Council's existing decision-making framework and normal Council budget setting processes. In accordance with the regulations all members of the Health and Wellbeing Board are voting members and as such will be governed by West Berkshire Council's Code of Conduct.

6.3 All members must therefore notify the Council's Monitoring Officer of disclosable pecuniary interests within 28 days of being appointed to the Board and are prohibited from participating in discussion or voting on any matter where they have a disclosable pecuniary interest.

7.0. Referencing Up

7.1 The Health and Wellbeing Board has been established as a sub-committee of the Executive. There may be occasions when decisions of the Board impact on the finances or general operation of the Council and in these instances any recommendation of the Board must be referred up to the Executive for final determination and decision.

7.2 It is suggested that the report template includes a question on page 2 as follows which will require the author of the report to consider the impact of their recommendation(s).

"Will the recommendation require the matter to be referred to the Council's Executive for final determination - Yes/No"

7.3 Where there is a requirement for the Council's Executive to make a final decision on a matter before the Health and Wellbeing Board arrangements will be made for a special meeting of the Executive to be held where this is appropriate.

Appendices

There are no Appendices to this report.

Consultees

Local Stakeholders:	N/A
Officers Consulted:	Nick Carter, Rachael Wardell, David Holling, Sarah Clarke, Moira Fraser, Jessica Bailiss
Trade Union:	N/A

Health and Wellbeing Development Session
2 – 5pm on 4th December 2014

Objectives of the Session:

- To compare the Board's position in comparison to other Health and Wellbeing Boards across the country and explore what good practice looks like.
- To carry out a self assessment against what was agreed at the last Development Session and progress made.
- To seek agreement on what success will look like in two years time.
- To explore and identify the next steps the Board will need to take in achieving its ambition of becoming an Executive Decision Making body.

Draft Outline of the Session:

2pm **Introduction**
Welcome and scene setting

2.05pm **Health and Wellbeing Boards – Good Practice**

- What does good practice look like?
- Where is West Berkshire's Health and Wellbeing Board in comparison to others?

Practical session

- *How the Board should be working with providers in light of the letter from the Secretary of State.*
- *How local relationships should be aligned in order to deliver better care.*

3.00pm Refreshment break

3.05pm **Where are we now?**

- Self assessment against what was agreed at the last development session and how well this has been achieved.
- What outcomes have been achieved in this time (deliverables such as the BCF and revised Health and Wellbeing Strategy)?
- How is the Health and Wellbeing Board working (agendas/the Management Group/process that supports the work of the Board)?

4pm **Looking ahead**

- What will success look like in two years time and what content should the Board be covering?
- What more needs to be done in reaching the aspiration of becoming an Executive Decision Making model and what are the next steps that need to be taken (building upon the Board's Development Plan)?

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Title of Report:	**Better Care Fund Update Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27th November 2014

Purpose of Report: **To update the Health and Wellbeing Board of progress on the Better Care Fund plans**

Recommended Action: The Health and Wellbeing Board to approve submission, to the Department of Health, of the joint plans agreed between the CCGs and the Council for use of the Better Care Fund.

Health and Wellbeing Board Chairman details	
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Contact Officer Details	
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Executive Report

1. Introduction

1.1 A detailed report setting out the implications of changes to social care funding arrangements as a result of the Care Act and performance targets for the Better Care Fund (BCF) was considered at a special meeting of the Health and Wellbeing Board on the 18th September 2014.

1.2 The report highlighted two main challenges: the change in performance target to focus on non-elective admissions and the financial implications for adult social care of the change in eligibility criteria from critical to substantial.

1.3 The size of the funding gap created by the change in eligibility was considered to be the main issue for HWB to consider ahead of submission of the latest BCF template on the 19th September.

1.4 The report also outlined that Wokingham Borough Council faced the same challenge in relation to the change in eligibility.

1.5 HWB approved submission with the following caveat 'To approve the Better Care Fund Plan subject to clarification that an adequate level of funding will be provided to meet the cost to West Berkshire District Council of moving to the new national minimum eligibility criteria being received from the Department of Health by 31ST October 2014 and if a positive response is not received to address this issue then the Health and Wellbeing Board reserves its right to withdraw the Plan.

1.6 Given the implications it was agreed that West Berkshire and Wokingham, with the support of the CCG, would work together on this.

2. Progress update

2.1 Following a meeting with senior officials from the DH on 6th October it was agreed that both councils would provide evidence of the funding implications arising from the change in eligibility criteria.

2.2 For West Berkshire the evidence provided consisted of two main areas, the numbers of new people would be eligible for support and the additional costs of meeting the increased eligible needs of existing clients.

2.3 For the first area a comparison of our client numbers against 6 social care councils from our CIPFA comparator group was undertaken. This suggested that we should expect to see client numbers increase by around 12% which would by 224 more clients at a cost in the region of £2.21m.

2.4 For the second area we undertook a desktop exercise of 49 existing clients. This involved a detailed review of all of the information gathered as part of the original care needs assessment. We identified the eligible needs that would have had to be met if we were operating at 'substantial' and compared the cost of the care plan against the cost of the package of care put in place following the original assessment. This exercise identified the following;

- the cost for those existing clients would increase by 20.69%.

- The client groups that would be impacted the greatest would be Memory & Cognition (particularly clients with dementia) and Physical Support.
- The key areas where additional services would be required are domestic routines and community support.

On the assumption that these findings are reflective of our overall caseload, this would provide an increase in costs of £5.09m per annum. However it is recognised that it would not be appropriate to apply any increase in respect of those clients in residential, nursing or supported living (LD clients) placements as we would not expect to see any increase in the required levels of support. This would reduce the increase in costs for existing clients to £1.87m per annum. This brings the total estimate of cost pressure to £4.08m which is off set by the £1.5m already provided in the Better Care Plan, beyond the nationally mandated amount. The resulting net pressure is £2.58m

2.5 This evidence was provided to the DH in the last week of October and discussions are continuing.

2.6 The deadline for resolution has been extended to the end of November to allow for negotiations to continue.

2.7 DH confirmed that the West Berkshire Locality were among 90 areas who had BCF plans approved subject to conditions. 5 areas including Oxfordshire and Essex have not had their plans approved. The letter from DH set out the financial risks associated with failing to meet the conditions. "If the conditions are not complied with NHSE reserve the right to withhold or recover funding, or direct the CCG that it be spent in a particular way."

2.8 All areas had to submit an action plan to the DH setting out how they would address the challenges by 14th November (Appendix A).

2.9 Resolution of the financial implications created by the change in eligibility was highlighted as the main 'show stopper'; other issues were identified but actions have been agreed.

2.10 DH has provided a consultant to support both us and Wokingham with the completion of the action plan.

Further discussions are due to be held with the DH week commencing 17th November to look at the evidence and agree a way forward. Newbury and District and North West Reading CCGs have confirmed their continued support to the Council in negotiations with DH, providing senior presence at all meetings, and the discretionary allocation of the £1.5m towards Care Act pressures in the Better Care Plan.

2.11 The national deadline for submitting BCF plans is 9th January (See Appendix B for latest version of BCF Template 1). Subject to resolution of the Care Act funding for Adult Social Care it was felt that our plans were strong enough to be submitted by 12th December.

2.12 This will require production of Project Initiation Documents for the locally led projects to be agreed at the joint West Berkshire Integration Steering Group on 10th December.

2.13 It must be stressed that, whilst no major changes will be made to the template between now (dispatch of HWB papers) and the submission date, there are still a small number of areas where data is being gathered and some tidying up of the paper is required.

3. **Summary**

3.1 All parties remain committed to the schemes outlined in the draft plan originally submitted to the DH in February 2014.

3.2 Subject to resolution of the Care Act funding we will be seeking to submit our BCF plans on the 12th December 2014.

Appendices

Appendix A: BCF Action Plan
Appendix: B: BCF Template 1

Consultees

Local Stakeholders:

Officers Consulted: Steve Duffin, Head of Service

Shairoz Claridge, Operations Director Newbury & District CCG

Trade Union: N/A

Local Government Association

Reviewer Body:
PWC

NHS England

West Berkshire

Please select 'preliminary' Quality of written plan (y-axis):
Medium-Low Quality

Priority order for HWB Discussion	Review Area	Risk Category	Risk Applicable \ Line of Enquiry (please select from dropdown list)	Reviewer's Reasoning \Notes	Notes of discussion with HWB and Area Teams	Outcome Status \ Pending HWB Action (please select status from dropdown list in the first box)	Link to Conditions Applied (please write your conditions in bold)	How Agreed Action Will be Met You will also need to consider what additional resources and skills sets will be required within your local area to meet these actions	Target Date for Completion	Support Required (to be agreed with Better Care Advisor) Please note that although support can be provided, resource and skill sets are limited and so you will need to prioritise your requests for support with your Better Care Advisor
Example	Analytics	Showstopper	**A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results**	DTOCs (in 6. HWB Supporting Metrics tab, template 1) shows increase in rate quarter on quarter for two quarters, but no rationale is given in the box provided (cell R29), as required by the guidance. Increase is fairly marginal on each so may be due to local factors	HWB understood the issue during the call and agreed to look into before the final assessments day	**No longer a risk - if the following action is put in place (enter action in box below)** A rationale is added to the required box for the red ratings in 6. HWB Supporting Metrics tab, template 1, that explains the increased DTOCs in the two quarters.	Assist in correcting issues with condition: **Must address outstanding analytical risks in plan** by ensuring data integrity.	eg. Review of raw data	10/12/14	Analyst time. Access to raw data
1	Narrative	Showstopper	**N1-The National Conditions have not been met**	9 a) In section 7 does the plan demonstrate how it meets the national conditions set out below? i) Protecting social care services. The applicant lists pooled funding of £2.5m to deliver schemes to protect adult social care & £1.507m allocated for Care Act implementation. The applicant describes arrangements to meet the new Care Act duties (e.g. Care Act work programme). But the applicant highlights the current allocation to meet the Care Act duties is 'woefully inadequate' as the local council is 1 of the 3 in England currently operating at the eligibility criteria of critical. The funding gap of £4m is significant at present, & this has been reflected in the risk log but with no detailed mitigating actions.	The HWB explained that this local authority has been "critical" since 2003, but with a planned shift in legibility, plus the new requirements for carers, there will be a funding gap of £4m. The applicant states that they wish to highlight this as a risk, and emphasise that the HWB, Local Authority and Area team are working together to address this as a system challenge. If this funding gap is not filled, there will be insufficient funding for the HWB to meet the Care Act requirements.	**Risk remains outstanding** The HWB explained that this local authority has been "critical" since 2003, but with a planned shift in legibility, plus the new requirements for carers, there will be a funding gap of £4m. The applicant states that they wish to highlight this as a risk, and emphasise that the HWB, Local Authority and CCG acknowledge this is a system risk as it will impact both Health and Social Care. A joint letter from the two local authorities and CCGs has already been sent to local MPs outlining the issue and Chief Executives from both the Local Authorities and CCGs are meeting with the Department of Health officials this Friday 3rd October. If this funding gap is not filled, there will be insufficient funding for the HWB to meet the Care Act requirements.	**Condition 1a: The plan must further demonstrate how it will meet the national condition of protecting social care to ensure people can still access the services they need.**	The HWB is concerned that Care Act funding for the national eligibility change, allocated within the BCF, does not adequately reflect the true cost of implementation given that West Berkshire is one of only three authorities currently operating at critical. The Department of Health has acknowledged the issue and is currently in dialogue with West Berkshire Council and Newbury & District CCG. A meeting is being arranged for w.c. 17th November with the aim of agreeing a resolution. Any requirement to review the BCF allocations will be considered after the outcome of the meeting.		
2	Narrative	Showstopper	**N1-The National Conditions have not been met**	9 a) In section 7 does the plan demonstrate how it meets the national conditions set out below? ii) 7 day services to support discharge? Further details are required regarding: -Evidence of engagement with the Action Plan to deliver 7DS contained in the Service Development & Improvement Plan section of NHS local contracts between CCGs and providers. -Detailed delivery plan for moving to 7DS including key milestones, priority actions and key next steps. -How local partners will work together to ensure that NHS providers meet the milestones for 7DS in 2014 to 2017 -Any risks associated with appropriate mitigating actions.	The HWB confirmed that it can provide a further level of detail in Section 7, setting out its work to meet the 7 day services requirements. The HWB noted that it already undertaking a variety of work in this area, and for example the 7 day services requirements are included within the Joint Provider Contract.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide a further level of detail of its work to meet the 7 day services requirements in Section 7 of template 1, including: - Evidence of engagement with the Action Plan to deliver 7DS contained in the Service Development & Improvement Plan section of NHS local contracts between CCGs and providers. - Detailed delivery plan for moving to 7DS including key milestones, priority actions and key next steps. - How local partners will work together to ensure that NHS providers meet the milestones for 7DS in 2014 to 2017 - Any risks associated with appropriate mitigating actions.		First action - CCG will amend section 7 of template 1 to provide evidence of reporting against the CQUIN by Health providers on delivery of 7DS. Template 1 will also be amended to confirm that evidence of engagement with providers is available through the minutes of contracting meetings. Persons responsible for ensuring action is delivered - Shairoz and Tim Second action - The Joint Care Provider project brief provides an initial outline plan, with timescales, for the enhancement of existing 7 day services. The action will be to summarise this information in Section 7 of the Plan Template 1. Person responsible for ensuring action is delivered -Steve Third action- Section 7 of template 1 will be amended to explain that the Joint Care Provider scheme and the 7 Day Services scheme have been brought together in a shared LA, CCG and BHFT project . That project will engage with local NHS providers to ensure alignment of plans. Person responsible for ensuring action is delivered - Tandra and Shairoz Fourth action - The full programme risk register, including mitigating actions, will be review	20/11/14	
3	Narrative	Top Risks	**N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area**	2 a) In section 2, is there a description of a high level but realistic picture of how health and social care services will look in five years' time, and a clear comparison of how this is different to the current state? The plan contains a clear description of a high level picture of how health and social care services will look in five years' time. The section specifies the aspects of the changes and the schemes the local area is intending to deliver using the BCF, and these are mapped to the local vision. However, some further details are required, as listed in the "Action" section right. f	The applicant agreed it can provide further details of the planned changes it intends to make between 2014/15 and 2018/19 in the next iteration of the BCF Plan. The applicant noted that the issue regarding the shift in legibility is highly relevant to their Vision, and they will also emphasise this in Section 2. The applicant noted that they are concerned regarding the availability of BCF funding beyond 2015/16 and they are seeking assurance from the Department of Health in relation to this.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide the following details in Section 2 of the next iteration of their BCF Plan: - A clear comparison between current and 2018/19 state, described in terms of changes to patient and service user experience and outcomes - Reference the JSNA and JHWS, and any other locally relevant strategic plans - A clear description of how these changes effectively respond to changes to the local public health needs and the broader demographic, and socio-economic changes in the local area - Evidence of the input of service users and public engagement - A description of who is delivering the care and support, and who is receiving the care and support, where and when the care and support will be delivered, and how. - A description of which aspects of service change would not otherwise be delivered without the Better Care Fund Note - the HWB has raised a concern regarding availability of BCF funding beyond 2015/16.		The 'vision' in section 2 to be amended to cover all of the points outlined in column H. This will require a review by CCG colleagues as the vision is a shared one covering both social care and health. Person responsible for ensuring this action is delivered - Tandra	Complete	
4	Narrative	Top Risks	**N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area**	3 c) In the response to "Please set out a clear, analytically driven understanding of how care can be improved by integration in your area" also referencing sections 2 and 4? Is it clear what aspects of the change would not otherwise be delivered without the Better Care Fund? Section 3 of the plan is closely linked to section 2 'vision for the Health and Social Care Services' and section 4 'Plan of Action', but there is no clear reference in the section. The aspects of the change that would not otherwise be delivered without the BCF are stated in section 2.	The HWB confirmed that it can provide an amended Section 3 in the next iteration of its BCF Plan, which explicitly references both Section 2 Vision and Section 4 Plan of Action. The HWB also confirmed that it can include a statement in Section 3 regarding which services it would be unable to deliver should BCF funding not be provided as planned.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide an amended Section 3 in the next iteration of its BCF Plan, which explicitly references both Section 2 Vision and Section 4 Plan of Action. The HWB to include a statement in Section 3 regarding which services it would be unable to deliver should BCF funding not be provided as planned.		First point - Section 3 will be amended to more clearly articulate the link between the vision in Section 2 and the plan of action in Section 4. This will be done once the vision has been amended, see previous row. Persons responsible for ensuring this action is delivered - Tandra and Shairoz Second point - Steve & Tandra to add the required statement. The list of services that we would be unable to deliver includes those preventative services paid from existing S256 agreement monies and those Care Act duties where the BCF is supposed to be the funding source. It may also be appropriate to include the "chart of doom" showing how falling LG funding will impact on social care services. Person responsible for ensuring this action is delivered - Steve	20/11/14	
			N5-The plan is not aligned	8 a) In section 6 does the plan demonstrate that alignment with other initiatives related to care and support has occurred and inter-	The HWB confirmed that there is significant alignment between other initiatives and the 7 BCF initiatives, and for example the HWB is already involving the voluntary sector, and the Urgent Care	**No longer a risk - if the following action is put in place (enter action in box below)**				

5	Narrative	Top Risks		dependencies and responsibilities are understood? The section referenced links between the BCF plan and other integrated care initiatives/programmes relating to personal health budgets, extra care housing, urgent care services, Care Act 2014 programme, plan to refocus communities directorate toward restorative practices, and voluntary sector prospectus. Further details are required as listed in the "Actions" section.	Board discussed relevant issues in their workshop on 25 September 2014. The HWB confirmed that it can provide further details of this alignment in Section 6 of the next iteration of its BCF Plan.	The HWB to provide further details in Section 6 of the next iteration of its BCF Plan, of the alignment between other initiatives and the BCF Plan schemes, including: - An articulation of how those initiatives can support the delivery of the BCF and where there are any arrangements to share resources - Identification of any inter-dependencies, demonstrating an understanding of how one initiative impacts or depends on another - Responsibilities for bringing together and ensuring ongoing communications between the related initiatives - Evidence that the local area has considered alignment with local plans for the use of technology.		1st Action - Section 6 of template 1 to be amended to explain how the BCF plan and other initiatives (CCG and LA) align. Person responsible for ensuring this action is delivered - Tandra and Shairoz 2nd Action - Section 6 of template 1 to be amended to explain the interdependencies of the various initiatives how they impact on each other. Person responsible for ensuring this action is delivered - Tandra and Shairoz 3rd Action - Greater clarity to be added to Section 6 as to how the governance arrangements ensure all parties remain fully sighted on all initiatives regardless of lead body. Persons responsible for ensuring this action is delivered - Tandra and Shairoz 4th Action - Information on the 'Connect Care' project to be added to Section 6 in order to evidence that all parties understand that effective technology has a key role in the integration agenda. Persons responsible for delivery of this action - Tandra and Shairoz	Complete	
6	Analytics	Top Risks	**A2-P4P: the non-elective plan does not reach the expected 3.5% reduction in non-elective admissions**	Reduction of 1.0% in non-elective activity is below threshold of 3.5%.	The HWB confirmed that they can provide narrative in the next iteration of their BCF submission, template 2, explaining the key reasons for their planned 1% reduction in non-elective admissions and why this is below the expected 3.5%.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide narrative in the next iteration of their BCF submission, template 2, explaining the key reasons for their planned 1% reduction in non-elective admissions and why this is below the expected 3.5%.		Additional wording has been added to Section 8 (c) of template 1 to reflect further clarification of rationale for the 1% target for NEL. Template 2 will also be amended to cross reference back to Section 8. Person responsible for ensuring this action is delivered - Debbie	Complete	
7	Analytics	Top Risks	**A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions**	14/15 '176' from 4. HWB Benefits Plan tab versus '106' from HWB P4P Metric tab change in activity – difference of 70 admissions – raise on call. 15/16 '506' from 4. HWB Benefits Plan tab versus '106' from HWB P4P Metric tab change in activity – difference of 400 admissions – raise on call.	The HWB explained that the change in activity from non-elective admissions in the Benefits Plan (tab 4, template 2) reflects specifically BCF schemes, whereas the P4P metric for non-elective admissions (tab 5, template 2) reflects the general population and includes assumptions regarding demographic changes and population growth in the area. The HWB confirmed it can provide further details of the data it used to calculate the reduction in non-elective admission (using information from the local area), if required in the next phase of review.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide further details of the data it used to calculate the reduction in non-elective admissions (using information from the local area), if required in the next phase of review.		The numbers in the two tabs do not match as the 506 is the number of admissions avoided by the scheme and the 106 is the net number of admissions avoided after 4% growth - this is detailed in Section 8 (c) of template 1. Template 2 will be amended to make this clear (cell N9 of tab 5) Person responsible for ensuring this action is delivered - Edward	Complete	
8	Analytics	Top Risks	**A5-P4P: the non-elective plan does not reach the expected 3.5% reduction and the rationale provided is not satisfactory**	No justification provided in template 2.	As noted in Risk 6 above, the HWB confirmed it can provide narrative in the next iteration of their BCF submission, template 2, explaining the key reasons for their planned 1% reduction in non-elective admissions and why this is below the expected 3.5%. In particular, the HWB can include this explanation with cell N9 of the P4P metric tab, i.e. tab 5 of template 2.	**No longer a risk - if the following action is put in place (enter action in box below)** As noted in Risk 6 above, the HWB to provide narrative in the next iteration of their BCF submission, explaining the key reasons for their planned 1% reduction in non-elective admissions and why this is below the expected 3.5%. In particular, the HWB to include this explanation within cell N9 of the P4P metric tab, i.e. tab 5 of template 2.		This seems to be a repeat of the previous row so it does not appear that any further action is required.	n/a	
9	Analytics	Top Risks	**A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions**	P4P • No clear link or obvious reference to P4P within any of the schemes. Residential Admissions • No clear link or obvious reference to residential admissions within any of the schemes. Reablement • No clear link or obvious reference to reablement within any of the schemes. Reablement mentioned within scheme BCF01; 'Community Nurses Directly Commissioning Care / Reablement Services' but not mentioned within 'Impact of the scheme' and 'Feedback Loop'.	The HWB confirmed that the schemes listed in Annex 1 are all designed to help reduce the P4P (non-elective admissions) or Supporting Metrics. In order to make this link clearer, the HWB confirmed it can amend Annex 1 of template 1 to explicitly reference the relevant metrics within each scheme's description.	**No longer a risk - if the following action is put in place (enter action in box below)** In the next iteration of its BCF submission, the HWB to amend Annex 1 of template 1 to explicitly reference the relevant metrics within each scheme's description.		The annexes for each BCF scheme will be amended by the addition of some standard wording that explains how the scheme contributes to each metric. Person responsible for ensuring this action is delivered - Steve	20/11/14	
10	Finance	Top Risks	**F3-Schemes are not financially evidence-based or financially modelled adequately for full benefits realisation**	6 (b) In Section 5a of Template Part One 'Risk Log', are appropriate financial risks highlighted for NHS Providers and NHS and Local Government? A detailed Risk Log has been provided, & the applicant states that beneath this sit individual project risk registers - It is unclear whether "each project" means each of the seven BCF Plan schemes. - The Risk Log contains a reasonable level of detail regarding risk ratings and mitigating actions, but the owners of the mitigating actions is not clear and the timeframe for the risks and actions is not clear. - Financial risks are not quantified and details / examples of the modelling / analysis involved would be helpful.	The HWB explained that there are 5 projects which form this programme, and each project has an individual risk log which contributes towards the overall program Risk Log provided. The HWB confirmed it can provided further details of the risks and mitigating actions, and the financial risks and underlying analysis.	**No longer a risk - if the following action is put in place (enter action in box below)** In the next iteration of its BCF Plan, the HWB to provide further details in Section 5 of template 1 regarding the Risk Log, including: - Clarifying the owners of the mitigating actions, and the timeframe for the risks and actions is not clear. - Providing further details of financial risks, and quantifying these where possible, and providing details or examples of the modelling / analysis used to identify and quantify these risks.		First action - The risk register in section 5 of template will be amended to ensure the owner of each risk is identified and timescales are added if applicable (most risks will remain throughout delivery of the BCF schemes although the level of risk and mitigating actions will be subject to change). Additional entries will also be made to the risk register to cover the interdependencies issue. Person responsible for ensuring this action is delivered - Steve Second action - An additional table containing this further detail has already been provided but this will also be added into template 2. Person responsible for ensuring this action is delivered - Edward	19/11/14	
11	Finance	Top Risks	**F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership**	6(c) In Section 5b of Template Part One 'Contingency and risk sharing', does the plan reflect a contingency plan and risk sharing in the event that the target... is not met? .... (i)There are references to "detailed modelling" but the financial risk is not quantified and further details of the modelling / analysis involved would be helpful. There is no link to the P4P metric. (ii)The mitigating actions lack owners & timeframes to deliver (iii)There is a draft Risk Sharing Agreement, but further detail is required, inc. an explanation of whether the CCG / Council will share the risk, and whether this Risk Share Agreement will be in place for all seven of the BCF Plan schemes.	The HWB explained that the main financial risk is that the planned benefits are not realised from the 7 individual BCF schemes, i.e. £1,167k. The applicant stated that they have modelled the investments robustly in each case, so they do not expect the costs for each scheme to exceed the planned budget. The HWB highlighted that they have set aside £250,000 of the fund as a "buffer" in case risks do crystallise.	**No longer a risk - if the following action is put in place (enter action in box below)** In the next iteration of its BCF Plan, the HWB to include further details of Risks within Section 5 of template 1, including: - Detailing the financial risk from not realising the planned benefits of £1,167k And, as noted in Risk 10 above: - Providing further details of other financial risks and quantifying these where possible, and further details of the modelling / analysis used to quantify them. - Clarifying links between risks and the P4P metric (reducing non-elective admissions). - Clarifying the owners of mitigating actions, and timeframes for delivery. - Regarding the draft Risk Sharing Agreement, explaining whether the CCG / Council will bear the risk of non-delivery relating to each of the 7 BCF schemes.		First Action - This has been covered in the additional table referred to in row 10 above. Second Action - A joint review of the financial risks will be undertaken and this section amended. Person responsible for ensuring this action is delivered - Edward Third Action - Additional wording will be added to Section 5 of template 1 Edward to provide wording. Person responsible for ensuring this action is delivered - Steve Fourth Action - This will be dealt with as a result of addressing row 10 above. Person responsible for ensuring this action is delivered - Steve Fifth Action - This will be covered in the additional table referred to in row 10 above. Person responsible for ensuring this action is delivered - Edward	Complete	
			F5-Full budgets are not identified to meet the additional costs resulting	6 (f) In Section 7a (vi) of Template Part One: I. Has the plan considered the impact on the local authority's budget	The HWB confirmed that it has not fundamentally changed the schemes that are listed in its current BCF Plan, when compared to their original BCF submissions. The big chance is the new	**No longer a risk - if the following action is put in place (enter action in box below)**				

12	Finance	Top Risks	**from the new Care Act duties**	of the revisions to the £1bn performance and NHS commissioned services pot? II. Has the plan articulated a figure? (i) Yes - The applicant states that the BCF plan has been developed since it was originally submitted, using guidance from the Department for Health and other bodies. (ii) No – The applicant has not quantified the level of change. The applicant states that the funding to protect adult social care services and Care Act costs remains "significantly (£4m) above any identified sources of funding at the present time".	explicit guidance regarding Care Act requirements, which has contributed towards the £4m funding requirement (driven by the proposed shift in eligibility).	In its next iteration of the BCF plan, the HWB to highlight in Section 7a (vi) of template 1 that it has not fundamentally changed the schemes, benefits or expenditure included in its original submission. The key changes are clarity around the Care Act requirements which, in conjunction with the planned change in eligibility, indicates the HWB has a funding requirement of circa £4m.		Section 7a will be amended to add some wording that confirms that no fundamental changes were made from the original submission. A brief summary of how the funding gap became apparent (using the timeline document already produced for Members) will also be added Person responsible for ensuring this action is delivered - Steve	Complete	
13	Narrative	Further Risks	**N8-Insufficient documentation of the risks**	7 a) In section 5 is there a populated and comprehensive risk log, including risks and mitigations in the areas of deliverability, finance and not meeting targets and alignment? The risk register is an extract from a Programme Risk Register. This covers finance, capacity, deliverables etc. A consistent scale has been used to describe the likelihood of the risk arising, but the potential impact relating to financial risk is not quantified. Existing & expected controls for each risk are described in the risk log, but further details of mitigating actions are needed with clear ownership by actors such as CCGs and the council, timeframe of the actions, & indicating the involvement of key stakeholders in its development.	As noted in relation to Risks 10 and 11 above, the applicant has agreed to provide a further level of detail regarding the Risks in Section 5 of Template 1.	**No longer a risk - if the following action is put in place (enter action in box below)** (As noted in Risks 10 and 11 above) In the next iteration of its BCF Plan, the HWB to provide details that include: - Quantifying the potential impact relating to financial risk - Further details of mitigating actions with clear ownership by actors such as CCGs and the council, timeframe of the actions, and indicating the involvement of key stakeholders in its development.		The actions required to address this risk will be covered when Section 5 of template 1 is updated to deal with the risks in rows 10 and 11. Person responsible for ensuring this action is delivered - Steve	20/11/14	
14	Narrative	Further Risks	**N8-Insufficient documentation of the risks**	7 b) In section 5 is there a clear articulation of the risk sharing arrangements that are in place across the health and social care system, and how these are reflected in contracting and payment arrangements? This section is currently light on detail. It describes in high level how to meet growth in activity and financial shortfall in the local area. The draft risk sharing agreement between West Berkshire Council, Newbury and District CCG and North West Reading CCG on BCF pooled budget has been included in this section. However, it is not clear whether this has been agreed by these parties. Additional information is required as detailed in the "Actions" section.	As noted in relation to Risks 10 and 11 above, the applicant has agreed to provide a further level of detail regarding the Risks and Risk Sharing in Section 5 of Template 1.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide further details of Risk Sharing, including further information in following areas: - A quantified pooled funding amount that is 'at risk', which has been calculated using clear analytics and modelling, and link to Payment for Performance tab in part 2 of the template - An articulation of an agreed plan for how this funding will be spent including what series or development will be funded, and which quarter the fund will be received and the implications this has for financial management - An articulation of any other risks associate with not meeting the target for reduction in unplanned emergency admissions, e.g. will this have any knock on implications? How far can these be mitigated through pre-emptive actions? - An articulation of how the agreed risk sharing arrangements across the local health and care system are reflected in contracting and payment arrangements		The comments in the 'Outcome Status' column would suggest a lack of understanding of the approach being taken to the sharing of financial risk. The wording in Section 5 of template 1 will be reviewed to ensure that all 4 actions listed in this row are addressed. Edward will provide the additional wording for Steve to add to template 1. Person responsible for ensuring this action is delivered - Steve	Complete	
15	Narrative	Further Risks	**N8-Insufficient documentation of the risks**	7 c) In section 5 does the plan confirm that the Health and Wellbeing Board has been consulted on the plan of action and that they are aware of the spend? There is no confirmation in the section that the HWB have been consulted on the plan of action and that they are aware of the spend.	The applicant confirmed that the HWB has been consulted on the plan of action and they have signed-off on the BCF Plan. The sign-off occurred at the extraordinary meeting on 18 September 2014.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to provide written confirmation that they have been consulted on the BCF plan of action and signed-off on the plan, for example the minutes from the extraordinary meeting on 18 September 2014.		The written confirmation, HWB minutes of 18th September 14, has already been provided. However we will ensure that both these minutes and those from the HWB meeting on the 27th November 14 are provided as supporting documentation when the amended templates are submitted.	Complete	
16	Analytics	Further Risks	**A6-Supporting Metrics: validity issue with values submitted - errors in plan values entered are causing incorrect results**	• Annual change increases extremely high for Residential Admissions. Flag on call. • Annual change reductions extremely high for DTOCs. Flag on call.	The HWB stated that the forecast increases in Residential Admissions of 23% and 18% per annum are due to the increasing population in West Berkshire and the increasing proportion of the population that are elderly. In addition, the Care Act changes are expected to result in a large number of people already in residential care coming forward to apply for a care package. The HWB stated that the data which has resulted in a forecast decrease in DTOCs of 25% to 46% per annum will be double-checked before the next phase of the BCF review.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to double-check the data which drives the forecast decreases in DTOCs (of 25% to 46% per annum) before the next phase of the BCF review.		The data has been reviewed and the forecast decrease in DTOCs amended in Template 2.	Complete	
17	Analytics	Further Risks	**A7-Supporting Metrics: the level of ambition for a given metric is not consistent with the quantified impact of the schemes contributing to it**	Residential Admissions • 14/15 – no data to make comparison • 15/16 – no data to make comparison Reablement • 14/15 – no data to make comparison • 15/16 – no data to make comparison DTOCs • 14/15 – no data to make comparison • 15/16 – no data to make comparison	The HWB confirmed that the planned quantified benefits to be generated from the BCF schemes in the Benefits Plan are based on reductions in non-elective admissions. The applicant does intend to use the BCF schemes to reduce certain other metrics, but these are not forecast to generate monetary benefits (that can be quantified), hence the other metrics are not listed in the Benefits Plan (Residential Admissions, Reablement and DTOCs). The HWB stated that the Reablement metric in particular represents a small cohort hence it is difficult to quantify the impact of any increase.	**No longer a risk - no further action required** The HWB has fully explained why the only metric used to calculate quantified benefits in the Benefit Plan (tab 4 of template 2) is the P4P metric, non-elective admissions.		No action required	Complete	
18	Analytics	Further Risks	**A8-Supporting Metrics: contextual information indicates that the plan(s) may be under or over ambitious**	Residential Admissions • Not meeting the statistically significant improvement level. • 14/15 increase of 22.9% does not meet statistically significant improvement level of a reduction of 10%. • 15/16 increase of 18.2% does not meet statistically significant improvement level of a reduction of 7.6%. Reablement • Not meeting the statistically significant improvement level. • 14/15 increase of 2.1% does not meet statistically significant improvement level of an increase of 10.9%. DTOCs • They meet statistically significant improvement level by a considerable amount. Need to flag on call.	The HWB confirmed that they are not forecasting the required reduction in Residential Admissions (10%) or the planned increase in Reablement (10.9%), because they have taken a prudent approach to their forecasts, they are aware of the forecast changes in demographics (increased elderly proportion of population) and the Care Act requirements. The HWB highlighted that the small population of patients in relation to the Reablement metric meant that small changes in patient numbers could have a large impact on the metric.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to add an explanation into Template 2, to clarify that they are not forecasting the required reduction in Residential Admissions (10%) or the planned increase in Reablement (10.9%), because they have taken a prudent approach to their forecasts, they are aware of the forecast changes in demographics (increased elderly proportion of population) and the Care Act requirements.		Susan has provided the wording for template 2 and sent to Edward. Only outstanding action is to ensure that template 2 has been updated. Person responsible for ensuring this action is delivered - Edward	Complete	
19	Analytics	Further Risks	**A9-Supporting Metrics: under or over ambitious plans are not explained fully or appropriately**	Residential Admissions • Red ratings present – justified as Admissions to residential/nursing homes expected as a result of the changes introduced by the Care Act and increase in numbers of people aged 75 and over with needs that can only be met in these settings.	As noted in Risks 16 and 18 above, the HWB stated that the forecast increases in Residential Admissions of 23% and 18% per annum are due to the increasing population in West Berkshire and the increasing proportion of the population that are elderly. In addition, the Care Act changes are expected to result in a large number of people already in residential care coming forward to apply for a care package.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to add an explanation into Template 2, to clarify that they are not forecasting the required reduction in Residential Admissions (10%) or the planned increase in Reablement (10.9%), because they have taken a prudent approach to their forecasts, they are aware of the forecast changes in demographics (increased elderly proportion of population) and the Care Act requirements.		The wording of the required action is a repeat of the previous row and has therefore been dealt with.	Complete	
20	Analytics	Further Risks	**A11-Supporting Metrics: information provided on Local Metric is not valid**	Local Metric • No baseline date • No data • Justification as 'Baseline data being validated. The metric will be populated in Q4 of 2014/15'.	The HWB explained it had planned to use a national metric, but as it is not available they will look to utilise data regarding the "fit list" from their Alamac system. This new data will be added before the next BCF review phase.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to add relevant data to populate the "Local Metric" before the next BCF review phase.		The plan had been to use a national metric, but as it is not available we will utilise data regarding the "fit list" from our Alamac system. This new data will be added to template 2 before the next BCF review phase. This will require joint work involving Debbie and Tandra and then a request to Edward to amend the template.	20/11/14	
21	Analytics	Further Risks	**A11-Supporting Metrics: information provided on Local Metric is not valid**	Local Metric • No numerator and denominator • No improvement direction selected • No data as outlined in commentary of question 3.2 'a'.	As noted in Risk 20 above, the HWB explained it had planned to use a national metric, but as it is not available they will look to utilise data regarding the "fit list" from their Alamac system. This new data will be added before the next BCF review phase.	**No longer a risk - if the following action is put in place (enter action in box below)** As noted in Risk 20 above, the HWB to add relevant data to populate the "Local Metric" before the next BCF review phase.		This action links directly to the previous row and simply requires us to ensure the 3 key items of data are included. This should therefore be covered in the above action. Person responsible for ensuring this action is delivered - Edward	20/11/14	
			A10-Supporting Metrics: information provided on Patient Experience	Patient Experience Metric • No clear and obvious link between metric and schemes.	As noted in relation to Risk 9 above, the HWB confirmed that the schemes listed in Annex 1 are all designed to help reduce the P4P (non-elective admissions) or Supporting Metrics. In order to	**No longer a risk - if the following action is put in place (enter action in box below)**		The action is a repetition of that for row 9. All need to work through the annex for each		

22	Analytics	Further Risk	**Metric is not valid**	Local Metric • No clear and obvious link between metric and schemes.	make this link clearer, the HWB confirmed it can amend Annex 1 of template 1 to explicitly reference the relevant metrics within each scheme's description.	In the next iteration of its BCF submission, the HWB to amend Annex 1 of template 1 to explicitly reference the relevant metrics within each scheme's description.		The action is a repetition of that for row 3. Linked to work through the detail for each scheme and explain how they contribute to the metrics. Some will be very clear but others may just be about improving the customer experience. Person responsible for ensuring this action is delivered - Steve	20/11/14	
23	Finance	Further Risks	**F7-Incompleteness\lack of evidence-based financial planning**	6 (e) In Section 7a (v) of Template Part One, has: I. a financial sum been included for 'carer specific' support from within the BCF pool? (i) No – the applicant states that £738k will be allocated from the BCF towards carer-specific support, made up of £417k from the existing s.256 agreement and a further £321k from the CCG. It is unclear how these sums tie to the Expenditure Plan (tab 3 of template 2).	The HWB explained that the carer-specific support is contained within two lines in the Expenditure Plan (tab 3 of template 2). The HWB confirmed it will either (i) amend Section 7a(v) to clearly reference the relevant lines of the Expenditure Plan, or (ii) amend the Expenditure Plan to highlight the funding for carer-specific support.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to either (i) amend Section 7a(v) to clearly reference the relevant lines of the Expenditure Plan, or (ii) amend the Expenditure Plan to highlight the funding for carer-specific support.		The simplest of the two options appears to be to amend the Expenditure Plan to highlight the funding for supporting carers. Steve to provide Edward with the split of the main S256 spend and then Edward will update template 2. Person responsible for ensuring this action is delivered - Edward	Complete	
24	Finance	Further Risks	**F8-Insufficient funding for critical schemes**	4 (a) Has the 'HWB Expenditure Plan' tab been completed fully and all the columns been completed against each scheme? We note the following gaps: - For BCF01 and BCF02 there appears to be no expenditure. It is not clear whether this is intentional. - For "Existing CCG re-ablement spend" Contingencies, Disabled Facilities Grant, Social Care Capital Grant and Connected care (interoperability), the area of spend in Column E has not been specified.	The applicant explained that the lines "BCF004" and "CCG reablement" on the Expenditure Plan (tab 3 of template 2) contain the funding for BCF plan BCF001. The applicant also explained that the line named "Health Hub" on the Expenditure Plan (tab 3 of template 2) contains the funding for BCF plan BCF002. The HWB confirmed that it will amend the Expenditure Plan to make the expenditure for each of the 7 BCF schemes clearer. The HWB also confirmed it will complete the gaps in cells E18 and E20 to E25 to specify the area of spend in each case.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to amend the Expenditure Plan (tab 3 of template 2) to make the expenditure for each of the 7 BCF schemes clearer. The HWB to also complete the gaps in cells E18 and E20 to E25 to specify the area of spend in each case.		Changes need to be made to template 2, tab 3 and the 3 blank cells need completing. Edward to do this with input from Steve if required. Person responsible for ensuring this action is delivered - Edward	Complete	
25	Finance	Further Risks	**F9- Unrealistic savings**	4(b) Are the expenditure plans valid in terms of being: ... (ii) Free of disproportionate allocations to individual schemes that require local context to fully assess the reasonableness and criticalness of schemes and allocations to them? (ii) No – the largest expenditure is recorded against the following schemes, and reasons have not been given as to why these schemes are receiving significant funding: Care Act costs – £1,507k (16% of total spend) Existing s.256 spend - £2,114k (22% of total spend)	The HWB explained that the larger allocations are to meet Care Act costs and existing s.256 spend because these are schemes aiming to meet the National Conditions and reduce the non-elective admissions and residential admissions metrics.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to add an explanation to the Expenditure Plan (tab 3 of template 2) to clarify that the larger expenditure allocations are to meet Care Act requirements and existing s.256 spend because these are schemes aiming to meet the National Conditions and reduce the non-elective admissions and residential admissions metrics.		This action involves some additional wording to be added in template 2. Edward will amended template 2 tab 3 to add additional rows this allowing for a greater level of these large expenditure sums. Steve to provide detail of the split of the S256 monies between support for carers and preventative/universal services. Steve also to provide a split of care act monies between eligibility and new carer duties. Person responsible for ensuring this action is delivered - Edward	Complete	
26	Finance	Further Risks	**F10-Schemes are implemented but not monitored**	5 (a) Has the Tab 4 'HWB Benefits Plan' been completed fully for both 2014/15 and 2015/16 specifically: i) Have all of the columns been completed, where necessary? ii) Has the 'How is the savings value calculated' column been completed appropriately? (i) No – In 2014/15, there are two schemes listed (Hospital at Home and Nursing Home Support) with planned activity changes but no quantified benefits. It is not clear why this information has been excluded. (ii) No – In each case the applicant has stated that the savings have been "Identified via Business Cases". It is not clear what this means and further details are required.	The applicant explained that on advice from its BCF consultants, it removed from its Benefits Plan the benefits to be generated in 2014/15. Hence these cells are blank in the Benefits Plan, tab 4 of template 2. The applicant also explained that quantifiable benefits are planned for schemes BCF01 and BCF02. The five other BCF schemes are enabling schemes, which will assist schemes BCF01 and BCF02 and help fulfil National Conditions. The applicant confirmed it can provide further details regarding how the benefits were calculated for each of the two BCF schemes, BCF001 and BCF002 (i.e. the unit prices and activity levels).	**No longer a risk - if the following action is put in place (enter action in box below)** The BCF team to provide guidance to each HWB to clarify what is required in the Benefits Plan (tab 4 of template 2) regarding benefits planned in 2014/15. The HWB also requested further guidance from the BCF regarding what funding elements are assumed to fall within the BCF. For example, it appears that capital grants from the Department of Health fall within the BCF, but these are provided directly by the Department. The HWB to provide further details regarding how the benefits were calculated for each of the two BCF schemes, BCF001 and BCF002 (i.e. the unit prices and activity levels).		The first two actions appear to be for the BCF team? The wording of the third action would suggest that we are required to provide details of how we calculated the financial benefits for BCF01 and BCF02. However neither of these schemes have any financial benefits attached. It is assumed that the schemes are in fact Hospital at Home (BCF06) and Enhanced Care & Nursing Home Support (BCF07). Edward to provide this information. Person responsible for ensuring this action is delivered - Edward	Complete	
27	Finance	Further Risks	**F10-Schemes are implemented but not monitored**	5 (b) For benefits arising from the P4P Metrics: i) Are they free of errors? ii) Are there disproportionate allocations\linkage to individual schemes .... and iii) In the 2.Summary tab .... if there is a difference ....in cell D44 vs E44, has a valid explanation been provided in cell G44? (i) No in the BCF Benefits Plan, the annual reduction in admissions is stated to be 106. However, in the Benefits Plan, the activity in 2014/15 is planned to reduce by 176, and in 2015/16 the activity is planned to reduce by 506. (ii) No - All benefits appear to be generated by the two schemes. (iii) No – There is a difference which is unexplained.	As noted in the Risks above, (i) the HWB confirmed that the planned activity reductions in non-elective admission in the Benefits Plan (tab 4) do not meet the planned activity reductions in the P4P metric tab (tab 5), because the former is based on local data and the latter includes the planned growth rate in admissions due to changing demographics and population growth. Also as noted above, (ii) the HWB confirmed that only two of the seven individual BCF schemes are shown to generate quantified benefits because the other five schemes are enabling schemes, and/or designed to meet National Conditions or reduce the P4P and other metrics but the benefits cannot be quanitified. And as noted above, (iii) the difference in quanitifed benefits, from reducing non-elective admissions, between tabs 4 and 5 (and shown on Summary tab 2, cells D44 and E44) is due to the differences in activity levels, which are explained in part (i) above.	**No longer a risk - if the following action is put in place (enter action in box below)** (i) and (iii) The HWB to explain the difference between the activity changes (reductions in non-elective admissions) between tabs 4 and tabs 5, and add this explanation to Summary tab 2 of template 2 in cell G22. (ii) The HWB to clarify on the Benefit Plan (tab 4 of template 2) that the five BCF schemes which are not generating quantified benefits are enabling schemes for the two other BCF schemes, and designed to meet National Conditions.		First action - this will be covered in addressing the risk in row 7 above. Second action - all schemes to be included on tab 4 of template 2 and it to be made clear that these are enabler schemes designed to contribute both towards achieving the improvements in key metrics and the meeting of the National Conditions. Person responsible for ensuring this action is delivered - Edward	20/11/14	
28	Finance	Further Risks	**F10-Schemes are implemented but not monitored**	5 (e) For ALL benefits, does the plan indicate how the financial benefits will be monitored? No – In relation to all quantified benefits on the Benefits Plan (tab 4, template 2), the applicant states that they will be monitored "as part of overall performance management system". This statement requires further explanation; it is unclear what reporting will be used, to which forum, and the frequency of it, and so further details are required.	The HWB explained that monitoring will be undertaken as part of the overall programme management, with regular reporting to the Steering Committee. Details are already provided within template 1; the HWB confirmed it can add a cross-reference to the final column of the Benefits Plan (tab 4 of template 2) to highlight to readers that details of the monitoring of benefits is provided in the relevant section of template 1.	**No longer a risk - if the following action is put in place (enter action in box below)** The HWB to add a cross-reference to the final column of the Benefits Plan (tab 4 of template 2) to highlight to readers that details of the monitoring of benefits is provided in the relevant section of template 1.		This looks to be a very simple addition to tab 4 of template 2 ensuring that the cross-referencing back to the template 1 annexes is in place. Person responsible for ensuring this action is delivered - Edward	Complete	

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Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**West Berkshire Council**
Clinical Commissioning Groups	**Newbury and District CCG** **North West Reading CCG**
Boundary Differences	West Berkshire Health & Wellbeing Board has membership of two Clinical Commissioning Groups – Newbury & District CCG and North West Reading CCG. North West Reading CCG has 3 GP practices within the boundaries of West Berkshire Council. Newbury & District CCG and North West Reading CCG are both represented at the HWB, have contributed to the pooled funding and are aligned on the West Berkshire schemes. A number of the schemes proposed for West Berkshire will also operate across neighbouring authorities, making best use of provider services which operate across

	local authority boundaries. Details of relevant schemes, and their cross authority impact and management, are found within the main body of this submission.
Date agreed at Health and Well-Being Board:	**27/03/2014**
Date submitted:	**Revised 09/07/2014**
	Revised 27/11/2014
Minimum required value of ITF pooled budget: 2014/15	**£417,000**
2015/16	**£9,533,000**
Total agreed value of pooled budget: 2014/15	**£417,000**
2015/16	**£9,533,000**

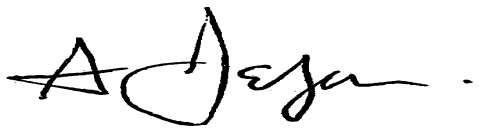
b) Authorisation and signoff

West Berkshire's initial Better Care Fund submission was approved by the West Berkshire Health & Wellbeing Board on 27thMarch 2014. Updated submissions were subsequently approved by the Health & Wellbeing Board on 9th July 2014. This latest revision has been approved, **subject to the caveat below**, by an extraordinary Health & Wellbeing Board of 18th September 2014.

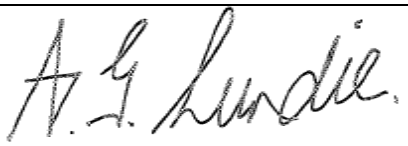
Health and Wellbeing Board resolved
To approve the Better Care Fund Plan subject to clarification that an adequate level of funding will be provided to meet the cost to West Berkshire District Council of moving to the new national minimum eligibility criteria being received from the Department of Health by 31ST October 2014 and if a positive response is not received to address this issue then the Health and Wellbeing Board reserves its right to withdraw the Plan.

All of the organisations represented at Health and Wellbeing Board are fully committed to working together in order to achieve a satisfactory outcome that protects the wider health and social care economy of West Berkshire

The Chief Executives of West Berkshire District Council and Wokingham Borough Council will be writing to the Department of Health, Local Government Association and the local Members of Parliament seeking support but also drawing their attention to the flawed methodology of the allocation of the funding to meet the costs identified in the Department of Health's Impact Assessment signed by the responsible Minister on 23rd May 2014.

Signed on behalf of the Clinical Commissioning Group	 Newbury & District CCG
By	Dr A Irfan
Position	Chair & Clinical Lead
Date	3rd April 2014 (Revised 09/07/14) Attended special HWB 18/09/14

Signed on behalf of the Clinical Commissioning Group	 North West Reading CCG
By	Dr R Smith
Position	Chair & Clinical Lead
Date	3rd April 2014 (Revised 09/07/14) Attended special HWB 18/09/14

Signed on behalf of the Council	 West Berkshire District Council
By	Gordon Lundie
Position	Leader of the Council
Date	3rd April 2014 (Revised 09/07/14) Attended special HWB 18/09/14

Signed on behalf of the Health and Wellbeing Board	 West Berkshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Marcus Franks
Date	3rd April 2014 (Revised 09/07/14) Chaired special HWB 18/09/14

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Berkshire West CCG's 5 Year Strategic Plan	This is the five year Strategic plan for the four Berkshire West CCGs (unit of planning) for 2014-2019. Document attached.
Communication and Engagement	This working document provides the principals that

Document or information title	Synopsis and links
Plan	we will use for Communication and Engagement. Document attached.
Newbury & District CCG 2 Year Operational Plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvements in health services for 2014 – 2016. Document attached.
North & West Reading CCG 2 Year Operational Plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvements in health services for 2014 – 2016. Document attached.
West Berkshire Council Strategy 2014-18	Describes the local authorities overarching vision, purpose and priorities for the next 4 years
Joint Strategic Needs Assessment (JSNA)	Describes and profiles the demographic needs of the West Berkshire population, and informs NDCCG commissioning activity. Link http://www.westberks.gov.uk/index.aspx?articleid=25800
Berkshire West Pioneer Application	Berkshire West 10 application to become an integration pioneer Document attached
Health and Wellbeing Strategy	Integrated Health and Wellbeing Strategy for West Berkshire Document attached
Newbury & District CCG 'Call to Action' Report	Agreement on the consequential impact of changes in the acute sector Document attached
Adult Social Care User Experience Survey 2013	A report that summaries the results of the annual survey of users of adult social care services in West Berkshire. Document attached

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our Vision – To Add Life to Years and Years to Life for all our residents

Our vision for better care is based on improving outcomes for individuals through the delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with (rather than to) service users/patients and therefore meaningful engagement is a key part of how we will implement change.

Introduction to West Berkshire

West Berkshire has a population of around 156,000 people. It makes up over half of the geographical area of the county of Berkshire - covering an area of 272 square miles. Largely rural, it has the most dispersed population in the South East with 253 people per hectare.

70% of people (around 108,000) live in settlements along the Kennet Valley and in the suburban areas immediately to the west of Reading borough. The largest urban area in the district is Newbury / Thatcham, where around 67,000 (44%) of West Berkshire residents live. 16% of residents live in the suburban area adjoining Reading borough.

Our Joint Strategic Needs Assessment indicates that the overall level of health of the local population is good in comparison to the national average. However we do experience the impact of socio-economic factors on the inequality in health with areas of greater deprivation having a lower life expectancy and higher mortality rate than the local authority average.

This highlights that the biggest challenge to West Berkshire is the increasingly ageing population. It is projected that the number of older people with complex physical and mental health problems (for example dementia) and increased social care requirements will increase, along with the number of ageing carers and the societal costs of supporting them. Therefore, primary prevention to help older people maintain positive social engagement, good physical health and mental wellbeing is crucial. Our current system is already under pressure with a number of challenges including:

- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking
- Increasing demand for planned (elective) care
- Inequality of access to services across the “whole system :the whole week”
- Care Workforce Availability
- Care Act 2014 – new national eligibility criteria for social care

The current patient/service user experience is poor because our local system is

fragmented with different access points, working hours, eligibility and assessment arrangements. This creates multiple hand-offs, with patients/service users passing on to different waiting lists and having to repeat their 'story' each time. This not only leads to a frustrating experience for people trying to get a service when they are at their most vulnerable, but a delay in getting the help they need when they need it very often results in a requirement for a more intensive service, as needs have increased in the intervening period.

The geography of the district brings additional challenges. For service users/patients living in rural areas services cost more and are less resilient because of the travel time. Concerns about reliability reduce confidence and, therefore, choice for service users/patients about where their care is delivered. This in turn increases demand for more institutional forms of care and places further financial pressure on an already challenged economy.

We recognise that the challenges facing the local health and social care system are significant. Demand for services is forecast to increase and this is not sustainable in the current systems. Funding pressures are set to continue and it is clear that without wide scale transformation we will not be able to meet future needs.

We see the Better Care Fund as an opportunity to stimulate the integration of Health and Social Care Services both within West Berkshire and across West of Berkshire and have created a range of projects to help us deliver this.

By 2019 we expect to see:

- Person centred services that focus on outcomes rather than outputs
- Provision of good quality information and advice that empowers people to make good choices and self-manage
- Care closer to home as the first option
- Flexible services that operate across 7 days where appropriate.
- Services will be simpler to access, have less duplication and reach service users/patients earlier.
- Delivery of health and social services to be localised wherever possible including access to crisis,
- A&E and other services that meet local residents' needs – with appropriate specialist or wider access to regional services that improve outcomes on a sustainable basis.
- A greater range of local services that promote independent living
- Reduction in avoidable hospital admissions.
- Lengths of stay in Hospitals will be kept to a minimum
- Increased numbers taking up Health and social care personal budgets

Patient/service user confidence will increase as the system becomes more cohesive. Their experience will improve because access to our services is simplified, they are proactively supported to get the help they need, and care wraps around their lives because services will be available more flexibly. Shared care plans will mean that information travels with them, reducing duplication and creating a more effective response. Our improved response to patient/service user needs will allow for a greater

focus on prevention and early intervention. Combined Health and Social care personal budgets will mean the patient/service user will drive their own solutions, focusing on the outcome rather than being constrained by a complex, task focused process.

Delivery of our vision will achieve system sustainability and therefore deliver value for money. We will do this by commissioning new models of care based on integrated Health and Social care pathways that focus on outcomes for users/patients.

In achieving transformational change we will draw on our patient's and population's views, and use robust health needs assessment in identifying our ongoing priorities. The commissioning and redesign of services will be informed by recognised best practice, and performance data analysis, in a context of an absolute requirement for improving health and social care outcomes and achieving system sustainability.

As a partnership we will jointly commission services unless there is evidence that it will not deliver the following:

- Enable us to respond to the needs of our local populations by targeting services to give the greatest impact on health and social care outcomes
- Address the views expressed by our local populations of how they wish services to be provided through partnership and co-production
- Avoid duplication and ensure value for money & efficiency
- Promote further health and social care integration where a case for change is made
- Where appropriate we will combine resources, sharing best practice and expertise

The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10, have developed a direction setting vision around integration which formed the basis for a Pioneer Bid in 2013. Despite being unsuccessful with this bid, the 10 partners are united in their ambition to undertake a methodical and systematic journey towards more integrated care for the people we serve. The integration programme presents an opportunity now underpinned by the Better Care Fund to test different models of integration across different settings and care groups.

Based on our earlier analysis (see Capita report and Berkshire West 10 Pioneer bid provided as "Related documentation) the first phase of our Integration Programme is focussed on the integration of services for older people, and the development of a frail elderly pathway will form the service user/patient centred backbone of system changes.

This pathway has been developed through a multi-agency project supported by the King's Fund and by an economic modelling element which was led by Finnamore. The outcome of this financial modelling has yet to be formally signed off however this is expected to be approved over the coming months.

The defined pathway aims to improve experience of patients and carers, make better use of existing resources and achieve significant cost savings across the system through

reduction of duplication in provision and workforce changes.

It is envisaged that the pathway will be accessed through a single hub for both social care and health, simplifying access to robust information and guidance that enables service users/ patients to understand the range of options available to them. Our services will have an enablement focus to enable people to self-manage where ever possible. Where care is required it will be delivered by care workers skilled in health and social care tasks to enable consistency, it will be supported by identified care co-ordinators and multidisciplinary teams structured around localities: the overall aim being to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health. Crisis support will be streamlined with care being provided in the most appropriate setting according to service user/patient and carer need. When hospital admission is unavoidable, the stay will be of high quality with discharge supported by a personal recovery guide ensuring people don't get lost in the system and are able to be get back to a more settled environment promptly. Support will be enhanced to enable people living in residential and nursing homes to receive their care and treatment there, and end of life care improved so that people are not admitted to hospital unnecessarily. In bringing key elements of the frail elderly (older peoples) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

We also recognise that people need to access health and social care services flexibly. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Admission rates may also be affected by GP practices being closed over the weekend period. Where admissions occur there is a need to ensure that care and support is available so patients can be discharged from hospital when they are clinically fit. We are therefore looking to ensure that a range of health and social care services is available seven days a week.

Primary Care will play a pivotal role in delivering our vision to meet people's needs in the community wherever possible and we will look to facilitate this through the development of primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care.

Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable clinician for patients who may be at risk of admission; co-ordinating care provided by a range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients As well as fulfilling this function within their practices, our GPs will increasingly play an active role alongside other professionals in multidisciplinary services locally.

b)What difference will this make to patient and service user outcomes?

Through our Better Care Fund schemes we aim to deliver the following improved outcomes;

- Less duplication between sectors, faster and more efficient joint assessments with lead professionals for those with long term conditions.

- Earlier diagnosis, treatment, and support that prevents crises or better enables responses to crises without admissions to hospitals or care homes.

- Improved access to information, advice, advocacy and community capacity to manage health and social care needs at low or nil cost to the user or carers. This will include online and flexible locally developed access.

- Improved choice and control through better access to a wider range of care and support in the local health and social care market especially for those with long term conditions. This will include the use of personal health and social care budgets to allow greater flexibility in how needs are met. We are committed to reducing the need for out of area placements enabling people to maintain family connections. Sometimes a local option is not available, where this occurs we will look at how we can support them to maintain family connections.

- “Hard to reach” groups with health and social care needs that then require higher levels of intervention will have better access to tailored information, advice, care and support which is person centred and aligned to cultural, faith, or other requirements. During the Newbury Call to Action event, our plans for integrating care were discussed and some of comments on what Newbury’s new integrated system will make to patients and service users are provided below:

Patients/service users want to be able to say:

- "There are no gaps in my care"
- "I am fully involved in the decisions and know what is in my care plan"
- "My Team always talk to each other to provide me with the best care"
- "I will always know who is in charge of my care and who to contact"
- "I won’t have to wait in all day for lots of different people to come at different times"
- "it is less time consuming if all services are together in one place"
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

By creating a cohesive system, with streamlined care pathways that allow a holistic and flexible response to need, and which don’t constrain, people will feel confident and better supported. The shared care plan will allow them to direct their support and enable a more effective response if an urgent need arises.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Over the next five years, the pattern and configuration of services will be changed in West Berkshire to better respond to local health and social care needs placing the patient/service user at the centre of care, empowering them to live well at home.

We will have simplified the access arrangements, implemented a shared care plan and agreed a consistent approach to assessments for Health and Social Care to minimise the number of contacts required to get a service. By ensuring an outcomes-focused approach, we will have a much better understanding of individual needs, including the wider determinants such as home circumstances, environment and the impact they have. This will allow us to address their well-being as well as physical needs.

To achieve this we will need to change services from being targeted on the basis of either a health or social care needs to one that encompasses all needs.. The Better Care Fund schemes will be critical to driving these changes.

Developing patient/service user centred care pathways across health and social Care

We will continue to create joint system-wide integrated pathways across key areas such as frail elderly, mental health and children's services that transcend organisational boundaries to deliver high quality, efficient care and support for patients/service users. We will go beyond traditional health and social care services to include wider determinants of physical and emotional wellbeing, linking with services such as housing, transport and leisure. We will engage with both voluntary sector and user-led organisations to build on existing good work in the community. The JSNA identifies that more people registered with a GP in West Berkshire are recorded as having depression than the national average. Depression and mental wellbeing are identified as key priorities in our Health and Wellbeing Strategy and therefore we aim to give mental health parity of esteem with physical health, commissioning high quality evidence based services which reflect the national mental health strategy and other key guidance.

In response to the high cost of care for older adults, and the growing numbers of older adults in West Berkshire, the frail elderly pathway has been developed to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health and are likely to need intensive social care support. As part of this, care will be delivered by care workers, supported by identified care co-ordinators .This pathway has been developed through a multi-agency project supported by the King's Fund and is supported by an economic modelling element led by Finnamore. The outcome of this financial modelling has yet to be formally signed off however this is expected to be approved over the coming months. In bringing key elements of the frail elderly (older people's) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

Changes to health and social care services over the next five years:

We will build capacity in the community across primary, community health and social services by working collaboratively and through integrated services to better meet the

needs of local residents. We will have a strong prevention focus working with patients/service users to avoid admissions to hospital or care homes.

Our joint provider project will allow us to expand the reablement capacity, embedding 7 day working across the system and linking it more closely to appropriate primary and community healthcare on a localised basis (via Locality Hubs).
As community capacity is increased overall including targeted in-reach to acute, realign acute sector capacity to achieve improved patient outcomes, greater efficiency and sustainable acute provider capacity on a reduced basis.

We will develop cross sector working that targets intervention and support to those most at risk of admissions, including enhancing clinical capacity in the community that also supports those admitted to acute hospitals to return home quickly.

We will maximise the capacity of local people to self-care through implementation of the Care Act enhancing provision of information, advice, advocacy and carer support. We will work proactively with people, co-producing solutions that are preventative, reduce dependency, the need for more intensive support and risk of hospital admission.

- Our workforce development strategy will allow us to understand more clearly the skills gap so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be supported by fewer people who get to know them better.

- A proactive approach to provide information, advice and guidance that enables people to understand what universal services are available. Our Personal Recovery Guide project will support people to navigate the health and social care system, ensuring they don't get lost and are able to make informed choices that support them to maintain their independence for longer.

- We will strengthen our community based asset approach, building on our 'doing with' rather than 'to' approach. We will seek to understand patient/service user needs and look at more flexible ways of supporting them that are person centred; outcome focused and continues to develop their re-ablement potential.

Modernising and Expanding the Model of Primary Care

New models and approaches to primary care are required to meet the workforce challenge and the new demands on the primary care sector in a transformed system. We will look to facilitate this through the development of primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care. The role of primary care will be increased, with GPs working in larger units that will strengthen integration with community and health and social care, building on the success of joint triage between GPs and the ambulance service.

Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable Clinician for patients who may be at risk of admission; co-ordinating care provided by a

range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients. As well as fulfilling this function within their practices, our GPs will increasingly play an active role alongside other professionals in multidisciplinary services locally.
The Better Care Fund will provide us with a robust platform to take this work forward. The projects set out in our programme are key to promoting new ways of working; without it we would not have the traction required to be able to deliver the projects either in West Berkshire or across the West of Berkshire. Residents would not benefit from the more resilient system that removes the postcode lottery.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Our vision for better care is based on improving outcomes for individuals through the delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with (rather than to) service users/patients and therefore meaningful engagement is a key part of how we will implement change.

The following table provides a very high level of overview of how the vision links to our planned BCF schemes.

Vision for Health & Social Care in West Berkshire	**BCF Supporting Scheme**
Person centred services that focus on outcomes rather than outputs	Joint Care Provider (BCF04) Patients Personal recovery guide/keyworker (BCF03) 7 Day week Service BCF05
Provision of good quality information and advice that empowers people to make good choices and self-manage	Patient's Personal Recovery guide/keyworker (BCF03) Access to Health and Social Care Services through a single hub (BCF02)
Flexible services that operate across 7 days where appropriate	7 Day Week Service (BCF05) Joint Care Provider (BCF03)
Services will be simpler to access, have	Access to Health and Social Care Services through

less duplication and reach service users/patients earlier	a single hub (BCF02) Joint Care Provider (BCF04) 7 Day Week Service (BCF05)
Delivery of health and social care services to be localised wherever possible including access to crisis	Joint Care Provider (BCF03)
A&E and other services that meet local resident's needs – with appropriate specialist or wider access to regional services that improves outcomes on a sustainable basis	7 Day Week Service (BCF05)
A greater range of local services that promote independent living	Patients Personal Recovery guide/keyworker (BCF03)
Reduction in avoidable hospital admissions	Enhanced Care & Nursing Home Support (BCF07) 7 Day Week Services (BCF05)
Lengths of stay in hospital will be kept to a minimum	Patients Personal Recovery guide/keyworker (BCF03) Joint Care Provider (BCF03)
Increased numbers taking up Health and Social care personal budgets	Access to Health and Social Care Services through a single hub (BCF02)

In West Berkshire we share with our Berkshire West 10 colleagues an understanding that integrated care delivers the best outcomes for our patients and service users. We believe(supported by evidence) that working in partnership, is the most effective way for us to ensure that we are providing person centred, personalised, co-ordinated care in the most appropriate setting. As a partnership of ten organisations, with a full range of services across the health and social care sector, we can deliver end to end integrated care for our population, radically reducing the number of assessments and transactions individuals are subjected to and improving their experience of care.

There is a significant financial challenge facing West Berkshire over the next two years as we cope with increasing demand for high quality services while contending with a constrained and challenging financial position in the local health and social care economy.

There are 9 key areas, which collectively, provide sufficient evidence of growing demand pressures in West Berkshire's Health and social care economy. These areas are:

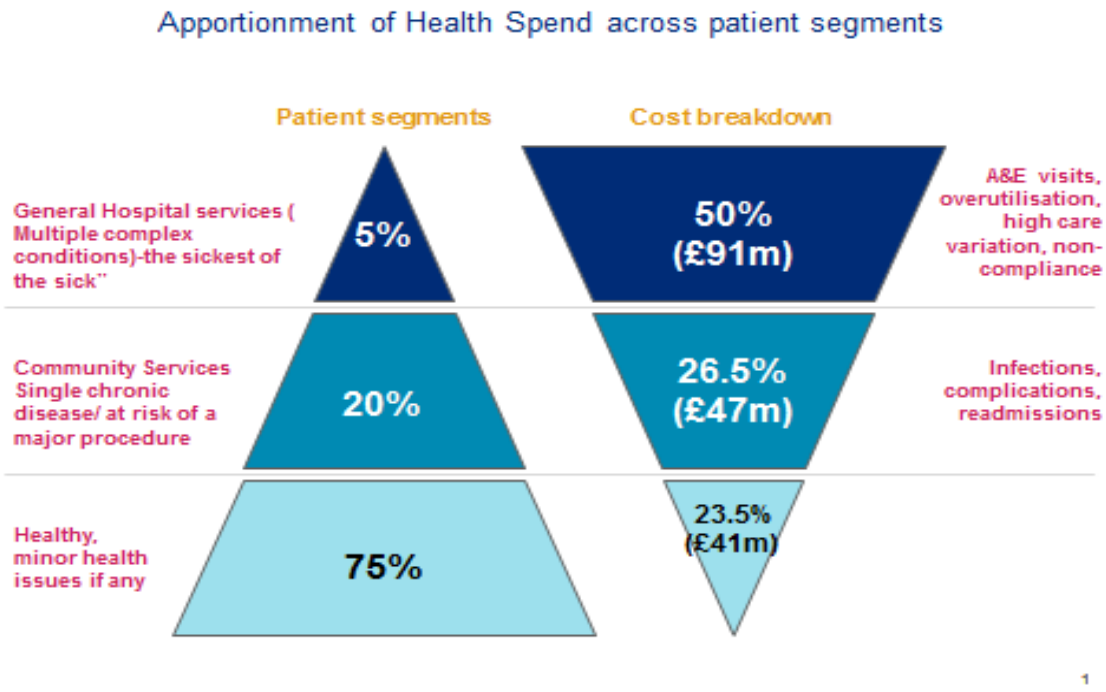
- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking
- Increasing demand for planned (elective) care
- Inequality of access to services across the "whole system :the whole week"
- Workforce Availability
- Care Act 2014 – new national eligibility criteria for social care

These pressures are likely to present the biggest challenges to affordability and sustainability over the next five years.

Our intention over the next five years is to transform the local health economy to support patients to manage their conditions at home, to keep well and remain out of hospital. As can be seen from the triangle of care needs below, small numbers of the population are associated with the highest cost and demand, whilst those lower down the triangle account for much lower cost impact per head of population.

We have a strong foundation in our shared vision and our track record, but we know that we need to increase momentum to tackle the system pressures and demographic challenges described above.

We simply do not have the resources to meet the expected increases in demand over the next few years if we continue to provide services in the same ways as we do now. Unless we find better ways of supporting people who are frail or living with long term health conditions, costs will increase exponentially. This will include the cost of care home placements, A&E attendances, and emergency admissions to hospital, readmissions, and ambulance conveyance costs. Co-ordinated community based care is what people are asking for and what we know works. Indeed it is the only way to build a sustainable future.



Consequently our approach has been to identify the key challenges to the economy within the various segments of the diagram above. Combining best practice examples, a sound evidence base, alongside local knowledge, analytics and intelligence, we have been able to identify potential new models that will meet the needs of our population and address the key challenges we face over the coming years. Using a variety of risk stratification tools and methodologies, we have identified the cohorts of individuals that are most likely to benefit and the models of care most suited to meet the challenge in the most effective way. The key target populations are generally older adults and people with long term conditions.

Risk Stratification Methodology:

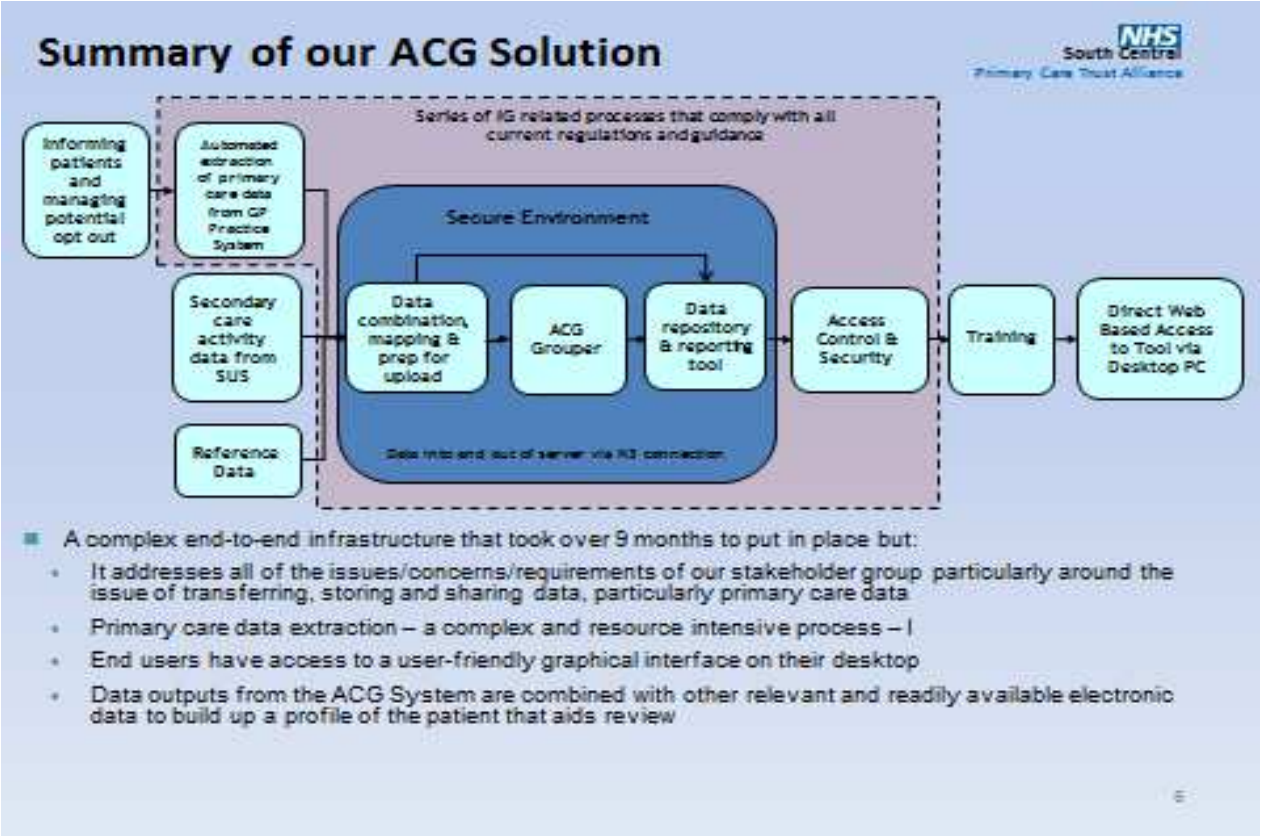
Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. A one size fits all approach is inadequate and different sets of people have different needs. Grouping has helped us create models that are based on similar, holistic, individually-focused needs, and will also help us think about the health- and social-care system in a more holistic way.

By making these groupings explicit, we are able to provide a more logical way of informing the new models of care that are likely to be needed, identifying the outcomes we plan to achieve and by which we will measure our success, as well as allowing us to create payment models to incentivise providers to achieve these outcomes.

Risk Stratifying our High Risk of an Emergency Admission Population

In 2009, nine of the then PCTs in South Central decided to collaboratively procure a risk stratification tool which would support case finding for community health staff as well as supporting other programmes for patients with long term conditions. The Adjusted Clinical Groups (ACG) tool was implemented into all 54 GP practices within the Berkshire West

PCT, including the 14 GP practices in North and West (3) and South Reading (11) CCGs. This tool has allowed us, in collaboration with our Berkshire Community Health Service, to have a richer source of information about the health needs of the local practice population and to be able to support a reduction in emergency admissions.



The Case for Change

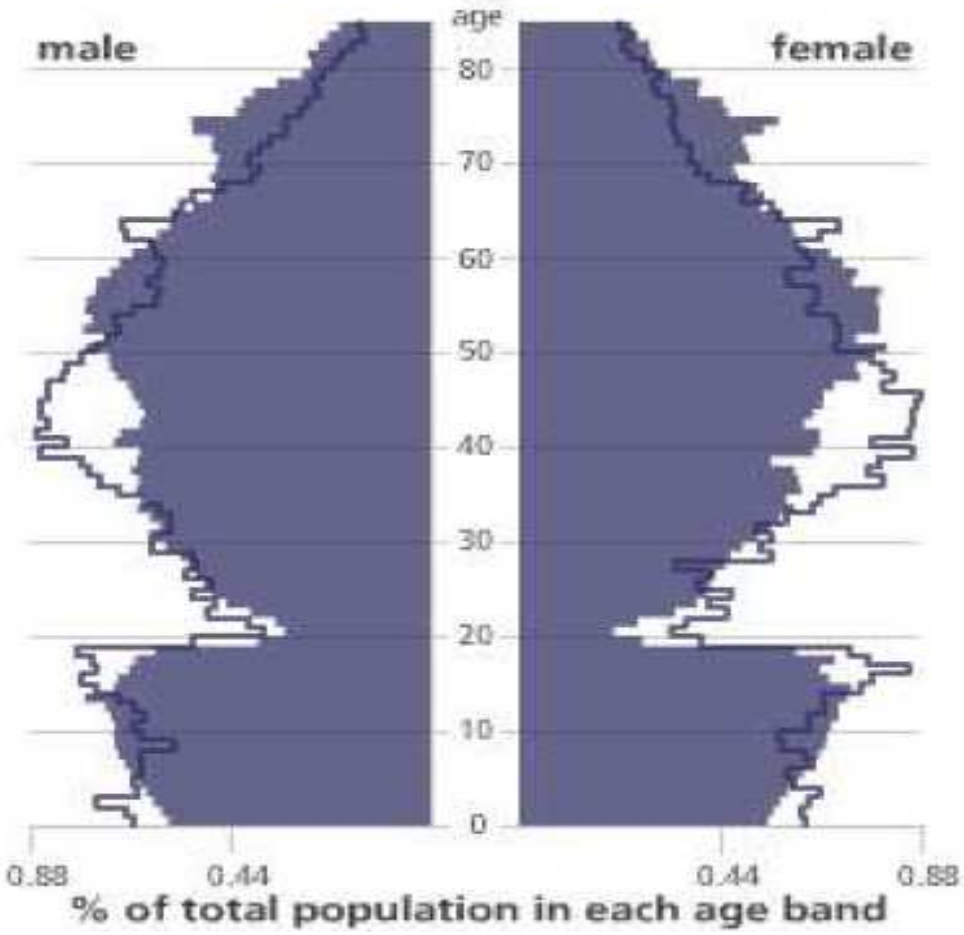
Challenge 1: Increasing Demand

A growing population particularly in those over the age of 65, with disproportionately high health and social care needs leading to a growth in health and social care requirements across the Berkshire West economy

The latest (2011) population *projections* by the Office for National Statistics, in predicting population growth across the country, estimate the population of West Berkshire to be 170,100 by 2021 – an increase of some 10%. This compares with an average increase in population across the South East of 9.3%.

Changes in population will not be universal across the age bands. Most graphically, the population pyramid below shows how the age profile of West Berkshire is expected to change over the next decade. The solid outline shows West Berkshire's population profile in 2011, whilst the shaded area represents the district's new population profile in 2021.

Projected population age profile for West Berkshire, 2011-2021.



Source: ONS, Interim 2011 sub-national population projections

Noticeable, is that, almost without exception, the reduction in the relative size of age groups under the age of 65. The district's 'waist band' remains reflecting a significant number of people leaving the district at around 20 years of age, but then returning over the proceeding two decades.

If the pyramid above shows how the relative size of age bands will change in relation to one another over the next decade, the table below describes this in absolute terms.

This estimates the number of 0-9 year olds living in West Berkshire to have grown by 3,300 by 2021 (or 17%). This compares to a similar expected growth across the South East of around 15%. The numbers of 10-19 year olds is anticipated to have increased by around 1,500 (or 8%), which is in line with the projected growth rate for the district as a whole.

At the other end of the age spectrum, the figures show an anticipated growth in the over 65 population of 34% (or 8,000 people) compared to 26% regionally. Breaking this down, the most significant growth is in the oldest age groups (75+).

Projected change in population 2011-21 – by age						
	West Berkshire			Berkshire	South East	England
	Pop'n 2021	Change in pop'n (nos)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)
0-4	10,516	418	4%	5%	6%	9%
5-9	11,961	2,911	32%	27%	24%	23%
0-9	22,477	3,329	17%	15%	15%	16%
10-14	11,797	1,851	19%	19%	11%	9%
15-19	9,509	-304	-3%	1%	-6%	-8%
0-19	43,783	4,876	13%	13%	8%	8%
20-24	6,221	-1,060	-15%	0%	-4%	-4%
25-29	8,499	114	1%	6%	7%	9%
30-34	10,267	941	10%	7%	11%	16%
20-34	24,986	-6	0%	4%	5%	7%
35-39	11,314	342	3%	6%	5%	9%
40-44	11,613	-959	-8%	0%	-8%	-8%
45-49	11,688	-782	-6%	-2%	-9%	-10%
50-54	12,505	1,460	13%	15%	13%	11%
55-59	12,070	2,547	27%	29%	30%	26%
60-64	10,201	417	4%	8%	3%	2%
35-64	69,390	3,024	5%	8%	4%	4%
65-69	8,401	833	11%	12%	7%	7%
70-74	8,497	2,992	54%	41%	43%	37%
75-79	6,386	2,009	46%	29%	32%	26%
80-84	4,258	955	29%	24%	19%	18%
85-89	2,757	662	32%	36%	28%	26%
90+	1,664	629	61%	75%	63%	62%
65+	31,963	8,080	34%	29%	26%	24%
85+	4,421	1,291	41%	50%	40%	39%
All	**170,123**	**15,975**	**10%**	**11%**	**9%**	**9%**

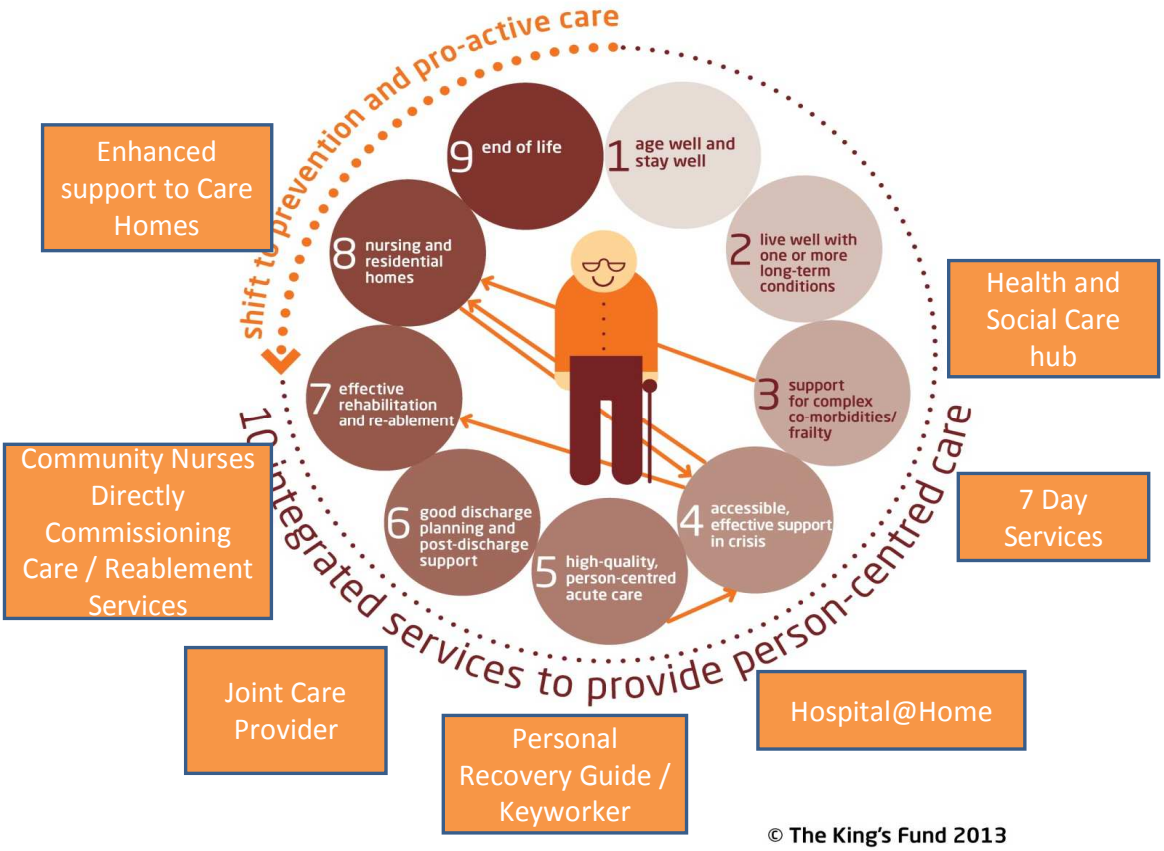
Source: ONS, Interim 2011 sub-national population projections

As the graph and table above indicates, it is predicted that the number of over 65s will increase 24% by 2021 and those over 85 years of age by 39%. The impact of this demographic change on the health and social care systems will be vast – 30% of the population in West Berkshire will be living with a long term condition and we expect there to be a large rise in the numbers of older people living with more than one long term condition, e.g. Cardiovascular disease, Dementia, Respiratory Disease, Liver disorders and Diabetes. West Berkshire has a significant number of older people living alone and consequently at risk of social isolation with the negative impacts on physical and emotional wellbeing which this brings; integrating across the whole health and social care system

becomes an imperative. These increases are likely to present the biggest challenge to affordability and sustainability over the next five years.

We know that the Health and Social care requirements of the elderly population over the age of 65 population are set to grow significantly over the next seven years and that will place huge financial pressure on the health and social care system within West Berkshire.

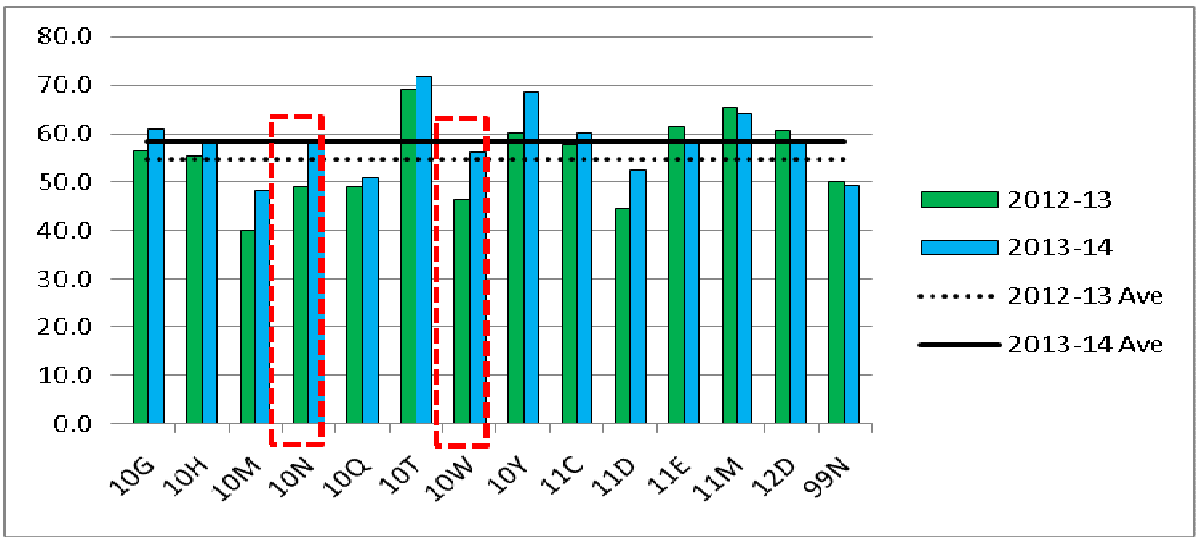
The solution: Extensive work is already underway in the frail elderly pathway, which was Identified as a key Integration work stream in our Pioneer bid last year. This Berkshire West wide work stream forms the backbone of system change and our local West Berkshire BCF schemes will be critical to delivering a number of elements of this as outlined in the orange boxes below:



Challenge 2: Growth in Non-Elective Admissions

Non-elective admissions are rising in West Berkshire, and future projections suggest that due to the increased age profile and expected double digit increase in certain long term conditions, this trend will continue unless there is system wide change. The graph below illustrates this trend across the whole of our South central CSU geography,

Graph: A & E attendance rates resulting a Non Elective Admission 2012/13 compared with 2013/14



Analysis of these figures reveals two specific problematic areas which have the potential to be amenable to change:

1. Non elective admissions with a medical event where patients are clinically stable and do not require diagnostic input such as acute infections, deteriorating long term conditions, unstable COPD, dehydration.

   Over 2012/13 there were 10,116* emergency admissions to hospital each year for Berkshire West residents with at least one long term condition, of which 4,590 were relevant to the patient type that with intensive support for a defined period of time, would be possible to manage in the community.

**Note that these figures are for total Berkshire West not just Newbury & District CCG*

2. Patients whose place of residence is a care home.

   Within Berkshire West there were a total of 2770 people residing in care homes (residential and nursing care) who were associated with the following activity during 2013-14 and for the first quarter of 2014-15.

	Places	1 Calls		2 Conveyance		3 A&E		4 Admissions	
		2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Grand Total	2770	898	545	238	303	1326	354	961	260

In West Berkshire, during 2013/14 there were 201 Non elective admissions from Care Homes costing £640k. This therefore offers us a considerable level of opportunity to impact on this specific cohort of our population.

The Solution:

The outcomes for both of these cohorts can be dramatically improved by integrated care, and as such we have allocated two of our Better Care Fund schemes to address these issues.

The first scheme, Hospital at Home (BCF06) will provide an alternative to an Acute admission, for a sizeable patient cohort. This service will keep the patient in the community, and provide Acute-level treatment from a multidisciplinary team including nursing, social care and linking in with specialist nurses and therapists, to provide a patient-centric model of delivery, rather than the traditional disease specific organisation of care, to patients who are clinically stable. By identifying the right patient cohort, it is estimated that this service will reduce non-elective admissions significantly (84% reduction for the patient cohort).

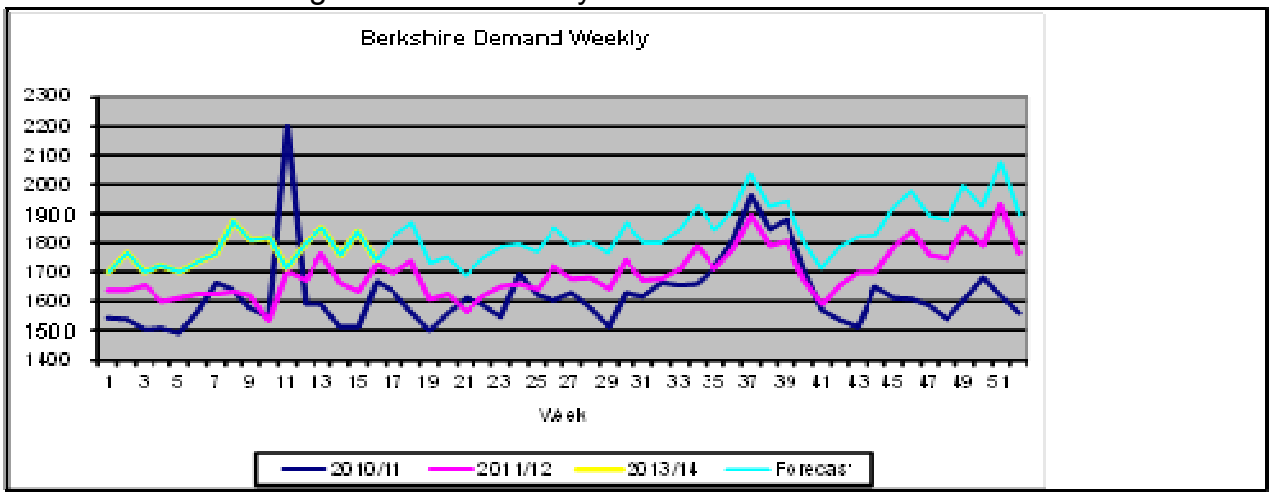
The second scheme is in response to the pressure on the acute sector coming from care homes. The enhanced support to care homes scheme (BCF07) provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents. We aim to reduce Care Home resident non-elective admissions in West Berkshire by 40% in 2014/15.

As a result of these schemes, non-elective admissions will reduce by 1.1% in 2015/16vs. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that Newbury and District CCG is already in the top performers for non- elective admissions in the South of England.

The Health & Wellbeing Board has forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, this results in an expected net reduction of 1.1% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

Challenge 3: Increasing A&E Attendances and Pressure on Urgent Care Capacity

A&E is under increasing pressure in West Berkshire, as the chart below shows, with attendances increasing for the last three years.



Between April–July 2013 and the same time period in 2014 West Berkshire has seen an increase in A&E attendance of 5.3%. In North & West Reading A&E increases are associated with a much older age group in line with their demography. This pattern is also seen across the other CCGs within Berkshire West.

The Solution:

In addition to a review that was undertaken in January to assess the causes of A&E breaches, a number of Better Care Fund schemes will also seek to target key populations at high risk of A&E attendance to reduce the pressure on urgent care.

The first cohorts of patients are those with long term conditions and frail elderly patients. Both of these cohorts will benefit from the increased provision of care in the community, via the Hospital at Home scheme, the extended availability throughout the week for this care via the 7 day working schemes and the changing eligibility threshold for social care in West Berkshire.

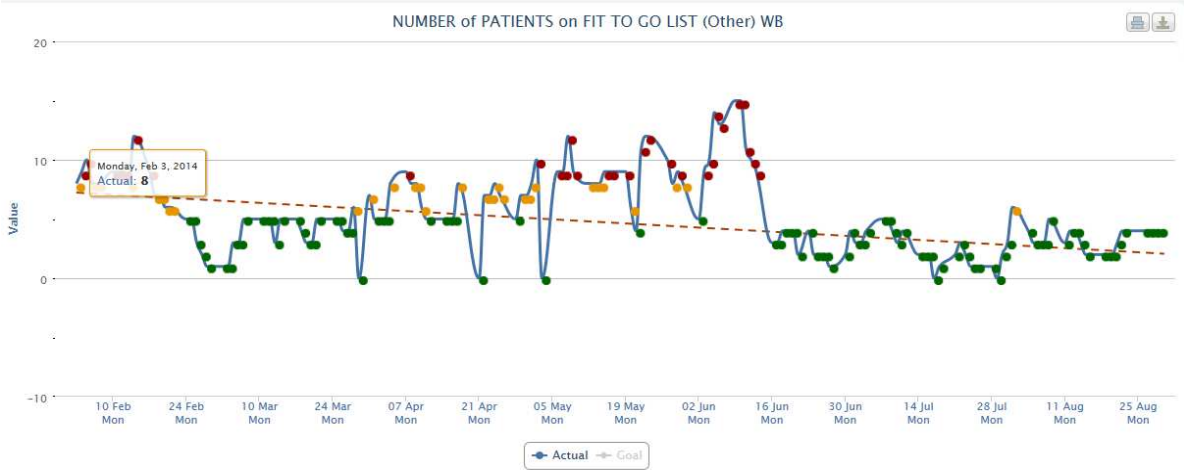
The third group is care home residents, of which 48% across Berkshire West had an attendance at A&E in the last year. The Care Home project will address the training of care home staff, and the maintenance of relevant, up to date care plans and reviews to keep care home patients out of A&E.

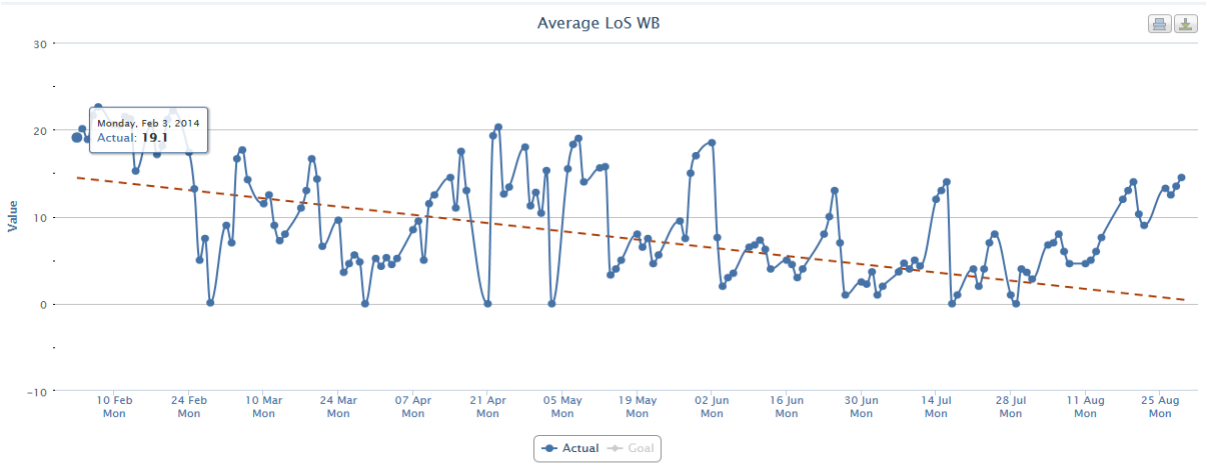
Patient cohort at high risk of A&E attendance	**BCF scheme to support**
Patients with LTCs and frail elderly patients susceptible to dehydration etc.	Hospital at Home 7 day access to GP care Joint Provider Service
Patients residing in Care Homes	Enhanced service for Care Homes

Challenge Statement 4: Rising Delayed Transfers of Care and Subsequent Bed Days Lost

An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs. the average patient.

The following graphs show the number of patients and duration of time on the “Fit To Go” List (Feb to Aug 2014). Despite a significant amount of resource being focussed on this area we still experience widely fluctuating figures. Whilst we have had some success in bringing down the number of patients, the average length of time that patients remain on the “Fit to Go” List has remained above the system wide target of five days agreed as part of the A&E Recovery Plan and is currently above 9 days. This in turn contributes to the impeded flow through the inpatient beds.





Solution:
There are a number of factors that we have identified where integrated care can help reduce delayed transfers of care, and as result we have developed our BCF schemes accordingly.

1. The number of patient discharges on an average weekend day is less than half the number of patients who are discharged on an average weekday. A key reason for this is access to health and social care in the community over the weekend. In response we will use our 7 Day Services Scheme (BCF05) to enhance the existing 7 day arrangements across both health and social care. Our Health and Social Care Hub Scheme (BCF 02) will enable us to take referrals and direct services seven days of the week, facilitating discharge over the weekend.

2. Another key reason for delayed transfers of care is the cohort of patients who are waiting for social care packages, who often have to wait for their care, despite being fit to be discharged. Our Joint Care Provider Scheme (BCF04) will reduce these delays by the using the benefits of a single service, operating with a pooled budget, to provide an appropriate onward destination for this cohort of patients, with a focus on maximising their independence.

Challenge Statement 5: Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking.

Like every other local authority in the country, West Berkshire faces challenges in delivering its priorities against national government settlements. Through its Corporate Plan, the local authority has affirmed its commitment to caring for and protecting the vulnerable in its community However, there is an explicit acknowledgement of the need to work differently to avoid the consequences of a widening funding gap over the next 3 years.

The key areas of demand for adult social care in West Berkshire are amongst those over 75 and those with dementia, both of whom have a longer than average lengthof stay due to waiting for community based services.

As described above, the number of patients on the "fit to go" list continues to increase due to the increasing demand for nursing care, residential care and communityreablement, and the lack of supply. This lack of supply is felt most acutely in the rural areas of West Berkshire where the distances involved in getting to and from client's in the very sparsely populated communities is prohibitive for providers.

The Solution:

The Better Care Fund spending plans for 2015/16 include a significant sum to protect social care services, particularly the universal preventative services that have been established. The Personal Recovery Guide / Keyworker scheme (BCF03) will initially focus on helping move patients through the care pathway with one of the aims being to facilitate their prompt discharge from hospital. We understand that most people will not have had the need to access care services prior to a hospital admission and will be faced with the need to make life changing decisions. This scheme will prevent them from getting lost in the system and connect them to good quality information about what services are available and what the impact of their choices will be. As the scheme develops we will seek to expand the focus to support people to access community based services, both universal and commissioned, and link into some of the Public Health funded initiatives including the 'Village Agent' scheme. Most people want to stay in their communities and this scheme will be developed to support them to do that.

Challenge Statement 6 Increased Demand for Planned Care Services

Work is currently underway across our health economy to address these issues and this is outside the scope of the BCF. However it is very clear that without the BCF the local authority would be unable to meet the costs of a number of its existing services and its ability to meet its Care act duties would be further impaired.

The key existing services that would not be able to continue to be delivered in their current form without the BCF (existing S256 funding)in 2015/16 are as follows;

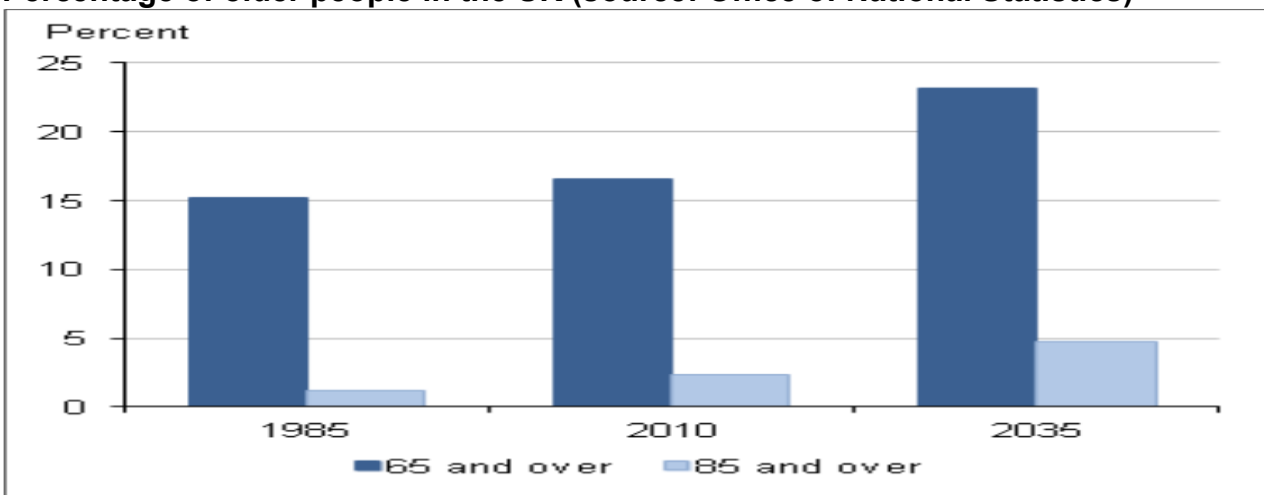
- Integrated Crisis and Rapid Response Service
- Reablement Services
- Support for Carers
- Early Supported Hospital Discharge Schemes

- A wide range of preventative services for all client groups commissioned from the voluntary sector

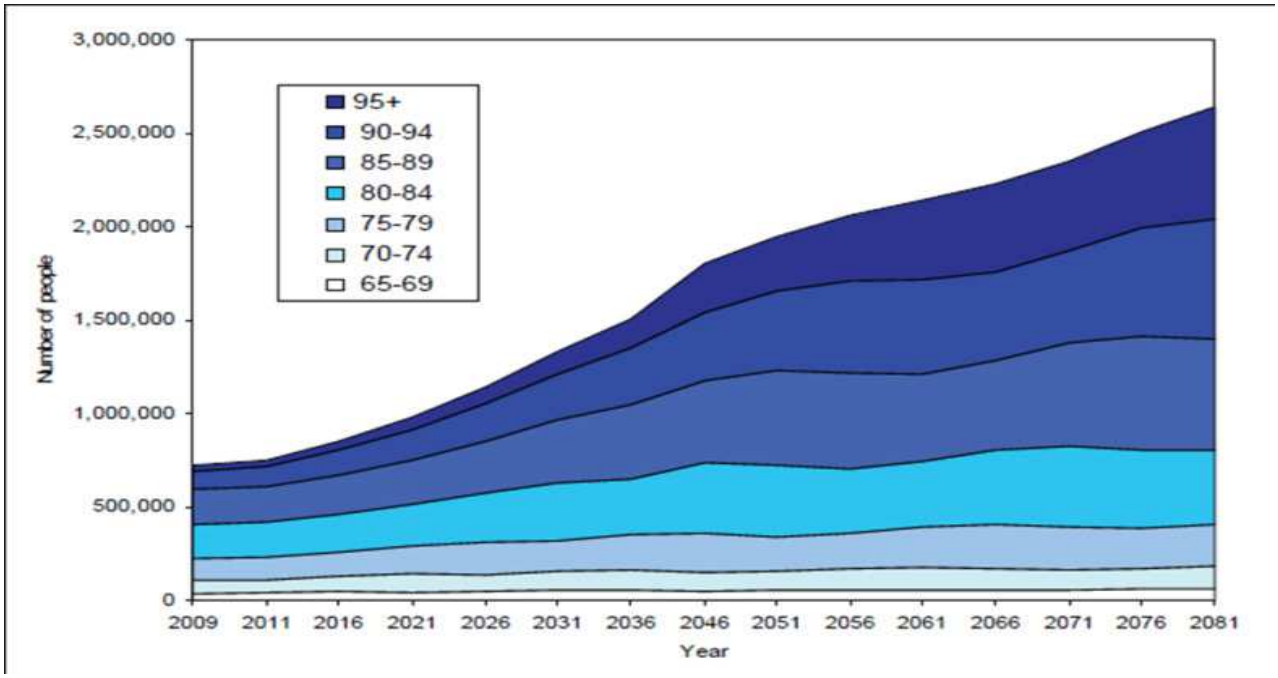
The funding being provided via the BCF will help the local authority meet its new duties to Carers and contribute to the significant cost of the introduction of the national minimum eligibility criteria that will see the local authority providing more social care support to more people.

Whilst the BCF is a positive development there remains significant risk to social care services due to the project growth in demand and the reducing level of overall funding. The following 2 tables provide an indication of the level of risk being faced.

Percentage of older people in the UK (source: Office of National Statistics)



Projected number of people with late onset dementia in UK (source: Dementia UK 2007)

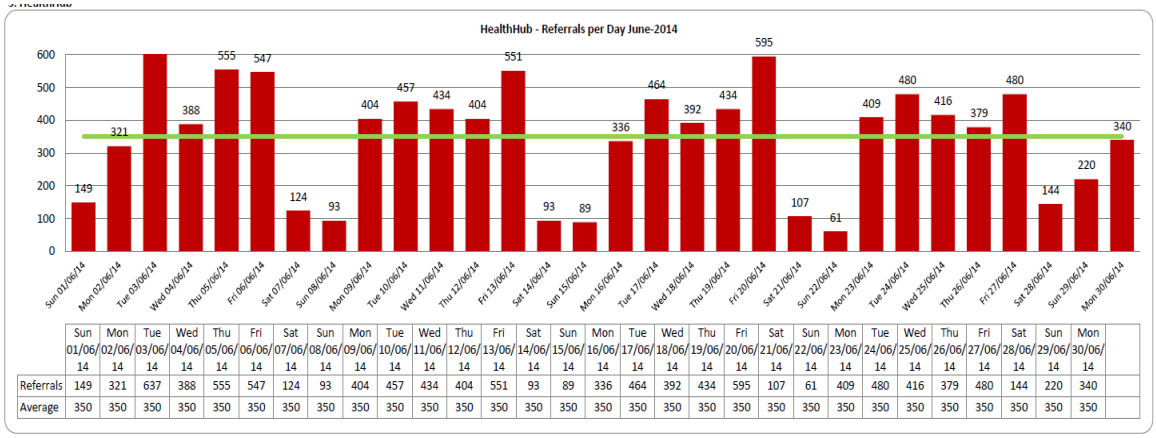


Challenge Statement 7: Inequity in Access to Services 7 Days a Week

It is widely accepted that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients in hospital, including raising the risk of mortality.

Local acute data from Royal Berkshire Foundation Trust shows that there are far fewer discharges at the weekend vs. during the week with less than half the weekday average number of discharges. This is due to system that does not operate flexibly across the seven days, our 7Day Week service will address deficits in cover from the acute services, primary care and community based social.

Since all requests for discharge support (health and social care) from our main acute provider (Royal Berkshire Foundation Trust) as well as requests for community support are processed through the current Health hub, the graphs below clearly demonstrate a marked reduction in referrals into the hub for these services at weekends which is likely to affect discharge rages and admission rates.



	Sun 01/06/14	Mon 02/06/14	Tue 03/06/14	Wed 04/06/14	Thu 05/06/14	Fri 06/06/14	Sat 07/06/14	Sun 08/06/14	Mon 09/06/14	Tue 10/06/14	Wed 11/06/14	Thu 12/06/14	Fri 13/06/14	Sat 14/06/14	Sun 15/06/14	Mon 16/06/14	Tue 17/06/14	Wed 18/06/14	Thu 19/06/14	Fri 20/06/14	Sat 21/06/14	Sun 22/06/14	Mon 23/06/14	Tue 24/06/14	Wed 25/06/14	Thu 26/06/14	Fri 27/06/14	Sat 28/06/14	Sun 29/06/14	Mon 30/06/14
Referrals	149	321	637	388	555	547	124	93	404	457	434	404	551	93	89	336	464	392	434	595	107	61	409	480	416	379	480	144	220	340
Average	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350

Solution:

In response to issues created by a lack of provision over the weekend, our 7 Day Scheme (BCF05) will seek to enhance the existing 7 day provision across both health and social care in a coordinated and affordable way. The Joint Care Provider Scheme (BCF04 and the Community Nurses Directly Commissioning Care / Reablement Services (BCF01) will also play a key role in improving and simplifying the 7 day arrangements. These plans will support all patient cohorts but the provision is expected to be particularly effective for patients with complex needs, those identified as part of the national service to avoid unplanned admissions including the over 75 year olds.

In addition the single point of access health and social care hub will operate seven days a week to act as a point of contact for patients, signposting them throughout the week to the most appropriate service.

Challenge Statement 8: Workforce Availability

A major challenge already facing West Berkshire is the lack of carers both those directly employed by the local authority and those employed by private sector providers. The shrinking working age population (see census data above) and high employment rates in

the area have resulted in a lack of people willing to enter into what are relative low paid carer jobs. This impacts on our ability to commission domiciliary care in particular where providers regularly turn down work due to their lack of staff.

Solution:

As one of the Better Care Fund Plan 'enablers', the Workforce Development project aims to help us understand more clearly where the gaps are so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be supported by fewer people who get to know them better.

Challenge Statement 9: Care Act 2014 – new national eligibility criteria for social care

West Berkshire District Council is one of just 3 local authorities in England currently operating an eligibility criteria for social care of 'critical only'. As a result it faces significant challenges in complying with the new national eligibility criteria that comes into force on the 1st April 2015. The change will result in more residents being eligible for social care support and an increased level of support for a large number of existing clients. The challenges will be finding sufficient workers to enable delivery of the additional care and meeting the cost of the change at a time when budgets are reducing.

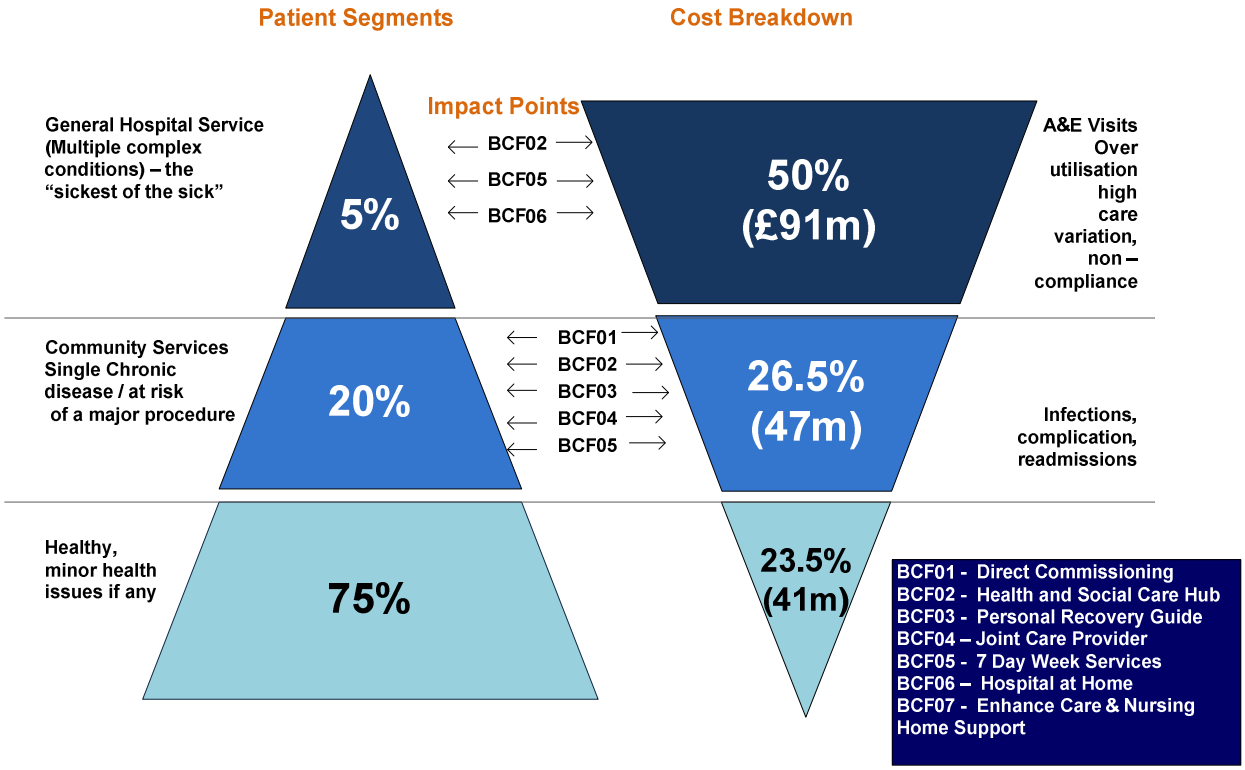
Solution:

Within the constraints of the money available, the BCF spending plans include a significant contribution toward the Care Act costs, recognising that no specific allocation was made into the fund by the Department of Health to recognise the 'critical only' issue. As already mentioned it is hoped that the Workforce Development enabler will contribute towards addressing the workforce issues in West Berkshire.

Delivering Change via the BCF

We have built our Better Care Fund submission around the key challenges in West Berkshire with a focus on those areas where we feel care can most be improved by integration, based on our experiences in West Berkshire and the evidence base. The diagram below shows on a high level how our BCF schemes will cater to the population across Reading, with a strong focus on the most costly patients.

Apportionment of Health Spend Across Patient Segments



The table below summarises at a high level how the schemes will address a number of the key challenges in the Reading health and social care economy. More detail on these schemes can be found in Annex 1.

Pressures vs Schemes table

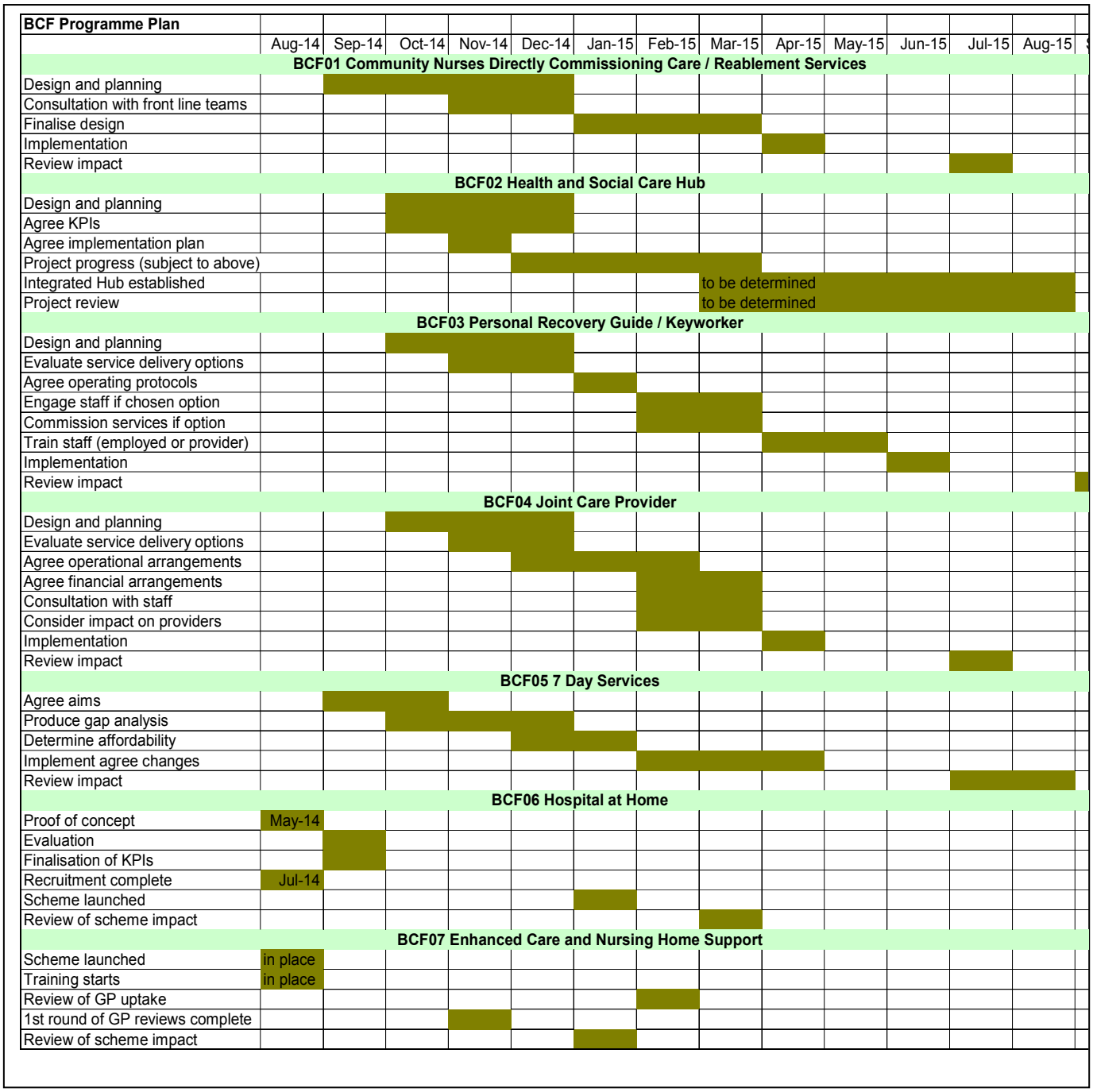
Key: Direct Impact / Indirect Impact	BCF01 - Direct Commissioning	BCF02 Health and Social Care Hub	BCF03 - Personal Recovery Guide	BCF04 – Joint Care Provider	BCF05 - 7 Day Week Services	BCF06 – Hospital at Home	BCF07 - Enhance Care & Nursing Home Support
Growing Population	Direct	Direct	Indirect	Direct	Indirect	Direct	Direct
Rise in non elective care	Direct	Direct					
Increasing A&E attendance		Direct				Direct	Direct
Delayed transfers of care				Direct		Direct	Direct
Increasing pressure on social care			Indirect	Direct	Indirect		
Inequity of access throughout the week	Direct	Direct				Direct	Direct

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Milestones

The programme plan below illustrates the high level key milestones by scheme for the delivery of the Better Care Fund plan. The key milestones for each scheme are laid out in the relevant project briefs and project initiation documents. Under the governance arrangements (see section 4c) these milestones are approved and progress monitored by the Integrated Care Steering Group, West Berkshire Partnership Board and the Health and Wellbeing Board.



Interdependencies:

Within our Better Care Fund plan, there are a number of schemes that are enablers of some of the key improvements in non-elective admission, reducing delayed transfers ofcare and improving patient experience.

Connecting Care is the name of the enabler project which will deliver the interoperability between various health and social care providers. The project is being run on a West of Berkshire basis with all 3 local authorities committed to delivering the agreed outcomes. This enabling project will be critical to the efficiency and smooth running of the Hospital at Home (BCF06)and Health and Social Care Hub (BCF02) Schemes. Service delivery will run more efficiently, and decisions will be able to be made quicker as a result of a more complete set of information in real time. In the Hospital at Home pilot, we found that the lack of data sharing, (which is not yet in place), led to delays as health and social care professionals had to spend time getting updates on the progress of the patient from other professionals directly. IT interoperability will be critical to the smooth running of this service, allowing professionals to access the data they require instantly and therefore increasing productivity. In addition it will facilitate a more robust assessment of the patient's fitness for the scheme in the acute setting as the community geriatrician will have access to a more comprehensive information set. Similarly the Health and Social Care hub, which will form a single point of access for health and social care professionals, and eventually patients, will be critical to the success of the schemes. The Health and Social Care hub will signpost patients and professionals to the most appropriate services, and ensure that there is adequate awareness of new services to ensure optimal uptake.

The schemes connected to seven day working are all interconnected. In order to be as effective as possible, 7 day requires a full complement of services – i.e. hub to be a port of call to direct patients and professionals to the most appropriate service, and the GP and community teams so that they can interact with each other to ensure that patients receive the right service at the right time.

The underlying feature of integration is working in ways that eradicate silo working. The aim of which is to benefit the individual who is in need of care and support. Integration, in relation to the Better Care Fund, will require a change to the way that we work, as well as a change within the relationships with have created with our partner organisations.

The complexity of such interdependencies requires new ways of working. The Hospital at Home Project is the first project to work in such a joined up way and as such a Memorandum of Understanding has been developed. This ensures that all partners are clear about the role they play in project delivery. A copy of the Memorandum of Understanding has been provided a one of the supporting documents.

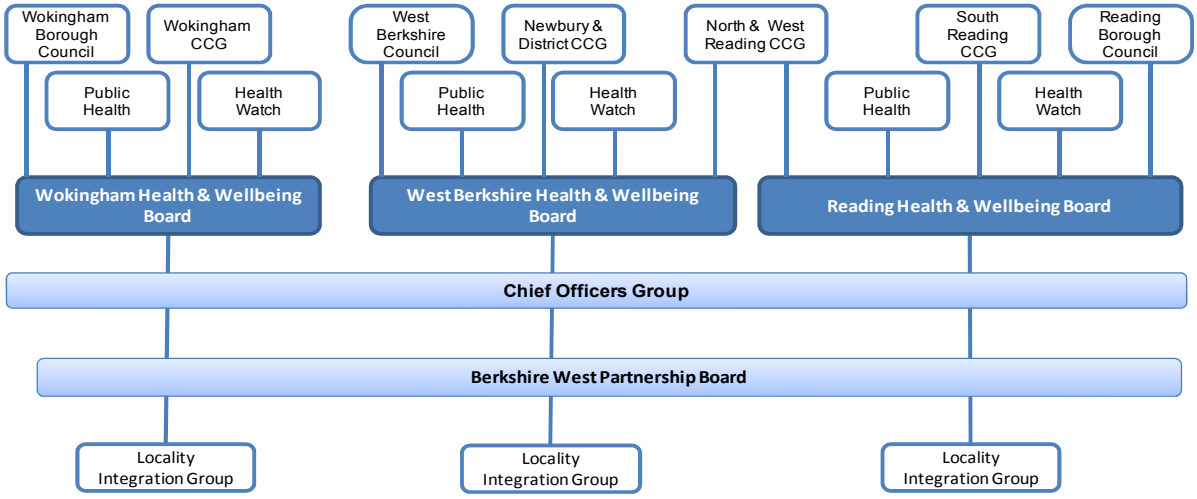
Our health economy in West Berkshire also reflects our patient flows to other acute providers, namely Hampshire Hospitals NHS Foundation Trust (Basingstoke) and Great Western Hospitals Foundation Trust (Swindon). Our CCG maintains close links with both North Hampshire CCG and Swindon CCG. Within our BCF governance structure, it should be noted that Hampshire Hospitals are already members of our Berkshire West Integration Steering Group and within that the groups role in overseeing and assuring partnership to deliver our BCF programme. Additionally, Newbury & District CCG are members of the North Hampshire CCG Systems Resilience Group, further demonstrating the cross-boundary nature of our local partnerships.

Whilst the Hospital at Home Project is exclusively for patients who attend the Royal Berkshire Hospital for treatment; the Council will take forward the learning from this project in the planning for improved discharge arrangements for patients at the two other key acute hospitals at Basingstoke and Swindon, as well as the West Berkshire Community Hospital.

b) Please articulate the overarching governance arrangements for integrated care locally

The West Berkshire Health and Wellbeing Board will have strategic oversight and governance for the West Berkshire Better Care Fund and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with Newbury & District CCG, North West Reading CCG and West Berkshire Council. This Board meets regularly and will receive reports on progress, outcomes and exceptions on performance and risks. This board will ensure appropriate monitoring of progress against national and local performance in the BCF, and regular updating of the risk register associated with such performance.

Because the local health and social care economy works across our Berkshire West boundaries many of the schemes within the plan are part of a wider Integration Programme, as outlined below:

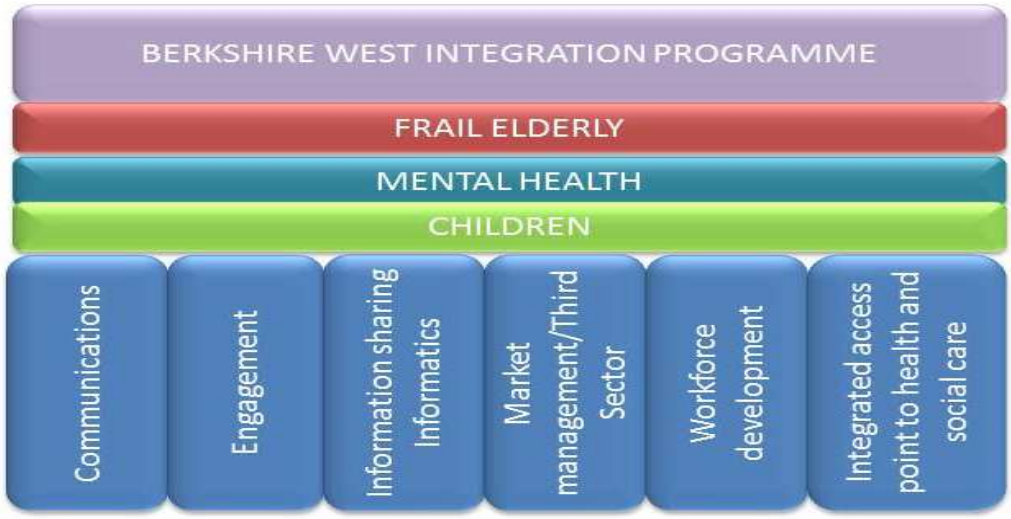


There are monthly Berkshire West Partnership Board meetings with representatives from each of the partner organisations are in attendance. For projects that span all three unitary authorities in Berkshire West (Reading Borough Council and Wokingham Borough Council as well as West Berkshire Council), accountability is held with the Berkshire West Partnership Board.

This Board will oversee the delivery of the Workforce Development strategy and other overarching system wide schemes which are included within the BCF programme. The partnership has appointed an Integration Programme Manager who is responsible and accountable for ensuring the system wide objectives of the wider integration programme are delivered We recognise that both provider and voluntary sector representation is essential to ensure engagement and improvement of the workforce across the system.

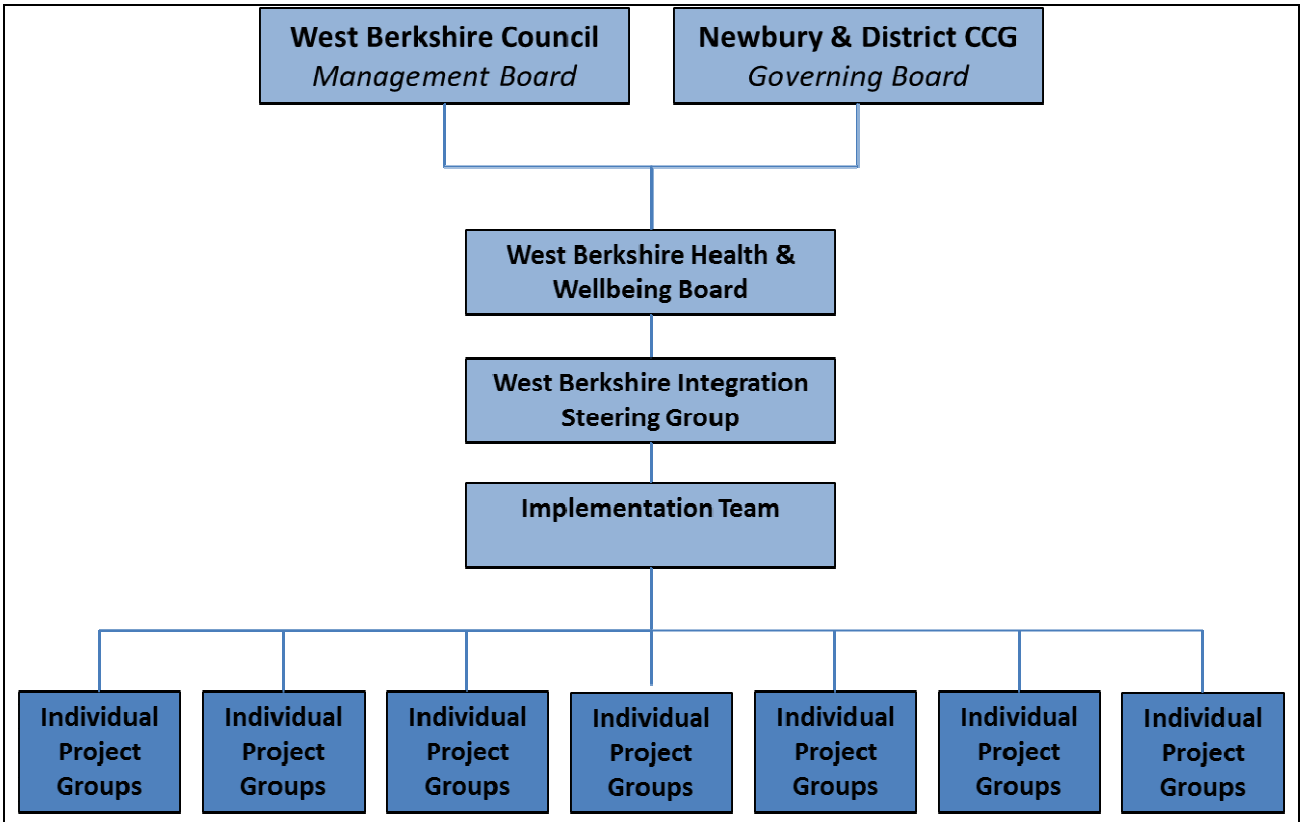
The structure and the relationship to the work streams within the Berkshire West

integration programme is represented thus:



West Berkshire's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the district. The Health and Wellbeing Board has already overseen the production of the latest Joint Strategic Needs Assessment for West Berkshire, and led the development of a Health and Wellbeing Strategy and Delivery Plan. The Board is therefore well placed to ensure West Berkshire's integration plans draw on local evidence of need and health inequalities.

We now have a Programme Office across Berkshire West in order to ensure there is sufficient project management capacity to deliver both the local and wider enabling schemes identified within this submission. The next section describes the management and oversight which monitors project delivery to ensure our identified schemes remain on track.



Within the Programme Management Methodology being used to implement the BCF the Health and Wellbeing Board act as the Programme Board and the West Berkshire Integrated Care Steering Group acts as a Projects Board

Every project is sponsored by one or more senior manager and clinician from across the health and social care economy.

There are implementation teams for each of the named projects with assigned Project Managers.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

We are utilising the Office of Government Commerce (OGC) best practice framework "Managing Successful Programmes" to manage the overarching programme and the Prince 2 Project Management Methodology for management of the individual projects within it.

The Partnership Board will be the governance group for the overarching integration programme and it will report progress at regular intervals to the sponsoring group. The BCF projects will be monitored and controlled through a Projects Board known as the Integrated Care Steering Group who will report directly to the Partnership (Programme) Board. Project Managers will report to the Projects Board at regular intervals. Terms of reference exist for all groups and specific responsibilities have been documented for named roles, e.g. Programme Manager

Governance Strategies for the Programme have been formulated and documented to ensure consistency across the projects and encompass the following:

- Benefits management
- Information management;
- Risk management;
- Issue resolution;
- Monitoring and control
- Quality management;
- Programme resource management;
- Stakeholder engagement/consultation/communication

For example project issues or risks which have been identified and logged at the project level but cannot be resolved/managed there, will be escalated to the Projects Board (Integration Steering Group) through regular Highlight Reports and if they cannot be resolved/managed there, they will be escalated to the Partnership Board and so on. Programme risks will be regularly reviewed by the Steering Group and an action plan put in place for any risks that remain red following mitigation.

This programme will have the support of an experienced Programme Office

d) **List of planned BCF schemes -**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
BCF01	Community Nurses Directly Commissioning Care/ Reablement Services
BCF02	Access to Health and Social Care Services through a single Hub
BCF03	Patient's Personal Recovery Guide / Keyworker
BCF04	Joint Care Provider
BCF05	7 Day Week Service
BCF06	Hospital at Home
BCF07	Enhanced Care & Nursing Home Support

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

The following Programme Risk Register is owned and regularly reviewed by the West Berkshire Integration Steering Group. Any risks that cannot be managed at this level are escalated up to West Berkshire Health and Wellbeing Board.

Beneath this Programme Risk Register sits a risk register for each project which project managers are required to review on a regular basis and escalate unmanageable risks up through the governance structure.

PROGRAMME RISK REGISTER

No	Risk description	Date Identified	Consequences	Gross Rating: Likeli-hood	Gross Rating: Impact	Gross Rating: Score	Controls (existing and expected)	Net Rating: Likeli-hood	Net Rating: Impact	Net Rating: Score	Owner	Status	Date of last update
1	We may have insufficient skills or capacity to deliver the programme or projects within it.	01/04/2014	We would fail to deliver on time or to the required quality. Given constraints on staff capacity, delay and reduced scope/quality are the most likely.	4	3	12	Programme management methodology deployed Some additional resources identified Paths for escalation of issues.	3	3	9	Locality Programme Lead	Open	10/11/2014
2	The delivery of the programme may adversely affect day-to-day operation	01/04/2014	Customer service levels fall Performance indicators would be adversely affected. Safeguarding issues increase	3	3	9	Incremental approach to change. Additional resources to backfill staff where possible. Role of Project Sponsors (Heads of Service) and Programme Sponsor (Director) in balancing project and operational pressures. Project planning to minimise impact.	2	3	6	Locality Programme Lead	Open	10/11/2014
3	We may not win the hearts and minds of staff who may then resist change.	01/04/2014	We would not achieve our objectives.	2	3	6	PM & HoS to provide regular updates on programme progress to senior and 3rd tier management (Programme Comms Plan) Individual Project Communication plans to incorporate specific staff group involvement where appropriate Involvement of front line staff in	1	3	3	Locality Programme Lead	Open	10/11/2014
4	Lack of certainty regarding the existence of the Better Care Fund after 2015/16	01/04/2014	If the BCF is not available in future years oranisations will be left with revenue costs arising from the new schemes for which there is no funding.	3	4	12	Maintain links with external bodies to understand current thinking. Close monitoring of government policy developments. Possible appointment of new staff on fixed term contracts Any commissioned services to be contracted for 1 year only with options to ex	3	3	9	Locality Programme Lead	Open	10/11/2014
5	The public may find the changes unacceptable.	01/04/2014	The reputation of the organisations involved would be adversely affected.	1	3	3	Communication and Engagement plan. Communications plan agreed and resourced.	1	2	2	Locality Programme Lead	Open	10/11/2014
6	We may not have the political support to carry through the planned changes.	01/04/2014	We would not achieve our objectives.	2	4	8	Communication and Engagement plan. Regular updates to HWB Regular briefing of WBC Management Board.	1	3	3	Head of ASC	Open	10/11/2014
7	Providers may not respond with the speed, quality and range of services needed.	01/04/2014	The rate of change would be impeded. Savings would be threatened.	4	3	12	Early identification of requirements Use of existing provider engagement networks Possible pump priming of service developments	2	3	6	Locality Programme Lead	Open	10/11/2014
8	New schemes and processes may prejudice financial control.	01/04/2014	Organisation would not be clear about the financial consequences of our decisions.	3	4	12	BCF Finance Leads Group in place Finance specialist input to all process change work	1	4	4	Finance Group	Open	10/11/2014
9	New policy and processes may prejudice safeguarding.	01/04/2014	We could put vulnerable people at risk, with potentially very severe consequences for them and for the reputation of the organisations involved.	2	4	8	Senior Management involvement in projects. Formal process for organisations to 'sign up' before new schemes go live. Ensure safeguarding teams sighted on changes.	1	4	4	Locality Programme Lead	Open	10/11/2014
10	Schemes may not deliver the level of expected savings	01/04/2014	If required, the savings money would have to be identified from elsewhere, impacting on operational budgets, or other project work.	3	3	9	Realistic savings targets set with clear understanding how they would be delivered from each project. Clear overall financial framework at Programme level. Project management disciplines for each project. Accountability and monitoring via Programme Board.	2	3	6	Finance Group	Open	10/11/2014
11	Our IT systems may not be able to support new ways of working	01/04/2014	We may not be able to fully achieve our objectives. Project or operational efficiency may be adversely affected.	3	2	6	Project management disciplines for each project, identifying requirements and dependencies early. Engagement of IT lead officers from organisations as required Clear long term plan for system interoperability (Connecting Care enabler project)	2	3	6	Locality Programme Lead	Open	10/11/2014
12	Higher priority corporate initiatives may impact on an organisations ability to support the programme	01/04/2014	We may not be able to deliver on time or to the required quality.	3	3	9	Appropriate level of priority to be assigned by all organisation Programme management arrangements to identify delays /issues and escalate in accordance with the governance structure.	2	3	6	Head of ASC	Open	10/11/2014
12	Key people on whom delivery of the programme depends may become unavailable through sickness etc, prejudicing our ability to deliver the programme.	01/04/2014	Loss of momentum or quality, resulting in delay and/or increased cost.	2	3	6	Establish project teams to reduce dependency on individuals Centralised ownership of key documentation through programme office. Accept some loss of momentum - if sustained consider re-allocation of resources.	2	3	6	Locality Programme Lead	Open	10/11/2014
13	Changes in government policy forcing a strategic change of direction	01/04/2014	This could result in fundamental changes to agreed plans or financial arrangements.	4	3	12	Maintain links with external bodies to understand current thinking. Close monitoring of government policy developments. Application of change management procedures.	4	2	8	Locality Programme Lead	Open	10/11/2014

A number of entries on the above risk register have a potentially **significant** financial impact on the BCF plans. The following table provides further detail of those with a financial risk and the planned mitigating action

Risk No	Description	Level of Financial Risk	Mitigating Actions
4	Lack of certainty regarding the existence of BCF after 2015/16 – if funding does not continue in its current form then there is a risk of ongoing spending commitments being e made that become unfunded. Lack of certainty regarding the existence of BCF after 2015/16 – if funding does not continue in its current form then that sum allocated to protect social care services will no longer be available and thereby creating a significant budget pressure.	£1,680,000 £2,514,000	Constraints placed on those schemes that involve either the employment of additional staff or the commissioning of services. All contracts will initially be of a fixed term nature. This constraint will apply to all parties involved in each scheme. No mitigating actions have been identified at this time. Risk rests initially with the local authority but any reduction is social care services would impact negatively on the wider health and social care economy.
10	Schemes may not deliver the expected level of savings	£1,167,000	The savings expected will all fall to the CCG. The CCG has set what they believe are a realistic level saving and have robust arrangements in place that will track the savings achieved. The savings expected from these schemes will result in reduced costs within the services funded by the CCGs (for services provided in the Acute Health sector). If these savings do not occur, the year to date position and forecast outturn will be reported through the CCG governance structure, both at a Berkshire West CCG federated level (through the QIPP and Finance committee) and at an individual CCG level through the Governing Bodies. At these meeting potential mitigating actions are discussed and agreed. These could be a combination of a) Changes to Schemes to resolve issues, b) Agreement to other replacement saving schemes to bridge gap (these could be non-recurrent in nature), c) Call on BCF performance fund of £243k (set aside in line with

			NHSE guidance and against which no spending commitments have yet been made), d) Call on other uncommitted contingencies with BCF, e) Call on CCG reserves and contingencies

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The Clinical Strategy Programme for Berkshire West federation of CCGs is focusing on three specific areas:

- Establishing the financial baseline
- Undertaking service line reviews of three clinical services (respiratory care, chronic pain and liver disease) to develop an optimal patient pathway spanning all settings of care
- Determining the system attributes that will required to deliver care according to our vision

The objectives of the programme are to:

- Articulate a clear case for change, setting out the impact of proposed changes on viability and sustainability of individual providers.
- Determine the preferred configuration of services for safe and effective care
- Articulate the roadmap for "Berkshire West PLC" in securing the long term viability (clinical and financial) of healthcare services for the local population
- Agree the key attributes of the health system - including financial incentives and governance, and design the operating model.

As part of our Clinical Strategy programme we have completed an externally supported clinical services review with Royal Berkshire Foundation Trust and Berkshire Healthcare Foundation Trust to determine the best care pathway models which improve patient outcomes and support financial sustainability. This review process considered 3 Initial pathways, respiratory care, chronic pain and liver disease.

It is our intention that the clinical pathway review will deliver redesigned care from a patient perspective, eliminating variation in outcomes. We are confident that the size and scale of the initial pathways identified will have a transformational impact on activity levels as well as clinical outcomes, and we expect to see full implementation of the benefits including the associated efficiencies of this programme realised as part of our QIPP plans for 2015/16 onwards.

The Clinical Strategy programme will also provide us with a framework for future elective pathway reviews which in collaboration with our providers will deliver safe and effective care, and support the long term clinical and financial viability of the healthcare system in

Berkshire West.

As identified above, we are conducting a review of three clinical pathways. It is anticipated that this work will generate savings which could be used to meet growth in activity. If this is insufficient to meet the financial shortfall, we would use the contingency monies set aside and identified in the Health and Wellbeing Board financial submission and which supports this narrative. If after both of these measures are implemented a financial gap still remains, we would investigate further savings through existing or new QIPP projects.

Draft Risk Share Agreement

Parties to agreement: West Berkshire Council (The Local Authority), Newbury and District CCG and North West Reading CCG (The CCGs)

Better Care Fund Pooled Budget - Risk Sharing Agreement

1. Introduction

1.1 By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The general principles for risk-sharing are:

(a) The financial impact of unpredictable incidences on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effectively delivery of the schemes

(b) Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to ensure that their service delivery arrangements mitigate the impact as far as is possible.

2. Scope of Agreement

2.1 Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board).

2.2 Responsibility for the management of the Better Care Fund that is the Pooled budget is split between the CCGs and The Local Authority by mutual agreement. The assigned responsibility for the different elements of the Pooled budget is shown in pooled budget responsibility table (para 7 below).

2.3 All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual organisational budgets outside the Better Care Fund.

2.4 The principle risks to the CCGs are those associated with failure to achieve the savings associated with the delivery of the QIPP schemes incorporated into the BCF and in particular the failure to reduce non-elective activity in the acute sector which means that the CCG is also likely to incur additional costs in terms of financial over performance.

2.5 As most of the Better Care Fund has been provided from CCG budgets the principle financial risk to The Local Authority is the failure to earn the performance elements of the fund. In order to fully mitigate this risk for the Local Authority the performance element of the fund is held by the CCGs and is not factored into the BCF schemes expenditure plans. This also avoids the opportunity costs and effort in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the 1.1% reduction in non-elective activity.

3. Risk Categories

3.1 Financial Risk

- Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation (as set out in the table below) and will not be funded through the BCF, unless agreed by all parties.
- Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end.
- Under achievement of planned savings and KPIs will be met from contingency and retained performance fund.

3.2 Delivery Risk

The Local Authority and the CCGs are responsible for ensuring that they deliver their inputs required to deliver the BCF KPIs.

3.3 Performance Risk

- Failure to achieve the non-elective admissions reduction will mean that the performance element of the fund (calculated at £243k in line with NHSE guidance and Part 2 of template) is not payable for use on the BCF schemes.
- Achievement will be on a proportionate basis:-

○ 100% achievement	100% performance fund payable
○ 75-99% achievement	75% performance fund payable
○ 50-74% achievement	50% performance fund payable
○ 25-49% achievement	25% performance fund payable
○ < 25% achievement	No performance fund payable

- The performance fund remaining for non/reduced performance will be used by

CCGs to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector, subject to agreement of Health and Wellbeing Board.

- Payment of funds to BCF on achievement will be in line with NHSE guidance. Once achievement has been confirmed detailed plans on use will be discussed and agreed at the Health and Wellbeing Board.

3.4 Reputational Risk

- Reputational risk will be managed through an aligned communications and engagement plan.

4. Risk Management Framework& Governance Arrangements

4.1 A comprehensive risk register will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan.

4.2 Resources to support the development and maintenance of the risk register will be identified by the parties.

4.3 The Risk Log will be reviewed by groups that are responsible for the individual identified risks – e.g. the finance risks will be reviewed on a monthly basis by the finance group who will update the Risk log for the Programme and provide these updates to the Programme manager for inclusion into the Master Risk Log. The Programme Manager has overall responsibility for ensuring the Risk Log is updated regularly and reported to the Integration Board. Significant risks will be escalated to the Partnership Board and the Health and Well Being Board and up to the key decision making bodies in both organisations as appropriate

4.4 The Risk Log will also be reviewed in both health and social care individual governance frameworks.

5. Accounting Arrangements

5.1 In determining the pooled budget arrangements the following factors have been considered

(a) Whether the funds are being transferred or not from health to social care
(b) Who is commissioning the service associated with the budget
(c) Which organisation is providing the resources to run/manage the service
(d) Who are parties to any associated contracts
(e) Which organisation bears the risk of any overspend
(f) Where any cost savings benefit arise
(g) Which staff are involved

5.2 The appropriate accounting standards of each organisation will apply in relation to

any joint arrangements that are put in place.

5.3 Each of the CCGs and the Local Authority will recognise its share of the pooled budget in it individual accounts and memorandum accounts will be maintained.

6. Contracting Arrangements

6.1 All contracts will be drafted reflecting the terms agreed within this risk sharing agreement.

7. Pooled Budget Responsibility Table

BETTER CARE FUND					
Investments Planned					
		Operational responsibility	**Fund**	**Investment risk held by**	**Savings risk held by**
			£k		
	LA's Services funded from historic S256	LA's	1,793	WBC	
	DFG	LA's	726	WBC	
	Social care capital grant	LA's	279	WBC	
	Carers funding	LA's	321	WBC	
	Contingency	joint	120	joint	
	Reablement	NHS	740	CCG's	
			3,979		
New Spend - from minimum BCF					
	Social Care Act costs	LA's	1,507	WBC	
	7 Day working - other	LA's	500	WBC	
	Personal recovery guide	LA's	310	WBC	
	Intermediate care assessor & service	LA's	400	WBC	
	Hospital at Home (fye) - LA spend	LA's	390	WBC	
			3,107		
	Hospital at Home (fye) - NHS spend	NHS	738	CCG's	
	Nursing / care home projects (fye)	NHS	167	CCG's	
	7 Day working - PC	NHS	870	CCG's	
	Connected care (interoperability)	NHS	248	CCG's	
	Health Hub	NHS	70	CCG's	
	Performance fund	NHS	243	CCG's	
	NHS schemes - other	NHS	112	CCG's	
			2,447		
			5,554		
Total			9,533		
Savings Planned					
	Hospital at Home - NHS spend		-1,123		CCG's*
	Nursing / care home projects		-44		CCG's*
			-1,167		
*	Initially any overperfromance against NEL plan will be funded from the perfromance fund.				

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

All parties in West Berkshire are committed to promoting integrated care, and as a result we already have in place a number of integrated teams. The BCF schemes align well and bolster these existing initiatives.

Personal Budgets are embedded into the social care pathway and are utilised extensively across all client groups to enable people to meet their eligible needs in a person centred way. The Care Act reinforces the importance of personal budgets and places them in law for the first time. Personal Budgets can improve outcomes for people, enable them to exercise choice and control and places the person at the centre of their care. The BCF schemes aim to deliver a personalised approach and improved outcomes for people. This natural synergy with the established Personal Budget offer will support people to maintain control over their care and support as far as possible and in turn improve their wellbeing.

The Council has recognised that not all dwellings in the district are 'care ready' to provide a base for care at home as people become frailer, which is part of our Better Care Fund vision. The Council is committed to increasing the supply of Extra Care Housing, over the last 2 years two developments have been completed increasing the number of units by 97. We have a commitment to continue to identify land in the East of our district to increase provision by a further 50 units. Strategic partnerships are being established with supported housing providers and social enterprises to support timely hospital discharge through direct provision for people with complex needs.

Our Better Care Fund proposals are also clearly aligned with the vision that we have for urgent care services going forward. In his report on " Transforming Urgent and Emergency Care Services in England " Sir Bruce Keogh sets out a vision for the NHS to " *provide highly responsive , effective and personalised services outside of hospital for those people with urgent but non-life threatening conditions. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families…."* Both CCGs' Two Year Operational Plans and Five Year Strategic Plans articulate a commitment to working to achieve this vision in partnership with health and social care partners. Strategic oversight for this work is provided by the Urgent Care Programme Board which has representation from health and social care partner organisations. Both CCGs' Two Year Operational Plans and Five Year Strategic Plans articulate a commitment to working to achieve this vision in partnership with health and social care partners. Strategic oversight for this work is provided by the Urgent Care Programme Board which has representation from health and social care partner organisations.

All Urgent Care Programme Board (UCPB) partners have recently contributed to the development of a Berkshire West Operational Resilience and Capacity Plan 2014-15 (ORC) which confirms how the system will work together to manage operational resilience throughout 2014/15. The UCPB and its members have a key role in supporting improved integration between health and social care and improving outcomes for local

people. The ORC Plan demonstrates the clear link between the BCF principles and the wider urgent care agenda and plans for 14-15. Many of the initiatives being funded from national resilience monies will act as a precursor to the BCF schemes.

All organisations recognise that partnership working will be more effective through sharing information and maximising the benefits of modern technology. A key enabler project has been established called Connected Care, where service leads, technology leads across the organisations are actively working to establish robust mechanisms that allow us to communicate and share information more effectively. As well as looking at systems that support organisations delivering health and social care we are also at technological solutions to support patients and services to live independently.

Other Local Authority plans

Care Act 2014
The Care Act 2014 is the single largest programme of work being currently being undertaken by social care. The focus of this work relates to the first phase of the Care Act changes that come into force on the 1st April 2015. A similar programme of work will be required next year for the 1st April 2016 changes.

The key changes for 1st April 2015 are as follows;

- New national eligibility criteria (West Berkshire Council currently one of just 3 councils currently operating at 'critical only'.
- New duty to support carers
- New statutory duty to provide preventative services
- Universal deferred payment schemes
- New duties in respect of information and advice
- New duties in respect of market management and dealing with provider failure

Beneath these headline items sits a huge level of detailed new 'must do' duties for councils.

Whilst uncertainty remains around the final guidance the greater concern for West Berkshire Council is the level of funding that will be provided to cover the costs of the changing eligibility criteria.

Plan to refocus Communities Directorate toward Restorative Practice
We recognise that funds will continue to be limited and that the Council will need to move away from a paternalistic approach to a more enabling role, helping people to self-manage. Our focus will be on developing community capacity, working collaboratively with the voluntary sector and supporting people to access universal services. We will be seeking to actively promote self-management rather than creating dependency by focusing on traditional approaches.

Voluntary Sector Prospectus
We recognise that the voluntary sector is a valuable resource and have sought to build on this by developing an outcomes based prospectus that allows services to be co-

produced and results in longer term agreements providing more confidence about funding.

b)Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Integration plays a central part in the **CCG's two year operational plans and five year strategic plans.** We believe that working in partnership is the most effective way for us to ensure that we are providing person–centred, personalised and coordinated care in the most appropriate setting. All the schemes identified in this submission are included within our CCG Operational plan along with other local priorities and projects.

Our unit of planning, for the purposes of our five year Strategic Plans has been agreed with NHS England to be as a "Berkshire West" Economy, The **Five Year Berkshire West Strategic Plan** is our overarching strategy which aligns the Berkshire 10 organisations and our five year plan, this document clearly articulates that the Better Care Fund will act as a key vehicle to lever the transformation of health and social care services in the provision of integrated care and support.

Consequently, a number of our West Berkshire schemes also feature in the Integration programmes described in the BCF submissions for Reading and Wokingham Unitary Authorities. Schemes such as Hospital at Home, Care Home support, Connecting Care, , seven day working in primary care and the Health and Social care Hub appear in all three BCF submissions. This clearly offers us the ability to take forward the integration agenda at pace and scale and provides a catalyst for change. It also allows us the unique opportunity to have the flexibility to design schemes which are specific to our local areas

The BCF has required the formulation of joint plans for integrated health and social care and these plans have been developed through Berkshire West's three local Integration Steering Groups, which include representation from the CCGs, local authorities, health and social care providers and the voluntary sector, and the on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services both at a local and Berkshire wide level.

The West Berkshire Council Strategy 2014-18

The purpose of the Council as stated in the above publication includes the following;

1.Helping you to help yourself – this means enabling people to get access to the information and support they need to help them getting on with living their lives without relying on the direct provision of council services.

Whilst there are clear links with many of the BCF schemes and other BCF spending plans, the alignment is strongest with the following schemes;

BCF01 Community Nurses Directly Commissioning Care / Reablement Services. This scheme will enable both care and reablement services to be in place sooner than at present and will contribute to returning service users maintaining their independence

for longer.

BCF02 Health and Social Care Shared Hub – this scheme will improve the 'front door' service provided to residents of West Berkshire. The early provision of good advice and signposting to services will again help residents maintain their independence.

BCF03 Personal Recovery Guides / Keyworker – the aims of this scheme includes helping people to move through the care pathway in a timely manner thus improving their ability to maintain their independence.

BCF05 7 Day Services – enhancing the availability of services across 7 days will play a key role in helping residents of West Berkshire to help themselves.

2. Helping you when you cannot help yourself – this means supporting and protecting the vulnerable in our communities, be they children or adults.

Again there are clear links with many of the BCF schemes and other BCF spending plans, the alignment is strongest with the following schemes;

BCF03 Personal Recovery Guide / Keyworker – this scheme is very much aimed at providing personalised support to patients and service users to help them move smoothly through the care pathway.

BCF05 7 Day Services – enhancing the availability of services across 7 days will play a key role in supporting residents.

BCF07 Enhanced Care and Nursing Home Support – enhanced training of Care and Nursing Home staff will improve the quality of care provided to some of the most vulnerable service users.

3. Helping you to help one another–this means working with and supporting people and communities to achieve their own ambitions

Whilst not scheme specific, the use of the BCF includes protecting existing funding levels for support to carers provided by both the LA and the CCG.

All of the BCF schemes and spending plans align very clearly with the priority of 'Caring for and protecting the vulnerable' set out in the Council Plan.

Interdependencies

As a partnership already experienced in working together, we recognise it is important to remain sighted on developments across all organisations involved in health and social care. To achieve this a formal, multi layered governance structure is established that brings together representatives from all organisations at appropriate levels. See section 3 (b) for detailed governance arrangements.

We recognise that there are significant interdependencies within the BCF schemes and also with other significant programmes of work such as Care Act and extended hours and primary care. The Berkshire Partnership Board is where all 10 organisations come together to ensure that they are sighted on work across Health and Social Care. A good

example of this would be work across the Elderly Frail Pathway to which brought all partners together as it was clearly identified at a very early stage that decisions taken by one partner would have an impact on other partners within the system. There are numerous other examples that have already been identified and where joint working is already underway.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Newbury & District CCG has submitted an Expression of Interest to NHS England's Area Team to undertake co-commissioning of primary care services from 1st April 2015 with possible shadow arrangements in place in the interim. This was developed through the Primary Care Programme Board which includes GP representatives of each CCG who communicate with other GPs through GP Council structures. The Better Care Fund schemes have also been discussed in both of these forums - at the Primary Care Programme Board and with the GP Councils to ensure the alignment of primary care.

It is envisaged that co-commissioning will underpin integration, encouraging the development of new models of service provision outlined in the BCF. In addition a number of BCF schemes link closely to the enhanced GP service that is to be delivered through "Transforming Primary Care". For example, the care home project (BCF07) will also facilitate the Proactive Care programme for over 75s living in residential care.

A further area of the BCF plan that will support the enhanced GP service is the scheme to deliver a much wider and integrated range of seven day services (BCF05). Co-commissioning will support the implementation of this scheme, enabling the CCGs to influence the working hours incorporated into any new GP contracts tendered, there are opportunities to further pool funding with NHS England, for instance that used for the current Extended Hours DES, to better incentivise practices to increase their availability, thereby also mitigating any potential risks associated with practice engagement.

There are a number of risks relating to the involvement of primary care with the BCF schemes, which are captured in the risk log. The main risk is around GP engagement in relation to the schemes – in particular the Care Home scheme and 7 day working scheme. These schemes rely heavily on GP engagement, for example if GPs do not engage with the Care Home scheme, the non-elective admission reductions will not be realised as the service is contingent upon GP participation. To mitigate this risk, we are reviewing GP uptake of these schemes on an ongoing basis, and where this is falling short; we will proactively engage GPs to ensure that they participate with the schemes. To help ensure participation, the BCF is an ongoing agenda item at the Primary Care Programme Board.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The local definition of protecting adult social services is to focus upon prevention, early intervention and for health and social services delivery aimed at avoiding admissions to institutional care (especially care homes and hospitals) together with maximising people and their communities' capacity to self-care. It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.

The social services lead on multi agency safeguarding adults will be developed under the Care Act, with local priorities secured within the BCF for Mental Capacity Act assessments, Deprivation of Liberty assessments, and general multi-disciplinary safeguarding adults' activity.

West Berkshire Council is committed to delivering the good quality affordable services to residents who have care or support needs. The Council is committed to working with its partners (particularly the voluntary sector, local providers of care and the NHS) to develop services for residents that help people live as independently as possible with minimal interference.

We will deliver a fair system of Social Care where the resources that are offered relate to the level of assessed needs a person might have and where their contribution towards the costs of that care clearly relates to their ability to pay. On the 1st April 2015 West Berkshire will make a significant move from its current eligibility threshold (set at supporting those who face a 'critical risk to their wellbeing or independence) to the new national eligibility criteria. This move will result in both more residents being supported and the level of such support being greater.

We will promote health and well-being through the effective development of universal services. We will draw on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living safely at home. We will give priority in our future service delivery to helping people recover, recuperate, and rehabilitate so that they are able to live as independently as possible. We will ensure that all staff (Health and Social Care) and providers understand how to work with service users in ways that promote their independence, ensure their safety and support their recovery.

We will promote a 'whole family' approach that seeks to promote great outcomes for children by supporting their parents. We will develop staff awareness and expertise in

dealing with issues like domestic violence, mental ill health and substance misuse that can prevent adults from nurturing children. We will also plan good transitions from Children's Services to Adult Services for both service users and young carers.

Whilst the Health and Wellbeing Board have attached a significant caveat to the submission of this plan (Section 1(b) refers), no changes have been made to either the planned schemes, the expenditure plan or the expected benefits from the original submission.

As one of the 3 councils required to change its eligibility criteria as a result of the Care Act the financial implications have been a matter of concern for the Health and Wellbeing Board since February 2014 when it discussed the submission of the original template. These concerns have escalated as further information on the funding arrangements has been released.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Adult Social Care has to provide a range of statutory services to all residents who are eligible under the existing Fair Access To Care criteria; for West Berkshire these services are currently only provided to residents meeting the 'Critical' criteria (West Berkshire is one of just 3 Local Authorities in England operating at this level). From April 2015 the Care Act 2014 will introduce a new national minimum eligibility criteria that is expected to be something akin to the existing 'Substantial' level. This will impact on social care in West Berkshire very significantly and result in a far greater number of residents being entitled to receive support from the Council and the level of those support packages to be far greater. In accordance with the guidance, a significant element of the BCF will be used to support the Council in meeting the key new duties (eligibility & support for carers) of the Care Act 2014.

BCF03 – The Personal Recovery Guide / Key Worker scheme will contribute to the protection of social care by minimising the period a person stays in hospital. Independent evidence shows that the longer a person remains in hospital the quicker their condition deteriorates and the more dependent they become on long term social care. Ensuring unnecessary delays are avoided should place downward pressure on social care costs. If successful in the hospitals, the intention would be to expand the scheme into community based services with the aim of moving residents through what can be a complicated pathway as efficiently as possible. Again this should help residents maintain their independence and become less reliant on social care services.

BCF04 – The Joint Provider scheme, bringing together the separate care assessment and delivery units operated by the local authority and the Berkshire Health Foundation Trust, will provide a more efficient service therefore maximising the use of the pooled resources. It will offer increased opportunities to manage the external provider market more effectively and therefore allow the diminishing social care budgets to be utilised to provide the maximum benefits. The BCF will also protect social care by enabling the planned budget reduction for its reablement function to be cancelled thereby protecting this valued service.

BCF05 – 7 Day Services, whilst social care already provides a range of 7 Day Services, anything that enables their further development and integration with the Health offering would protect social care. Avoiding hospital admissions and the early discharge of patients to social care would place downward pressure on the level of ongoing social care required.

The capital funding associated with Disabled Facilities Grants (DFG) within the BCF will also build upon the successful record West Berkshire has in working with housing partners in securing wider investment in homes that promote independence. The DFG also allows significant adaptation of existing housing stock to meet the needs of individual social care clients.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total sum allocated from the BCF to protect adult social care services is £2.514m. This includes protecting existing S256 funding for preventative services and supporting carers and funding to maintain reablement services at present levels. The above figure does not include the contribution of £1.507m from the BCF towards those significant new duties under the Care Act 2014 defined in the BCF guidance. As one of the 3 local authorities in England currently operating an eligibility level of 'critical only' the proportion of the £135m national sum is woefully inadequate to meet the new demands faced by adult social care in West Berkshire.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met.

At present, with the final version of the Care Act guidance not expected until October / November 2014 and significant uncertainty over the level of funding to be provided it is very difficult how the new Care Act 2014 duties will be met. As already highlighted the financial implications of the change to the eligibly criteria are a particular concern due to the uncertainty around the level of funding to be provided.

From an operational viewpoint, a Care Act work programme has been established and significant numbers of staff are engaged in theme based projects to ensure new duties will be met. A formal programme management methodology has been adopted including a governance structure that includes both senior officers and senior elected Members.
At the senior levels staff working on the preparation for the implementation of the Care Act are linked into the BCF programme through regular meetings at project, finance and programme levels. Progress, issues and risks are reported regularly to the Programme Board.

In addition to the local implementation arrangements, a Berkshire wide Care Act leads group has been established to share ideas / issues and also to jointly commission services where appropriate.

As a locality within Berkshire West we are part of an area wide integration programme which aims to promote integrated commissioning and delivery across the whole health and social care system. The Better Care Fund is a source of funding within this wider integration programme. The priorities of the programme are to deliver better outcomes for individuals within a sustainable health and social care economy.

The full integration programme is underpinned by the need to address the duties of the Care Act. It also addresses ongoing work which has taken place within the whole system on an agreed frail elderly care pathway. This process seeks to prevent, delay and, reduce needs and to reduce delayed discharge from care through a whole system response to care closer to home. It is thus closely interlinked with the Care Act duties.

In addition to the specific projects within the Better Care Fund, the wider integration programme has been designed to take account of the new duties set out within the Care Act. There are work streams within the programme that support a whole system approach to market management, carers and workforce development which in turn contribute to delivering against Care Act duties.

v) Please specify the level of resource that will be dedicated to carer-specific support –

We recognise the significance of supporting carers within an integrated care system, particularly through ensuring they are able to take breaks from caring. This is a key preventative service which helps keep carers themselves and those they support, well and out of hospital.

Carers have comparatively poor health, which is recognised as a critical public health issue. They are a high risk population as they tend to neglect their own health; sometimes for practical reasons (like not being able to leave the home to attend appointments or hospital treatment) and sometimes simply because their sole focus is caring for the person they are looking after. They often do not even notice their own

health is deteriorating. Carers may also forget to make or miss routine health appointments like 'flu vaccinations or check-ups with doctors or dentists. Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy. Emotional impacts such as worry, depression and self-harm have been identified in both adult and young carers.

A total of £738k from the Better Care Fund will be dedicated to carer specific support

Existing s256 agreement has £417k that is dedicated to support Carers	This used to fund a range of support services to carers delivered by the voluntary sector, these are accessible whether they meet the Council's eligibility criteria or not.
CCG passport a further £321k, via a s256 agreement, to the Council	Used to fund a range of services to prevent carer breakdown including respite services.

The Carer specific support will entail the following:

Carers Assessments

The Care Act introduces a new obligation on the local authority to offer all carers an assessment on the appearance of need, including additional entitlements for young carers and parent carers of disabled children to receive carer assessments. The carer assessment is an opportunity for the carer to consider how caring impacts on them, how they can be supported to care and to enjoy a life outside caring. It is an important element in ensuring that many people with care needs can be supported informally and so stay safe and well at home for longer.

We have used the 'Lincolnshire model' to estimate the cost of delivering additional carer assessments to meet the local authority's extended duties in this respect from April 2015. The additional assessment costs are expected to be £117k p.a.

Support Packages for Carers Eligible for Adult Social Care

The Care Act also introduces a new entitlement for carers to receive services in their own right, provided they meet new national eligibility criteria. This is currently a discretionary provision, and adult carers in West Berkshire are able to apply for grants to be spent on alleviating the stain of caring. Both health and social care funding are applied to this service, with a Section 256 agreement in place relating to the relevant CCG funding transfers to the local authority.

Again using the Lincolnshire modelling tool, we estimate that the additional cost of meeting this statutory obligation in West Berkshire will be £585k p.a. from 2015.

Information & Advice for Carers

The CCG and local authority collectively contribute £136k p.a. towards a carer information advice and support service which is jointly commissioned across Berkshire West (i.e. with neighbouring local authorities and CCGs as additional commissioning

partners). This provides an initial information and contact point for any carer, whether or not eligible for statutory services, and supports carers to connect with further guidance and services relevant to their particular situation or current priorities. The service is designed to prevent carers' own support needs from escalating, and hence to reduce or delay the level of formal care required by those supported by family/unpaid carers.

Carers Community-Based Services

We fund a wide range of carers support services to prevent carer breakdown including sitting services and crisis response.

Other Community Support for Carers

NHS Berkshire West Clinical Commissioning Groups (CCGs) currently commissions Carers services through Section 256 agreements of the National Service Act 2006 to fund a range of services described as 'carers respite' through the 3 local authorities and jointly funds information, advice and support through Berkshire Carers. The CCG also has a contract with Berkshire Healthcare Foundation Trust to support Carers activities as well as commissioning a range of services through the Partnership development fund.

Future Aspirations

A Berkshire West Carer Commissioning Forum has been established to oversee the future commissioning and development of carer support across Berkshire West. This is identified as one of the enabling work streams within our integration programme, and is being led by the CCG Director of Joint Commissioning. This Forum will ensure that carer specific resource identified within the Better Care Fund allocations is used effectively to improve outcomes for carers. The Forum will lead on the development of strategic plans and commissioning arrangements for supporting carers across Berkshire West, and also inform the development of other plans and arrangements which have the potential to improve outcomes for carers. The Berkshire West CCGs investment of £120k in twilight nursing, for example, whilst retained within a block contracting arrangement covering wider provision, comes within the remit of the Berkshire West Carer Commissioning Forum to scrutinise.

We are committed to promoting choice for carers as well as service users, the Care Act allows joint health and social care personal budgets and we will aim to use this flexibly. We also recognise that there is still a need for some joint services and we continue to jointly commission services where it makes sense to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Since the original BCF plan was submitted the modelling of the costs of the Care Act has continually been developed using information and guidance coming from both the DH and the numerous models being promoted by DH, LGA and ADASS.

The funding level required to protect adult social cares services and to fund the Care Act costs remains significantly (£4m) above any identified sources of funding at the present time. The need for West Berkshire Council to change its social care eligibility criteria is the key issue and until there is certainty around the level of government funding this remains a significant financial risk for social care.

The Council is aware of the level of the risk arising from the Care Act and also the Government's stated commitment to fund the implications in full.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We are committed to planning jointly across the health system to increase availability of services at weekends. West Berkshire Council and the CCG already provides and funds a large range of services on a 7 day basis but through the Better Care Fund will further explore the development of processes to allow increased movement between services at weekends. Building upon what is already in place, the initial emphasis will be on ensuring we can deliver safe planned discharges from acute hospitals on a 7 day basis. As the acute hospital deliver increased levels of 7 day discharge services then social care will develop services to match this change of demand. A key element will be to ensure that external providers of both residential care and domiciliary care are able to meet any new requirements, this both a capacity issue and a cost issue in West Berkshire.

Currently within Newbury & District CCG a number of services are working extended hours. Berkshire Healthcare Foundation Trust provides community nursing 24 hours a day, 7 days a week. Other services such as Intermediate Care, Rapid Response run a 7-day service (but not 24hrs)

West Berkshire Council has an Extended Hours Service provided by the In House Domiciliary Care Service 6am to 11pm 7 days per week; this initially provides care in urgent circumstances, for example for avoidance of admissions into Care Homes or Hospitals; it could provide support where a carer becomes unwell; it may also deal with urgent referrals being passed over from health services. The service will also expedite discharges from hospitals either through the Council's direct service or through a care provider which is already supporting an individual. Planned admissions to care homes or to domiciliary care agencies following a hospital assessment can be effected at weekends on a limited basis.

Whilst we have a distinct BCF scheme for 7 Day Services (BCF05) all of other BCF schemes will contribute to the enhancement of our existing 7 day arrangements. The planned enhancement of these arrangements will be underpinned by our 7 day health and social care hub (BCF02), a single point of access to health and social care that will signpost professionals and patients throughout the whole week.

Delivery of the 7 day working arrangements will be ensured through the implementation

plan (scheme BCF05) and governance arrangements overseen by the Health and Wellbeing Board. All changes will need to be developed in partnership to ensure that services are coordinated and therefore provide a clear care pathway for the local community and also deliver best value for the investment being made from the BCF.

We have a 7 day working CQUIN with our main acute provider to deliver the following;

> 75% of patients admitted as an emergency by A&E or directly from the community must have been assessed face to face by a consultant and documented within 14 hours of admission to the hospital.

This CQUIN will support a move towards an equitable service on weekends and weekdays in terms of consultant cover and assessment for patients.

We are also in the process of agreeing a Service Development & Improvement Plan (SDIP) with the main acute provider to ensure a clear and robust plan is in place to determine what level of services each department will be required to deliver 7 days a week by when with clear milestones and deliverables included.
The expansion of GP service provision beyond core hours (8am - 6.30 pm, Monday – Friday) to offer access into early mornings, evenings and at weekends, particularly Saturday mornings will assist in the delivery of safe discharge.

Practices will offer both routine and urgent appointments during these extended periods, interfacing with other services to support admissions avoidance, reduce type 3 A&E attendances and maximise opportunities for discharge back to GPs. During these hours there will be requirements to ring fence some appointments for patients who have been discharged to access their GP practice (particularly on a Saturday morning) and a requirement to give a priority to patients identified by practices as being at high risk of admission. These will include patients included on the 2% care management registered developed by GPs as part of the national Avoiding Unplanned Admissions Directed Enhanced Service (DES) (see section 7d)

The scheme will provide more opportunity for patients and providers such as nursing homes) to access GP services to help manage their long term conditions in the community, thereby avoiding unnecessary admissions and/or attendances to A&E.

Schemes BCF04 Joint Care Provider, BCF05 7 Day Services and BCF01 Community Nurses Directly Commissioning Care/Reablement Services have been brought together into a single project due to their very significant interdependencies. The table below provides a **Summary Project Timetable** for this project as forecast at Project Initiation.

The membership of this project team includes senior representatives from the key local NHS and Local Authority providers (Berkshire Healthcare Foundation Trust, Royal Berkshire Foundation Trust). By working directly with these key providers we are able to review all the existing 7 day services, identify gaps and agree changes that will be both deliverable and affordable for all organisations. This should enable solutions to be identified that are resilient. In health we have monthly quality and contract review meetings with our main acute provider to ensure that the 7 days working CQUINs are on track for delivery and we will use this existing meeting structure to ensure the main acute provider are sighted on the changing requirements as the 7 days services develop. Within this project we also recognise the important role of the independent social care market and plans are in place to ensure they are kept aware of our requirements (Market

Position Statement).

Copy in table from PID para 3.12 after meeting on Wednesday

c) Data sharing

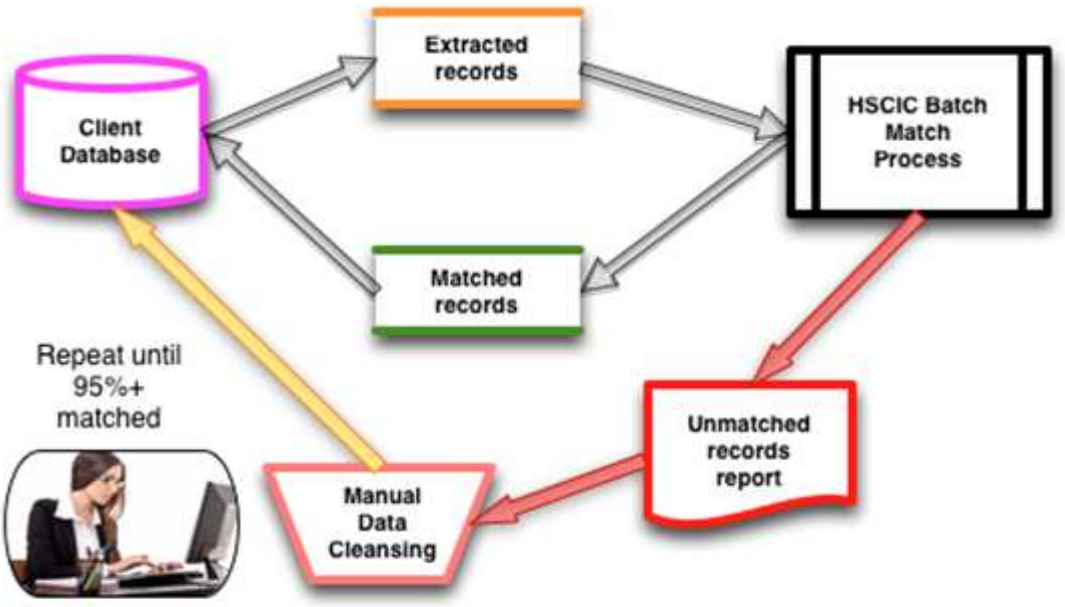
i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number as the primary identifier for correspondence will be implemented by April 2015. This will be critical to the success of our system wide Interoperability initiative (Berkshire West – Connected Care)

A project group has been established to oversee the implementation of NHS Number throughout the Berkshire West system, led by Reading Borough Council, reporting to the Berkshire West Interoperability Programme Board. This group will oversee the delivery of the plan and milestones. The key actions in place for primary identifier:

1. Royal Berkshire Foundation Trust, Berkshire healthcare Foundation Trust to ensure all patient communication to include NHS Number by April 2015

2. Reading, Wokingham and West Berkshire Local Authority Board adopt the process of Batch Matching through Demographic Batching System, commencing in October 2014, as demonstrated below



A West of Berkshire project manager has been identified to facilitate the batch uploading of NHS numbers to all clients within the social care systems. This batch uploading will be a one-off process to ensure all records held within social care systems hold the NHS

Number. The project has started and the planned completion date is March 2015.

Follow up work will be required to ensure that all new clients have an NHS number added to the record. One way this can be achieved is through access to the NHS spine application PDS (**person demographic service**). As part of the "registration" process when a new client is added, the PDS could be interrogated to provide the NHS number which would then be recorded. In order to gain access to the PDS, an N3 connection is required.

Key risks include timescales for obtaining an N3 connection to be able to use the PDS; timescales for all organisations becoming IG Toolkit Level 2 accredited; and the process for recording NHS number in unitary authorities becoming embedded. Work, led by the Project Manager, is underway to mitigate these risks.

The use of the NHS number within all systems in use in Health and Social care organisations is critical for the proposed integration solutions to work. The NHS number is needed to ensure the correct records in each of the systems are interrogated to present a holistic view of the patient's record. The NHS number is already used in Health organisations in Berkshire West, and once social care organisation systems hold the NHS number, portal solutions will be able to accept data from all organisations in Berkshire West. This will be critical to the success of our system wide Connected Care enabler project, which seeks to ensure health and social care professionals have access to accurate and timely information regarding patients by facilitating the sharing of information. IT interoperability is critical to improving the quality and experience of care that patients receive, removing silos to ensure that health professionals have access to comprehensive records, and that patients only have to tell their story once.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the Berkshire West Interoperability Programme Board an Application Programming Interface (API) is being pursued, as part of the Connecting Care project, a key enabler to the delivery of the Better Care Fund schemes. This project aims to remove the IT silos that exist in health and social care and has the ultimate aim of ensuring that patient information and social care records will be accessible to all who need them.

The Interoperability programme Board has engaged with IT development partners (Central Southern Commissioning Support Unit) to undertake work on the feasibility of a 'medical interoperability gateway' which will provide a greatly enhanced information sharing of records providing access to live data on various systems in use across the local health and social care sector.

A proposed IT solution has been identified and phases for connectivity determined, starting with GPs and out of hours services in October, followed by key NHS Trusts in December, and then in phase 3 . Connections with the individual social care systems have been agreed for consideration.

Appropriate information sharing agreements are being developed through this project. The CCGs across Berkshire West have moved to a system of secure email for all

communications within and across partner organisations in addition to the use of GCSX.

In primary care there is a contractual obligation for clinical system providers to have open API's to allow direct integration with their systems. This came about as part of GPSOCr in April and the first examples of integration should be implemented by the end of 2014. To facilitate information sharing without being dependent on suppliers opening their API's and waiting for the development work required by at least two suppliers, a third party system has been purchased- Medical Interoperability Gateway (MIG) by Healthcare Gateway which facilitates data sharing from GP Practice systems in use in Berkshire West. Longer term, integrated records portal solutions will be required to integrate directly with primary care systems using open API's as part of the core requirements when going through a formal procurement. The pilot phase using Orion will utilise the MIG to share primary care data.

Discussions with Cerner, Adastra and OpenRio indicate that they will work with other providers to facilitate information sharing although there is no national contractual obligation. To ensure information sharing can begin as soon as possible, a key requirement for the procurement of an integrated records portal solution will be for there to be examples of integration with these suppliers or evidence that they can utilise open API's to develop a good level of integration into these systems.

Further discussion need to take place with Careworks (provider of the LA's current social care system) to ensure that they will open their API's to ensure the systems can provide data and also allow for a portal solution to be integrated within their systems.

Not all suppliers are contractually obliged to open standards and there could be significant costs or delays for development work required to ensure a good level of integration. This is mitigated by ensuring the portal solution can provide a web- based view but this would not be as beneficial for the end user.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

There is a firm commitment to ensuring appropriate IG controls.

We acknowledge and support the findings of the Caldicott 2 review and the inclusion of the new 7th Principle. In terms of the 26 Recommendations arising from the report the Berkshire West System partners (Acute, Community, CCG, LA) already comply or we are working actively to address these areas together between and across health and social care. The key areas which require new protocols and information systems to support them are common to all UK Health services and Local Authorities and we are forward thinking in our approach to resolving them.

To ensure adherence to these controls each organisation operates its own Information Security Policy underpinned by legislation which details principles used for data sharing. This includes:

- Protection against unauthorised access
- Availability of information to authorised users when needed e.g. for the benefit of the service user or patient
- Maintaining confidentiality of information
- Integrity of information through protection from unauthorised modification.
- Ensuring regulatory and legislative requirements will be met as a result of robust policies and procedures and training for staff

There is a commitment to creating a joint framework across the organisations by October 2014 through the establishment of joint Informatics governance group. This will build on the Berkshire NHS "Overarching Policy for sharing personal information Between Organisations 2010."

Primary care data is being shared with the urgent care system in Berkshire West. An information sharing agreement has been established which lists the data items that can be shared and who can view the data. This has been signed by all participating organisations in Berkshire West (apart from one GP Practice). The system for viewing is based on role-based access and will ensure only those who are allowed to access, can access the data. There is also a full audit module that will enable organisations to check if a record has been accessed inappropriately.

An IG professional will be part of the procurement process to ensure that the selected portal solution fully complies with all IG standards and protocols. We will ensure we are compliant with NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice Caldicott 2.

West Berkshire Council has adopted an Access to Information policy the purpose of which is to ensure that it complies with the requirements of the existing access to information legislation, including the Data Protection Act 1998, the Freedom of Information Act 2000, the Environmental Information Regulations 2004, and the Local Government Act 1972 Schedule 12A, and with any subsequent legislation. This policy is supported by an ongoing programme of mandatory staff training.

In order to share information with Health West Berkshire Council needs to undertake two key steps;

- A need to adopt NHS IG standards. This will involve a major project to identify how the council's existing policy differs from the NHS IG requirements and implement a programme of work to deliver any changes that are required. There will also be a need to identify if the NHS IG standard falls short of the Council's requirements in any area. This work will be undertaken as part of the Berkshire West Interoperability Project

- The Care Management system used by West Berkshire Council is coming towards the end of its life. The BCF requirements around data sharing have hastened the need for the Council to make a major investment in new software. This work is being progressed through the usual Council approval process.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

2,659* West Berkshire patients have been identified as being at high risk of hospital admission in 2014/15. The criteria defined within the national Directed Enhanced Service for Unplanned Admissions, the top 2% of registered patients aged over 18 and at the highest risk of an unplanned admission, has been used to identify these patients.

The risk stratification approach used to identify the 2% of patients at the highest risk of an unplanned admission was done through the use of the ACG tool which identifies characteristics such as condition and utilisation of healthcare resources (excluding community and social care data) to stratify those at risk. The ACG model is underpinned by clinical algorithms and is driven by each patient's diagnostic and prescribing records. The ACG tool also clusters co-morbidity and compounded impact on resource needs.

The success of using this tool is evidence through work conducted in 2012/13. At this time patients lower down the risk pyramid were identified by recent presentations at A&E alongside local intelligence from health and social care services. This was known locally as our care coordination project which was designed to minimise the risk of increased resource use by these patients and to reduce hospital unplanned admissions. Developing this multidisciplinary approach enabled us to proactively identify management strategies to avoid increased use of resources and was a valuable first step to providing more integrated care co-ordination across health and social care.

Multi- disciplinary team meetings (MDTs) are the centre of providing local integration with health and social care teams, and have enabled joint patients review and joint planning to support the reduction in unnecessary admissions to hospital by improving preventative clinical care.

Patients with LTC and those who are a high risk of being admitted to hospital have been identified via the ACG risk satisfaction tool and discussed at the a MDT meeting by key professional including community health staff, primary care, social care, medicine manager and voluntary sector and a health improvement plan is put in place.

A lead professional is named for each patient to ensure the effective delivery of actions form health improvement plan and co-ordinate integrated services when there are a number of professionals/service involved

We are committed to ensuring that there is joint assessment and accountable lead professionals and our further plans will detail how we will achieve this. In the Newbury & District CCG area joint care lead training will take place over the next year.

Monthly multi-disciplinary team (MDT) meetings in GP surgeries are used to identify people at high risk of hospital admission or of needing long term care, and to develop a preventative plan, with the appropriate organisation taking the lead for the plan. MDTs are attended by GPs, Community Health staff and social care staff.

We recognise the role of GP practices in taking the lead professional role, but also the importance of social care and health professionals in supporting coordinated care and

support plans. We are working on plans to deliver a model of accountable lead professional, focused on those most in need. The Hospital at Home team and Integrated Short Term Health and Social care team developments will support those most at risk by providing a coordinated, timely care plan.

Through the governance arrangements being put in place, the implementation of the schemes outlined in this paper will be overseen by senior professional from across both health and social care. The integration changes envisaged will strengthen the joint assessment arrangements, simplify procedures and allow for clearer identification of the appropriate lead professional.

* Includes 50% of North & West Reading High Risk Population

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The Case Coordination Model as described in i) above has been operating for 12 months in the Newbury and District CCG surgeries and jointly identifies risk for a small number of key patients constructing joint support solutions to minimise the risk of Care Home or Hospital admissions.

Locally, outside of the BCF programme, we have invested our £5/head funding for GP's as the Accountable Health Professional for the over 75 year olds within practices to further drive and support this work. This will ensure all care plans are uploaded onto a central repository, for access by multiple organisations, provide further support in the form of administrators and health professionals for the delivery of the admissions avoidance DES and a commitment to develop 50% of care plans following a face to face consultation for over 75 year olds who are also in the top 2% risk category.

The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). The named GP will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary. A number of patients within this cohort will have dementia or mental health problems and the lead professional will be responsible for ensuring that these patients have a personalised care plan and that they and their carers are closely involved in the development and implementation of the plan, as described above. This will be particularly beneficial for these groups, ensuring that proactive care is given, rather than responding to crisis.

The lead professional will be supported in their role by a practice team made up of a mixture of clinical and administrative roles. They will act as the main point of contact for the patients and their families. They will support clinicians in following up referrals/results/investigations/letters and liaising with other health and social professionals and they will make regular telephone contact with patients, carers and families to update them on progress of their care plan (this might be general health status or after a particular acute event such a bereavement). This may be as agreed in healthcare plans or simply courtesy calls. Many frail elderly do not have family who live locally and this would improve the quality of care delivered and provide comfort to relatives that their loved ones are in safe hands.

This dedicated resource should provide focus and continuity of care for patients and their

carers/families and provide them with assurance that their concerns and issues can easily be resolved with minimal fuss. They will facilitate navigation from the Practice reception service to the right person who can take immediate action when required, and support the GP in prioritising responses, to ensure that any problems are dealt with appropriately. They will also ensure that care for the patient is coordinated across all health and social agencies involved in the care of the patient.

Practices are required to assess the impact that the scheme has on the care of these vulnerable patients. It is expected that this will be discussed at regular practice meetings and there will be a specific practice review meeting, involving all clinicians in the practice at year end to assess the impact on patient care and outcomes. As part of this, the practice will consider the results of the annual patient/carer satisfaction survey which will be developed in consultation with the practice patient group.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We currently have 787* individuals at high risk with joint care plans in place. This is the case load associated with the "specialist community nursing teams" i.e. Community Matrons, Heart Failure, and Respiratory teams. This therefore represents 29% of the total high risk stratified population at risk of an unplanned admission (The 2% on the risk registers).

In addition we also have a further 594* patients, lower down on the risk triangle with joint care plans in place as a result of work carried out in 2013/14 through our case coordination project and the National enhanced service for risk stratification.

Care plans will also be in place for those patients on the community nursing case load who are not in the high risk category.

**Includes 50% of N & W Reading high risk population*

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The views of patients, service users and the public have been critical to shaping this plan. Members of the public have shared their experiences of local health and social care, and their aspirations for the future. This has given us a firm mandate to develop integrated services with the individual at the centre. The distinction between health and social care makes no sense to the people who need support. They perceive the hand-offs between health and social care as unnecessary bureaucracy standing in the way of them receiving the services they need.

Consultation and engagement has been through a variety of methods, most noticeably through NHS 'Call to Action' events which have featured both CCG and West Berkshire Council collaboration. This event involved good high quality engagement with patients and the public about the future of both health and social care services in the district, which has in turn shaped our collective planning submissions.

Call to Action 20 March 2014, Visual Minutes

Working in partnership, health and social care came together in March 2014 to set up and run a 'pop up shop' called Wellbeing in West Berkshire in the Kennet Centre, Newbury. This unique and innovative engagement with the public afforded us an opportunity to listen to patient and public views on integrated services, and also allowed health and social care partners to provide high quality and tailored information on local services to those who visited the pop-up shop.

The following are a sample of the wide range of comments gathered from service users during events such as that described above and from the surveys undertaken.

Health and Social Care staff also attended both the Newbury Culture Festival (July 2014) and Newbury Youth Festival (August 2014), engaging with a more diverse and younger audience around their health and social care expectations.

Going forward, we will proactively engage with a wider range of community forums to reach those who may identify more readily with neighbourhood, cultural or other interest groups. Both the local authority and the CCGs have in the past taken part in local festivals to raise awareness of services or proposed changes to these. This has been highly successful in reaching large numbers of people. Our communications and engagement strategy therefore identifies opportunities for interactions in places the public is naturally drawn to; for example, shopping centres, supermarkets, town centres and a vast range of summer and winter festivals and carnivals. Average attendance by number and demographic profile is being mapped so that our integration programme makes best use of the various opportunities for public engagement as are most appropriate for different aspects of the programme.
Further and ongoing engagement is being planned, with follow-up 'Call to Action' events scheduled to continue an inclusive and open dialogue with the public.

Within the CCG, the Patient Panel Group has also been consulted on plan developments.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We recognise the need to work across health and social care boundaries in order to move towards our vision of fully integrated health and social care for the residents of Newbury & District. GP Commissioners and providers have come together to develop the vision and schemes described in this plan, including developing our understanding of the behavioural and attitudinal shifts needed to achieve real and lasting change. Lead Members for Health and for Adult Social Care within the local authority have been closely involved in the preparation of this submission. Through them, commitments have been secured from across the Council to enable us to draw on a range of services which can support and promote wellbeing for local residents.

This submission has been developed over a series of meetings involving community health providers, Social Care and Primary Care and also discussed at the West Berkshire Integration Steering Group. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

Early development plans have been shared with Royal Berkshire Hospital through a Berkshire West planning meeting, which included acute and provider sector organisations and their input has been taken into account. We will continue to involve them in our plans going forwards.

The main local NHS Providers Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital Foundation Trust have been engaged in the development of all the schemes. Both clinicians and managers from the Trusts have played into the development of business cases and models of care delivery. Hampshire Hospitals NHS Foundation Trust are now members of the Berkshire West Integration Steering Group, reflecting patient flows from Newbury & District towards Basingstoke. Plans are also in place to involve the Great Western Hospital.

Developing and refining our Better Care Fund projects will continue to be undertaken via whole system workshops including key stakeholders.

The main local acute provider Royal Berkshire Hospital Foundation Trust is aligned to the figures, as outlined in Annex 2. This will be reflected in the 2015/16 operational plan that is currently in development.

ii) primary care providers

Primary care providers have been engaged in the development of the BCF plan through discussion at the Newbury & District CCG Council of Practices. These discussions were informed by feedback from the GP lead who attends both the West Berkshire Health & Wellbeing Board and the West Berkshire Integration Steering Group.

Likewise the CCG's Council of Practices has a representative on the Primary Care Programme Board (which meets every four weeks), through which the primary care aspects of the BCF plan, such as 7 day working (BCF05), and the Care Homes project (BCF07) have been developed.

These engagement mechanisms will continue as the plan moves into the implementation

stage, and the various BCF schemes are discussed on an ongoing basis.

iii) social care and providers from the voluntary and community sector

Representatives from the independent and voluntary sector were involved in the Call to action events and have commented on the locality's proposals. We have established provider forums and these will be used to inform integration work ongoing.

c) Implications for acute providers

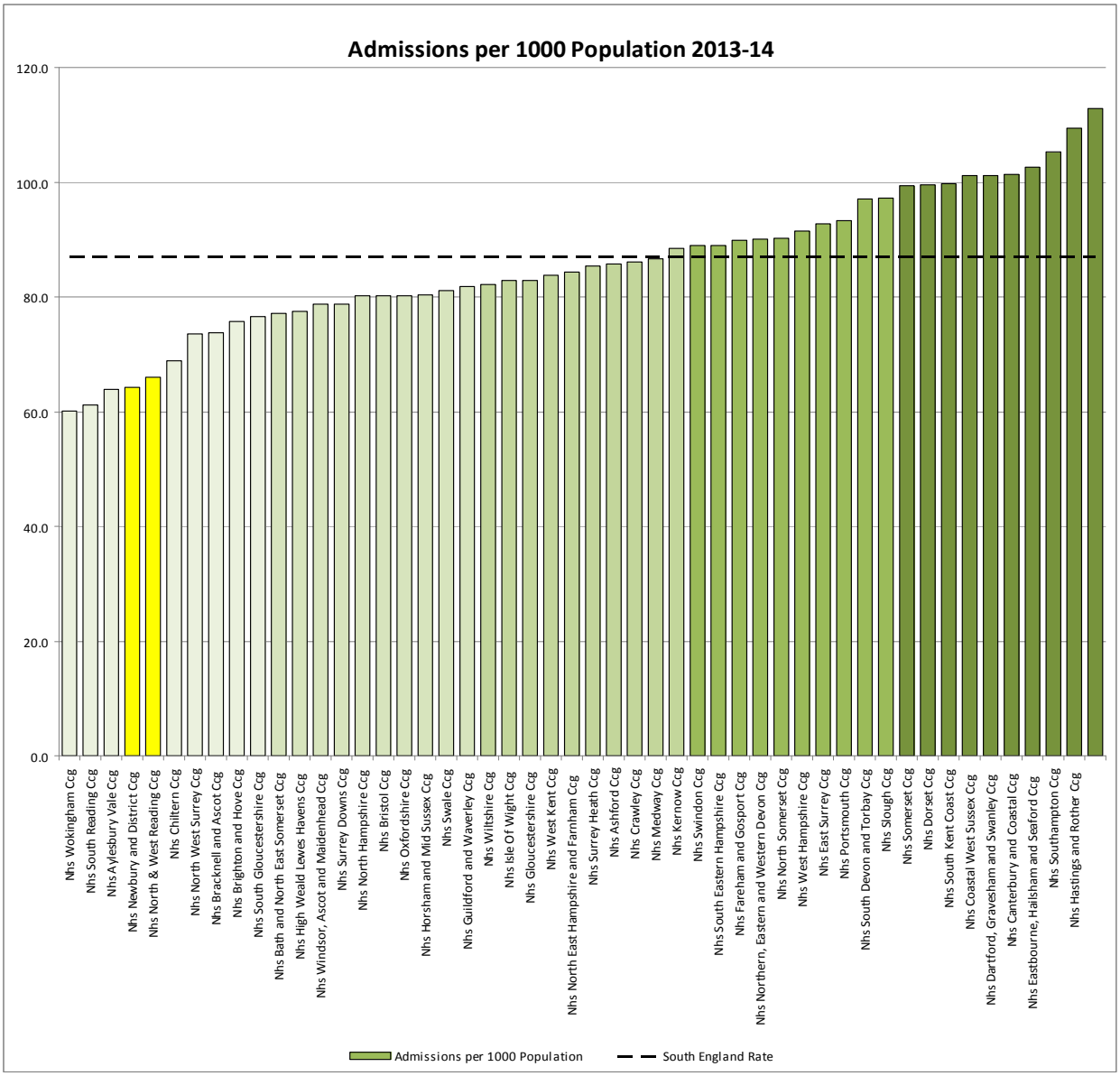
Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The BCF schemes are intended to transform the pattern of activity in West Berkshire reducing non-elective admissions, delayed transfers of care and admissions into care placements.

Extensive work has been done to model the impact of the schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by <1.1%> in 2015/16 vs. 2014/15.

Although this is not at the 3.5% target, this is a very ambitious plan, given that Newbury & District CCG is already in the top performers for non-elective admissions in the South of England:



The graph shows non-elective admissions per 100,000 population for the South of England. The two West Berkshire CCGs are highlighted in yellow and as can be seen are in the upper quintile of the South of England. The rates of non-elective admissions have been increasing year on year for the last 3 years which would again suggest a large reduction in rates would not be possible.

The H&WB has forecast 4% (400 spells) growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting the defined schemes resulted in savings of 5% (506 spells) of non-elective admissions, giving a net reduction of 1% (106 spells) in non-elective admissions in 2015/16 compared with 2014/15 forecast.

West Berkshire patients are often admitted to hospitals other than RBFT, however the hospital at home scheme only impacts on those attending RBFT and therefore the scheme does not target all West Berkshire non-elective admissions.

In addition to this there are a number of other metrics that the schemes will affect, which will impact on the income and activity of the acute providers, around key areas including delayed transfers of care, reablement, and A&E attendances.

In line with the in depth analysis that we have done to reach our non-elective reduction, we are now modelling the other impacts of all schemes, in granular detail in order to accurately model the impact on the acute sector. This is currently a work in progress, but we anticipate we will have this finalised with the acute sector in line with the business cycle.

The 2014/15 impact has already been modelled into this year's contract, and we would expect through our contracting conversations for 2015/16. We would expect that where there is an indicated reduction in non-elective activity, we will be building these reductions into the RBH contract for next year, and we would expect that these would be reflected in their 2015/16 operating plan.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF01
Scheme name
Community Nurses Directly Commissioning Care / Reablement Services
What is the strategic objective of this scheme?
The scheme aims to significantly reduce the time taken from a District Nurse identifying a social care need to that care being in place. The early provision of care will minimise the risk of loss of independence and the resulting need for higher levels of care. The local authority agreeing to health staff directly commissioning services on its behalf will allow the removal of a number of layers of the existing process thus reducing the bureaucratic burden on front line staff.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The point of contact for the majority of patients in the community who are either eligible for Council services, or who are at risk of admission to care homes or hospitals is the District Nurse. Currently if a District Nurse identifies the need for care they will have to refer the case for assessment by Council staff or other Health teams who may then refer for Crisis, Reablement, Carer's, Council commissioned or in house care provision services; in all cases the District Nurse is able to initiate and commission in broad terms the care that is needed. If the initial care delivery for all services is through the in house care provision system District Nurses could directly prescribe this service, leading to safe care being put in place and then worked up to the practical ongoing solution for that individual. In addition, WBC's physical disability team will aim to build upon joint working with Health's Long Term conditions teams to progress integration further. Process development: • Identification of range of Health Clinicians from Unscheduled Services under the scheme • Training of Health Professionals • Health Professionals will commission services directly to provide a prompt response to patient needs, and therefore there should not be any ongoing cost implications • In the first few days of the service Council staff will assess the suitability of the service as an ongoing commitment, consider any equipment needs, confirm eligibility, and confirm the individual's personal budget as the ongoing funding source for care; this will establish the standard controls that are used for the Council's commissioning budgets

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This service will be jointly commissioned by West Berkshire Council and Berkshire Healthcare Foundation Trust. West Berkshire Council will be the main provider for the service

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A review of the existing process from a District Nurse identifying a social care need to the care being put in place identifies layers of the process that are only in place to avoid a situation whereby the health professional would be committing social care to expenditure.

Social care accepting the professional judgement of the District Nurse and allowing them to determine the initial social care needs of their patient it would enable a far simpler and speedy process that would benefit all.

The expected outcomes would be;

- The District Nurse would only need to make a single call
- Social care 'control' stages could be removed
- The patient / service user would benefit from the social care package being in place sooner.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of this scheme will not be able to be measured by any specific single metric nor is expected to deliver cashable savings. It will however deliver a better outcome for the service user and will reduce the administrative burden placed on District Nurses freeing up time to do what is important.

The metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – this scheme aims to speed up the process for getting social care services in place when a need has been identified by a District Nurse. Getting care in place earlier should contribute to this metric.

Residential Admissions – getting social care services in place earlier should contribute towards people being able to be supported in their own home for longer and delay any care home admission.

Reablement – again getting social care services in place earlier should contribute towards people being able to be supported in their own home and therefore increase performance for this metric.

Delayed Transfers of Care – this scheme should contribute to this metric in two ways. As explained above it should help keep people out of hospital and will ensure that the right social care is in place immediately upon discharge should they have had to be admitted.

Patient / Service User Experience – clearly any scheme that speeds up the delivery of a service and removes unnecessary barriers between health and social care should result in an improved experience for the patient / service user.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- The key measure of the scheme will be feedback from the District Nurses regarding the effectiveness of the new process for requesting social care for their patients. A mechanism for gathering this feedback will be agreed with the Berkshire Health Foundation Trust.
- The local authority will monitor the consistency of District Nurse initiated services with the social care eligibility regulations.

It is recognised that, as with most new arrangements, the processes are likely to require adjustment once they have been live for a period of time.

What are the key success factors for implementation of this scheme?

- Shared vision from staff from all organisations involved in the current process
- Agreement on new processes
- Training of District Nurses to ensure consistent understanding of the new national social care eligibility criteria.

Scheme ref no.
BCF02
Scheme name
Berkshire West Health & Social Care Hub
What is the strategic objective of this scheme?
To improve the communication between the individual, their family, carers and health and social care professionals. The aim is to create an effective integrated single point of access for health and social care across West Berkshire, Reading and Wokingham by: • providing one centralised point of contact for patients, service users and health/social care professionals, available 24/7; and, • developing a model that provides a simplified process, a consistent approach, less bureaucracy and less duplication.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are currently around 56 different points of access to care across Berkshire West, all with different arrangements and resources, using different referral criteria for eligibility into specific services. Few of the existing points of access are available 24/7. This creates inconsistency, fragmentation and duplication. The aim is to create a model of referral and assessment that moves from a fragmented set of health and social care services to a co-ordinated service that is easily accessible through a single point. It will build on and integrate with the newly established Berkshire-wide Health Hub and on the "Berkshire 10" system wide approach to integration. A Berkshire West Health Hub, hosted by Berkshire Healthcare Trust, our community and mental health provider, has been operating for some time and is demonstrating efficiency benefits for the staff as well as improving delays in discharge, evidenced by a reducing "Fit To Go list" within the acute sector. The aim will be to replicate some of these gains into the new single point of access health and social care hub. Detailed works is underway through consultation and engagement with all key stakeholders to scope out, plan and develop an integrated single point of access Health and Social Care Hub across Berkshire West. This will include mapping of existing patient flows with the aim of improving efficiency and productivity. The service will operate throughout the week providing a 7-day service, 24 hours a day. As part of the detailed scoping work, the Project Board will explore options relating to who will deliver the Integrated Health and Social Care Hub and from where – e.g.: it could be incorporated into the existing health hub run by BHFT or into one of the existing points of access run by one of the local authorities.

It is important to recognise that the development of an integrated single point of access Health and Social Care Hub will require a significant culture shift to achieve better collaboration, partnership working and integration, not only across local government and the local NHS at all levels but also across and between the three localities in Berkshire West. There will be a need for staff to embrace change and to focus on doing things differently and not just delivering more of the same.

This initiative will align with the frail elderly pathway work, and will be closely interrelated with a number of other BCF schemes.

- The Berkshire West Connecting Care IT solution - true interoperability will significantly enhance the efficiency and effectiveness of the Hub.
- A 24/7 single point of access for health and social care will support the implementation of neighbourhood working and increased GP access over the week by providing an effective and timely resource for triage, provision of advice, information, support and signposting and so potentially reducing delay in the management of referrals.

It is proposed to target patients and services users most likely to benefit: i.e. those in high risk groups with complex health and social care needs and with multiple long term conditions, with the intention of reducing the occurrence of additional health problems in this group and supporting them to achieve greater control and ability to manage their health and social care.

The volume of patients that will benefit from this scheme is yet to be determined, as the detailed design of hub has not yet been agreed. However it is anticipated that the 2% with high risk of unplanned admissions will be included. The baseline will be determined from the current activity through the Health Hub, West Berkshire Council and all other main points of entry into the system.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this scheme will be designed, managed and controlled by a dedicated Integrated Health & Social Care Hub project board, reporting to the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board.

The aim is to establish the Hub by June 2015.

A key part of the detailed planning will involve the key stakeholders, the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board agreeing the commissioner(s), budget, performance metrics and management structure for the Hub.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. (National Voices 2011). Emerging evidence suggests that developing an integrated single point of access health and social care hub where services are co-located (either virtually or in reality) is more convenient for users, and has

the potential to help enable more integrated and timely care (Imison *et al* 2008).

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

The literature confirms that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007) and that focusing on improving patient care helps to overcome professional boundaries for staff working in an integrated and collaborative structure (Heenan and Birrell, 2006).

The provision of information and support for patients / carers / members of the public through a single point of contact will create better informed service users. Being informed is a prerequisite to being involved and engaged, and there is a growing consensus that more engaged patients experience better outcomes (Health Education England, 2014).

The establishment of a single point of access for health and social care in conjunction with other transformational improvement schemes is identified as being best practice, as demonstrated by initiatives across the country, eg: NHS North West London, Torbay & Southern Devon Care Trust, Bridgewater Community Health NHS FT. However, many of these initiatives have yet to publish robust, evidence based evaluations of their impact. In addition, as most of the initiatives include a number of different improvement schemes, it is not yet possible to identify with certainty the unique impact of developing a single point of access health and social care hub.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The outcomes anticipated are as follows;

- Improved communication, transmission of information and data sharing within and between health and social care teams across all 3 localities
- Faster response times which should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care
- Contributing to enhancing patient and service user satisfaction as the difficulties and frustrations they experience in navigating a complex and un-coordinated health and social care system will be reduced if not removed entirely
- Assist the acute unit in achieving greater efficiencies through improved patient flows

The metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – any scheme that enables the right support to be provided at the right time should make a positive contribution towards reducing non-elective admissions.

Residential Admissions – to be added

Reablement – again ensuring the right service is provided at the right time should contribute towards people able to be supported in their own home and therefore increase performance for this metric.

Delayed Transfers of Care – the improved communication and sharing of information between health and social care teams should make a positive contribution to this metric as it should ensure that the right support is in place ready for a patient discharge.

Patient / Service User Experience – this scheme should make it far easier for a person to obtain the support they require from just the one phone call. A person would no longer be required to identify if the support they need should come from health or social care. As the technology improvements are rolled out this should also see a person only having to tell their story once. This should all result in an improved performance in respect of the patient / service user experience metric

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

During development of this scheme, the Single Point of Access Health & Social Care Hub project board will undertake ongoing monitoring of progress. As part of implementation, the project board will determine the process for regular assessment, review and evaluation of the Hub.

It is likely to be agreed that providers working within the Integrated Health & Social Care Hub will be required to collect data around service utilisation and service user satisfaction; in particular from the perspective of whether the new model of service provision makes a difference to those on the receiving end and whether patients and service users report a better, more seamless, experience of care.

Project evaluation will involve both qualitative and quantitative evaluation to ensure that the Hub is operating effectively and is achieving its objectives. Key performance indicators will be agreed during development and will include delivering better outcomes and customer experience for patients and service users and the Hub's contribution to the achievement of any of the targets within the Better Care Fund metrics. Evaluation will be undertaken through analysis of data and satisfaction surveys and recorded on the project dashboard.

The findings from the reviews will be reported to The Health and Well Being Boards in all localities via the Berkshire West Partnership Board and also to the Berkshire West Integration Programme Board (meetings for the remainder of 2014 are scheduled for 18 Sept, 16 Oct, 20 Nov, 18 Dec).

What are the key success factors for implementation of this scheme?

The scoping, planning and development of an integrated single point of access Health and Social Care Hub will take place during 14/15 with the aim of having an agreed model of an integrated Health and Social Care Hub in place and operational by June 2015, although this might be in the form of a pilot across a smaller area initially, to ensure the success of the initiative prior to full roll-out.

Whatever the final design of the hub, there will be a need to:

- Achieve agreement, support and commitment for the scheme from all key stakeholders, including agreement of a project plan. This will include identifying any conflicting organisational priorities / different ways of working between the various organisations, any potential impact on the services required by other providers and any perceptions of professional boundaries that may hinder the project and agreed action to address these
- Agree where/how the Hub is to be established, be that in a virtual or actual location
- Ensure that effective IT systems are in place to support delivery of care via the Hub
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on the development of the Hub
- Ensure appropriate governance processes are in place relevant to the integrated health & social care hub
- Ensure availability of staff in sufficient numbers with the right skills to provide adequate staffing for the hub in response to anticipated no of contacts
- Provide the required education and training to equip the existing and future workforce for this new models of care

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Scheme ref no.
BCF03
Scheme name
Patient's Personal Recovery Guide / Keyworker
What is the strategic objective of this scheme?
The strategic objective of this scheme is to ensure that patients who have been assessed as requiring social care do not remain in hospital for longer than is necessary. We know that a hospital environment is not conducive to supporting a person to maintain their independence and any avoidable delays in their discharge has a negative impact on the outcome of their social care assessment and can result in more intensive long term social care support being required. The aim will be that the length of time individuals remain on the "Fit to Go List" will be reduced. The second phase of the scheme will be the concept of dedicated personal support through the care pathway rolled out to community based services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The first phase of the scheme will be available to all vulnerable or frail hospital patients. If the model is successful it will then be rolled out to provide similar support through the care pathway for vulnerable patients/service users in the community. The patient will be supported for the journey through the care pathway. This support may be provided by either a Social Worker a qualified clinician, a trained Care Worker or volunteers or staff working for a voluntary organisation; there would be a strong attraction of building on the latter as a model detaching the function from other more defined roles. The complexity of each case will determine the level of professional support required. The key elements of the service would include; • Recovery Agreement: as a deliberate discipline, an agreement will frame the journey ensuring that the priorities are set by the patient, and creating flexibility as circumstances, speed of progress and conditions change along the way. • Delivery of service elements: the Recovery Guide can engage the different service elements as would a Personal Shopper, ensuring that the right choices are made and the practical delivery arrangements are in place. • Case Management: when the active intervention is complete monitoring will be needed initially to ensure the transfer to normal life is successful, and in cases where long term support is indicated to ensure that this is successful and appropriate. Currently this is covered by a Council review system which cannot effectively deliver. For many stable low cost long term support plans it may be possible for Community Nurses, or other health staff who regularly visit patients to

deliver other services to periodically 'sign off' an annual renewal of service.

Other integrated initiatives that will support this scheme include, 7 Day Services, Health and Social Care Hub and Joint Care Provider.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery role of each organisation will be determined as the project goes through the design stage. There are a number of options available that need full evaluation before any final decisions are taken.

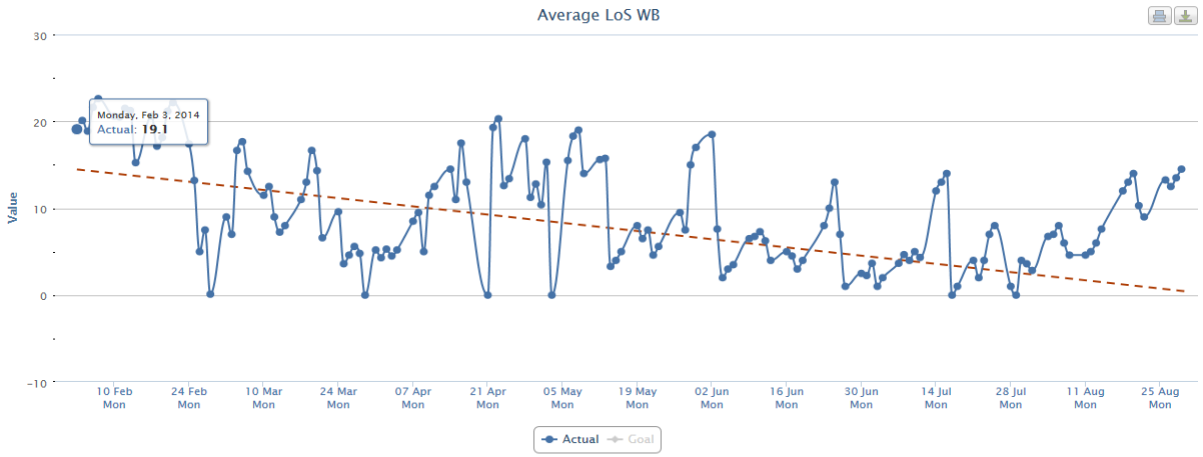
At this stage it is anticipated that the service will be commissioned by West Berkshire Council.

The options for service delivery include the direct employment of staff by West Berkshire Council, contracting with the voluntary sector for the service or organising through the Joint Care Provider service (BCF04), a joint arrangement between West Berkshire Council and the Berkshire Health Foundation Trust.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs. the average patient. The following graph shows that the numbers of patients who are medically fit to be discharged, but are still in hospital have steadily increased over the last six months with the recent norm being between 50 and 60. This is against a system wide target, agreed as part of the A&E Recovery Plan, of no more than 20 patients on this list at any one time.

The following graph shows the duration of time on the "Fit To Go" List (Feb to Aug 2014), both of which are increasing.



The average length of time that patients remain on the "Fit to Go" List has remained significantly above the system wide target of five days agreed as part of the A&E Recovery Plan and is currently above 10 days. This in turn contributes to the impeded flow through the inpatient beds.

For social care the impact of these delays often manifest themselves in the service users having an increased dependency resulting in greater long terms social care needs than would have otherwise been the case.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

With the demographic changes facing all health and social services over the coming years it is very difficult to set achievable targets. In the first 5 months of 2014/15 West Berkshire social care has seen a 7% increase in client numbers with the resulting increase in care and nursing home placement numbers.

This scheme will place downward pressure on the delayed transfer of care figures and should also contribute in a small way to social care's challenge of managing increasing demand at a time of reducing budgets.

The metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – whilst the initial phase of this scheme will focus on ensuring those in hospital do not stay longer than necessary, the second phase will be about supporting people to navigate through the care pathway helping to ensure they get access to the right services at the right time. This should make a positive contribution towards reducing non-elective admissions.

Residential Admissions – we know that extended hospital stays are not conducive to people maintaining their independence and can result in people going straight from a hospital bed to a to a care home bed. This scheme should help people move through the system quicker and thus place downward pressure on the number of residential home

admissions

Reablement – to be added.

Delayed Transfers of Care – the key aim of phase 1 of this scheme is to avoid unnecessary delays in the discharge from hospital into social care. This scheme should therefore make a key contribution to delivering an improvement in this metric.

Patient / Service User Experience – providing support to hospital patients in the first phase and people in the community in the second phase should have a very positive direct impact on the patient / service user experience metric

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Use of data from the Alamac Kitbag on the 'fit list' which will include numbers and length of stay. This data is input by each partner in the health and social care system, produced by the Royal Berkshire Hospital and circulated to local authorities on a daily basis.
Detailed analysis of the length of stay in hospital for patients using the scheme and comparing to average lengths of stay.
Measure of patient satisfaction for those using the scheme;

What are the key success factors for implementation of this scheme?

- Drafting and sign off of protocols for role across whole range of Health and Social Care operation.
- Link with Elderly Care Pathway Project for definition, responsibilities, duties and powers of keyworker role.
- Defining role and host organisation
- Determining delivery vehicle, including option of Voluntary Organisation.
- Redefining of some roles within existing services to release funding
- Patient/service user "buy in"

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Scheme ref no.
BCF04
Scheme name
Joint Care Provider
What is the strategic objective of this scheme?
The strategic aim of this scheme is to improve the service user experience by removing duplication caused by having separate health and social care teams delivering similar services. This will enable the referral process to be reacted to more quickly thereby achieving a more accurate first time match between the individual and the service. The intention is to build on existing informal joint working at an operational level to create a combined service that breaks down organisational barriers to ensure that care is provided at the right time and in a way that is seamless for the service user. By working together the organisations involved will be able to make better use of their diminishing resources.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Council's Maximising Independence Team and Homecare Team, and the Berkshire Health Foundation Trust's Intermediate Care, as part of the Integrated Community Health services, have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system Developing these three staffing units into a shared service would simplify the deployment to support individuals, would cut out artificial service transfers, increase continuity of service, and create efficiencies by avoiding duplication; initially this could be created as a 'pooled' service, developing into a Pooled Budget. There a number of forms this shared service could take and this will be evaluated during the scheme design stage. Operating as if a single service would improve the service user experience by removing the duplication that often exists. There would also be an opportunity to better manage the external provider market where at present both organisations can find themselves competing for the same services at peak times. The flexibility of this proposed shared service may make it possible for both Health and Social Care to reduce their commissioning of external care. The services provided by the teams are available for people in the community as well as those discharged from hospital. The Better Care Fund will also provide a key role in protecting the capacity of the social care reablement service that would otherwise have to be reduced in 2015/16 in response to falling council budgets.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The two organisations providing the assessment and care delivery services are Berkshire Health Foundation Trust and West Berkshire Council. The key categories of staff involved are as follows;

Berkshire Health Foundation Trust

- Occupational Therapists
- Nurses,
- Physiotherapists
- Therapists
- Multi therapy assistant staff
- Care Delivery Assistants (various levels)

West Berkshire Council

- Senior Carers,
- Care Assistants
- Occupational Therapists
- Social Workers
- Personal Budget Support Workers

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The selection and design of this scheme has very much been driven by service managers and front line staff across both Berkshire Health Foundation Trust and West Berkshire Council. These staff have very clearly articulated the duplication that exists and the regular actions they take on an informal basis to try to improve the overall system.

By developing these informal arrangements into a shared service arrangement we expect to build on the existing joint working and design arrangements that make best use of the resources available to each organisation.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Whilst this scheme has been driven by a desire to make best use of resources across the two organisations involved, it will provide other benefits. The sharing of resources should

result in a far more flexible service allowing the required care to be put in place much quicker. This flexibility will be particular important as we move to a model of 7 Day services. This scheme should help reduce the number of people readmitted to hospital within 91 days as a direct result of the right care being delivered at the right time.

The metrics where this scheme is expected to make a positive contribution are;

Reablement – this scheme will have a direct impact on this metric as it will enable the right care to be delivered at the right time thus enabling more people to be looked after in their own homes

Delayed Transfers of Care – by the health and social care teams working together as one we will simplify the deployment of support to individuals, cut out artificial service transfers and avoid duplication. This should result in a service that is far more effective and able to support timely hospital discharges thus improving this metric.

Patient / Service User Experience – this scheme should make it far easier for a person to obtain the support they require. The removal of artificial service transfers should see a person only having to tell their story once and then experience being supported by professionals behaving as if a single organisation. This should all result in an improved performance in respect of the patient / service user experience metric

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The success of this scheme will be measured by the following;

- Monitoring the number of those service users readmitted to hospital within 91 days
- Monitoring the number of contacts at the Council's Access for All (front door) Team.
- The level of service user satisfaction, this will be measured via the annual statutory customer survey.
- The views of front line staff managers will be gathered as part of a formal review of the scheme post go-live

What are the key success factors for implementation of this scheme?

- Agreement to be reached between Berkshire Health foundation Trust and West Berkshire Council on the design of the new scheme
- Buy in from staff of both organisations for the new working arrangements

Scheme ref no.
BCF05
Scheme name
7 Day Week Service
What is the strategic objective of this scheme?
The strategic aim of this scheme is to enhance the range of health and social care service that are currently available on a 7 Day basis. The new offering will need to be both seamless across the services and on a scale that is affordable to each of the organisations involved in the delivery.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Across health and social care in West Berkshire there is already a combination of services that are available 7 days per week. Currently within Newbury & District CCG a number of services are working extended hours. Berkshire Healthcare Foundation Trust provides community nursing 24 hours a day, 7 days a week. Other services such as Intermediate Care, Rapid Response run a 7-day service (but not 24hrs) West Berkshire Council has an Extended Hours Service provided by the In House Domiciliary Care Service 6am to 11pm 7 days per week; this initially provides care in urgent circumstances, for example for avoidance of admissions into Care Homes or Hospitals; it could provide support where a carer becomes unwell; it may also deal with urgent referrals being passed over from health services. The service will also expedite discharges from hospitals either through the Council's direct service or through a care provider which is already supporting an individual. Planned admissions to care homes or to domiciliary care agencies following a hospital assessment can be effected at weekends on a limited basis. Whilst we have this distinct BCF scheme for 7 Day Services all of other BCF schemes will contribute to the enhancement of our existing 7 day arrangements. The planned enhancement of these arrangements will be underpinned by our 7 day health and social care hub (BCF02), a single point of access to health and social care that will signpost professionals and patients throughout the whole week. Building upon what is already in place, the initial emphasis will be on ensuring we can deliver safe planned discharges from acute hospitals on a 7 day basis. As the acute hospital deliver increased levels of 7 day discharge services then social care will develop services to match this change of demand. A key element will be to ensure that external providers of both residential care and domiciliary care are able to meet any new requirements, as much a capacity issue as a cost issue in West Berkshire. The model will involve an expansion of GP service provision beyond core hours (8am -

6.30 pm, Monday – Friday) to offer access into early mornings, evenings and at weekends, particularly Saturday mornings. This builds upon and enhances existing extended hour arrangements that have been commissioned by NHS England.

Practices will offer both routine and urgent appointments during these extended periods, interfacing with other services to support admissions avoidance, reduce type 3 A&E attendances and maximise opportunities for discharge back to GPs. During these hours there will be requirements to ring fence some appointments for patients who have been discharged to access their GP practice (particularly on a Saturday morning) and a requirement to give a priority to patients identified by practices as being at high risk of admission. These will include patients included on the 2% care management registered developed by GPs as part of the national Avoiding Unplanned Admissions Directed Enhanced Service (DES) (see section 7d)

The scheme will provide more opportunity for patients to access GP services to help manage their long term conditions in the community, thereby avoiding unnecessary admissions and/or attendances to A&E.

This increased access will also enable private home care and residential and care home providers to be confident about taking patients on at the weekend as they will be able to speak to a GP if necessary.

Practices are being commissioned to increase extended hour arrangements during 2014-15 under pilot arrangements which will make more early morning, evening and Saturday morning services available. The service to be commissioned from April 2015 will be shaped by the findings of these pilots, and national best practice including emerging results from the Prime Minister's Challenge Fund pilots, together with the audit of in-hours capacity and utilisation currently being undertaken.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The detailed design for enhanced 7 day services needs to involve all of the health and social care organisations in West Berkshire. No one organisation should make changes without the full engagement of the other partners otherwise we risk ineffective and disjointed services**.**

The delivery chain would therefore involve the following;

- Royal Berkshire Hospital
- Berkshire Health Foundation Trust
- West Berkshire District Council
- Newbury and District CCG
- South Central Ambulance Service

It is anticipated that extended GP hours will be delivered by existing GP providers, working as collaboratively as appropriate, with an interoperable IT solution in place as soon as possible and if appropriate. The service is likely to be commissioned by the CCGs as a Community Enhanced Service, potentially linking with NHS England around

the existing Extended Hours DES.

GP Providers will commence extended hours working once appropriate plans are in place that ensure there is a sustainable workforce, services are being delivered from an appropriate site, and that the model of delivery is an improvement on existing access arrangements and better meets the needs of patients. It is anticipated that this will be from April 2015.

The GP element of this scheme will be overseen by the Primary Care Programme Board, with the Primary Care Team within the Berkshire West CCG Federation taking responsibility for setting service specifications and monitoring delivery. The Primary Care Programme Board will in turn feed into the West Berkshire Integration Group. It will be for individual GP providers to implement local practice arrangements.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Experience tells us that inflexibility in current service arrangements in the community results in delayed transfers of care. Proposals will enable people to be able to access services across 7 days whether this is returning home with a package of care or admission in to a residential/nursing home**.**

The evidence base around extending GP hours is still emerging and the arrangements will be commissioned as pilots initially with a requirement to collect capacity and utilisation data which will then be triangulated with A&E and Westcall attendance rates and admissions data.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Providing an enhanced offering across the week should be a key contributor to delivering a wide range of improvements across both health and social care. Being able to provide the right support at the right time should prevent situations escalating and reduce the prospect of individuals make inappropriate decisions regarding the carer pathway to follow. It is expected that this will play a role in delivering a reduction in unnecessary A&E attendances and a reduction in delayed hospital discharges.

The metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – whilst both health and social care already have a wide range of services operating across the week, it is recognised that enhancing their services to better support people particularly at weekends will have a positive impact on this metric.

Residential Admissions – improving social care support at weekends will prevent wrong decisions being taken and unnecessary residential admissions taking place. Making long

term care decisions when people are in crisis should be avoided and therefore improving the availability of empowered professional support, along with increased social care provider capacity, should make a positive contribution to this metric.

Reablement – good extended hours services are already in place for health and social care but as health partners begin to expand their range of 7 day activity it is important that social care are able to respond to increased demand. This will ensure that no person is readmitted to hospital simply because their need for support happened outside normal hours. For this reason the 7 Day Services has a key role in the delivery of improvements for this metric.

Delayed Transfers of Care – building upon what is already in place, ensuring social care services are able to react to increasing levels of hospital discharges at weekends is essential to minimising delayed transfers of care

Patient / Service User Experience – increasing the range and level of support out of hours and at weekends can only have a positive impact on this patient / service user experience metric

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Crediting performance improvements against any one scheme would be impossible but enhanced 7 days services should contribute to a number of the key performance indicators that are already monitored across the health and social care systems. The key ones being;

- A&E attendances
- Delayed Transfer of Care
- 91 day post discharge data
- Social care long term care client numbers
- Social care annual service user experience results

What are the key success factors for implementation of this scheme?

- Effective engagement of all partners across health and social care
- Joint planning with all partners then delivering the agreed changes
- Engagement with external service providers to ensure they are able to meet requirements
- Increasing community resources to deliver enhanced models of 7 day working in order to reduce pressures in the acute sector.
- Increased certainty around the continued existing of the Better Care Fund resources, in whatever form, after 2015/16.

Scheme ref no.
BCF06
Scheme name
Hospital at Home
What is the strategic objective of this scheme?
The service aims to enable care to be delivered closer to home, reducing avoidable non-elective admissions into the Acute Trust, providing a positive patient experience and journey of care through intensive, integrated and seamless multi-disciplinary case management in the patient's own home. A large number of non-elective admissions are a result of acute episodes that could be treated at home, as the patients are clinically stable and do not require diagnostic assessment. The Hospital at Home scheme will facilitate this by providing a "virtual ward" by which patients can be cared for at home. The service will provide safe intensive health support at home for people who are high acuity.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service is being provided by Berkshire Healthcare NHS Foundation Trust (BHFT), a Community Services Provider. Patients attending Royal Berkshire ED department, that meet the inclusion criteria and are considered suitable for H@H, will receive full diagnostics and treatment in RBFT and then will be transported home by South Central Ambulance Services, to be met at the home by the Matron from BHFT. Daily virtual ward rounds including Social Services, BHFT medical team, and the clinicians responsible for the well-being of the patient will take place. Visits to the patient home will occur as necessary, and it is expected that there will be multiple visits per day. Social Services will support the patient where applicable. The Hospital at Home Service will need to be coordinated, both proactively and reactively, providing clear and integrated pathways of care. This means that those patients that are already known to clinicians within the community and are already receiving continuous care would benefit from contacting a single point of access to the Hospital at Home Service when experiencing a crisis. The target population for this service is those patients with acute infections, or deteriorating long term conditions, or conditions like dehydration, where they are clinically stable, but require intensive support. Patients will be selected by the Community Geriatricians when they consider that an admission would be appropriate and the patient would normally have had a greater than zero length of stay in hospital. We will use the National Early Warning Score (NEWS) and suitable patients will have a NEWS score of 5 or less and be assessed as being stable. They will also be carefully selected according to the inclusion and exclusion criteria for the scheme, but could potentially be anyone over the age of 18 who is registered with a West Berkshire GP and resides within the West Berkshire Council area. The patient needs to consent to be treated in their usual place of residence (home). Patients who meet these criteria therefore are likely to cover a wide

age span of suitable patients who may have a variety number of different medical conditions.i.e. the inclusion criteria are not disease specific but offer a more holistic and outcomes focused view of the patient.

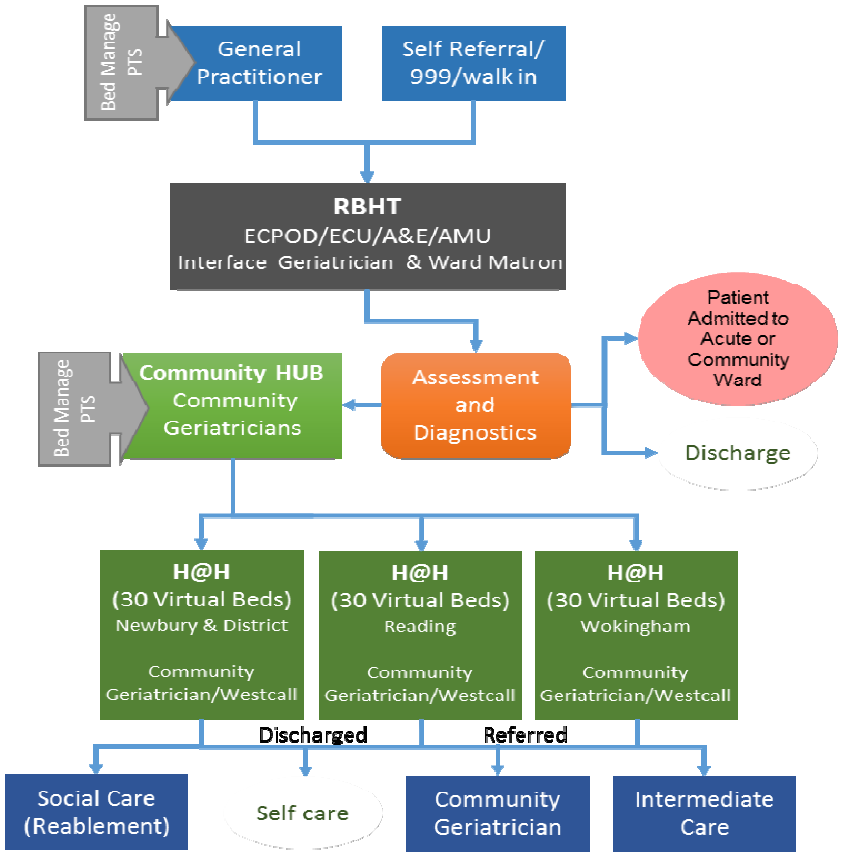
Hospital at Home will deliver:

- Locality sensitive operational pathways that deliver sub-acute care in the individual's home, seven days a week
- Clinical assessment and intervention within 4 hours of attendance at the ED in the RBH and effective interface arrangements to ensure as many patients as possible are offered the opportunity to be treated in their own home wherever clinically appropriate, and therefore supported in early and proactive discharge from Emergency Department
- Multi-disciplinary assessment, intervention and review of patients referred into the service led by a Community Geriatrician
- Effective operational liaison between community health and social care services to ensure coordinated and seamless patient care, and timely and safe discharge from Hospital at Home

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Wokingham CCG is leading the commissioning of this service. RBFT is the secondary Trust provider that will be responsible for identifying, diagnosing and treating the patient initially, before transferring the patient into the ward at home. BHFT will be the main provider of all clinical and medical staff that will support the patient during their admission, through to discharge, where the community re-ablement team and other appropriate community services provided by BHFT and Adult Social Care may be engaged, where necessary.



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Non elective admissions to hospital are rising due to the increased age profile in Berkshire West, and there is also an expected increase in long term conditions that will have an impact on services. Older people stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.

The people admitted who are elderly or have long term conditions are often acute but clinically stable. In these instances it is possible to care for patients in the community via a virtual ward.

Evidence base – hospital at home

With specific reference to the "Hospital at Home" Scheme a recent report from the King's Fund ***"Avoiding hospital admissions – what does the research evidence say?"***confirmed that a systematic review of trials comparing 'Hospital at Home' schemes with inpatient care found that, for selected patients, avoiding admission through provision of hospital care at home yielded similar outcomes to inpatient care at similar or lower cost. Elderly patients with a medical event such as stroke or COPD, who were clinically stable and did not require diagnostic or specialist input, had slightly more subsequent admissions in the hospital at home group, but had greater levels of satisfaction, and their care at home was less expensive. This report went on to recommend that commissioners should consider implementing hospital at home.

In addition, the *Nuffield Trust study (June 2013*) of 3 current Virtual Ward programmes,

has shown an overall reduction in Electives, Outpatients, A&E and Emergency costs for the first 6 months post discharge to the ward of around 5% overall, compared to the costs of the patients pre referral. However:

- In Devon emergency admissions were reduced by 25.7%;
- In Wandsworth it was a 45% reduction in the first few months;
- In North East Essex they expect a 25% reduction over the first year.

There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different outcomes, but all show a reduction in costs of at least 19%.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes anticipated are:

- A reduction in non-elective admissions from the defined cohort of patients by approx. 84%;
- High patient satisfaction levels;
- Successful discharge from the service to integrated community teams; and
- No avoidable readmissions back to hospital from the H@H service.

Therefore the metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – A reduction in non-elective admissions from the defined cohort of patients by approx. 84%;

Reablement – No avoidable readmissions back to hospital from the H@H service.

Delayed Transfers of Care – by treating people in their own homes we will reduce the number of hospital admissions and therefore place downward pressure on delayed discharges.

Patient / Service User Experience – this scheme is expected to high patient satisfaction levels and therefore have a positive impact on this metric

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

What are the key success factors for implementation of this scheme?

Key success factors for the Hospital at Home scheme:

- Awareness of the service to ensure that there is enough uptake of the service
- Adherence to a length of stay of seven days to avoid bed blocking
- Sustaining the workforce – although a lot of the staff for this will be redeployed from elsewhere, this will be critical to the success of the scheme
- The model is dependent on a quick turnaround of diagnostic/pathology results
- The volume of calls may impact on the ability for the HUB to manage the coordination process
- Availability of patient transport to convey patients home
- A robust risk assessment of the patient environment will be critical

Scheme ref no.
BCF07
Scheme name
Enhanced Care and Nursing Home Support
What is the strategic objective of this scheme?
This scheme provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents. Residents and their families will experience improved communication with those responsible for their care across the whole of the health and social care system. Their care will be more patient centric, making their experience of care a more positive one. When a crisis occurs, the needs and wishes of the individual will be fully documented in their pre prepared care plan, allowing the right care to be provided at the right time in the right place, This will include avoiding any unnecessary visits to A & E or an unplanned admission to hospital, thus reducing the pressures on the urgent and emergency care system. Care home residents will have equity of access to the care that meets their need over the whole week that is independent of their place of residence, including avoiding any delayed discharges or transfers of care. This scheme will support our aspiration to reduce delayed transfers of care as well as our local metrics of reducing the "Fit to Go" list and the length of time individuals remain on this list. With more people being supported to live at home for longer, those who need 24 hour support in a care home are likely to have complex or multiple long term health conditions. This has growing cost implications for the health and social care economy. These costs can include Accident & Emergency attendances, emergency admissions to hospital, and readmissions. Some admissions are potentially avoidable, such as those for fractures or urinary tract infections. The aim is to reduce non-elective hospital admissions from care homes through introducing a GP enhanced community service, providing additional training to care home staff, and additional community pharmacist resource. The scheme overall will strengthen partnership working between care home providers, community geriatricians, and health and care staff to improve the quality of life for residents. This will include reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents. .
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
West Berkshire has chosen to target Better Care Fund resources on care home residents because their medical needs are complex and rapidly changeable. 80% will have mental health needs such as dementia, depression or a long term mental health diagnosis. They have higher needs than other patients for essential medical cover because they are not able to attend their local GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions. Currently, however, the range, type, quality and consistency of overall care can vary widely between the individual care homes.

The project is expected to deliver an improved quality of life for patients in care homes through a reduction in emergency admissions, the number of falls, and poly-pharmacy. It will also deliver improved end of life experience through advanced care planning, which will in turn improve the overall health and wellbeing of the patients in homes. The work streams within this project are detailed below.

(a) GP Enhanced Community Service

Each care home will have a named GP for each resident who is their principal point of contact with the general practice looking after their residents. There will be a comprehensive and formalised assessment and formation of an individual Supportive Care Plan (SCP) for each resident. This will be completed by the GP with input from a social worker.

There will be regular contacts and visits by GPs with care home staff and community geriatricians to monitor the health status of care home residents. This will pre-empt crises and emergency calls wherever possible through planned care interventions. It will enable a consistent, efficient approach to the use of medical cover, reducing the need for emergency call outs to individual patients and thereby non-elective admissions to hospital.

Joint medication reviews will be performed annually by the GP and the care home pharmacist from the Medicines Management Team using the CCG protocol. Prescribing interventions should maximise clinical benefit and minimise the potential for medicines related problems, e.g. incidence and impact of falls. Prescribers will adhere to the CCG antipsychotic prescribing protocol.

(b) Enhanced training to care home staff

This scheme will also include additional nurse trainer resource going into care homes. Currently, the Royal Berkshire Healthcare Trust and the South Central Ambulance Service receive a high number of referrals from care homes which turn out to be either inappropriate or avoidable if there was better knowledge within the care home setting of how to manage long term conditions. There are very significant numbers staff employed in a care or nursing capacity across care homes in West Berkshire. Developing capability within this workforce has the potential to make a significant impact on hospital admission rates.

(c) Introduction of an additional Community Pharmacist Resource

Increasing the community pharmacist resource will ensure the community pharmacist is able to visit each care home twice a year to undertake medication reviews and provide training on medicines.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Berkshire West CCGs will commission this enhanced service from local GP practices.
Berkshire Healthcare Foundation Trust's Care Home In-reach team, supported by CCG medicines management pharmacists, will deliver a programme of training to all care home staff across the nursing and residential homes within Berkshire West.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The case for change

As the UK population ages, GPs and NHS providers face an increasingly difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. The case for change is unequivocal. In 2011 more than 400,000 people were living in care homes across England, equivalent to the population of Bristol. Over the next 40 years, this is expected to rise to 825,000.

In 2008 Sheffield PCT reported[1] that 'medical cover to care homes is haphazard, evident in a rising and variable rate of emergency admissions that is unacceptable'. In 2005, for example, Sheffield admissions rose by 30 per cent and after a 2006 drop, peaked at 2,270 in 2007. A 2004 local bed usage survey showed 40 per cent of these were for long term condition exacerbations and 25 per cent of admissions from care homes were 'avoidable'. Analysis of non-elective admissions data showed a nearly ten-fold difference in admission rates between homes, indicating inconsistency of care between care homes.

Evidence base for impact

The Cornwall and Isles of Scilly PCT project[2] to train nursing home staff resulted in:

- Reduction in falls and injuries;
- Reduction of hospital admissions by 50%; and
- Prescription savings of £100 per patient per year.

Similarly in Sheffield, savings were evidenced, and if extrapolated to apply to the Berkshire West population the overall cost of secondary care admissions from care homes could be reduced by approximately £941,500.

The introduction of an additional Community Pharmacist and eradicating issues from poly-pharmacy along with a further 5% reduction due to improved training could realise gross savings of £1,258,500.

Sheffield - Integrated care and supporting care homes, BGS March 2012
Improving the Quality of Dementia Care, HSJ October 2012
Nursing Homes in Walsall, Improving care for elderly people, December 2011

[1] Sheffield - Integrated care and supporting care homes, BGS March 2012
[2] Improving the Quality of Dementia Care, HSJ October 2012

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Care Homes scheme should:

- Reduce unnecessary NEL admissions ;
- Reduce prescription costs (to be further modelled and quantified);
- Increase the skills of care home staff(numbers trained will be monitored and competency levels assessed as part of the training programme);
- Improve end of life experience through advanced care planning(numbers of care plans in place will be monitored, which will include those with end of life planning templates in place, and in addition the number of residents being admitted and dying within 0 days will be captured);
- Avoid unnecessary A&E/Clinical Decision Unit (CDU) attendances(to be monitored through acute activity data by the project board as it is has not been possible to retrospectively differentiate by patient address from current data, only by postcodes which includes neighbouring properties to the care home);
- Support the reduction of the incidence of falls by appropriate prescribing of medication and referral to Therapy Services(monitored through the Falls Prevention QIPP project);
- Reduce the number of care home residents appearing on the "fit to go list" (Local Metric HWB Supporting metric tab, monitored through "Alamac Kit Bag"); and
- Reduce length of time on the "fit to go list" for care home residents (Local Metric HWB Supporting metric tab, monitored through "Alamac Kit bag").

Therefore the metrics where this scheme is expected to make a positive contribution are;

Non-Elective admissions – the key aim of this scheme is to reduce non-elective admissions by improving the quality of care and support provided to care and nursing home residents.

Delayed Transfers of Care –.improving the quality of care received by care home residents should contribute to reducing delays in their transfer of care following a hospital admission.

Patient / Service User Experience – improving the quality of care provided in care and nursing homes should have a direct impact on the resident's quality of life and therefore improve this metric.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

Indicator/Outcome	Baseline (Current Value)	Target Value	How Measured?	Frequency of Measurement
Number of patients assessed by GP by CH within 4 weeks of admission to CH	10%	< 80%	Adastra System	Monthly
Number of patients assessed by GP by CH within 8 weeks of admission to CH	50%	100%	Adastra System	Monthly
Number of staff trained by Nurses by CH within 6 months	10%	< 50%	BHFT Training Records	Monthly
Number of staff trained by Nurses by CH within 12 months	10%	< 95%	BHFT Training Records	Monthly
Number of dysphagia training sessions provided by CH in 12 months	0	48	BHFT Training Records	Monthly
Number of CH staff trained by Pharmacist by CH in 12 months	50%	< 95%	Pharma Training Records	Monthly
Number of patients reviewed by pharmacist by CH	50%	100%	Service Record	Monthly
Number of patients reviewed by GP by CH within 6 months of commencement	10%	< 50%	Adastra System	Monthly
Number of patients reviewed by GP by CH within 9 months of commencement	10%	100%	Adastra System	Monthly

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

In addition the project board will closely monitor the participation in the scheme by GPs as this will be critical to the success of the scheme.

What are the key success factors for implementation of this scheme?

The critical success factors for this scheme are:

- GP engagement and participation as the scheme relies on GPs as the accountable lead professional
- Care home staff to be released to attend training
- Availability of training to care home staff
- Defining the care and support delivered by GPs to patients & care homes.
- Supporting the establishment of standards for care planning, medicines reviews, information & communication
- Improved end of life experience through advanced care planning which in turn will improve the overall health and wellbeing of patients in homes

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	West Berkshire
Name of Provider organisation	RBFT
Name of Provider CEO	Jean O'Callaghan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10132
	2014/15 Plan	10301
	2015/16 Plan	10196
	14/15 Change compared to 13/14 outturn	1.67% Growth
	15/16 Change compared to planned 14/15 outturn	1.03% Reduction
	How many non-elective admissions is the BCF planned to prevent in 14-15?	176 for pump priming BCF although BCF not actually in place in 14/15
	How many non-elective admissions is the BCF planned to prevent in 15-16?	506

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes – the numbers are based on the HWB catchment rather than RBFT as a provider and therefore this does not match our provider plan exactly (West Berkshire HWB is around 1/3rd of our total activity). However, we understand and have been involved the calculations arriving at the numbers above and as such recognise the impact of the BCF on the Trust.
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes – the main impact on the Trust is the reduction in non-elective admissions as a result of the Hospital at Home project within the BCF (487 of the 506 above) The Trust is fully engaged with this project and sits on the Project Board. The Trust is actively working with the health and social care system to ensure that there are mechanisms in place to support discharge from the provider into community and home settings with associated investment in schemes such as reablement, carers, 7 day working in primary and social care

Title of Report:	**Better Care Fund – Progress Report**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	27th November
Forward Plan Ref:	N/a

Purpose of Report: To inform the Health and Wellbeing Board on the current position regarding the Better Care Fund schemes.

Recommended Action: For information

Reason for decision to be taken: N/A

Other options considered: None

Key background documentation: None

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Executive Report

1. Introduction

1.1 This covering report introduces an Integration Programme status report setting out progress on the West Berkshire Locality Better Care Fund projects.

2. Background

2.1 The Better Care Fund (BCF) has been established, using existing CCG funding, to promote greater integration between Health and Social Care. Whilst final approval of the plans by the Department of Health is not expected until November, work to deliver the projects is underway.

2.2 The West of Berkshire Integration Programme has been established around 3 key priorities – Elderly Frail, Mental Health and Children. The initial focus is on Elderly Frail as this is seen as the area that will create the most demand and BCF projects were selected on the basis that they would have the most impact in addressing this area.

3. BCF Projects

3.1 The BCF proposals comprised 7 schemes which have now been grouped into 5 projects:

(1) **Hospital At Home**

Reducing non-elective admissions into hospital by enabling patients to receive treatment in their own home

(2) **Integrated Health and Social Care Hub**

Create a single point of contact for health and social care services

(3) **Enhanced Care and Nursing homes support**

Reduce non-elective admissions from care homes by enhancing the level of support available to homes from health professionals.

(4) **Joint Provider Project** (incorporating 7 day working and direct commissioning by specified health staff)

Developing a more cohesive service which will reduce duplication, improve access and increase capacity. This will allow us to support more people to regain their independence after a stay in hospital and reduce demand for longer term care.

(5) **Personal Recovery Guide**

Reduce delayed transfers of care by supporting vulnerable clients to navigate the health and social care system.

3.2 The programme status report is attached at Appendix A; this includes information about the key enabler projects supporting delivery of the programme. Health & Wellbeing Board should note that the Hospital At Home Project is flagged as red.

Appendices

Appendix A – Highlight Reports

Consultees

Local Stakeholders: n/a

Officers Consulted:

Trade Union: Not applicable

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Berkshire West 10 Integration Programme Status Report

Reporting Period: 13 October 2014 to 14 November 2014

Scheme / Project		Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Reason for Slippage
Berkshire West Projects	Health and Social Care Hub	Mapping exercise of existing points of contact for each of the 3 councils completed Workshop held on 10 November for all key stakeholders to: - agree a definition of a single point of access and agree to work together to deliver this - review the existing points of access to identify how to improve efficiency and productivity and what could be achieved as a whole system - identify locality specific requirements, including consideration of the potential challenges and barriers and how these can be overcome - consider options for the integrated single point of access health and social care hub All agreed on the principle of developing an integrated H&SC Hub across Berks W. A number of different elements to be included in the H&SC Hub were identified – these will need to be phased in	SRO - Katie Summers / Project Manager TBC	Provisional programme of (phased) work to be developed and agreed; then presented for approval to Berks W Partnership Board. Detailed plans, resources required, timescales, anticipated outcomes, risk & gain sharing agreements etc. to be developed. FEP had previously developed financial assumptions re the H&SC Hub – to be reviewed and assumptions to be tested. Steering group to be established to progress the project.	Green	
	Hospital at Home	POC completed, Analysis of results in progress	SRO Katie Summers CCG & Fiona Slevin Brown Providers	Paper to be presented at Partnership Board	Red	
	Enhanced Services for Care Homes	Arrange Workshop (leadership styles and skills) to devise specified Care Home training supported by the TV Leadership academy (16/10/14) Analyse Adastra data to see how Care Plans are being updated on a Practice level. Liaise with Rachael D'Coe regarding project for the frail & elderly Provide recommendations relating to aforementioned HRG analysis.	SRO Katie Summers / Project Manager Kurren Varma	• Obtain and analyse length of stay data by HRG code • Breakdown of A&E vs Admissions • Report on length of stay by Care homes for LTC board meeting (18/11) • Liaise with Maggie Woods, Unitary Authority leads & In reach teams regarding leadership training course. o Designing the program o Promoting the course o Share with Unitary Authorities	Green	
Frail Elderly	Workstreams	Further mapping and analysis to be undertaken of pathway and metrics See also Health and Social Care Hub updates above	SRO's Lindsey Barker/ Bev Searle	Meeting to be re-arranged to take forward the work on the FEP financial modelling Finnamore tool	Amber	
	Generic Care Worker	Draft Job description developed and reviewed at the Workforce Project meeting	SRO's Lindsey Barker/ Bev Searle	Draft tasks list completed. List is currently with BHFT to validate the tasks and ensure clinically sound. Next steps to be identified at Workforce development meeting on: 26-11-14 and to further develop the social care aspects.	Green	
West Berkshire	Green	Detail of schemes still be developed, urgent work required to develop PIDS, overarching programme plan, risk, issue and dependency logs prior to the next West Berkshire Steering Board meeting on the 10th December Risk regarding Eligibility Criteria Funding Locality Integration and BCF Programme Manager responsibilities being shared by Tandra Forster and Steve Duffin Further scoping of affordable 7 Day services to include Primary Care				
	Joint Care Provider (inc 7 day services and direct commissioning)	• Project Brief approved by Integrated Care Steering Group on 14th August 2014 • Project team in place • Project Manager appointed • 2 full day workshops held focusing on 'as is' and 'to be'	SRO Rachel Wardell Project Manager Toby Ellis Tandra Forster	• Joint Provider 'To Be' Model to be agreed • Affordable 7 Day Service model to be agreed • Procedure allowing direct commissioning of social care by Community Nurses to be agreed and documented		
	Personal Recovery Worker	• Project Brief approved by Integrated Care Steering Group on 14th August 2014 • Project team in place • Project Manager appointed • First Project scoping meeting held	SRO Rachel Wardell Project Manager Toby Ellis Ian Mundy and Bal Bhalia	• Detailed definition of the role to be produced • Key decision around service delivery method to be taken (employed staff, commissioning, use of voluntary sector or combination)		

Berkshire West 10 Integration Programme Status Report

Reporting Period: 13 October 2014 to 14 November 2014

Scheme / Project		Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Reason for Slippage
Enabling Projects / Work streams						
	Connecting Care - West Berkshire	Phase 1 • Reading WIC, vendor config changes did not resolve the issue. Vendors have requested more information from failing test cases Phase2 • Contract received from Orion - under review • CSC delay in providing hosting costs - escalated to Mike Robinson @RBFT • Business continuity (exit planning) - scenarios identified - working on possible solutions • Comms Plan in progress - identified existing comms routes • Draft Benefit Realisation Approach documented and circulated for Board discussion • Recommend sub-groups for comms and benefits - Board discussion • Requirements straw man available in draft format (required for main procurement process) • Procurement options updated for Board presentation	SRO Katie Summers / Programme Manager John MacDonald	Phase 1 • Reading WIC complete UAT and sign off - ongoing Phase 2 • Pursue base line measures pre-launch of Phase 1 for Reading Walk In Centre • Arrange Benefit sub-group kick off and prepare Benefit survey • Arrange Comms sub-group kick off (will be asking for sub-group members at board meeting) • Detailed statement of work discussion w/Orion - waiting on dates • Planning session w/Orion - waiting on dates • Get 3rd party procurement advice • CSC to provide hosting quote - follow up • Continue to build the comms and benefits plans • Complete the main requirements document	Green	
	Market Management	Nursing care market brief and joint commissioning options report produced. Potential MI system (to improve market intelligence and information sharing) demonstration arranged for 14 Nov.	SRO Stuart Rowbotham / Project Manager Lyndon Meade	Plan on a Page being presented at Partnership Board Proceed with selected market management option: • MI system review • Fair fee review • Berkshire MPS – including joint market engagement planning • Draft market/provider failure protocol	Green	Resource Issue identified - PM only available 3 days per week until Christmas
	Integrated Carers Commissioning	Completed review of jointly commissioned carer breaks service Identified carer services suitable for transfer to joint commissioning arrangements.	SRO Gabrielle Alford	Develop detailed proposals for governance of the carer elements of Better Care Fund. - Review PH proposal and formally commission the development of a Berkshire Carers Needs Analysis	Green	
	Whole System Organisational Development	• LGA attended Partnership Board on the 16th October • Steering group membership agreed and first meeting date scheduled. • Named enablers/facilitators for Berkshire West system agreed. Matt Gott and Jill Barrow. • Invitation for 24th November launch event received and circulated to Steering group	SRO's Fiona Slevin Brown & Rachael Wardell TBC	• Steering Group meeting on the 17th November with Matt Gott • Matt and Jill will be contacting organisation leads to canvas their views on programme benefits • 24th November launch event in London		
	7 Day Working	• Further Newbury and North and West Reading practices will start providing evening and Saturday morning sessions over the next 4-6 weeks. South Reading and Wokingham CCGs are currently considering similar arrangements with their practices. • South Reading and Wokingham have now agreed to commission this service from their practices and it will commence soon.	Helen Clark	• Practice participation rate to be reviewed on an ongoing basis. • Opportunities to develop new ways of working with NHS 111 are being explored further.	Green	
	Integrated Workforce Development	HETV Poster Presentation Event Completed Recruitment process for Project manager/ workforce specialist started Next meeting scheduled for 26 November	SRO Bridgid Day Project Manager - Vacant	Scope and define the workstreams that will form part of the strategy Interviews for vacant project manager post N.B Funding for project mgmt post from HETV Bid monies, hosted by Wokingham BC	Green	Project Manager Post vacant

Berkshire West 10 Integration Programme Status Report

Reporting Period: 13 October 2014 to 14 November 2014

Scheme / Project		Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Reason for Slippage
Integration Programme	Delivery Arrangements	Interviewed and appointed a PMO support, start date delayed due to query funding availability Progress made towards identifying funding to fill Strategic Comms and Engagement, confirmation still outstanding from some Partners Delivery Group Established Links established with Finance sub group, Rob Poole, Reading BC identified as the finance lead for input at the Delivery Group Standardised Reporting, Risk , Planning templates provided with support on completing	Naseema Khan	Further 1:1 programme planning sessions with Locality Programme Managers to review PIDS/ Milestone plans/ Dependencies, Risks etc. urgency to complete prior to next BCF deadline Further work to refine elements of FEP with Leads Action to finalise funding requirements for PMO Resources - (to be raised at Partnership Board) Action to identify additional support and resource requirements to Partnership Board	Amber	Funding to meet Partnership wide roles PMO, Finance and BCF Pooled Fund Manager, Health and Social Care Hub Project Manager Locality Programme and Project Manager Vacancies NHS Number project manager

BCF National Conditions
Protecting Social Care Services –
7 Day Services
Data Sharing and the NHS Number
Joint assessments and the accountable lead professional

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West of Berkshire

Safeguarding Adults Partnership Board

'Achieving by working together'

West of Berkshire Safeguarding Adults Partnership Board

Annual Report 2013-14

Contents Page

Forward by the Independent Chair

Welcome to the 2013-14 Annual Report of the West of Berkshire Safeguarding Adults Partnership Board.

I am delighted to have the opportunity to thank all the Board members and those who have supported the Board within subgroups and task and finish groups for all their commitment and hard work this year. I hope the content of this report will give you all a flavour of some of the achievements and progress made in a number of areas of work.

This coming year is going to be both exciting and challenging for the Board with the long awaited arrival of the Care Act in April 2015 which, for the first time, will place safeguarding responsibilities for adults on a statutory footing. These are exciting times and I am determined that the Board will embrace all opportunities and challenges that this will bring.

Once again this year, adult safeguarding has received greater media attention but locally there is still a gap in the wider community regarding adult safeguarding responsibilities, and specifically the work of the Safeguarding Adults Partnership Board. The Board has seen this as one of its priorities and has produced its first Communication Strategy this year. This work is still in its infancy but I am committed to explore ways of improving links both with partner agencies but more importantly the wider community that we all serve.

I look forward to an exciting year ahead for the Board and commend this Annual Report to you.

Sylvia Stone

Independent Chair

West of Berkshire Safeguarding Adults Partnership Board

Introduction

The Safeguarding Adults Partnership Board and its member agencies continue to work hard to ensure residents in the West of Berkshire live full and safe lives. This involves a range of activities, from raising awareness of safeguarding adult issues; delivering and commissioning high quality services; training and developing staff to recognise and respond appropriately to potentially harmful situations; investigating allegations of abuse or neglect; and supporting victims and perpetrators of abuse and neglect.

The Board recognises that there is much work still to be done, not only in the provision of quality services but in raising public awareness of the risks as well as the benefits of supporting adults at risk.

Board Members

As the Board at this time is not statutory there is no clear authority over partner agencies in terms of their engagement. However, we are fortunate that there is excellent commitment to the Board and to its subgroups by our partners.

The Board is made up of representatives from the following agencies:

- Berkshire Healthcare Foundation Trust
- Berkshire West Clinical Commissioning Groups
- Emergency Duty Service
- Joint Legal Services
- Reading Borough Council
- Royal Berkshire Fire and Rescue Service
- Royal Berkshire NHS Foundation Trust
- South Central Ambulance Trust
- Thames Valley Police
- Thames Valley Probation Service
- West Berkshire District Council
- Wokingham Borough Council

Membership of the Board is broad, although the significant majority of those attending Board meetings are from statutory health and social care services. In the coming year the Board is looking to widen the membership of both the Board and its subgroups to ensure better representation from the private, voluntary and independent sectors.

Local Context

The function of the Board is to co-ordinate strategic safeguarding adult activity across all sectors and service user groups in order to prevent abuse and neglect occurring and to ensure that when it does, it is recognised and appropriately responded to. The Board forms a view of the quality of safeguarding locally, challenging organisations when necessary.

The West of Berkshire Safeguarding Adults Partnership Board Mission Statement:

"West of Berkshire Safeguarding Adults Partnership Board: Preventing abuse and empowering adults to stay safe."

This mission statement has been a reference point for the Board, shaping and driving its actions throughout the year.

The four goals of the Partnership Board were reviewed and revised during the reporting year. These are to:

- Establish effective governance structures for the Board to align the Board to the new statutory requirements, improve accountability and ensure the safeguarding adults agenda is embedded within other organisations, forums and Boards,
- Raise awareness of safeguarding adults, the work of the Board and improve engagement with a wider range of stakeholders.
- Develop oversight of safeguarding activity and need in order to target resources effectively and improve safeguarding outcomes.
- Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and outcomes for service users.

The Business Plan details how these four goals will be achieved. The Plan is delivered through five subgroups, with progress monitored regularly by the Board, and is updated annually to ensure that priority areas remain relevant. The Business Plan 2014-15 is included as Appendix A.

Subgroups

Partnership and Best Practice Subgroup

The Partnership and Best Practice Subgroup assists the Board in promoting good quality safeguarding practice. During the reporting year, the group has audited partners' strategic and operational arrangements to safeguard and helped to link the three Safeguarding Forums across the area in order to develop communication routes and improve ways to engage with service users. The group has revised the Difficult to Work With Protocol to reflect recent learning from the SCIE pilot. The end product has been termed the *Multi-Agency At Risk Pathway for working with those who do not engage with services*. Further information is given below.

Performance and Quality Subgroup

During the reporting year, the function and membership of the Information and Analysis Subgroup was reviewed and widened, and the title Performance and Quality Subgroup was felt to more accurately reflect its broader purpose.

The purpose of the Performance and Quality Subgroup is to oversee performance of adult safeguarding activity in the West of Berkshire, highlighting the effectiveness and risks of key processes and practices. The group will assure the Board that good practice to safeguard vulnerable adults is delivered consistently by partner agencies. Areas of weakness will be identified and strategies developed to make improvements when the need arises.

Governance Subgroup

The purpose of the Governance Subgroup is to ensure the Board has robust governance arrangements with clarity of purpose and public accountability. In the previous year the group commissioned an independent evaluator to assess the governance arrangements and communication processes of the Board. The findings from this audit were embedded into the Business Plan 2013-14 and the Governance Subgroup has been key to delivering the priorities. Other highlights include establishing a bi-annual meeting between the three Directors of Adult Social Care and Independent Chair, and a Protocol Agreement between the SAPB and Health and Well-being Boards.

Communication and Publicity Subgroup

The Communication and Publicity Subgroup was convened in 2013 in response to the findings of the external assessment earlier in the year. Its purpose is to support the messages that safeguarding is everyone's business and that good communication is the responsibility of all partners sitting on the Safeguarding Adults Partnership Board.

The subgroup developed a Communications Strategy which was approved by the Board in March 2014. The overall aim of this Strategy is to improve people's understanding of the work in relation to safeguarding adults in the area. To support this aim, there are three main objectives:

I. To promote public awareness in the wider community about how everybody can contribute to safeguarding and work towards the prevention of abuse.

II. To promote awareness across organisations within the area – statutory, independent and voluntary agencies – of how they should co-operate to safeguard and promote the welfare of vulnerable adults and ensure that developments in safeguarding practice are widely communicated.

III. To ensure an effective process for communicating with the media, thereby promoting public confidence in the arrangements for safeguarding and promoting the prevention of abuse.

The need to further promote Safeguarding Adults is recognised. One of the main strategies moving forward will be to develop a dedicated, independent Safeguarding Adults Website.

Learning and Development Subgroup

The purpose of the Learning and Development Subgroup is to develop, implement, review and update the multi-agency Workforce Development Strategy for the protection of adults at risk. The aim of this Strategy is to provide an effective, coordinated

approach to learning in order to support all agencies to prevent abuse and respond to safeguarding concerns with timely, proportionate and appropriate action. This year the group has:

- Completed a joint awareness training mapping;
- Reviewed Level 2 training delivery and resources;
- Updated the Workforce Development Strategy to be valid for a further 3 years 2014-17;
- Supported the delivery of SAPB/LSCB Joint Conference;
- Delivered a pilot project by Kingwood Trust to produce a resource pack to support learners after attendance on Level 1 training was completed, with positive evaluation. Kingwood Trust shared this resource as an example of good practice.

Two Level 1 Train the Trainer programmes have been delivered by Wokingham BC in September 2013 and March 2014, with places offered to PVI sector across the West of Berkshire.

In Berkshire Healthcare Foundation Trust (BHFT), Safeguarding Adult Level 1 training has continued to be delivered as part of Induction for all new starters working in clinical services and the compliancy figure for the Trust is 92%. Level 1 continues to be refreshed every three years and the Trust has introduced an E-Assessment. In addition across BHFT there are now over 300 Senior Clinicians Trained at Level 2. Overall the Trust is 7% above the target set for safeguarding adult's compliance of 85% for 2013/14. The Trust's safeguarding team have been delivering Health WRAP training as part of the national Counter Terrorism Strategy during 2013/14; across the organisation over 350 staff have been trained. During 2013/14, BHFT identified that further Mental Capacity Act and Deprivation of Liberties training was required. A training needs analysis was completed and a training Strategy developed and launched in January 2014.

All Royal Berkshire Hospital NHS Foundation Trust staff, both clinical and non-clinical, are expected to undertake safeguarding adults (level 1 awareness) training every three years. Work is ongoing to improve levels of compliance with training and current compliance figures as of March 2014 are 76% of all Trust staff having attended training.

Training Data for 2013-14 is included in Appendix 2.

Key Developments in 2013-14

Safeguarding Adults Reviews

scie social care institute for excellence

During 2012-13 the West of Berkshire Safeguarding Adult's Partnership Board took part in a pilot run by Social Care Institute for Excellence (SCIE) on the Learning Together Model. The pilot aimed to develop a more systemic way of undertaking reviews into serious incidents.

The SCIE process is *not* primarily about blame, but about open and transparent learning from practice, in order to improve inter-agency working. This does involve appraising the quality and appropriateness of individual and team practices, but always in tandem with explaining *why* particular actions and decisions were made. The process highlights what factors in the system contributed to actions making sense at the time. Importantly, it also highlights what is working well and patterns of good practice.

The pilot was completed in May 2013 when the findings were shared more widely with local partners and neighbouring Safeguarding Adults Boards and Local Safeguarding Children's Boards.

During the reporting year, the Board also commissioned a Learning Together review into the sad death of Mrs E.

The findings from the SCIE pilot and the Mrs E Review have been explored by Board members. Certain findings have been taken forward as areas for development within individual organisations, whereas those findings that have clear implications for multi-agency working have been embedded into the Business Plan for 2014-15.

The review of a serious incident in Wokingham towards the end of the reporting year included a well attended and productive multi-agency learning day. Learning has already been put in place within individual organisations and teams, and the final report will be presented to the Board in June 2014 for consideration and action.

MULTI-AGENCY SAFEGUARDING ADULTS REVIEW OF SERIOUS CASES

A *Multi-Agency Safeguarding Adults Review Of Serious Cases* guidance document has been developed by a Pan-Berkshire working group. It includes high level principles and a toolkit of options, in order to encourage more consistent, flexible and proportionate response to serious cases. In developing the guidance, the Safeguarding Adults Boards in Berkshire seek to ensure that:

- We have processes for learning and reviewing that are flexible and proportionate and open to professional and public challenge.
- We can determine locally what type of review is appropriate dependent on the nature of the case and the agencies involved.
- A culture of transparency is created that provides for a positive shared learning culture.

This guidance document sets out the Boards' expectations for a Safeguarding Adult Review of a serious case, within which there is room for professional judgement and flexibility.

NHS Newbury and District Clinical Commissioning Group
NHS North and West Reading Clinical Commissioning Group
NHS South Reading Clinical Commissioning Group
NHS Wokingham Clinical Commissioning Group

Clinical Commissioning Groups

As reported in last year's annual report, the NHS has experienced extensive restructuring. There are four CCGs serving the populations of Berkshire West and each has their own safeguarding children and adults policy. CCGs in Berkshire West commission health services from two main healthcare provider organisations: Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital NHS Foundation Trust.

NHS England (NHSE) provides oversight and assurance of the safeguarding arrangements of Clinical Commissioning Groups and supports them in meeting their responsibilities. This includes working with the Care Quality Commission (CQC), professional regulatory bodies and other national partners. The four CCGs in Berkshire West are supported and held to account locally by the Thames Valley Area Team (TVAT) which is the Local Area Team of NHSE.

A Berkshire West CCG federation has been developed by the four CCGs to share some of their activity across Berkshire West, with safeguarding a federated activity. Wokingham

CCG is the host CCG for safeguarding for Berkshire West and has responsibility for employing the Designated Nurse for Safeguarding, the Named GP Safeguarding Children and also the Named Nurse Safeguarding Children for primary care. A service level agreement is in place between the CCGs and BHFT to secure the role of Designated Doctor Safeguarding Children.

CCGs are now the major commissioners of local health services and, in turn, need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. This is achieved in a number of ways including contract monitoring arrangements and self- assessment. In addition the services commissioned by Berkshire West CCGs are required to complete an annual self-assessment of their organisations safeguarding activities. Where there are deficits, an action plan is agreed between the provider organisation and the CCGs to address the deficits.

The CCGs have also developed a pan-Berkshire Safeguarding Committee which meets four times a year to address safeguarding children and adults issues, to review action plans from serious case reviews, and share information and learning about safeguarding matters at a senior level. Any risk areas, or areas of non-compliance, are reported through the Berkshire West Quality Committee, when a decision will be made to add to the corporate risk register and what further action may need to be taken.

The CCGs are represented on the Board by the Nurse Director and the Designated Nurse for Safeguarding. Since April 2014, the Designated Nurse for Safeguarding role has been extended to include the strategic role for safeguarding adults. To support this, two new posts to support the safeguarding agenda have been recruited to. The new roles will enable wider representation of the CCGs on subgroups of the SAPB.

Joint Adult and Children's Safeguarding Conference

The annual Joint Adult and Children's Safeguarding Conference, planned with the three West of Berkshire's Local Safeguarding Children's Boards, took place on Friday 27 September 2013 at Sindlesham Court.

The focus of the conference was the various forms that the sexual abuse of children and vulnerable adults can take and topics included: recent high profile cases; local and national trends and themes; the grooming process; female genital mutilation; forced marriage; understanding child sexual abusers; post-sentencing interventions; and protecting vulnerable people from sexual predators.

Keynote speakers included Belinda Schwehr and Dr Cornelius Ani with workshops facilitated by the Lucy Faithfull Foundation, Forced Marriage Unit, Barnardos, AFRUCA and Thames Valley Probation. The hard-hitting performance of Chelsea's Choice by the Alter ego Theatre Company was cited as the highlight of the day by many delegates.

Partner Agencies' Self-Assessment

Using an audit tool developed by the Partnership and Best Practice Subgroup, partner agencies completed a self-assessment in order to assure the Board that they have in place robust strategic and operational arrangements to safeguard adults. Common findings were shared at the Board's Business Planning Day in January and these key areas have been incorporated into the work plans of the Subgroups or the Board's Business Plan for 2014-15. Areas for development by particular agencies are being taken forward within that agency and the Board has requested an update on progress during 2014.

Engaging with Service Users

The Board and its partner agencies have been exploring ways to increase service user involvement and this continues to be a key priority for the Board moving into the next year.

During the reporting year **BHFT** have continued to explore strategies to increase service user involvement and participation in safeguarding adults' policies and procedures. Patient involvement and participation are included as a central part of both level 1 and level 2 training. Methods of raising awareness for both patients and visitors are currently being explored but a number of challenges have been noted in developing procedures and information that can be used across all six Berkshire Local Authorities. This target will be carried over to the 2014/15 work plan.

A workshop was held in July for all three **Safeguarding Forums**, attended by local authority and health representatives and people who use services in the Wokingham area. With the help of Wokingham's Learning Disability Partnership, common overarching terms of reference for the Forums have been developed, which can be localised to reflect the needs of each area.

Wokingham Learning Disability Partnership Board

The agreed aims and functions of the Forums are:

- To tell everyone about their local Forum.
- To get good results for people who need their help.
- To set good standards so that the risk of abuse and neglect is less.
- To work with other groups to make sure everyone knows what they should be doing and they are doing it well.
- Act as champions for safeguarding.
- Ask people what they think about the safeguarding process.
- Tell everyone about local and national issues.
- Think about what training people need.
- Work with other agencies to find out what is needed to keep people safe.
- Write an action plan.
- Make reports in different formats.

A further workshop is planned for 2014 so that all three areas have the opportunity to explore how to further develop the function of the Forums and widen the membership to include community groups and service users.

Working with those who do not engage

Adults at risk who, for whatever reason, do not engage with services can have complex and diverse needs that often fall between different agencies; their needs are generally longstanding and recurring and they may put themselves and others at high risk.

An analysis of such cases in Reading indicated potential cost savings of £110,000 pa in staff time could be made by a post specialising in complex cases. Specialist practitioners have been appointed in the West of Berkshire. Holding a small caseload, the workers provide intensive support and, importantly, also provide advice and support to other practitioners working with people with complex needs.

An ***At-Risk Pathway for working with those that do not engage*** has been developed, to be followed where the level of risk previously being managed has reached a level that is unacceptable, and all other reasonable attempts to minimise this risk have failed. Aims of the pathway are:

- To improve outcomes for adults at risk who do not to engage with services.
- To deliver a coordinated, multi-agency response to providing solution based approaches.
- To establish consistent best practice across the West of Berkshire.
- For agencies to work in partnership and share information to ensure the best outcomes for the person.

Royal Berkshire Hospital NHS Foundation Trust

During the reporting year, the Royal Berkshire Hospital NHS Foundation Trust's Safeguarding Team has been re-located allowing the team to be based together. The team includes Lead Nurse for safeguarding adults, Learning Disability Coordinator, Mental Health Coordinator, Named Midwife for Child Protection and Named Nurse for Child Protection. The team members give professional support and supervision to each other and cross cover when individuals are on leave. This cohesive safeguarding philosophy underpins the Trust's commitment to patient safety and this is further re-enforced with wider members of the safeguarding team [Child Protection administrator, Designated Doctor for Child Protection, Professor of Elderly Care Medicine, Sexual Health Nurse Consultant, Corporate Lead for Safeguarding] supporting the safeguarding function.

Moving Forward – Priorities for 2014-5

The Board acknowledges that there is much work still to be done to build on the successes of 2013-14. The Board's Business Plan attached as Appendix A outlines the key priorities the Board will focus on in the coming year.

Implications of the Care Bill

The Care Bill will put Safeguarding Adults Boards on a statutory footing from 2015, with core membership including the local authority, an appointed representative from each Clinical Commissioning Group (CCG), and the chief officer of police for the area.

Under the Bill, the SAPB must publish a yearly strategic plan that sets how it will meet its main objective and what each member will do to achieve that objective. This plan should be developed involving the local community and in consultation with the Local Healthwatch organisation. An Annual Report must be published describing what the SAPB has done during the year to achieve its main objective and its strategy, and how each member of the SAPB has helped to contribute to the strategy. Findings of Safeguarding Adults Reviews must be recorded, with the number of ongoing reviews

Under the Bill, the SAPB will have a legal duty to conduct a Safeguarding Adults Review into certain cases, to ensure that lessons are learned to improve future practice and partnership working, and to minimize the possibility of it happening again. Every member of the SAPB must contribute to carrying out the review and applying the lessons learnt.

SCIE Learning Together Training

Following the successful participation in the national pilot in 2012-13 and a subsequent review of a serious incident in Reading using the SCIE Learning Together model, the Board is assured that the SCIE model supports transparent learning in order to improve inter-agency working. One of the Board's priorities for the coming year is to develop expertise amongst a wider group of staff to become accredited Lead Reviewers, and partner agencies have nominated staff to participate in a three-day training course by SCIE in August.

Joint Adult and Children's Safeguarding Conference

The annual Joint Adult and Children's Safeguarding Conference, planned with the three West of Berkshire's Local Safeguarding Children's Boards, will take place on Friday 26 September at Easthampstead Park in Wokingham.

The conference will be based on the theme of domestic abuse and some acclaimed speakers and facilitators have already been secured to present on a range of topics including, the Local Government Association's Safeguarding Lead, Berkshire Women's Aid, Wokingham BC Safeguarding Adults Team, A2 Dominion, Action on Addiction and CAADA (Coordinated Action Against Domestic Abuse).

It is again expected to be a well attended and thought provoking event where delegates will also have the opportunity to learn about support services available locally.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) provide additional protection for the most vulnerable people living in residential homes, nursing homes or hospital environments through the use of a rigorous, standardised assessment and authorisation process. They protect those who lack capacity to consent to arrangements made for their care and/or treatment, but who need to be deprived of their liberty in their own best interest to protect them from harm.

They also offer the person concerned the right to challenge the decision to deprive them of their liberty, the right for a representative to act for them and protect their interests and the right to have their status reviewed and monitored on a regular basis.

DoLS help to make sure that a care home or hospital only restricts someone's liberty safely and correctly, and that this is done when there is no other way to take care of that person safely.

The Local Authority manages this process for residential homes. From April 2013 Local Authorities became responsible for assessing any applications from registered hospitals, in place of the PCT. Throughout the reporting year, DoLS numbers continued to be extremely low in the West of Berkshire although there is a wide variation of applications across the country.

However, following the Supreme Court judgement on cases in Cheshire West and Surrey, there has been a broadening the circumstances of care that might now constitute a deprivation of liberty and reports indicate that figures have increased dramatically in the first quarter of 2014-15. A priority for the coming year is to understand the impact of these changes in the local area.

Protocol Agreement between Reading, West Berkshire and Wokingham Health and Well-being Boards and the SAPB

The Health and Well-being Board aims to improve health and well-being for people in Reading / Wokingham / West Berkshire. It is a partnership that brings together the Council, NHS and the local Healthwatch organisation. It is important that the HWB in each area and the SAPB align priorities and share information a protocol agreement has been developed to support closer working. Under this agreement, both organisations will:

- Have an ongoing and direct relationship, communicating regularly.
- Work together to ensure action taken by one body does not duplicate that taken by another.
- Ensure they are committed to working together to ensure there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.

Board members look forward to building even further on these collaborative partnerships through support, integration and challenge.

Communication and Publicity

The Board is clear that it needs to communicate better with external partners and stakeholders. The results of the on-line survey undertaken as part of the external assessment in 2013 suggests that communications need to be delivered through various routes and methods, such as emails, briefings, a newsletter and a website. The Communication and Publicity Subgroup is currently working to commissioning a website

provider, with the view that the Safeguarding Adults Partnership Board Website will be launched at the end of the year.

Berkshire Healthcare Foundation Trust Clinical Champions

In the last Annual Report, BHFT reported that they aimed to develop a Mental Health Safeguarding Adult Champions Group across the Trust. BHFT are taking a proactive stance and raising awareness directly on the wards, which has involved attending ward rounds, being available for staff on site, attending the mandatory Mental Health staff training week and the physical intervention training for the Learning Disability staff. In light of considerable changes in the Mental Health services, including ward relocation, it was decided that this work would be carried over to 20014. Mental Health Staff have been offered an opportunity to engage in the current Clinical Champions group until a specialist Mental Health Group is formed. The current Clinical Champions group continues to meet on a quarterly basis to share best practice and learning from Serious Case Reviews to ensure that information is disseminated across the organisation.

Thames Valley Probation

In June 2014, Thames Valley Probation will cease to exist as a Probation Trust. It will be replaced by two organisations - the National Probation Service (NPS) and Thames Valley Community Rehabilitation Company (TV-CRC). Both organisations will continue to cover the Thames Valley area but with different responsibilities. NPS will provide a service to the courts, hold all MAPPA and high risk cases, deliver sex offender treatment interventions, manage the area's five Approved Premises and deliver Victim Liaison services. TV-CRC will manage the remaining offenders, Integrated Offender Management, Domestic Abuse and general offending behaviour programmes and Unpaid Work. In addition, TV-CRC will supervise all prisoners serving less than twelve months once new legislative changes are enacted. In autumn 2014, there will be tendering of the TV-CRC with share-sale planned for October 2014 and full mobilisation from 1 April 2015. Both NPS and TV-CRC will continue to meet partnership responsibilities.

Thames Valley Probation has been a valued member of the SAPB and partners look forward to working with colleagues from the re-configured services in the coming year.

Workshops for Managers and Practitioners

Over the coming year, the Partnership and Best Practice Group will develop opportunities for practitioners and managers to learn from recent cases and share good practice in an open and supportive forum.

A series of multi-agency workshops have been planned, with topics reflecting findings from recent local serious case reviews as well as other pertinent local and national issues.

Performance and Quality

One of the Board's key priorities is to develop its oversight of the quality of safeguarding performance and practice, and challenge organisations where poor practice is identified. This has been achieved in part though an audit of partner agencies' strategic and operational arrangements to safeguard.

In the coming year the Board will be supported by the Performance and Quality Subgroup in its efforts to:

- Analyse data to evaluate the impact and importance of specific initiatives and ensure effective analysis is in place to target future work.
- Identify appropriate performance targets for the SAPB and partner agencies, including outcomes for service users and carers and their experience of the safeguarding process.
- Identify risks for the SAPB.

Performance Data

There continues to be no national performance indicators for safeguarding adults and there are also differences in operational practice between the three local authorities, which influence the type and volume of data recorded. These factors make it difficult to draw meaningful comparisons between the performance and activities of the three authorities, between the Board and other Safeguarding Adults Boards, and even across individual agencies within Berkshire West.

Annual safeguarding performance data is collected and analysed by Reading, West Berkshire and Wokingham local authorities and presented in their safeguarding annual reports.

Additional detailed performance information for each authority is included in the AVA Comparator Reports published on the NASCIS website https://nascis.hscic.gov.uk/index.aspx

Performance data for 2013-14 submitted as part of the statutory return is in the process of being validated.

2012-13 Combined Headline Data West of Berkshire SAPB

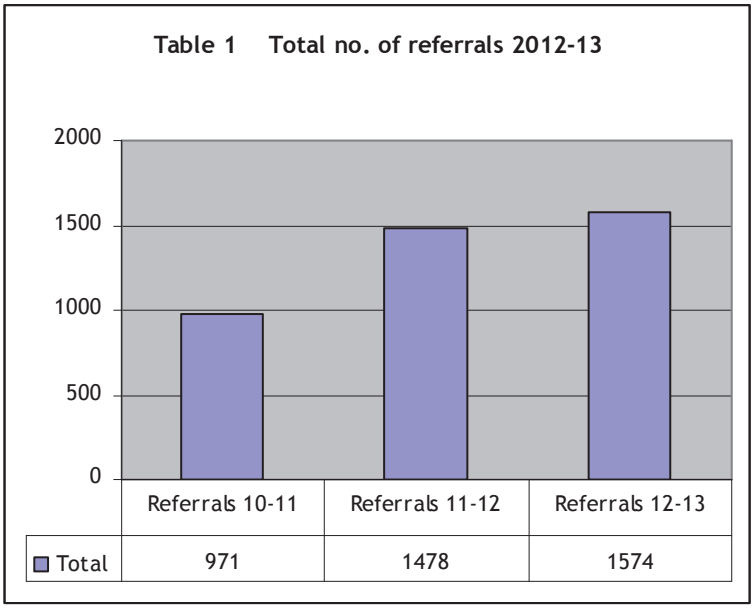
Performance in 2012/2013

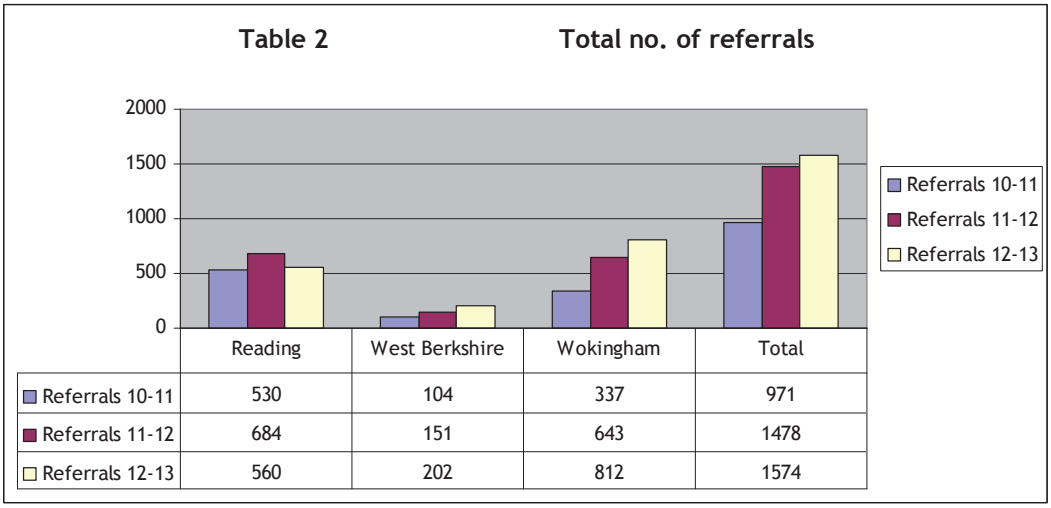
The data is sourced from the statutory AVA (Abuse of Vulnerable Adults) return for 2012-13 and unless specified, represents combined data for Reading, West Berkshire and Wokingham Local Authorities.

This report does not include the combined number of alerts since previously Wokingham counted all alerts as referrals making the distinction difficult. The Council has undertaken a complete review and re-design of their business processes to enable alerts to be counted separately from 2013-14.

Number of referrals

Across the three Local Authority areas the total number of referrals continued to increase this year, from 1478 in 2011/12 to 1574 in 2012/13, a 6% increase (but a 62% increase from 2010-11). This illustrates the increased volume of safeguarding work that must be responded to and investigated by the care teams and the key monitoring role of Safeguarding Triage.





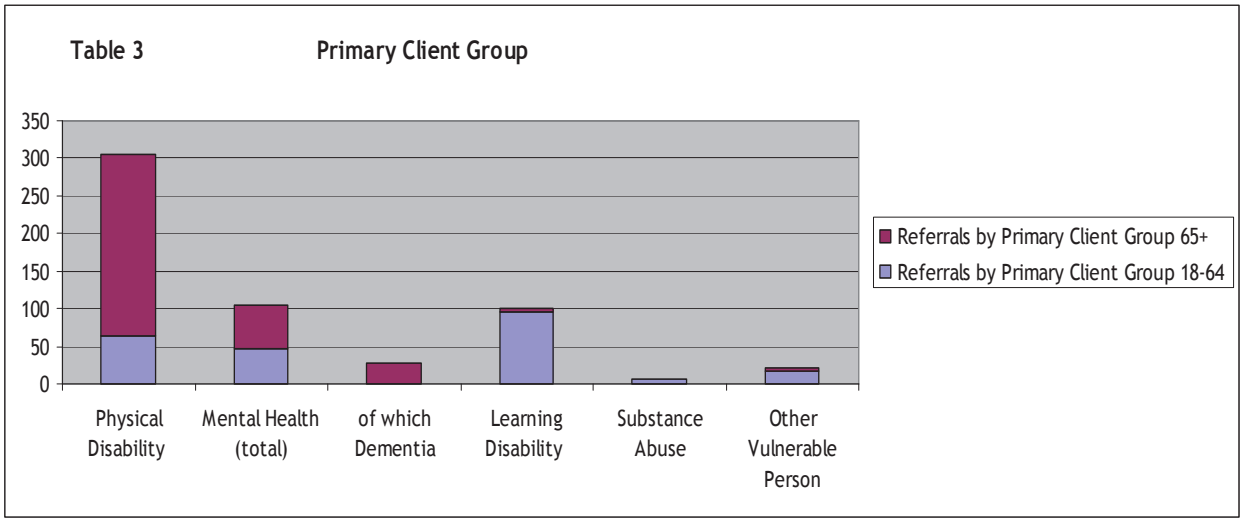
Per 100,000 population, the number of alerts in Reading is largely in line with its comparator group and only slightly above the England average. However, referrals are high, 560 compared to 220 (comparator group average) and 260 (national average).

In West Berkshire, the number of referrals is slightly below the comparator group and national average, but there is a higher number of alerts compared to the national average. A comparatively high number of alerts may indicate good awareness of safeguarding procedures in the community.

In Wokingham, the number of referrals is higher than the comparator group and national average

Referrals by Age and Primary Client Group

In 2012/13, across the area the highest percentage of alerts were received for people over the age of 65 who had a physical disability, followed by adults between the age of 18 and 64 who had a learning disability.



Per 100,000 population in Reading, the breakdown of primary client groups is largely in line with its comparator group and the national average, as is the case in West Berkshire although there is marginally greater number of clients with mental health needs here. Wokingham has a greater number of clients with learning disability and fewer with mental health needs compared to its comparator group and the national average.

In Wokingham, the largest percentage of clients are aged 18-64, whereas the trend elsewhere is a slightly larger number over 85 years of age. West Berkshire and Reading reflect the national pattern.

Repeat Referrals as a percentage of all referrals

Referrals are classed as repeat referrals when they involve a separate incident about the same vulnerable adult during the same collection period. As a percentage of all referrals, repeat referrals in Reading were 19%, slightly higher than the England average. West Berkshire was just under 10%, considerably lower than the national average of 17% and its comparator group average of 15%. In Wokingham the number of repeat referrals was high, over 30%.

Completed Referrals as a percentage of all referrals

Compared to a national average of 79%, 100% of Reading referrals were completed, 87% of referrals were completed in West Berkshire and 65% in Wokingham.

Completed referrals relate to referrals which were completed during the reporting year. Some completed referrals could have been opened in the previous reporting period. Therefore, the number of completed referrals can be higher or lower than the number of referrals. If the percentage is comparatively low, this may indicate difficulties in recording completed referral data on the council system.

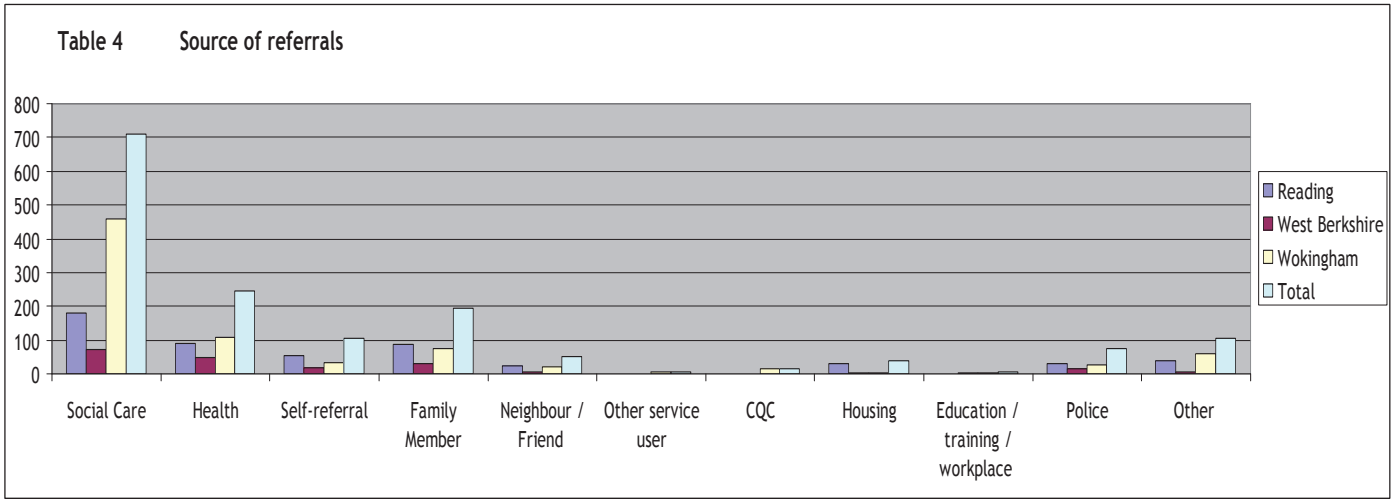
Percentage of referrals where the adult was previously known to the council

In Reading the percentage of referrals where the adult was previously known to the council was 73%, higher than an England average of 65%. In West Berkshire, the percentage was 77% and in Wokingham 92%. If values are comparatively high this may indicate that safeguarding is not reaching the wider community.

Source of Referral (who reported the alleged abuse)

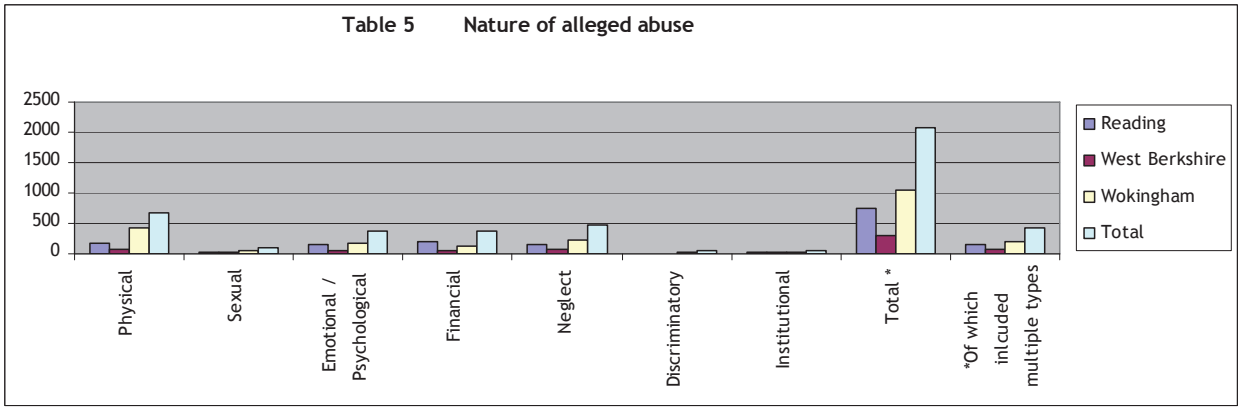
The West of Berkshire has a comparatively high proportion of referrals made by family, friends and neighbours, illustrating a good awareness of safeguarding procedures within the community. Reading has 31%, West Berkshire 27% and Wokingham 16%, compared to a national average of 11%.

Referrals from social care staff remain the highest source of referrals across the area. A comparatively high percentage of referrals from partner agencies may indicate good partnership working between these organisations and the councils. The percentage of referrals in Reading from social care, health, police and housing colleagues is comparatively low compared to the comparator group and national average. West Berkshire is more in line with comparator groups and national trends, whereas Wokingham has a comparatively larger number of referrals from social care staff.

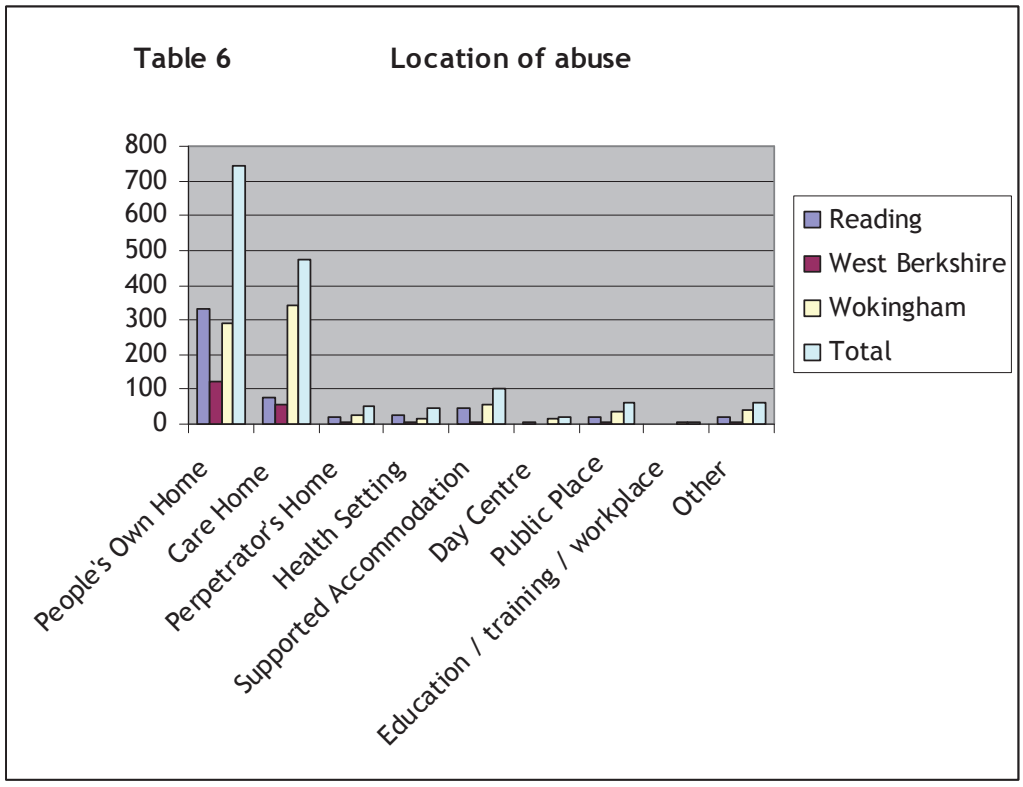


Referrals by Alleged Abuse Type

Across the area, the two most prevalent types of abuse are physical abuse and neglect. This is followed by financial and psychological abuse. The number of cases which recorded multiple abuse indicate there are a quarter of referrals with increased complexity received by Safeguarding Teams.



Location of alleged abuse



In Reading and West Berkshire, the highest number of referrals reported the alleged abuse occurring within the *person's own home*; this is higher than both the comparator groups and the national average.

Wokingham's data is largely in line with the national picture, with *care homes* slightly higher than national or comparator group averages. Wokingham has a large residential Learning Disability provider within its borders. Targeted safeguarding work has been undertaken with its staff following the high volume of inappropriate alerts raised. It is thought that as a result of the work undertaken, the number of inappropriate alerts being made has significantly reduced in the following year, that is, where no harm has been caused and no risk of further harm identified.

Care Home Setting includes both permanent and temporary placements in care or nursing homes. Health Setting includes acute and community hospitals, mental health inpatient settings and those recorded as Other Health Settings in the return. Other Locations include day centre/services, public places, education/ training/ workplace establishments and those recorded as Other in the AVA return.

Acceptance of protection plans

A comparatively high percentage of protection plans accepted may indicate that appropriate plans are being offered and that the vulnerable adult is being effectively engaged with during the process.

Reading was the third highest (87%) in its comparator group for the number of protection plans accepted, higher also than the national average, both of which were below 60%.

In West Berkshire there has been a renewed focus on effectively engaging with the vulnerable adult during the safeguarding process and ensuring an appropriate

protection plan is in place. As a proportion of protection plans offered, the number of plans declined has fallen considerably since 2010/11 (12% declined in 2010/11 and only 2% this year).

However, in West Berkshire almost 50% of cases were judged as *could not consent to offer* and this is higher than both comparator group and national averages of approximately 25%. There was a similar picture in Wokingham, as 45% of cases were judged as *could not consent to offer*.

Outcome of Completed Referrals for vulnerable adult

Tables 7, 8 and 9 below show the outcomes of completed referrals for the vulnerable adult for each of the three areas: increased monitoring, community care assessment and services, and no further action being the most common outcomes.

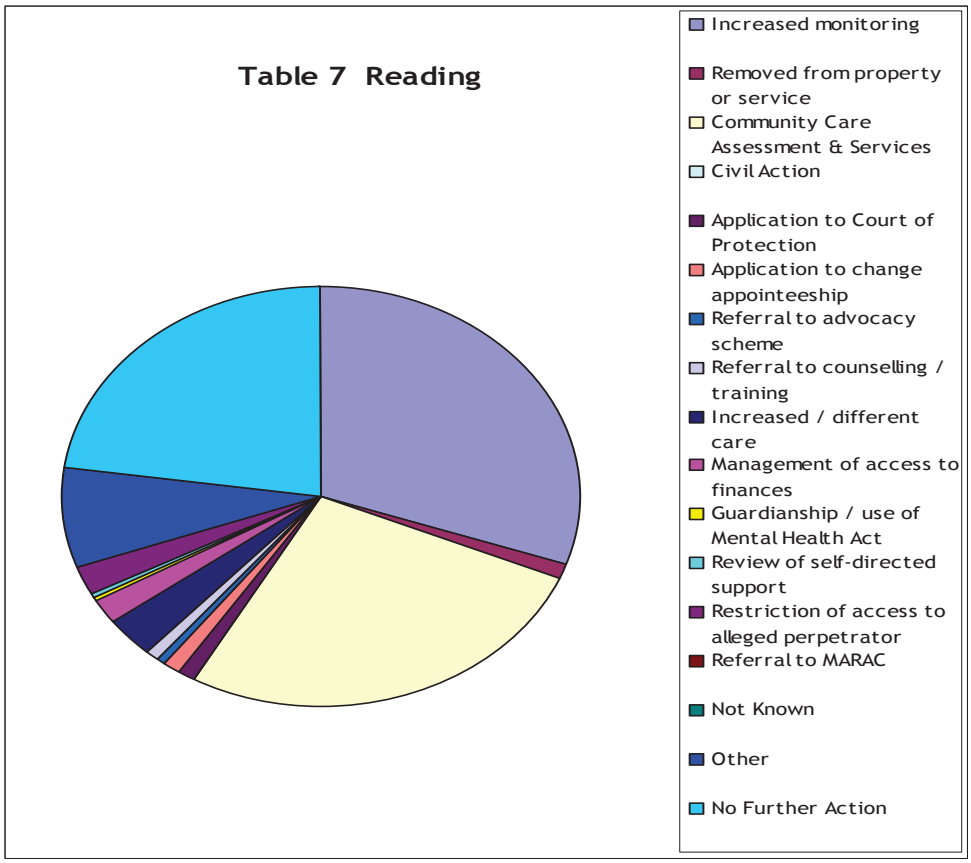
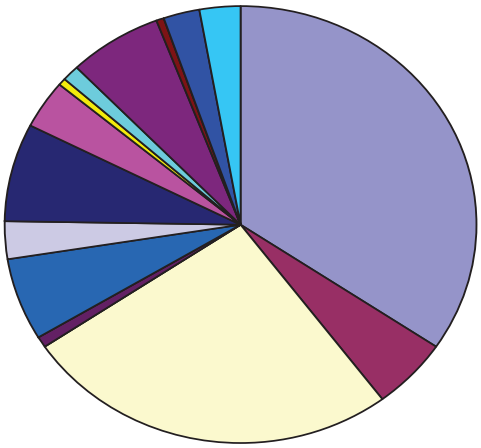
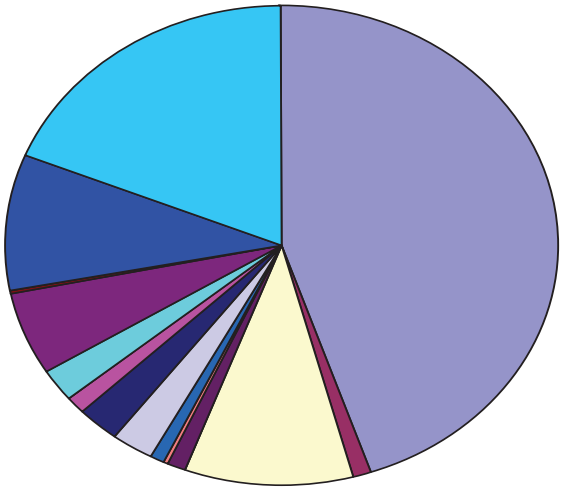


Table 8 West Berkshire



- Increased monitoring
- Removed from property or service
- Community Care Assessment & Services
- Civil Action
- Application to Court of Protection
- Application to change appointeeship
- Referral to advocacy scheme
- Referral to counselling / training
- Increased / different care
- Management of access to finances
- Guardianship / use of Mental Health Act
- Review of self-directed support
- Restriction of access to alleged perpetrator
- Referral to MARAC
- Not Known
- Other
- No Further Action

Table 9 Wokingham



- Increased monitoring
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- Management of access to finances
- Guardianship / use of Mental Health Act
- Review of self-directed support
- Restriction of access to alleged perpetrator
- Referral to MARAC
- Not Known
- Other
- No Further Action

BHFT raised the following number Safeguarding Adult Alerts between 1/4/13-31/3/14:

Reading – 176
Wokingham – 93
West Berkshire - 54

It has been recognised that there may be a discrepancy in figures as BHFT currently record a Safeguarding Alert as any concern that is shared with the local authority. However, these are not always recorded as an Alert on Local Authority systems. This has been acknowledged as an issue across Berkshire and there is working group to address this which is chaired by BHFT. BHFT plan to change their reporting methods to more clearly identify those that are recorded as alerts by LAs. This can be difficult as obtaining feedback is at times a challenge.

The Mental Health Hospital is based in Reading which explains part of the reason for much higher numbers but it does appear to be an area where there is a greater number of reports.

Berkshire Multi-Agency Safeguarding Policy and Procedures

In June 2010 the Berkshire Multi-Agency Safeguarding Policy and Procedures went live 'on line', with the online version provided by Tri-X. There is an editorial group in place that ensure the procedures are updated every 6 months.

The procedures are available via this hyperlink
http://berksadultsg.proceduresonline.com/index.htm

If you would like this report in a different format or would like further information about the work of the Safeguarding Adults Partnership Board in the West of Berkshire, please contact:

Natalie Madden, SAPB Business Manager

Email natalie.madden@reading.gov.uk

Tel: 07718 120601

Safeguarding Adults Training Activity 1st April 2013 to 31st March 2014

% own staff compliant if known		Number of staff attended training in 2013-14, per sector						
	Reading Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
	Level 1	64	282	1	1	0	283	
	Level 1 Refresher n/a	0	0	0	0	0	0	
	Level 1 E-learning	44	167	0	0	0	0	
	Level 2	23	48	1	0	0	0	
	Level 3	7	31	0	0	0	0	
	Advanced refresher	17	1	0	0	0	0	
	Level 1 Train Trainer	0	0	0	0	0	0	
	RBC Total	**148**	**529**	**2**	**1**	**0**	**283**	**963**
	West Berkshire Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
	Level 1	72	27	0	0	0	37	
	Level 1 Refresher	22	9	0	0	0	92	
	Level 1 E-learning	69	283				0	
	Level 2	14	3	0	0	0	0	
	Level 3	0	0	0	0	0	0	
	WeBC Total	**177**	**322**	**0**	**0**	**0**	**129**	**628**
	Wokingham Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
	Level 1	38	72	4	0	36	99	
	Level1 E-learning	12	108	0	0	0	0	
	Level 2	20	21	1	0	7	0	
	Level 1 Train Trainer		14				0	
	WoBC Total	**70**	**215**	**5**	**0**	**43**	**99**	**432**
94% complaint L1	**Berkshire Healthcare NHS Foundation Trust**	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
	Level 1	0	0	0		0		
	Level 2	400	0	0	0	0		**400**
84.3% compliant	**Royal Berkshire Hospital NHS Foundation Trust**	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**		

West of Berkshire

Safeguarding Adults Partnership Board

'Achieving by working together'

BUSINESS PLAN 2014-15

Objective	Action	Lead	Timescale	Outcome
Goal 1 - Establish effective governance structures for the Board to align the Board to new statutory requirements, improve accountability and ensure the safeguarding adults agenda is embedded within other organisations, forums and Boards.				
1.1 Develop oversight of the quality of safeguarding performance and practice, and challenge organisations where poor practice is identified.	a) Notify all partner agencies to develop action plan to improve all areas graded red / amber in the self-assessment audit.	Natalie Madden	July 2014	Board has a robust oversight of performance and practice and can challenge organisations to improve where poor practice has been identified.
	b) Monitor and measure improvement through self-assessment audit review.	Partner agencies	Partner agencies review audit by Dec 2014	Board has a robust oversight of performance and practice and can challenge organisations to improve where poor practice has been identified.
	c) Explore the development of a Quality Assurance framework that can evidence high quality safeguarding performance across all agencies, in particular domiciliary care agencies.	Suzanne Westhead / Natalie Madden	Sept 2014	Board is assured of high quality safeguarding practice across partner agencies.
1.2 Continue to raise awareness amongst primary and acute medical services of policies, procedures and processes for safeguarding adults.	Raise awareness across primary health care services of available training, ensure highlights from SAPB meetings are communicated with GP practices.	Debbie Daly / Kathy Kelly	Sept 2014 and ongoing	Local medical practitioners are supported to follow safeguarding adults processes and have opportunities to contribute to the strategic work of the Board.
Goal 2 – Develop oversight of safeguarding activity and need in order to target resources effectively and improve safeguarding outcomes.				
2.1 Collate knowledge of need across the region, set within a safeguarding context, in order to ensure resources are targeted effectively to achieve the	a) Use information and self-assessment audit results to set performance indicators in order to evidence improved outcomes.	Natalie Madden	Sept 2014	There is a clear mechanism in place to monitor performance, identify need and determine action to improve outcomes for

best outcomes for clients.				vulnerable adults.
	b) Analyse conversion of BHFT alerts to referrals by unitary authority safeguarding teams, and outcomes of safeguarding investigations.	Gemma Nunn	June 2014	Improve understanding across sectors about what constitutes a safeguarding alert and referral.
2.2 The views of adults at risk, their family/carers are specifically taken into account concerning both individual decisions and the provision of services.	a) Review findings from national Outcome Framework for each unitary authority.	Natalie Madden	July 2014	Accurate data is available with which to benchmark service developments.
	b) Include additional box on Part 2 Referral Form to say whether service users' views on the safeguarding process have been sought and considered.	Natalie Madden	July 2014	Board is able to evidence impact and effectiveness of the safeguarding process.
2.3 Understand the impact and potential increase in risk caused by broadening the circumstances of care that might now constitute a Deprivation of Liberty.	Local Authorities report on the impact, pressure on resources, and potential increase in risk.	Sylvia Stone	Sept 2014	Board has overview of the impact and is assured that Local Authorities are managing risk effectively.
Goal 3 - Raise awareness of safeguarding adults, the work of the SAPB and improve engagement with a wider range of stakeholders				
3.1 Raise awareness of the work of the Board and increase public awareness of safeguarding adults.	Develop costing proposal for development and roll out of SAPB website.	Natalie Madden	Dec 2014, with ongoing development	Independently branded website defines the Board as a separate multi-agency entity.
3.2 Ensure clarity about safeguarding processes and responsibilities amongst staff.	a)Audit what proportion of job descriptions within partner agencies include the responsibility to safeguard and promote wellbeing and dignity.	Natalie Madden	Sept 2014	Board has overview of the proportion of job descriptions that prioritise safeguarding and promote wellbeing and dignity.
	b) Safeguarding Teams audit minimum of 10% case files each month, feeding back issues to the Partnership and Best Practice Group on quarterly basis.	Jo Wilkins Sarah O'Connor Sue Brain	Quarterly PBP Subgroup meetings	Board is assured that practice supports the safeguarding processes and staff understand the importance of accurate, good quality recording and decision making
	c) Review impact of Skills Development programme in Reading BC to improve practice for both workers and managers.	Sylvia Stone	Dec 2014	Board is assured that practice supports the safeguarding processes and staff understand the importance of accurate, good quality recording and decision making.

Goal 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.				
4.1 Continue to ensure staff receive appropriate and effective level of training.	a) Review training material to reflect learning from Serious Case Reviews.	Eve McIlmoyle Natalie Madden	Sept 2014	Training material reflects most recent learning from serious case reviews.
	b) Joint Safeguarding Conference with LSCBs	Natalie Madden	Sept 2014	Conference provides learning and networking opportunity for full range of staff.
	c) Consider extending dignity training to all agencies.	Eve McIlmoyle	Dec 2014	Staff have the confidence and skills to promote well being and dignity of clients.
4.2 Ensure sufficient numbers of staff in the West of Berkshire are skilled in undertaking reviews of serious cases.	a) At least 6 members of staff trained to be accredited SCIE Learning Together lead reviewers.	Natalie Madden	Sept 2014	Sustainable skills base to enable proportionate and flexible response to learning lessons from serious cases.
	b) The Learning Together Review used as Continuous Professional Development and / or safeguarding refresher training.	Eve McIlmoyle	March 2015	Sustainable skills base to enable proportionate and flexible response to learning lessons from serious cases.
4.3 Develop improved mechanisms to critique good and bad practice and share learning more widely.	Develop workshop style support sessions.	Sylvia Stone	Sept 2014	Staff have opportunity to explore, reflect and learn from different cases.

Title of Report:	Pharmaceutical Needs Assessment Briefing
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27th November 2014

Purpose of Report: To present a summary of neighbouring PNAs to the Board for comment

Recommended Action: To note the findings of neighbouring PNAs and formally respond.

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Marcus Franks (01635) 841552
E-mail Address:	mfranks@westberks.gov.uk

Contact Officer Details	
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Job Title:	Strategic Director of Public Health (Berkshire)
Tel. No.:	
E-mail Address:	Lise.Llewellyn@bracknell-forest.gov.uk

Executive Report

Introduction

The Health and Wellbeing Board is required under statute to produce a pharmaceutical needs assessment (PNA) for its economy. The PNA for West Berkshire is out for formal consultation (closing date 16 December 2014).

In addition the Health and Wellbeing Board is a consultee on neighbouring authorities PNAs. Appendix 1 (slide presentation) to this report outlines the key recommendations proposed by these immediate neighbours.

Recommendation

It is recommended that the Board note the presentation and agree neighbouring area responses to their surveys.

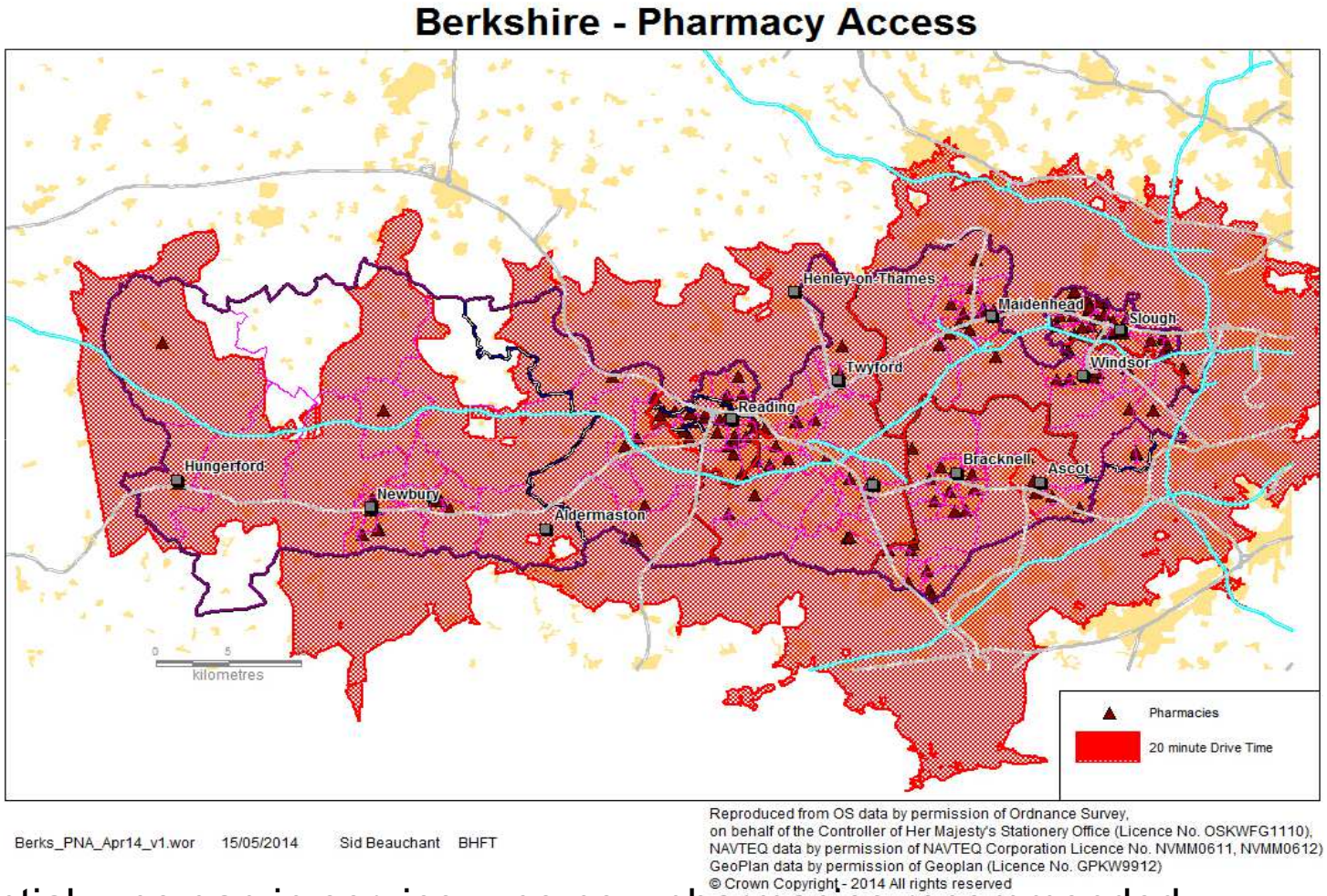
Appendices

Appendix 1 - slide presentation

Neighbouring PNAs

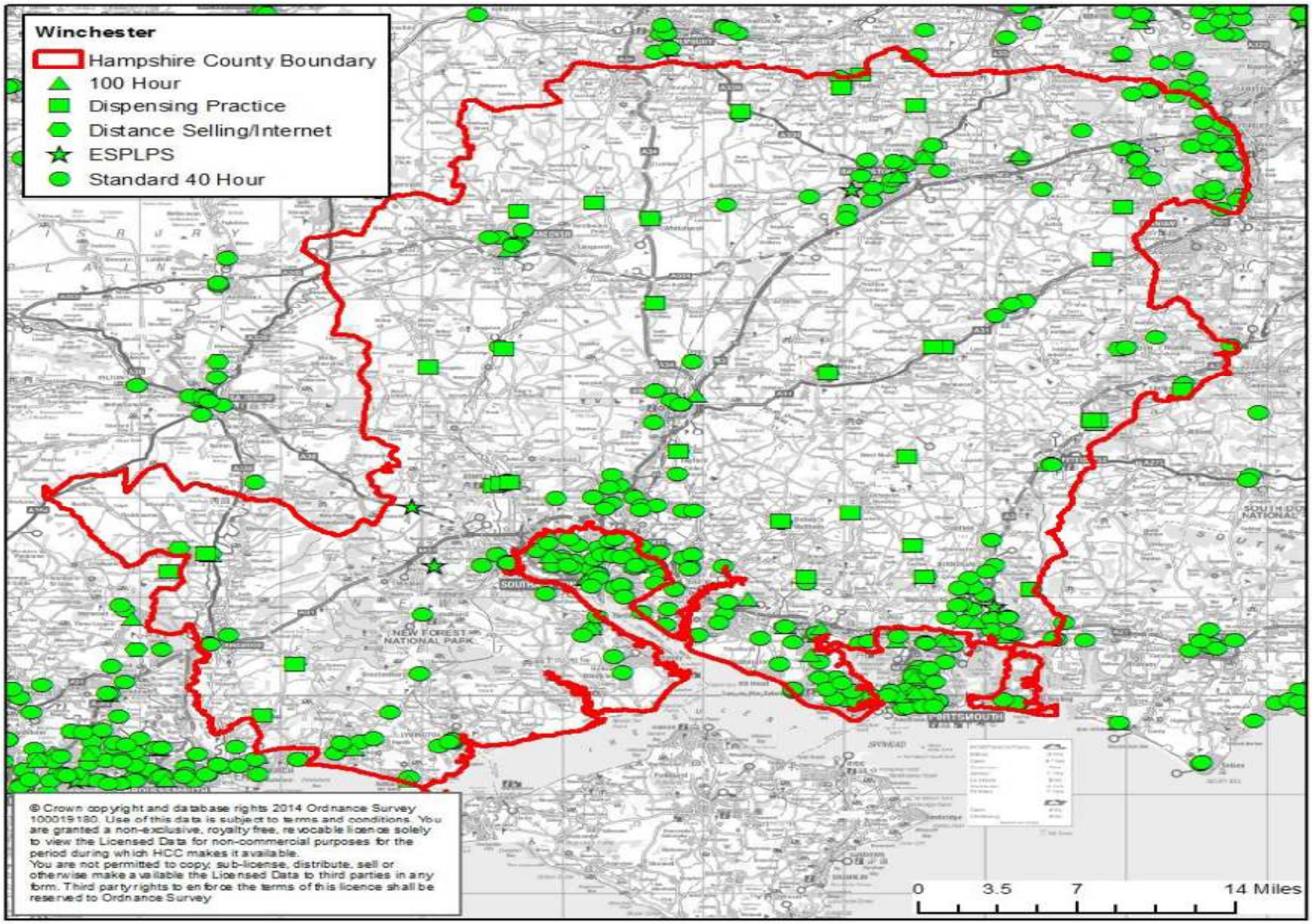
- Each HWB board must consult its neighbours on its PNA .
- This is part of the local consultation plan
- This presentation summarises the key messages in the neighbouring areas

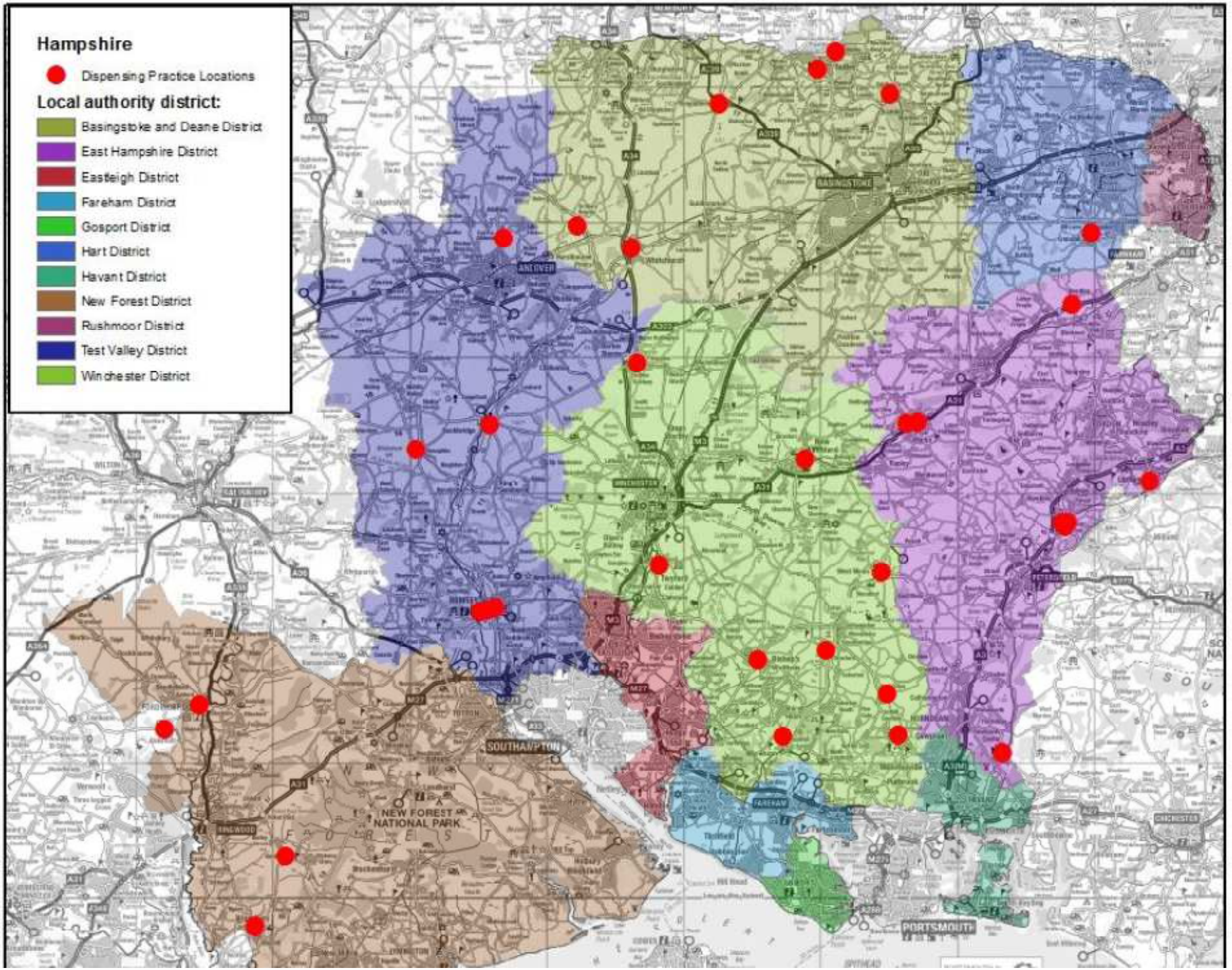
Other Berkshire PNAs

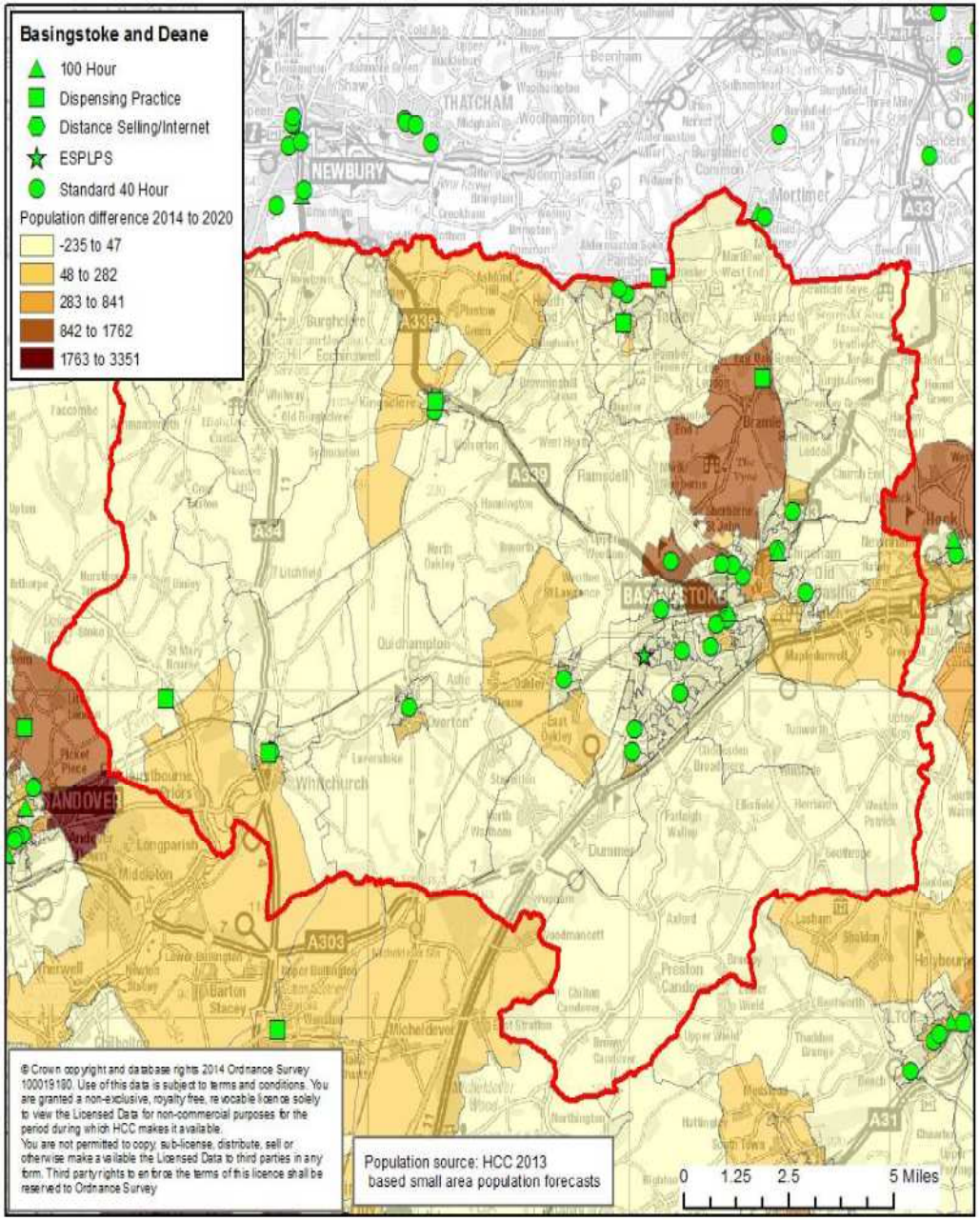


Essential - no gap in service - no new pharmacies recommended
Local commissioned - similar pattern of local additional services described for long term conditions, and self care - additionally reading and slough infectious diseases

Hampshire PNA




Hampshire
Dispensing Practice Locations
Local authority district:
Basingstoke and Deane District
East Hampshire District
Eastleigh District
Fareham District
Gosport District
Hart District
Havant District
New Forest District
Rushmoor District
Test Valley District
Winchester District
NEW FOREST NATIONAL PARK
SOUTHAMPTON
PORTSMOUTH



Within Basingstoke and Deane the 168,000 population is slightly younger than the Hampshire population. Deprivation is lower than average

There are 27 community Pharmacies, including one 100 hour pharmacy and an essential small pharmacy.

68% population within 5 miles of pharmacy

Good provision of pharmacy

Hampshire Recommendations

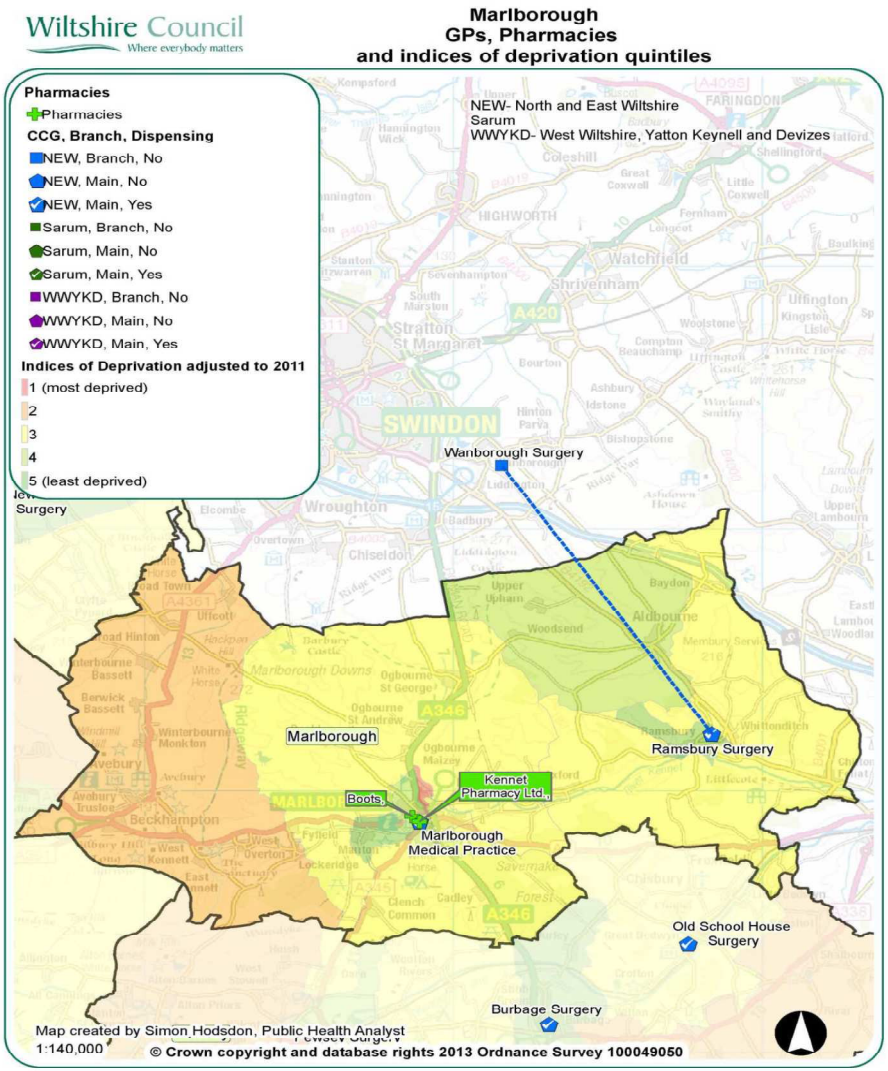
- Further work is desired to confirm that the delivery services are safe and effective along with an understanding of the scope (i.e. what can be delivered) and standards of these delivery services operating
- The need for Essential Small Pharmacies close to standard pharmacies should be reviewed to ensure the most effective and cost effective pharmaceutical provision in line with the population need
- This is a gap in for translation provision as there is no formal translation service for patients. This should be considered.
- The Healthy living pharmacy service will need clear on going specification and regular evaluation of outcomes to ensure effectiveness of services
- A review of the uptake and quality of the MUR and NMS service locally should be undertaken to ensure best use of this service by patients with Long Term Conditions

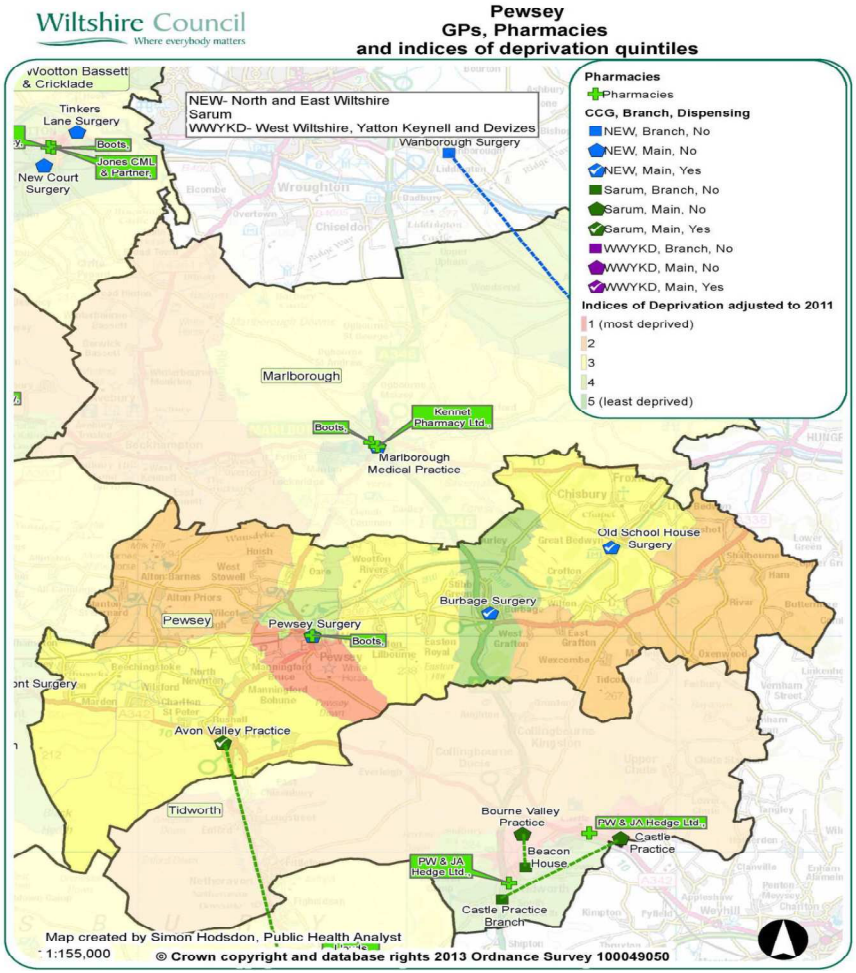
Wiltshire PNA

Wiltshire has a total of 74 community pharmacies

21 Dispensing General Practices

Sufficient - looking to explore new local commissioned services in line with needs





Oxford PNA

- Unavailable at this time - will be updated

Summary

- Essential - no new pharmacies
- Advanced - increase roles of advanced services to support LTCs
- Local - self care, sign posting, long term conditions support
- Expanded role

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NHS

FIVE YEAR FORWARD VIEW

October 2014

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

NHS support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – enhanced health in care homes

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage

recruitment and retention in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along by route of diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.

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West Berkshire LSCB

Local Safeguarding Children Board

Annual Report 2013-2014

"The West Berkshire Local Safeguarding Children Board was established in 2004, as a major element in the Every Child Matters Change for Children agenda and in support of the five key outcomes with a particular focus on staying safe."

Essential information

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WBC/CCHS/RH/0614

Contents

Foreword by Independent Chair

Everyone has a responsibility for safeguarding children and young people. It is vital that all agencies work together to ensure children and young people are safe and achieve good outcomes.

The LSCB has a statutory duty to co-ordinate how agencies work together to safeguard and promote the well-being of children and young people in West Berkshire and to ensure the effectiveness of local safeguarding arrangements.

This year has seen a focus on implementing the revised government guidance Working Together to Safeguard Children 2013. This has led to the development of threshold criteria for Children's Services, along with a single assessment form. The Threshold document aims to help practitioners identify a child's level of need and to be familiar with the best way to access the support needed.

Over the past year there has been increased national awareness in relation to sexual abuse, including historical abuse and links to child sexual exploitation. West Berkshire LSCB has put in place strategic and operational developments, with strong multi-agency support led by West Berkshire Council and Thames Valley Police.

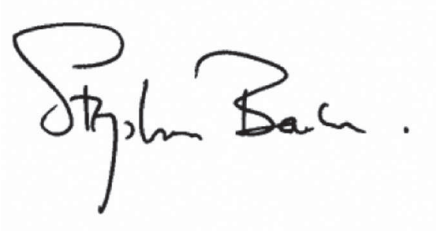
Changes in the health service structure came into effect in 2013, with the establishment of Clinical Commissioning Groups and NHS England Local Area Teams. The LSCB worked with the new groups to ensure good links were made and safeguarding remained a priority.

A major restructure in currently underway in Thames Valley Probation Trust. The LSCB will work with the Trust to ensure partnership working remains effective and children are safeguarded.

Working Together 2013 requires the Chair of the LSCB to publish an Annual Report on the effectiveness of safeguarding arrangements and setting out how well agencies promote the welfare of children in the local area.

This Report aims to provide an overview of the performance and effectiveness of local services. It identifies areas of weakness, the causes of any weaknesses and the action being taken to address them as well as other proposals for action. Each agency has been asked to provide its own assessment of performance; these are summarised in the Report, along with contributions from sub-groups which undertake a significant amount of the work of the Board.

The report is presented to the Chief Executive of West Berkshire Council, the Lead Member, Chair of the Health and Well-Being Board and the Police and Crime Commissioner. It is also formally reported to the Boards of the local Health Trusts. It is intended for a wide audience including the professional workforce and local communities.



Stephen Barber, Independent Chair

Executive summary and key messages

The Annual Report provides an insight into the work carried out locally to safeguard children, outlining progress made during 2013/14 and summarising the key priorities and challenges ahead.

The LSCB is working to increase its effectiveness by focusing on outcomes for children and young people. At a business planning session in October 2013, members decided to review the vision and values of the LSCB; following consultation, a set of LSCB Values were agreed by members in April 2014.

West Berkshire LSCB Values

West Berkshire LSCB:

- works together as an inter-agency partnership to safeguard and promote the welfare of children and young people
- puts children's wellbeing at the centre of its thinking and actions
- listens to children and takes their views into account
- is committed to helping children be safe in their families and settings
- keeps up to date with national developments and promotes good practice locally
- listens to front-line practitioners and takes their views into account
- addresses diversity issues in all aspects of its work
- offers a constructive challenge and support to partner agencies

The LSCB has identified the following key messages to support effective safeguarding within the West Berkshire area.

Messages for Chief Executives and Directors

- Senior officers must ensure that their workforce is able to participate in LSCB safeguarding training, to attend training courses and learning events.
- Every agency's contribution to the work of the LSCB must be categorised as the highest priority in the allocation of time and resources.
- The LSCB needs to understand the impact of any organisational restructures on the capacity to safeguard children and young people in West Berkshire.
- Performance information needs to be produced and contextualised to demonstrate the effectiveness of safeguarding within services.
- Ethnicity and disability information needs to be used in a strategic context to commission relevant services.

Messages for the children's workforce

- All members of the children's workforce, from all agencies and the voluntary sector, should use safeguarding courses and learning events to keep them up to date with lessons learnt from research and to improve their practice.
- All members of the children's workforce, both paid and voluntary, should be familiar with the role of the LSCB and Berkshire Child Protection Procedures.
  Link: Berkshire LSCB Child Protection Procedures

"Committed to helping children be safe in their families and settings".

Messages for Thames Valley Police

- Ensure adequate attendance at initial Child Protection Case Conferences.
- Ensure referrals into children's social care take account of the thresholds for statutory intervention.
- Ensure work with the Local Authority on domestic abuse remains a priority.
- Continue to improve identification of risk in domestic abuse cases.
- Ensure that police officers receive safeguarding training appropriate to their level and evidence this.
- Ensure police officers are able to participate in multi-agency training events.
- Continue to improve responses to child sexual exploitation and the identification of risk when children and young people are reported missing.

Messages for Thames Valley Probation

- Ensure any safeguarding risks, arising out of the current restructure, are identified and mitigated against.
- Demonstrate that the Multi-Agency Public Protection Arrangements (MAPPA) and the Multi-agency Risk Assessment Conferences (MARAC) protect children from harm and promote children's wellbeing.
- Continue to support the work with children of prisoners or in contact with offenders.

Messages for Berkshire Healthcare NHS Foundation Trust

- Continue the work to ensure looked after children receive appropriate, high quality health services.
- Promote the Think Family approach within adult mental health services.
- Participate in developing early help services, ensuring health visitors and school nurses understand thresholds for statutory intervention and where to get help for families whose needs do not merit a statutory intervention.

Messages to Clinical Commissioning Groups

- Complete Section 11 self audits.
- Ensure all commissioned services are monitored to ensure they meet safeguarding standards and to share health safeguarding data with LSCBs.
- Promote the need for GP involvement in all aspects of Child Protection Conferences

Messages for NHS England Local Area Team

- Play a full part in LSCB work.
- Complete Section 11 return.
- Ensure that the Sexual Assault Referral Centre (SARC) achieves a quality service and provides regular performance information to partner agencies.

Messages to Schools in West Berkshire

- Continue to complete the annual Section 11 audits.
- Work with other agencies to support the Domestic Abuse Champions project.
- Support the LSCB in raising awareness of child sexual exploitation.
- Ensure all staff are recruited safely.
- Ensure all staff are appropriately trained in safeguarding.

Local area profile

West Berkshire makes up over half of the geographical area of the county of Berkshire - covering an area of 272 square miles. It lies on the western fringe of the South East region. West Berkshire covers a geographical area stretching from Hungerford in the West to Calcot in the East.

Although West Berkshire is a relatively affluent area, there are pockets of deprivation within the district. One area (the Nightingales estate in south Newbury) falls within the bottom quintile nationally when measured against the overall Indices of Multiple Deprivation (IMD) measure, with 2 other areas (in Calcot in the east and central Thatcham) falling within the bottom third. The one domain where the indices show a greater number of areas falling within the bottom quartile nationally is in relation to education, skills and training.

The 2011 census showed West Berkshire with a population of just under 154,000. The number of young people 0-19 years in West Berkshire was 38,629.

Between 2001 and 2011 the number of young people in the 0-19 age group rose by 4% (slightly smaller than the regional and national change) but there was an increase of 14% in the 0-4 age group, reflecting a national change and suggesting a mini 'baby-boom'.

Population projections over the next decade estimate the number of 0-9 year olds living in West Berkshire to have grown by 3,300 by 2021 (17%). This compares to a similar expected growth across the South East of around 15%. The numbers of 10-19 year olds is anticipated to have increased by around 1,500 (8%), which is also in line with the projected growth rate for the district as a whole.

The rate of child poverty is relatively low in West Berkshire, at 11.6% (3800) for children aged under 16 years, compared with the South-East average of 15.5%. However the level of poverty increased by 0.8% in West Berkshire during the period between 2008 and 2011.

The 2011 Census shows that, when compared nationally, there is a significantly lower proportion of people in West Berkshire who define themselves as coming from a black or minority ethnic (BME) background - 5% of West Berkshire residents as a whole, compared to 14% of people in England and Wales generally.

The largest increase in ethnic group over the last decade is 'Asian or Asian British', an increase of 1.7%, compared to an increase twice that in England and Wales.

1.4% of the population in West Berkshire were born in one of the EU accession countries (Malta, Cyprus, Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Slovenia, Hungary, Bulgaria and Romania), equating to just over 2,000 people. This compares to 2% of the population nationally. Aside from the UK, the most common countries of birth are India, Poland, South Africa, Ireland and Germany.

Just over 3000 people in West Berkshire speak a European language as their primary language. Of these, Polish is the highest number, at just over 1000, and just over 800 speak a South Asian language as their primary language, just over 600 an East Asian language and just over 200 an African language.

Source; the West Berkshire District Profile 2013 and the West Berkshire Child Poverty Needs Assessment Refresh 2014. These documents can all be found via the West Berkshire Council website www.westberks.gov.uk

Major Factors Influencing the Work of the LSCB

Changes in partner agency structures

Changes in the health service structure came into effect in 2013, with the establishment of Clinical Commissioning Groups and NHS England Local Area Teams. The LSCB continues to work with the new groups to ensure good links are in place and that safeguarding remains a priority.

A major restructure in currently underway in Thames Valley Probation Trust. From 1st June 2014, Thames Valley Probation Service will be replaced by the National Probation Service and Thames Valley Community Rehabilitation Company. The LSCB will work with the National Probation Service and the Community Rehabilitation Company to ensure partnership working remains effective and children are safeguarded.

Funding

All public sector organisations face resource restrictions with new challenges locally in relation to a rising child population. The LSCB provides regular opportunities for agencies to highlight pressures on safeguarding at meetings.

Child Sexual Exploitation (CSE)

2013 saw an increase in national awareness in relation to sexual abuse, including historical abuse and links to child sexual exploitation. The LSCB has established both Strategic and Operational CSE groups to take this work forward locally, with strong multi-agency support led by West Berkshire Council and Thames Valley Police.

Missing Children

New statutory guidance in relation to missing children (January 2014) provides detail on how Local Authorities and their partners should take action to prevent children from going missing and to protect them when they do. A new expectation that a return interview will be completed by an independent person after every missing episode is being responded to locally but will have major resource implications in future. Safe and well checks continue to be completed by Thames Valley Police, and the LSCB carried out a sample to check these were being carried out appropriately.

Female Genital Mutilation (FGM)

The publication of a report by The Royal College of Midwives entitled Tackling FGM in the UK – Intercollegiate recommendations for identifying, recording and reporting (November 2013) identified key principles and recommendations to safeguard girls at risk of FGM. In response to the recommendations, a local multi-agency task group has been formed and an action plan developed.

The Munro Review of Child Protection

The Munro Review of Child Protection 2011 made recommendations for creating a work environment that will better support professionals in giving children, young people and families the help they need. In West Berkshire, the Munro Implementation Board has been working to implement the recommendations since 2012. One specific recommendation was made in relation to the collection and use of data; this has been responded to locally by developing 'The Data Zone', a new management information bulletin which provides the data needed at a strategic level, focusing on information which is key for understanding and evaluating activity within the service. Work is also underway on recruitment and retention of social workers to attract and keep staff in this area.

A Youth Offending Team Case Study

Stevie committed his first offence when he was 16 years old. It was a violent offence for which his co-defendant was imprisoned. He was sentenced to a community order under the supervision of the Youth Offending Team (YOT) and an assessment was carried out including information from his school, social worker, a parenting assessment and a self-assessment.

Stevie had very quickly shown genuine remorse for his offence but wasn't able to repair the harm to his victim directly, so as reparation worked each week at a soccer academy with younger children, some with learning difficulties. In an article he wrote for the YOT Newsletter he said "this was very rewarding because it made me feel that I had been taking things for granted in my life and that other young people are not so fortunate and do not have the same opportunities…. This was a perfect way to repair the hurt and damage I caused and for others in the local community to benefit".

Stevie worked with his YOT Officer on issues within his family and on strategies to ensure he did not offend again. He is now studying for A Levels, continuing to volunteer at the soccer academy and voluntarily supporting younger children with rugby coaching. His reparation has helped put his offence behind him and to move forward positively with his studies and future life. His increased confidence led him to volunteer to talk to the LSCB about his views on safeguarding children in West Berkshire, gaining the respect of all those who attended the meeting.

"This was a perfect way to repair the hurt and damage I caused and for others in the local community to benefit".

Governance and accountability arrangements

Statutory objectives and regulations

Section 13 of the Children Act 2004 requires each local authority to establish a LSCB for their area and specifies the organisations and individuals that should be represented on LSCBs.

The core objectives of the LSCB are set out in section 14(1) of the Children Act 2004 as follows:

a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in West Berkshire, and

b) to ensure the effectiveness of what is done by each such person or body for that purpose.

The role and function of the LSCB is defined by Working Together to Safeguard Children 2013 and related safeguarding national, regional and local guidance.

Members are reminded of their roles and responsibilities at meetings and during their induction. A member development session was held in October 2013 to support members on leadership and challenge. This was well received with the majority of members attending.

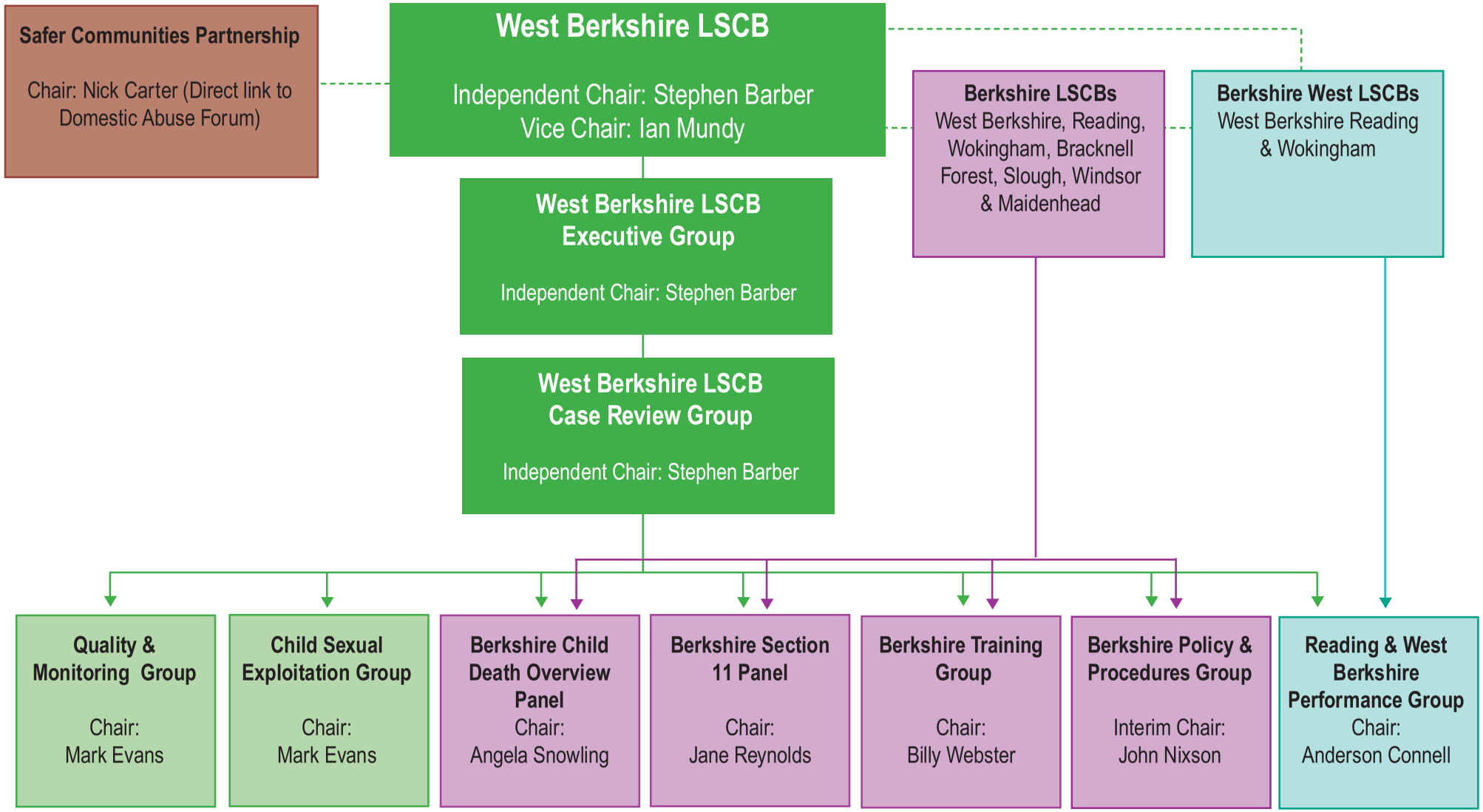
LSCB Chair, accountability and resourcing

Working Together 2013 states that, in order to provide effective scrutiny, the LSCB should be independent. The West Berkshire Chair, Stephen Barber, is independent of partner agencies to allow the LSCB to exercise its local challenge function effectively. The Chair has a crucial role in making certain that the LSCB operates effectively and secures an independent voice for the LSCB. Stephen also chairs the Reading and Wokingham LSCBs to support joint working and consistency across agencies. To ensure effective communication between the LSCB and other partnerships the Chair also attends the Health & Wellbeing Board annually and works closely with the Chair of the West of Berkshire Safeguarding Adults Partnership Board.

In order to meet its objectives, the LSCB has several sub-groups, each of which is accountable to the LSCB and produces a workplan which is monitored.

An overview of the work of the sub-groups can be found on pages 24-29.

West Berkshire Local Safeguarding Children Board Structure



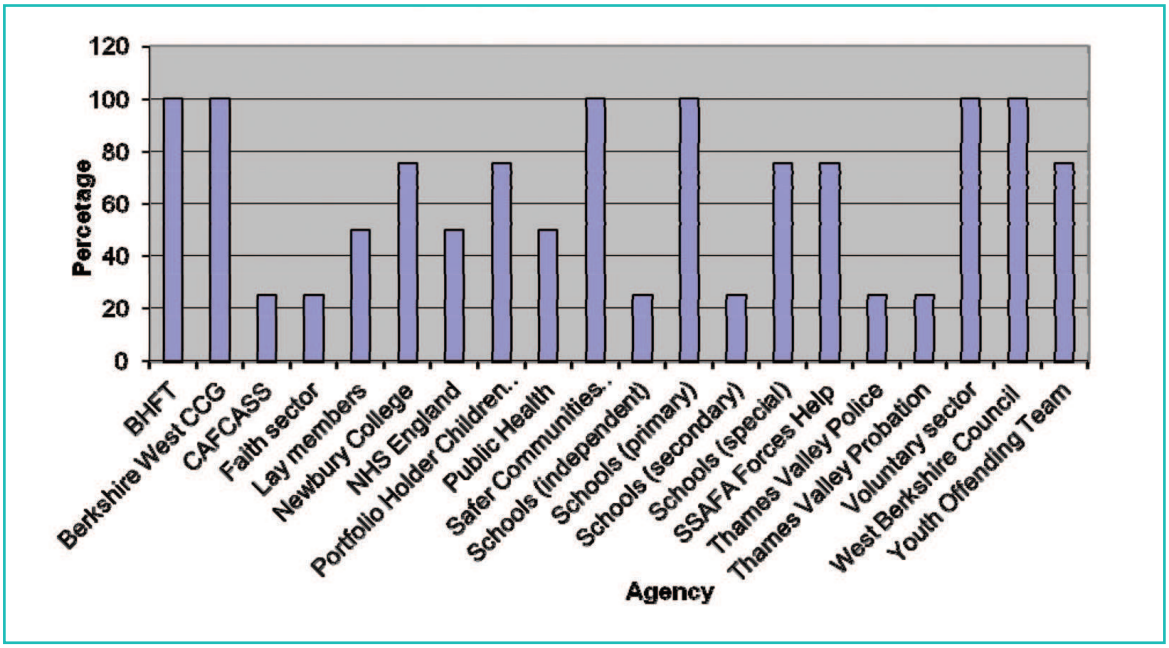
Membership/Attendance

LSCB members have a responsibility to attend all meetings and disseminate relevant information within their agency. Attendance at meetings is monitored to ensure attendance is regular and at an appropriate level. These records are presented to members on an annual basis as part of the LSCB's quality assurance process.

Attendance in West Berkshire is generally good and, if a member is unable to attend, they are asked to send a deputy to ensure all messages are disseminated to each agency. Any lack of agency attendance is addressed directly by the Business Manager or escalated to the Chair.

Attendance figures by agency, based on four meetings held from April 2013–March 2014, are shown below.

Agency representation at LSCB meetings 2013-2014



In addition, the Designated Doctor attends meetings once a year by arrangement.

Engagement with children and young people

The LSCB recognises the importance of listening to children and young people, and taking their views into account, this being one of the agreed LSCB values.

Opportunities to hear the views of young people directly at LSCB meetings are being actively sought. At a recent meeting, a young person spoke about his experience of working with the YOT and the benefits of reparation. He also gave his views on the risks to safeguarding, which included drugs and the shortage of out of school activities, especially in rural areas. A future meeting will include attendance by young people involved in peer mentoring.

The views of particularly vulnerable children and young people are sought when they are in the Council's care, with extracts being included in an annual report to the Board.

A recent audit of service user feedback within West Berkshire Council identified areas of good practice and ways in which recognition of feedback could be strengthened.

Feedback from children in the Independent Reviewing Officers Report April 2013 - March 2014 indicated that 98.3% felt safe being looked after.

Feedback from foster carers said they valued the Independent Reviewing Officers for: "their knowledge of the child's rights, entitlements, etc" and that "he is very knowledgeable and helpful and we feel he is very approachable".

LSCB Business Plan

The current three year Business Plan 2014-2017 was agreed by members in April 2014. The Plan has multi-agency actions and represents work from most LSCB partners. The priorities addressed in the plan are:

- Early intervention/early help
- The child's journey
- Sexual abuse/sexual exploitation
- Domestic abuse
- Governance and communication

The full Business Plan can be viewed on the LSCB website **www.westberkslscb.org.uk**

Effectiveness of safeguarding arrangements over the past year

LSCB

LSCB Achievements

- Hosting arrangements have been put in place for all sub-groups to improve communication links with LSCBs;
- Child Sexual Exploitation (CSE) strategic and operational multi-agency sub-groups established to address CSE locally;
- Reduction in number of young people subject to CSE following successful multi-agency intervention;
- CSE sub-group identified young people at risk and perpetrators in Operation Forte disruption order;
- Workshop on Serious Case Review models held March 2014 to consider the range of models available;
- A survey of members was carried out in September 2013 to identify priorities for the 2014-2017 LSCB Business Plan;
- LSCB member development session held in October 2013 on leadership and challenge, with a further session for Executive members in June 2014;
- Berkshire West LSCBs and Safeguarding Adults Partnership Board held their annual joint safeguarding conference in September 2013; the theme for the conference was Sexual Abuse;
- Raising awareness of CSE amongst young people, parents and the wider community through a LSCB and Thames Valley Police jointly funded project delivering performances of 'Chelsea's Choice' in West Berkshire secondary schools. During September 2013, the play was delivered by Alter Ego Creative Solutions Ltd, reaching 1969 young people and staff;
- West Berkshire safeguarding information updates distributed to a wide mailing list on a weekly basis;
- Developed effective links with CCGs in their first year of operation; including representatives for the LSCB and LSCB Executive;
- New CSE e-learning course launched for all LSCB partner organisations;
- Carried out a review of the support and activities provided to voluntary and community organisations operating in West Berkshire;
- Published threshold criteria and assessment protocol for Children's Services;
- Successfully recruited a new lay member;
- Berkshire wide lay members meetings held to increase awareness of the role and to network with others across Berkshire;
- Commissioned a presentation on the Serious Case Review of Daniel Pelka which was delivered to the LSCB and made available as a PowerPoint presentation for dissemination to all LSCB partners;
- Agreed a protocol between the Thames Valley LSCBs and the Sexual Assault Referral Centre to improve communication and reporting;
- Task-group set up to take forward the intercollegiate recommendations Tackling FGM in the UK;

- Guidelines put in place to improve the engagement of LSCB members through effective challenge at meetings;
- Berkshire Child Protection Procedures have been updated in relation to recent guidance on CSE, missing children and safe staffing;
- In response to an LSCB survey on domestic abuse, a lunchtime seminar has been held on 'Identifying and responding to domestic abuse – particularly in situations of emotional abuse'.

LSCB Challenges

- Developing an agreed dataset with agencies providing context and commentary to the data;
- Monitor police and GP attendance and reporting to Child Protection Conferences to ensure contribution is effective;
- Regular data is provided by Thames Valley Police but representation on the Training Sub-Group is still needed;
- Improve links with NHS England Local Area Teams and ensure they are fulfilling their Section 11 duties; including providing regular reports on the Sexual Assault Referral Centre (SARC);
- Obtaining performance data from the SARC through NHS England.

Partner agencies safeguarding effectiveness

West Berkshire Council

West Berkshire Council Achievements

- Help for Families team set up, providing a single route for enquiries and support for children and families with additional needs that do not meet thresholds for social care or other high need services;
- Turnaround Families programme is working effectively with families to help children back to school, reduce antisocial behaviour and offending and help adults back to work;
- School staff and volunteers all receive universal safeguarding training. In addition to this specific training for Designated Persons in school is provided every 2 years. A wider group of managers is now attending this training; early years settings, independent schools and other staff from WBC have found this training extremely informative;
- A system for information sharing of domestic abuse cases with schools has been developed;
- The Gypsy, Roma and Traveller (GRT) Practitioners Group is a multi-agency group which shares best practice for better outcomes for Gypsy, Roma and Traveller families. It aims to enhance communication, providing effective links within the group and the GRT community;
- Work carried out with Unaccompanied Asylum Seeking Children;
- Work carried out supporting parents (under Child in Need or Child Protection) to engage and fulfil safeguarding requirements;
- Bilingual Pupil Support Officers liaise in first language to support schools and parents where there are concerns and/or children are in vulnerable circumstances.

West Berkshire Council Challenges

- Increase in workload due to a rise in the number of children and young people subject to Child Protection Plans and increase in numbers of Looked After Children. Between 2011/12 to 2013/14 the number of Looked After Children has increased by 22% (125 to 161) and children subject to a Child Protection Plan rose by 48% (78 to 116).
  Two additional social worker posts have already been created to address this increase and there are plans for further new posts to be recruited to in September 2014. The increased capacity will enable the additional demand to be met;
- Children's Services continue to experience significant recruitment and retention difficulties across a range of teams. The R&A, Locality and DCT teams are the most seriously affected. Work will continue to develop and roll out a new Recruitment and Retention strategy to improve the ability to retain existing staff and attract new staff. This will be finalised in July 2014;
- Despite extensive attention, delays are still being identified in progressing Plans for some children and young people. Work is continuously underway to improve quality assurance processes to improve identification and resolution of these issues. Work is also being carried out with teams to provide training and development to help minimise delays.

Children and Family Court Advisory and Support Service (CAFCASS)

CAFCASS Achievements

- Ofsted Inspection of Services for children and young people in the area in March 2014 showed that safeguarding outcomes were "Good" in both Private and Public Law work;
- Local Management performance was assessed as "Good" by Ofsted and Senior Management was assessed as "Outstanding";
- The proportion of open public law care cases allocated to an appointed Children's Guardian is currently 100% (against a target of 97%);
- The current timescale for allocation to an appointed Children's Guardian for a public law care application is less than a working day (against a target of 0-3 days on average);
- The current public law care application duration is 24 weeks in West Berkshire on average; this is 2 weeks below the national average and is the lowest for at least 12 months;
- Proportion of open private law workload allocated to a Family Court Adviser is currently 100% for Berkshire (against a target of 97%);
- Percentage of Section 7 reports that meet the agreed filing times is currently 98% for Berkshire (against a target of 97%);
- Private law, there are currently 170 open cases in Berkshire. This is the lowest number for at least 12 months;
- Section 16.4 cases (begin as private law but require a Guardian role) continue to reduce through active case management. There are currently 21 of these cases in Berkshire. This is the lowest figure for at least a year;
- Time taken for private law reports to be filed in Berkshire is currently 12.4 weeks on average. This compares to a national average of 12.0 weeks.

CAFCASS Challenges

- Impact of Public Law Outline and the Child Arrangement Programme in Private Law have led to significant structural and operational changes across the area as well as nationally.

Berkshire West Clinical Commissioning Groups (CCG)

CCG Achievements

- In January 2014 the CCGs successfully recruited to the post of Named Nurse Primary Care. This new role has been developed to support GPs in their safeguarding work and to encourage the contribution of GPs to the child protection conference process;
- The CCG continues its duty to ensure that there is senior representation from the CCG at all LSCB meetings and its sub-groups.

CCG Challenges

- Completion of Section 11 audit as commissioners of health services.

Berkshire Healthcare NHS Foundation Trust (BHFT)

BHFT Achievements

- Training compliance above target;
- Establishment of on call urgent advice line for BHFT staff;
- Provider of inter-agency training sessions and forums;
- Development and continuation of good communication lines between team and BHFT managers including adult and mental health services, adult safeguarding team, LAC team. This includes active representation at the Service Improvement Group and children's safeguarding meetings;
- Development of regular inter-agency meetings and on-going links with external agencies;
- Widely respected representative and active member of LSCB sub-committees across BHFT;
- Increased communication across BHFT; intranet site established and two newsletters published;
- On-going monitoring of Section 11 Audit;
- Visible and active promoters of dissemination of actions from four serious case reviews and integration into practice;
- Child Protection clinical supervision policy published and practice standardised;
- Domestic abuse policy reviewed;
- Completion of safeguarding training outcome audit;
- New case conference report template designed and widely disseminated for staff use;
- Contribution to LSCB reviews;
- All members of staff have received specialist safeguarding training in addition to mandatory/statutory requirements;
- Production of quarterly safeguarding data and assistance with development of safeguarding dashboard to commence 2013/14;
- Partnership working with Local Authorities and LSCB has increased across the team;
- Promotion of child sexual exploitation across the Trust with a named professional appointed to collect data on concerns raised within the Trust;
- Promotion of LADO and a central point of contact within the safeguarding children team to record all LADO enquires;
- Supported services and clinicians in external and internal investigations;
- Staff survey on awareness of child sexual exploitation;
- Implementation across BHFT health for data reporting for the LSCB by introduction of the score card.

BHFT Challenges

- Embed and continue good practice;
- Two safeguarding audits to be completed in 2013/14;
- Increase provision of targeted training;
- Ensure targeted training is 85% compliant at March 2015;
- Ensure single agency training is 95% compliant in 2015;
- Ensure supervision compliance is 85% at March 2014;
- Implement a new evaluation outcome tool for internal training;
- Share learning across the Trust in multi-media formats and through the Service Improvement Group;
- Continue to be a strong representative on the LSCB.

Schools

School Achievements

- Schools have again completed their annual safeguarding S11 audit with good results;
- Online child sexual exploitation training has been introduced this year, which school staff are encouraged to complete. This will be added to the next audit to monitor the numbers of those completing the training;
- Schools continue to focus on raising attendance and achievement for pupils. A wide range of support, advice and interventions take place in order to help and support children to attend school regularly;
- Anti-bullying information is disseminated to schools via the West Berkshire Anti-bullying e-newsletter;
- Fourteen schools have now achieved 'Safe in Our Hands', West Berkshire's anti-bullying self-evaluation and accreditation, which was written to support schools in their anti-bullying work;
- A number of primary schools are working towards 'Safe in Our Hands';
- Students from West Berkshire secondary schools attended the Council Chambers in February 2014 for the annual Peer Mentoring Conference;
- Peer Mentoring Leads in 10 of our secondary schools gained certification in peer mentor training from the "Mentoring and Befriending Foundation" following a recent day's training at Trinity School.

School Challenges

- Safer recruitment training is being promoted to school Governors again through Governor Services to increase the numbers of governors who attend this training;
- Adhering to the Keeping Children Safe guidance for schools.

Thames Valley Police

Police Achievements

- Multi-agency working on CSE locally. As a result of the excellent partnership arrangements, West Berkshire is now in a strong place to safeguard children and to work to reduce the risk of CSE, targeting perpetrators and supporting the victims;
- Partnership arrangements have been agreed to allow agencies to better identify and help people who are repeatedly victims of domestic abuse, even though the victims often avoid engaging with the police and other agencies. These arrangements will help prevent children from being witnesses or suffering from domestic abuse.

Police Challenges

- Increase in workload due to a rise in the number of child protection cases and the need for the police to be involved in all initial Child Protection Conferences.

Thames Valley Probation Service

Probation Achievements

- All new staff attend Child Safeguarding training and all current staff attend refresher training on a regular basis;
- A successful Joint Inspection of safeguarding procedures took place in August 2013 with an action plan put in place and completed for any areas requiring improvement.

Probation Challenges

- The Government's Transforming Rehabilitation programme is now taking effect with the formation of two new organisations, the National Probation Service and Thames Valley Community Rehabilitation Company, from 1 June 2014. The two organisations will ensure that safeguarding matters continue to be a priority and both will be represented at LSCBs to maintain the sharing of best practice;
- To ensure that both organisations work effectively with the wider local partnership so that children and young people affected by the imprisonment/offending of a parent or carer are supported.

Youth Offending Team (YOT)

YOT Achievements

- West Berkshire YOT works with some of the most vulnerable young people, often open to Children's Social Care, CAMHs and/or the Edge Young Substance Misusers Service. All young people known to the YOT are assessed in relation to their level of vulnerability, as well as their likelihood of reoffending and risk of committing serious harm to others;
- An audit has been undertaken addressing the vulnerability of young people known to the YOT which recognised the active and effective partnerships in place to protect young people;
- Taken responsibility for providing appropriate adults for 17 year olds as well as those under 17 being interviewed at the police station;
- Benchmarked practice against an HMIP inspection of services for children who sexually offend;
- Ensured all staff have up-dated safeguarding training, and training in relation to child sexual exploitation.

YOT Challenges

- To proactively monitor that young people open to Children's Social Care, in police cells or in the secure estate, are safeguarded, particularly when placed out of area as Looked After Children or remanded or sentenced to custody;
- To implement action plan from the audit of services for young people who sexually offend;
- To ensure that YOT staff have confidence in working with young people to keep themselves safe, Protective Behaviours' training will be commissioned for the team;
- To develop a role for a member of the team to be the team CSE Champion and develop a role description.

Voluntary Sector

Voluntary Sector Achievements

- The Children & Young People's Voluntary and Community Sector (VCS) Forum continues to support the safeguarding needs of a diverse number of charities and community groups providing services to children and families across the West Berkshire area. Regular newsletters and our website (http://wbcypforum.moonfruit.com/) highlight local and national safeguarding information and training events;
- The Forum's Safe Network Ambassador has been available to support individual organisations manage safeguarding concerns particular to their agency and advise on appropriate safeguarding policies and procedures;
- The Forum has provided free to those working or volunteering in the VCS four Level 1/ Universal safeguarding training courses following the West Berkshire training programme and three Safe Recruitment Training courses following the Safe Network programme;
- The Forum led a West Berkshire multi-agency task group "to understand the relationship between parental emotional and mental health issues and children's school readiness and propose solutions to enhance available support" which was well received by the West Berkshire Children and Young People's Partnership;
- The Forum maintains a close relationship with Safe Network, attending regional events, to ensure that national VCS safeguarding information disseminated promotes current and best practice.

Voluntary Sector Challenges

- The Forum has no authority over VCS organisations; it can only endeavour to encourage best safeguarding practices to those organisations registered with it;
- The introduction of the Disclosure and Barring Service (DBS) regulations has challenged VCS organisations to understand the implications for their respective services especially those concerning 'regulated activity' and 'supervision'; support and free training will continue to help VCS organisations become confident in meeting these regulations;
- Small VCS organisations with little infrastructure can struggle to meet Section 11 requirements of the 2013 Working Together to Safeguard Children. The Forum plans to provide training for Trustees/Committee members to help them better understand their safeguarding responsibilities.

Sub Groups and Task Groups

LSCB Sub-Groups undertake significant work to meet the LSCB's responsibilities. Some of these are co-ordinated across Berkshire West or the whole of Berkshire.

Child Death Overview Panel - Berkshire

The Child Death Overview Panel (CDOP) started in 2008 and meets quarterly to review all child deaths and share lessons learnt to prevent further deaths. The Panel consists of representatives from all six Local Safeguarding Children Boards in Berkshire, health, the police, coroners, social care and the voluntary sector. The Panel analyses all child deaths in Berkshire and makes recommendations to prevent deaths in the future.

In Berkshire as a whole, there was a 28.8% reduction in reviewed deaths, from 80 in 2011/12 to 57 in 2012/13. This reduction in 2012/13 was fully investigated and coincided with a reduction in the number of multiple births that year, which are known to carry an increased risk related to low birth weight. It is difficult to attribute causes for the reduction; however the Panel took consistent action to promote:

- neonatal reviews and risk factor monitoring;
- the 'one at a time' message for those undergoing IVF treatment;
- a consistent set of recommendations for 'safe sleeping', which all agencies adopted.

It is pleasing to note a similarly low number of deaths has been sustained in 2013/14 and a total of 59 child deaths have been recorded and 42 reviewed. Of these, five deaths occurred in West Berkshire, of which three related to 2012/13 and three to 2013/14; one will be reviewed in 2014/15 as part of the next quarterly neonatal review.

Performance Group – Reading and West Berkshire

The Performance Sub-Group is a multi-agency group which reviews performance information from partner agencies. The Group provides challenge to an agreed set of performance indicators before reporting any concerns to each LSCB Executive for further action. Over the past year the Group has carried out an extensive review to define a new set of performance indicators. This was initially in relation to the Munro review and a new Ofsted performance framework and more recently in relation to the Quality Assurance framework developed by the south east regional LSCBs and adopted locally. The aim is to agree the dataset across the three Berkshire West LSCBs (Reading, West Berkshire and Wokingham) before extending across Thames Valley.

Policies and Procedures Group - Berkshire

The Berkshire-wide Child Protection Policies and Procedures are published online. The Policy and Procedures Group ensures they are regularly updated.

During the year 2013-2014 the Group met on four occasions. They addressed recommendations identified by Tri.x, who provide the procedures, and the Working Together 2013 Impact Checklist to achieve compliance with Working Together 2013.

Changes over the past year have included a revised chapter on Safe Recruitment, Selection and Supervision of Staff, a new chapter on Allegations against Staff, Carers and Volunteers and a new chapter Safeguarding Foreign National Children who go Missing. The chapter Missing Child, Adult or Family is currently under review to reflect new statutory guidance. The sub-group also began development of a new chapter relating to child sexual exploitation using an example from Sheffield and incorporating learning from Thames Valley Police involvement in Operation Bullfinch.

The Group will continue to work closely with Tri.x over the coming year, including the development of a reporting mechanism for monitoring accessing of the procedures by practitioners.

Quality and Monitoring Group - West Berkshire

The Quality and Monitoring Group meets every two months to agree an audit programme and review outcomes from partner agency audits. The audit programme covers key areas of safeguarding; audits carried out include case audits, sample studies and on-line surveys using SurveyMonkey. Partner agencies are also asked to contribute and bring to the Group audits they have completed in their own agency. Membership of the Quality Group has seen a drop in attendance by some partners over the past year. In addition, the chairs of the three Quality Groups in West Berkshire, Reading and Wokingham have met twice to develop a core programme of audits; this will not only provide consistency across the three areas but also build capacity by sharing audits across the area, which is particularly relevant for those agencies which sit on all three groups. Recent audits include children in need and categories of abuse at child protection conferences.

Maintaining membership by all partner agencies and ensuring there is capacity to carry out multi-agency audits are on-going challenges.

Section 11 Panel - Berkshire

The Section 11 Panel meets regularly to oversee the Section 11 process for all Berkshire statutory and voluntary organisations and to support improvement.

The Panel now has an ongoing role in improving the self-assessment process for organisations. The Panel has a new remit to:

- Receive and evaluate the three year Section 11 self-assessment audits
- Monitor progress against the action plans at a mid-year (18 month) point
- Review and improve the process of submission and reporting, so it is more inclusive and enables discussion and learning
- Ensure the self-assessment template is adapted and improved according to policy and local developments.

Over the past year, the Panel's achievements included the following:

- Membership renewed for Thames Valley Police
- Lay member joined the Panel
- New terms of reference adopted
- New mid term review process agreed and implemented
- New relationships and membership developed for the NHS Local Area Team and the CCGs

Child Sexual Exploitation (CSE) Group – West Berkshire

In response to a rise in national awareness of CSE, both a Strategic and Operational CSE Group are now well established in West Berkshire. The Strategic Group is working to a clear strategy and action plan and there are good links in place between the Strategic and Operational Groups. Good progress has been made in the identification and mapping of CSE locally and action has been taken by both the police and social care where there are concerns over young people. The Operational Group meets regularly to identify young people at risk of CSE and to develop plans to protect them. A CSE indicator tool is used, based on best practice and currently being agreed across Berkshire. A recent success through disruption was Operation Forte where police and social care worked together and identified young people at risk, and the potential offenders. Further work is being carried out to raise awareness of the issue of young boys and sexual exploitation. Work is underway with the Blast Project - the UK's leading male only exploitation project. The Group is undertaking this as part of the See Me, Hear Me framework produced by the Office of the Children's Commissioner's Inquiry November 2013. This area of work has also been identified as one of the LSCB Business Planning priorities for 2014-2017.

Case Review Group - West Berkshire

The Case Review Group considers any serious incidents and makes recommendations to the LSCB Chair on whether the criteria for a Serious Case Review (SCR) are met. When a SCR is carried out, the Group agrees the review model to be used and manages the SCR process. One SCR has been conducted in West Berkshire over the past year – report published July 2014. The Case Review Group also meets regularly to review local and national SCRs. A Learning and Improvement Framework sets out how all agencies working with children should reflect on the quality of their services and learn from their own practice and that of others, creating a culture of continuous improvement.

Over the past year, the Case Review Group has considered a number of SCRs carried out in other areas, including several high profile reviews. A presentation on the Daniel Pelka SCR was commissioned by Reading, Wokingham and West Berkshire LSCBs to outline learning from the case, including issues around professional communication and practice issues for all agencies involved. A case study was also produced for use by training officers following a review carried out by the Youth Offending Team. The Group continues to identify learning and notifies agencies of relevant SCRs; for instance the West Sussex SCR was sent to all schools to ensure they were aware of lessons learnt and good practice.

Training Group - Berkshire (West and East)

The Training Group is accountable to the six LSCBs across Berkshire and ensures access to appropriate multi-agency training. Universal safeguarding training remains the responsibility of each agency represented on the LSCB.

The LSCB Training Group produces a multi-agency programme designed to cover key safeguarding subjects. Over 50 LSCB multi–agency courses have been provided across Berkshire in 2013-2014, covering a wide variety of subjects including children with disabilities, safer care for children with parents with mental health, domestic abuse, disguised compliance, e-safety, child sexual exploitation and substance misuse. All of the courses have been in accordance with, and based on, the six LSCB Business Plans and agreed priorities. The overall evaluation of courses and attendance has been positive. The multi-agency representation has been maintained; however, the Group has raised concerns about some partner agencies' representation on courses.

To ensure training meets the desired objectives and is effective, the courses are quality assured, usually by a member of the Training Group. To measure the impact, competency questions are asked on the evaluation forms and, on a sample of courses a follow-up telephone call is made to find out what difference the training has made.

The introduction of the Learning and Improvement Framework, agreed across Berkshire and included in the Berkshire Child Protection Procedures, has improved dissemination of learning from reviews; this is now a standing item on each Strategic Training
Group agenda, where key messages from reviews in each of the LSCBs can be shared.

Achievements to date:

- Observation guidance developed to monitor the quality assurance of training;
- Work undertaken with the Section 11 Panel to identify gaps in agency training or refresher training. The Section 11 Panel agreed an amendment to the Section 11 self-assessment tool to request that agencies provide evidence of their training strategies and comments on training compliance in relation to issues of diversity;
- E-learning packages continue to be reviewed but use of these lies with the relevant organisation;
- Kwango e-learning safeguarding training has been updated in line with Working Together 2013;
- Safeguarding Training Pathway has been produced, for adults and children's services staff;
- Joint meetings held with Berkshire East and Berkshire West Training Officers to produce the East and West LSCB Training Programmes;
- Managing Allegations identified as a need amongst practitioners and training courses arranged in the East and the West;
- Evaluation of training for LSCB courses and outcome audit completed;
- Review of LSCB Training Sub-Group work plan;
- Launch of CSE e-learning training was agreed by 5 of the 6 Berkshire LSCBs. This has been disseminated and used widely. The remaining LSCB has made suitable alternative arrangements.

Challenges:

- CSE Training Pathway – there has been a challenge in ensuring all relevant agencies are attending the meetings arranged in order to progress this;
- Concerns in relation to partnership participation on the Training Sub-Group have been raised annually and there is still a significant gap in the contribution of some LSCB partners to the group. Work has been carried out to try and improve this but to no avail. The Training Group continues to have no representation from Police, Housing or Probation. Historically and currently, information is received from Probation and Thames Valley Police and the Group has linked with the Section 11 Panel to obtain more information. The Group understands and acknowledges the resource pressures for services; however, absence of physical representation from these sectors has been a long standing issue. The Research in Practice Ensuring Effective Training briefing for LSCBs publication identifies the need for LSCBs to evidence within inspection that *"opportunities for learning are effective and properly engage all partners".* This is currently not being achieved by the absence of significant LSCB partner agencies;
- There remains an issue with Thames Valley Police accessing multi-agency LSCB courses across Berkshire. This has been escalated to the Berkshire LSCB Chairs. Police attendance at multi-agency courses also varies nationally. It is worth noting that the Police do provide in-house training, including specialist areas, which they could benefit from opening up to other agencies to improve multi-agency practice;
- Receiving data in a co-ordinated way from the operational team to the Strategic Group in a timely manner has proved to be a difficulty for the Group at times;
- Monitoring of single-agency training is a requirement of the LSCB and additional resources will need to be identified to ensure this function is carried out sufficiently by the Training Sub-Group;
- Many of the tasks required of the Training Sub-Group are resource intensive, including the Training Needs Analysis and outcome evaluations. Adequate resources need to be identified;
- Some agencies are providing their own specialist single-agency safeguarding training e.g. Local Authorities for their social work teams, Probation and the Police, but these courses are not currently being offered to a multi-agency audience. There could be an opportunity for more co-ordination of these courses if the agencies bring them to the attention of the Training Sub-Group. Otherwise, there is a missed opportunity for all practitioners to learn in a multi-agency context;
- Keeping Safe – new DfE guidance for schools, does not mention the three year refresher period; as the Sub-Group has agreed this as a standard, members will have to work with schools to ensure this standard is met.

Conclusions

The LSCB has been effective in challenging partner agencies over their roles and responsibilities as members of the LSCB. This has been demonstrated through development sessions held on leadership for all LSCB members and two sessions for executive members, one on challenge and one on Serious Case Review models.

Whilst LSCB attendance is good, better consistency in attendance is needed, particularly through the engagement of the NHS Local Area Team.

Agencies are under significant pressure, with rising numbers of vulnerable children needing services, and the LSCB has a key role ensuring partners continue to work together effectively.

Locally and nationally there has been a significant increase in the workload of Children's Services driven by changes in demography, increased expectations in relation to the quality of services, responses to specific issues (e.g. Child Sexual Exploitation) and a series of high profile child death tragedies. In the local context this has led to a significant increase in workload.

A positive development over the past year has been the inclusion of young people attending LSCB meetings. This provides an opportunity for members to hear first hand the views of young people, for the young people to talk about how services have worked for them, and for LSCB members to consider how to respond to the concerns they raise.

Lay members provide an objective view and bring insight to board meetings. Six- monthly network meetings are held across the Thames Valley area providing an opportunity for them to meet and discuss their role. As part of this, statutory partners attend to give talks on their agency. To date these have included Thames Valley Police, a representative from the Clinical Commissioning Group and a planned presentation from Probation. As their role has become embedded, lay members are now sitting on and chairing some LSCB sub-groups.

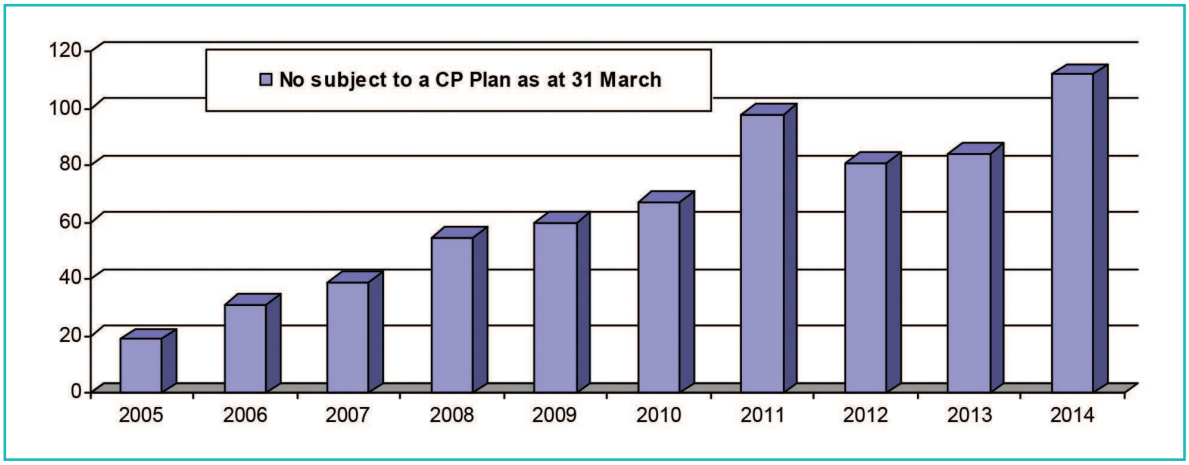
Looking ahead, the challenges that face the LSCB are:

- an increasing number of children with Child Protection Plans and rising numbers of Looked After Children make it crucial that LSCB partners and their agencies work together effectively to address the needs of these vulnerable groups;
- to ensure the views of children and young people are taken into account when planning services;
- to ensure the continued involvement of young people at LSCB meetings;
- to ensure Children's Social Care do not allow drift in cases of children either on Plans or looked after by the local authority.

Appendix A - Child Protection Data

Total of Children and Young People subject to a Child Protection Plan by Year

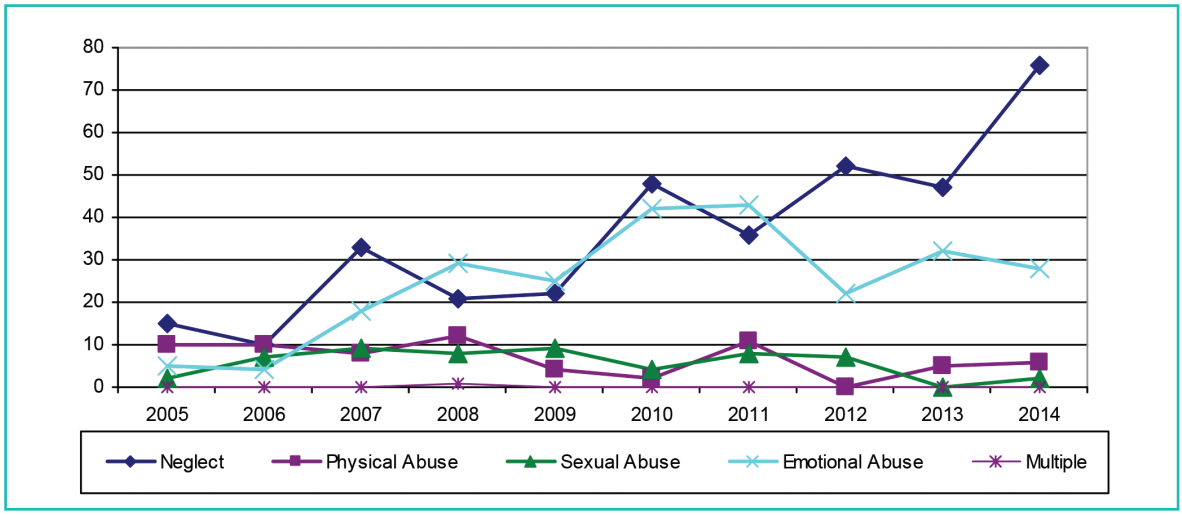
Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
No subject to a CP Plan as at 31 March	19	31	39	55	60	67	98	81	84	112



The total of young people subject to Child Protection Plans in West Berkshire as at 31 March 2014 was 112. This is a rate of 23 per 10,000 population aged under 18 which is below the national average of 38 per 10,000 and below our comparator group of 30.3 per 10,000 (March 2013). The number of young people for 2013/14 represents a 33% increase over the previous year.

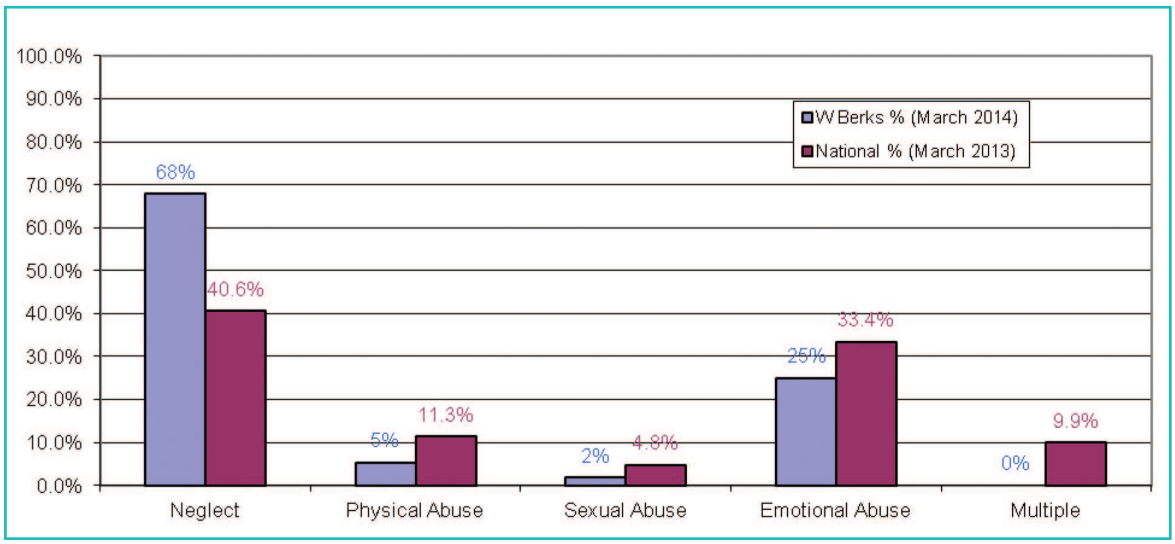
Reasons for CP Plan Trends

Year *(as at 31 March)*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Neglect	15	10	33	21	22	48	36	52	47	76
Physical Abuse	10	10	8	12	4	2	11	0	5	6
Sexual Abuse	2	7	9	8	9	4	8	7	0	2
Emotional Abuse	5	4	18	29	25	42	43	22	32	28
Multiple	0	0	0	1	0	0	0	0	0	0
Total Reasons for CP Plan	32	31	68	71	60	96	98	81	84	112



As at 31 March 2014 Neglect continued to be the most frequent reason for Child Protection Plans, showing a steep upwards trend especially from 2011 onwards. Emotional Abuse on the other hand, which had shown an increase in numbers in 2012/13, is showing a small decrease in the 2013/14 year. In 2012/13 there was a slight increase in the number of CP Plans made for the category of Physical Abuse while in 2013/14 there has been little change. There were two sexual abuse CP cases recorded as at 31 March 2014.

National and Local Reasons for CP Plan Percentage Trends



The above graph compares West Berkshire's reasons (31 March 2014) for CP Plans with national (2012/13) percentages. In the case of "Neglect" West Berkshire is greater than the national average (68% and 40.6% respectively) In the instance of "Emotional Abuse", West Berkshire is lower than national figures, with West Berkshire being 25% and the national average 33.4%. Sexual Abuse for West Berkshire at 2% is opposed to the national figure of 4.8%. Physical Abuse is lower than the national average (5% for West Berkshire as opposed to 11.3% for the national figure)

Children subject to Protection Plans Profile as at 31 March 2014

As at 31st March 2014, there were 112 children subject to Child Protection Plans. There were 48 boys (43%), 60 girls (54%) and 4 unborn children (4%). Nationally (March 2013), 51.4% of those subject to a CP Plan are male, and 48.6% female.

Under 1's accounted for 15%; 1-4's for 29%; 5-9's for 24%; 10-15's for 29% and 16+ for 4%. (unborn 4%).

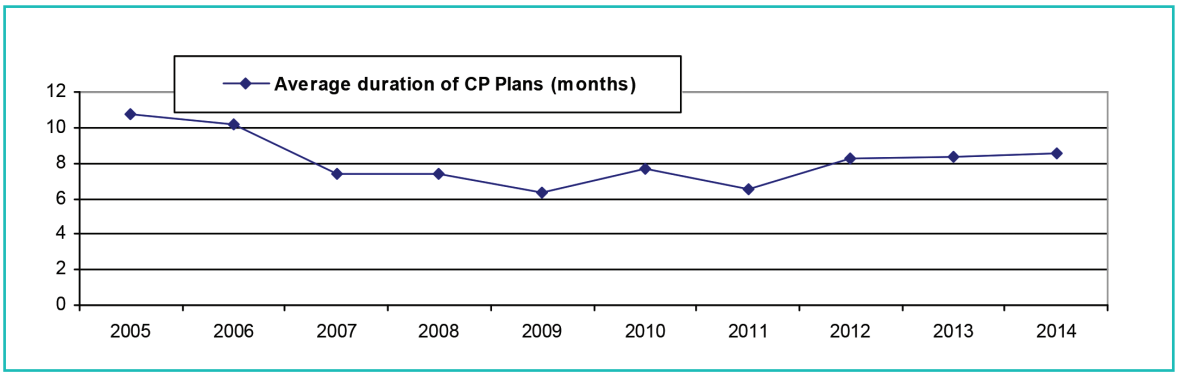
13% of children who were subject of Child Protection Plans at 31 March 2014 were from an ethnic minority. This compares with 11.7% of young people in West Berkshire's schools from ethnic minorities.

Children subject to a second or subsequent Child Protection Plan

In 2013/14, West Berkshire made 5 (3.5%) children subject to a 2nd or subsequent CP Plan within 2 years of a previous CP Plan. The national average for the period 2012/13 was 14.9%.

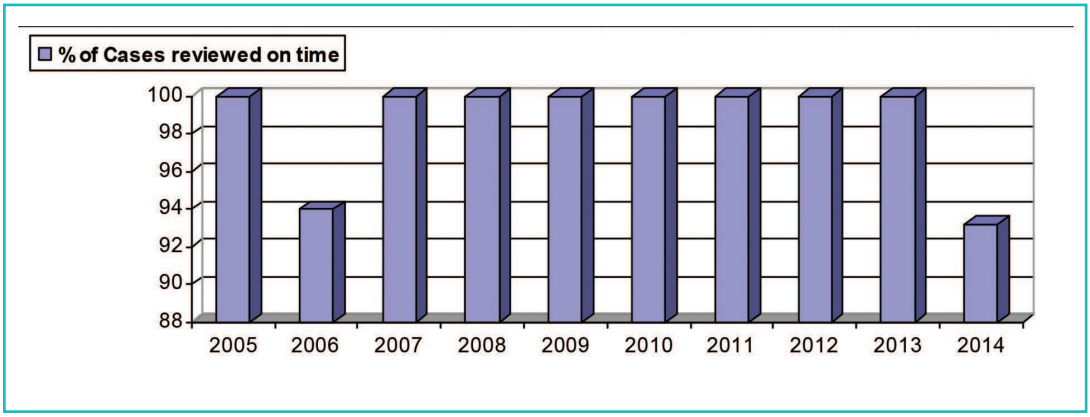
Duration of CP Plans by Time for Children subject to a CP Plan

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Less than 3 months	8	1	17	16	35	25	33	31	24	25
3 months - 6 months	6	5	7	11	14	12	12	25	19	21
6 months - 12 months	8	8	27	14	19	38	56	39	55	35
12 months - 24 months	29	4	5	13	15	18	12	26	25	32
> 2 years	0	1	4	0	0	0	1	2	3	2
Total CP Plans Endings	51	19	60	54	83	93	114	123	126	115
Average duration of CP Plans (months)	10.8	10.2	7.4	7.4	6.3	7.7	6.5	8.3	8.4	8.5



Percentage of Child Protection Cases Reviewed in Timescale

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
% of Cases reviewed on time	100	94	100	100	100	100	100	100	100	92.3



In 2014, 92.3 per cent of Child Protection cases were reviewed on time.

Appendix B - Training

Safeguarding training is essential to ensure staff and volunteers are kept up to date with legislation and information.

All agencies have a responsibility to provide their staff and volunteers with suitable training which is appropriate to their role.

The West Berkshire training team provides training at Universal level for Social Care, Early Years team, schools and the voluntary sector. This first introduction to safeguarding explains what signs and symptoms to look for and who to report to.

All training is evaluated; attendees are asked to score their knowledge before and after the event, to measure the change and impact as part of the evaluation process.

Local Authority safeguarding training which took place in West Berkshire 2012-2013

Safeguarding Training delivered in West Berkshire		
	Number of courses	**Number of delegates**
Universal		
Universal, in house (school site) Universal, delivered at council venues Total	52 11 63	700 142 842
Designated Person training		
Designated person introduction & refresher	4	160
Targeted Safeguarding		
LSCB Multi-agency programme - various	7	88

West Berkshire also provides e-learning opportunities. There are currently three e-learning packages available to all staff and volunteers throughout the area.

E-learning usage information for 2013-2014 is as follows:

Domestic abuse course	491
Safeguarding children course	148 (version 2 launched May 2014)
Child Sexual Exploitation course	166 (launched January 2014)

The e-learning training provides information on practice and legislation. A quiz is completed at the end of each course; successful completion produces a certificate which can be used as evidence of Continuing Professional Development.

Appendix C – Membership at May 2014

Name	Role
Stephen Barber	Independent Chair
Robin Askew	Vice Principal (Care), Mary Hare School
Judith Colby	Lay Member
Debbie Daly	Nurse Director, Berkshire West Clinical Commissioning Group Federation
Mark Evans	Head of Children's Services, West Berkshire Council
Leila Ferguson	Lay Member
Kevin Gibbs	Head of Service, Children and Family Court Advisory and Support Service
June Graves	Head of Care Commissioning, Housing & Safeguarding, West Berkshire Council
Liz Housden	Headteacher St Finian's Catholic Primary School
Ros Haynes	LSCB Business Manager, West Berkshire Council
Jon Hewitt	Headteacher, The Castle School
Sarah Holland	Senior Probation Officer – Partnerships, Thames Valley Probation Trust
Julie Kerry	Associate Director for Patient Experience, Thames Valley Area Team, NHS South of England
Rosemary Lilley	Voluntary Sector representative
Alexandra Luke	Head of Mental Health Service West Berkshire, Berkshire Healthcare NHS Foundation Trust
Ian Mundy	Locality Director (West Berkshire), Berkshire Healthcare NHS Foundation Trust
Irene Neill	Portfolio Holder Children and Young People, West Berkshire Council
Davy Pearson	Manager, Youth Offending Team
Ian Pearson	Head of Education Service, West Berkshire Council
Karen Pottinger	Principal Education Welfare Officer, West Berkshire Council
Susan Powell	Safer Communities Partnership Team Manager, West Berkshire Council
Robin Rickard	Superintendent, Thames Valley Police
Janet Scott	Service Manager, West Berkshire Council
Lorna Sherlock	Tutorial Team Leader, Newbury College
Maureen Sims	Deputy Headteacher, St Bartholomew's Secondary School
Rachael Wardell	Corporate Director, Communities (statutory DCS), West Berkshire Council
Louise Watson	Consultant Paediatrician, Designated Doctor
Ian Wootton	Commissioning Manager (Substance Misuse), Public Health & Wellbeing, West Berkshire Council

Appendix D – Financial information

The budget is monitored by the Business Manager and reports are provided for each LSCB meeting. The majority of the budget is spent on staffing to support the work of the Board.

The LSCB budget 2013-2014 is made up of contributions from the Local Authority, the CCG, Police, Probation, CAFCASS and Berkshire Healthcare NHS Foundation Trust.

Supplies and services include expenditure for the cost of an Independent Chair, updates to the Child Protection Procedures and the costs associated with administering the LSCB training programme and the annual conference. This also covers any printing costs for publicity materials and leaflets.

In addition a small amount is spent under premises to cover the hire of meeting rooms, refreshments and venues for LSCB activities and meetings.

Income and Expenditure 2013 – 2014

Income	£
Local Authority	89,830.00
CCG	20,000.00
Police	2,000.00
Probation	895.00
CAFCASS	550.00
Berkshire Healthcare Foundation Trust	1,000.00
Additional income collected to cover the costs of the SCR from those agencies whose staff attended the learning event	2,500.00
TOTAL INCOME	**116,775.00**

Expenditure	£
Employees	89,729.80
Supplies and Services *	22,581.60
Premises	674.00
TOTAL EXPENDITURE	**112,985.40**

*Additional costs due to SCR

Appendix E – List of acronyms

BHFT	Berkshire Healthcare NHS Foundation Trust
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CSE	Child sexual exploitation
DBS	Disclosure and Barring Service
DfE	Department for Education
FGC	Family Group Conference
ISVA	Independent Sexual Violence Advisors
LAC	Looked After Child
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
SARC	Sexual Assault Referral Centre
SCP	Safer Communities Partnership
SCR	Serious Case Review
SHIP	Sexual Harm Intervention Project
TVP	Thames Valley Police
VCS	Voluntary and Community Sector
YOT	Youth Offending Team

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Mental Health Crisis Concordat

What is it?

The Mental Health Crisis Concordat is a national multi-agency commitment to improve the experience and outcomes for people facing mental health crisis. Linked to the national commitment to achieve "parity of esteem" between how we respond to mental health and physical health needs, the signatories to the concordat commit to the following:

> *"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.*
>
> *We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.*
>
> *Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England."*

Who's involved?

Principally the NHS, local authorities and criminal justice system are involved. Key partners include: the Department of Health, Home Office, Mind, NHS England, police services, ambulance services, community mental health trusts, social services, children's mental health, Health Education England, Public Health England, General Practitioners and CCGs,

A full list of national Concordat signatories can be found in appendix 1

What needs to happen and when?

The concordat requires that "localities" adopt the Concordat and develop:

1. A local Mental Health Crisis Declaration that brings together the key agencies to commit to "work together to continuously improve the experience of people in mental health crisis in their locality"
2. Shared action plan to review, monitor and track improvements
3. Reduction in use of police stations as "places of safety"
4. Evidence of sound governance arrangements

NHS England has advised that all declarations and action plans must be agreed locally and uploaded to a national system by **31 December 2014**.

The expectation of NHS England is that this process would be led by the local mental health commissioners

What are the expected outcomes?

The Concordat defines a set of principles which all services involved in crisis care should adhere to.

A. Access to support before crisis point
B. Urgent and emergency access to crisis care
C. Quality of treatment and care when in crisis
D. Recovery and staying well / preventing future crises

These are used as the foundation for the declaration and action plans for local organisations across Thames Valley; in addition there is a further objective specifically for commissioners, 'Commissioning to allow earlier intervention and responsive crisis services'.

What support is there for the key partners in delivering the declarations and action plans?

The Department of Health has established a national Crisis Care Concordat team to support localities in developing plans as well as a dedicated website with additional information and templates. www.crisiscareconcordat.org.uk

At a regional level Strategic Clinical Networks (SCNs) for Mental Health are also actively supporting developments. The focus for SCNs is to support the local development of plans as well as coordinating a wider regional alignment with partners such as crime and emergency response teams. In Thames Valley a regional Crisis Care Concordat event will be held on Wednesday 17 September, at the Hilton Hotel in Reading. Further details may be found by contacting a member of the MHDN team: Linda.tait1@nhs.net or eva.morgan@nhs.net

Appendix 1

Signatories to the Concordat
Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
NHS Confederation
NHS England
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

The national organisations that are signatories to this Concordat have made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England.
In addition, a number of third sector and voluntary organisations have agreed to be identified formally as supporters of the Concordat.

The list of supporter organisations is available at www.gov.uk[i]

[i] With our thanks to Ian Bottomley, Assistant Director of Adult Service Oxford CCG, who allowed us to use his initial summary of the Crisis Care Concordat