Reading Shadow Health and Well Being Board

15 March 2013

12.30pm in the Kennet Room, Civic Offices, Reading

(a sandwich lunch will be provided)

AGENDA

1. **Minutes of meeting on 25 January 2013** (page 1)

2. **Updated Health Management & Strategy Development Programme Plan** (Zoë Hanim) (page 10)

3. **Transfer of Public Health - Joint Arrangement** (Zoë Hanim) (page 12)

4. **Berkshire PCT Cluster Quality Handover document** (Sara Whittaker) (page 21)

5. a) **Draft North & West Reading CCG Commissioning Plan** (Rod Smith/Maureen McCartney) (page 186)
   b) **Draft South Reading CCG Commissioning Plan** (Elizabeth Johnston/Eleanor Mitchell) (page 262)

6. **Progress Report on Healthwatch** (David Shepherd) (page 319)

7. **Transfer of Public Health - Health & Wellbeing Board** (Zoë Hanim) (page 320)

8. **Reading Health & Wellbeing Strategy** (Asmat Nisa) (page 329)

9. a) **Communications Action Plan** (Derek Plews) (page 363)
   b) **Draft Health & Wellbeing Briefing Pack for Stakeholders** (Zoë Hanim) (to follow)

10. **Any Other Business**

11. **Dates and times of future meetings**

    possible dates:
    2pm Friday 21 June 2013 (Kennet Room)
    2pm Friday 20 September 2013 (Conference Room G29/30, 57-59 Bath Rd)
    2pm Friday 13 December 2013 (Conference Room G29/30, 57-59 Bath Rd)
    2pm Friday 21 March 2013 (Kennet Room)

Contact: Nicky Simpson, Committee Services, Reading Borough Council
email: nicky.simpson@reading.gov.uk ☎ 0118 937 2112

Present:

Councillor Lovelock (Chair)	Leader of the Council, Reading Borough Council (RBC)
Councillor Ennis	Lead Councillor for Education & Children's Services, RBC
Elizabeth Johnston	South Reading Clinical Commissioning Group (CCG)
Catherine Kelly	North & West Reading CCG
Councillor Orton	Lead Councillor for Adult Social Care, RBC
David Shepherd	Board Member, Reading LINk
Councillor Tickner	Lead Councillor for Health & Wellbeing, RBC

Also in attendance:

Councillor Ballsdon	RBC
Gwen Earl	Consultant
Zoë Hanim	Head of Policy, Performance & Community, RBC
Councillor Hoskin	RBC
Keith Jerrome	South Reading Patient Voice
Tom Lake	South Reading Patient Voice
Maureen McCartney	Assistant Director of Primary Care Commissioning, NHS Berkshire
Eleanor Mitchell	Operations Manager, South Reading CCG
Asmat Nisa	Consultant in Public Health for Reading, RBC
Rob Poole	Head of Finance & Resources, Housing & Community Care, RBC
Nicky Simpson	Committee Services, RBC
Fiona Slevin-Brown	Director for Reading Locality, Berkshire Healthcare Foundation Trust
Councillor Stanford-Beale	RBC
Nigel Webb	Consultant
Suzanne Westhead	Head of Adult Services, RBC
Cathy Winfield	Chief Officer, Berkshire West CCG Federation

Apologies:

Stephen Barber	Independent Chair, West Berkshire, Reading and Wokingham Local Safeguarding Children Boards
Julie Curtis	Interim Director of Joint Commissioning, NHS Berkshire
Lise Llewellyn	Berkshire Director of Public Health
Dave Peasley	Director & Council Manager, RBC
Rod Smith	North & West Reading CCG
Sylvia Stone	Independent Chair, West of Berkshire Safeguarding Adults Partnership Board
Avril Wilson	Director of Education, Social Services and Housing, RBC

1. MINUTES & MATTERS ARISING

The Minutes of the meeting held on 2 November 2012 were confirmed as a correct record and signed by the Chair, subject to deletion of the last sentence of Minute 6, as both CCGs had had conditions attached to their authorisation.

Further to Minute 10 of the last meeting, when the draft Healthwatch specification had been considered by the Board, David Shepherd reported that the final specification had been approved by Cabinet on 3 December 2012, and that LINk/Healthwatch representatives had been happy with the final specification. He also gave an update on Reading LINk and the development of Healthwatch, noting that the application to set up Healthwatch had just been sent to the Charity Commission, a new forum to engage with the voluntary sector was being developed, two representatives from the CCGs were now Board members and LINk had just published the First Phase Summary Report of their joint project with the Council on Home Care Service Users Research.

Further to Minute 11 of the last meeting, Zoë Hanim reported that the bid to the Warm Homes Healthy People Fund had been successful, and £105k of funding had been awarded.

AGREED:

That the positions be noted.

2. HEALTH TRANSITION & STRATEGY DEVELOPMENT PROGRAMME PLAN

Zoë Hanim submitted the latest version of the Health Transition and Strategy Development Programme Plan for 2012-13, which gave details of the different work streams involved in health transition, setting out leads, activities, timescales, general commentary and the status of each work stream. She also submitted the Public Health project plan.

Councillor Ennis reported that the Children's Trust had recently had an awayday on children's health and had identified a number of issues that they would want to bring to the Health & Wellbeing Board. Zoë said that she and the Director of Education, Social Services and Housing had been discussing the importance of ensuring that children's health was included in the Health & Wellbeing Strategy. It was suggested that the involvement of young people could be added to the stakeholder engagement section of the programme plan, and also that there could be an item on the agenda for the next Board meeting on the involvement of the Children's Trust.

David Shepherd reported that there would be a seat on the Healthwatch Board for a member of the Youth Parliament.

AGREED:

(1) That the position be noted;

(2) That the involvement of young people be added to the stakeholder engagement section of the programme plan and an item be added to the agenda for the next meeting on the involvement of the Children's Trust.

3. PUBLIC HEALTH TRANSFER – UPDATE ON TRANSITION PLANNING

Rob Poole submitted a report on the progress of Public Health (PH) transition to local authorities, who would be taking on responsibility for delivering PH functions from 1 April 2013. Appendix 1 to the report set out the PH functions that would be transferring.

The report gave a high level overview of progress in some of the key issues in the areas of staffing, resource allocations and finance & contracts, and also gave details of some of the areas which still needed agreement, due to the complexity of the transfer in Berkshire.

AGREED:

That the progress being made in Public Health transition planning and the actions in planning for the transfer of Public Health functions to the Council in April 2013 be noted.

4. PUBLIC HEALTH ADVICE SERVICE TO CLINICAL COMMISSIONING GROUPS – THE "CORE OFFER"

Asmat Nisa submitted a report which gave an overview of the Public Health Advice Service (also know as the "core offer") that local authorities (LAs) would need to provide to Clinical Commissioning Groups (CCGs) as part of the LA's new statutory responsibilities for Public Health from April 2013.

Appendix 1 to the report set out a number of possible elements which could be included within the service, in each of the three areas of strategic planning, procurement and monitoring and evaluation, but the report noted that local requirements would vary, so LAs and CCGs would need to work together closely to develop and agree a service to help support the needs of the local population. It stated that the Director of Public Health for Berkshire was leading the work on developing the detail of the service and had asked the Consultants in Public Health already in post across Berkshire to liaise with CCGs to establish what they would like to see included within the service, within the constraints of the resources available.

Asmat reported that Reading was unusual in having two CCGs, with some of the CCG boundaries crossing borough boundaries, and so she was seeking support from West Berkshire to help support the North and West Reading CCG. She said that a memo of understanding was being developed.

Councillor Hoskin expressed concern at how things like strategic planning would be able to be done effectively in light of the eccentric boundaries of the CCGs even within the borough boundaries. He noted that the system was set up for patients rather than communities, which would make planning for communities difficult. It was reported that this issue would be taken back to the core team and the Director of Public Health when shaping the core offer. It would be important to look at both patients and communities and the LA would take the lead in working with all the health and social care stakeholders in addressing this issue.

AGREED: That the report be noted.

5. UPDATE ON CCG AUTHORISATION

Elizabeth Johnston submitted a report giving an update on the progress of the CCG Authorisation process.

Both the South Reading and North & West Reading CCG had received notification of being authorised, with South Reading CCG having four conditions and North & West Reading CCG 14 remaining "red" conditions, details of which were appended to the report.

A rectification plan had been submitted to the Area Team on how the remaining conditions could be removed by April 2013 and both CCGs were confident of entering the new financial year clear of any remaining reds. As part of the assurance process, both CCGs would be meeting with the Area Team on a monthly basis to review Commissioning and Financial Plans. The next opportunity to have the remaining reds turned to green was 4 April 2013.

AGREED: That the report be noted.

6. UPDATE ON CCG COMMISSIONING PLANS

Elizabeth Johnston gave a verbal update on the development of the South Reading CCG Commissioning Plan and Catherine Kelly presented a set of slides summarising the development of the North & West Reading CCG Commissioning Plan. Elizabeth Johnston said that she would circulate the draft "Plan on a Page" version of the South Reading CCG Commissioning Plan.

The presentations covered the strategic context for each of the CCGs in relation to their differing populations, demographics and health inequalities and addressed their national and local priorities. For example, South Reading CCG had a young, ethnically diverse population, whereas North & West Reading CCG had fewer children and young adults than the whole of Reading, and a projected proportionally greater increase in the number of elderly, and these differences were reflected in local health needs.

The three local targets chosen by the CCGs for quality premium were:

South Reading CCG

- Increase uptake of immunisations from 93% to 95%
- Carry out an extra 804 Cardio Vascular Disease health checks
- Achieve 45% coverage (a 9% increase) of the nine care processes for diabetes

North & West Reading CCG

- Increase bowel cancer screening uptake
- Increase referrals to pulmonary rehabilitation service for COPD (Chronic Obstructive Pulmonary Disease), to improve care and reduce emergency admissions
- Improvement in the nine care processes for diabetes to increase coverage from 45% to 55%

It was reported that the two CCGs were working well together in a federated model. This involved fortnightly meetings of the CCG Chairs, and this joint working allowed emerging issues to be dealt with effectively. One of the reasons for choosing a federated model had been that this allowed different priorities to be set for different practices.

Elizabeth Johnston reported that, in relation to communicating priorities and other information to patients, there was a working party looking at the CCG websites and a prospectus was being prepared to be handed out at various venues so that people would know which CCG they were in. In response to a query about the lower profile of patient groups in North & West Reading CCG compared to those in South Reading CCG, Catherine Kelly noted that the CCG was aware that this was an area which needed development and they were aiming to get more of a cross-section of patients to join their patient groups. Both CCGs would have a lay member on their Board.

AGREED:

(1) That the positions be noted;

(2) That Elizabeth Johnston circulate the draft South Reading CCG "Plan on a Page" to members of the Board.

7. DEMAND & CAPACITY MODELLING ACROSS THE BERKSHIRE WEST HEALTH & SOCIAL CARE ECONOMY

Cathy Winfield submitted a report which explained that the four CCGs and three unitary authorities in Berkshire West had decided to work together to look at demand projections for health and social care, the evidence-based service response to that demand, and identify any immediate procedural and productivity opportunities to maximise capacity in the system.

The report set out the work that would be carried out, and explained that the following outputs were expected:

- An initial report, to be delivered by the end of January 2013, which identified "quick wins" in terms of productivity opportunities that could be acted on immediately and service solutions that could be incorporated into the 2013/14 planning round by health and social care commissioners.

- A final report, to be delivered by the end of March 2013, which would provide a five year view of demand and an evidence-based strategic service redesign proposal for health and social care commissioners.

It was reported that joint working had already started on this, with a conference on 22 January 2013, and that there was to be an event on 29 January 2013 looking at what next in Reading and how to get benefits financially and for patients.

Cathy said that the final report would be brought back to a future Health & Wellbeing Board, but that it might be possible to bring the initial report to the next Board meeting.

AGREED:

(1) That the report be noted;

(2) That, if it was ready, the initial Demand & Capacity Modelling report be submitted to the next Board meeting.

8. HEALTH & WELLBEING BOARD GOVERNANCE PROCESS & HEALTH SCRUTINY

Zoë Hanim submitted a report giving an update on the Government's evolving thinking on the governance arrangements for Health & Wellbeing Boards and health scrutiny.

It explained that both had been the subject of Department of Health (DoH) consultation exercises during 2012 and resultant Government proposals made in December 2012. The DoH were expected to issue separate Regulations on both during January 2013, to have effect from April 2013, and the report gave further details of what was expected to be in the Regulations, regarding setting the Board up as a Committee of the authority and covering, for example, membership, voting and registration of interests.

A further update would be given to the next meeting of the Board once the Regulations had been issued. Reports would be submitted to Council on 26 March to set up the Health & Wellbeing Board from 1 April 2013 and on 22 May 2013 to re-establish the Board and establish the health scrutiny arrangements for the new Municipal Year.

AGREED: That the report be noted and a further update be submitted to the next meeting.

9. READING'S HEALTH & WELLBEING STRATEGY

Further to Minute 4 of the last meeting, Zoë Hanim submitted a report on the results of the consultation on the draft Reading Health & Wellbeing Strategy and outlining further work required to complete the Strategy ready for sign off by Council in March 2013. The consultation response report was attached at Appendix 1.

The report gave details of the consultation exercise with key stakeholders and partners which had begun in October 2012, stating that feedback had been collected from a range of events and 22 written responses from organisations and individuals had been received. The consultation response report would be published on the website along with a specific question and answer document, both of which would be sent to those who had responded to the consultation.

The consultation feedback would be used to inform changes to the strategy and a final draft would be presented to the Health and Wellbeing Board on 15 March 2013 and to Council for formal sign off on 26 March 2013. A review within the first year was suggested, once the public health function within the authority had had a chance to embed.

The report noted that it was essential that a robust delivery plan was put in place to take the strategy forward and a number of consultation responses had raised the importance of this. Officers were mapping out existing work within the Council that contributed to the delivery of the strategy, and a specific Health and Wellbeing delivery plan would be developed with partners over the coming months.

It was noted that it was important that the CCG Commissioning Plans aligned with the Strategy, and that partners would meet to ensure this was the case.

AGREED: That the report be noted and the final draft strategy be submitted to the next meeting.

10. CONSULTATION ON STRENGTHENING THE NHS CONSTITUTION

Zoë Hanim tabled a report giving details of a Department of Health (DoH) consultation on strengthening the NHS Constitution, and its implications for local authorities. The report had appended an officer briefing note (Appendix 1) and a LGiU policy briefing (Appendix 2).

The report explained that the consultation exercise was on strengthening the NHS Constitution in the light of the passage of the Health & Social Care Act 2012, with the main proposed changes covering:

- a new responsibility for staff to treat patients not only with the highest standards of care, but also with compassion, dignity and respect;
- a new pledge making it explicit that patients could expect to sleep in single-sex wards;
- a new pledge to patients that NHS staff must be open and honest with them if things went wrong or mistakes happened – this 'duty of candour' would become a condition in the NHS Standard Contract from April 2013.

The changes also made it clearer that:

- patients, their families and carers should be fully involved in all discussions and decisions about their care and treatment, including their end of life care;
- patients who were abusive or violent to NHS staff could be refused treatment;
- the NHS was equally concerned about physical and mental health.

The report explained that the consultation paper referred to a new duty on local authorities to have regard to the NHS Constitution in the exercise of their public health functions. The briefing note gave further details and noted that the LGIU had produced a Policy Briefing on the DoH consultation (Appendix 2) which suggested that in response to the question 'Do the proposed changes to the NHS Constitution make it clear what patients staff and the public can expect from local authorities and that local authorities must take account of the Constitution in their decisions and actions?', the answer had to be no, and the briefing note set out the reasons for this.

A response was being drafted by the Local Government Association (LGA) and the detail of that response had been requested, but was not available at the time of the meeting, and the consultation period ended on 28 January 2013.

AGREED:

(1) That a response to the consultation from Councillor Lovelock, Chair of the Board and Leader of the Council, be submitted to the Department of Health in line with the comments set out in the briefing note;

(2) That a copy of the consultation response and the LGA's consultation response be circulated when available.

11. CANCER SCREENING GROUP

Further to Minute 6 of the meeting held on 7 September 2012, Zoë Hanim gave a verbal update on the work being carried out by the Cancer Screening Group. The Group involved representatives from the Board, CCGs and Public Health officers, had met twice already and would be meeting again in early February 2013. The Group had agreed a scoping document and were mapping current screening activity, with a view to suggesting value-added support that was manageable and affordable. Work had begun on offering support and sharing expertise, including reviewing GP screening letters and drafting pathway guides for GPs on screening.

AGREED:

That the position be noted and a report be submitted to the next meeting.

12. HIGH ENERGY DRINKS

Further to Minute 13 of the last meeting, Zoë Hanim gave a verbal update on work being carried out to investigate what additional measures could be taken in relation to the responsible sale of high energy drinks to children.

All the relevant literature on high energy drinks had been reviewed by the Senior Programme Lead for Obesity and Diabetes and a public health perspective had been received. Zoë gave brief details of the public health recommendations, as follows:

- Raise awareness about high energy drinks, suggesting healthy alternatives and signposting children and families to health lifestyle programmes
- Establish sustainable links and partnerships with ongoing and successful Eatout Eatwell scheme running in neighbouring areas
- Develop a common communications strategy, including the use of social media
- Strategic involvement of the public health team in a media campaign
- Local efforts and outcomes of the media campaign to be highlighted in the Houses of Parliament through local MPs, aiming for necessary legislative measures at national level

She noted that there was limited resource within the Council to take this work forward, and there would need to be further discussions about how to use resources across Berkshire to carry out this work.

AGREED:

That the position be noted and a report be submitted to the next meeting.

13. HEALTH & WELLBEING BOARD DEVELOPMENT

a) Simulation Event on 21 September 2012

The Board received feedback notes and an action plan which had now been received in relation to the Health & Wellbeing Board Simulation Event which had been held on 21 September 2012.

b) Offer of Bespoke Support from the LGA

Nigel Webb and Gwen Earl explained that they were working as consultants sponsored by the LGA and the NHS to help develop and grow Health & Wellbeing Boards. They were offering a bespoke programme of support to Reading, and would like initially to speak to members of the Board to find out what issues there were for the Reading HWB Board and to then hold a workshop event in March 2013 for the Board to look at those issues and discuss how it could work best as a Board. They could also feed in experience from work with other HWB Boards.

It was suggested that the workshop be held on the same day as the next Board meeting, with an hour for the Board meeting and three hours for the workshop, and that the start time should be brought forward to accommodate this.

AGREED:

(1) That Nigel Webb and Gwen Earl contact members of the Board to obtain feedback for planning the workshop;

(2) That the next Board meeting start at 12.30pm and include a one hour Board meeting and a three hour workshop to be facilitated by Nigel Webb and Gwen Earl.

14. DATE OF NEXT MEETING

AGREED:

That the next meeting of the Health & Wellbeing Board be held on Friday 15 March 2013 at 12.30pm until 4.30pm, to include a workshop.

(The meeting started at 2.00pm and closed at 3.45pm)

Health Management and Strategy Development Programme Plan 2013-2014

Work stream	Leads	Activity	Timeline	RAG Tracking	Progress	Risks/Issues
Health and Well being Board, Governance and management arrangements	Avril Wilson (Director of Education, Social Services and Housing, RBC)/ Zoe Hanim (Head of Policy, Performance and Community, RBC)	Move from shadow board to fully operational with agreed work plan	Shadow May 12 Full board April 13	Green	Governance paper drafted and will go to Health & Wellbeing Board – 15 March, Cabinet – 18 March, Council – 26 March and Annual Meeting – 22 May re-setting up Board for 2013/14.	Management and links with commissioning arrangements not clear.
Development of the Health and Well Being Strategy and implementation plan	Zoe Hanim (Head of Policy, Performance and Community, RBC) Asmat Nisa (Consultant in Public Health)	Identify key priorities for health	March 2013 final Council sign off.	Amber	Strategy going for sign of at Council 26 March. A mapping exercise aligning current council activity under each of the objectives is taking place. Activity will be measured against the outcomes frameworks incorporated in the strategy. A set of performance measures are being drafted to fit with standard corporate process.	Time delays with mapping/baseline of existing service provision. Delayed Delivery/action planning activity.
Public health transfer to local authority	Suzanne Westhead (Head of Adult Care, RBC) Asmat Nisa (Consultant in Public Health)	Berkshire Transition plan to be developed and implemented	April 13	Amber	A joint advisory board has been proposed to replace the current transition arrangements. Legal input is being provided on contracts and management arrangements for April 2013. IMT work stream have identified the weekend of the 22 March to migrate data and information. Matrix working arrangements and the allocation of specialist areas across the six UAs linked to the needs and priorities for each is	Complex contracts and commissioning structures are in place across Berkshire. Administration concern over joint advisory board arrangements. No admin support will be transferring over with the Reading team.

					underway.	
Healthwatch & Independent Complaints Advocacy Service (ICAS) Healthwatch the independent consumer champion for the public. ICAS advocacy support to those wanting to complain about the service	Irene Cameron (Team Leader-Funding Services, RBC)	**Transition:** change of this scale will require a transitional period before the new arrangements will be fully functional.	April 2013	Green	A service specification has been agreed. Surrey Council is leading the ICAS commissioning at almost regional level. Following the tender process the existing provider of advocacy services SEAP have been awarded the contract.	Corporate procurement resource is limited at Reading. Links to the Council's complaint procedures are not clear.
Leadership and workforce development	Suzanne Westhead (Head of Adult Care, RBC) Zoe Hanim (Head of Policy, Performance and Community, RBC)	Consider the training / briefing needs for staff, councillors and key personnel.		Amber	Staff induction session rescheduled for the 13 March. An online e-learning course has been identified and is being considered for wider circulation. A briefing pack for Cllrs is being prepared.	
Communication plan - Engagement with the public	Derek Plews (Head of Communications RBC)	Develop communication plan and activity.		Amber	A detailed communication plan is being developed. A public health web page has been created.	
Stakeholder engagement GPs, Provider trusts, Voluntary sector, Children's Trust.	Zoe Hanim ((Head of Policy, Performance and Community, RBC) Suzanne Westhead (Head of Adult Care, RBC)	Inform stakeholders/ public of key changes		Amber	Initial discussions on how best to involve the voluntary sector have begun a briefing paper is being produced.	No agreed way forward for engaging the voluntary sector.

READING BOROUGH COUNCIL

REPORT BY MONITORING OFFICER

TO:	**CABINET**		
DATE:	**18 MARCH 2013**	**AGENDA ITEM:**	**3**
TITLE:	**TRANSFER OF PUBLIC HEALTH - JOINT ARRANGEMENT**		
LEAD COUNCILLOR:	**CLLR TICKNER**	**PORTFOLIO:**	**HEALTH & WELLBEING**
SERVICE:	**ALL**	**WARDS:**	**BOROUGH-WIDE**
LEAD OFFICER:	**CHRIS BROOKS**	**TEL:**	**0118 937 2602 / 72602**
JOB TITLE:	**HEAD OF LEGAL AND DEMOCRATIC SERVICES**	**E-MAIL:**	**Chris.brooks@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report seeks authority for the Council to enter into an agreement with the other Berkshire Unitaries for a joint arrangement concerning the Public Health function which will transfer to local authorities from the NHS on 1 April 2013. The proposed arrangement will cover:-

(a) the provision of a "core service" by Bracknell Forest Borough Council to the Berkshire Authorities, and

(b) the vesting in Bracknell Forest Borough Council of "cross-boundary" NHS contracts and the management and administration of those contracts by the Council on behalf of the other Berkshire Unitary Authorities.

1.2 The report also deals with:

(c) the appointment of a Director of Public health and the delegation of functions to her, and to the Consultant for Public health in reading;

(d) the designation of a responsible person, and a complaints officer, for handling complaints about the public health service for which the Council will become responsible.

1.3 There will be a separate report to full Council on 26 March 2013 on the formal establishment of a Health & Wellbeing Board for Reading, as a committee of full Council.

1.4 The Health and Social Care Act 2012 ("the 2012 Act") provides for the transfer of public health functions from the NHS to local authorities. The relevant statutory provisions will come into effect on 1 April 2013. The 2012 Act requires the Council to establish a Health and Well Being Board ("the Board") and to appoint a Director of Public Health.

1.5 The transfer of public health functions in Berkshire will involve the abolition of the two Primary Care Trusts (PCTs) covering the county – for East Berkshire, and the West of Berkshire – and the transfer of relevant functions to the six Unitary Authorities.

This process has been planned and coordinated by a Transition Board made up of officers from the six Unitary Authorities, and overseen by the Berkshire Chief Executives and Berkshire Leaders' Groups. They have agreed, in consultation with the Department of Health, that:

- there will be one Strategic Director of Public Health for Berkshire, who will be appointed jointly with the Department of Health and employed by a host authority
- each Unitary authority will have a Consultant in Public Health who will be accountable professionally to the Director.
- Bracknell Forest Borough Council will be the host authority for the Berkshire-wide public health service, and the employer of the Director of Public Health, and will provide a "core" public health service to all the Berkshire Unitary Authorities
- These arrangements will be the subject of a joint agreement between the six Berkshire Unitary Authorities, to run for two years until 2015 with the option of a further 1 year extension.

1.6 The terms of the joint arrangement include the arrangements for the transfer of existing PCT contracts to the Berkshire local authorities as successor authorities. Unless these are specific to an individual authority, they will transfer to Bracknell Forest as host authority who will manage them on behalf of the successor authorities under the terms of the joint agreement (including payment).

1.7 The joint arrangement will be overseen by a Joint Advisory Board which will act in an advisory role reporting through the Berkshire Chief Executives to the Berkshire Leaders. The Board will comprise the Director of Public Health, a Berkshire Chief executive, and a senior officer from each authority. This report recommends the identification of the senior officer to represent Reading on the Joint Advisory Board, and the delegation to that officer of authority to take action to implement decisions of the Board, in consultation with the Leader and Lead Councillor for Health & Wellbeing.

1.8 The joint agreement also involves each Unitary Authority entering into a formal arrangement with Bracknell Forest under Section 113 of the Local Government Act 2013 to place the Director of Public Health, as Bracknell's employee, at the disposal of the other authorities for the purposes of their public health functions.

1.9 Finally, the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 require the authority to designate a responsible person to ensure compliance with the arrangements made under the Regulations (the person who acts as the chief executive or other person designated as the authority's head of paid service pursuant to Section 4 of the Local Government and Housing Act 1989); and to designate a complaints manager to manage the procedures for handling and considering complaints in accordance with the arrangements made under these Regulations.

2. RECOMMENDATIONS

2.1 That the Council enters into a joint agreement with the other Berkshire Unitary Authorities for the provision of public health services in Berkshire, as described in Paragraph 4 of this report, from 1 April 2013.

2.2 That the Head of Legal & Democratic Services be authorised to enter into the joint agreement on behalf of the Borough Council.

2.3 That the Director of Education, Social Services & Housing (or in her absence the Head of Policy, Performance & Community) represent the Borough Council on the Public Health Joint Advisory Board and, in consultation with the Leader and Lead Councillor for Health & Wellbeing, be delegated authority to take action to

implement decisions taken on the recommendation of the Board insofar as they require the exercise of functions by the Borough Council, and subject to the decisions and actions being published in the Decision Book.

2.4 That the appointment by Bracknell Forest Borough Council and the Department of Health of Dr. Lise Llewellyn as the Director of Public Health for Berkshire be noted, and the authority enter into an arrangement with Bracknell Forest Borough Council under Section 113 of the Local Government Act 1972 by which Bracknell will place the Director of Public Health, as their employee, at the disposal of Reading Borough Council for the purposes of the authority's public health functions.

2.5 That the appointment of Asmat Nisa as the Consultant in Public Health for Reading Borough Council, be noted; and that she be the Director of Public Health's named substitute on the Health & Wellbeing Board;

2.6 That the Scheme of Delegation to officers be amended to include and provide that both the Director of Public Health and the Consultant in Public Health will have delegated authority for those matters which they are required to be responsible for under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

2.7 That the Managing Director (Ian Wardle), as head of paid service, be designated as the authority's responsible person to ensure compliance with the HNS Bodies and Local Authorities (Partnership Arrangements, Care Trust, Public Health and Local Healthwatch) Regulations 2012; and the Complaints Manager (Nayana George) be designated as the complaints manager under these Regulations.

3. POLICY CONTEXT

3.1 The purpose of this report is to ensure that the Council complies with the provisions of the Health and Social Care Act 2012 relating to the transfer of public health functions from the NHS to relevant local authorities from 1 April 2013.

3.2 Cabinet, on 14 March 2011, set up a shadow Health & Wellbeing Board to provide a basis for partnership working with the Primary Care Trust, the local Healthwatch, the local Clinical Commissioning Groups (CCGs) and other local health partners, to oversee the planning for this transfer. The Councillor membership comprised the Leader and the Lead Councillors responsible for health, children's services, and adult social care. The opposition Group Leaders each have had the right to appoint one shadow lead councillor to attend Board meetings as observers.

3.3 The appointment of a single Director of Public Health for all of the Berkshire Unitary Authorities and the delivery of a core public health service to all of the Authorities will achieve value for money.

3.4 The proposed agreement will make a substantial contribution towards securing a "safe landing" for the transfer of the Public Health function to local authorities in Berkshire.

3.5 The management and administration by a single Authority of existing NHS Public Health Contracts which will transfer to local authorities on 1 April will help to ensure the continuing effective delivery of services under such contracts.

4. SUPPORTING INFORMATION

Overview

4.1 The Health and Social Core Act 2012 ("the Act") provides for the transfer of the Public Health function to relevant local authorities with effect from 1 April 2013. In Berkshire, all six Unitary Authorities are relevant local authorities. Each relevant local authority is required to appoint a Director of Public Health.

4.2 The transfer process has been planned and coordinated by a Transition Board made up of officers from the six Unitary Authorities, and overseen by the Berkshire Chief Executives and Berkshire Leaders' Groups. They have agreed, in consultation with the Department of Health, that:

- Bracknell Forest Borough Council will act as the lead authority for the Public Health function in Berkshire
- a Joint Agreement will be developed to ensure appropriate arrangements are established for Bracknell Forest Borough Council to lead in the delivery of Public Health functions for Berkshire and
- final details relating to the strategic core be determined by the Chief Executive of Bracknell Forest in consultation with the Berkshire Leaders

4.3 In accordance with this decision, Bracknell Forest have prepared a draft agreement, in conjunction with the Heads of Legal Services of the other five Unitary Authorities. The drafting of the agreement is not yet complete and in particular most of the schedules to the agreement have yet to be finalised. The schedules will be subject to the Transfer Order for Berkshire to be issued by the Department of Health.

Joint Agreement

4.4 The essential elements of the proposed agreement are set out below.

4.5 The Core Services

4.5.1 Most Public Health functions will be delivered by teams employed locally by each authority. However, the Transition Board and the Berkshire Leaders and Chief Executives have recognised that it would be more cost-effective and appropriate for some "core" services to be delivered on a Berkshire-wide basis. Those services include:-

- Health Protection
- Public Health Intelligence
- Data Analysis
- Screen and Immunisation Co-ordination
- Epidemiologist

It is proposed that a small team to deliver the Core Service be hosted (i.e. employed) by Bracknell Forest Borough Council.

4.5.2 The costs of the Core Team service are proposed to be appointed as follows:

- One half of the cost will be apportioned equally between the six authorities.
- The other half of the costs will be apportioned in proportion to the grant which each authority receives for Public Health for the relevant year from central government.

4.6 NHS Contracts

4.6.1 NHS bodies have, as one would anticipate, entered into a number of contracts to secure the delivery of services in connection with the Public Health function. Most if not all of those contracts will not expire on 31 March 2013 (the Transition Board

agreed in principle that any contracts which were due to expire should be extended by a year) and some have a term which will extend two or three years beyond the abolition of the relevant NHS bodies. The Act provides that the Secretary of State may make "Transfer Schemes" in respect of the assets, rights and liabilities of the abolished bodies. In the context of Public Health that will mean that NHS contracts are "transferred" to local authorities.

4.6.2 Public Health functions in Berkshire are currently primarily delivered by the East Berkshire PCT (which includes Bracknell Forest) and the West Berkshire PCT. It is anticipated that contracts will primarily have been let on a PCT-wide basis. It is proposed that if any PCT contracts are confined to the area of one authority then the contract should vest in that authority. However, it is proposed that all other contracts (including those relating to West Berkshire) should vest in the Council.

4.6.3 If the arrangements alluded to above should be implemented, then Bracknell Forest Borough Council will, vis-à-vis the other contracting party, be liable for any payments under the contract. The draft Agreement provides for the apportionment of expenditure under contracts in the following ways:

- For those contracts where the area benefitting from the delivery of services can be identified (what the draft Agreement terms "Part A contracts") expenditure will be apportioned according to area benefitting.
- For other ("Part B") contracts, where the area benefitting cannot be identified, expenditure will be apportioned in proportion to Public Health grant received from central government.
- In respect of Part B contracts the Authorities will endeavour to put in place mechanisms to match expenditure with the area benefitting and with effect from the date such mechanisms are put in place expenditure will be apportioned according to area benefitting.

4.7 Duration of Agreement

4.7.1 The draft Agreement provides that it may be terminated on one year's notice expiring on 31 March. The Berkshire Leaders have recently agreed that the Agreement should run for two years, ie until 31 March 2015, with an option to extend it for 1 further year. If only one or two authorities wish to cease the joint arrangement then those authorities must bear the costs (e.g. redundancy payments) arising. Otherwise, termination costs will be borne in proportion to payments for the Annual Core Service Charge for the last year.

4.8 Future Commissioning

4.8.1 Given the uncertainty as to future commissioning arrangements the draft Agreement does not cover them.

4.9 Joint Advisory Board

4.9.1 The joint arrangement is not proposed to be operated under the auspices of a Joint Committee. It is proposed though to establish a Joint Advisory Board which will act in an advisory role reporting to the Berkshire Leaders Group. The Board will comprise the Director of Public Health, a Berkshire Chief Executive and a senior officer from each authority.

4.10 **Director of Public Health**

4.10.1 As stated above, the Act requires each local authority to appoint a Director of Public Health. Such appointments must be made jointly with the Secretary of State. Such posts command high salaries and the pool of suitably qualified candidates is limited.

The Transition Board, which was established by the Berkshire Unitary Authorities to oversee the transition of the Public Health service from the NHS, has agreed, in consultation with the Department of Health, that there will be one Strategic Director of Public Health for Berkshire, who will be appointed jointly with the Department of Health and employed by a host authority; and that Bracknell Forest Borough Council will be the host authority for the Berkshire-wide public health service, and the employer of the Director of Public Health, and will provide a "core" public health service to all the Berkshire Unitary Authorities. Each Unitary authority will have a Consultant in Public Health who will be accountable professionally to the Director.

4.10.2. The Director of Public Health is required to have responsibility for the following functions:-

- the duty imposed upon the Council to "take such steps as it considers appropriate for improving the health of the people in its area".
- any public health functions of the Secretary of State which he requires local authorities to discharge on his/her behalf
- dental health functions of the Council
- the duty to co-operate with the prison service to secure and maintain the health of prisoners
- the Council's duties set out in Schedule 1 of the National Health Act 2006, which include medical inspection of pupils, the weighing and measuring of children and sexual health services
- arrangements for assessing the risks posed by violent and sexual offenders

4.10.3 Bracknell Forest Borough Council, as lead authority, has appointed Dr Lise Llewellyn to the position of Director of Public Health. The Consultant in Public Health appointed for Reading is Asmat Nisa, who will transfer to the authority on a full-time basis from 1 April 2013.

4.10.4 Section 113 of the Local Government Act 1972 provides that a local authority may enter into an agreement with another authority for "placing at the disposal of the latter for the purposes of their functions" the services of an officer employed by the former. For the purposes of all relevant legislation the officer is to be treated as an officer of the authority at whose disposal he / she is placed. Dr Llewellyn is employed by Bracknell Forest Borough Council. The draft Agreement provides that, pursuant to Section 113, she will be placed at the disposal of (i.e. work for) the other Berkshire Authorities. In the event of Bracknell Forest Borough Council ceasing to employ Dr Llewellyn, that Council will endeavour to appoint a replacement who is willing to act as Director of Public Health across Berkshire.

4.10.5 This report therefore recommends that the Council notes the appointment both of Dr Llewellyn and Ms Nisa; enters into the necessary Section 113 agreement; and delegates authority to both of them to exercise those matters for which they are required to be responsible under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

4.11 Complaints

4.11.1 Under Section 395 of the 2012 Act, the Secretary of State may make Regulations setting up procedures for dealing with complaints about the exercise of public health functions by local authorities in England. These are included in the NHS Bodies and

Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

4.11.2 Under Regulations 21 and 22, the local authority must make arrangements for dealing with complaints, and must designate a responsible person to ensure compliance with the arrangements, and a complaints manager for managing the procedures for handling and considering complaints.

4.11.3 Regulation 22(4) requires the responsible person to be the authority's head of paid service. In Reading, this is the Managing Director (Ian Wardle).

4.11.4 This report recommends the designation of the Managing Director as the responsible person, and the Council's Complaints Manager, Nayana George, as the complaints manager, under the above Regulations.

Alternative Options Considered

4.12 Each of the Berkshire Authorities could appoint their own Director of Public Health and make their own arrangements for the delivery of services proposed by this report to be comprised in the Core Service. However, that would not secure value for money nor the other advantages which can be obtained under a collaborative arrangement.

4.13 "Cross-boundary" contracts could vest in all of those authorities whose area benefits from the contract. However, that would not secure efficiencies in the management and administration of contracts and would cause confusion with contractors.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The proposals in this report contribute directly to the strategic aim of promoting equality, social inclusion and a safe and healthy environment for all

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

6.2 The joint arrangement proposed in this report arises from an extensive programme of consultation between the six Berkshire Unitary Authorities, the Department and Health and local NHS bodies including the two PCTs, planned and coordinated by a cross-authority officer Transition Board and overseen by the Berkshire Chief Executives and the Berkshire Leaders.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 An equality impact assessment is not seen as relevant to the decisions in this report. This is because the report concerns the implementation of new legislation and Regulations.

8. LEGAL IMPLICATIONS

8.1 From 1 April 2013, the authority, as a Unitary Council and therefore a relevant body, will take on new public health responsibilities under the Health & Social Care Act 2012. This follows the abolition of the Primary Care Trusts, of which in Berkshire there were two (for East and West of Berkshire).

8.2 Under Section 28 of the National Health Service Act 2006, the authority must take such steps as it considers appropriate for improving the health of the people in its area.

8.3 Section 193 of the 2012 Act amends Section 116 of the Local Government & Public Involvement in Health Act 2007 ("the 2007 Act") to require the Council, as a relevant authority, to prepare, with its partner clinical commissioning groups (CCGs), a Joint Health & Wellbeing Strategy to meet the health needs of area relating to the exercise of public health functions by the authority, the NHS Commissioning Board or the CCGs. Section 192 of the 2012 Act further amends Section 116 of the 2007 Act to place a duty on the CCGs to prepare the Joint Strategic Needs Assessment and Strategy for their area, in consultation with local people living or working in the area and the local Healthwatch. It further introduces a new Section 116B to the 2007 Act by which the local authority, and its partner CCGs, have a duty to have regard to these documents.

8.4 As mentioned above, under Section 194 of the Health & Social Care Act 2012, the authority must set up a Health & Wellbeing Board, to operate as a committee of full Council under Section 102 of the Local Government Act 1972 as amended by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2012. The Board may also discharge any other health functions delegated to it by the authority. There is also a power for two or more Boards to exercise functions jointly.

8.5 The new public health functions which will transfer to the Council as a relevant authority under the 2012 Act have not, to date, been listed as functions which cannot be exercised by an authority's executive. Therefore, under Section 13 of the Local Government Act 2000, they are functions which only the executive of the authority (Cabinet) can exercise. This is why Cabinet, and not full Council, is being asked to agree to enter the joint arrangement at this stage.

9. FINANCIAL IMPLICATIONS

9.1 Financial Implications

9.1.1 The report sets out the statutory Public Health responsibilities that will be transferring to the Council from 1 April 2013. To meet these responsibilities each upper tier Council has received a ring fence grant from the Department of Health and for Reading: this is £7.466 million for 2013/14.

9.1.2 This is a formula allocation based on a number of factors but starts from a baseline of the actual expenditure of the Berkshire West PCT in 2011/12. A review has been undertaken by the six Berkshire Council working together to understand how the services are being delivered across the East and West of the County. Many of these services as set out in the report have been commissioned on a PCT-wide basis (e.g. west of Berkshire) and therefore can only be commissioned on that basis for 2013/14.

9.1.3 By working together in this way the six Councils will be able to continue to provide these services and the costs will be apportioned on the basis on the share of the funding received. Reading received a 47.6% share of the total resources for the West of Berkshire to provided Public Health services.

9.1.4 The analysis of the funding allocation and the commitments indicates that the formula allocation will be sufficient to meet the Councils' commitments in 2013/14.

9.2 Value for Money (VFM)

9.2.1 It is not presently clear whether all of the services that are being inherited from the health service currently offer value for money. The proposal through this joint agreement is to review the services and the outcomes during 2013/14 through the advisory board, to determine whether they are VFM, and ensure that arrangements are put in place that more clearly offer VFM from 2014/15.

9.3 Risks

9.3.1 This is a new area for the Council and the national resource allocation exercise has been a complex process. For the last eight months the Councils have been working closely together with the PCT to understand the services (and cost) that will be delivered from the 1st April 2013. Within the services there are some elements which are demand lead (e.g. Sexual Health services) and others which have complex links into other services provided by the health service (e.g. Children services). The Council is aware of these potential issues and these will be monitored carefully through the Advisory Board, and the Council's normal budget monitoring arrangements.

10. BACKGROUND PAPERS

10.1 Draft Joint Agreement

BERKSHIRE PCT CLUSTER QUALITY HANDOVER

Health and Well Being Board – Reading - 15 March 2013

Purpose of Paper
To outline to the Reading Health and Well Being Board the purpose of the Berkshire Cluster PCT Quality Handover Document.

Summary
The Quality Handover document provides an overview of healthcare services in Berkshire and sets out for successor organisations the key risks, challenges, achievements and ambitions for quality and patient safety in Berkshire, in preparation for handover from the Berkshire PCT Cluster on 31 March 2013.

The document covers:

- The context of transition
- The organisation of the local health care system
- Key personnel
- Governance arrangements
- Provider Quality profiles
- Patient Experience

The document has been drawn up to meet the quality and patient safety needs of the receiving organisations. It also provides information on quality and patient safety that is needed by other organisations, for example in relation to public health.

The document has been updated as appropriate with comments and actions as a consequence of the exchange of intelligence with receiving organisations. Receiving organisations include Clinical Commissioning Groups, Commissioning Support Units, Local Area Teams, Local Authorities, Health and Wellbeing Boards and others.

The document is designed to complement the quality handover documents of neighbouring PCT Clusters, and the SHA South of England Quality Handover document. Benchmarking data from Oxfordshire and Buckinghamshire Cluster PCT is included where available. This reflects the collaborative approach to the production of the Quality Handover document and the joint working that has taken place over a number of years.

The key quality areas that have been identified are:

Royal Berkshire NHS Foundation Trust

- Large acute foundation trust (covering West of Berkshire).
- Commissioner attendance at Clinical Governance Committee
- Reduction in Hospital Acquired C Difficile infections.
- Declared 1 never event - Wrong Site Surgery in 2012/13
- HSMR (Hospital Standardised Mortality Ratio) 102.65
- Stroke performance <4hr admission to stroke unit (November 2012 = 54% vs target of 95%)
- Impact of new Electronic Patient Record system – cancelled operations/appointment issues, VTE risk assessment performance also affected but back up to >90% (October 12)
- CQC Inspection (Dignity and Nutrition) in August 2012 was positive

HWPFT

- Acute foundation trust, 2 main sites (East Berkshire)
- Improvements in culture following new CEO in post. Increased visibility and leadership of senior management
- A&E-capacity and quality concerns. Visit undertaken by East CCG leads in February 2013.
- Maternity-recent improvements in culture of unit, c section rate remains above limit. 2 external reviews
- Serious Incidents Requiring Investigation (SIRIs) – reporting less SIs than RBFT but fewer are subsequently downgraded. 3 never events reported during 2012/13.
- HSMR 96.4
- Stroke service poor performance on <4hr admission to stroke unit (December 2012 - 55%) and 90% stay on stroke unit, related to late diagnosis of stroke and bed capacity issues.
- Discharge – concerns re level of use of electronic discharge letters and quality of information provided. Recent concerns raised by care home provider regarding timing and quality of discharge.
- Poor results for 2011 CQC Staff and Inpatient surveys (lowest 20% of trusts)
- A&E waits (due to high demand and capacity issues)
- Maternity experience improving.
- CQC Inspections – no compliance issues at HWPFT Maternity Unit during November 2011 inspection.

BHFT

- Integrated mental health and community services provider (across Berkshire)
- Suicides by patients in receipt of mental health services – on-going monitoring of reported SIRIs and review of RCA (root cause analysis) reports to identify themes and trends. (32 suicides/attempted suicides/unexpected deaths April-December 2012)
- Poor results for 2011+2012 CQC Inpatient survey (Some improvement for 2012)
- CQC unannounced inspection at Wokingham Community Hospital (Windsor and Ascot Wards) February 2013 – initial feedback positive

The Quality Handover document will be approved by the PCT Cluster Board before final handover to the receiving organisations. During the development phase the Board has received assurance from the PCT Transition Committee that appropriate information is being assembled in a timely way and is shared and discussed face to face with key individuals in the receiving organisations.

An earlier draft of this document has been presented at the Health Management group, it has also been shared with the Wokingham, Royal Borough of Windsor and Maidenhead and Bracknell Forest Health Scrutiny Committees in January 2013. The West Berkshire and Slough Health Scrutiny Committees will receive a draft in March 2013.

NHS Berkshire

Maintaining and improving quality during transition
BERKSHIRE PCT CLUSTER QUALITY HANDOVER DOCUMENT
VERSION 4
February 2013

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1. EXECUTIVE SUMMARY

This Quality Handover document provides an overview of healthcare services in Berkshire and sets out for successor organisations the key risks, challenges, achievements and ambitions for quality and patient safety in Berkshire, in preparation for handover from the Berkshire PCT Cluster on 31 March 2013.

The contents cover:

- The context of transition
- The organisation of the local health care system
- Key personnel
- Governance
- Quality profile
- Patient Experience
- Risk register
- Communication of plan

The document has been drawn up to meet the quality and patient safety needs of the receiving organisations. It also provides information on quality and patient safety that is needed by other organisations, for example in relation to public health.

This document will be updated as appropriate with comments and actions as a consequence of the exchange of intelligence with receiving organisations. Receiving organisations include Clinical Commissioning Groups, Commissioning Support Units, Local Area Teams, Local Authorities, Health and Wellbeing Boards and others.

The Quality Teams in Berkshire, Buckinghamshire and Oxfordshire have been working together for five years. In 2010 a MOBBB (Milton Keynes, Oxfordshire, Berkshire East and West and Buckinghamshire) Quality Group was established which standardised the core quality schedules in contracts and reduced duplication of work. This group also shared good practice and tackled concerns from providers. With the transfer of Milton Keynes to the East Midlands SHA this work continued through the South Central Commissioning for Quality Group currently chaired by the Assistant Director of Quality from the Berkshire cluster. Clustering into a Buckinghamshire and Oxfordshire cluster and a single Berkshire cluster made these arrangements even more resilient and used the strengths of the individuals in these small teams to the maximum benefit of the whole health economy.

These systems and processes will be built on in the development of the Commissioning Support Unit. The Quality Team in NHS Berkshire has actively contributed to the development of the Central Southern Commissioning Support Unit and responded to the consultation on structures.

This document is designed to complement the quality handover documents of neighbouring PCT Clusters, and the SHA South of England Quality Handover document. Benchmarking data from Oxfordshire and Buckinghamshire Cluster PCT is included where available. This reflects the

collaborative approach to the production of the Quality Handover document and the joint working that has taken place over a number of years.

The data and information will continue to be reviewed, added and amended up until the final version is approved by the PCT Cluster Board on 26 March 2013. The yellow highlighting tool has been used to help distinguish where data and information is still being finalised.

2. CONTEXT

The Health and Social Care Act 2012 describes the new structures and processes which will be in place by 1st April 2013 to commission healthcare in England. This reorganisation differs from previous reorganisations in that there is no one successor body, functions and individuals will move to a variety of different organisations. It is therefore important that robust arrangements are in place for the maintenance of quality both during transition and into the future. Evidence shows that to maintain a safe system of health and social care it is important to have clarity of role and responsibility at all times. This document describes how NHS Berkshire, as the 'sending' organisation and the various 'receiving' organisations will ensure that the quality of care is maintained during transition and how organisational memory will be assured into the future.

The National Quality Board report, Maintaining and Improving Quality during the Transition: safety, effectiveness, experience (March 2011) set out a range of recommendations for Boards aimed at sustaining quality during the transition. One of the themes identified by the report was the potential risks to quality posed by the loss of organisational memory during a time of transition. This theme has also been raised during the inquiry into the failings at Mid Staffordshire NHS Foundation Trust. There is an expectation that a formal handover on quality and safety should take place with the same discipline and rigour that occurs in financial handovers.

The National Quality Board report, How to Maintain Quality during the Transition: Preparing for handover (May 2012) reviewed lessons learned from the handover process that took place in 2011.

The Berkshire Cluster has set up a Transition Committee to co-ordinate the transition of the various functions to receiving organisations and to assure the Cluster Board that safe transition is being achieved.

The NHS Constitution sets out the behaviours and values of all staff working in the NHS. These behaviours and values will form the core of the new organisations. In Berkshire we wish to not only handover information on how to minimise risk, but also the ambition for continuous quality improvement. We aim to implement our Duty of Candour by sharing our handover documents with the public through presentation at a Cluster Board meeting. The handover documents will be based on the principles of transparency, honesty and probity.

Key issues for quality transition:

- To ensure that during transition the needs of the patient remain the key focus for the health and social care economy.
- To maintain clear lines of accountability at all times to ensure early warning of any concerns about the quality of care.
- To maintain clear communication channels with staff and patients and to make time to listen to what they are saying.
- To set up systems whereby hard and soft intelligence on quality is shared with the receiving organisations.

This quality handover document provides an overview of the quality of services in Berkshire and incorporates key issues for Clinical Commissioning Groups in Berkshire.

A Central Southern Commissioning Support Unit is being established to support Clinical Commissioning Groups; this will serve Bath, **Berkshire**, Buckinghamshire, Oxfordshire, Gloucestershire, Swindon and Wiltshire.

Commissioning of primary care services will be undertaken by the NHS Commissioning Board, Thames Valley Local Area Team.

Specialised services will be commissioned by three specialised commissioning hubs, including Thames Valley and Wessex (commissioned by Wessex Local Area Team).

3. TRANSITION LEAD

The Transition Lead responsible for the Quality Handover document is the PCT's Director of Nursing, Marion Andrews-Evans. Sara Whittaker, Assistant Director of Quality is the author of the Quality Handover document. Dr David Buckle, Medical Director is the PCT's Lead for Quality.

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4. THE ORGANISATION / SYSTEM

4.1 Berkshire West

Berkshire West Primary Care Trust is a statutory body which came into existence on 1st October 2006. The principal place of business of the Primary Care Trust is 57-59 Bath Road, Reading, Berkshire.

Currently there are four Clinical Commissioning Groups covering the populations in Newbury & District, North and West Reading, South Reading, and Wokingham. These form the West Federation of CCGs in Berkshire. Traditionally the practices have demonstrated low levels of referrals and prescribing compared to the rest of the country. The generally affluent and healthy population with low prevalence of health conditions has meant low levels of funding for the health system. Despite this the health economy has remained in balance with robust financial plans across all organisations and the PCT has been the top performing PCT across South Central for World Class Commissioning.

About the area

The estimated resident[1] population in Berkshire West in 2011 was 464,300 and the GP registered population[2] is about 474,781. (List[3] is 498,021)

West Berkshire makes up over half of the geographical area of the county of Berkshire, and is largely rural. It is in the top 50 least deprived local authority areas. Reading is a relatively small geographic area but combines some very affluent communities with more deprived neighbourhoods. It is a mid-ranking local authority in terms of deprivation. Reading is England's top performing urban area and its economy is expected to grow by 3.4 per cent per year until 2020, putting it top of the UK growth list. Wokingham borough is an affluent area with good economic prospects, high levels of economic activity and high average earnings. The borough is the fifth least deprived local authority area in England according to the Index of Multiple deprivation 2010.

There are three Unitary Authority areas covering the PCT boundaries (although not co-terminous):

- West Berkshire District Council – local MP Richard Benyon (Conservative)
- Reading Borough Council – local MPs Reading East - Rob Wilson (Conservative), Reading West - Alok Sharma (Conservative)
- Wokingham – local MP John Redwood (Conservative)

4.2 Berkshire East

Berkshire East Primary Care Trust (PCT) was established in October 2006. Its principal place of business is King Edward VII Hospital in Windsor.

[1] The resident population is an estimate of all people resident in the relevant geographical area

[2] The registered population is an estimate of all those people registered with GP practices in the relevant geographical area. It will include people who are resident outside the area, and exclude people inside the area who are registered with GP practices from other areas. It is "adjusted" from the GP list population so that the resident and registered populations are equal at regional level.

[3] The list population is the number of people registered with a GP practice.

There are 3 Clinical Commissioning Groups within the PCT covering the populations in Windsor & Maidenhead, Slough, and Bracknell & Ascot. These form the East Federation of CCGs in Berkshire.

Berkshire East comprises both rural and urban areas within three unitary authority areas and five main towns; Slough, Windsor, Maidenhead, Bracknell and Sandhurst.

There are three unitary authorities covering the area:

- Bracknell Forest Council – local MP Philip Lee (Conservative)
- Royal Borough of Windsor & Maidenhead Council – local MPs Windsor - Adam Afriyie MP (Conservative), Maidenhead – Theresa May (Conservative)
- Slough Borough Council – local MP Fiona MacTaggart (Labour)

The estimated resident population of Berkshire East at July 2011 was 411,435 (204,166 males and 207,269 females). This is considerably larger than the sum of all three local authority areas which was 399,500 (based on ONS mid-year estimates for 2011). This is because the resident GP population includes the two Englefield wards. The GP registered population in 2011 was 402,710. (List is 423,993)

In Berkshire health care is provided to the community by primary health care services comprising:-

4.3 General Practice

Across Berkshire there are 107 GP practices - 62 of these work under a GMS contract; this is a nationally negotiated but locally sensitive and managed contract. 42 Practices have a PMS contract; this is a locally agreed and managed contract. 2 practices have APMS contracts; these are also locally agreed and locally managed contracts. 1 practice has an EAPMS contract.

4.4 Out of Hours Service

WestCall is the organisation that provides urgent NHS GP services to all patients in Berkshire West during the times that normal GP surgeries are closed. WestCall operates two Primary Care Centres, one in Reading and one in Newbury. This service is commissioned from Berkshire Healthcare Foundation Trust.

East Berkshire Primary Care (Out of Hours Services) is the organisation that provides urgent NHS GP services to all patients in Berkshire East during the times that normal GP surgeries are closed. It operates three primary care centres at Heatherwood Hospital, Herschel Medical Centre and St Marks Hospital.

4.5 Dental

The PCT commissions NHS services from 129 dental practices, of which 4 provide orthodontic services only.

4.6 Community Pharmacies

There are 147 community pharmacies in Berkshire, some of which are commissioned to provide enhanced services as follows: EHC, Sexual Health, Chlamydia, NRT, Needle Exchange and Supervised Consumption.

4.7 Opticians

There are 104 optician premises in the Berkshire area, ranging from individual or partnership practices to the large body corporates.

4.8 Acute providers

Table of Main Acute Providers to Berkshire 12/13

Provider	Services	Lead Commissioner
Royal Berkshire NHS Foundation Trust	General acute & maternity	Berkshire West
Heatherwood & Wexham Park NHS Foundation Trust	General acute & maternity	Berkshire East
Great Western Hospitals NHS Foundation Trust	General acute & Maternity	Wiltshire
Basingstoke & North Hampshire Hospital NHS Foundation Trust	General acute & maternity	Hampshire
Oxford Radcliffe Hospitals NHS Trust	General acute & maternity	Oxfordshire
Nuffield Orthopaedic	Orthopaedic	Oxfordshire
Frimley Park Hospital	General acute	Hampshire
Ashford & St Peters	General acute	Surrey

4.9 Tertiary & Specialist Services

Management of contracts with providers in London, and specialist commissioning (including blood stem cell transplantation, renal services and spinal cord care) is carried out on behalf of Berkshire by the South of England Specialist Commissioning Board. The Specialist Commissioning Board is established as a joint subcommittee of each of the PCT Boards which are party to the arrangement.

4.10 Mental Health Services

Berkshire Healthcare NHS Foundation Trust is the key provider of mental health services to Berkshire residents. A small number of patients with specialist conditions, such as forensic psychiatry, are placed with independent providers.

Provider	Services	Lead Commissioner
Berkshire Healthcare NHS Foundation Trust	Mental Health	Berkshire East

4.11 Community Health Services

Community services, such as physiotherapy, podiatry, speech and language therapy, dietetics, occupational therapy and community and specialist nursing are mainly provided by Berkshire Healthcare NHS Foundation Trust. These services were transferred to the Trust from the PCT itself in April 2011 as part of the Transforming Community Services work programme. As part of the same

programme, provision of end of life care for the West of Berkshire was transferred to Sue Ryder from the PCT in April 2011.

4.11.1 West Berkshire Community Hospital

DETAIL ON HISTORY AND REFERENCE POINTS TO BE INCLUDED

4.11.2 Battle Health and Well Being Centre

DETAIL ON HISTORY AND REFERENCE POINTS TO BE INCLUDED

Table of main community providers to Berkshire 12/13

Provider	Services	Lead Commissioner
Berkshire Healthcare NHS Foundation Trust	Community services including community hospitals	Berkshire East
Sue Ryder Care	End of life care	Berkshire West
TVIC Dermatology	Dermatology	Berkshire
SCAS - Non emergency Patient Transport	Non-emergency transport	As required
SCAS -emergency Patient Transport	Emergency transport	As required
Surrey Community Health Services	Community services	Surrey

4.12 Ambulance services/patient transport

Emergency and non-emergency patient transport services are commissioned from South Central Ambulance Service.

4.13 Other Independent & Voluntary Sector

Some routine acute procedures are commissioned from independent sector providers with End of Life Care for the East of Berkshire provided by Thames Hospice Care:

Provider	Lead Commissioner
Spire Dunedin	Berkshire West
Ramsey Healthcare (The Berkshire Independent)	Berkshire West
Circle Reading	Berkshire West
IHG	Berkshire West
Spire Healthcare Thames Valley	Berkshire East
Thames Hospice Care	Berkshire East
BMI – Princess Margaret	Berkshire East

5. KEY PERSONNEL

In May 2011 Berkshire East and West Boards adopted a Memorandum of Understanding and Scheme of Delegation for the new Cluster Board. At its June 2011 meeting a revised Standing Orders and Standing Financial Orders were approved.

As at January 2013 the **Cluster Board** is constituted as follows:

Role and Name	Future destination
PCT Chair of Berkshire East & Berkshire West (Sally Kemp)	
NED Audit Chair - Berkshire East (Tony Dixon)	
NED Audit Chair - Berkshire West (David George)	
NED - Berkshire East and West (Tony Devine)	
NED – Berkshire East and West (Wendy Bower)	
NED – Berkshire East (Nasreen Bhatti)	
NED – Berkshire West (Clive Wiggett)	
NED – Berkshire West (Saby Chetcuti)	
Chief Executive (Charles Waddicor)	
Director of Finance & Performance (Janet Meek)	Berkshire West CCGs Federation – Chief Financial Officer
Director of Public Health East (Pat Riordan)	Public Health England (Secondment basis)
Medical Director and Controlled Drugs Accountable Officer (Geoff Payne)	Thames Valley Area Team
Accountable Officer – (Matthew Tait)	Thames Valley Area Team
Director of Commissioning – Non voting member (Helen Clanchy)	
Director of Nursing and Governance (Marion Andrews-Evans)	
Director of Joint Commissioning – Non voting member (Julie Curtis) (Interim from 1 October 2012)	

Business Critical Staff:

Role and Name	Future destination
PCT Cluster Medical Director – Dr David Buckle	Central Southern Commissioning Support Unit – Secondment basis from February 2013
Assistant Director Continuing Healthcare - Liz Rushton	
Assistant Director Human Resources – Jonna Hussey (Interim)	
Assistant Director Communications and Engagement - Corrine Yates	Central Southern Commissioning Support Unit
Head of Corporate Governance - Steph Bennett	
Head of Patient Experience - Malcolm Mackenzie	Patient Experience Manager - Central Southern Commissioning Support Unit

Role and Name	Future destination
Designated Doctor, Child Protection - Louise Watson	
Designated Nurse, Child Protection - Jenny Selim	
Head of Commissioning, Children & Young People - Sally Murray	Central Southern Commissioning Support Unit
Head of Commissioning, Mental Health & Learning Disability - Nick Buchanan	Central Southern Commissioning Support Unit
Assistant Director Primary Care East - Jacky Walters	
Assistant Director Primary Care West - Maureen McCartney	Operational Director, North and West Reading CCG
Deputy Director of Finance and Performance - Nigel Foster	Chief Finance Officer, Central Southern Commissioning Support Unit
Associate Director of Informatics - Catherine Mustill	Associate Director of Information and Analytics, Central Southern Commissioning Support Unit
Associate Commercial Director – Gail Newmarch (Interim)	
East GP Quality Lead/Deputy Medical Director (East Berkshire PCT) - Dr Jackie McGlynn	Bracknell CCG Lead and East Federation Quality Lead
Head of Performance - Debbie New	Berkshire West CCGs – Head of Performance
Transition Lead – Jen Sanger (Interim)	
Assistant Director of Quality – Sara Whittaker	Associate Director for Quality - Central Southern Commissioning Support Unit

People/organisations proposed to be in receipt of the final Quality Handover document:

- CQC
- Monitor
- CCG Chairs
- CCG Accountable Officers
- Central Southern Commissioning Support Unit
- Local Area Office Director
- Public Health England
- Local Authorities
- Health Scrutiny Panels
- LINKS – West Berkshire, Reading, Wokingham, Slough, Bracknell Forest, RBWM
- Berkshire Healthcare NHS Foundation Trust
- Heatherwood and Wexham NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Independent Providers

- Health and Well Being Boards
- NHS Trust Development Authority
- Local Education Training Board (part of Health Education England)

6. GOVERNANCE

The Quality Handover document will be approved in public by the PCT Cluster Board before final handover to the receiving organisations. During the development phase the Board will receive assurance from the Transition Committee that appropriate information is being assembled in a timely way and is shared and discussed face to face with key individuals in the receiving organisations.

7. TIMEFRAME

PCT Cluster Board Meeting Date - 26 March 2013.

8. QUALITY PROFILE

8.1 Triangulation

The information contained in this Quality Handover document has been triangulated with the Care Quality Commission Quality Risk Profiles; external reports and reviews by regulating bodies, Royal Colleges, and peer review teams.

The first draft will be shared with the provider organisations and future drafts will be shared with LINks and other patient groups to ensure the information reflects the perception of patients and carers. The table below details the programme for sharing the Quality Handover with partners and key stakeholders:

Organisation	Meeting
East Berkshire LINKS	14 November 2012
West Berkshire LINKS	5 December 2012
Wokingham Health Scrutiny Panel	22 January 2013
Royal Borough of Windsor and Maidenhead Health Scrutiny Panel	22 January 2013
Bracknell Forest Health Scrutiny Panel	24 January 2013
Reading Health and Wellbeing Board	15 March 2013
Slough Health Scrutiny Panel	18 March 2013
West Berkshire Health Scrutiny Panel	19 March 2013

Arrangements for sharing with organisations, detailed in Section 5, will be developed further during early 2013.

8.2 Ambition for quality

At the start of 2012 the NHS Berkshire PCT Cluster Board and Berkshire-wide Clinical Commissioning Groups recognised their joint role in putting quality and safety at the centre of what the PCT and clinical commissioners aimed to do throughout 2012-13. One of the key objectives of this has been to continuously improve the quality of services and therefore the experience of patients.

High Quality Care for All, the final report of the NHS Next Stage Review (2008) set out ambitious commitments for making quality improvement the organising principle of the NHS. It defined quality as having three dimensions: ensuring that care is safe, effective and provides patients with the most positive experience possible.

The strategic approach had four objectives that were addressed at every stage of the commissioning cycle. These objectives were:

1. To ensure that services being commissioned are safe, personal and effective
2. To ensure the right quality mechanisms are in place so that standards of patient safety and quality are understood, met, and effectively demonstrated
3. To provide assurance that patient safety and quality outcomes and benefits are being realised, and recommend take action if the safety and quality of commissioned services is compromised

4. To promise the continuous improvement and innovation in the safety and quality of commissioned services

8.3 Specific Challenges in Primary Care Clusters[4]

Challenges for all Primary Care Trust clusters in maintaining quality during the transition include:

- maintaining the focus on improving quality of care through improved patient safety, clinical effectiveness, the patient experience and access to care;
- delivery of quality and productivity plans for 2012/13 and beyond;
- ensuring compliance with national standards including waiting times, single sex accommodation and healthcare-associated infections;
- ensuring the establishment of successful clinical networks and senates;
- supporting Clinical Commissioning Groups in developing and maintaining constructive relationships with local HealthWatch, patients and the public;
- maintaining a focus on public health delivery of health improvement and health protection, including NHS Health Checks, smoking cessation and emergency planning;
- supporting Health and Wellbeing Boards in developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies;
- ensuring the smooth transfer of staff, skills, knowledge and information to new bodies.

Specific challenges for the Berkshire Primary Care Trust cluster are detailed below:

- Take forward plans to resolve the service configuration, quality, performance and financial sustainability at Heatherwood and Wexham Park Hospitals NHS Foundation Trust.
- Take forward improvements in quality, performance and financial sustainability in the wider Berkshire health economy.

8.4 CQUIN priorities for 2012/13

Nationally mandated

i. **VTE Risk Assessment** – 90% achievement on a month by month basis.
ii. **Responsiveness to personal needs of patients** which requires improvement on an aggregate score on the CQC national inpatient survey.
iii. **Improving diagnosis of dementia in hospitals** – requires 90% of patients over 75 to be screened dementia, risk assessed and referred if appropriate**.**
iv. **Use of the NHS Safety Thermometer** – The NHS Safety Thermometer is an improvement tool that allows NHS organisations to measure harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and VTE) and the proportion of patients who are "harm free". The CQUIN will reward submission of data generated from the use of the tool.

[4] As identified by the SHA South of England *Maintaining and improving quality during transition: handover document*. Version 1 – draft 13 September 2012

Local CQuIN priorities

Acute (RBFT)

v. **High Impact Innovations** - four areas of development in line with *Innovation Health and Wealth* (Young People's Digital Diabetes Clinic, Intraoperative Fluid Management Technologies, Digital by Default and Child in a Chair in a Day)

vi. **Improvement in Management of Unscheduled Care** – incentivise the appropriate diversion of patients who present at the Emergency Department and Clinical Decision Unit, with conditions that can be treated in the Community.

vii. **Reduction in elective admissions** - encourage the trust to work alongside and support GP colleagues in their gatekeeping role, and incentivise the trust to perform to an agreed level of activity, to move from current activity towards national mean.

viii. **Sepsis** – increase the percentage adult emergency admissions to the Emergency Department and Clinical Decision Unit (ED and CDU) with a diagnosis of sepsis, who receive intravenous antibiotics within 1hr of medical assessment.

ix. **Maternity** -for the Trust to deliver one to one care in labour 100% of the time

x. **End of Life** – improving achievement of preferred place of death

xi. **HIV** - for the Trust to improve the current rate of testing, and prepare the Trust for routine testing of all acute medical patients, regardless of clinical indicator diseases, in 2013/14.

Acute (HWPFT)

xii. **High Impact Innovations** - two areas of development in line with *Innovation Health and Wealth* (Intraoperative Fluid Management Technologies, and Digital by Default)

xiii. **Improvement in Management of Unscheduled Care** - incentivise the appropriate diversion of patients who present at A&E, with conditions that can be treated in the Community.

xiv. **End of Life** – improving recording of expressed preferred place of death and understanding reasons for non-achievement of preferred place of death.

xv. **Fractured Neck of Femur** – improving the #NoF pathway by improving the time to surgery following diagnosis and the recovery experience postoperatively.

xvi. **Gastroenterology** - incentivises the development of appropriate protocols in secondary care, specifically in relation to Gastroenterology

Mental Health and Community (BHFT)

xvii. **High Impact Innovations** - three areas of development in line with *Innovation Health and Wealth* (Assistive Technologies, Carers of People with Dementia and Digital by Default)

xviii. **Long Term Conditions** - Recognising the increase in unplanned admissions to acute settings across the country for patients with chronic conditions, and BHFT's role in reducing this.

xix. **Physical Health Screening for those with a Mental Health Diagnosis** – increase the percentage of service users on the Care Programme Approach (CPA) and all adult psychiatric inpatients to be offered a physical health check

xx. **Practice to Support Recovery** – increase the percentage of people on CPA to have been offered to use of the tools, the Mental Health Recovery Star or WRAP (Wellness Recovery Action Plan).

xxi. **End of Life** – improving achievement of preferred place of death

xxii. **Improving Carer Experience of Mental Health Services** - increasing awareness of carers of people who use mental health services, to build relationships with them and to offer information and support.

xxiii. **Improving Access to Psychological Therapies for People for have problems with Psychosis** - each locality to establish a psychosis forum for clinicians led by an experienced practitioner in the psychological treatment of psychosis.

xxiv. **Improving the Outcomes for Children and their Families** – through the allocation of a lead professional and the development of an information sharing protocol.

xxv. **Primary Care Engagement** – increasing GP satisfaction levels within selected aspects of community health and mental health service delivery.

8.5 Care Quality Commission Registration and Compliance

Royal Berkshire NHS Foundation Trust

August 2012

CQC made an unannounced visit on the 17 August 2012. It was a themed review and looked at Dignity and Nutrition for older people. They visited two of the elderly care wards and were looking at the following outcomes:

- Outcome 1 - Respecting and involving people who use services
- Outcome 5 – Meeting nutritional needs
- Outcome 7 – Safeguarding people who use services from abuse
- Outcome 13 - Staffing
- Outcome 21 – Records

All the patients the CQC spoke with said they were treated kindly and with respect. Most said the doctors had discussed their treatment with them.

Patients said the meals were ''good'' or ''very good.'' They said they had different options to choose from and were served their preferences. They said portion sizes were sufficient.

Most patients thought there were enough staff but said they were always busy.

The CQC reported that all the standards reviewed were being met by the Trust.

March 2012

The CQC visited the termination of pregnancy service to review:

- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential.

They did not speak to people who used this service as part of this review. The visit was to check that current practice ensured that no treatment for the termination of pregnancy was commenced unless two certificated opinions from doctors had been obtained.

The Trust was compliant with the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

November 2011

The Care Quality Commission undertook an inspection at the Royal Berkshire Hospital on Castle ward (acute medicine - respiratory) Burghfield (care of the elderly) and the Clinical Decision Unit. The following outcomes were reviewed:

- Outcome 4 (Care & welfare of people who use services)
- Outcome 7 (Safeguarding people who use services from abuse)
- Outcome 14 (Supporting workers)

Patients told the CQC that they were generally happy with the quality of care provided by the hospital. They said staff maintained their dignity and privacy at all times. Members of staff were patient, kind and helpful and quick to respond to calls for assistance and staff provided patients with sufficient information about their care and offered those appropriate choices in relation to their treatment.

The Trust was found to be compliant with the three outcomes inspected and no formal follow-up action was issued to the Trust.

Heatherwood and Wexham Park NHS Foundation Trust

June 2012

CQC carried out a visit on 21 June 2012, to check the provider's records, observe how people were being cared for, and look at records of people who use services. They talked to staff, reviewed information from stakeholders and talked to people who use services. They reviewed the following outcomes:

- Outcome 01 - Respecting and involving people who use services
- Outcome 04 - Care and welfare of people who use services
- Outcome 05 - Meeting nutritional needs
- Outcome 06 - Cooperating with other providers
- Outcome 11 - Safety, availability and suitability of equipment
- Outcome 16 - Assessing and monitoring the quality of service provision

The inspection concluded that the Trust was compliant in all six outcomes.

November 2011

A review of the Maternity Unit at Wexham Park Hospital was undertaken to review the following outcomes:

- Outcome 1 (Respecting and involving people who use services)
- Outcome 4 (Care and welfare of people who use services)
- Outcome 13 (Staffing)
- Outcome 14 (Supporting Staffing)
- Outcome 16 (Assessing and monitoring the quality of service provision)

The CQC were told that people had made a choice to attend the Wexham Park Hospital as the service was thought to be good, and was close to home with good facilities.

They found that the information that was provided was in sufficient detail to assist in making choices about birth arrangements. Service users told the CQC that staff always treated them with dignity and respect, and that they were caring and supportive.

The overall impression expressed to the CQC was that there was a high standard of service and declared that the Trust was meeting all the essential standards of quality and safety.

June 2011

Wexham Park Hospital (all areas)

The Care Quality Commission (CQC) carried out a review of Wexham Park Hospital in June 2011.
The following outcomes were reviewed:

- Outcome 04: Care and welfare of people who use services
- Outcome 07: Safeguarding people who use services from abuse
- Outcome 20: Notification of other incidents

The CQC received complementary comments regarding staff and the level of kindness and caring nature. Negative comments related to the attitude of some staff toward patients and appearing as lacking enthusiasm for the work to be done.

Some patients indicated that they were not kept informed sufficiently about the changes in treatment and what would be happening next. In addition to this, patients receiving care at the time of visit had not been made aware of their personalised plan of care.

Moderate concerns were identified for all 3 outcomes and action place was put in place.
HWPFT sent action plans and further evidence to CQC and following a further visit the Trust was found to be compliant.

June 2011

Heatherwood Hospital

CQC also carried out a review at Heatherwood Hospital to review the following outcomes:

- Outcome 04: Care and welfare of people who use services
- Outcome 08: Cleanliness and infection control
- Outcome 20: Notification of other incidents

During the visit the CQC spoke to patients on ward 8, rehabilitation and ward 4, orthopaedics. Patients provided mainly positive feedback about their experiences at the hospital, including complementary comments about staff. They were told by a patient that, "Nothing is too much trouble." Another patient said, "Staff are prepared to give good care to all the patients."

There were variations in the level of delivery of care that reflected individual preferences and choices expressed by patients. One patient indicated that he had at times felt rushed and that there was a degree of nursing impatience. However, overall, the patients were happy about the care delivered and they felt encouraged, safe and supported.

Moderate concerns were identified for 2 outcomes. Actions were taken by the Trust and following a further visit the Trust was found to be compliant.

June 2011 - Dignity and Nutrition for Older People review

The CQC inspected 100 NHS hospitals between March 2011 and June 2011. The selection was partly based on what they already know about a trust's performance and partly at random. All the inspections were unannounced.

Wexham Park Hospital had an inspection in June 2011. The findings were as follows:

- Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
- Outcome 5: Food and drink should meet people's individual dietary requirements.

Overall they found that Wexham Park Hospital was meeting both these essential standards and the overall CQC Report was good.

April 2011

The Care Quality Commission undertook an inspection in the Obstetrics and Gynaecology department at Heatherwood and Wexham Park NHS Foundation Trust on 25 April 2011 and the following outcomes were reviewed:

- Outcome 01 – Respecting and involving people who use services
- Outcome 04 – Care and welfare of people who use services
- Outcome 14 – Supporting staff
- Outcome 16 – Assessing and monitoring the quality of service provision

The inspection identified that the Trust was meeting all the standards and found to be compliant with the four outcomes inspected.

Berkshire Healthcare NHS Foundation Trust

Berkshire Health Care Trust (Campion Unit)

January 2012

The Care Quality Commission (CQC) undertook an inspection at Prospect Park Hospital's Campion unit (short term placements for people with learning disabilities for assessment and treatment who present with additional difficulties around their mental health/ or challenging behaviour/complex needs) as part of a targeted inspection programme of services that care for people with learning disabilities. The following outcomes were reviewed:

- Outcome 4 (People should get safe and appropriate care that meets their needs and supports their rights).
- Outcome 7 (People should be protected from abuse and staff should respect their human rights) were reviewed.

The CQC found that Campion Unit were meeting all the essential standards of quality and safety they reviewed but, to maintain this, suggestions for improvement were made.

Outcome 4:

The CQC found that assessment and treatment of people's needs was effective, allowing for a short admission period. The majority of comments received from relatives about the care delivered were positive. Minor concerns were raised with regards to patient care plans. The CQC define minor concerns to mean "people who use services are safe but are not always experiencing the outcomes relating to this essential standard". Each patient has a copy of their individual care plan created during initial assessment and reviewed on a regular basis. It was found that care plans were "generally well written" but "none of them were created in an easy read format". Concerns were therefore raised "that people using the service may not be able to understand their care plans." Not all of the people using the service were literate.

Outcome 7:

People should be protected from abuse and staff should respect their human rights.

Campion Unit is compliant with Outcome 7. The CQC concluded people were being protected by Trust policies, staff training and individual behavioural support guidelines.

Berkshire Health Care Trust

October 2011

The CQC visited and reviewed the four outcomes that BHFT were not previously compliant with. These were:

- Outcome 07 – Safeguarding people who use services from abuse
- Outcome 12 – Requirements relating to workers
- Outcome 16 – Assessing and monitoring the quality of service provision
- Outcome 20 – Notification of other incidents

The CQC found that BHFT were compliant in all these areas in the services visited.

Little House in Bracknell has also been visited by CQC as part of their review of services for people with learning disabilities. The following outcomes were reviewed:

- Outcome 04 – People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 07 – Safeguarding people who use services from abuse

The CQC found that Little House was meeting all essential standards of quality and safety that were reviewed.

Berkshire Health Care Trust

April 2011
The Care Quality Commission (CQC) undertook an inspection of Berkshire Health Care Trust. The Trust was not compliant with the following standards that were reviewed:

- Outcome 07 – Safeguarding people who use services from abuse
- Outcome 12 – Requirements relating to workers
- Outcome 16 – Assessing and monitoring the quality of service provision
- Outcome 20 – Notification of other incidents

Outcome 7:
The Trust has not made suitable arrangements to ensure that patients are safeguarded against the risk of abuse, is not taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and is not responding appropriately to allegations or incidents of abuse.

Overall the CQC found that improvements were needed for this essential standard.

Outcome 12:
People should be cared for by staff who are properly qualified and able to do their job. The Trust does not have effective recruitment procedures to ensure that people, employed to carry on the regulated activity, are of good character and the Trust does not ensure that all information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 is obtained and available in respect of people employed.

Overall the CQC found that improvements were needed for this essential standard.

Outcome 16:
The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

The CQC found that the Trust has not developed and put in place effective systems that enable the registered person to regularly assess and monitor the quality of the services provided in carrying on of the regulated activities against the requirements of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2010, or to identify, assess and manage risks related to the health, welfare and safety of patients and others who may be at risk.

The CQC found that there is no effective system in place, at trust or location level, that enables the trust to identify, monitor and analyse individual incidents of patient to patient abuse for trends or for risks to patients from incidents of patient to patient abuse that result in, or have the potential to result in, harm to another patient.

Overall the CQC found that improvements were needed for this essential standard.

Outcome 20:
The service should notify the Care Quality Commission, without delay, of important events that affect patients' welfare, health and safety. The Trust has failed to notify the Commission (or National Patient Safety Agency), without delay, of incidents specified in regulation 18 (1) and (2)(b)(e) of the Care Quality Commission (Registration) Regulations 2009.

The CQC are taking further action to protect the safety and welfare of people who use services.

The CQC asked the provider to send a report, in relation to Outcomes 7, 12 and 16 setting out the action they will take to improve.

The Trust was declared compliant with all standards in December 2011.

Berkshire Health Care Trust (Charles Ward in St Mark's Hospital, Maidenhead)

December 2010
The CQC carried out a planned review of Charles Ward in St Mark's Hospital, Maidenhead in December 2010. For four of the essential standards they were not satisfied that Charles Ward at St Mark's Hospital was compliant. Two areas of particular concern where Charles Ward was not compliant with essential standards were:

- Outcome 16 - Assessing and monitoring the quality of service provision
- Outcome 20 - Notification of other incidents

As a result of concerns raised in this review, CQC also then carried out a review of BHFT as a whole over concerns identified for the same four essential standards. It was found that the Trust had considerable delays in notifying the authorities about incidents.

The Trust received a warning from the CQC regarding their registration status. After submitting the above information warning was lifted and the Trust has maintained full compliance since March 2011.

Following a further review in April 2011, the CQC found that the Trust had made the improvements required. All actions are now completed and significant improvements have been made resulting in the CQC declaring that the trust is now compliant.

8.6 Monitor Ratings

Monitor ratings				
Organisation:	**Year:**	**Financial Risk Rating**	**Governance Risk Rating**	**Detail:**
RBFT	2012/13 Q2	3	Amber Green	The governance risk rating for this foundation trust was amended from AMBER-RED to AMBER-GREEN in November 2012 due to the trust returning to compliance with healthcare target(s) in quarter 2 2012/13
HWPFT	2012/13 Q2	1	Red	The trust was found in significant breach of a term of its authorisation in July 2009, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. This was as a result of a rapid decline in its financial and operational performance. The trust will be subject to enhanced monitoring until Monitor determines that it is no longer in significant breach of its authorisation.
BHFT	2012/13 Q2	3	Green	
OUH	*Not applicable*			
BHT	*Not applicable*			
Oxford Health	*2012/13 Q1*	*4*	*Green*	*The Financial risk rating for this foundation trust was amended from 3 to 4 in August 2012 due to an improvement in the trust's financial position.*

Data Source: Monitor Website

Monitor publishes its assessment of financial and governance risk in all Foundation Trusts on its website. Governance risk, which takes into account quality, is rated using a traffic light scale.

Key

Governance risk rating
Red - Likely or actual significant breach of terms of authorisation
Amber-red - Material concerns surrounding terms of authorisation
Amber-green - Limited concerns surrounding terms of authorisation
Green - No material concerns

Financial risk rating
1. Highest risk - high probability of significant breach of authorisation in short-term, e.g. <12 months, unless remedial action is taken
2. Risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action
3. Regulatory concerns in one or more components. Significant breach unlikely
4. No regulatory concerns
5. Lowest risk - no regulatory concerns

8.7 Quality Impact Assessment of Provider Cost Improvement Programmes

Following the submission of the Annual Operating Plans and cost improvement programmes for 2012/2013 a risk based review was undertaken by the South of England clinical teams under the leadership of the Director of Nursing and Medical Director to gain assurance that there would be no adverse impact on the quality of services.

For those plans with total savings of more than 5.5% of total trust income additional assurance was sought. No providers in Berkshire were required to provide this additional assurance.

8.8 Providers

8.8.1 Royal Berkshire NHS Foundation Trust – Overview

Royal Berkshire NHS Foundation Trust is a large general hospital providing acute medical and surgical services to Reading, Wokingham and West Berkshire and specialist services to a wider population across Berkshire and its borders. It employs nearly 5000 staff and has been a Foundation Trust since June 2006.

The Trust provides services from the following bases:

- Royal Berkshire Hospital, Reading with just under 700 beds and capacity for over 200 day patients.
- The Prince Charles Eye Unit, Windsor, provides eye services to the patients of East Berkshire
- Dialysis services at a dedicated unit in Windsor.
- West Berkshire Community Hospital - day surgery unit and acute outpatients department.
- Royal Berkshire Bracknell Clinic – cancer, renal and outpatient services.
- Townlands Hospital, Henley – outpatient services.

Quality initiatives

RBFT hosts the Patient Safety Federation and has been a strong champion for the programme since it began: http://www.patientsafetyfederation.nhs.uk/

RBFT participates in the Productive Care Programme, specifically in the Productive Ward and the Productive Operating Theatre.

The Trust has a comprehensive system of Clinical Governance, which has quality improvement at its heart. The Commissioner attends the Trust's Clinical Governance Committee, allowing an extra level of assurance to be attained.

The Trust participated in an early pilot of the national NHS Safety Thermometer.

Achievements

In 2011/12 the Trust won the Health Service Journal's (HSJ) National Patient Safety Award. This was awarded for an initiative to prevent hospital acquired pneumonia in patients which led to a 60 per cent reduction in cases.

In 2012/13:

- for the third year in a row they have been named as one of the fastest hospitals in the country for treating heart attack patients. This is for the number of patients who receive a primary angioplasty within 150 minutes of calling 999.
- the regulator for health and social care, the Care Quality Commission registered the Trust to practice 'without conditions' at each of its sites.
- The trust was named as one of CHKS 40 Top Hospitals.
- a member of staff was named Gastroenterology Nurse of the Year and also won the Pride of Reading Healthcare Worker category.
- the team working with diabetic patients won three silver Quality in Care (QiC) awards.
- in December 2011 the first dialysis patient completed treatment in his own home. This scheme is currently running as a pilot and means that some patients no longer need to come into hospital three or four times a week.

Key issues

Healthcare Acquired Infections

The Trust struggled for a number of years to meet *Clostridium Difficile* targets set by the Department of Health. *C DIff* infection is the most important cause of hospital-acquired diarrhoea. Associated significant clinical risks include associated mortality, associated morbidity and high cost to healthcare.

C DIff infection is usually spread on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. Spores are produced when *C Diff* bacteria encounter unfavourable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

Politically there is high profile focus from both the Department of Health and the Strategic Health Authority on incidence of *C Diff* in Berkshire. New testing methods for 2012/13 (only 'excretors' not 'carriers' have to be mandatory reported) mean that all organisations are testing in the same way, and RBFT's figures have benefited from this. The Trust is reporting 17 cases at the end of Q3 2012/13 against a target of 77 cases for the year. This is as a result of a robust zero tolerance approach in addition to changes in the reporting mechanism. However, the joint focus on infection control will be maintained to ensure that changes in practice are effective in controlling the spread of infection.

Current Actions:

RBFT participated fully in the jointly run Symposium on Infection Control in February 2012 facilitated by the Director of Public Health for Berkshire East.

RBFT now hold a Joint Infection Control Meeting which the Director of Public Health for Berkshire East attends. This meeting is chaired by the Trust's Chief Executive.

Joint Senior Governance (senior meeting between the Trust, CCGs and PCT) has antibiotic prescribing and the *C DIff* recovery action plan as standing items on the agenda.

A Public Health Consultant (West) attends the Trust's internal Infection Control Meeting.

A *C Diff* zero tolerance campaign has been initiated in Berkshire.

An Infection Control Nurse post for the Community has been approved.

A detailed analysis is underway to investigate the prescribing patterns, over time of Antibiotics and Proton Pump Inhibitors across primary and secondary care in Berkshire. The aim of the ongoing epidemiological analysis is to investigate the relationship between cases of *C Diff* and risk factors including, prescribing of the four Cs (3rd generation Cephalosporins, Ciprofloxacin, Clindamycin and Co-amoxiclav) and Proton Pump inhibitors.

UPDATE AGAIN BEFORE MARCH 2013

Cancelled Appointments

During 2012 the PCT received a number of GP concerns regarding patient experience of cancelled appointments with the Trust:

- A 2 week wait patient was not seen appropriately, attending the appointment to find no paperwork and it was therefore cancelled.
- Experiences of patients arriving for appointments where the clinic isn't expecting them, even when Choose and Book shows that they should be.
- Experience of patients appointments being cancelled short notice and re-booked for 3-4 weeks ahead.

Additionally NHS Berkshire PALs has received 10 queries since May 2012 that relate to appointments at RBFT.

The issue was raised with the Trust in August 2012. RBFT responded that the issue was down to the implementation of the new Electronic Patient Record (EPR) system. Significant change to infrastructure, systems, processes and daily operational activities have been made. The Trust anticipated a number of "bedding in" challenges and as a result a small number of patients have experienced issues relating to appointments. The Trust has written to apologise to all patients who have experienced issues.

As an organisation the Trust has stated that they are acutely aware of the impact both on patients and GP colleagues. Additional clinics have been set up with extra administrative support to try to resolve this. Ghost clinics appearing on the system has been resolved. PALS are dealing with patients on an individual basis.

Current Actions:

The Trust has produced a comprehensive overview of what happened, what actions they have taken to resolve the issue and detailed who within the Trust individual GPs can call for assistance if they are still being faced with patients who have had unacceptable cancelled appointments. This was disseminated to all Berkshire GPs at the end of 2012.

At the end of 2012 there had been a reduction in the number of patients reporting cancelled operations (resulting from issues with the EPR system) to their GPs however this issue will continue to be monitored closely.

UPDATE AGAIN BEFORE MARCH 2013

VTE Risk Assessments

The Trust implemented a new patient management system/electronic patient record (EPR) on 18 June 2012. The process for recording VTE risk assessments changed and unfortunately as a result performance fell below the national target of 90% of all patients receiving a VTE risk assessment.

2012 Data: April - 90.1%, May - 91.0%, June - 66.7%, July - 82.5%, Aug – 86.2%, Sept – 88.5%, Oct - 91.0%, Nov 92.4%.

Current Actions:

RBFT responded to the issues by producing a Proactive Remedial Action Plan (RAP) setting out the actions and measures that the Trust would be taking to ensure performance was rectified. The action plan was approved by the interim Chief Medical Officer and Care Group Boards. The Care Groups are monitored against this internal RAP and will be held accountable through the Trust's Executive Performance Meetings. Progress and updates will be shared with Commissioners against the plan in line with the Performance meeting schedule.

The issue was discussed with the action plan at the Clinical Quality Review Group meeting with RBFT on 5 September 2012.

As at October 2012 the Trust recovered its position and is achieving the threshold of 90%.

UPDATE AGAIN BEFORE MARCH 2013

Cancer 2 week waits

The percentage of patients who have been seen within 2 weeks of GP referral for suspected cancer at RBFT has been below the 93% standard during the first 5 months of the year:

2012 Data: April 91.4%, May 94.7%, June 88.7%, July 90.4%, August 87.9%, September 91.0%, October 94.8% (YTD 91.4%)

The poor performance is as a result of increased two week wait referrals as a result of the bowel cancer campaigns earlier this year. The performance has also been affected by patient choice, especially during holiday periods, and the implementation of the new patient administration system resulting in the booking process being more complicated at RBFT and also clinic times have taken longer as a result of the changed system so less patients have been booked per clinic.

A meeting took place with RBFT and Thames Valley Cancer Network on 14 December 2012. A detailed action plan is in place at RBFT which addresses capacity issues in areas of sub-speciality underperformance. Some work is required around long term demand and capacity modelling and the Cancer Network are going to support the Trust in January to complete some capacity modelling. October saw an improvement in performance that we hope will be sustained.

UPDATE AGAIN BEFORE MARCH 2013

A&E Performance

The percentage of patients who have spent 4 hours or less in A&E at RBFT has been below the 95% standard for Quarter Two of 2012/13 at 94.6% and Quarter One only marginally achieved the indicator at 95.1%. The poor performance is as a result of patient flow issues through the hospital and also through the whole system. There are a significant number of medically fit patients in the hospital who do not need to be there which affects the patients that need to be admitted to hospital from A&E. The Quarter Three position up until 2nd December is 95.6% so is on track to achieve the quarterly target assuming performance continues at the current rate.

A number of short term initiatives are being put in place to support improved patient flow. Examples of this include:

- Funding allocated to support complex social care patients who do not meet the CHC criteria
- Further investment into the Patient Transport Service to support discharges from the hospital
- Increases in community bed numbers
- Pilot of a twilight community nursing service
    - Increased number of Emergency Nurse Practitioners and Consultants within the A&E department

In addition to short term initiatives to support the winter period, QIPP schemes are being developed for 2013/14 to further improve the patient flow for Berkshire West patients.

The Emergency Care Intensive Support Team (ECIST) are being brought into do a review of RBFT processes in relation to urgent care and this will also pick up system wide issues to support discharges from RBFT. Fortnightly System Resilience meetings are also in place to ensure all initiatives are being implemented and delivered appropriately.

UPDATE AGAIN BEFORE MARCH 2013

8.8.2 Heatherwood and Wexham Park NHS Foundation Trust – Overview

Heatherwood and Wexham Park Hospitals NHS Foundation Trust is a district general hospital that serves a population of more than 450,000 people from the areas of Ascot, Bracknell, Maidenhead, Slough, Windsor and south Buckinghamshire.

The Trust employs approximately 3625 full and part-time permanent staff who deliver a wide range of quality healthcare services from two main sites; Heatherwood Hospital in Ascot opened in 1923, and Wexham Park Hospital in Slough opened in 1968. The Trust also provides outpatient clinics, a breast screening and diagnostic service, a chest clinic and other diagnostic tests at King Edward VII Hospital in Windsor, outpatient services and diagnostic tests at St Mark's Hospital in Maidenhead, and outpatient services at Chalfont's and Gerrards Cross Hospital, and Fitzwilliam House in Bracknell.

Heatherwood and Wexham Park Hospitals NHS Trust became a Foundation Trust in June 2007.

Quality initiatives

HWPFT participates in the Patient Safety Federation: http://www.patientsafetyfederation.nhs.uk/

HWPFT participates in the Productive Care Programme, specifically in the Productive Ward and the Productive Operating Theatre.

Enhanced Recovery is an innovative programme of care that supports patients during the recovery phase from surgery. After a successful trial in elective hip and knee surgery, the Trust now offers the Enhanced Recovery programme in elective colorectal and gynaecological surgery:

- 75% of patients are now discharged 4 days after undergoing a hip or knee replacement
- 75% of patients who have had a vaginal or abdominal hysterectomy are discharged within 3 days
- Patients who have had a excision of Rectum or a colectomy will be discharged within 7 days

Achievements

- Heatherwood and Wexham Park Hospitals NHS Foundation Trust was rated one of the CHKS 40 Top Hospitals (2011/12). The CHKS Top Hospitals Programme, now in its eleventh year, is the only data-driven set of awards in the UK using analysis of nationally available data sets to determine winners in each category. Performance is judged across a range of patient safety indicators including mortality rates, emergency readmissions and length of stay.

- Wexham Park Hospital attracted a worldwide audience of thousands in March 2012 by hosting the UK's first live webcast of robotic prostate surgery as part of National Prostate Cancer Awareness Month. The webcast was streamed around the world to GPs, surgeons and members of the public and is the first of its kind in the UK. The aim of the webcast was to showcase the latest advances in prostate cancer surgery and to highlight the latest techniques available to patients on the NHS.

Key issues

Maternity

Concerns have been raised about the quality of care within HWPFT's maternity service. Caesarean Section rates were high throughout 2011/12 with an average of 27.9%, against a limit of 23.5%. Current performance for 2012/13: April 26.1%, May 28.2%, June 28.3%, July 27.1%, August 24.60%, September 25.70%, October 28.2%, November 23.2%, December 26.8%.

An external review was carried out in 2010 following concerns raised by the Commissioners (Berkshire East PCT). As these concerns still existed in 2012, and there were 6 maternity serious incidents requiring investigation (SIRIs) reported between April 2011 and December 2011 (4 Intrapartum deaths and 2 Unexpected Neonatal deaths) an additional external review was carried out in 2012.

The CQC reviewed the service in April 2012 and found no concerns.

Current Actions:

The Berkshire East CCG Federation Clinical Quality Lead is a member of the Trust's Obstetrics and Gynaecology Steering Group, which monitors the Trust's detailed action plan.

In addition a PCT/Trust meeting was held on 25 April 2012, to discuss the PCT Cluster Board and clinical commissioner's concerns following receipt of the 2012 external review. After reviewing actions and discussing issues at length, it was felt the meeting illustrated the robust and transparent approach the Trust was taking. Actions were felt to be positive and important for the long-term aim of improving the quality of care delivered by the service. It was noted that culture change will take at least 18 months to completely take effect. Positive improvements in the quality of care provided may not be seen immediately.

A further meeting was held in November 2012 where the Trust updated the PCT on the progress of the action plan based on the recommendations following the external report. This includes the following changes:

- A new Clinical Leader and senior General Manager has been appointed.
- All staff have been trained and assessed as competent in the use of CTG monitoring.
- The Consultant Midwife has now commenced in post and will be focusing on high risk births, Labour Ward and associated pathways.
- The Department currently has two Consultants involved in the delivery of PROMPT training (practical obstetric multi-professional training) with the Practice Development Team.
- STAN monitoring has ceased to be used in the Unit.
- A review of job plans has been undertaken and the Department now provides 98 hrs Consultants cover on the Labour ward.

There are a number of recurring themes that need additional work: –

- C-section rates and lack of theatre availability 5 days a week
- On call rota
- Clerical support
- Access to Gynaecology work

Alasdair Gordon (Clinical Lead) has been reviewing Job Plans and looking at the clinical rotas of the Consultant Body. An external consultant is supporting this work and the review of the current allocation of PAs. It is recognised that a further review is required to streamline the middle grade Doctors. This will have a significant cost saving to the Trust.

Work has been ongoing looking at Theatre lists and a solution has been found to ensure women receive ERCPs (Evacuation of Retained Products of Conception) in a timely manner (next day). Previously they were waiting up to a fortnight for their operation.

There has been discussion at the Trust's O&G Steering Group about the C-section rate and it is recognised that a targeted piece of work is required Trust wide to fully understand the rate and clinical practice supporting the rate. This piece of work is being led by the Consultant Midwife.

The appointment of the General Manager will ensure managerial accountability within the Department.

Improving access to Gynaecology work for SHOs and Registrars including associated training needs is being addressed as part of the overall strategic direction.

The date of the next meeting is to be decided but will be held by end of March 2013.

In November 2012 the Trust achieved a C-section rate of 23.2% (below the limit of 23.5%).

UPDATE AGAIN BEFORE MARCH 2013

A&E

Between April 2011 and March 2012 there were 8 SIRIS involving the Accident and Emergency department and Acute Medical Unit (AMU) at HWPFT. These have been categorised as: 4 x Unexpected deaths, Other – increase in demand of the unit causing the unit becoming unsafe, and 3 x Sub optimal care of the deteriorating patient.

Current Actions:

There have been continued conversations and correspondence between the Trust and the PCT/CCG commissioners. A HWPFT consultant attended the October East Federation CCG Quality Committee to discuss measures that the Trust is taking to better manage the care of the deteriorating patient. Assurance was provided on a range of actions that have been implemented or are planned including:

- Allocating consultants to each ward rather than each patient being under the care of the admitting consultant.

- Improvements to weekend handovers.
- A&E consultants now have a team job plan rather than individual which supports more consistent cover for ward rounds.
- A&E handover process has been changed so that some staff remain on the unit which avoids a backlog of patients forming during handover.
- Step down wards are no longer used.
- Plans are in place to expand AMU; this will enable the most appropriately skilled staff to be able to continue care for the more vulnerable patients who need to stay on the AMU longer.
- A monthly mortality meeting takes place to review selected cases and look at whether anything could have been done differently, what decisions were made and why. Junior doctors attend these.
- Real time IT system to be rolled out across the hospital which will further improve handover.

The committee were assured that the changes are being clinically led and felt that the Trust was very open and transparent. CCG leads have been invited to attend unannounced walkabouts within A&E and visited the unit in January 2013.

On 4 December 2012 the Trust declared a serious incident due to significant pressure on bed capacity following unprecedented levels on demand. The peak was due to a sustained rise in the volume of ambulance conveyances (quoted by SCAS as a 20% sustained increase compared to the same period the previous year) and self-presenting attendances resulting in a high volume of patients requiring both medical and surgical admission. To ensure patient safety the Trust needed to cancel all non-urgent elective activity and reverse triage the patients with EDDs (Expected date of discharge) within 24 hours to expedite discharge and to open every available patient space.

Two further serious incidents relating to bed capacity have been declared for 31 December and 27 January. Full Investigation reports will be sent to the PCT in lines with the SIRI policy.

UPDATE AGAIN BEFORE MARCH 2013

Stroke

HWPFT operates an acute and rehabilitation service for stroke. For the national target of percentage of patients who spend 90% of time on stroke unit (target 80%), the Trust missed this target during 2011/12 for 8 months of the year. 2012/13 performance has been much more positive: April 84%, May 81%, June 96.7%, July 80%, August 81%, September 75%, October 78%, November 81%, December 86%.

Additionally the Trust did not meet the national target of percentage of patients admitted to a stroke unit within 4 hours (target 95%), during 2011/12 and is still not meeting this for 2012/13: April 68.4%, May 62.5%, June 83.3%, July 72.5%, August 74% September 53%, October 67%, November 81%, December 55%.

Current Actions:

The Trust has identified the following issues affecting direct admittance to the stroke unit: delay awaiting medical clerking; waiting on a bed in the stroke unit; late referral; and late diagnosis.

The new stroke consultant met with the A&E consultants to discuss the stroke pathway. He has started training sessions with the junior doctors on stroke diagnosis all aiming to get admitted to stroke bed within 4 hours. He has also met with the Consultant in Stroke at Frimley Park Hospital to discuss Early Supported Discharge (ESD).

The Stroke Team is preparing Pathway Training for ward staff to include: the referral process and out of hours Stroke Consultant cover.

The Stroke Consultant and the Operations Director for Division C attended the February East Federation Quality Committee to provide a further update on actions being taken to improve stroke care and performance.

UPDATE AGAIN BEFORE MARCH 2013

Patient Experience

In the 2011 CQC Staff Survey, HWPFT's score of 3.46 was in the lowest (worst) 20% when compared with trusts of a similar type. This was a decrease on the 2010 year's score of 3.48.

The following were the bottom four ranking areas that the Trust compared least favourably with other acute trusts in England:

- Staff intention to leave jobs
- Staff recommendation of the trust as a place to work or receive treatment
- Percentage of staff reporting good communication between senior management and staff
- Percentage of staff experiencing physical violence from staff in last 12 months

In the CQC Inpatient Survey for 2011, the Trust results meant that they hold the worst performance across South Central with an aggregate score of 63.

Current Actions:

The Trust's Deputy Director of Nursing and Director of HR attended the July East Federation CCG Quality Committee to talk through current actions being taken by the Trust to improve patient and staff experience.

An Insight Survey (in-house quarterly) was conducted with staff in June 2012, with a 33% response rate. Key areas for action included: work pressures/resources, procurement processes, staff development/career progression, organisational change/decision making, targets and finances, management, communication, bullying/blame, staff engagement, and car parking. Positive areas included: Heatherwood, New CEO, training and development and working together/team work.

Key Outcomes: workshop session – executive team and key staff representatives, facilitated staff focus groups, CEO-led E&D Steering group, development of health and wellbeing strategy, supported development including action learning sets, re-establishment of recognition programmes, support from the South of England Quality Improvement Initiative.

UPDATE AGAIN BEFORE MARCH 2013

Discharge

SUMMARY OF ISSUES TO BE ADDED IN.

8.8.3 Berkshire Healthcare NHS Foundation Trust - Overview

Berkshire Healthcare NHS Foundation Trust provides mental health and community health services for the people of Berkshire. They provide this care in the patient's home or as close to home as possible. Where necessary, inpatient mental health care is available through wards at Prospect Park Hospital, Wexham Park Hospital, Heatherwood Hospital and St Marks Hospital[5].

For people with physical health problems which cannot be managed at home there are community hospital beds at St Marks Hospital, Upton Hospital, Wokingham Hospital and West Berkshire Community Hospital. Some services are also based at King Edward VII Hospital. The Trust started providing community health services in April 2011 taking over this service from the Primary Care Trusts. Before April 2011 the Trust only provided mental health services. As such the Trust doubled in size at the beginning of the year and has a much larger range of services including, community nursing (for helping people at home with physical health problems), health visitors (specialist nurses supporting families with young children at home), school nursing and speech and language services, out of hours GP service for West Berkshire, sexual health services, community dental services, specialist diabetes services and end of life care.

The Trust has engaged in programmes involving clinicians, patients and other partners to improve the services they provide in mental health and community health and to use the available resources better. These service improvement initiatives are called 'Next Generation Care' for mental health services and 'Tomorrow's Community Health' for community health services. Next Generation Care was implemented at the end of 2011 after over 2 years of planning.

Quality initiatives

Productive Ward achievements to date include:

- Wokingham Hospital has reduced expenditure on dressings by working out acceptable stock levels and stopping same day delivery. The prices of all dressings are also displayed on shelving. Expenditure on dressings was reduced from £453 in September 2011 to £71 in February 2012.
- Wokingham has also halved the cost of continence products by identifying which products are used, better storage and education on the use of pads.

[5] Inpatient beds in the East are currently subject to transfer to Prospect Park Hospital.

- 'Patient Status at a Glance' (PSAG) boards for each of the three wards at Oakwood have helped with the communication of the patient's journey from admission to discharge and reduced the length of time staff take to find information. Oakwood is using an admission pack and will soon complete a discharge pack. Through this work, length of stay has been reduced dramatically.
- West Berkshire Community Hospital's Highclere ward reduced expenditure through work on distribution and use of disposables by £450 in January compared to previous months.
- Highclere occupational therapists have completely re-organised their office which has resulted in better management of space for equipment and stationery and easier communication between staff.
- Improvements have been made to ward handovers, so they take less time and staff are getting off duty promptly. Audits at Wokingham have shown it's possible to save 74 shifts a year by decreasing handover time.

WRAP (Wellness Recovery Action Planning) - Mental Health

WRAP is a self-management and recovery system. People are supported to create their own wellness recovery action plan, setting out their goals, what help they need to get there, what helps keep them well and what puts their mental health at risk. WRAP aims to increase the person's sense of control over their mental health problems, increase personal empowerment, improve quality of life and assist people in achieving their own life goals and dreams

In 2011/12 the Trust had a target of 75% of people to be offered to participate in the recovery system. 89% of people have been offered use of the tool during the year with 29.5% accepting and taking place. The Trust is now working on increasing take-up.

Performance of Talking Therapies (IAPT)

In 2011/12 BHFT were required to achieve a standard of 45% of patients treated within Talking Therapies services reaching Recovery, as defined in the Improving Access to Psychological Therapies (IAPT) service model. BHFT achieved 48% in East and 56% in West.

For 2012/13 the target was set at 54% for the West and 50% for the East. Year to date performance (Quarters 1 and 2) is 56.6% and 51.1% respectively.

Star Wards

Star Wards is a project which works with mental health trusts to enhance mental health inpatients' daily experiences and treatment outcomes. Star Wards is a service user led initiative, based on individual experience and from consultation with service users who use inpatient services.

The Trust was set a standard of 80% of those surveyed in Q4 2011/12 to demonstrate satisfaction with Star Wards implementation (based on 3 patient questions). The Trust achieved 81%.

Achievements

- In 2012 mental health inpatient wards at Prospect Park Hospital (PPH), Reading and St Mark's Hospital, Maidenhead received "excellent" ratings from the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services (AIMS) scheme. The achievement of excellence, which is a recognition of the high standards of organisation and patient care, was

awarded to Jasmine Ward (PPH) for the second time, to Daisy Ward (PPH) and to Charles Ward (St Mark's). Jasmine and Charles Wards are two of only 15 older adults' wards which were awarded an excellent score in England and Wales, and Daisy Ward is one of only 41 acute mental health wards to achieve an excellent rating.

- A pan-Berkshire team from Community Health services won £50,000 to set up a befriending service for learning disabled people. The service will be based on a secure, staff managed database which matches up users with friends of similar interests and suitable events they can attend, as well as provide information about accessing clubs and other activities, quiet times at pools and cheap cinema tickets. It aims to improve mental health and confidence for service users.
- In 2011 the West Berkshire Community Hospital and the Oakwood Unit at Prospect Park scored top marks in the National Patient Safety Agency's (NPSA) annual PEAT (Patient Environment Action Teams) assessments of food, cleanliness, infection control and patient environment. The Trust's other six facilities scored 'excellent' and 'good' – the top two scores – in all cases and the food received top marks in seven units.

Key issues

Suicides

Suicide is the main cause of premature death in people with mental illness. Nationally there are three main areas of concern:

- Inpatients dying by suicide whilst being off the ward without permission;
- The transition from inpatient to community care;
- The management of risk and risk assessment.

From the categories reported on the national SIRI database (Serious Incidents Requiring Investigation), between 1 January and 31 December 2012, BHFT have reported the following:

- 17 suicides (3 inpatient) (1 whilst on Section 17 leave)
- 2 attempted suicides (all inpatients)
- 1 suspected suicide
- 12 unexpected deaths (1 inpatient)

Current Actions:

On initial review of 2011/12 data BHFT had a lower numbers of suicides/unexpected deaths in South Central compared to other mental health trusts. BHFT had 14 incidents and the trust with the highest number had 54 incidents during the same period.

A commissioner meeting took place on the 11 October 2012 with CCG mental health representatives to look in detail at the investigation reports for a subset of the serious incidents to ascertain whether there are any themes associated with the incidents. The following concerns were identified

- Robustness of risk assessments taking place
- Trust response to urgent suicide risk referrals from GPs
- Safeguarding considerations with vulnerable individuals
- Assessment of suicide risk
- Multi agency working with complex individuals (social care/ mental health)

Work is underway to look at ways to address the above concerns including potential CQUINs for 2013/14 to incentivise improvements.

A regional suicide benchmarking project is also planned for 2013. Hosted by Oxford Health, the project aims to enable regional bench marking of suicides of patients in contact with secondary mental health services, with a view to establishing and sharing best practice particularly in relation to risk management, standardised assessment, and interventions.

UPDATE AGAIN BEFORE MARCH 2013

GP Engagement/Liaison

As part of the Trust 2010/11 CQUIN scheme, a survey of GPs undertaken to establish awareness , understanding and satisfaction with mental health services offered in Berkshire. In 2011/12 there was a CQUIN with a requirement for improvement on the 2011/12 results.

The survey was undertaken via Survey Monkey and all GP practices were informed of the survey and a reminder sent out. The percentages for the "very satisfied" and "quite satisfied" have been added together. This has also been done for the "not very satisfied" and "very unsatisfied" to gain some understanding on whether there has been improvement since the last survey. The chart below shows the results from 87 GPs in 2012 and 93 in 2011.

Service	2010/11 Satisfied	2010/11 Not Satisifed	2011/12 Satisfied	2011/12 Not Satisifed	Conclusion
CAMHS	43%	54.8%	51.2%	42.8%	There has been an improvement in those that are satisfied and in those that are not satisfied with the service.
BAU	29%	28%	36.5%	22.4%	There has been an improvement in those that are satisfied and in those that are not satisfied with the service..
Adult Inpatient	59.2%	24.8%	52.4%	23.2%	There has been a reduction in those satisfied with the service but an improvement in those that are not satisfied.
Adult CMHT	59.2%	38.8%	47.7%	44.2%	There has been a reduction in those satisfied and an increase in those who are not satisfied with service.
Eating	36.5%	33.4%	36.5%	31.8%	There is no change in

Service	2010/11 Satisfied	2010/11 Not Satisifed	2011/12 Satisfied	2011/12 Not Satisifed	Conclusion
Disorder service					those that are staisfied with the service and an improvement in those that are not satisfied with the service.
Psychiatric intensive care	6.5%	7.5%	14.2%	12.9%	There has been an improvement in those that are satisfied but an increase in those that are not satisfied with the service.
IAPT	85%	15.4%	86%	8.8%	There has been an improvement in those that are satisfied and in those that are not satisfied with the service.
Psychology	34.4%	34.4%	43.6%	27.3%	There has been an improvement in those that are satisfied and in those that are not satisfied with the service.
Older adult CMHT	73.1%	23.7%	66.1%	16.1%	There has been a reduction in those satisfied with the service but an improvement in those that are not satisfied with the service..
Older Adult inpatient service	31.2%	16.1%	38.2%	7.3%	The has been an improvement in those that are staisfied and an improvement in those that that are not satisfied with the service.

From the 10 mental health services surveyed the data shows that when compared to the previous year:

- 6 out of the 10 areas show improvement in those satisfied
- 5 out of the 10 areas show improvements in those satisfied and improvement in those not satisfied
- 8 out of 10 areas show an improvement in those not satisfied with the services
- 3 out of 10 show improvement in one of the measures but not the other
- 1 out of 10 shows same level of satisfaction and improvement on those not satisfied
- 1 out of 10 shows deterioration in those satisfied and those not satisfied. (Adult CMHT)

The Trust has stated in the clinical quality review meetings with the PCT that they are committed to improving GP perceptions of their services. A meeting was held in September 2012 with mental health and community health CCG leads and the following actions were agreed:

1. Audit of urgent referrals to CPE be conducted.
2. Letters back to GPs will state waiting times for treatment.
3. A follow up survey later in the financial year at a CCG level will be conducted with further improvement expected.
4. Clinical interface group between GPs and BHFT Clinicians will be held.

UPDATE AGAIN BEFORE MARCH 2013

Transfer of East Berkshire Inpatient Mental Health Services to Prospect Park Hospital

In March 2012 the NHS Berkshire Primary Care Trust Cluster Board approved the transfer of mental health inpatient services from Wexham Park Hospital in Slough, St Marks Hospital in Maidenhead and Heatherwood Hospital in Ascot to Prospect Park in Reading. The approval was made on the basis that these sites are not fit for purpose. Under the Clinical Services Reconfiguration (CSR) Programme a number of workstreams have been delivering the work required to make the transfer successful:

- Prospect Park Transition – Move of Ward 10 by Spring 2013
- East Transition – August 2013
- Reading Transition – April 2013
- Community Pathways – February 2013

A report to the January 2013 PCT Cluster Board **(CB/12/45)** provided an update on the overall status of the programme against key milestones and recent changes to the programme structure.

At the time of approval a set of conditions were imposed on the scheme in summary the conditions set are as follows:

1) Completion of implementation plan with clear gateways - complete
2) Establishment of appropriate community services – agreed and in development
3) The phasing of closure of East Berkshire facilities to prioritise ward 10 - complete
4) Establishment of Transport support – agreed and in development
5) Patient experience feedback to CCGs – RAISE currently undertaking inpatient interviews. Report planned for mid February
6) Quality Improvement indicators included in contractual terms and conditions – in negotiation for 2013/14 contracting round

A Commissioner Monitoring Group is in place to monitor progress on the delivery of these conditions. The group includes PCT commissioning leads, GP commissioning leads for Mental Health in East Berkshire and Programme Leads from Berkshire Healthcare NHS Foundation Trust. Overarching Programme Plans have been shared with the Commissioner Monitoring Group and a

key milestones report and risk log for the programme is presented to the group on a monthly basis. Agreed measures of key deliverables have also been monitored by this group on a regular basis.

The overall status of the CSR Programme (at January 2013) is **Green/Amber** and there is a high level of confidence that continued robust programme management will deliver the transfer successfully.

UPDATE AGAIN BEFORE MARCH 2013

8.8.4 Independent Hospitals

The PCT holds NHS contracts with a number of independent hospitals which have been approved by the Department of Health to provide treatment to NHS patients. All contracts will expire in June 2014, where they will have to be renegotiated with the providers. Deed of variations will be required in April 2013 in line with the national NHS contract.

The independent hospitals in the Berkshire West area are Spire Healthcare, Ramsay and Circle and in the Berkshire East area, Spire Healthcare and BMI.

Spire Healthcare - Reading

Spire Healthcare Reading provides services from the Dunedin hospital base on Bath Road Reading. They are registered with the CQC without conditions.

Spire Healthcare has a fully trained and equipped medical team working 24 hours a day to deal with any medical emergencies. Below gives a summary of the hospital facilities.

Total number of beds	50
Single rooms	29
Endoscopy suite	Yes
Radiology services	Yes
Operating theatres	2
High dependency unit	Yes

GPs can refer NHS patients using Choose and Book, or if there is an urgent request then referrals can be sent via a secure fax.

Spire provides Out-Patient consultations, diagnostics and In-Patient treatment to NHS patients in the following specialities working within the limits of the procedures of limited clinical value policy:

- Ear, Nose and Throat
- Gastroenterology
- General Surgery
- Gynaecology
- Pain management
- Trauma and Orthopaedics
- Urology

They have clear criteria of which NHS patients can be seen as well as specifying those who are excluded. The exclusion list includes:

- Anyone under the age of 18 years old.
- Anyone with a Body Mass Index greater than 40.
- Anyone with an acute psychiatric disorder.
- A patient that is deemed to be a high anaesthetic risk.
- A patient where a potential cancer diagnosis may be made.

Quality of services

The provider is monitored on the quality of services through the contract quality schedule and through national and local Commissioning for Quality and Innovation schemes (CQUINs). These are discussed at quarterly performance management meetings between the provider and the commissioner.

Achievements for 2011/12

- 100% of all inpatients were assessed for VTE and received appropriate prophylaxis.
- 97% of all patients would recommend the provider as a place for treatment.
- No Serious Incidents Requiring Investigation were reported.
- No falls were reported.
- No grade 2, 3, or 4 pressure ulcers developed during in-patient stays.
- The provider achieved 100% bookable appointments via the Choose and Book system.

CQUINs for 2012/13

The provider has agreed to the following CQUINS for 2012/13:

National CQUINS

- VTE - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.
- Patient Experience - The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme.
- National Safety Thermometer - monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE).

Local CQUINS

- Smoking - To improve health by ensuring that all NHS in patients who smoke are identified and provided with advice on quitting and referral to the Stop Smoking Service.
- Phlebitis Score- Percentage of adult NHS inpatients who have undergone surgery and have a peripheral cannula are assessed using the Visual Infusion Phlebitis Score.

Any Issues identified

In 2012 the provider had identified that only 70% of staff were trained in safeguarding for vulnerable adults; an action plan was put in place with the aim to have all staff trained by October 2012. The

position by January 2013 was that 96% of all staff have had the training and 100% will have received by end of March.

Ramsay Berkshire Independent Reading

Ramsay provides services from the Berkshire Independent hospital base in Wensley Road, Reading. They are registered with the CQC without conditions.

Ramsay has a fully trained and equipped medical team working 24 hours a day to deal with any medical emergencies. Below gives a summary of the hospital facilities.

Total number of beds	70
Single rooms	52
Endoscopy suite	Yes
Day surgery	Yes
Radiology services	Yes
Operating theatres	3
High dependency unit	Yes

GPs can refer NHS patients using Choose and Book, or if there is an urgent request then referrals can be sent via a secure fax.

Ramsay provides Out-Patient consultations, diagnostics and In-Patient treatment to NHS patients in the following specialities working within the limits of the procedures of limited clinical value policy:

- Ear, Nose and Throat
- Gastroenterology
- General Surgery
- Gynaecology
- Pain management
- Trauma and Orthopaedics
- Urology

They have clear criteria of which NHS patients can be seen as well as specifying those who are excluded. The exclusion list includes:

- Anyone under the age of 18 years old.
- Anyone with a Body Mass Index greater than 40.
- Anyone with an acute psychiatric disorder.
- A patient that is deemed to be a high anaesthetic risk.
- A patient where a potential cancer diagnosis may be made.

Quality of services

The provider is monitored on the quality of services through the contract quality schedule and through national and local CQUINs. These are discussed at quarterly performance management meetings between the provider and the commissioner.

Achievements for 2011/12

- 100% of all inpatients were assessed for VTE and received appropriate prophylaxis.
- No reported cases of MRSA bacteremia.
- 100% of all in-patients have a pain management plan and reviewed regularly following surgery.
- 100% of patients who have had a Modified Early Warning Score (MEWS) risk assessment on admission to hospital.
- No grade 2, 3, or 4 pressure ulcers developed during in-patient stays.
- The provider achieved 100% bookable appointments via the Choose and Book system.

CQUINs for 2012/13

The provider has agreed to the following CQUINs for 2012/13:

National CQUINS

- VTE - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.
- Patient Experience - The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme.
- National Safety Thermometer - monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE).

Local CQUINS

- Smoking - To improve health by ensuring that all NHS in patients who smoke are identified and provided with advice on quitting and referral to the Stop Smoking Service.
- WHO checklist - Percentage of NHS Daycase/Inpatients who are undergoing a surgical procedure who have the WHO Checklist completed prior to surgery.
- Phlebitis Score - Percentage of adult NHS inpatients who have undergone surgery and have a peripheral cannula are assessed using the Visual Infusion Phlebitis Score.

Any Issues identified

During 2012-13 Ramsay have reported one never event – wrong site surgery (inguinal hernia). Following the investigation it was identified that staff did not undertake the Surgical Pause Prior to Surgery as indicated in the WHO Surgical Safety Final Verbal Checklist. Additionally the thigh was marked which then became obscured with the drapes. In future for hernias the side will be marked on the abdomen. As a result all theatre staff are to undergo additional training on the importance of the WHO process; ensuring all staff are empowered to instigate the pause.

Circle Reading (contract commenced September 2012)

Circle Reading provides services from the hospital base on Drake Way in South Reading. They are registered with the CQC without conditions.

Circle has a fully trained and equipped medical team working 24 hours a day to deal with any medical emergencies. Below gives a summary of the hospital facilities.

Total number of beds	30
Single rooms	30
Endoscopy suite	Yes
Day Surgery	20 pods
Radiology services	Yes
Operating theatres	5
High dependency unit	Yes

GPs can refer NHS patients using Choose and Book, or if there is an urgent request then referrals can be sent via a secure fax.

Circle provides Out-Patient consultations, diagnostics and In-Patient treatment to NHS patients in the following specialities working within the limits of the procedures of limited clinical value policy:

- Ear, Nose and Throat
- General Surgery
- Trauma and Orthopaedics
- Urology

They have clear criteria of which NHS patients can be seen as well as specifying those who are excluded. The exclusion list includes:

- Anyone under the age of 18 years old.
- Anyone with a Body Mass Index greater than 40.
- Anyone with an acute psychiatric disorder.
- A patient that is deemed to be a high anaesthetic risk.
- A patient where a potential cancer diagnosis may be made.

Quality of services

No quality data is available as the contract only started in September 2012.

UPDATE AGAIN BEFORE MARCH 2013

The provider has agreed to the following CQUINs for 2012/13:

National CQUINS

- VTE - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool

- Patient Experience - The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme.
- National Safety Thermometer - monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE).

Local CQUINS

- Falls - Percentage of patient falls to be below 3% and a proactive prevention group established to reduce the risk.
- Phlebitis Score - Percentage of adult NHS inpatients who have undergone surgery and have a peripheral cannula are assessed using the Visual Infusion Phlebitis Score.

BMI Princess Margaret, Windsor

BMI Princess Margaret (PM) Windsor provides services from the Princess Margaret hospital base on Osborne Road, Windsor. They are registered with the CQC without conditions.

BMI PM has a fully trained and equipped medical team working 24 hours a day to deal with any medical emergencies. Below gives a summary of the hospital facilities:

Total number of beds	78
Single rooms	78
Endoscopy suite	Yes
Radiology services	Yes
Operating theatres	4
High dependency unit	Yes – 2 beds

GPs can refer NHS patients using Choose and Book, or if there is an urgent request then referrals can be sent via a secure fax.

BMI PM provides Out-Patient consultations, diagnostics and In-Patient treatment to NHS patients in the following specialities working within the limits of the procedures of limited clinical value policy:

- Breast Surgery
- Dermatology
- Gastroenterology
- General Surgery
- Pain management
- Plastics
- Trauma and Orthopaedics
- Urology

They have clear criteria of which NHS patients can be seen as well as specifying those who are excluded. The exclusion list includes:

- Children under the age of 18

- the physical status of the referred NHS patient: BMI would not be able to treat patients with unstable ASA3 and above; where the procedure is to be undertaken with general anaesthetic; or
- Where the NHS patient will require general anaesthetics, the NHS patient has a Body Mass Index of more than forty (40). Patients with BMI in excess of 40 (forty) will be reviewed on individual basis.
- patients requiring treatment for cancer who should be referred directly on to the appropriate cancer pathway

Quality of services

The provider is monitored on the quality of services through the contract quality schedule and through national and local CQUINs. These are discussed at quarterly performance management meetings between the provider and the commissioner.

Achievements for 2011/12

- 100% of all inpatients were assessed for VTE and received appropriate prophylaxis
- No Serious Incidents Requiring Investigation were reported
- No grade 2, 3, or 4 pressure ulcers developed during in-patient stays

CQUINs for 2012/13

The provider has agreed to the following CQUINS for 2012/13:

National CQUINS

- VTE - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool
- Patient Experience - The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme.
- National Safety Thermometer - monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE)

Local CQUINS

- Smoking - To improve health by ensuring that all NHS in patients who smoke are identified and provided with advice on quitting and referral to the Stop Smoking Service
- Pain - Pain scores are documented in patient's notes with every set of observations
- Discharge letters - Electronic submission of discharge letter from consultant to GP within 5 days

Any Issues identified

None Identified.

Spire Healthcare Thames Valley

Spire Healthcare Thames Valley provides services from the Thames Valley hospital base on Wexham Street Wexham and the Spire Windsor clinic on Highbury Place, Windsor. They are registered with the CQC without conditions.

Spire Healthcare has a fully trained and equipped medical team working 24 hours a day to deal with any medical emergencies. Below gives a summary of the hospital facilities:

Total number of beds	45
Single rooms	45
Endoscopy suite	No
Radiology services	Yes
Operating theatres	2
High dependency unit	Yes

GPs can refer NHS patients using Choose and Book, or if there is an urgent request then referrals can be sent via a secure fax.

Spire provides Out-Patient consultations, diagnostics and In-Patient treatment to NHS patients in the following specialities working within the limits of the procedures of limited clinical value policy:

- Ear, Nose and Throat
- Gastroenterology
- General Surgery
- Gynaecology
- Oral surgery
- Pain management
- Trauma and Orthopaedics
- Urology

They have clear criteria of which NHS patients can be seen as well as specifying those who are excluded. The exclusion list this includes:

- Children under the age of 18
- the physical status of the Referred NHS patient: BMI would not be able to treat patients with unstable ASA3 and above; where the procedure is to be undertaken with general anaesthetic; or
- Where the NHS patient will require general anaesthetics, the NHS patient has a Body Mass Index of more than forty (40). Patients with BMI in excess of 40 (forty) will be reviewed on individual basis
- patients requiring treatment for cancer who should be referred directly on to the appropriate cancer pathway

Quality of services

The provider is monitored on the quality of services through the contract quality schedule and through national and local CQUINs. These are discussed at quarterly performance management meetings between the provider and the commissioner.

Achievements for 2011/12

- 100% of all inpatients were assessed for VTE and received appropriate prophylaxis.
- 96% of patients rated the care received good or above.
- No Serious Incidents Requiring Investigation were reported.
- 98% compliant in hand hygiene audits.
- No post-operative infections or return to theatre within 48 hours.
- No grade 2, 3, or 4 pressure ulcers developed during in-patient stays.

CQUINs for 2012/13

The provider has agreed to the following CQUINS for 2012/13:

National CQUINS

- VTE - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool
- Patient Experience - The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme.
- National Safety Thermometer - monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE).

Local CQUINS

- Discharge letters - Electronic submission of discharge letter from consultant to GP within 5 days
- Phlebitis Score - Percentage of adult NHS inpatients who have undergone surgery and have a peripheral cannula are assessed using the Visual Infusion Phlebitis Score.

Any Issues identified

The provider has reported a Serious Incident Requiring Investigation which involved a confidential information leak. The investigation is taking place and has already highlighted a few issues around transportation of notes between two sites.

8.8.5 Hospice Care

Sue Ryder Care (Duchess of Kent House)

The Duchess of Kent House provides specialist palliative care services, aiming to help people live as well as possible with the effects of their illness by offering care, symptom management and support by a team of health care professionals. They offer a consultant-led medical, nursing and therapeutic service, which specialises in *palliative* care. Their services include:

- physiotherapy
- occupational therapy
- family support
- lymphoedema management
- complementary therapy
- bereavement support
- spiritual and psychological support for patients and their families
- Inpatient beds (15 bedded unit in Reading with Nettlebed Centre being available if required.)

Quality of services

The provider is monitored on the quality of services through the contract quality schedule. These are discussed at quarterly performance management meetings between the provider and the commissioner.

Finance

The building is owned by the commissioners (Berkshire West PCT) and ownership will be transferring to NHS Property. The costs, including the commissioner's rent, is £3,663k per annum which also includes an Education Facilitator. These costs are subject to CQUIN payments.

Thames Valley Hospice (Windsor)

Thames Hospice care provides in-patient and community care for people who require Hospice care. They are registered with the CQC without conditions.

They provide in-patient care at Windsor in a 17 bedded unit where they provide:

- **Symptom Control**: An admission planned to alleviate symptoms through medical intervention, usually between one and two weeks in duration.
- **Planned Respite Care**: For up to two weeks, enabling both cared for and carers to have some time off and return refreshed. Bookable in advance.
- **End of Life Care:** Specialist palliative care nursing to help patients live their lives well, right up to the end of life, and offering support to families and carers too.

They also provide other services including:

- **Patient & family services** Providing practical and emotional support to patients and their families both up to and following bereavement.
- **Complementary Therapy**, Providing a wide range of therapies in the local community.
- **Lymphoedema therapy**: a nurse-led service of people with Lymphoedema as a result of cancer and its treatment.
- **GP advice** and information sharing line.

Quality of services

The provider is monitored on the quality of services through the contract quality schedule. These are discussed at quarterly performance management meetings between the provider and the commissioner.

Finance

As it is a charity Thames Hospice Care is provided with a grant of £1,168,000 per annum. This, if charged as cost per activity, equates to around 50% of the total cost of the service provided, but allows the Hospice to continue working, in full co-operation with the commissioners, on other projects. Within that envelope an End of Life consultant who works with the local health economy is also funded.

8.8.6 Primary Care

Primary Care Commissioning will form part of the Local Area Team (LAT), structure in the new NHS Commissioning Board arrangements. This involves a period of transition between now and 1st April 2013, where there is significant focus on ensuring that all 510 existing contracts are stable and up to date in order for transfer. This work is progressing well and is expected to meet its milestones. A specific group meets monthly to ensure that risks are identified and the work is on track.

As well as this preparatory work there is business as usual with the important responsibility of ensuring that services delivered to patients are safe and of a high quality. This involves meeting with individual contractors, dealing with issues of underperformance and sharing areas of good practice. Regular newsletters are produced across Berkshire to keep in touch.

All Primary Medical contract providers will have to be registered with the Care Quality Commission for the first time by 31st March 2013. In addition, Primary Medical contractors are busy focussing on the establishment and authorisation of Clinical Commissioning Groups (CCGs).

CCGs and practices are currently working to complete the agreed requirements for the 2012-13 Quality Outcomes Framework (QOF) Quality and Productivity (QP) indicators. In the West these are aligned with CCG priorities to reducing elective referrals and non-elective admissions. CCGs and practices are currently working to complete the agreed requirements for the 2012-13 QOF QP indicators. In the East the QP indicators are aligned to working to QIPP targets on elective referrals and non – elective admissions. CCGs are working to manage the QP targets with practices.

The PCT's ***Programme of Contract Review Visits*** is continuing. There is currently a focus on East practices found to be outliers on the quarterly Practice Profile documents. Documents are now produced quarterly for all practices in East and West Berkshire. Of the 107 practices across Berkshire, 17 practices have been visited since January 2012 (and 43 since the programme began), and it is currently intended to visit a further 19 practices by March 2013.

As well as assuring compliance with key contractual requirements, the visits look to agree actions for improvement on indicators where performance is below expected levels. Completion of actions is tracked and their impact on performance is then assessed. 31 practices currently have follow-up actions in place and progress on these is reported to the GP Commissioning and Contracting Group.

Key aspects of the contract visit have included:

- Improvement in QOF achievement

- Improvement in Childhood Immunisation
- More practices providing Enhanced Services
- Improvement in practice websites to included more information for patients on performance of the practice

Other areas of development include:

- Electronic Mapping of practice boundaries – for the first time all practice boundaries are being mapped electronically to create an electronic database. This will allow all NHS bodies to identify which practices are responsible for geographical area and ensure that patients can access GP services.
- Bringing contracts up to date – all practices have been issued with revised contract documentation to ensure that contracts are up to date before the transfer to NHS Commissioning Board
- Work has also been undertaken to facilitate the transfer of Local Enhanced Services to the CCGs and the Local Authorities in advance of April 2013.

The ***GP Clinical Governance Group*** receives a regular update from visits and visiting teams are made aware of any other issues about practices raised through this group. Visits have been arranged to 3 practices following concerns identified at their Contract Review Visit.

Dental Services

The PCT has continued to achieve improvements in ***Patient Access*** with 434,779 patients accessing NHS Dental services in the 2 years up to the end of November 2012. This is a growth of 73,034 patients 20.2%) when compared to the start of the Dental Access Programme in March 2009. Most of the new patients attending NHS Dentists have returned from the private sector.

Further to Social Marketing research carried out in 2010, the PCT is now pursuing schemes to improve access for the more hard to reach groups. This includes a mobile service travelling to the more deprived parts of the county. This ***'Toothbus'*** provided free NHS check-ups for nearly 500 patients, identifying oral health issues and signposting patients to local practices. It has received very favourable local publicity including a TV report. The service covered Reading, Slough and the rural parts of West Berkshire in the period up to November 2012.

The PCT is also working with practices and local authorities to pilot the provision of ***Dental Services to Care Homes***. The service, which commenced in 7 care homes in December 2012, provides health assessments, treatments and work with the care home providers to support residents to improve their oral health.

The dental team has been working with the other two PCTs in the Thames Valley Local Area Team to develop a ***new Orthodontic contract*** to take effect from 1st April 2013. The proposed contract will combine service and quality payments. The KPIs for the quality payments will incentivise contractors to optimise resources for patient treatments, to complete treatments, use best practice treatments,

achieve effective clinical outcomes and achieve patient satisfaction with their treatment. Contract offers were made to contractors across the Thames Valley at the end of November 2012.

The Thames Valley PCTs have introduced criteria in relation to specialist referrals for ***Restorative Treatments*** (Endodontic, Periodontal and Prosthodontic) with common criteria, prior approval and the use of Any Qualified Providers for these services. The criteria were approved by the PCT in September with implementation on 1st October 2012. The 4 PCTs in the Thames Valley are now working together on commissioning services from Any Qualified Providers so that if an application is approved, the referring practices can refer to one of the providers on the list of Qualified Providers.

Current contracts for the commissioning of Oral Surgery services cease on 31st March 2013. The Berkshire PCTs are pursuing a procurement to align the service to be commissioned across the county to take effect from 1st April 2013. The PCTs are also working with the Oxfordshire PCT and the Oxford Health Foundation Trust to pilot the commissioning of a triage service that can support access to the service across the Thames Valley.

The 4 PCTs in the Thames Valley have introduced common approaches to the commissioning of Community Dental Services with establishment of PDS contracts and are aiming to move to Cost and Volume contracts in 2013/14. Alongside this, the PCTs are working with the CDS providers to develop care pathways to achieve best fit to the local dental care systems.

The Berkshire PCTs have recently commissioned additional Dental Practice Adviser support to carry out a programme of practice visits and decision making in relation to applications for Restorative treatments.

There have been two Significant Untoward Events with Dental practices this year, which have been followed up with the practices concerned with the lessons learned communicated to the wider Dental community via the PCT's 'Dentistry Matters' newsletter.

Thames Valley PCTs have been identified as a national pilot site for the development of ***Local Professional Networks (LPNs)***. The LPNs are designed to act as the vehicle for developing clinical leadership in dental commissioning. Three clinical members have been appointed, engagement events held and work has commenced on the implementation of the work programme to be pursued up to 31st March 2013.

Community Pharmacy

The Department of Health published the new Pharmaceutical Regulations 2012 on 23rd July 2012 and these came into force on 1st September 2012. The regulations govern the rules on dealing with new applications for Pharmacies and also the NHS Pharmacy contract and services provided as part of the contract.

The main ***changes to the Regulations*** are as follows:-

- All future applications for new Pharmacies will be based on the PCTs Pharmaceutical Needs Assessment which was published in 2010. This details services currently provided and identifies any needs within the area.

- The new regulations remove a number of exemption categories that currently exist in the 2005 Pharmaceutical Regulations. These were:
    - Pharmacies wanting to provide 100 hours of opening
    - Pharmacies wanting to open in "out of town complexes"
    - Pharmacies wanting to provide a "one stop shop"

  Previously it was almost impossible to refuse such requests even if they seemed completely inappropriate.
- The new regulations have also introduced a new performance management system for monitoring of the pharmacy contract. This allows the PCT to issue remedial and breach notices where compliance has been a problem including withholding of financial payments proportionate to the issue.

The annual ***Contract Compliance*** visits tor Pharmacies for 2012/13 is underway. All 153 Pharmacies have completed the self-assessment questionnaire and Pharmacies with outstanding actions have been issued with an action plan to carry out the remaining actions with a specific deadline. They are being followed up rigorously to ensure they are fully compliant with all aspects of Clinical Governance and the contact. A number of Pharmacies have been selected for a contract compliance visit following assessment using a risk matrix and as part of the PCT rolling programme. Seventeen visits have been carried out under this process. In addition there have 7 Clinical Governance visits relating to dispensing errors, concerns raised by GPs, failure to complete self-assessment questionnaire. All were issued with action plans which have satisfactorily been completed.

A ***new pilot flu vaccination service*** started on the 1st November in 17 Pharmacies in the Berkshire West area. This will be for those patients under 65 who are in the 'clinically at risk' categories and has been extended from 1st December to include any remaining over 65s who remain unvaccinated. The service is to complement services already offered by GP Practices and will give patients further choice and accessibility to flu vaccination services.

Quality of Primary Care and Primary Care Practitioners

Quality of primary care and primary care practitioners is monitored via the Primary Care Clinical Governance Group and the Primary Care Practitioners Performers Group (PCPPG) respectively and through the robust management of the Berkshire Performer Lists and the GP Appraisal scheme.

The **Clinical Governance Group** meets monthly and considers triangulated data relating to complaints, GMC queries, Significant Events and incidents. Reports benchmark performance by area and practice population size and facilitate the early identification of potential risk. Clinical Governance visits are initiated where concerns are raised, either via the work of the Group or as output from the contract review visits. To date, 9 clinical governance visits have been completed or scheduled this year. The Clinical Governance Group also oversees the review of primary care incidents reported via the Datix system or from safeguarding teams. 17 such cases have been reviewed this year with significant event analyses and learning outcomes identified and implemented.

The **Primary Care Practitioners Performers Group** meet, bi-monthly, to consider cases of individual performer concerns. As at December 2012, there were 1,545 performers on the performer's lists across East and West Berkshire. The breakdown is as follows:

Performer Group	East	West
Medical (incl GP Registrars)	410	455
Dental	249	206
Ophthalmic	106	119
Total	765	780

In the first 3 quarters of 2012/13, the PCPPG has considered 25 cases and agreed actions delivering a range of outcomes which support quality and safety for our patients. 60% of these cases related to medical performers, 20% to dental, 12% to pharmacy and 8% to ophthalmic.

The PCT has currently one Pharmacy Contractor that is undergoing an NCAS assessment and the PCT is awaiting the formal report from NCAS on this Contractor.

The Group also considers applications to the various performer's lists which have been referred by the Thames Valley Primary Care Agency (TVPCA), who manage the list process on behalf of the PCT Cluster, as queries have been identified and performer list monitoring and cleaning. In 2012/13 it has considered 74 cases, 21 of which are new applications and 53 are cases where it has been identified that the performer is no longer working in the Berkshire area.

8.8.7 Offender Health – Her Majesty's Prison and Young Offenders Institute Reading

The Health Care service at HMP & YOI Reading provides offenders with access to the same quality and range of health care services as the general public receives. This includes primary care, mental health and public health components.

The objectives of the health care service are to provide:

- Equitable access for young offenders to primary care services
- Equitable access for young offenders to mental health services liaising with external agencies to ensure integration back into the community
- Improved access to Mental Health services supporting non re offending behaviours
- Collaborative working within the prison environment with offender management and safer custody colleagues

The Primary Care Services Include:

- GP Surgery clinics (daily excluding Sundays)
- Reception Screening
- Medical response to all alarm calls
- Secondary screening following the initial Screening in reception
- Twice weekly dentist clinics
- Monthly optician appointments
- Weekly sexual health clinics (provided by an external Consultant and specialist nurses)

- Twice daily medication/treatment room clinics supported by the use of Patient Group Directions where required
- Five times daily medication administration for prescribed / regular medications
- Support early morning prisoners attending court
- Pharmacy Clinic held to offer help and support with any medicine queries supported by Medicines Management advice and support
- Chlamydia screening
- Immunisation Clinics offering MMR, Hepatitis B, Hepatitis A and Men C to all offenders.
- Hepatitis C screening
- Sexual Health provision and education
- Smoking cessation
- Physiotherapy
- Routine treatments including
    - Dressings
    - Ear syringing
    - Removal of sutures
    - Healthcare advice
- Additional healthcare support to isolated and vulnerable offenders
- Discharge packs
- Suturing
- Minor ailment triage
- Support to the Mental Health services based on clearly defined policies and procedures
- General health responses and support to all prisoners

Overall this approach provides a holistic, multi-faceted young-person centred approach to health care allowing focus on the specialist skills necessary to work with vulnerable young men and enabling a more consistent approach to transition back into the community.

Mental Health services include:

- Crisis intervention/resolution
- Primary Mental Health access and follow up
- Short term focussed work using cognitive behaviour therapy approach
- Urgent mental health assessments for high risk individuals i.e. Assessment, Care in Custody, and Teamwork (ACCT)
- Reception screening for all new receptions
- Comprehensive initial assessments which support other specialist services
- Facilitating mental health act (1983) transfers
- Case management of severe enduring mental illness using the Care Programme Approach
- Brief solution therapy
- Early intervention in psychosis
- ACCT (suicide and self harm procedures)
- Support for safer custody and those most vulnerable and needy.
- Medication review at request of general practitioner i.e. treatment resistance depression
- Mental health assessment by a psychiatrist

- Responsible medical officer for transfers
- Multi disciplinary reviews of high risk individuals
- Court reports/other report for clients receiving service from the team
- Medical management of ADHD
- Group work to include: (relevant to the client group)
    - Sleep therapy
    - Anger management
    - Anxiety
    - Coping skills
- Teaching – i.e. mental health awareness for
    - Healthcare staff
    - Prison officers

Public Health services include:

Overall responsibility for co-ordinating public health data and statistical information

- Smoking Cessation awareness and education to support primary care
- Sexual health awareness and education
- Immunization and vaccination awareness and education
- Education on Blood Borne Viruses (BBV's)
- Healthy lifestyle and coping skills workshops
- Oral hygiene education and dental triage
- Health promotion days run alongside Department of Health, Health Promotion Calendar i.e.
    - World AIDS day
    - Healthy eating week
    - Diversity
- Developing Infection control awareness, treatment and use of established pathways
- Liaise with communicable disease agencies to ensure education and awareness including Tuberculosis
- Staff training and awareness
- Established links with external Health Promotion agencies
- Parenting skill workshops
- Support group work in conjunction with Safer custody and Mental Health team where appropriate
- Health Promotion Awareness and Education
    - Healthy Eating
    - Healthy Lifestyle
    - Parenting skills
    - Health Promotion Events in line with national guidance

These services are commissioned from Berkshire Healthcare NHS Foundation Trust who sub contract elements of the primary care service out (e.g. GP and dental care). Substance misuse service is also provided by the Trust (under a separate Service Level Agreement) although this is currently out for re-tendering (not expected to be re-commissioned until 2013/14).

Prison Health Performance and Quality Indicators

Ind.No	Subject Area	Rating
1.1	Patient safety	Green
1.2	Healthcare environment	Green
1.3	Medicines management	Green
1.4	Chronic disease and long term conditions care	Green
	(incorporating GMS Quality Outcomes Framework)	
1.5	Discharge planning	Green
1.6	Clinical governance	Green
1.7	Corporate governance	Amber
1.8	Information governance	Green
1.9	Financial governance	Green
	Accepted Finance Plans based on PHDP and Prison Healthcare Budget	Yes
	Spend against budget is transparent and maintained within acceptable limits	Yes
	Prison and PCT processes are in place to review expenditure against plan	Yes
1.10	Workforce plan	Green
1.11	Equality and Human Rights	Amber
1.12	Service user involvement	Green
1.13	Health needs assessment	Green
1.14	Access and waiting times	Green
1.15	Prison dentistry	Green
1.16	Substance Misuse Activities - IDTS	Green
1.17	Alcohol Screening, Intervention and Support	Green
1.18	General health assessment	Green
1.19a	Services for Children and Younger people (under 18s only)	N/A
1.19b	Services for Older Adults (not YOI Estate)	N/A
1.20	Services for Adult Women	N/A
1.21	Primary care mental health	Green
1.22	Suicide prevention	Green
1.23	Care Programme Approach Audit	Green
1.24	Access to specialist mental health services	Green
1.25	Section 117	Green
1.26	Mental Health transfers	Green
1.27	Learning Disability	Amber
1.28	Hepatitis B Vaccination of Prisoners	Green
1.29	Hepatitis C	Green
1.30	Health Promotion	Amber
1.31	Sexual Health	Green
	Means of accessing condoms	Yes
	Access social/life skills modules on SRE education or similar	Yes
	Access to GUM clinic in prison	Yes
	Access to chlamydia screening programme	Yes
	Access to barrier protection and lubricants	Yes
1.32	Communicable disease control	Green
	TOTAL GREEN	26
	TOTAL AMBER	4
	TOTAL RED	0

Data Source: PHPQI Submission – 26 June 2012

8.8.8 South Central Ambulance Service NHS Foundation Trust

South Central Ambulance service are contracted to provide both a 999 emergency service and a Non-Emergency Patient Transport Service to the residents of Berkshire. Compliance with national standards is monitored both via the lead Commissioner (Hampshire) and within the Cluster. In Berkshire West performance is monitored at monthly review meetings and at the CCG Federation Urgent Care Programme Board. In Berkshire East performance is monitored at monthly review meetings and at the Integrated Care Board and Capacity Planning Groups. SCAS face challenges in meeting national response time targets for the Berkshire Cluster. SCAS are a key partner in the Urgent Care Programme Board which looks at their role in the wider urgent care system. Berkshire West works continually with SCAS on clinical effectiveness and access and the Berkshire Division has one of the highest non conveyance rates in the country at around 40%. The conveyance of GP urgent cases is currently being reviewed with SCAS establishing a control desk to improve this flow. Berkshire West continually work with SCAS in recognising their potential to become far more than a conveyance service and are always looking at the potential for SCAS to access alternatives pathways to A&E and develop their 'hear and treat' service. In the East the pressures around Wexham Park hospital have put a large strain on SCAS services both emergency and non-emergency over the winter months. SCAS are key partners on the capacity planning group and join daily system resilience teleconferences to help alleviate operational pressures where possible.

The most significant patient safety challenge is achieving the ambulance handover delays target. Berkshire West and the Royal Berkshire NHS Foundation Trust have worked hard with SCAS on this issue during 2012 and performance has improved. Berkshire East and Heatherwood and Wexham Park have worked hard with SCAS on this issue during 2012 and continue to recognise it as a priority. This focus needs to remain in 2013 in light of new guidance on zero tolerance to long handover delays.

8.8.9 NHS 111 implementation

SCAS have been awarded the contract to run a two year pilot of NHS 111 for the Berkshire Cluster and this will commence in Spring 2013. Patient safety underpins provision of this service and the DH will undertake robust tests of the Clinical Governance arrangements before the service goes live. Once the service is live daily reporting to the DH commences and the patient dispositions and pathways will be continually reviewed. Compliance with the National Quality standards forms part of the agreed service specification and performance against all NQR standards will be robustly monitored. NHS 111 forms part of the work programme of the CCG led Urgent Care Programme Board in the West and the work to redesign urgent care services in the East and is seen as both an enabler for the urgent care QIPP programme and a driver for improved commissioning of urgent care services.

8.9 Patient Experience

Patients tell us that they care about their experience of care as much as clinical effectiveness and safety. They want to feel informed, supported and listened to so that they can make meaningful decisions and choices about their care. They want to be treated as a person not a number and they value efficient processes.

The Government has made it clear that patient experience is a crucial part of quality healthcare provision. The NHS Constitution, the Outcomes Framework 2011/12 and the NICE Quality Standards for patient experience and service user experience in adult mental health all reinforce the need for patient centred care.

NHS Berkshire Cluster has consistently concentrated on patient experience of commissioned services as part of its overall approach to quality.

Quantitative and qualitative data on patient experience is gathered via contracts with providers, and this is triangulated with a range of other quality data and information. The PCT has a history of LINKS representatives sitting on PCT Quality Committees, and both East and West CCG Federation Quality Committees now have equivalent representation.

Most of the data gathered via contracts with providers is reflected in the sections below. Bespoke patient experience surveys are sometimes requested from providers if quality issues are identified through triangulation of other quantitative data.

8.9.1 National Patient Survey Results

The Care Quality Commission's most recent Inpatient Survey was undertaken between October 2011 and January 2012.

Heatherwood and Wexham Park NHS Foundation Trust

HWPFT had a response rate of 51% compared to a national average of 53%. The surveys sent out related to care that was provided by the Trust during August 2011. This was the Trust's busiest month and capacity was stretched with a major incident in relation to this declared.

The results of the survey showed a number of areas where the Trust were one of the worst performing including:

- The general care that was provided
- The wait to be transferred to a bed once a decision for admission had been made
- Cleanliness of the wards
- Privacy when being examined
- Noise at night on the wards
- No help at mealtimes if required
- Doctors washing hands between patients

As a result of the In-Patient survey the Trust are focusing on five key improvement areas:

- Improving communication between staff, patients and family as well as other departments in the hospital.
- Addressing privacy when discussing patient's condition and whilst having treatment.
- Reducing delays in discharge and involving the patient. Improving the flow of information to other agencies on discharge.
- Ensuring the ward environment is clean and quiet and improving the admission process to reduce waits for beds.
- Joint working between all staff to improve the overall quality of care delivered.

The Trust has already started work to address these issues by introducing CQC walkabouts, protected mealtimes, recruitment to nursing vacancies and an agency ban in general areas. They have introduced the enhancing your experience programme and started a "real time" project to look at discharge.

The Trust has acknowledged that there is a lot of work needed to improve the results, and attended the East CCGs Federation Quality Committee in July 2012 to talk in detail about the challenges and issues faced.

Royal Berkshire NHS Foundation Trust

RBFT had a response rate of 54% compared to a national average of 53%. The surveys sent out related to care that was provided by the Trust during July and August 2011.

The results of the survey showed a number of areas where the Trust was about the same in performance to the majority of trusts including:

- The level and details of information given regarding condition and treatment
- Privacy when being examined and treated
- The length of time being on the waiting list prior to admission for elective care
- The hospital not changing admission dates once agreed
- Single sex accommodation and bathroom areas
- Availability of hand gels on the ward

The following is a list of areas where improvements could be made:

- Choice of admission dates
- Noise from other patients on the wards at night
- Quality of food
- Delayed discharges
- Being informed of the side effects of medicines
- Being asked the views of the quality of care they received

Priorities for improvement for 2012/13:

- Providing a positive patient experience by improving staff attitude and communication
- Patient experience – improve staff awareness of respect and dignity

The Trust has also introduced Patient Experience Executive Walk-arounds in outpatient areas as well as inpatient wards, as these provide real time monitoring and the opportunity for instant resolution of outpatient issues.

During 2012, the Trust will also be re-instating quarterly outpatient meetings where clinical leads and other staff share ideas to develop new and innovative solutions for outpatients.

Berkshire Healthcare NHS Foundation Trust

The Care Quality Commission (CQC) published the results of the 2012 community mental health patient survey in August 2012. BHFT has historically scored poorly on this survey and the Commissioners have worked closely with the Trust on actions and improvements.

In 2012 the Trust achieved a response rate of 32%, which was in line with the national response rate for the survey. This is a significant improvement upon the 2011 survey, when the Trust achieved a response rate of 25%. The demographic characteristics were in line with the responses received nationally, and there were no significant respondent percentages within the categories of gender, age, ethnicity, religion or sexuality to note.

The CQC survey consists of 38 questions, categorized within nine Sections. A score for each question is calculated out of 10. There were some questions that were not included within the 2012 survey that were in the 2011 survey, and as part of the CQC methodology, questions with less than 30 responses are omitted from the results. The survey uses a Red / Amber / Green rating of:

Red – Lower than the majority of Trusts i.e. within lowest 20% nationally
Amber – About the same as the majority of Trusts i.e. within the average 60% nationally
Green – With the best performing Trusts i.e. within top 20% nationally

In the 2012 survey the Trust scored generally the same as other trusts in the following 6 areas; health and social care workers; medication; talking therapies; care plans; crisis care and day to day living. The Trust scored worse than other trusts in 3 areas these were: care co-ordinator; care review; and overall. The results from the 2012 survey are shown below covering the above categories in more detail.

Health and Social Care Workers

The Trust's overall score for this section was 8.5 out of 10 in 2012 and 8.2 in 2011. Although there is an improvement in the score this improvement is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are also generally about the same.
Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Did this person listen carefully to you?	8.7	8.5
Did this person take your views into account	8.3	8.1
Did you have trust and confidence in this person?	8	7.6

Did this person treat you with respect and dignity	9.3	9.2
Were you given enough time to discuss your condition	7.9	7.5

Medications

The Trust's overall score for this section was 6.6 out of 10 in 2012 and 7.0 in 2011. Although there is a decrease in the score it is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are also generally about the same.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
views were taken into account in deciding which meds	6.9	6.9
Were the purposes of the medication explained to you?	8.2	8.3
Were you told about possible side effects of the medication?	5.0	5.9
Were you given information about the medication in a way that was easy to understand	6.7	7.4
In the last 12 months, has a mental health or social care worker checked with you how you are getting on with your medication	6.3	6.6

Talking Therapies

The Trust's overall score for this section was 7.0 out of 10 in 2012 and 6.6 in 2011. Although there is an improvement in the score this increase is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are also generally about the same.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Did you find the NHS talking therapy you received in the last 12 months helpful?	7.0	6.6

Care co-ordinator

The Trust's overall score for this section was 7.9 out of 10 in 2012 and 7.9 in 2011. The Trust score on this section remain the same. The Trust scores in comparison to other Trusts in the 2012 survey are also generally worse.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Do you know who your Care Co-ordinator is?	7.6	7.0
Can you contact your Care Co-ordinator if you have a problem?	8.3	8.4
How well does your Care Co-ordinator (or lead professional) organise the care and services you need?	8.0	8.2

Care Plan

The Trust's overall score for this section was 6.6 out of 10 in 2012 and 6.5 in 2011. Although there is an improvement in the score this increase is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are also generally the same.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Do you understand what is in your NHS care plan	6.2	7.0
Do you think your views were taken into account when deciding what was in your NHS care plan?	6.5	7.5
Does your NHS care plan set out your goals?	5.8	5.4
Have NHS mental health services helped you start achieving these goals?	7.0	6.5
Does your NHS care plan cover what you should do if you have a Crisis?	6.8	6.4
Have you been given (or offered) a written or printed copy of your NHS care plan?	7.3	6.2

Care Review

The Trust's overall score for this section was 6.9 out of 10 in 2012 and 7.3 in 2011. There is a decrease in the score and this decrease is statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are generally worse.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
In the last 12 months have you had a care review meeting to discuss your care	7.5	6.5
Were you told that you could bring a friend, relative or advocate to your care review meetings?	7.1	9.0
Before the review meeting, were you given a chance to talk to your care co-ordinator about what would happen?	6.8	6.4
Were you given a chance to express your views at the meeting?	7.7	8.5
Did you find the care review helpful?	6.4	7.0
Did you discuss whether you needed to continue using NHS mental health services?	6.0	6.2

Crisis Care

The Trust's overall score for this section was 5.8 out of 10 in 2012 and 4.4 in 2011. There is an increase in the score and this increase is statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are generally the same.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Do you have the number of someone from your local NHS mental health service that you can phone out of office hours?	6.1	4.4
The last time you called the number, did you get the help you wanted?	5.5	-

Day to Day Living

The Trust's overall score for this section was 5.2 out of 10 in 2012 and 5.3 in 2011. There is an decrease in the score and this decrease is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are generally the same.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Has anyone in NHS mental health services ever asked you about your alcohol intake?	6.1	6.0
Has anyone in NHS mental health services ever asked you about your use of non-prescription drugs?	4.0	4.6
In the last 12 months, did anyone in NHS mental health services ask you about any physical health needs you might have?	4.6	-
In the last 12 months, have you received support in getting help with your physical health needs?	4.4	4.0
In the last 12 months, have you received support in getting help with your care responsibilities?	4.0	3.7
In the last 12 months, have you received support in getting help with finding or keeping work?	6.0	5.9
In the last 12 months, have you received support in getting help with finding and/or keeping your accommodation?	6.1	6.7
In the last 12 months, have you received support from anyone in NHS mental health services in getting help with financial advice or benefits?	6.5	6.1

Overall

The Trust's overall score for this section was 6.2 out of 10 in 2012 and 6.0 in 2011. There is an increase in the score and this increase is not statistically different. The Trust scores in comparison to other Trusts in the 2012 survey are generally worse.

Specific scores for each question in this section are listed below:

Question	2012 Result	2011 Result
Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?	6.8	6.2
Have NHS mental health services involved a member of your Family or someone else close to you, as much as you would like?	5.5	5.8

The Trust has advised that they will be implementing the following actions:

- Each year prior to the survey, a letter which includes all the key information and a copy of the care plan, will be sent to each service user so that they are potentially more able to complete the survey
- Continuing the care pathways work
- Introduce supervisor and peer review of care plans
- As many service users only come into contact with services through out-patients the Trust will consider how they can influence patient experience in this single session
- Communicate regularly with patients and staff about the choice and medication website

A detailed action plan has been requested from the Trust, and discussions will be on-going between the Trust, CCG colleagues and PCT commissioners and quality leads.

8.9.2 CQC Staff Survey results

In the results of the 2011 CQC National NHS Staff survey each trust was given a summary score. This score is calculated by converting staff responses to particular questions into number. The minimum score is always 1 and the maximum score is 5. For the 2011 survey the national average for all trusts was 3.62.

The results for the Berkshire Cluster providers are below.

Royal Berkshire NHS Foundation Trust

RBFT scored 3.71 which was an improvement on the 2010 result of 3.63. The Trust remained in the highest (best) 20% when compared with trusts of a similar type.

The following were the top four ranking areas from the survey where the Trust compares most favourably with other acute trusts in England:

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Percentage of staff receiving job-relevant training, learning or development in last 12 months
- Percentage of staff suffering work-related stress in last 12 months
- Percentage of staff agreeing that their role makes a difference to patients

The following were the bottom four ranking areas that the Trust compared least favourably with other acute trusts in England:

- Percentage of staff having well-structured appraisals in last 12 months
- Percentage of staff appraised in last 12 months
- Percentage of staff appraised with personal development plans in last 12 months
- Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

The list below highlights the four key findings where staff experiences have improved the most at RBFT since the 2010 survey:

- Percentage of staff appraised with personal development plans in last 12 months
- Percentage of staff appraised in last 12 months
- Quality of job design (clear job content, feedback and staff involvement)
- Percentage of staff working extra hours

Heatherwood and Wexham Park NHS Foundation Trust

The Trust's score of 3.46 was in the lowest (worst) 20% when compared with trusts of a similar type. This was a decrease on the last year's score of 3.49.

The following were the top four ranking areas from the survey where the Trust compares most favourably with other acute trusts in England:

- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- Percentage of staff appraised with personal development plans in last 12 months
- Percentage of staff appraised in last 12 months

The following were the bottom four ranking areas that the Trust compared least favourably with other acute trusts in England:

- Staff intention to leave jobs
- Staff recommendation of the trust as a place to work or receive treatment
- Percentage of staff reporting good communication between senior management and staff
- Percentage of staff experiencing physical violence from staff in last 12 months

This list below highlights the four key findings where staff experiences have improved the most at Heatherwood and Wexham Park Hospitals NHS Foundation Trust since the 2010 survey:

- Percentage of staff appraised in last 12 months
- Percentage of staff appraised with personal development plans in last 12 months
- Perceptions of effective action from employer towards violence and harassment
- Fairness and effectiveness of incident reporting procedures

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust scored 3.71 which was an improvement on the 2010 result of 3.70. The Trust remained in the highest (best) 20% when compared with trusts of a similar type.

The following were the top four ranking areas from the survey where the Trust compares most favourably with the other mental health/learning disability trusts in England:

- Percentage of staff suffering work-related stress in the last 12 months
- Staff motivation at work
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months
- Percentage of staff receiving health and safety training in the last 12 months

The following were the bottom four ranking areas that the Trust compared least favourably with other mental health/learning disability trusts in England:

- Percentage of staff appraised with personal development plans in the last 12 months
- Percentage of staff appraised in the last 12 months
- Percentage of staff working extra hours
- Percentage of staff receiving job-relevant training, learning or development in the last 12 months

The list below highlights the three key findings where staff experiences have improved the most at Berkshire Healthcare NHS Foundation Trust since the 2010 survey:

- Percentage of staff experiencing discrimination at work in last 12 months
- Fairness and effectiveness of incident reporting procedures
- Percentage of staff having equality and diversity training in last 12 months

8.9.3 Internal survey results

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust undertook a Bespoke Mental Health Service User Survey between November 2011 and January 2012. This was in response to the Trust's poor results in the Care Quality Commission (CQC) patient survey, in August 2011. The Trust took steps to put in place an action plan to improve results. The bespoke survey used a number of questions from the National Service User Survey undertaken in 2011.

The sample for the survey was generated at random from all clients on the CPA register, and also those not on CPA but still receiving specialist care and treatment from all services and teams in the Trust and who were seen between 1st June and 31st August 2011. The results from the survey are shown below covering 4 broad areas of: care and treatment; health and social care workers; care co-ordinators, care plans, care reviews & crisis care; and overall satisfaction

Care and Treatment

56% of those surveyed said their last contact with the service was in the last month compared to 23% in the 2011 CQC survey. Between 2011 and 2012 the Trust changed its contact regime so that the frequency of contact in the county now matches closely the pattern of contact nationwide; the Trust is no longer an outlier.

The Trust is committed to ensuring that all service users needing regular contact with the service are seen at appropriate intervals in line with their condition. The Trust will maintain this change of approach and scheduling of contact.

Health and Social Care Workers

67% of service users said they definitely had trust and confidence in the staff member they saw. Overall BHFT scores about trust and confidence in health professionals in comparison to 2011 have remained about the same. The Trust scores in comparison to other Trusts in the 2011 survey on trust and confidence in health professionals are also generally about the same.

BHFT are committed to ensuring that service users' views are taken into account and they are engaged with when discussing their condition and care with health or social care workers. BHFT are implementing advanced communications training for key staff, as a means of addressing issues of trust and confidence voiced by service users.

Care Co-ordinators, Care Plans, Care Reviews & Crisis Care

In the Trust's 2012 bespoke survey of patients, progress has been made in improving the organisational scores. The following key points arose:

- The proportion of service users knowing who their care co-ordinator/lead professional was rose from 40% in 2011 to 72% in 2012;
- The proportion saying they were given or offered a copy of their care plan in the last year rose from 18% to 42%;
- The proportion of service users who had a care plan setting out their goals rose from 36% to 45%;
- The proportion of service users with a care plan who said the plan covered what they should do in a crisis rose from 43% to 52%;
- The proportion of service users who knew they had had at least one care review rose from 29% to 65%; and,
- The proportion of service users who knew the out-of-hours number rose from 41% to 56%.

The results above indicate that the plans put in place by the Trust are having a positive effect on awareness.

The Trust have committed to a continuation of the process in the following areas to maintain and improve performance:

- Ensure that all service users are told who their care co-ordinator is, and how to contact them when necessary.
- Ensure that all care plans contain information about goals and crisis management if appropriate, and are regularly updated with updates independently audited to ensure compliance with Trust policies.
- Discuss with professionals ways of ensuring that understanding of the contents of care plans is improved.
- Ensure that all service users have access to a current written or printed copy of their Care plan.
- Ascertain whether the incidence of care reviews is in line with expectations.
- Review the out-of-hours access arrangements given the proportion of service users who did not have a telephone number in the local service to contact if they needed to.

Overall satisfaction

The Trust's score on the overall rating of care has improved when compared with CQC national results since 2011. The improvement in overall care ratings between 2011 and 2012: the proportion or respondents thinking that care is "Excellent" or "Very Good" rose from 48% in 2011 to 58% in

2012; and the proportion thinking that care was "Fair", "Poor" or "Very Poor" dropped from 33% to 21%.

Heatherwood and Wexham Park NHS Foundation Trust

In the 2011 CQC Staff Survey, HWPFT's score of 3.46 was in the lowest (worst) 20% when compared with trusts of a similar type. This was a decrease on the 2010 year's score of 3.49.

In the CQC Inpatient Survey for 2011, the Trust results meant that they hold the worst performance across South Central with an aggregate score of 63.

Subsequent to these results, the Trust is conducting a quarterly in-house survey to actively monitor staff perception of working and receiving care in the Trust. Results from June 2012, with a 33% response rate indicated that key areas for action included: work pressures/resources, procurement processes, staff development/career progression, organisational change/decision making, targets and finances, management, communication, bullying/blame, staff engagement, and car parking. Positive areas included: Heatherwood, New CEO, training and development and working together/team work.

8.9.4 Net promoter scores / NHS Choices

NHS Choices provides patients and the public with snapshot information about the full range of healthcare providers. Alongside indicators such as "number of weeks MRSA free" and "quality of the environment", members of the public are invited to leave comments on their experience of care with the provider. Healthcare providers are additionally given the option to respond to the comments as they are made in a public forum.

The Berkshire Cluster Quality Team has historically monitored this qualitative information, in a move to enhance the range and depth of patient experience information that is considered within the PCT. People posting on the website rate healthcare providers according to set criteria such as environment, dignity and respect, and whether they are involved in decisions about their care, and are also able to leave their own comments.

The information below covers the entire data posted on NHS choices, since the service started, unless otherwise stated.

Royal Berkshire Hospital

Total number of patients posted on NHS choices – 149
Total number of patients that would recommend the Trust – 59 out of 80 - 73%
Patient survey score for cleanliness of wards – 9.06 out of 10
Patient survey score for overall care – 8.26 out of 10

Positive comments (since June 2012):

- *I was fortunate to see a doctor in the Pain management clinic who really took the time to understand my concerns regarding my long term back pain.*

- *The Royal Berkshire Hospital provided me with first rate care and attention, not just on the date of my operation but also appointments leading to my operation were also first class.*
- *Best hospital I've ever been to. Truly brilliant!*
- *Staff were polite and helpful*
- *Liked the staff and doctors on Dorrell Ward. They were very caring and professional. The nurses explained everything they were doing for me. I could not have had a better experience on Dorrell Ward. I would like to thank all the staff who cared for me.*
- *I was so happy with the doctor who served us. My mum had injured her foot and he was so supportive and brilliant. He told us all of the needed information along with additional information. I was so pleased with the service!*
- *Medical staff – Doctors and Nurses as always brilliant - excellent - caring etc. Let down by receptionists see below.*

Negative comments (since June 2012):

- *Disastrous*
- *Worst possible experience. Never again. - I would not ever recommend this hospital. In fact I would refuse to be treated here again.*
- *Why do the receptionists think it is acceptable to talk amongst themselves when dealing with patients - even though I was the other side of the counter I might as well have been on Mars! I am not really interested in listening to the receptionists gossiping about each other - I learnt that "...is pregnant ..." "...it's been a bad week...." One of the receptionists told another that she had been trained to undertake a computer function but could not remember how to do same.*
- *Spoken to by a consultant pediatrician in an aggressive and rude manner. He shouted at me for bringing my 4 month old son to A&E as there was nothing wrong with him. My son hadn't been feeding properly for days. I got no help, no suggestions of what to do, nothing.*
- *We appreciate the fact that it isn't your fault if there are not enough Drs but there were many, many nurses on shift and nobody communicated to the people who had been waiting 3+ hrs (having been told only a 90 minute wait) that there would be an even longer delay because of several ambulance emergencies.*
- *The new booking system is a joke. This needs sorting out ASAP. Double booked, cancelled appointments, it's unacceptable.*

Heatherwood Hospital

Total number of patients posted on NHS choices – **29**
Total number of patients that would recommend the Trust – **10 out of 11 = 91%**
Patient survey score for cleanliness of wards – **8.5 out of 10**
Patient survey score for overall care – **8 out of 10**

Positive comments (since June 2012):

- *I was treated within half an hour. My ailment was assessed accurately and I was given pain relief which worked within 24 hours.*

- *The Orthopedic Unit staff was at all times professional, approachable, cheerful, compassionate and caring. They made a traumatic experience for me manageable. I couldn't have wished to have been in better hands. I would be very happy to return to the Orthopedic Unit at Heatherwood. I was treated with dignity at all times and especially when I needed assistance dressing for my discharge the next day.*

No areas highlighted negatively (since June 2012).

Wexham Park Hospital

Total number of patients posted on NHS choices – **107**
Total number of patients that would recommend the Trust – **32 out of 45 = 71%**
Patient survey score for cleanliness of wards – **8.5 out of 10**
Patient survey score for overall care – **8 out of 10**

Positive comments (since June 2012):

- *I must comment on the efficient and pleasant manner of all staff - from the receptionists and the triage nurses in both hospitals and finally the nurse who removed the item. I know that both hospitals were not very busy at that time but I have say that the level of service was exceptional. Well done NHS.*
- *I liked how kind and caring everyone was, they made me feel relaxed and offered me drinks the whole way through. The medical care was excellent; you can tell they knew their stuff!*
- *The most wonderful nurse collected Dad from A&E and put her arm around him in the most assuring way it bought a tear to my eye. He was then admitted over night to reduce a buildup of fluid. When Mum and I collected Dad the following afternoon he was happy and couldn't stop telling us about the staff that worked their socks off all night without a single moan. Well done to everyone who works at WPH my gratitude to you all.*

Negative comments (since June 2012):

- *Waiting times and lack of explanation.*

Berkshire Healthcare NHS Foundation Trust

There have been two comments left on NHS choices during Q1 of 2012/13 in relation to BHFT they are as follows:

Location of Service	Comment	Action Taken
Mental Health Services – the location was not specified	The patient shared their experience of the mental health services from July 2010 and concerns re staff apathy.	The comments were fed back to the Locality Director and Clinical Director. The patient was encouraged to contact the Trust to discuss their experience in more detail but assured that the issues they raised would be investigated.

Mental Health Services – the location was not specified	The patient had been an inpatient during April 2012 and explained that there had been concerns around the attitude of staff and the supply of medication.	The patient was encouraged to contact the Trust to enable their experience to be investigated in more detail. The limited information that was available was shared with the locality management and reinforces the Trust's commitment to review customer service training and look more closely at issues around staff attitude.

The Trust has a rating of 5 out 14 who rated the Trust under this measure 'would recommend the Trust to a friend' (35%).

8.9.5 Friends and Family State of Readiness

Improving patient experience is a key priority in the Government's vision and is set out in the White Paper '*Equity and Excellence*'. The 2012/13 Operating Framework made clear the priority for the NHS to put the patient centre-stage and to have a focus on improving patient experience:

> *"NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from "real time" data techniques.*
> *The national patient experience surveys should continue to be monitored and acted upon. In addition, as part of the National Standard Contract we shall expect each local organisation to carry out more frequent local patient surveys, including using "real time" data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made."*

Within this policy context, there will be a clear focus within the emerging NHS structures and organisations on prioritising the patient experience when commissioning care. Clinical Commissioning Groups will be expected to commission care from organisations that improve the quality of patient experience through better insight provided by individual patient feedback. Organisations providing NHS care will be expected to demonstrate that they are collecting, publishing and quickly responding to patient feedback.

On the 25th May 2012, the Prime Minister announced the introduction of the 'Friends and Family' test to improve patient care and identify the best performing hospitals in England. The introduction of the test was based on recommendations from the Nursing and Care Quality Forum who also made a number of other proposals after consulting frontline nurses, care staff and patients.

The Prime Minister said:

> *"To really make sure that patients get the right care, we're moving ahead quickly on one of their [the Nursing and Care Quality Forum] main recommendations: the friends and family test. In every hospital, patients are going to be able to answer a simple question: whether they'd want a friend or relative to be treated there in their hour of need. By making those answers public we're going to give everyone a really clear idea of where to get the best care – and drive other hospitals to raise their game."*

All healthcare providers commissioned in Berkshire were asked in September 2012 to complete a 'State of Readiness Survey' to indicate whether they were already using a 'Friends and Family test' and to identify gaps in their systems and processes that will need to be closed before the introduction of the test on 1 April 2013.

All providers ask questions in their internal patient experience surveys about whether they would recommend the hospital as a place to receive care. This is asked of all patients who have been in-patients. This is in line with what the national test will be, although the final wording of the question has not yet been agreed so providers are understandably reluctant to change wording until final guidance is published.

The providers give out their internal patient experience questionnaires on discharge using either an electronic device or a paper form. Providers vary from on the day of discharge to up to 6 weeks post-discharge as to when they ask the patient to complete and return the survey. All providers are able to track individual responses down to ward level and all providers give feedback on the results.

All providers are currently able to provide the information in a variety of languages but work needs to be done to ensure the opportunity to answer the questions is offered to people with learning disabilities or people with visual impairment.

RBFT offer patients in the emergency department the opportunity to answer the question via paper survey, website, kiosks and QR (Quick Response) devices. HWPFT do not currently offer this to patients in their emergency departments, and will need to develop systems to do so should the national test require this.

No providers currently use external sources to evaluate the responses.

8.9.6 Quality Accounts

2012/13 Quality Account Priorities[6]

RBFT

- Providing a positive patient experience by improving staff courtesy and communication, measured by reducing the average (mean) number of complaints received relating to behaviour and attitude from 4.76 to 4.3 and by increasing the weighted score from the

[6] Taken from Provider Quality Accounts which are published on individual Trust websites.

rolling inpatient survey for the question: "Involved as much as desired in decisions about care and treatment" from an average of 83 to an average of 85 for April 2012-March 2013.

- Improving the Outpatient Experience by doubling patient participation in the online NHS Choices feedback (from 31 to 62 responses per year) by March 2013.
- Decreasing hospital-associated infections by reducing the numbers of patients who are infected with Clostridium difficile while in hospital to less than 77 patients by March 2013.
- Reducing harm from sepsis by ensuring that at least 70% of patients (in the Emergency Department and Clinical Decision Unit) with a diagnosis of sepsis receive antibiotics within an hour by March 2013.

HWPFT

- Objective 1 - To ensure the early assessment of patients with cognitive impairment
- Objective 2 - To ensure that patients receive the appropriate VTE prophylaxis
- Objective 3 - To develop and launch the enhanced recovery programme for fractured neck of femur.
- Objective 4 - To increase the percentage of mothers attempting vaginal birth after caesarean section.
- Objective 5 - To improve the patient referrals and outpatient appointments booking system
- Objective 6 - To improve the patient pathway (to reduce the number of operations cancelled on the day)
- Objective 7 - To improve the documentation of preferred place of death

BHFT

- Patient experience – Patient and staff recommendation to a friend or relative of the standard of the service / overall rating
- Recovery and Wellbeing – Recovery or Wellbeing Star (or equivalent) implementation and outcomes for people with mental health problems and long term conditions.
- Physical and mental health – Psychiatric liaison and health psychology contacts.
- Clinical effectiveness – NICE implementation across the whole Trust
- Health Inequalities – Health visitor numbers and deployment in deprived areas.

8.9.7 Complaints data and information

The total number of formal complaints received by providers in 2012/13 of Q1 was 114 for RBFT, 117 for HWPFT and 58 for BHFT. Both acute trusts have received a greater number of complaints compared to the same period of last year. BHFT are below their internal threshold for the expected number of complaints for this period.

Royal Berkshire NHS Foundation Trust

The total number of formal complaints received increased during July by 81%. Of the 47 complaints received in July, 25 related to clinical treatment (16 medical, 8 nursing, 1 midwife), 11 related to communication (including behaviour and attitude), and 11 to administration.

The Trust Memory Check reports identify patient safety events that have occurred in each year that are organisational failures due to multiple factors. Incidents are identified from those reported as

Serious Incidents and describe the event and recording lessons learned. These reports are passed to the Executive for ratification before being presented at the Clinical Governance Board. Greater detail on specific themes and learning complaints has been requested from the Trust.

Heatherwood and Wexham Park NHS Foundation Trust

During Q1 2012/13 HWPFT received a total of 117 complaints. This was an increase of 42 compared to the same quarter of last year.

The consistent themes across the divisions were:

- Treatment and Diagnosis - *not happy with treatment 20%, delay in treatment, 8% results not available 3% and delay in diagnosis 4%*
- Communication - *communication with family 14%, patient/family unable to speak to someone 5%, lack of communication with patient 2%, incorrect/inaccurate information communicated 4%*
- Professional Conduct - *attitude/behaviour of staff 17%, staffing issues 2%, requests/needs not responded to 1%*
- Discharge – *discharge inappropriate 2%, discharge not co-ordinated with patient/family/carer/third party 3%*
- Appointment issues – *change in booking process 2%, long wait to receive an appointment 2%*

Examples of learning from feedback:

- The Trust has provided and continues to provide training on discharge planning.
- Any patient who returns to the Emergency Department(ED) with the same clinical complaint, within one week of initial attendance will be seen and assessed by a senior Doctor.
- Recommendations for the use of ultrasound scans in the ED to identify underlying organ injury in patients with low level rib fractures are being introduced by the Lead Consultant.
- Ensure patients are able to discuss their concerns outside of the procedure room and that staff explain as per protocol the effects that may be experienced following any procedure and that the patient understands.
- Staff to ensure patients understand reasons why admission is not necessary.
- Staff to ensure patients are given information on the criteria for ambulance transport
- The Coronary Care Unit (CCU) information letter is to be re-launched within the Acute Medical Unit (AMU) and given to all patients awaiting an inpatient angiogram so that they are aware of the treatment pathway and the timescales.
- Named consultant and medical secretary contact numbers to be sent to all parents of children with on-going care needs.
- Introduction of the Learning Disability link nurse who can support the ward staff with looking after patients with learning disability, can liaise with carers and ensure that the learning disability traffic light assessment tool is completed.
- Patients with repeated admissions to A&E should be assessed and advice sought from the consultant on call and considered for inpatient investigation.
- Nursing staff to be clear in communicating to patients that it is possible for patients to see the doctor should this be necessary and to keep patients informed when this will happen.

- Staff reflection on patient experience and learning outcomes developed for the ward from these complaints and comments.
- Development of communication boxes to support staff looking after patients with disabilities such as blindness, deafness or other communication issues.
- An additional fail safe procedure has been implemented to ensure that all clinic lists are cross checked and separated into routine follow up or further review/recall patients.
- Mental health nurses are working throughout the Trust to support staff with the management of patients with challenging behaviour as a result of mental health problems
- A review of the process that we use for transporting several patients to their discharge destinations using 1 ambulance whether they are SCAS services or private providers. There needs to be an assessment of the patients' physical condition, the length of journey that will be involved and the external weather conditions to ensure that vulnerable patients are not adversely affected by their transfer from the hospital.
- Where transport bookings are cancelled, each ward will keep a log of the reason for the cancellation to allow for reference in the future.
- Ensure that relevant patient information leaflet is given to parents at their pre-clerking appointment or as part of discharge process.
- Improve communication process for secretaries to be aware of outstanding issues during periods of absence.
- To ensure that staff are aware of and use the discharge checklist provided to ensure that relatives are kept informed and that all the necessary information goes with the patient.
- Reiterate to staff the importance of communication and managing expectations of the patient and carers/family.

The training from the 'Enhancing Your Experience' programme has been drafted and is currently being reviewed as to how best it can be delivered across the Trust. This will help to skill staff to communicate better and understand the impact certain behaviours, both positive and negative, can have. It is hoped that along with the launch of the Trust's values, which have been compiled based on feedback from both staff and patients, improvements over time will be seen in relation to poor attitude and communication.

Posters for confidentiality and consent which were approved by the Trust's Legal Department and the Lead Named Nurse for Safeguarding Children are now available and will be displayed in key areas in the Ward, PAU, Children's Outpatients and ED. This is a major part of 'You're welcome' and will be useful in educating the adult doctors in what teenagers expect. (see attached)

Berkshire Healthcare NHS Foundation Trust

BHFT received 58 formal complaints in quarter one of 2012/13. In addition, the Trust received two formal complaints that are being led by RBFT and the PCT, which involve services managed by the Trust. The three services with the highest number of direct formal complaints received by the Trust during quarter one (and the themes of their complaints) were:

Child and Adolescent Mental Health Services (CAMHS) –WAM (four) and Bracknell (two) received the highest number of complaints

- Accessibility of service
- Inaccuracies of information contained within reports

CHS – District Nursing (Bracknell one, Wokingham three) and Oakwood Ward (two) received the highest number of complaints

- Care and Treatment - this generic theme covers a number of elements of patient experience including communication, patient property and the quality of contact from staff
- Quality of dressings
- Staff knowledge of equipment

West Call – five direct complaints received and one complaint being led by the PCT

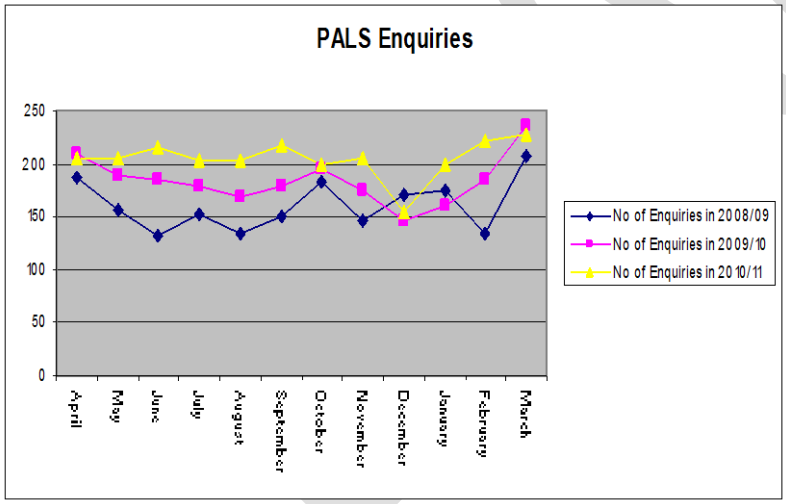
- Delays – four of the complaints contained elements around delays in waiting for Doctors.

8.9.8 PALS data and information

Royal Berkshire NHS Foundation Trust

The total number of PALS enquiries received in 2011/2012 was 2423 which is small decrease on the 2010/11 PALS figure of 2460.

Total Number of PALS Enquiries per month (2008-2011)



The table below shows the top 5 themes for 2010/11. Almost half (44%) of PALS enquiries related to administration, typically these were about appointments or the need for information. Communication and clinical treatment enquiries made up the majority of the rest. Half of the PALS enquiries were made by telephone, with visits to the office and emails equally making up most of the rest.

Subject Areas/Themes for PALS Enquiries

THEME	2010/2011
Administration	1073
Communication	633
Clinical Treatment	443
Building, Environment and Equipment	109
Personal Care	99
Others	103
Total	2460

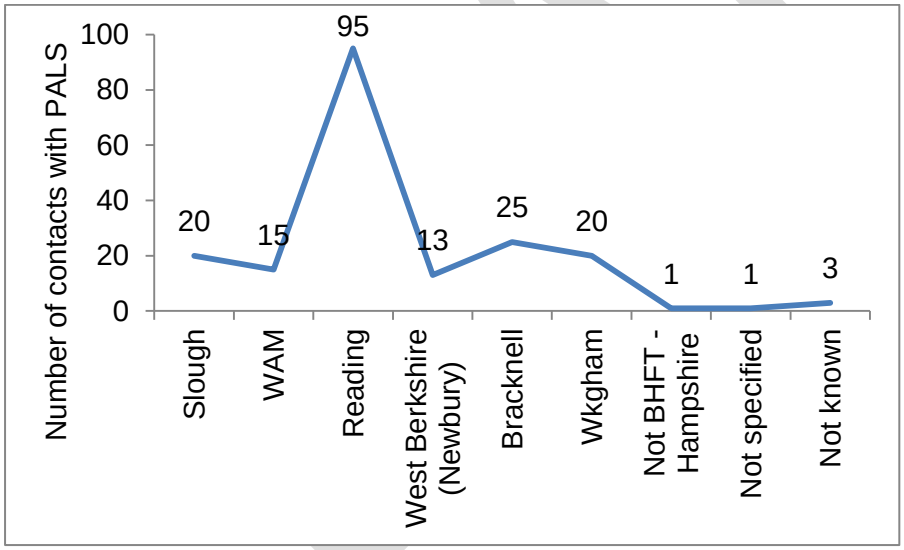
Breakdown of 2011/12 enquiries to be added.

Heatherwood and Wexham Park NHS Foundation Trust

PALS data to be added.

Berkshire Healthcare NHS Foundation Trust

The graph overleaf shows that there were 193 contacts with PALS during quarter one, 2012/13.



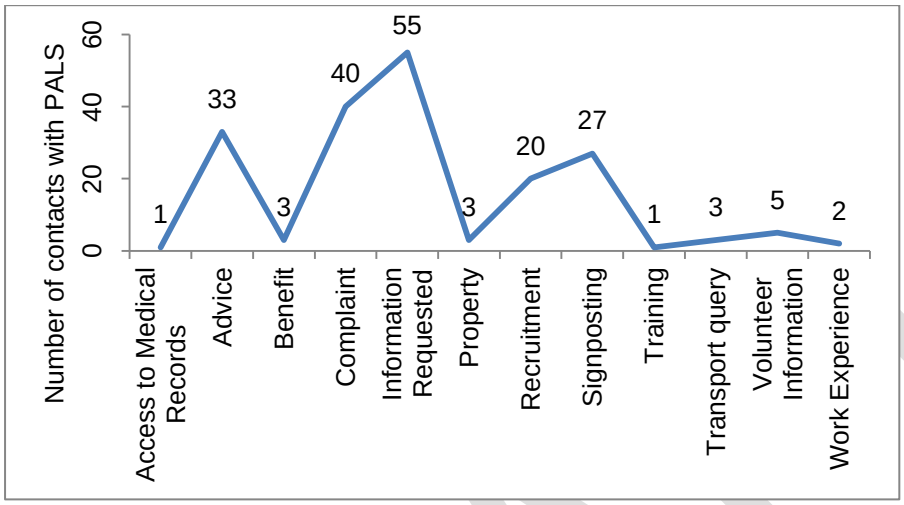
Data for quarter one 2012/13 is broken down by location of PALS service not the service locality the enquiry related to. This led to the spike in Reading on the chart above. Future data will be broken down into location of service the enquiry relates to and this will be reflected in the final Quality Handover document.

Action being taken:

- A Business Case is under review to introduce the web based Datix module for PALS which will enable greater reporting functionality for the service. This will include being able to report on informal complaints resolved within 24 hours and those which take greater than 20 days to resolve, in line with the Complaint Regulations 2009.

- There have been concerns raised at the Trust's Patient Experience and Engagement Group about the accessibility of PALS across the organisation. The Patient Advice and Liaison Officer and Head of Service Engagement and Experience are actively reviewing the service to ensure that it is equitable across the Trust.

The graph below demonstrates the types of contacts with PALS during quarter one.



Action to be taken:

- As 14% of the contacts with PALS within quarter one were in relation to recruitment, work experience and volunteer opportunities within the Trust, PALS are to review the information that is held within the service to ensure that a consistent level of information is available across the services and that they are signposted to the appropriate area. This will also be fed back to the Communications Team as PALS are being seen as a point of contact for such a wide spectrum of issues.

- PALS to ensure that contacts of this type are used as an opportunity to inform the enquirer of the benefits of becoming a member of the Trust.

8.9.9 PCT Cluster Complaints and PALS information (2011/12)

Under the Complaints Regulations 2009, patients are able to choose whether to complain directly to the NHS provider (e.g. an acute trust, dentist or GP) or to the commissioning PCT. The data below is for PALS queries and complaints received and handled by the PCT Cluster as a commissioning body.

	2012/13						**2011/12**	
	Q3		**Q2**		**Q1**			
	West	**East**	**West**	**East**	**West**	**East**	**West**	**East**
PALS Enquiries	332	334	426	385	602	420	1784	1642
Formal Complaints	52	47	39	30	19	27	82	106

PALS

For 2011/12 the most frequent enquiry method has been via the telephone, with 89% in the East and 81% in the West. Email use is increasing with 8% enquiries received by this method in the East and 14% in the West. The remaining contacts are via personal callers or letters.

The most common subject of the enquiry is:

- Information request 50%
- Access to services 15%
- Care and treatment 9%
- Financial issues/policy 7%

The patient experience team have assisted a significant number of patients with their individual issues and has also been able to support changes to service within the PCT.

In the East, the team provided the Public Health team with a list of parents who had enquired about BCG immunisation for their children in the high risk SL1 postcode area. As a result of this feedback, a number of catch-up clinics were arranged in association with the acute provider, to produce a positive outcome.

In the West, enquiries relating to dentistry ran to nearly 700 (40% of the activity level). In addition to supporting new patients registering with a dental surgery, the team determined a problem that new patients were experiencing difficulty in accessing an emergency appointment. Following discussions with the primary care team, a letter was sent to all practices reminding them of their contractual requirements, which eased the issue significantly.

Across the County, the team supported the initiative launched by Public Health team in raising breast screening awareness in the over 70 age group. This resulted in just over 170 enquiries and the team were able to reassure callers as to the rationale behind the mail out and assist them in making a screening appointment.

Complaints

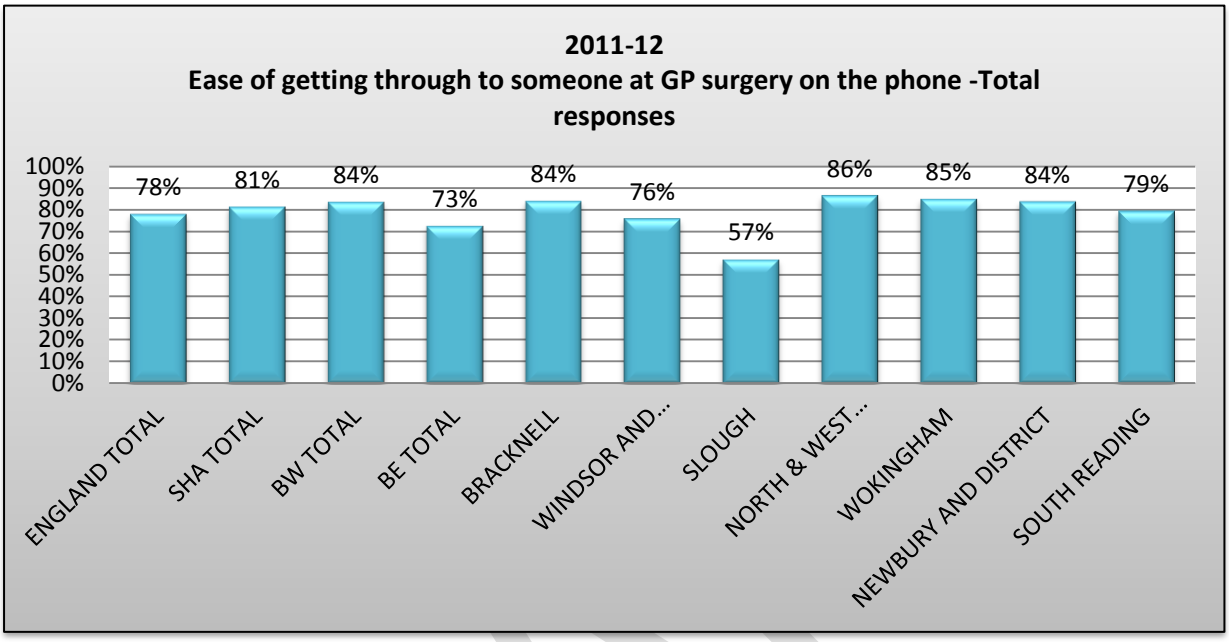
A total of 188 formal complaints were received by the PCT during 2011/12. All were acknowledged within the required three day period.

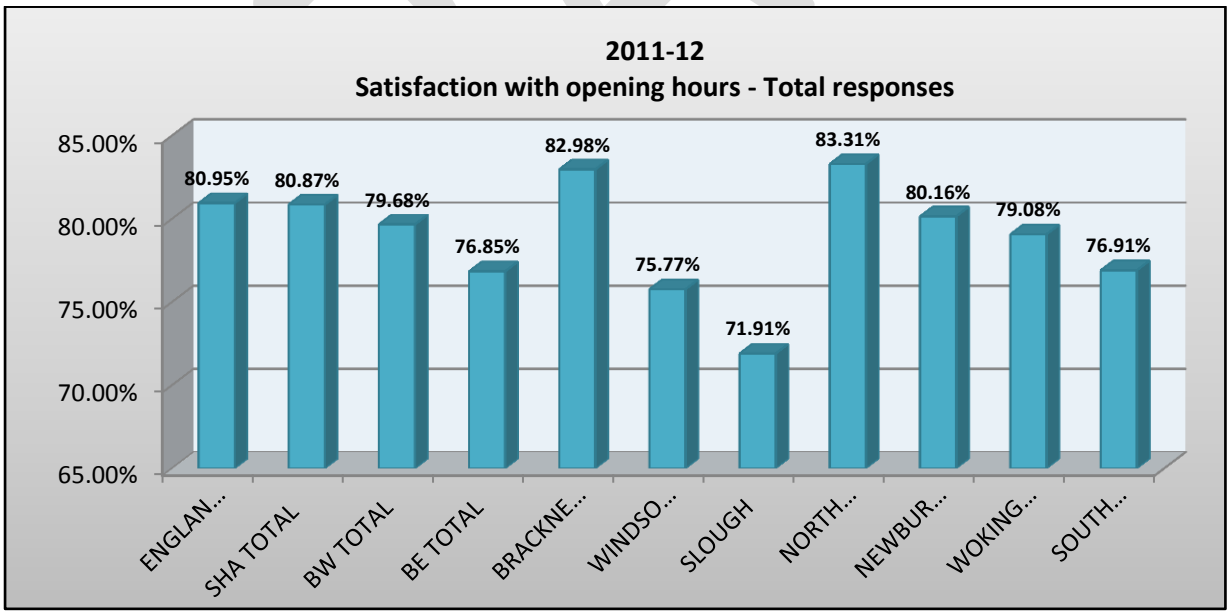
The breakdown of complaints received by the PCT in the East relate to GP surgeries (47%), acute providers (10%), dentistry (9%), commissioning (8%) and Continuing Care (7%).

For the West the breakdown is GP surgeries (41%), acute providers (16%), dentistry (11%), and commissioning (9%).

8.9.10 GP Patient Survey results

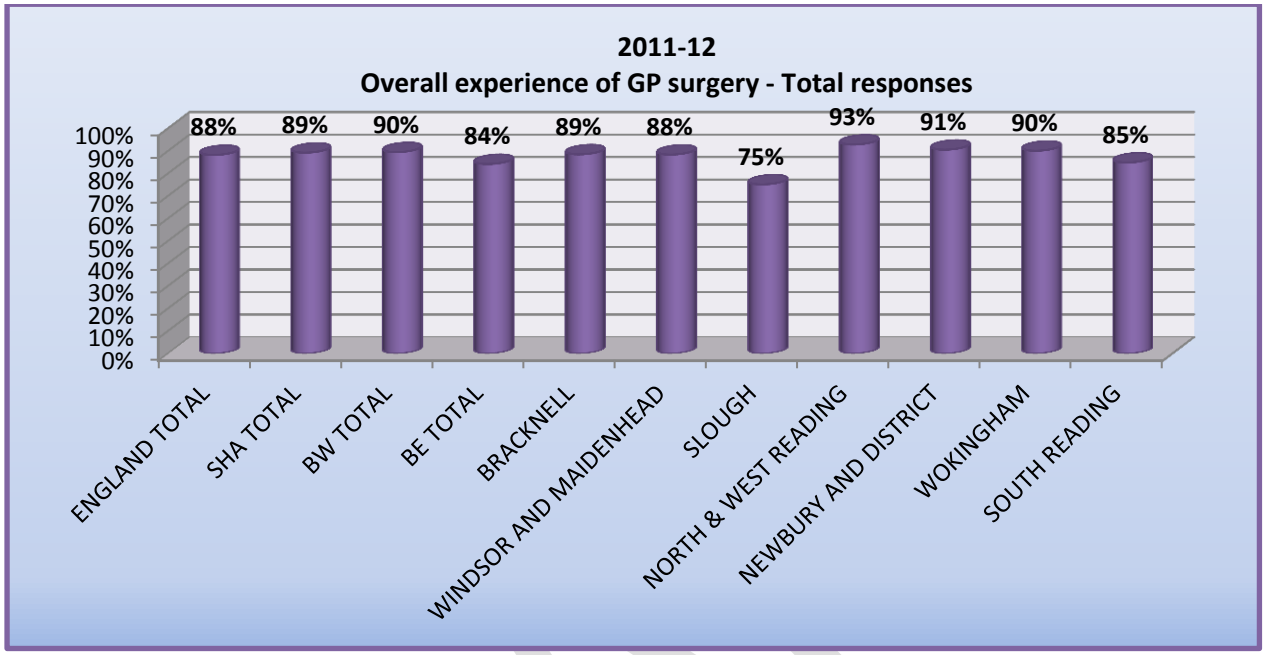
Results from national GP Patient Survey data (July 2011-March 2012) have been analysed and shared with the PCT Cluster Board and Clinical Commissioning Boards. Overall patients express a high level of satisfaction in their experience of GP surgeries across Berkshire, with five of the seven CCGs exceeding the England average. Bracknell and North/West Reading CCGs achieved above the English average to all questions.



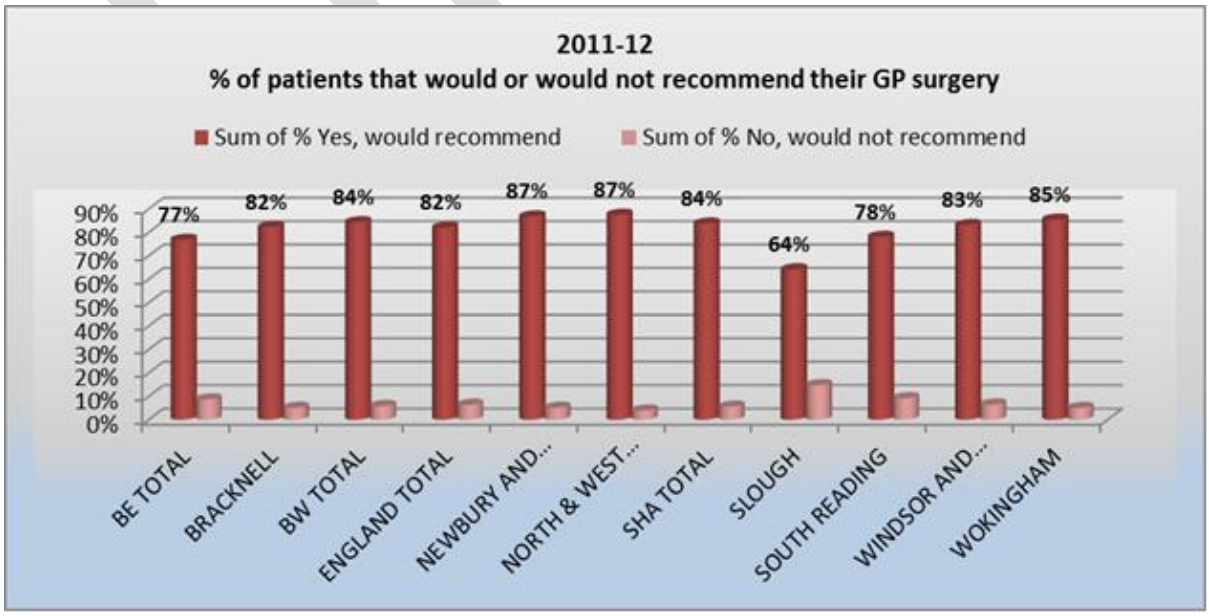


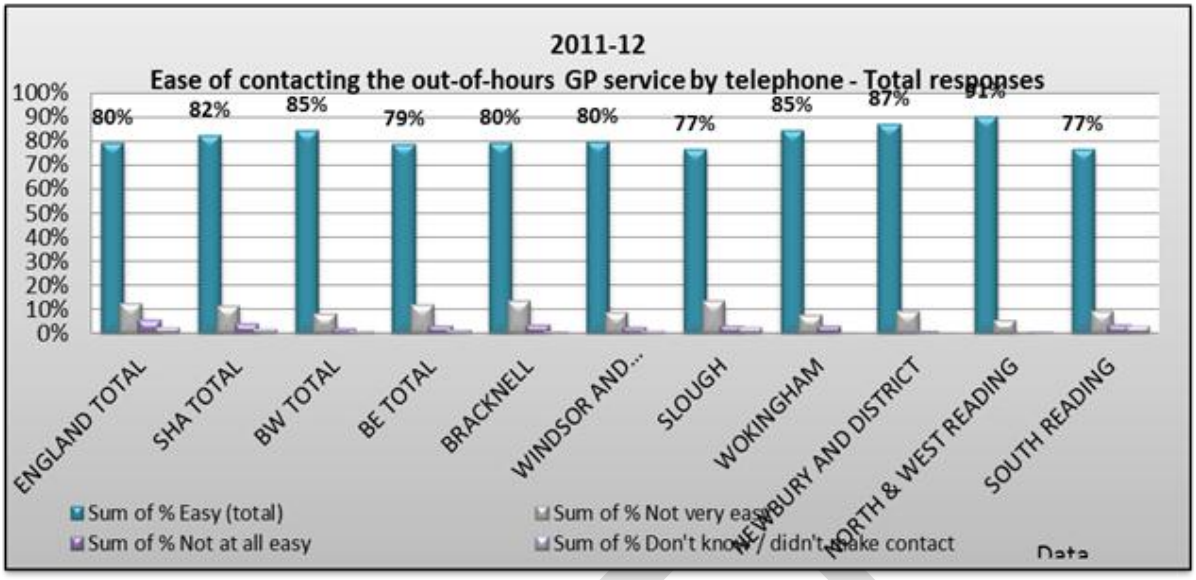
Slough CCG results are below England average across all questions and continue to present the highest area of challenge. There are some areas of specific concern when comparing Slough CCG and the England average: telephone access (57% vs. 78%), overall experience of GP surgery (75% vs. 88%), and recommending GP practice (64% vs. 82%). Slough CCG has recently reviewed and assessed its offer of appointments and collectively it does meet the national average of 5

consultations per registered patient per year. However, the CCG is committed to improving the patient experience and is now looking at variance and has commissioned a productive general practice programme aimed to assist practices to review their appointments systems. It will also work with patient groups to improve appointment systems and enable patients to access them appropriately.



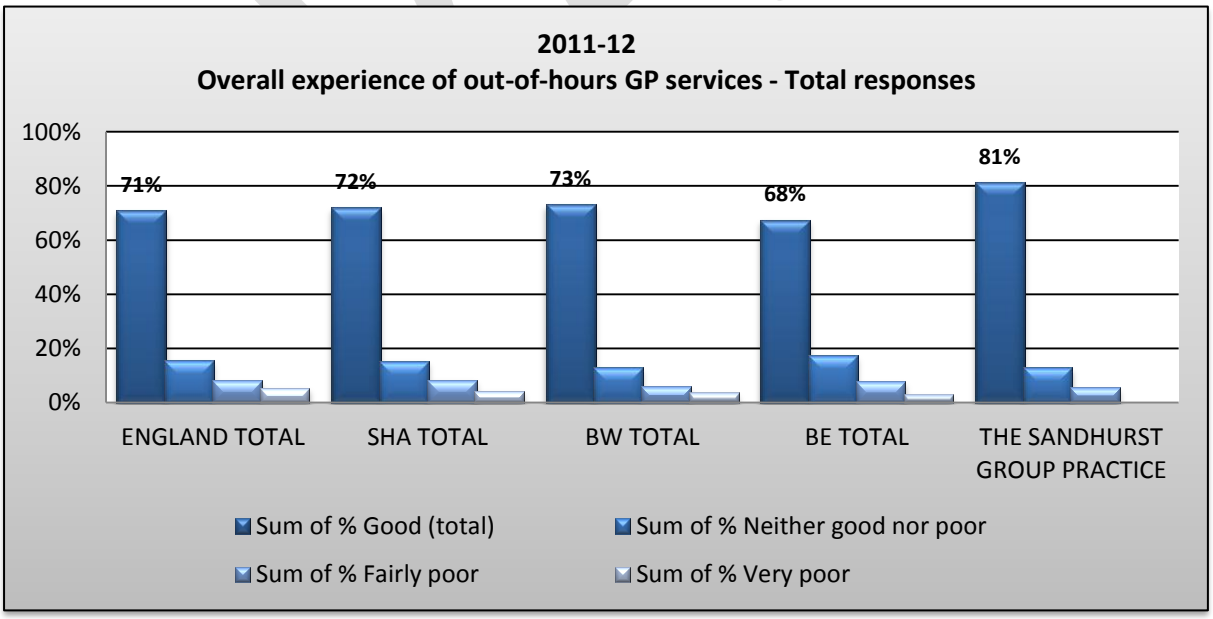
Across Berkshire, patient feedback on the whole reflects a positive experience of the GP surgeries with 5 of the 7 CCGs having over 80% of their patients state that they would recommend their surgery to others. There will be some variance within CCGs and the PCT is working with individual practices through a series of contract and clinical governance visits to address areas where improvements can be made.





Patients across Berkshire have a high level of satisfaction with the **GP Out of Hours Service** with in excess of 79% finding it easy to contact and around 70% having an overall positive experience.

Responsibility for the commissioning of GP Out of Hours service's across Berkshire will transfer from Primary Care to CCGs from 1 April 2013. Discussions are currently underway to ensure that this is a smooth transfer and that patients receive a seamless service. This is running concurrently with the establishment of the '111' service which will be closely linked to the Out of Hours.



8.9.11 Real time patient experience data

Berkshire Healthcare NHS Foundation Trust

Patient experience trackers (PETs) have been used across BHFT as a means of monitoring patient experience enabling timely change and improvements in quality of services. The Trust has reviewed and changed its PET systems across all services in the last quarter of 2011/12 so only data from the first three quarters are available.

Mental Health PETs Question	Agree / strongly agree 2010/11	Agree / strongly agree 2011/12	Strongly disagree 2010/11	Strongly disagree 2011/12	Improvement
Treated with Dignity & Respect?	96%	98%	3%	1%	Improved
Did you feel safe on the ward	73%	76%	12%	9%	Improved
Listened to?	95%	92%	2%	3%	Not improved
Involved in Care?	95%	92%	1%	3%	Not improved
Care Plan / Review?	78%	74%	6%	4%	Not improved
Know care coordinator?	91%	93%	4%	3%	Improved

Ensuring that patients accessing mental health services feel they are treated with respect and dignity and that patients on the mental health wards feel as safe as possible have been key objectives for the Trust during the past 2 years.

Patient Experience tracker results from community health services across Berkshire suggest high levels of overall satisfaction.

As part of the Trust's commitment to capturing patient experience, new electronic patient feedback devices are being rolled out across the Trust in 2012/13. Community Inpatient and Mental Health Inpatient areas have been receiving devices as part of a roll out during quarter one, with remaining areas across the Trust to follow. Some services continue to capture patient experience information through electronic devices that have previously been used, kiosks and paper surveys.

These devices contain five core questions which are asked across the organisation to enable comparison, in addition to service specific questions and demographic information. The five corporate questions are:

- How do you rate the overall care with us?
- If required, how likely are you to recommend this service to a friend or family member?
- Do you feel that you have been treated with dignity and respect?
- Do you feel you were given all the information you needed?
- Staff were polite and approachable?

Heatherwood and Wexham Park NHS Foundation Trust

Data to be added

Royal Berkshire NHS Foundation Trust

RBFT have only recently introduced trackers - data will be shared in the final version of the Quality handover in March 2013.

8.9.12 Patient Experience at the Interface between NHS Services

The NHS Future Forum report on Integration recommended that new patient experience measures should be developed to evaluate patients' experiences across whole journeys of care.

There is currently no single bespoke measure of patient experience of integration in or across the NHS. Developing measures of integration is difficult due to the very large number of potential patient journeys. But this publication highlights the data sources already available that can help NHS organisations assess experience of integrated care locally.

The Department has identified seven core questions that relate to integration of care that are already asked in existing surveys. NHS organisations can use the answers to these questions to develop a sense of how patients feel about integration between services locally at present. The seven core questions are:

Question	Source
How well does your care co-ordinator (or lead professional) organise the care and services you need?	Community Mental Health Survey 2011
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Adult Inpatients 2011
Did you receive copies of letters sent between hospital doctors and your family doctor (GP)? (Or the equivalent outpatient question – depending on response rate).	Adult Inpatients 2011
Did the doctor seem aware of your medical history?	Adult Outpatients 2011
In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?	GP survey 2011-12
Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	Cancer survey 2010
Care at Home. When s/he was at home in the last three months of life, did all these services work well together?	National Bereavement (VOICEs) Survey

When looking at specific results to questions, the results support what is already known from overall results to national surveys. Berkshire Healthcare Trust score below the standardised national figure on whether the care co-ordinator organised the care and services that the service user needed (81.7 for BHFT; 83.6 national).

RBFT scored above the standardised national figure for all questions relating to care provided by them except for whether the doctor seemed aware of the patient's medical history in outpatients (86.9 for RBFT; 89.5 national). HWPFT scored below the standardised national figure for all questions that related to care they deliver.

8.10 Safeguarding

8.10.1 Safeguarding: Transition

Until 1 April 2013 the statutory NHS responsibility and accountability for local safeguarding remains with NHS Berkshire PCT Cluster. These statutory duties will transfer from PCTs and SHAs to CCGs and the NHS Commissioning Board (NHSCB) in April 2013. Until the transfer the Interim Director of Joint Commissioning retains the executive responsibility for the Cluster. The Director of Joint Commissioning (or Representative) is the formal statutory member of the six Local Safeguarding Childrens Boards (LSCBs) and four Safeguarding Adults Partnership Boards (SAPBs) and this will continue until 31st March 2013. The Nurse Director in each CCG Federation will be the lead NHS responsible officer for Safeguarding from 1st April 2013.

Since October 2012 the seven CCGs, six Local Safeguarding Childrens Boards and four Safeguarding Adults Partnership Boards have all regularly received comprehensive briefings on the transition process and the future arrangements that will be in place from April 2013.

Slough CCG and Windsor, Ascot and Maidenhead CCG have agreed and adopted a new CCG Safeguarding Childrens and Vulnerable Adults Policy in place for transition. The other 5 CCGs will have adopted their new policy by April 2013.

Collaborative Safeguarding Training for each CCG Board has been arranged and will be completed by 31st March 2013.

From 1st April 2013 the Nurse Directors will attend the LSCBs and SAPBs in their relevant federation areas as the CCG representative.

The establishment of a Berkshire Designated & Named Healthcare Professionals Child Protection Network accepted as best practice.

There are currently no Serious Case Reviews in Berkshire.

There are currently two Partnership Reviews underway; one in Bracknell Forest Local Authority and one in Royal Borough of Windsor and Maidenhead Local Authority. Full details are included under 8.10.6.

Following the joint Ofsted and CQC Inspections undertaken over the last three years six action plans (Local Authority based) are being monitored by the Berkshire wide Safeguarding Group on a quarterly basis to ensure successful delivery and improvement.

The newly formed Central South Commissioning Support Unit has additional capacity to support and assist CCGs in discharging their duties for safeguarding vulnerable adults. These roles are in the Quality Directorate.

8.10.2 Safeguarding: Proposals for Future Arrangements Post April 2013

In September 2012, The NHS Commissioning Board published "Arrangements to secure children's and adult safeguarding in the future NHS. The new accountability and assurance framework – interim advice".

This states that CCGs will need to demonstrate as part of their authorisation process, that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding from April 2013. This includes securing the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood. This is in place for Berkshire.

The guidance also confirms that where the Designated Nurse for Child Protection is currently employed within PCTs, it is expected that their employment will transfer to a CCG. CCG hosting employment arrangements for the current Designated Nurse have now been confirmed and agreed for 1st April 2013.

Where the Designated Doctor for Child Protection is employed within a provider organisation, the CCG will need to have a service level agreement (SLA) with the provider organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their designated role. This will be in place by 31st March 2013.

The guidance goes on to state that both CCGs and the NHS CB will have a statutory duty to be members of LSCBs and (subject to the Care and Support Bill) SAPBs, working in partnership with local authorities to fulfil their safeguarding responsibilities. The draft Care and Support Bill (2012) proposes putting SAPBs on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs.

The NHS Central Southern Commissioning Support Unit (CSCSU) has additional capacity to assist the local CCGs in discharging their duties relating to Safeguarding. In early January 2013, staff in the newly formed Commissioning Support Unit together with the Interim Director of Joint Commissioning will build on this work by developing practical systems and processes that will ensure appropriate support to the CCGs is in place from April 13.

In addition, the NHS Commissioning Board will have a Director of Nursing in each Local Area Team (locally, this will be at Thames Valley level – Berkshire, Buckinghamshire and Oxfordshire). The Director of Nursing will have the lead responsibility for safeguarding for both adults and children. They will convene Local Safeguarding Networks bringing together the safeguarding leads and other key stakeholders.

CCG Governing Body Roles and Responsibilities

The NHS Commissioning Board and CCGs will have identical duties to those of PCTs, i.e. to have regard to the need to safeguard and promote the welfare of children and to be members of LSCBs. Safeguarding functions must be explicit and embedded within the duties of CCG Governing Bodies. Clinical Commissioning Groups and the National Commissioning Board will be statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and vulnerable adults. This includes specific responsibilities for Looked After Children (LAC) and for supporting the Child Death Overview process.

Discharging CCG Governing Body Safeguarding Duties

CCGs will need to demonstrate that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding, including:

CCG Governing Body Lead for Safeguarding

It has been agreed that the CCG Governing Body Executive lead for Safeguarding is the Nurse Director. In November 2012, the Berkshire West CCGs recruited to the position of Nurse Director and they will start in February 2013. The CCGs in Berkshire East have also appointed their Nurse Director who will start in March 2013.

The Nurse Directors will be an Executive member of all the CCG Boards in their respective Federation area. The role sits in the Federation and will be the lead Executive for Safeguarding. The following provides details of activities and how the role will discharge the safeguarding responsibilities of the CCG Governing Bodies:

Proposed Activities

- Member of CCG Boards as lead for Safeguarding
- Member of Local Childrens Safeguarding Boards as CCG Representative
- Member of the Local Safeguarding Adults Partnership Boards as CCG Representatives
- Member of the Federation Quality Committee to ensure safeguarding issues are reported and understood
- Member of the NHS Berkshire Wide Safeguarding Group
- Member of any Improvement Boards (where necessary)

Nurse Director Responsibilities relating to Safeguarding

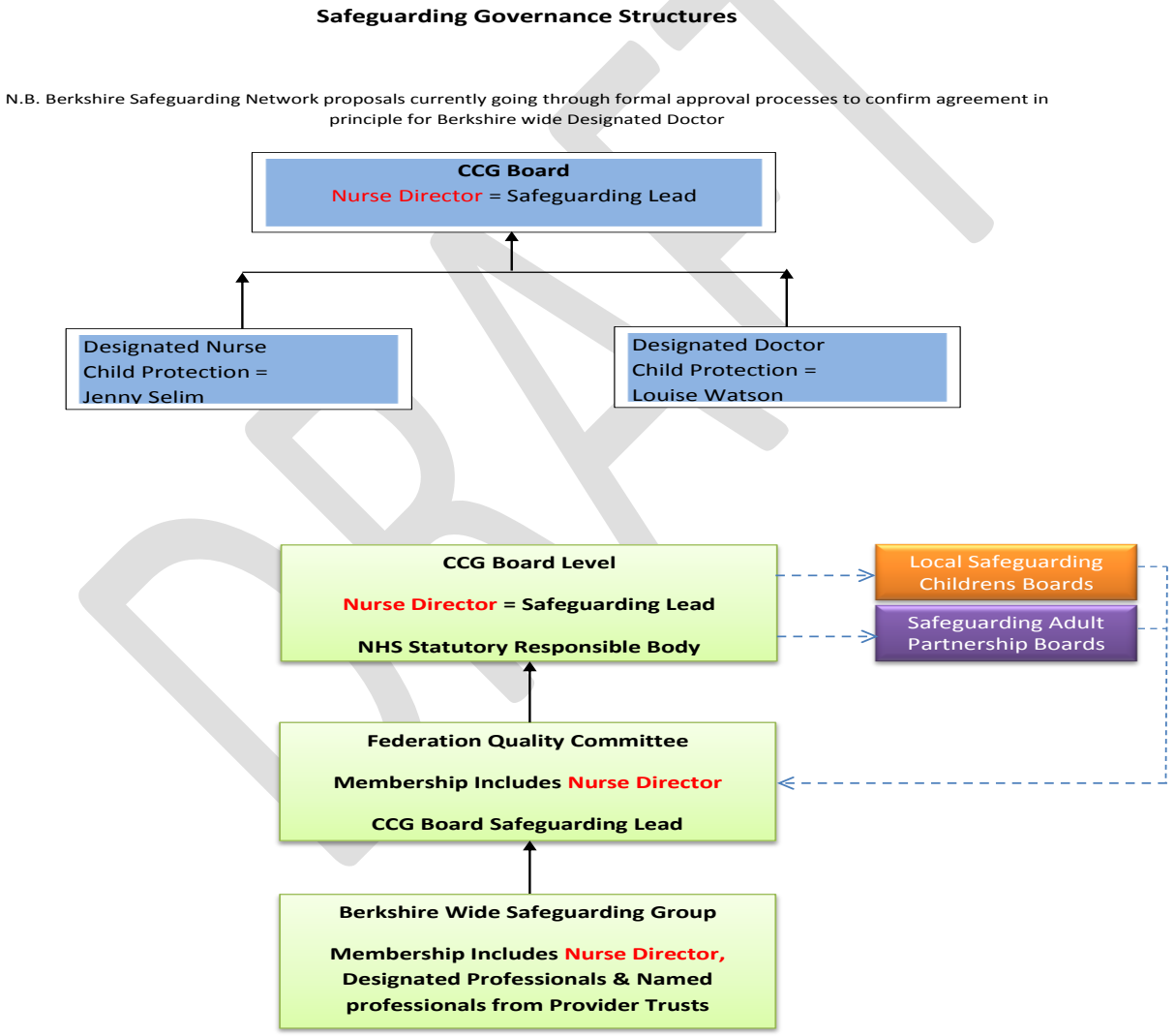
- Line management responsibility for Designated Nurse
- Safeguarding for Children and Adults: Provide support to:
  - Any Serious Case Reviews including IMRs
  - all Berkshire West Ofsted/CQC Safeguarding and Care of Looked After Children Inspections
- SUI reporting and investigation
- Provide assurance that Safeguarding training is undertaken by all Providers commissioned by the CCG
- Provide the lead for Quality and performance of Quality including reviews with all Providers.

- Provision of Quality and Safety Performance Reports to the CCG Boards
- Lead on requests from the Local Area Team (LAT) e.g. Winterbourne Assurance, Health Self-Assessment Framework for People With Learning Disabilities,

Current arrangements as set out in section 1 will remain until the Nurse Director is in post. Once in post, the Director of Joint Commissioning will transfer the responsibilities to the Nurse Director but will retain the NHS statutory accountability until 31st March 2013.

Clear Lines Of Accountability For Safeguarding Properly Reflected In The CCG Governance Arrangements

The following diagram shows the CCGs governance arrangements for safeguarding:



Plans in Place To Train CCG Staff In Recognising And Reporting Safeguarding Issues

Local CCG Governing Body Safeguarding Training has now been arranged for the CCG Boards and will be completed by the end March 2013. The training will include the staff members of the CCG Management Team.

The training will cover the new CCG governance, accountability and responsibilities for safeguarding children and vulnerable adults and the 2013/14 Revised CQC/ Ofsted Inspection Framework.

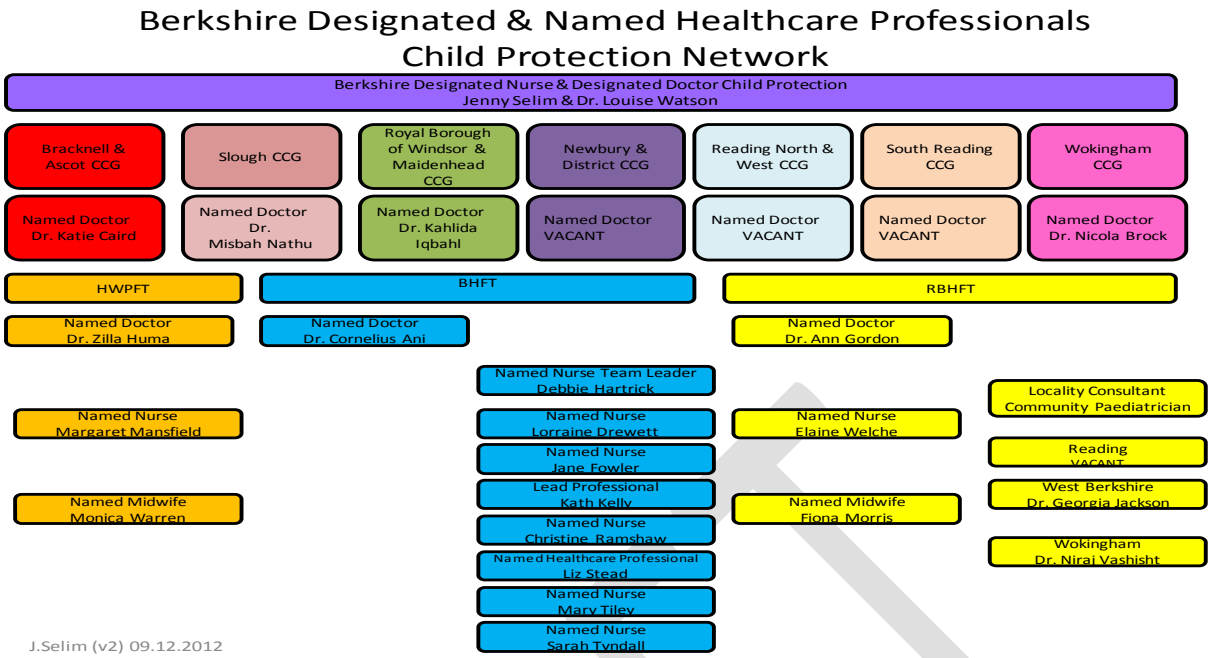
Appropriate Arrangements To Co-Operate With Local Authorities In The Operation Of Local Safeguarding Children Boards (LSCBs)and Safeguarding Adults Partnership Boards (SAPBs)

From 1st April 2013 CCGs will have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) working in partnership with local authorities to fulfil their safeguarding responsibilities. Although not a statutory requirement, it is strongly recommended that the CCGs continue to work in partnership with all agencies to safeguard adults at risk.

Securing The Expertise Of A Designated Doctor And Nurse For Safeguarding Children And For Looked After Children And A Designated Paediatrician For Unexpected Deaths In Childhood.

Local arrangements for a Berkshire wide network approach to recruitment, retention and support of Designated and Named Professionals has now been agreed and all aspects of the new Framework will be fully operational in January 2013. The proposed arrangements will provide:

- A Designated Doctor and Nurse working across Berkshire supported by:
    - Four Consultant Paediatricians (two East and two West) providing one session each for specified responsibilities.
    - An identified Community Paediatrician in each Council/LSCB area to provide support and advice to the relevant Council and LSCB, with the support of the Designated Doctor as required.
    - Named Doctors in Berkshire Healthcare NHS Foundation Trust, the Royal Berkshire NHS Foundation Trust and Heatherwood & Wexham Park Hospital NHS Foundation Trust and a Named GP for each Council/LSCB area.
    - Named Nurses in Berkshire Healthcare NHS Foundation Trust, the Royal Berkshire NHS Foundation Trust and Heatherwood & Wexham Park Hospital NHS Foundation Trust., which each also have a Named Midwife.
    - Designated Doctor and Designated Nurse for Looked After Children



Effectiveness and Assurance

The designated nurse and designated doctor will represent the CCG at any serious case review panels and continue the currently determined process for undertaking the SCR. This process is defined in the document Working Together to Safeguard Children (2010)

The CCGs Federation Quality Committee has responsibility for oversight of safeguarding adults and children. The Nurse Director will provide a monthly update report on safeguarding adults and children to the CCG Boards. The Board will also receive notification of safeguarding alerts, Serious Case Reviews (SCRs) and partnership reviews affecting local patients from the Nurse Director.

8.10.3 Adult Safeguarding Alerts

The number of adult safeguarding alerts has been increasing over recent years. It is thought that four key contributory factors to this increase are:

- The work of local NHS Trusts in raising awareness of adult safeguarding issues, and development of referral pathways.
- The new referral hub for Thames Valley Police and the increase in Police Officers' awareness of adult safeguarding issues.
- An increase in media coverage of adult safeguarding issues, which has led to increased awareness of the general public.
- An increase in demand for adult social care and health services, resulting in a proportional increase in safeguarding referrals.

The vast majority of safeguarding alerts concern older people and people with a physical disability. The next largest group of alerts relate to people with a learning disability.

Alerts concerning residential or nursing homes are usually communicated to the PCT from Local Authorities or the Strategic Health Authority. On one occasion in the last year, contact was made by the Care Quality Commission. Checks are then carried out to confirm whether there are patients for whom the PCT commissions treatment and care living in the relevant home. When this is confirmed, arrangements are made to review the safety and wellbeing of the patients. Occasionally it is necessary to move the patients to an alternative placement if their safety cannot be assured, or if it has been decided to close the home.

Work is currently in progress to ensure that the alert process is effectively transferred into CCG and CSU structures, so that the CCGs can effectively discharge their responsibility for patients who are receiving care which is commissioned by the CCG.

8.10.4 Serious Case Reviews / Domestic Homicide Reviews (Adults)

Safeguarding Adults Partnership Boards have responsibility for deciding whether or not to undertake a Serious Case Review (SCR). One potential SCR is currently being considered in Slough (an Individual Management Review (IMR) has already been undertaken and submitted with respect to this case) and one other has taken place in Berkshire in the last year.

When a SCR is required, investigating officers are identified in each NHS organisation from which a patient has received services, who then undertake an IMR. In the case of Primary Care, a review (including medical notes review and compilation of a chronology) is undertaken by one of the NHS Berkshire GP Quality leads and reviewed by the Medical Director prior to inclusion in the IMR. The IMR is then signed off by the Director Lead for Safeguarding and submitted to the Safeguarding Adults Board.

One Domestic Homicide Review has been required this year. These reviews are commissioned by Community Safety Partnerships and conducted in accordance with Home Office guidance. Recommendations of this review will be reported following the completion of formal processes.
Recommendations and actions for commissioners from Serious Case Reviews will be handed over in face-to-face meetings with relevant receiving organisations. The location of action plans at point of handover will be detailed in Section 11.

8.10.5 Serious Case Reviews (Children)

A key function of Local Safeguarding Children Boards' (LSCBs) is to undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or been seriously harmed, and there is cause for concern about the way in which agencies worked together to safeguard the child.

Three serious case reviews were undertaken in Berkshire during 2011. Each case is subject to criminal proceedings and therefore details are not included. Thematic learning from the cases has been shared with GPs via a newsletter and presentations at training events.

The quality of IMRs, recently submitted on behalf of health services in Berkshire, was evaluated by Ofsted to be adequate or good. The health overview reports were evaluated as being of good quality.

If cases do not meet the criteria for a SCR the LSCB may elect to undertake a partnership review of a case if it considers that there is multi-agency learning from the case. There are currently no partnership reviews in progress although a number have been completed across Berkshire recently and reported via the LSCBs and learning from the reviews is disseminated within provider organisations.

Recommendations and actions for commissioners from Serious Case Reviews will be handed over in face-to-face meetings with relevant receiving organisations. The location of action plans at point of handover will be detailed in Section 11.

8.10.6 Partnership Reviews (Children)

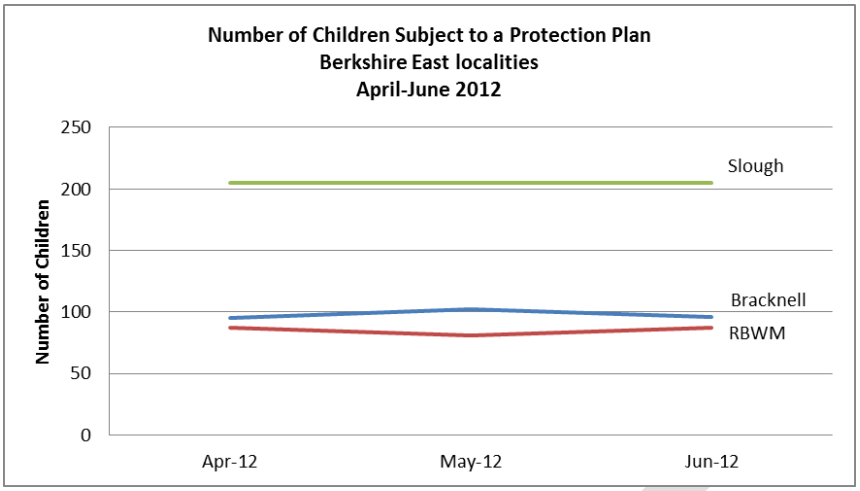
Currently there are two Partnership Reviews being undertaken in Berkshire:

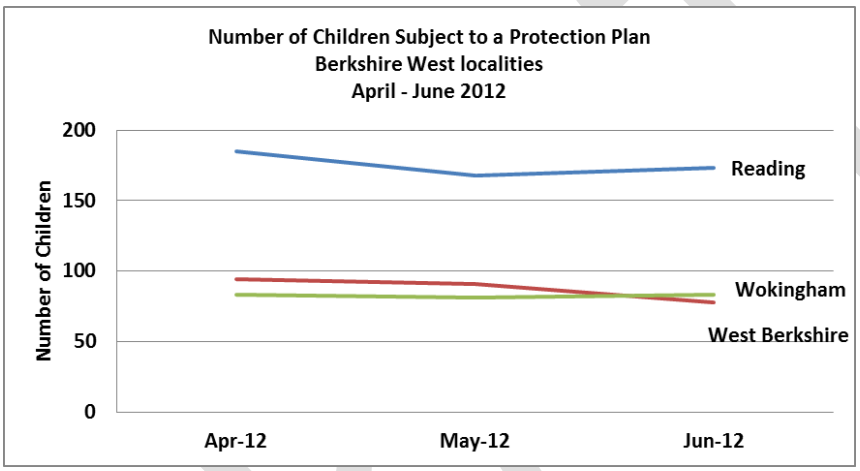
Bracknell Forest Local Authority. A child sustained physical injuries whilst in the care of his parents. The child is now in foster care and reportedly progressing well. The child's father has been arrested. The case is with the CPS so we have no further information about criminal proceedings. The LSCB determined that chronology of agencies involvement be undertaken. It is planned that an independent facilitator will be appointed to guide a partnership review involving practitioners involved with the case. The purpose being to identify learning and make recommendations for practice. This is still a work in progress at this point in time. The Designated Nurse for Child Protection will review the chronology once available to identify specific issues for health services.

Royal Borough of Windsor and Maidenhead Local Authority. A home visit was made by police following the arrest of a family member. At the home visit police observed a child to be unwell. The child was subsequently taken to hospital and found to have serious injuries. The child was transferred to JRH and is now recovering in foster care. The LSCB requested chronologies of agencies involvement. This is also a work in progress.

8.10.7 Number of Children subject to a Child Protection Plan

The following tables illustrate the numbers of children subject to a child protection plan in the first quarter of the 2012/13 in each of the localities across Berkshire East and West. The areas of Reading and Slough continue to have more children subject to a child protection plan than any of the other four areas. These Council areas also have a significantly higher number of referrals than their Berkshire neighbours. The highest category of abuse continues to be that of neglect. This is reflected in national statistics for category of abuse.





8.10.8 Joint OFSTED and CQC Inspections (Looked After Children and Safeguarding)

Ofsted and CQC completed their joint, announced, inspections of local arrangements for safeguarding and looked after children in Berkshire in July 2012.

Reports of the outcome of these inspections are available on the Ofsted and CQC websites. The table below provides a summary of CQC judgements. Areas of good practice across the health economy, in safeguarding children were identified by inspectors. Action plans are in place to address areas for improvement in services. The action plans are monitored at the PCT safeguarding children & adults meetings, chaired by the PCT Director of Joint Commissioning.

Joint OFSTED/CQC Reviews into LAC			
LA	**Last Inspection Date**	**Overall Rating**	**Being Healthy Rating**
Reading	February 2012	Adequate	Inadequate
Wokingham	July 2010	Adequate	Adequate
West Berkshire	July 2012	Good	Adequate
Bracknell Forest	October 2011	Good	Good
RBWM	March 2012	Adequate	Adequate
Slough	April 2011	Adequate	Good

Joint OFSTED/CQC Reviews into Safeguarding			
LA	**Last Inspection Date**	**Overall Rating**	**Contribution of Health Agencies to Keeping Children & Young People Safe Rating**
Reading	February 2012	Adequate	Adequate
Wokingham	July 2010	Adequate	Not Assessed
West Berkshire	July 2012	Adequate	Good
Bracknell Forest	October 2011	Good	Good
RBWM	March 2012	Adequate	Adequate
Slough	April 2011	Inadequate	Good

Data Source: PCT Monitoring and OFSTED Inspection Reports

A joint action plan is in place between the Local Authority (LA), health providers and commissioners for both safeguarding and Looked After Children (LAC). A needs assessment and service review of health services for Looked After Children across Berkshire has been undertaken and a draft strategy is with partners for sign off. A pan-Berkshire multi agency strategic group has been set up to monitor the quality of health services for LAC. An update against actions relating to the 'inadequate' rating in Reading will in included in the final version of the Quality Handover document in March 2013.

Although the health contribution of health agencies to keeping children safe was rated as "good" in Slough, the overall rating was "inadequate". Therefore, an independently chaired Safeguarding Improvement Board was established, which is accountable to the Department of Education. Regular progress reports are submitted, which reflect satisfactory progress. The PCT is represented on this group by the Director of Joint Commissioning.

A revised inspection programme will commence in April 2013. It is proposed that these inspections will be unannounced, will take place over a two week period and will include inspectors from Ofsted, CQC and HM Inspectorate of Constabularies. The revised inspection framework will focus specifically on a child's journey through services. Inspectors may request to accompany practitioners on visits to children and families in their homes or at other places where services are provided for children. These inspections will take place at a minimum interval of three years. The revised inspection framework will not specifically include services for looked after children as these services will now be inspected separately at a minimum interval of four years.

Preparation will be required to ensure adequate performance within the new performance framework – which will be led by the CCG and NHS Provider Trust Board leads, Designated and Named Professionals.

8.10.9 Providers with formal CQC warnings in place

No providers have current CQC warnings in place.

8.11 Learning Disabilities

8.11.1 Winterbourne Assurance

The BBC transmitted a Panorama programme in May 2011 that uncovered the mistreatment and assault of adults with a learning disability and autism at the hands of unmanaged staff at Winterbourne View. Following this programme South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review.

From this review, NHS South of England produced 115 recommendations that have been collated from the following reports of which 45 relate to the NHS and the local authorities:-

- Winterbourne View Hospital: A Serious Case Review
- Report of the NHS Review of Commissioning of Care and Treatment at Winterbourne View
- Care Quality Commission, Internal Management Review of Regulations of Winterbourne View
- Care Quality Commission, Learning Disability Services, Inspection Programme, National Overview
- Out of Sight, Mencap and Challenging Behaviour Foundation

The main focus in these recommendations is develop robust contractual agreements with a firm process for reviewing and tracking individuals in NHS and local authority funded placements. In addition ensuring a cohesive communication process for raising alerts to safeguard the well-being of vulnerable adults with a learning disability and autism.

NHS Berkshire developed a process to address these recommendations through forming a Learning Disabilities Steering Group that comprises representation from the six unitary authorities, Berkshire Health Care NHS Foundation Trust, Acute Trusts and PCT Commissioners.

The Steering Group will also address the requirements of letter issued on 28th November 2012 by the NHS Chief Executive, Sir David Nicholson that requires immediate action for Primary Care Trusts (PCTs) to ensure they identify all people with learning disabilities or autism, who also have a mental health condition or challenging behaviour, and who are in NHS-funded care. After completing this exercise PCTs will be required to make specific handover arrangements to ensure that every Clinical Commissioning Group (CCGs) knows whose care they are responsible for, and what they will need to do to review their care.

The steering group will look to complete this work before formal handover to CCGs in April 2013 and the primary aim for this group will be to provide assurance on key deliverables that are listed overleaf:

An interim report on the progress against the Winterbourne Assurance Action Plan was provided to the NHS Berkshire Cluster Board on 22 January 2013 **(CB/12/46).**

No	Descriptor	Task	Deliverable	Lead	Timeframe
1	Review the recommendations of the serious case review to provide assurance for people with a learning disability in residential placements	The Learning Disability steering group to oversee and develop actions to address the recommendations of the serious case review and report output to the CCGs	Develop a series of meeting with the steering group to align specific responsibilities for people to lead and action. Meet safeguarding lead to identify actions for LA's	Lead Commissioner for LD	On-going
2	NHS Contract for all 'spot purchased' patient placements which includes prominently both quality and safety measures, and in particular a requirement for the commissioner to be informed directly of any untoward incident.	Review all NHS funded learning disability placements and ensure that there are contracts between providers and commissioners. Develop a consistent contractual framework to safeguard the well-being of people with a learning disability. Contracts to include robust governance arrangements to achieve value for money demonstrating effectiveness and clear outcomes	Collate information related to individual NHS funded placements through CHC and local authorities to identify gaps in contractual agreements and consolidate these arrangements through issuing contracts to providers	Lead Commissioner for LD	31st March 2013
3	Health and Social Care Reviews	Collate information related to NHS funded placements through joint agreements with local authorities and Continuing Healthcare to identify review date Collate information related to the review process framework through gathering information from Local authorities and continuing health care to develop an overarching health and social care review process to achieve consistency across all health and social care organisations	Conduct a gap analysis in the provision of individual reviews and provide costings for ensuring that all individuals in placements have had a review from October 2012 to 31st March 2013 Develop a cohesive and consistent framework for reviewing individual placements that is embedded across all health and social care organisations	Lead commissioner for LD & Head of Learning Disabilities for BHFT Lead Commissioner for LD and the steering group	31st January 2013 25th January 2013
4	Safeguarding Alert Process	Consolidate and roll out the newly formed alert process to all NHS, Partnership Boards, CCGs and social care organisations	Roll out the NHS alert process to all stakeholders	Adult Safeguarding Lead – Quality team	To be agreed

Risks

Risk	Mitigating action	Responsible officer
Lack of compliance and commitment of the steering group to support the PCT to complete the above tasks	Continue to operate the LD steering group meetings to address the recommendations of the serious case review and develop a clear process for communicating key actions with all the stakeholders	LD Commissioning Manager
Identification of people in NHS funded placements'	This exercise has already been rolled out and information is being collated by the LD Commissioner	LD Commissioning Manager and Head of LD for BHFT
Cost and resources for conducting individual reviews by March 2013	LD Commissioning Manager to identify costs and numbers of patients that will be reviewed	Interim Director for Joint Commissioning
Contractual agreements with providers	Identify an effective contractual framework to agree with providers to include key performance indicators through effective communication and collaborative operations with all stakeholders	BHFT, Local Authorities and the PCT
Safeguarding process	PCT to ensure that the NHS alert process is agreed through all 6 unitary authorities, Acute Trusts, BHFT and the community teams to adopt a consistent approach to raise safeguarding alerts	Interim Adult Safeguarding Manager - Quality team

Monitoring Arrangements

The Learning Disability Commissioning Manager will arrange series of meetings with the 6 unitary authority partnership leads, the community learning disability teams and providers to complete the above tasks, track activity and report outcomes to the Head of Mental Health Commissioning and the Director for Joint Commissioning to update the CCGs

8.11.2 Learning Disability Health Self-Assessment Framework

The Learning Disability Health Self-Assessment Framework (LDSAF) is being implemented nationally by the DH as part of 'Valuing People Now' (2009) and the 'Six Lives Report'.[7]. The framework is designed to enable PCTs to have a better understanding of the needs, experiences and services provided for people with learning disabilities in their area, through data collection and consulting with people with learning disabilities and family carers.

Each year Primary Care Trusts across the country have to complete an Annual Learning Disability Health Self-Assessment Framework. This is an important report that explores how well Commissioners and providers are meeting the health needs of people with learning disabilities and

[7] Six lives: the provision of public services to people with learning disabilities. Parliamentary and Health Service Ombudsman 2009.

their families. In order to ensure that the report is an accurate reflection of people's real experience, the Primary Care Trust (PCT) made sure that the views of people with learning disabilities and families are included. The assessment gathered information of people's experience of access to health, people with complex needs, safeguarding, quality and governance. The 2012-13 assessment was based on providing assurance against the following national reports:-

(i) Death by Indifference – MENCAP
(ii) Six Lives Report
(iii) NHS Operating Framework
(iv) Winterbourne View Hospital – A Serious Case Review

Methodology

The PCT formed a Learning Disability Health Assessment Steering Group that comprised representatives from the 6 unitary authority Partnership boards, Provider services, Berkshire Healthcare NHS Foundation Trust, voluntary organisations and the PCT.

This group ran two pan-Berkshire meetings to gather information from service users, carers and professionals and to draw information about people's experiences of LD services. These meetings were an opportunity to celebrate the good work in Berkshire and identify gaps.

The process gave the LDSAF steering group an opportunity to discuss good practice within mainstream and specialist service health care practice, sharing direct feedback from people with learning disabilities and family carers about their experiences.

NHS South of England has commissioned the Health and Social Care Partnership (HSCP) to arrange and support the validation process for the LD HSAF 2012-13 submissions. This will be a two-part process and will differ to previous years to reflect the changing nature of the health system architecture and to provide an opportunity for greater involvement from Learning Disability Partnership Boards.

Stage 1

In previous years the SHA ran face to face validation meetings between commissioners, people with learning disabilities and family carers. In its place, HSCP will provide a written summary of Berkshire's submission, including any issues it identifies. A final version will be agreed between PCT commissioners and HSCP including recommendations and timescales for use in the second stage of the validation process.

Stage 2

This will be run through scheduled Learning Disability Partnership Board meetings where possible. At a future Partnership Board meeting, CCG leads and PCT leads will be invited to share the final validation report with their local Partnership Board. It is intended that at this meeting, people with learning disabilities and family carers will have an opportunity to ask questions about the plans of local health commissioners as CCGs take on local responsibility. Therefore, this meeting will also serve as a 'handover' from PCTs to CCGs.

The HSCP will advise the PCT and the Partnership board of the time-scales of their visits.

A copy of the full HSAF is available, please refer to Section 12 for details.

8.12 Continuing Healthcare

Continuing health care (CHC) is a service provided by the PCT Cluster and is a statutory function. The role of the CHC service is to assess and commission care for individuals with complex long-term healthcare needs who meet the eligibility criteria to receiving full funding of their care by the NHS. The majority of the care commissioned is on a named patient basis and is provided by the independent and to a lesser extent the voluntary sector. The range of patients receiving CHC funding is wide and includes such conditions as advanced dementia, specialist end of life care & palliative care, brain and spinal injury, advanced neurological conditions and other complex long-term conditions. In addition to providing this assessment and placement service the CHC team also assess and fund individuals in nursing homes who are entitled to have their qualified nursing costs funded by the NHS. This is called NHS funded nursing care. The CHC team also includes the commissioning of community equipment and the assessment process for children with complex care needs.

Retrospective Claims for CHC funding

As a result of the abolition of PCTs the Department of Health (DoH) made a decision to seek applications from individuals or their next-of kin for backdated funding from the PCTs for the cost of continuing healthcare (CHC) should they be eligible. This action was taken to ensure the full extent of the PCTs potential liabilities were understood and that there was no financial legacy passed to the new NHS organisations.

Future Management Arrangements for CHC claims / CHC service post 1 April 2013

The CHC service will be hosted by WAM CCG with the East Federation Nurse Director and West Federation Joint Commissioning Director leading the commissioning process for their respective CCGs.

TO BE REVIEWED AND EXPANDED ON FOR FINAL VERSION

8.13 Health Visiting

A growing body of evidence – including recent reviews by Tickell (2011), Field (2010) and Marmot (2010) – indicate that the first few years of life play a significant and formative role in shaping people's health, wealth and future happiness.

Health visitors have an invaluable part to play during this period – they are experts in public health, and are responsible for ensuring that children get all the usual health and development checks to make sure they are well, and progressing properly. They pick up any physical problems with the child that might need further care, such as sight, language or hearing problems, and can intervene early to address any issues before they become serious. They also deal with the needs of parents at that time, providing advice about relationship issues, breastfeeding, bonding, isolation or postnatal depression.

The new service vision for health visiting, which the taskforce will help to develop, sets out a 'service offer to families', which provides four levels of help and support – from a universal service for all, through to specific help for those who need it

The investment in the health visiting profession, and the plan to increase the workforce by over 50% by 2015, emphasises the importance of their role. The importance of good health and development in the early years is being recognised across the board, and reaches across both the health and education sectors.

Health Visiting trajectories

Berkshire East Health Visitors FTE	Mar-12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar-13
Health Visitors SIP FTE Plan	56.2	53.4	53.4	53.4	52.4	52.4	52.4	52.4	59.7	57.7	57.7	57.7	59.7
Health Visitors SIP FTE Actual	52.6	53.2	53.2	53.4	52.4	52.3	54.2	54.5	55.5	56.6			
of which - Qualified CPT's	6.0	6.0	6.0	6.0	6.0	6.0	7.0	7.0	7.0				
Qualified CPT's leaving	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
of which - RTP	0.0	0.0	0.0	0.6	0.6	0.6	0.6	0.0	0.0	0.0	0.0	0.0	0.0
Difference H.V. Plan : H.V. Actual	**-3.6**	**-0.2**	**-0.2**	**0.0**	**0.0**	**-0.1**	**1.8**	**2.1**	**-4.2**	**-57.7**	**-57.7**	**-57.7**	**-59.7**

All numbers expressed as FTEs

FNPs - Family Nurse Partnerships HVs - Health Visitors CPTs - Community Practice Teachers

RTP - Return to Practice Health Visitors Flexible Staff FTE - Bank, Agency, Overtime, Excess Hours, etc

Berkshire East achieved an actual figure of 55.5 wte against the 59.7 wte plan requirement in November 2012. This was due in part to two existing members of staff who left their posts in November and another successful interviewee withdrawing their interest. Berkshire Healthcare NHS Foundation Trust is working on recruiting further trainees to post in January 2013 which should reduce the gap from planned position considerably.

Berkshire West Health Visitors FTE	Mar-12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar-13
Health Visitors SIP FTE Plan	58.7	58.7	59.9	59.9	59.9	59.9	59.0	70.0	71.0	71.0	71.0	71.0	72.9
Health Visitors SIP FTE Actual	60.7	60.9	58.7	56.8	58.4	57.6	64.3	63.7	63.1	63.1			
of which - Qualified CPT's	7.4	7.4	7.4	7.4	8.1	8.1	8.1	8.1	8.1				
Qualified CPT's leaving	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
of which - RTP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Difference H.V.	**2.0**	**2.2**	**-1.2**	**-3.1**	**-1.5**	**-2.3**	**+5.3**	**-6.3**	**-7.9**	**-71.0**	**-71.0**	**-71.0**	**-72.9**

Berkshire West Health Visitors FTE	Mar-12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar-13
Plan : H.V. Actual													
Flexible Staff FTE	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Total Health Visitors FTE	**60.7**	**61.2**	**58.7**	**56.8**	**58.4**	**57.6**	**64.3**	**63.7**	**63.1**	**0.0**	**0.0**	**0.0**	**0.0**
Family Nurse Partnership Nurses	0	0	0	0	1	1	5.8	5.8	5.8				
of which - FNP's, also H.V's	0.0	0.0	0.0	0.0	0.0	0.0	3.0	3.0	3.0				
of which - FNP's, not H.V.'s	0.0	0.0	0.0	0.0	1.0	1.0	2.8	2.8	2.8				

Berkshire West achieved an actual figure of 63.1 wte against the 71.0 wte plan requirement in November 2012. The baseline number of Health Visitors required in Berkshire West changed in 2012 resulting in an additional 4.9 wte being required than originally planned for. The West CCG Federation has authorised a revised growth trajectory in response. In October 2012, 0.6 wte HV embarked on a career break. In November 2012, 0.6 wte HV retired. Some of the existing band 6 HVs have moved into the Family Nurse Partnership (FNP) roles within the area as these are promotions. 2 students who graduated locally have taken up posts in neighbouring areas. It was hoped that external HVs might be attracted into the FNP posts in Berkshire West. 2.8 wte of the new FNP positions have been taken up by midwives and community mental health practitioners which makes a well balanced team. One of the midwives plans to undertake a HV return to practice course which, when completed will boost HV numbers further. Berkshire Healthcare NHS Foundation Trust is working on recruiting further trainees to post in Q4 of 12/13 which should reduce the gap from planned position considerably.

Increase in training places and other initiatives to achieve growth

Berkshire Healthcare NHS Foundation Trust will continue to fully utilise their training space provision to ensure the system is best placed to meet the required growth trajectory to 2015. In Berkshire East 9 further students have been appointed to commence training in 2013. In January BHFT will re-advertise for 8 additional trainees to make a total of 20 to commence in September 2013. There is a requirement for 9 additional trainees in January 2014.

There are 20 currently HVs training in Berkshire West with a further 19 due to start the course in January 2013. Additional training places have been commissioned from Oxford Brookes University and have all been filled. Recruitment remains pro-active. 4 HVs are due to qualify in January 2013. BHFT has worked with the SHA and Oxford Brookes University to expedite registration (previously to happen in March, now Jan/ early Feb). A further cohort of students is due to graduate in September 2013.

Commissioners routinely meet with BHFT to review their recruitment plans and progress against this. Additionally it is clear that BHFT promote innovative recruitment and retention practices to ensure Health Visiting staff are incentivised to work in Berkshire.

Where HVs will be allocated

A Berkshire wide service specification is in place for BHFT within which there are teams which operate across the localities of Slough, Bracknell, Windsor & Maidenhead, Reading, Wokingham and West Berkshire. Allocation of additional health visitors to date has been proposed on the level of greatest need and deprivation as outlined within the JSNA, discussion with CCGs, and also understanding the present allocation of staff within BHFT.

The table below outlines the changes in caseload and nature of work that will occur to 2015 as a result of the investment in health visitors.

EAST

Increased number on targeted caseload within universal partnership plus post working with vulnerable families together with increase in universal antenatal assessment to all first time mothers. Reduced caseload, increased packages of care and fewer midwifery discharges	April 2012
Core HCP will be fully delivered once all mothers receive antenatal visit. Increase focus on uptake of the 9 month and 2 year reviews with all 'transfer in' clients receive a home visit	January 2014
More delivery to targeted groups focussed in areas such as community development, domestic violence, post natal depression, antenatal classes and breastfeeding support.	January 2015

WEST

Extend the capacity of the Family intervention Programme to deliver enhanced packages of care for targeted families	From April 2012
Commission FNP- 5WTE practitioners plus administrator	Supervisor in post from Q2 2012 Service starts Q3
Increase packages of care for Looked After Children Increase coverage of antenatal visit from targeted to universal	Q3 2012 Q4 2012
Extend coverage of 6-12 month visit from targeted to universal Extend enhanced packages of care to women at greater risk of Post Natal Depression Increase packages of care for Looked After Children Extend FNP by a further 2 practitioners	Q3 2013 Q3 2013 Q3 2013 Q3 2013
Full delivery of the Healthy Child Programme including additional enhanced packages of care where required	January 2015

Risks to continued achievement of growth plan

R1	Berkshire Healthcare Foundation Trust fail to recruit staff to support the planned growth	Berkshire Healthcare Foundation Trust to submit recruitment and retention plan to SHA as part of current monitoring arrangements **BHFT have provided recruitment and retention plan to the SHA and have committed to long term HV training places to provide necessary graduates for recruitment at key take up points.**	**Green**
R2	PCTs will be measured routinely in relation to the submitted Health Visitor Growth Plan	PCT commissioners and providers are meeting monthly to continually assess workforce growth as well as plans to retain existing staff. Next meeting with PCT / SHA /BHFT is January 23rd 2013.	**Green**
R3	Risk that members of existing team may migrate to other newly established or expanding sites. For example nurses may move to closer London areas because of pay weighting allowance	This is continually assessed within overall BHFT recruitment and retention plan. BHFT are being encourages to offer flexible packages to staff to retain their services.	**Green**
R4	Continued funding to support Provider recruitment of Health Visitors.	PCT confirmed commitment to 2015 HV growth plan in December 2011.	**Green**
R5	Although provider-led workforce initiatives will help to address capacity concerns, this may be insufficient to meet the planned increased trajectory without additional commissioner investment over the next 3 years	SHA are continually briefed on progress of plan and risks to delivery. This will inform the decisions the National Commissioning Board make regarding future investment in their role as overall commissioning lead in this programme.	**Green**

R6

Aside from the main Health Visitor function, BHFT also employ small numbers of HVs in other service provision such as Family Nurse Partnership and the Looked After Children's team. In the case of the FNP team, as their remit is also transferring to the National Commissioning Board (NCB), their interdependency with the overall HV growth programme is not a risk.

The Looked After Children's team will continue to be commissioned by CCGs via the Berkshire Healthcare NHS Foundation Trust community contract. Therefore 2 different sets of commissioners will have an interest in the staff complement of a service that will sit with the CCGs but whose numbers will count towards the target managed by NCB in the future. This issue will be raised further by commissioners at the SHA meeting on 23 January 2013.

8.13.1 Family Nurse Partnerships

The Family Nurse Partnership Programme has been in operation in Berkshire East since 2007 after being chosen as a Wave 1 pilot site, offering a highly intensive early intervention programme for first time teenage mothers. Continued investment is allowing the project to continue as previously operated across Berkshire East, with the Family Nurse Advisory Board providing an additional level of governance and chaired by a PCT commissioner. The Board will have key stakeholder input from the DH, Local Authorities, FNP practitioners as well as client representation. Quarterly data (by locality where possible) was provided from first Board meeting onwards together with the existing FNP Annual Report. It is hoped that the expertise of the 'East' team will help the newly established Berkshire West team quickly deliver better outcomes for young first-time mothers.

The most recent FNP Board had DH attendance which commended the Berkshire East site and stated the site was one of the best commissioned services in the country.

The Family Nurse Partnership Programme became operational in operation in Berkshire West from Q3 2012/13.

The Family Nurse Advisory Board provides an additional level of governance and is chaired by a PCT commissioner. The Board has key stakeholder input from the DH, Local Authorities, FNP practitioners as well as client representation.

The FNP programmes are interdependent with the overall Health Visitor growth programme as the team is made up of HVs counted within the overall numbers of HVs employed in Berkshire. Additionally the commissioning responsibility of this programme will transfer to National Commissioning Boards from 1st April 2013. Commissioners are in dialogue with the SHA to ensure smooth transition of this programme.

9. BENCHMARKING DATA

9.1 Domain 1 - Preventing people from dying prematurely

9.1.1 Acute Hospital Mortality

Acute Hospital Mortality - SHMI		
Organisation:	**Year:**	**Summary Hospital-level Mortality Indicator (SHMI):**
Royal Berkshire NHS Foundation Trust	Jan 2011 – Dec 2011	1.072
Heatherwood and Wexham Park NHS Foundation Trust	Jan 2011 – Dec 2011	0.9997
Oxford University Hospitals	Jan 2011 – Dec 2011	1.0014
Buckinghamshire Healthcare Trust	Jan 2011 – Dec 2011	1.1091

Data Source: NHS Information Centre website

SHMI is a mortality indicator that represents the ratio of observed deaths to expected deaths. Based on information coded within patient notes (age, sex, co-morbidities and a variety of other factors), an algorithm calculates an expected number of deaths that it would expect to see of patients that attend an acute hospital. A ratio of higher than 1 represents a higher than expected mortality rate, however, as this is a calculated value, the algorithm allows for a tolerance and will report a Trust as having a higher than expected mortality rate if it is statistically significantly higher than the national average. Whilst this is a calculated measure and is susceptible to provide a false picture if information is not correctly coded, it is a measure that can be used in conjunction with others to identify if a Trust is providing a good quality service.

All acute providers in the Thames Valley area have a SHMI mortality rate which is "as expected".

Acute Hospital Mortality - HSMR		
Organisation:	**1 year (11/12)**	**3 year (09/10, 10/11, 11/12)**
Royal Berkshire NHS Foundation Trust	102.65	102.11
Heatherwood and Wexham Park NHS Foundation Trust	96.4	96.27
Oxford University Hospitals	106.05	106.18
Buckinghamshire Healthcare Trust*	109.45	113.13

*One of 14 trusts which are now subject to investigation as a response to report into the Mid Staffs public inquiry

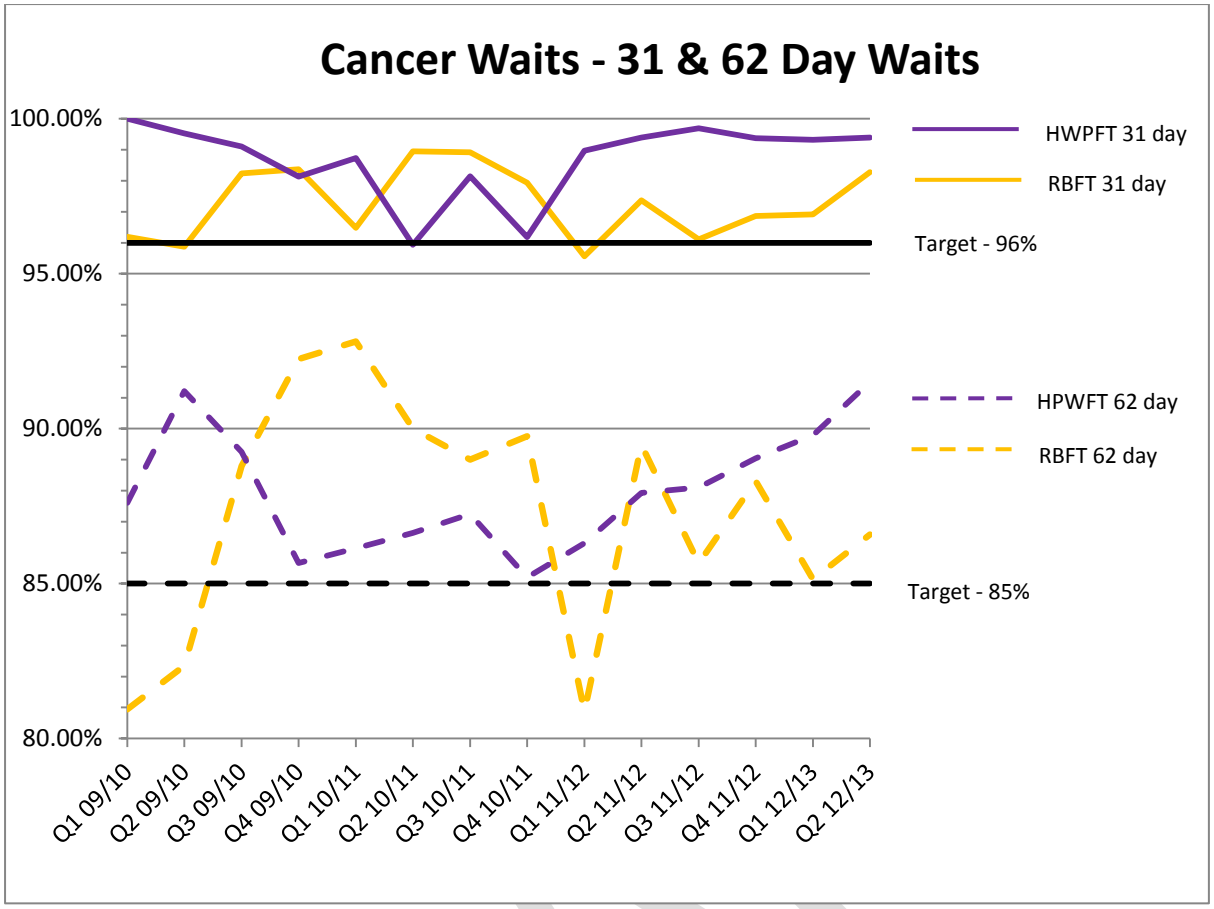
HSMR is the ratio of the observed number of in-hospital deaths during admissions with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100.

The ratio is calculated by dividing the actual number of deaths by the expected number and multiplying the figure by 100. It is expressed as a relative risk, where a risk rating of 100 represents the national average. If the trust has an SMR of 100, that means that the number of patients who died is exactly as it would be expected taking into account the standardisation factors. An SMR above 100 means more patients died than would be expected; one below 100 means that fewer than expected died.

9.1.2 Waiting times – cancer patients

Waiting times – Cancer patients								
	BW PCT		RBFT		BE PCT		HWPFT	
	31 day wait	62 day wait	31 day wait	62 day wait	31 day wait	62 day wait	31 day wait	62 day wait
Q2 12/13	97.99%	85.38%	98.28%	86.58%	97.92%	90.08%	99.40%	91.51%
Q1 12/13	97.11%	85.71%	96.92%	85.14%	98.05%	90.78%	99.32%	89.79%
Q4 11/12	97.01%	88.29%	96.86%	88.31%	97.52%	84.93%	99.37%	89.04%
Q3 11/12	96.05%	85.25%	96.11%	85.65%	98.88%	85.42%	99.69%	88.10%
Q2 11/12	97.18%	88.93%	97.37%	89.48%	99.19%	88.28%	99.39%	87.93%
Q1 11/12	95.99%	83.17%	95.56%	80.87%	98.42%	82.69%	98.97%	86.30%
Q4 10/11	97.78%	88.83%	97.94%	89.76%	96.44%	85.92%	96.18%	85.20%
Q3 10/11	98.90%	88.33%	98.92%	89.00%	99.02%	85.95%	98.14%	87.24%
Q2 10/11	98.88%	90.04%	98.95%	90.00%	97.17%	84.40%	95.93%	86.64%
Q1 10/11	96.72%	92.13%	96.48%	92.81%	98.79%	83.16%	98.73%	86.14%
Q4 09/10	98.63%	93.41%	98.37%	92.25%	98.07%	82.20%	98.13%	85.66%
Q3 09/10	97.82%	89.30%	98.24%	88.79%	98.18%	84.11%	99.11%	89.25%
Q2 09/10	96.63%	83.17%	95.87%	82.35%	98.92%	91.30%	99.53%	91.21%
Q1 09/10	97.23%	81.82%	96.19%	80.94%	99.66%	88.70%	100.00%	87.61%

Data Source: PCT Performance Management Team



Waiting times for cancer are an indicator of whether early detection and treatment of cancer is being achieved. The national cancer waiting time standards are:

- NHS Cancer Plan two week standard from urgent referral to first hospital assessment – 93%;
- Cancer Reform Strategy two week standard from referral for breast symptoms whether cancer is suspected or not to first hospital assessment – 93%;
- NHS Cancer Plan 31 day standard from decision to treat to first treatment – 96%;
- NHS Cancer Plan 62 day standard from urgent referral to first treatment standard – 85%;
- Cancer Reform Strategy 62 day standard from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment for cancer – 90%.

There are a number of national standards relating to Cancer wait times. Illustrated in the table and graphs above are two of these standards. The 31 day standard here relates to the percentage of patients who have received their cancer treatment within 31 days of a diagnosis of cancer. The 62 day standard relates to the percentage of patients who have received their cancer treatment within 62 days of the initial referral. So within these 62 days, the patient should receive their initial outpatient appointment and also any diagnostic tests or further outpatient appointments as well as the first definitive treatment.

9.2 Domain 2 – Enhancing the quality of life for people with long term conditions

9.2.1 Data from the Quality Observatory

Data from the East Midlands Quality Observatory Acute Dashboards is in the process of being analysed and reviewed. This will be included in the final version of the Quality Handover document.

Key messages from Quality Observatory data:				
Acute Trust Quality Dashboard – Indicators listed under "Enhancing Quality of Life for People with Long-Term Conditions" Summer 2012				
Quarter 4, 2011/12	**RBFT Value**	**HWPFT Value**	**National Mean**	**Comments**
% of emergency admissions for >65 years old with dementia	15.30%	15.80%	15.60%	
LOS (days) for patients >65 years old admitted in an emergency with dementia	15.5	15.5	14.9	
LOS (days) for patients >65 years old admitted in an emergency	10.4	10.2	10.3	
Ambulatory care sensitive conditions - % of emergency admissions for cellulitis and DVT	1.54%	1.53%	1.46%	
% of admission with zero day LOS for emergency ambulatory care conditions	21.20%	42.90%	41.20%	

Data Source: Acute Trust Quality Dashboard, Release 4, Summer 2012.

Mental Health

9.2.2 The number of new cases of psychosis served by early intervention teams

The number of new cases of psychosis served by early intervention teams				
	BW PCT	**BE PCT**	**BHFT**	**South Central**
Q2 2012/13	21	14	35	
Q1 2012/13	22	30	52	
Q4 2011/12	75	79	153	520
Q3 2011/12	55	55	109	
Q2 2011/12	41	46	86	
Q1 2011/12	28	19	47	

Data Source: PCT Monitoring

Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life - education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large. The mean age of onset of psychotic symptoms is 22 with the vast majority of first episodes occurring between the ages of 14 and 35. The onset of this disease is therefore often during a critical period in a person's development.

Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm. One in ten people with psychosis commits suicide - two thirds of these deaths occur within the first five years of illness. Intervening early in the course of the disease can prevent initial problems and improve long-term outcomes. If treatment is given early in the course of the illness and services are in place to ensure long-term concordance (co-operation with treatment), the prospect for recovery is improved. There is evidence that early intervention can be helpful in reducing suicidal behaviour.

Early intervention in psychosis services provide quick diagnosis of the first onset of a psychotic disorder and appropriate treatment including intensive support in the early years. A fully operational early intervention service typically serves a total of 450 people, but the caseload builds up over a 3-year period. (The service covers a population of 1 million, in that population there would be expected to be 150 new cases per year, and each person who is taken on by an early intervention service will remain on the caseload for 3 years.) As set out in the 2009/10 NHS Operating Framework, each PCT is required to continue to deliver its locally agreed share of the 7,500 people to be taken on as new cases by early intervention services throughout England.

The data presented above represents a cumulative figure with the overall target set as 48 cases in the West, and 51 cases in the East (99 in total for the Trust). This target was met in 2011/12, and performance for 2012/13 shows the Trust to be on track for this financial year.

9.2.3 % of inpatient admissions that have been gate-kept by Crisis Resolution/Home Treatment Teams

% of inpatient admissions that have been gate-kept by Crisis Resolution/Home Treatment Teams				
	BW PCT	**BE PCT**	**BHFT**	**South Central**
Q2 2012/13			97%	
Q1 2012/13			97.8%	
Q4 2011/12	95.8%	92.5%	94.4%	97.2%
Q3 2011/12	97.5%	90.9%	94.6%	
Q2 2011/12	100.0%	100.0%	100.0%	
Q1 2011/12	100.0%	100.0%	100.0%	

Data Source: PCT Monitoring

A crisis resolution team (sometimes called a crisis resolution home treatment team) provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. The NHS Plan target for crisis resolution teams was 335 teams by December 2004, but teams were not required to meet all of the criteria. Meeting all of the criteria, including being available to respond 24 hours a day, 7 days a week, was required by December 2005. In 2009/10, trusts are required to continue providing these services to the required level while also demonstrating that the teams in place are functioning properly as a gateway to inpatient care and also facilitating early discharge of service users.

The BHFT target for this indicator for 2012/13 is 95%, and this is being met in quarter one.

9.2.4 Proportion of people under mental illness specialties on the Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric inpatient care

% of people under mental illness specialties on the Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric inpatient care.			
	BW PCT	**BE PCT**	**BHFT**
Q2 2012/13	97.7%	94.3%	96.03%
Q1 2012/13	96.9%	97.4%	98.0%
Q4 2011/12	93.5%	97.2%	95.2%
Q3 2011/12	96.8%	96.9%	97.0%
Q2 2011/12	97.7%	94.3%	96.0%
Q1 2011/12	96.9%	97.4%	97.0%

Data Source: PCT monitoring

Reductions in the overall rate of death by suicide will be supported by arrangements for securing provision by PCTs of appropriate care for all those with mental ill health. This includes action to reduce risk and social exclusion and improve care pathways, it includes action to follow up quickly all those on the care programme approach (CPA) ('enhanced CPA' prior to October 2008) who are discharged from a spell of inpatient care. Guidance to support best practice, including the mental health national service framework and NHS plan is available to support local planning and service delivery. Measures by mental health services to achieve a reduced risk of suicide are also set out in the 'National suicide prevention strategy for England' and 'Preventing suicide: A toolkit for mental health services'.

The standard for this indicator is 95% and BHFT achieved this in quarter one and two of 2012/13.

Dementia

9.2.5 Reported numbers of people with dementia on GP registers as a percentage of estimated prevalence

Reported numbers of people with dementia on GP registers as a percentage of estimated prevalence		
PCT	**2009/10**	**2010/11**
Berkshire West	37.85	38.47%
Berkshire East	36.57	44.13%
Buckinghamshire	*34.09*	*38.70%*
Oxfordshire	*36.76*	*41.56%*

Data source: 2009/10 - NHS Atlas of Variation (November 2011), 2010/11 - QOF data, Dec 2011 and NEPHO estimates for 2010 (May 2008)

The NHS Atlas of Variation in Healthcare (November 2011) shows the variation in the reported numbers of dementia on general practitioner registers as a percentage of estimated prevalence by Primary Care Trust cluster for 2009/10. Nationally at least 40% of people thought to have dementia have not been diagnosed.

Within NHS South of England generally there are low reported numbers of dementia in comparison to estimated prevalence. Buckinghamshire is identified as having one of the lowest prevalence.

The PCT carries out an annual review of prevalence based on Quality Management and Analysis System (QMAS) Quality Outcomes Framework (QOF) data. This compares prevalence to national rates and local comparators (expected prevalence is not currently considered). Practices with low prevalence on a number of clinical areas may be selected for a pre-payment QOF visit. Such visits include a GP lead who spends time interrogating the practice's clinical system to identify if there are patients missing from disease registers. Where this is the case, actions are set for the practice to conduct further reviews. In addition, prevalence on a number of clinical conditions is discussed with practices at Contract Review Visits. Practices receive these visits as part of a rolling programme. Since the current programme began in 2009, 40 practices have been visited.

Learning Disabilities

9.2.6 % of primary school children in state-funded schools with a statement of SEN

% of primary school children in state-funded schools with a statement of SEN		
LA	**Year**	**%**
Reading	2011	1.73
Wokingham	2011	1.85

West Berkshire	2011	1.80
Bracknell Forest	2011	1.72
RBWM	2011	1.91
Slough	2011	1.86
Buckinghamshire	*2011*	*2.18*
Oxfordshire	*2011*	*0.87*

Data Source: DfE, SFR14/2011

Statements of Special Educational Need (SEN) are awarded by Local Authorities to individual children. Responsibility for funding any required health provision stated in part 3 of the statement of SEN lies with the Local Authority. Local Authorities in Berkshire have contracts with BHFT for the provision of these services e.g. physiotherapy and speech and language therapy.

There are no targets for the number of children who have a statement, although it is generally accepted that around 2% of the population will require a statement of SEN in order to access the curriculum.

The Department for Education and Department of Health plan to reform the 'statementing' process over the next 2 years. It is proposed that there will be a single assessment process leading to a joint education, health and care plan

Primary Care

9.2.7 % of people in the National Diabetes Audit receiving all nine key care processes

% of people in the National Diabetes Audit receiving all nine key care processes						
	2009/10			**2010/11**		
PCT	**% Type 1**	**% Type 2**	**Overall**	**% Type 1**	**% Type 2**	**Overall**
Berkshire West	16.1	27.2	25.6	25.5	35.9	34.4
Berkshire East	38.5	55.9	53.7	47.6	66.5	64.2
Buckinghamshire	*35.2*	*55.2*	*52.2*	*45.3*	*58.8*	*52.2*
Oxfordshire	*39.2*	*58.3*	*53.91*	*45.8*	*54.6*	*53*

Data Source: NHS Atlas of Variation (November 2011), NDA PCT/LCB Analysis Profiles 2010/11

The Berkshire West CCG Federation Chair Rod Smith, supported by CCG leads, has personally communicated the importance of improving the NDA Rating with all GPs. Following this show of clinical leadership 100% participation is expected in the next NDA audit process.

Additional targeted action, listed below, has also occurred and it is hoped that this will result in improvements in the reported position in future NDA reports.

- Public Health investigated and communicated to leads why a good QOF performance has not resulted in a similar NDA rating. One example of how this has helped using micro albumin as an example, a change in a clinical process has occurred which will ensure we NDA compliance.
- Public Health has produced a GP practice briefing pack which aims to support practices to review their specific NDA rating, with suggested actions as to how they could improve their position. It is hoped that more patients will be reported as having received all nine care processes in the future. This has been incentivised through QOF QP6 & QP7.

The comprehensive programme of work being undertaken to improve the whole Diabetes care pathway in Berkshire West should also support improvements.

In Berkshire East there are a number of key initiatives that are taking place to ensure, not only that people with diabetes receive their 9 annual key care processes, but also to ensure that the overall outcomes for people with diabetes are improved including:

- Working with Diabetes UK and the Department of Health, on a project to improve awareness of diabetes in BME communities (who have the highest risk of developing diabetes). To date 10 community champions have been trained to raise awareness in the communities.
- Improving the standard of care (including annual care processes) provided in GP practices by developing an education pathway and programmes aimed at enhancing the clinical skills for GPs, nurses and other health professionals caring for diabetes patients.
- Working with the CCGs to identify the practices with the poorest diabetes outcomes and then supporting them to make the required changes.
- Recently introduced a multidisciplinary (consultant dialectologist, consultant vascular surgeons, podiatrists, diabetic specialist nurses and dieticians) diabetic foot clinic (feet are one of the 9 key processes) running in Wexham Park Hospital and Bracknell to improve foot care for people with diabetes.
- Recently introduced joint Local Diabetic Specialist Nurses and Dietetic clinics in Bracknell and Slough to improve access and enable diabetic patients to receive their annual checks and recommended care.
- Currently 100% of all diabetic patients are offered screening and work is underway to look at ways to improve uptake of the screening through a number of initiatives including sending patients text reminders, offering additional mop up clinics out of hours and at weekends.
- Implementation of urgent slots to accommodate urgent GP referrals to the specialist diabetes service within two weeks.
- Diabetes health care professionals' helpline introduced to support healthcare professionals to manage diabetes better.
- The effective management of diabetes involves good quality advice and clinical treatments as well as patients who are supported and motivated to make the desired lifestyle changes. For this , we currently have a number of programmes such as the Diabetes Education and Awareness for Life (DEAL) and the Expert Patient Programme; that are available to help patients with diabetes to learn how to live with and better manage their conditions.

9.2.8 % of diabetic population (Type 1) receiving screening for diabetic eye screening

% of diabetic population (Type 1) receiving screening for diabetic eye screening		
	BW PCT	**BE PCT**
Q2 2012/13	72.3%	69.9%
Q1 2012/13	72.3%	70.2%
Q4 2011/12	73.6%	70.4%
Q3 2011/12	71.4%	68.8%
Q2 2011/12	66.9%	66.0%
Q1 2011/12	71.1%	67.6%
Q4 2010/11	70.6%	68.7%
Q3 2010/11	70.1%	64.9%
Q2 2010/11	68.6%	62.8%
Q1 2010/11	65.4%	63.3%
Q4 2009/10	63.5%	63.5%
Q3 2009/10	61.8%	61.8%

Data Source: http://transparency.dh.gov.uk/?p=20253

There is a single Diabetic Eye Screening (DES) service serving all of Berkshire, currently commissioned in Berkshire West with offices based in Wokingham Hospital. The annual screening is undertaken in GP surgeries wherever possible to make it more convenient for patients to attend. There are additional clinics run in some static sites throughout Berkshire which are used for catch up appointments. When a patient is referred for diagnosis and treatment of diabetic retinopathy or maculopathy they attend the Hospital Eye Service which is run at the Royal Berkshire Hospital for the West and the Prince Charles Eye Unit in King Edward VII Hospital, Windsor for the East.

The Berkshire Diabetic Eye Screening Board meets bi-monthly and is chaired by the Lead Commissioner, a Public Health Specialist. Other representatives include the Manager from the Berkshire DES Service, Locality manager from BHFT, the RBFT Ophthalmology Manager, a GP and the Clinical Lead from RBFT. Protocols are in place to govern all aspects of the screening service and Failsafe Officers are employed within the community and the hospital to track all patients. The Board considers data on all the national standards on a quarterly basis, following up and investigating if any standards are not being met. Uptake data from the BDES software is now sent to all GP practices on an annual basis to indicate to them if they are falling below the minimum standard of 70%. These practices are contacted prior to their screening visit to discuss ways of improving their uptake. A small group, which has 2 Practice Managers on it, meets on a monthly basis to discuss how to improve the uptake of the service. The Q1 KPI for uptake of the service was 70.4%, and we are working to improve this to 80%. Additional funding has been made available to BDES to increase the number of screening staff to deal with additional numbers of people with diabetes requiring annual screening.

The BDES Service complies with all aspects of the National Screening Programme and undertakes regular Internal Quality Assurance. All of the staff employed in the screening service are trained and becoming accredited as required by the English National Diabetic Eye Screening Board (ENDESB). Quarterly monitoring of national KPIs is completed.

Work is are currently underway to plan and achieve the implementation of the Common Pathway, whereby surveillance (including Ophthalmic Photographic Diabetic Review and Slit Lamp Biomicroscopy Clinics) will move from the HES into the Screening Service. The aim is for these changes to take place by 31March 2013.

9.2.9 Anti-dementia drug items prescribed per weighted population in primary care

Anti-dementia drug items prescribed per weighted population in primary care		
PCT	**Year:**	**Rate:**
Berkshire West	2009/10	0.038
Berkshire East	2009/10	0.054
Buckinghamshire	*2009/10*	*0.487*
Oxfordshire	*2009/10*	*0.857*

Data Source: NHS Atlas of Variation (November 2011)

9.2.10 Reported numbers of people with hypertension on GP registers as a percentage of estimated prevalence

Reported numbers of people with hypertension on GP registers as a percentage of estimated prevalence		
PCT	**2009/10**	**2010/11**
Berkshire West	55.4	52.2
Berkshire East	53.5	60.6
Buckinghamshire	*54.2*	*57.2*
Oxfordshire	*53.4*	*57.8*

Data source: 2009/10 - NHS Atlas of Variation (November 2011), 2010/11 - QOF data, Dec 2011 and APHO Disease prevalence estimates

The PCT carries out an annual review of prevalence based on QMAS QOF data. This compares prevalence to national rates and local comparators (expected prevalence is not currently considered). Practices with low prevalence on a number of clinical areas may be selected for a pre-payment QOF visit. Such visits include a GP lead who spends time interrogating the practice's clinical system to identify if there are patients missing from disease registers. Where this is the case, actions are set for the practice to conduct further reviews. In addition, prevalence on a number of clinical conditions is discussed with practices at Contract Review Visits. Practices receive these visits as part of a rolling programme. Since the current programme began in 2009, 40 practices have been visited.

9.2.11 Reported numbers of people with CHD on GP registers as a percentage of estimated prevalence

Reported numbers of people with CHD on GP registers as a percentage of estimated prevalence		
PCT	**2009/10**	**2010/11**
Berkshire West	68.7	76.8
Berkshire East	81.1	72.1
Buckinghamshire	*90.9*	*77.2*
Oxfordshire	*73*	*75.4*

Data source: 2009/10 - NHS Atlas of Variation (November 2011), 2010/11 - QOF data, Dec 2011 and APHO Disease prevalence estimates

The PCT carries out an annual review of prevalence based on QMAS QOF data. This compares prevalence to national rates and local comparators (expected prevalence is not currently considered). Practices with low prevalence on a number of clinical areas may be selected for a pre-payment QOF visit. Such visits include a GP lead who spends time interrogating the practice's clinical system to identify if there are patients missing from disease registers. Where this is the case, actions are set for the practice to conduct further reviews. In addition, prevalence on a number of clinical conditions is discussed with practices at Contract Review Visits. Practices receive these visits as part of a rolling programme. Since the current programme began in 2009, 40 practices have been visited.

9.2.12 % of people who succeeded in gaining access to NHS dentistry services after requesting an appointment

% of people who succeeded in gaining access to NHS dentistry services after requesting an appointment		
Year:	**BW PCT**	**BE PCT**
Mar-12	46.9%	50.5%
Mar-11	44.8%	49.2%
Mar-10	43.0%	47.6%
Mar-09	41.0%	45.8%
Mar-08	41.1%	45.2%
Mar-07	43.8%	46.8%

Data Source: PCT Primary Care Commissioning

(Target = 51% for West and 55% for East)

This is part of the national programme to improve NHS dentistry which the PCTs in the Thames Valley Local Area Team area have been pursuing since April 2009. These figures show the growth in the number of patients who have attended an NHS dentist within the previous two years.

9.3 Domain 3 – Helping people to recover from episodes of ill health or following injury

9.3.1 Stroke

There are two key national indicators in relation to stroke performance. The first of these indicators represents how long stroke patients spend on a dedicated stroke unit when in hospital. The target for this indicator is that 80% of stroke patients spend 90% of their stay in hospital on a stroke unit. This ensures the appropriate and adequate specialised stroke care can be received by the patients. In order to achieve this indicator, it is essential that patients are diagnosed quickly and then transferred to the stroke unit straight away rather than any other wards in the hospital.

The second of these indicators relates to high risk Transient Ischaemic Attack (TIA) patients who should receive treatment within 24 hours. A TIA is a mini stroke where patients receive a temporary fall in the blood supply to the brain. Where patients fall into the high risk category and suffer from a TIA, treatment should be received within 24 hours. The target for this indicator is that this happens in 60% of cases. Heatherwood and Wexham Park Hospital do not offer a high risk TIA service and Berkshire East patients therefore usually attend the hyper acute stroke unit in High Wycombe.

Stroke and TIA (By Provider)					
	RBFT			**HWPFT**	
	% patients spending 90% time on stroke unit	**% patients admitted to stroke unit within 4hrs**	**% High Risk TIA patients scanned and treated within 24 hours**	**% patients spending 90% time on stroke unit**	**% patients admitted to stroke unit within 4hrs**
Dec-12	83.60%	61.20%	87.90%		
Nov-12	85.20%	53.70%	94.00%	81.00%	81.00%
Oct-12	81.00%	65.50%	94.80%	78.00%	67.00%
Sep-12	84.80%	50.00%	89.10%	75.00%	53.00%
Aug-12	83.30%	52.40%	10.00%	81.00%	74.00%
Jul-12	80.40%	46.40%	90.90%	80.00%	75.00%
Jun-12	93.00%	64.90%	85.70%	97.00%	83.00%
May-12	84.30%	60.30%	97.00%	81.00%	63.00%
Apr-12	73.10%			84.00%	68.00%
Mar-12	63.5%		100.0%	89.0%	68.0%
Feb-12	80.0%		93.3%	81.0%	69.0%
Jan-12	67.8%		84.6%	70.0%	70.4%
Dec-11	88.3%		100.0%	75.0%	62.5%
Nov-11	89.1%		94.7%	79.0%	63.0%
Oct-11	85.4%		85.9%	81.0%	77.4%
Sep-11	94.2%		90.5%	79.0%	62.5%
Aug-11	92.9%		88.9%	77.0%	31.8%
Jul-11	81.5%		88.2%	87.0%	63.3%

Jun-11	84.9%		82.4%	85.0%	54.0%
May-11	81.9%		83.3%		61.0%
Apr-11	68.8%		71.4%		32.0%

Data Source: PCT Monitoring

Stroke and TIA (by PCT)				
	BW PCT		**BE PCT**	
Quarter:	**% patients spending 90% time on stroke unit**	**% High Risk TIA patients scanned and treated within 24 hours**	**% patients spending 90% time on stroke unit**	**% High Risk TIA patients scanned and treated within 24 hours**
Q2 12/13	85.5%	95.4%	81.5%	93.9%
Q1 12/13	83.8%	96.5%	88.1%	71.4%
Q4 11/12	71.3%	94.6%	89.4%	81.0%
Q3 11/12	88.3%	95.8%	76.6%	95.2%
Q2 11/12	88.9%	86.8%	86.6%	100.0%
Q1 11/12	77.5%	80.0%	88.4%	42.9%
Q4 10/11	82.5%	87.7%	72.1%	39.4%
Q3 10/11	84.9%	70.0%	81.3%	64.3%
Q2 10/11	68.4%	89.7%	76.9%	51.3%
Q1 10/11	56.3%	75.0%	48.6%	45.8%
Q4 09/10	61.9%	88.6%	49.1%	44.4%
Q3 09/10	73.1%	57.1%	55.6%	100.0%
Q2 09/10	82.8%	59.6%	28.8%	0.0%

Data Source:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Integratedperfomancemeasuresmonitoring/DH_119034

9.4 Domain 4 – Ensuring that people have a positive experience of care

9.4.1 National Patient Survey Results

Please see main Patient Experience section (8.6) for commentary and actions.

CQC Inpatient Survey CQUIN aggregate score		
	RBFT	**HWPFT**
2011	68	63
2010	66.8	65.9
2009	65.5	63.6
2008	68.5	65.3
2007	65.9	67.3
2006	67	62.6
2005	67.8	64.3
2003	64.8	67.5

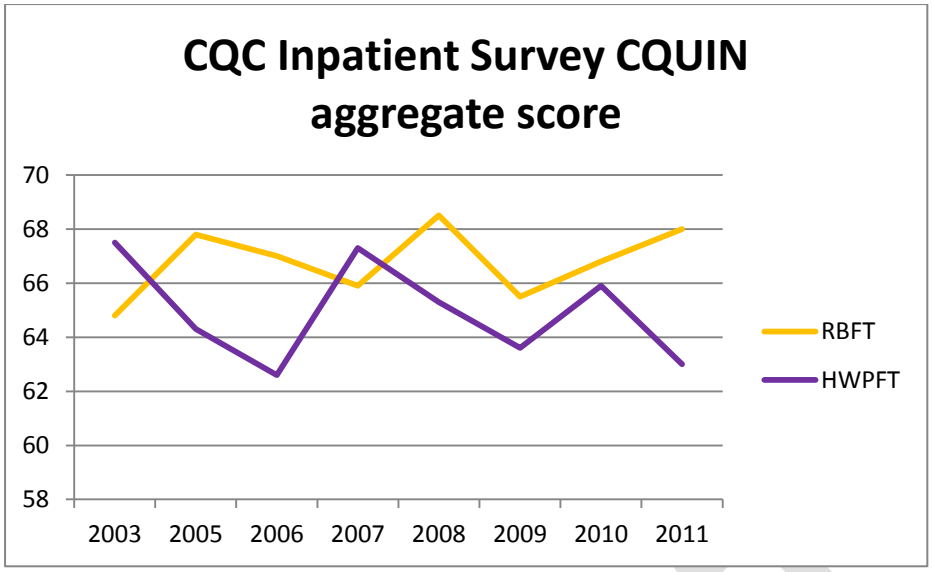
THE CQC Adult inpatient survey is conducted annually between October and January for patients who had an inpatient episode between July and August.

The CQC Inpatient Survey CQUIN aggregate score is an index-based score reflecting positive responses to the 5 questions within the composite indicator. The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England.

Each question describes a different element of the overarching patient experience theme: "responsiveness to personal needs of patients".

The elements are:

- Involved in decisions about treatment/care
- Hospital staff available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Being informed about side effects of medication
- Being informed who to contact if worried about condition after leaving hospital


CQC Inpatient Survey CQUIN aggregate score
70
68
66
64
62
60
58
2003
2005
2006
2007
2008
2009
2010
2011
RBFT
HWPFT

9.4.2 Waiting times – referral to treatment and diagnostics

Waiting times - Referral to treatment and diagnostics												
	BW PCT			RBFT			BE PCT			HWPFT		
Year / Month:	% admitted patients 18 weeks	% non-admitted patients 18 weeks	% diagnostic waits over 6 weeks	% admitted patients 18 weeks	% non-admitted patients 18 weeks	% diagnostic waits over 6 weeks	% admitted patients 18 weeks	% non-admitted patients 18 weeks	% diagnostic waits over 6 weeks	% admitted patients 18 weeks	% non-admitted patients 18 weeks	% diagnostic waits over 6 weeks
Nov-12	92.00%	99.00%	1.00%	91.30%	99.20%	0.44%	91.60%	97.90%	0.28%	90.01%	96.50%	0.06%
Oct-12	91.20%	99.10%	0.38%	91.30%	99.30%	0.34%	92.30%	97.70%	0.26%	90.00%	96.60%	0.11%
Sept-12	91.90%	98.40%	1.91%	91.50%	98.60%	1.67%	90.90%	97.50%	0.27%	90.20%	96.00%	0.00%
Aug-12	90.60%	98.70%	2.66%	90.80%	98.80%	2.72%	91.30%	98.20%	0.11%	90.10%	97.00%	0.03%
Jul-12	90.60%	98.40%	0.39%	90.00%	98.50%	0.10%	92.20%	97.70%	0.11%	90.40%	96.90%	0.00%
Jun-12	91.40%	98.80%	0.47%	91.60%	99.00%	0.23%	93.00%	98.20%	0.24%	91.00%	97.20%	0.07%
May-12	92.90%	99.10%	0.27%	93.70%	99.30%	0.00%	92.40%	98.00%	0.05%	90.00%	97.00%	0.03%
Apr-12	93.30%	99.30%	0.30%	94.00%	97.90%	0.00%	86.40%	98.30%	0.16%	80.70%	97.50%	0.00%
2011-12	91.70%	96.40%	0.89%	92.35%	99.50%	0.48%	85.40%	96.60%	0.67%	80.30%	94.20%	0.06%
2010-11	92.90%	95.90%	1.88%	94.00%	99.20%	1.72%	85.90%	96.20%	0.27%	80.90%	93.40%	0.10%
2009-10	92.60%	96.90%	0.14%	93.30%	99.70%	0.03%	90.80%	99.10%	0.16%	89.00%	95.60%	0.08%
2008-09	92.80%	96.90%	-	93.80%	98.20%	-	91.80%	97.60%	-	91.20%	96.40%	-

Data Source: PCT Monitoring

Referral to Treatment waiting times

Admitted is the % of completed pathways that required an admission to hospital for treatment that were treated within 18 weeks. For this measure 90% of patients should be treated within 18 weeks. This treatment would normally be in the form of a day case or elective procedure.

Non-Admitted is the % of completed pathways within 18 weeks that did not require an admission for the pathway to be completed, so this could be treatment in an outpatient setting or the decision not to treat as it is not required at this point in time. The target for this measure is 95% of patients should have their pathways completed within 18 weeks. RTT is often very complex from a data perspective but the key message is that patients should be treated within 18 weeks of referral from a GP. During 2011/12 the PCTs provided some investment to the 2 local providers to ensure improvement of RTT pathways to ensure that any backlogs of patients waiting were eliminated.

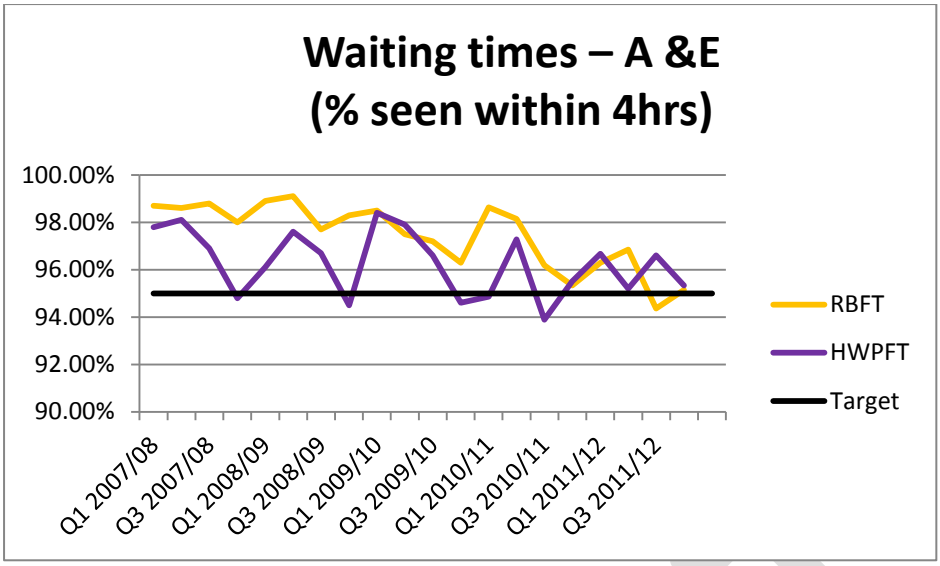
Diagnostics

Data is routinely collected on the percentage of patients waiting six weeks or more for a diagnostic test. The 2012/13 operational standard is that less than one per cent of patients should wait six weeks or longer.

9.4.3 Waiting times – A&E

Waiting times – A &E (% seen within 4hrs)		
Quarter:	**RBFT**	**HWPFT**
Q2 2012/13	94.57%	95.63%
Q1 2012/13	94.98%	95.23%
Q4 2011/12	95.15%	95.33%
Q3 2011/12	94.36%	96.60%
Q2 2011/12	96.85%	95.20%
Q1 2011/12	96.29%	96.67%
Q4 2010/11	95.34%	95.51%
Q3 2010/11	96.19%	93.89%
Q2 2010/11	98.14%	97.28%
Q1 2010/11	98.63%	94.86%
Q4 2009/10	96.30%	94.60%
Q3 2009/10	97.20%	96.60%
Q2 2009/10	97.50%	97.90%
Q1 2009/10	98.50%	98.40%

Data Source:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_087977



The national standard is that at least 95% of patients spend 4 hours or less in Accident and Emergency. This means that the patient is either treated and discharged within 4 hours or admitted to a hospital ward for further treatment or investigations within 4 hours of arriving at the A&E department. Performance for this standard is measured on a quarterly basis at a provider level. The two local providers have performed above the 95% target consistently for most quarters of the last few years.

9.4.4 Waiting times – Cancer 2 week waits

Urgent GP referrals for suspected cancer					
Organisation	**Year**	**Total Number of cancer referrals**	**% seen in 2 weeks**	**Population**	**Rate of referrals per 100,000 population**
Berkshire West	Q2 2012/13	2423	90.51%	Not Yet Available	
	Q1 2012/13	2415	92.01%		
	2011/12	8793	95.08%		
	2010/11	8745	95.54%	471431	1855
	2009/10	7212	93.14%	466718	1545
RBFT	Q2 2012/13	2615	89.87%	N/A	
	Q1 2012/13	2558	91.79%		
	2011/12	9599	94.77%		
	2010/11	9492	95.20%		
	2009/10	7682	93.68%		
Berkshire East	Q2 2012/13	1840	94.13%	Not Yet Available	
	Q1 2012/13	1957	95.15%		
	2011/12	6804	96.77%		
	2010/11	6214	97.22%	406726	1528
	2009/10	5556	96.83%	399700	1390

Urgent GP referrals for suspected cancer					
Organisation	**Year**	**Total Number of cancer referrals**	**% seen in 2 weeks**	**Population**	**Rate of referrals per 100,000 population**
HWPFT	Q2 2012/13	2558	91.78%	N/A	
	Q1 2012/13	2010	94.83%		
	2011/12	7019	96.85%		
	2010/11	6487	97.21%		
	2009/10	5910	97.09%		
Buckinghamshire	2010/11		98.20%		1754
Oxfordshire	2010/11		*To follow*		1821

Data Source: PCT Monitoring

There are a number of national standards relating to cancer wait times. Included in the table above is one of these standards. The two week wait standard here relates to the percentage of patients who have received their first appointment within 2 weeks of the GP referral for an urgent referral for suspected cancer. This is an important indicator to ensure that patients are seen quickly when cancer is suspected so that the necessary action can be taken.

9.4.5 Mixed sex sleeping accommodation breaches

Mixed sex sleeping accommodation breaches					
Period:	**BW PCT**	**RBFT**	**BE PCT**	**HWPFT**	**BHFT**
Dec-12	0	0	3	0	0
Nov-12	0	0	3	0	0
Oct-12	0	0	1	0	0
Sept-12	1	0	0	0	0
Aug-12	0	0	0	0	0
Jul-12	0	0	1	0	0
Jun-12	0	0	1	0	0
May-12	0	0	1*	0	0
Apr-12	0	0	0	0	0
2011/12	10	5	4	3	0
Dec 10 - Mar 11	34	0	14	0	0

* St Georges Healthcare NHS Trust

Data Source:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/MixedSexAccommodation/index.htm

The national target is that there should be no breaches in mixed sex sleeping accommodation.

There has been a significant improvement in all Trusts in the last two years. Comprehensive action plans were worked through by all providers and delivery is monitored regularly through the NHS South of England performance management framework and by Monitor.

Every patient affected is counted as a separate breach, i.e. one female patient admitted to a male bay with four patients will result in five breaches.

9.4.6 Complaints

Complaints data				
Organisation:	**2012/13 (Q1-Q3)**	**2011/12**	**2010/11**	**2009/10**
RBFT	335	383	395	460
HWPFT	309	436	389	372
BHFT	181	238	134	79

Data Source: Trust Board Papers, Quality Accounts, Quality Schedule data.

For narrative see section 8.9.7

9.5 Domain 5 –Treating and caring for people in a safe environment and protecting them from avoidable harm

9.5.1 Healthcare Acquired Infections

Infection rates - MRSA								
	BW PCT		RBFT		BE PCT		HWPFT	
	Actual	Limit	Actual	Limit	Actual	Limit	Actual	Limit
2012/13 (Apr - Dec)	3	4	1	0	2	7	0	1
2011/12	6	7	0	1	6	8	1	1

Data Source:
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/StaphylococcusAureus/EpidemiologicalData/MandatorySurveillance/

Infection rates – C Diff								
	BW PCT		RBFT		BE PCT		HWPFT	
	Actual	Limit	Actual	Limit	Actual	Limit	Actual	Limit
2012/13 (Apr - Dec)	92	194	17	77	38	101	15	37
2011/12	263	194	108	77	123	108	58	53

Data Source: http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1259151898525

The national target is that the number of cases of MRSA and clostridium difficile should decrease in line with the agreed plans of each organisation.[8]

Tackling Clostridium Difficile in Berkshire

Reducing the incidence of Clostridium Difficile (CDiff) infection is a national priority and a priority for Berkshire as incidence rates have been increasing. Recent national and local epidemiological patterns suggest that infection is becoming more common than was previously observed in younger people and in the general community (non-hospitalised) population.

Actions: Berkshire West

General and clinical leadership

A CDI zero tolerance campaign was initiated in Berkshire led by the Director of Public Health and with some funding from the Cluster. It was launched in February 2012 with a high profile conference/seminar to which key stakeholders across the local economy, national HPA and selected provider Trusts attended. The key expected outcome which was to raise awareness of the issue, adopt best practice, enhance leadership and secure Board-level ownership of the HCAI/CDI challenge across the health economy was met. This was followed in September 2012 by a similar symposium targeted at staff from Nursing/residential homes in Berkshire and this achieved similar outcomes, some of which are still emerging. The lead Director of Public Health for HCAIs engaged in national leadership programme that has local HCAI as a focal item for transformational change. The lead DPH has also been part of an Exec-level joint strategic infection control group where CDI is a standing item. This group meets in the RBFT. Public Health is now also an attendee at the Trust Infection Control Group meetings where HCAIs are discussed in detail and actions agreed and taken forward.

Root Cause Analysis of MRSA bacteraemia cases and CDiff deaths

We have a system of RCAs for every MRSA bacteraemia and cases where CDI is reported on the death certificate. This system is well established and brings together primary, secondary care clinicians and public health professionals to investigate the root causes for these HCAIs and make recommendations for changes and improvements in practice. Key benefits have emerged from this process including the changes to the electronic discharge letter from RBH which now provides valuable information to guide infection control in the community for patients discharged from hospital care.

Root Cause Analysis of every CDI case

In recognition of the recent shifting pattern of CDI cases occurring more often in community than in the Acute Trust, we have initiated a system of root cause analyses for every CDI case occurring in primary care. To facilitate this, Public Health prepared a simple RCA template for primary care and completed sample RCAs with few primary care clinicians to demonstrate the practicality and value of the RCA as an additional driver for changes in prescribing culture in primary care. More crucially, the RCAs will help to provide further information on risk factors for CDI not previously considered significant.

[8] Please note limits shown are for full year.

Antibiotic stewardship in primary care

A significant amount of work has taken place over the last three years to promote antibiotic stewardship in primary care. This has involved iterative reviews and updates to the Berkshire West Antibiotic Prescribing Guidance for Primary Care as well as practice visits by Public Health in liaison with the Medical Director and Medicines Management. This visits targeted practices performing relatively poorly on antibiotic prescribing. Public Health also attended CCG meetings to discuss improved antibiotic stewardship on various occasions. Finally, receiving feedback from GPs as part of practice visits and giving relevant advice on antibiotic prescribing was a key element of our antibiotic stewardship programme.

Antibiotic stewardship in primary care

The PCT have also worked with secondary care clinicians to improve antibiotic stewardship. As part of this, the Trust lead for this strand of work initiated and completed a review of drug charts which now requires all IV antibiotics commenced empirically to be reviewed within 72 hours of commencement.

Epidemiological analyses

Public Health has continued ongoing local data collection, collation and epidemiological analysis to refine existing local knowledge about CDiff, particularly in respect of specific medications with the greatest causal or associative links to the incidence of CDiff.

Improving Community infection control practices

When nursing or residential homes are identified as requiring a visit during root cause analyses for HCAIs, these visits are completed by trained personnel on behalf of the Cluster. An Infection Control Nurse post for the community has been approved by the Cluster and the CCGs. This person will be employed by BHFT and will work with care and nursing homes. In addition, a Specialist Registrar in Public Health is currently doing a survey of Berkshire's nursing homes for knowledge, attitudes and practices in relation to CDiff amongst staff. It is hoped that this work will throw light on gaps and set a baseline for monitoring improvements that accrue from the wider zero tolerance campaign in Berkshire.

HCAI external audit of RBFT

This external audit of RBFT standards in relation to HCAI was commissioned by the Trust and was completed by Professor Brain Duerden (former DH Chief Inspector of microbiology) and Jan Stevens (former Director of the HCAI team at the DH). The outcome suggested the Trust was doing all that was necessary to reduce HCAIs but just needed to do more of those.

Robust auditing in the RBFT

This refers to the adoption of the National Specifications for Cleanliness (NSC) cleaning audit tool which jointly audits nursing and housekeeping cleaning. Monthly audits are reported to the Infection control committee and triangulated with patient experience feedback. Since 2012/13, the Trust more aggressively audited antibiotic use, PPI prescription and isolation practice in secondary care.

Cyclical ward deep cleaning

Full decant and early deep clean of all high risk wards:

- "Deep Clean Plus" programme, supported by £750K capital expenditure, to enable 10 wards to be decanted for one week and for estates and maintenance work to be completed associated with the deep clean. This ensured radiators etc. are removed and cleaning was more effective.
- General deep clean of all other clinical areas with a programme completed by the Autumn of 2011
- Repeat deep clean at the end of autumn 2011 of high risk areas cleaned early on in the programme.
- Hydrogen peroxide fogging of all side rooms which had had patients with confirmed *C. diff*.

Renewed focus on PPI use in primary care

We are presently increasing our monitoring of PPI prescription in primary care in relation to practice level CDI incidence. Our epidemiological and prescribing analyses are the mechanisms through which we have done and are continuing to do this.

Actions: Berkshire East

Broad spectrum antibiotics, specifically the four C's (3rd generation Cephalosporins, Ciprofloxacin, Clindamycin and Co-amoxiclav) and Proton Pump Inhibitor usage remain important risk factors and recent evidence suggests a synergistic effect of both classes of drugs in those simultaneously exposed to them.

Progress to date

- Undertaking an enhanced epidemiological analysis to understand the exact exposures that may have predisposed an individual to CDiff infection.
- Berkshire "Zero Tolerance to CDiff" Campaign is underway to reduce the rates of CDiff both in the Community and Acute Trust.
- As part of this Campaign a Learning Event with national and international speakers and three Conferences with workshops have been held at Ascot Racecourse, targeted at the different sectors to engage and enhance understanding of integrated working.
- Implementing an integrated approach to tackling rising incidence of CDiff, e.g. RCA across Berkshire.
- Leading Large Scale Change Initiative funded by the NHS Institute of Innovations supporting CDiff Programme. This Programme of work involves health professionals from different health sectors coming together to drive large scale change in the prevention and treatment of CDiff. Team members include GPs, Acute Trusts, Health Protection Agency, Community and Care homes and public health.
- CCG prescribing of antibiotics is being monitored monthly/quarterly; medicines management are offering support to individual practices to reduce elevated rates of prescribing.
- Undertaking Clinical audit of individual CDiff cases.

Risks in the project

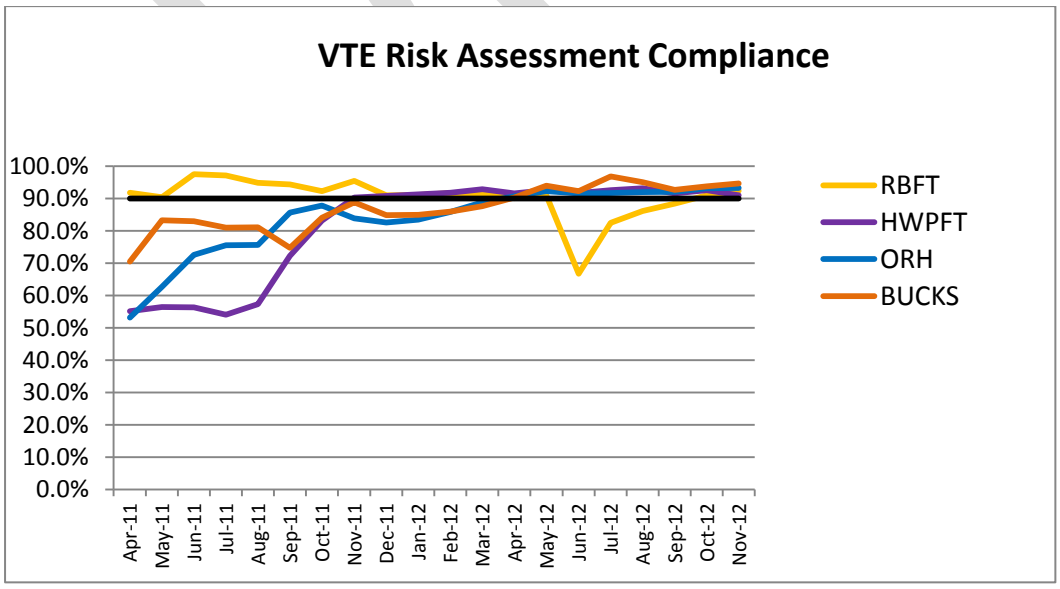
1. Timeliness of availability of data for CDiff cases from the Acute Trusts.

Risk Mitigation

1. Direct conversation with Acute Trust and Medical Directors.

9.5.2 VTE

VTE Risk Assessment Compliance				
	RBFT	HWPFT	ORH	BHT
Nov-12	92.4%	91.0%	93.3%	94.7%
Oct-12	91.0%	92.6%	93.2%	93.8%
Sept-12	88.5%	91.6%	92.1%	92.7%
Aug-12	86.2%	93.2%	92.0%	95.1%
Jul-12	82.5%	92.6%	91.7%	96.9%
Jun-12	66.7%	91.7%	91.6%	92.3%
May-12	91.0%	92.6%	92.3%	94.0%
Apr-12	90.1%	91.6%	90.7%	90.3%
Mar-12	91.4%	92.9%	88.8%	87.7%
Feb-12	91.7%	91.8%	85.9%	86.0%
Jan-12	91.1%	91.3%	83.5%	85.0%
Dec-11	91.0%	90.8%	82.6%	84.9%
Nov-11	95.5%	90.3%	83.9%	88.8%
Oct-11	92.3%	83.2%	87.9%	84.1%
Sep-11	94.4%	72.3%	85.7%	74.8%
Aug-11	94.9%	57.3%	75.7%	81.1%
Jul-11	97.2%	54.1%	75.6%	81.0%
Jun-11	97.6%	56.3%	72.6%	83.0%
May-11	90.4%	56.4%	62.7%	83.3%
Apr-11	91.8%	55.2%	53.2%	70.5%



Data Source: PCT Quality Monitoring

Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. Venous thromboembolism manifests as either deep vein thrombosis or pulmonary embolism and can be difficult to diagnose. In the United Kingdom it is estimated that without appropriate prophylaxis around 25,000 people a year will die from hospital-acquired venous thromboembolism.

The NHS has set a national target that at least 90% of patients within the acute care setting receive a documented venous thromboembolism risk assessment on admission.

HWPFT struggled to achieve this target throughout the first half of 2011/12, but brought performance into line with the national target from November 2011 onwards.

RBFT since the introduction of this indicator have performed highly against this national target. However, performance in 12/13 has fallen, following the introduction of a new patient management system / electronic patient record (EPR) on 18 June 2012. Change in internal Trust processes means that VTE risk assessments are now undertaken on the electronic system whilst previously they were undertaken on paper and flagged on the bed management system.

The Trust has produced a remedial action plan setting out actions and measure being taken to ensure performance is rectified.

UPDATE AGAIN BEFORE MARCH 2013

9.5.3 Serious incidents – Grade 1 and Grade 2

Serious Incidents - Grade 1 and 2 (excluding Never Events)		
Organisation	**2012/13 (Q1, Q2, Q3)**	
	Grade 2	Grade 1
RBFT	1	54
HWPFT	2	14
BHFT - MENTAL HEALTH	5	48
BHFT - COMMUNITY WEST	2	15
BHFT - COMMUNITY EAST	2	20

Data Source: PCT Monitoring

A serious incident is defined as an event or circumstance which resulted in unnecessary damage, loss or harm to a patient, staff, visitors or members of the public, or where a serious service failure did or might have occurred. These incidents extend beyond those that directly impact on patients and include those that may impact in the ability of an organisation to deliver on-going health services.

Serious incidents are reported to the Strategic Executive Information System (STEIS). This is a web based system that allows the logging and tracking of Serious Incidents.

Serious incidents are monitored by commissioners to ensure that patients are being kept safe and that Trusts learn from incidents and make improvements to prevent recurrence whenever possible. It is difficult to make comparisons between the reported levels of Serious Incidents in Trusts because of case mix and differences in reporting cultures.

Action plans are reviewed in Clinical Quality Review Groups or Serious Incident Review Groups with the Trusts.

9.5.4 Never Events

Never Events				
Organisation:	**2012/13 (Q1, Q2, Q3)**	**2011/12**	**2010/11**	**2009/10**
RBFT	1 (wrong site surgery)	1 (wrong site surgery)	1 (wrong site surgery)	0
HWPFT	3 (retained swab/surgical error/wrong site surgery)	0	0	0
BHFT - MENTAL HEALTH	0	0	0	0
BHFT - COMMUNITY WEST	0	0	0	0
BHFT - COMMUNITY EAST	0	0	0	0

Data Source: PCT Monitoring

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2009/10, eight core Never Events were identified. By 2011, a further 17 never events had been added to the national list, with some adaptation of the previous criteria.

In 2011/12 across the three SHAs now making up NHS South of England, 84% of the reported never events occurred within the following three categories:

- retained foreign object post operation (37 incidents, 46% of total);
- wrong site surgery (19 incidents, 24% of total);
- wrong implant / prosthesis (11 incidents, 14% of total).

Local reporting as detailed in the chart above is therefore in line with local and national reporting. Action plans are reviewed in Clinical Quality Review Groups or Serious Incident Review Groups with the Trusts.

9.5.5 Central Alerting System

Central Alerting System	
Organisation:	**Outstanding Alerts @ 5 September 2012:**
RBFT	EFA/2012/001 - Integral side-stay mechanism window restrictors fitted with plastic spacers and used in many window applications NPSA/2011/RRR003 - Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors NPSA/2011/PSA001 - Safer spinal (intrathecal), epidural and regional devices Part A: update
HWPFT	EFA/2011/007 - Electrolux (Dometic) absorption pharmacy / drug refrigerators, all models EFA/2011/003 - VIE (Vacuum insulated evaporator) Main storage vessel for bulk medical oxygen supply. NPSA 2011/PSA/003 - The adult patient's passport to safer use of insulin NPSA/2010/RRR018 - Preventing fatalities from medication loading doses
BHFT	MDA/2012/054 - SpeediCath Complete intermittent urinary drainage catheters. Manufactured by Coloplast. Multiple product codes and lot numbers.

Data Source: SHA

The Central Alerting System enables alerts and urgent patient safety specific guidance to be accessed at any time. Safety alerts, emergency alerts, drug alerts, 'Dear Doctor' letters and Medical Device Alerts are available on the Central Alerting System website. They are issued on behalf of the Medicines and Healthcare Products Regulatory Agency, the National Patient Safety Agency, and the Department of Health.

Commissioners review on-going compliance with alerts and ensure action plans are developed. NHS South of England also includes compliance with National Patient Safety Agency Central Alerts within the performance management system.

RBFT

The Trust remains non-complaint with NPSA/2011/RRR003 (Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors) and NPSA/2011/PSA001 (Safer spinal (intrathecal), epidural and regional devices). Due to a lack of suitable products on the market the potential for increasing the risk to patients is too high to implement these alerts in their current form at present time. Queries have been raised by the NPSA and SHA about their failure to close these alerts.

MORE NARRATIVE TO BE INCLUDED ONCE RECEIVED. UPDATE AGAIN BEFORE MARCH 2013

9.5.6 NPSA Reporting and Learning System data – Reporting rate

National Patient Safety Agency Reporting and Learning System data		
Organisation:	**Reporting period:**	**Reporting rate per 100 admissions/1000 bed days:**
RBFT	Oct 11 - Mar 12	5.42
		(Middle 50%)
HWPFT	Oct 11 - Mar 12	6.7
		(Middle 50%)
BHFT	Oct 11 - Mar 12	20.46
		(Middle 50%)
OUH	Oct 11 - Mar 12	6.23
		(Middle 50%)
BHT	Oct 11 - Mar 12	6.67
		(Middle 50%)
Oxford Health	Oct 11 - Mar 12	21.71
		(Middle 50%)

Data Source: NPSA Website

Since 2003/04 all NHS Trusts have shared anonymous patient safety incident reports with the National Patient Safety Agency. From these reports Organisation Patient Safety Incident Reports data are published by the National Patient Safety Agency on a six monthly basis. These data cover patient safety incidents occurring in a six month period as reported to the National Reporting and Learning System. In publishing the data the National Patient Safety Agency aims to provide tools to support NHS organisations to analyse and learn from safety incidents to prevent patient harm in the future.

It is a requirement of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 together with the Care Quality Commission Regulations 2009 that organisations report all patient incidents to the National Reporting and Learning System.

The most recent report in March 2012 covers the reporting period April to September 2011. A higher number of reported incidents from an organisation, specialty or location, does not necessarily mean that the organisation has a higher number of incidents; it may instead reflect an open reporting culture, something the NHS is striving to achieve across all organisations.

The rate of reporting is one measure of the safety culture of an organisation. The more an organisation understands the incidents occurring within it the more that can be undertaken to put systems in place to reduce the likelihood of reoccurrence.

9.5.7 NPSA Reporting and Learning System data – Severity of harm ratio

National Patient Safety Agency Reporting and Learning System data		
Organisation:	**Reporting period:**	**Ratio of severe harm and death to total number of reported incidents:**
RBFT	Oct 11 – Mar 12	0.005
HWPFT	Oct 11 – Mar 12	0.013
BHFT	Oct 11 – Mar 12	0.008
OUH	Oct 11 – Mar 12	0.015
BHT	Oct 11 – Mar 12	0.010
Oxford Health	Oct 11 – Mar 12	0.023

Data Source: NPSA Website

This indicator measures the number of incidents reported that result in severe harm or death, as a proportion of the total number of incidents reported. Berkshire providers rates are all equal to or better than the South Central average.

9.5.8 CNST and NHSLA Rating

Clinical Negligence Scheme for Trusts Maternity Standards and NHS Litigation Authority		
Organisation:	**NHSLA**	**CNST - Maternity**
RBFT	Level 1 (2011/12)	Level 2 (2009/10)
HWPFT	Level 1 (2011/12), due for renewal Jan 13	Level 1 (2011/12)
BHFT	Level 1 pending re-assessment following restructure	n/a
OUH	*Level 1 (2011/12)*	*Level 1 (2011/12)*
BHT	*Level 1 (2011/12)*	*Level 1 (2011/12)*
Oxford Health	*Level 1 (2011/12)*	*n/a*

Data Source: http://www.nhsla.com/RiskManagement/

The NHS Litigation Authority handles negligence claims on behalf of NHS bodies in England. The core of their risk management programme is provided by a range of NHS Litigation Authority standards and assessments. Most healthcare organisations are regularly assessed against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHS Litigation Authority.

A set of risk management standards exists for each type of healthcare organisation incorporating organisational, clinical and health and safety risks. These are the NHS Litigation Authority Acute, Community, Mental Health and Learning Disability and Independent Sector Standards, NHS Litigation Authority Ambulance Standards and the Clinical Negligence Scheme for Trusts Maternity Standards.

NHS organisations which provide labour ward services are subject to assessment against both the NHS Litigation Authority Acute (or Community) Standards and the Clinical Negligence Scheme for Trusts Maternity Standards.

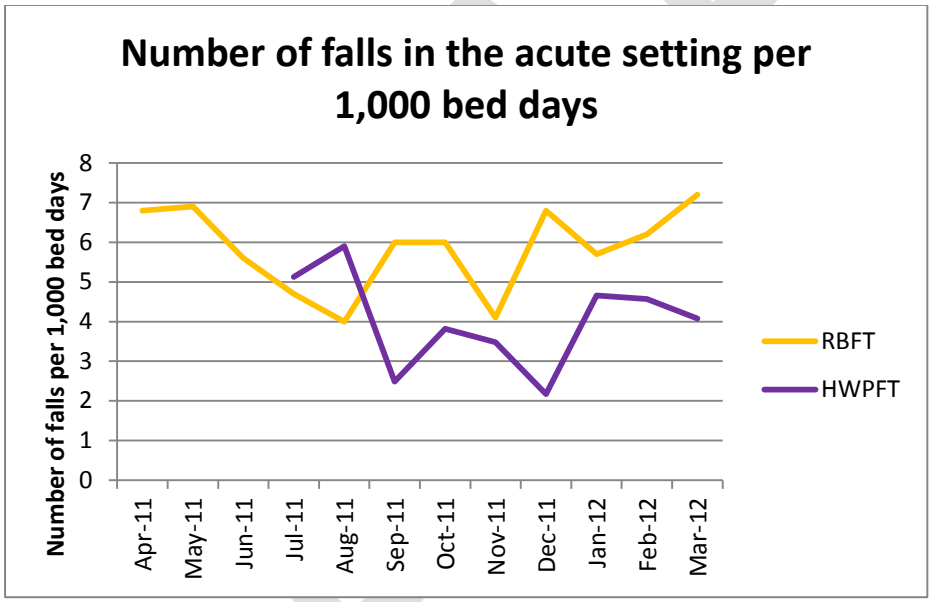
The NHS Litigation Authority standards are divided into three 'levels' one, two and three. NHS organisations which achieve success at level one in the relevant standards receive a 10 per cent discount on their contributions, with discounts of 20 per cent and 30 per cent available to those passing the higher levels.

The Clinical Negligence Scheme for Trusts Maternity standards are also divided into three levels and organisations successful at assessment receive a discount of 10 per cent, 20 per cent or 30 per cent from the maternity portion of their contribution. Level 1 deals with policy development and ensures that organisations have the correct policies to manage across the areas that are mostly reflected in terms of litigation. Level 2 deals with the implementation of the policies developed for level 1 assessment. Level 3 deals with the audit of the implementation of the policies to ensure that they are effective.

Whilst not mandatory, NHS Litigation Authority standards are one measure of quality across a number of key areas. Not meeting the standards (level 0) is an indication that an organisation does not have systems in place to management risk. No organisations are currently at level 0 within NHS South of England.

9.5.9 Inpatient Falls (acute)

Inpatient Falls (rate per 1000 bed days)		
	RBFT	HWPFT
Mar-12	7.2	4.08
Feb-12	6.2	4.57
Jan-12	5.7	4.66
Dec-11	6.8	2.17
Nov-11	4.1	3.48
Oct-11	6.0	3.82
Sep-11	6.0	2.49
Aug-11	4.0	5.90
Jul-11	4.7	5.13
Jun-11	5.6	
May-11	6.9	
Apr-11	6.8	



Data Source: PCT Monitoring

The data above reflects monitoring for 2011/12 when both acute providers established a baseline. For 2012/13 contractual limits were set for RBFT at no more than 5 falls per 1,000 bed days, and HWPFT agreed a limit of 4.8 falls per 1,000 bed days.

Data for 2012/13 to be added.

9.5.10 Inpatient Falls (community and mental health)

Falls reported as Serious Incidents		
Organisation:	**2012/13 (Q1, Q2, Q3)**	**2011/12**
	Total	**Total**
BHFT - MENTAL HEALTH	1	4
BHFT - COMMUNITY WEST	2	7
BHFT - COMMUNITY EAST	2	2

9.5.11 Pressure Ulcers

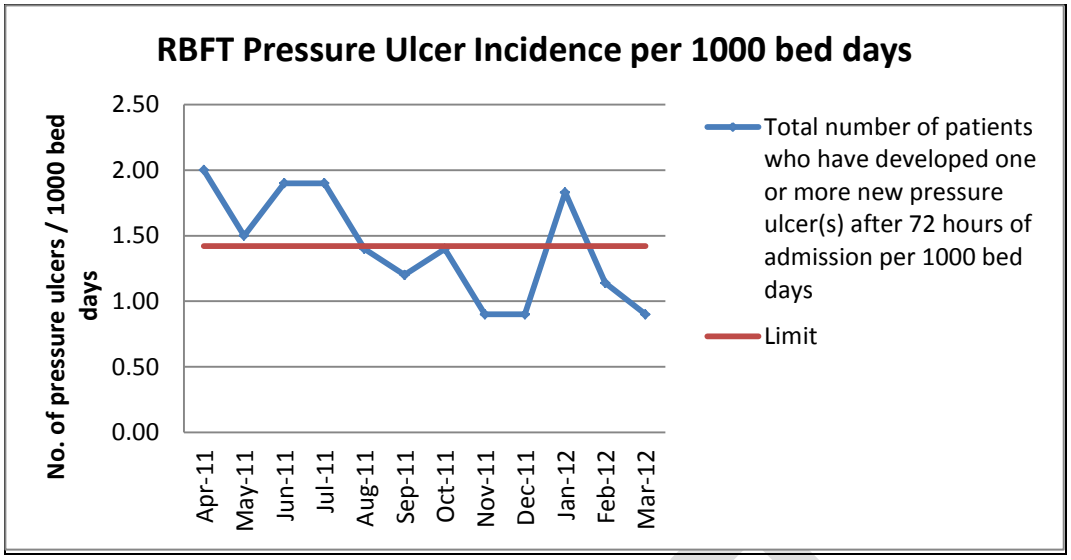
Pressure Ulcers (Grade 3 or 4 reported as SIs)		
Organisation:	**2012/13 (Q1, Q2, Q3)**	**2011/12**
RBFT	19	18
HWPFT	3	8
BHFT (MH)	0	1
BHFT (CHS West)	12	41
BHFT (CHS East)	16	40

Data Source: PCT Serious Incident Monitoring

Pressure ulcers are the most frequent serious incident across South Central. They are associated with significant morbidity and have a large impact on NHS resources and a proportion is avoidable.

In 2011/12 RBFT was required to keep pressure ulcers to a low level, and this was measured by the number of pressure ulcers per 1000 bed days. RBFT breached the limit of 1.42 in the first four months of the year, and produced an action plan detailing how they would improve performance against this standard.

Themes for action included: risk assessment; communication between primary, secondary care and care homes; obtaining equipment in a timely fashion; and documentation. The actions taken by the Trust had appeared to be having a positive effect as performance was below the limit for the subsequent 5 months, but unfortunately January saw incidence rise again to 1.83. This reduced back down to 1.14 in February and further to 0.90 in March.



HWPFT has a strong track record in the treatment and management of pressure tissue damage; a campaign entitled *No needless skin damage* was launched in 2010 with the Trust achieving positive results in reducing the incidence of hospital acquired pressure ulcers.

BHFT action plans for East and West community health services for reducing the number of category 3 and 4 pressure ulcers have been amalgamated. The action plan covers the areas of communication, documentation and pressure ulcer care pathway, managing workload and triage education and training and equipment.

The pressure ulcer care pathway and SKIN bundle is being piloted in the community and then will be extended across the Trust. A pressure ulcer and safeguarding protocol is also being piloted to assist in identifying when a pressure ulcer should be reported to the Local Authority safeguarding teams and reported as a serious incident requiring investigation. This has been as a result of joint working between the PCT providers and Local Authorities.

9.5.12 Homicides

Homicide/unlawful killings by people with mental health problems				
Organisation:	**Year:**	**Number of Incidents:**	**Category:**	**Independent Investigation Commissioned:**
BHFT	2011/12	1	Homicide by community patient	Pending independent investigation decision.

Data Source: PCT Monitoring

9.5.13 Maternity Services – LSMA report

Maternity services, Local Supervisory Midwifery Authority reports and audits		
Organisation:	**2010/11 – SOM Ratio**	**Key messages from LSA audit:**
The NMC set a standard that the supervisor of midwives ratio should reflect local need and will not normally exceed 1:15.		
RBFT	**01:20**	The ratio has reduced from 1:22 to 1:20 and there is 1 midwife who is suitable to be appointed in the summer of 2011. The LSAMO has held interviews and 5 midwives will commence the programme in October 2012. The LSAMO will work with the SoM team to support their work and their objectives for the 2011/12 year.
HWPFT	**01:18**	There are no midwives due to complete the course in 2011. In 2011/12 the LSAMO will continue to monitor that all SoMs are able to take their protected time and are able to carry out their role efficiently and effectively. The Trust has commissioned 4 places for the 2011/12 year and the LSA will hold interviews to ensure that there are 4 midwives who will be able to start the course in 2011.
BHT	**01:15**	
ORH	**01:16**	At ORH there are currently 2 SoMs who have taken a leave of absence for a year and there are 3 midwives due to complete the course and to be appointed in the summer of 2011. If the SoMs return to the role and all the midwives are appointed then the ratio will be 1:14. The LSAMO has held interviews for the programme and 5 midwives were found to be suitable. The Trust has commissioned 4 places for 2011/12 year and it is hoped that a fifth place can be funded.

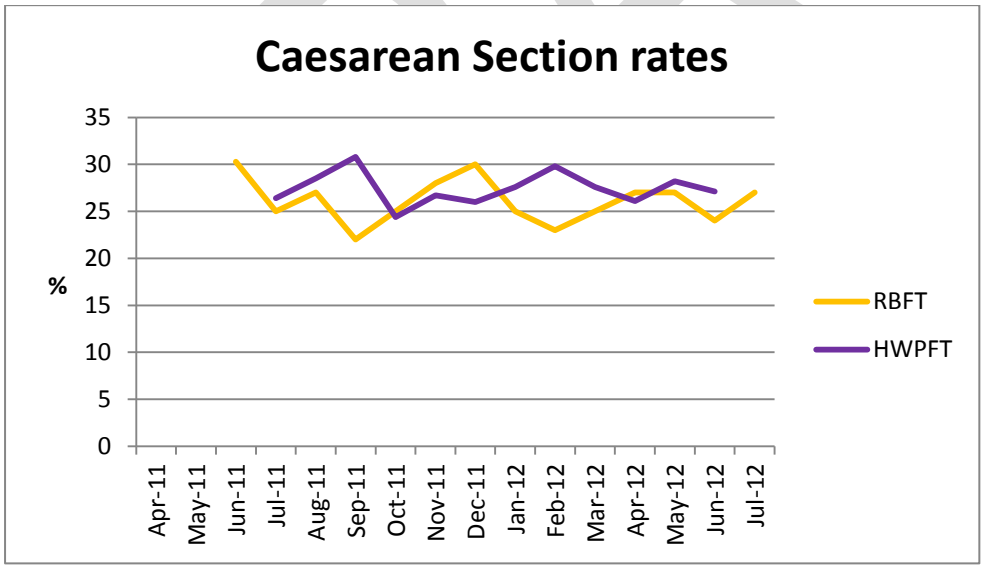
Data Source: South Central LSMA Annual Report 2010/11

Each year each Local Supervising Authority for Midwives sends an annual report to the Nursing and Midwifery Council.

9.5.14 Maternity Services – Caesarean Section Rates

Caesarean Section Rates (%)		
	RBFT	HWPFT
Jul-12	27	
Jun-12	24	27.1
May-12	27	28.2
Apr-12	27	26.1
Mar-12	25	27.6
Feb-12	23	29.8
Jan-12	25	27.6
Dec-11	30	26
Nov-11	28	26.7
Oct-11	25	24.4
Sep-11	22	30.8
Aug-11	27	28.5
Jul-11	25	26.4
Jun-11	30.28	
May-11		
Apr-11		

Data Source: PCT Monitoring



The Caesarean section rate reported by Trusts in NHS South Central ranged from 19% to 28.6% in 2009/10. The national average is 24.6% and the NHS Institute has concluded that on the basis of evidence and best practice it is possible for most units to achieve and sustain 20%.

The chart shows a reasonably similar position for the PCT Cluster's two main providers. RBFT had made significant progress on this quality indicator and towards the end of 2011/12, for the first time in over 3 years, performance had decreased below the 24% limit. February saw the Trust achieve

23% but this went up to 25% during March (11% elective and 14% for emergency caesarean sections). For 2012/13 performance has increased back up to 27% in July. The PCT has had CQUINS with RBFT on reduction of caesarean section rates for the financial years of 2009/10, 2010/11 and 2011/12. As the CQUIN in 2011/12 was partially achieved for c-sections, a different maternity CQUIN was introduced in 2012/13, focusing on the delivery of 1:1 care in labour. This was felt to give a more rounded picture of the quality of care in the maternity unit. The Trust has also been incentivised to measure and improve the mother's experience of care within the maternity unit.

In the financial year 2010/11 RBFT reported a serious of serious incidents relating to maternity care. An external review was commissioned which additionally considered issues such as ensuring a local response to national strategies such as Maternity Matters and the Darzi review, gaining assurance about the quality and safety of care, as well as considering local concerns about staffing capacity and high rates of Caesarean section. This was led by a Public Health Consultant in Berkshire West and reported in July 2010.

Actions from the review are monitored in a joint Maternity Steering Group, and contribute to a detailed programme of improvement with the Trust. Public Health staff from Berkshire West attend this meeting.

Berkshire East has also worked closely on maternity with HWPFT, as similar issues were experienced by this provider. There is a history of close working and monitoring, led by the CCG Federation Clinical Quality Lead who chairs the Clinical Quality Review Group with the Trust. C-section rates at HWPFT have proved equally challenging to bring down with it only dropping below 25% once in the past two years.

Following a series of serious incidents relating to maternity, external reviews were commissioned in 2010, and a follow up review was required in 2012. The CCG's Clinical Quality Lead attends the Trust's Obstetric and Gynaecology Steering group which oversees actions identified from the external review.

There is also an Executive-level meeting which meets periodically to consider progress on actions relating quality of care in maternity at HWPFT, giving high level assurance that the Trust is taking quality improvement in the area seriously.

9.5.15 Participation in South of England safety improvement programmes

Organisation	Participation in programmes
Royal Berkshire NHS Foundation Trust	Productive Ward, The Productive Operating Theatre
Heatherwood and Wexham Park NHS Foundation Trust	Productive Ward, The Productive Operating Theatre
Berkshire Healthcare NHS Foundation Trust	Productive Ward, Productive Mental Health Ward, Productive Community Hospital, Productive Series
Buckinghamshire Healthcare NHS Foundation Trust	Productive Ward, The Productive Operating Theatre, Productive Series
Oxford Health NHS Foundation Trust	Productive Ward, Productive Mental Health Ward,
Oxford University Hospitals NHS Trust (Nuffield)	Productive Ward
Oxford University Hospitals NHS Trust (Radcliffe)	Productive Ward, The Productive Operating Theatre
Oxford Learning Disability NHS Trust	Productive Mental Health Ward

Data Source: SHA Quality Handover Document

The implementation of the NHS Institute Productive Ward programme commenced in South Central Strategic Health Authority in 2008. Since then it has spread across all organisations in the region. The programme aims to empower ward teams to identify areas for improvement by giving staff the information, skills and time they need to regain control of their ward and the care they provide.

The South Central Productive Care work stream is led regionally from the Strategic Health Authority and nationally by the Institute for Innovation and Improvement. The steering group is chaired by the Chief Executive of Portsmouth Hospitals NHS Trust and the project is supported by a small project team at the Strategic Health Authority. Productive care is one of 12 national Quality, Innovation, Productivity and Prevention (QIPP) work streams with a focus on improving quality, safety and cost-effective care.

9.5.16 NHS Safety Thermometer

Safety Thermometer			
Organisation:	**Patients surveyed for Jun-12**	**% of patients harm free**	**Comments**
Royal Berkshire NHS Foundation Trust	651	93.10%	
Heatherwood And Wexham Park Hospitals NHS Foundation Trust	507	91.90%	
Berkshire Healthcare NHS Foundation Trust	217	94.50%	
Ramsay Healthcare- The Berkshire Independent Hospital	6	100.00%	
Spire Thames Valley	9	100.00%	
BMI - The Princess Margaret Hospital			Submitting from July 2012
Spire Dunedin	3	100.00%	

Data Source: SHA Quality Handover Document

TO BE UPDATED FOR MARCH 2013

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Throughout 2011, the Quality, Innovation, Productivity and Prevention (QIPP) Safe Care coalition and over 160 NHS provider organisations developed and tested the NHS Safety Thermometer. The tool measures four high-volume patient safety issues (pressure ulcers, falls in care, urinary infection (in patients with a catheter) and treatment for venous thromboembolism). It then calculates the proportion of patients who are considered to be free from these four harms. The data is collected by front line staff on one day per month.

For 2012/13, a national Commissioning for Quality and Innovation (CQUIN) is in place to improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and venous thromboembolism.

9.5.17 Clinical Audit

RBFT

During 2011/12, 43 national clinical audits and 2 national confidential enquiries covered NHS services that Royal Berkshire NHS Foundation Trust provides. The Trust participated in 83.72% of applicable national clinical audits and 100% of national confidential enquiries.

Exceptions:

- Non invasive Ventilation - adults (British Thoracic Society), Pleural Procedures (British Thoracic Society), Adult Asthma (British Thoracic Society), National Audit of Bronchiectasis (British Thoracic Society) - Instead focussed on robust implementation of the National audit recommendations.
- Medical use of blood (National Comparative Audit of Blood Transfusion) - Instead a more relevant local audit was undertaken with results compared to the national benchmark.
- Risk factors (National Health Promotion in Hospitals Audit) - Instead data were collated and reviewed as part of PCT contract.
- Diabetes (Adult) ND(A) - Focussed on Think Glucose, a more relevant local quality improvement initiative

HWPFT

In 2011/12 40 national clinical audits and six national confidential enquiries covered NHS services that Heatherwood and Wexham Park Hospitals NHS Foundation Trust provides. The Trust participated in 85% of applicable national clinical audits and 100% of national confidential enquiries.

Exceptions:

- Adult community acquired pneumonia, (British Thoracic Society), CABG and valvular surgery (Adult cardiac surgery audit) as participating in a similar Improving Quality Programme.
- Cardiac arrest (National Cardiac Arrest Audit), Diabetes (National Adult Diabetes Audit) due to staff shortages.
- Ulcerative colitis and Crohn's disease (UK IBD Audit), Bronchiectasis (British Thoracic Society), Acute stroke (SINAP) - not participating in 2011/12

BHFT

For 2011/12 the following 4 national clinical audits and 1 national confidential enquiry covered NHS services that Berkshire Healthcare NHS Foundation Trust provides. The Trust participated in 100% of applicable national clinical audits and 100% national confidential enquiries:

- National Parkinson's Audit
- National comparative audit of blood transfusions
- Prescribing in mental health services (POMH) (Various topics)
- National Audit of Schizophrenia
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Data Source: Trust Quality Accounts

The strategy embodied in the Next Stage Review, 'High Quality Care For All', in 2008, stressed more broadly that quality and quality improvement, including clinical audit, was the at the centre for improving the NHS and launched a stream of activity to drive quality, including work to improve clinical audit.

Participation in National Clinical Audits is additionally published as a statutory requirement in Provider Quality Accounts.

9.5.18 National Staff Survey results – Overall staff engagement score

Staff survey results (overall staff engagement score)				
Organisation:	**Year:**	**Overall Score**	**Position**	**National Average**
RBFT	2011	3.71	Highest 20%	3.62
RBFT	2010	3.63	Average	3.62
HWPFT	2011	3.46	Lowest 20%	3.62
HWPFT	2010	3.49	Lowest 20%	3.62
BHFT	2011	3.71	Highest 20%	3.61
BHFT	2010	3.70	Above average	3.64

Data Source: National Staff Survey 2010, 2011 Results

9.5.19 National Staff Survey results – Recommendation as a place to work or receive treatment

Staff survey results (KF34 – Recommendation as a place to work or receive treatment)				
Organisation:	**Year:**	**Score**	**Position**	**National Average**
RBFT	2011	3.67	Highest 20%	3.50
RBFT	2010	3.57	Above average	3.52
HWPFT	2011	3.18	Lowest 20%	3.50
HWPFT	2010	3.15	Lowest 20%	3.52
BHFT	2011	3.53	Above average	3.42
BHFT	2010	3.49	Average	3.49

Data Source: National Staff Survey 2010, 2011 Results

9.5.20 Nurse to bed and doctor to patient ratios

FTE Nurses per bed day (December 2011)				
Organisation:				
RBFT	1.98			
HWPFT	1.67			
BHFT	N/A			
South Central	***2.45****			
National	***1.85***			

Data Source: Acute Trust Quality Dashboard, Release 3, Spring 2012, SHA South of England *Maintaining and improving quality during transition: handover document*. Version 1 – draft 13 September 2012

Doctor to patient ratio				
Organisation:	**Year:**	**[ ]:**	**[ ]:**	[ ]
RBFT				
HWPFT				
BHFT				
South Central	***0.007***			

Data Source: SHA South of England *Maintaining and improving quality during transition: handover document*. Version 1 – draft 13 September 2012

Full data to be obtained and included by March 2013

A national quality dashboard is being developed in order to show comparative performance on quality for providers of NHS services. The dashboard will include information on nurse to bed ratio and doctor to patient ratios. These ratios have been calculated in NHS South of England using the metrics that will be applied nationally. The provisional data in the tables below will be confirmed in early 2013 when the national quality dashboard goes live.

9.5.21 Staff sickness

Staff sickness (December 2011)				
Organisation:	**Medical**	**Nursing**	**Midwifery**	**Other**
RBFT	0.94%	3.50%	4.40%	3.70%
HWPFT	0.35%	3.90%	8.80%	3.90%
BHFT	3.8% (Q3 2011/12)			
National	***1.19%***	***4.70%***	***5.10%***	***4.50%***

Data Source: Acute Trust Quality Dashboard, Release 3, Spring 2012 and Trust Board papers.

Staff sickness rates provide an insight into staff health and well-being, which in turn has an effect on quality of care.

Data provided by the Health and Social Care Information Centre shows that sickness rates in the South of England are lower than in the rest of the country, with the exception of London. Sickness absence rates in the South of England in March 2012 were between 3.6% and 4.1%.

Overall sickness rates in the NHS fell from 4.4% in 2009/10 to 4.1% in 2011/12.

9.5.22 GP Appraisal and Revalidation

GP Appraisal 2011/12 Year End Audit				
		BE PCT	**BW PCT**	**Total**
Doctors on Performers List as at 31/3/12		327	383	710
Doctors who completed their appraisal in Berkshire		313	352	665
Doctors who completed their appraisal elsewhere eg MOD		4	5	9
% of doctors completing appraisal in 2011/12		97%	93%	95%
Doctors whose appraisal was deferred	To Q1 2012/13 due to illness	1	5	6
	For maternity leave	4	9	13
	Due to retirement	2	3	5
	Long term sickness		1	1
Doctors who did not undertake appraisal		3	8	11

Data source: PCT Medical Revalidation Lead

There are robust monitoring arrangements in place to ensure that GPs are undertaking appraisal and that the quality of the appraisal is monitored and benchmarked taking action to improve performance where necessary. In 2011/12 95% of doctors across Berkshire completed their appraisal by the deadline. As at December 2012, 42.5% are complete with the majority due to be completed in February or March 2013. This is the normal pattern experienced for appraisals in Berkshire and we are forecasting a completion rate of 100% which is in line with SHA expectations.

Revalidation regulations officially came into effect in December 2012 meaning that every licensed doctor is now legally required to regularly revalidate and all designated bodies (organisations employing doctors as defined in the legislation[9]). The Berkshire PCT's Cluster Responsible Officer is currently responsible for the revalidation recommendations for the doctors on the performers list though GP Registrars will be revalidated through their Deanery. We have been preparing for the implementation and reporting and monitoring via the Organisational Readiness Self-Assessment tool which is submitted via the SHA. Berkshire is rag rated green on its implementation status.

All level 1 Responsible Officers (ROs) are expected to be revalidated by the SHA Responsible Officers during the first quarter of 2013. ROs have been provided with guidance and the collection of data

[9] Medical Profession (Responsible Officer) Regulations, 2010

will commence shortly. A dashboard will be used to monitor the performance of ROs and enable a decision to be made by the SHA ROs regarding recommendation for revalidation.

To deliver revalidation, the PCT's clinical governance and appraisal processes need to be robust and both of these have been strengthened over the last 18 months.

An Appraisal Policy has been implemented which includes provision for deferment in cases of ill health, maternity etc which encourages doctors to plan for any absences. All the appraisers in Berkshire have attended top up training and all appraisals completed after 1/09/12 are revalidation ready. Quality Assurance of the appraisal process and the appraisers has been strengthened with appraisers attending regular in house training sessions with feedback on elements of their practice being supplied.

The Clinical Governance group is part of the robust systems which are in place to collect information, investigate and then respond to concerns and specifically reviews issues relating to primary medical contracts and performers. The group undertakes its functions by triangulating information such as complaints, incidents, prescribing, practice profiles, local intelligence, PCT held data from regulatory bodies and previous records. All of this information is held, confidentially, within records which will support the RO in making a revalidation recommendation.

10. RISK REGISTER

Include a copy of the risk register at the point of compiling the handover.

To be inserted for March 2013.

11. DOCUMENT CONTROL

List of document / data sources relevant to this legacy document which should be stored electronically using a secure and approved system for data protection (see chapter five of the guidance). Details of custody and access should be provided. Explain data storage methods, achieve retrieval protocol(s) etc.

To be finalised by March 2013

Subject area	Document Name/Description	Pre 1/4/13 Location	Owner/contact point for access	Destination of files post 1/4/13
Commissioning quality services from main providers	Quality reports for PCT Board and internal PCT/CCG Quality Committees	Currently in PCT shared folders – to be moved as part of Document Management Transition work-stream.	Lisa Edwards	
	Quality and Risk Committee minutes		Lisa Edwards	
	East CCG Federation Quality Committee minutes		Lisa Edwards	
	West CCG Federation Commissioned Service Clinical Quality Committee		Lisa Edwards	
	Non-financial performance indicators reports		Lisa Edwards	
	MASTER Quality Spreadsheets		Lisa Edwards	
Commissioning Offender Health	Prison Health Performance and Quality Indicator assessment		Public Health	
	Prison health needs assessment		Public Health	
	Prison health contract meeting minutes		Public Health	
	Offender Health Strategic Partnership Board minutes		Public Health	

Subject area	Document Name/Description	Pre 1/4/13 Location	Owner/contact point for access	Destination of files post 1/4/13
Serious Incidents	SI performance monitoring spreadsheet		Lisa Edwards	
	Monthly SI figures		Lisa Edwards	
	SI reports for East/West Federation Quality Committee		Lisa Edwards	
	SI Review Group minutes		Lisa Edwards	
	SI case files		Lisa Edwards	
Primary Care – general	Practice profiles		Maureen McCartney / Jacky Walters	
	Practice overview spreadsheet		Helen Clark	
	Minutes of GP Clinical Governance meetings		Wendy McClure	
	Minutes of Dental Commissioning / Contract and Quality Group		Hugh O'Keefe	
	Minutes of Pharmaceutical Commissioning / Contract and Quality Group		Kath Havisham	
	Minutes of the Ophthalmic Commissioning / Contract and Quality Group		Hugh O'Keefe	
Primary care – individual	Individual case files		Wendy McClure	
	Minutes of GP Concerns Group		Wendy McClure	
Medical Revalidation	Case files		Wendy McClure	
	GP Appraisal data		Wendy McClure	
Safeguarding Vulnerable Adults and Children	Serious Case Review reports and action plans		Sam Otorepec / Jenny Selim	
	Safeguarding Board Annual Reports		Sam Otorepec / Jenny Selim	
	OFSTED Reviews and action plans		Sally Murray	
Deprivation of Liberty	DoLS – process, records, policy		Julie Curtis / Nick	

Subject area	Document Name/Description	Pre 1/4/13 Location	Owner/contact point for access	Destination of files post 1/4/13
decisions			Buchanan	
Infection prevention and control	Infection Control Quality and Risk Committee reports		Lisa Edwards	
CAS Alerts	CAS Policy – records		Karen Hampton	
Complaints	Complaints case files		Malcolm Mackenzie	CSCSU – Complaints Team
	Datix database (complaints)		Malcolm Mackenzie	CSCSU – Complaints Team
Patient Advice and Liaison Service (PALS)	PALS case files		Malcolm Mackenzie	CSCSU – Complaints Team
	Datix database (PALS)		Malcolm Mackenzie	CSCSU – Complaints Team
Research Management and Governance	Approved Research overview		Lisa Edwards	
QIPP	QIPP plans and milestones		Anshu Varma	
Incident reporting	Datix database (incidents)		Steph Bennett	
Screening	Coverage data		Chris Cook / Asmat Nisa / Angela Snowling / Lesley Wyman	
	Quarterly summary of screening reports		Chris Cook	
	Screening Oversight meeting		Kelechi Nnoaham	
Immunisation	Coverage data		Chris Cook / Rutuja Kulkarni	
CCG Performance data	Non-financial performance indicators reports		Debbie New	
Individual Funding Requests	IFR case files		Mavis Daniel /	

Subject area	Document Name/Description	Pre 1/4/13 Location	Owner/contact point for access	Destination of files post 1/4/13
			Aleksandra Connelly	
Learning Disabilities Commissioning	LD Partnership Board (by Local Authority) minutes		Sarita Rakhra	
	Winterbourne Assurance		Sarita Rakhra	
	Learning Disability Self Assessments		Sarita Rakhra	
Out-of-Hours Commissioning	Out-of-hours annual reports		Jacky Walters	
	SHA out-of-hours returns		Jacky Walters	
AWP/AQP	Files relating to assessments and decisions		Shairoz Claridge / Georgie Sullivan / Nicky Gurr / Alistair Nixon / Trevor Keable	
Patient Engagement	Duty to Involve Report 2011/12		Cath Price	
Maternity	Berkshire West Maternity Review		Jane Wells	
	Berkshire East Maternity Review		Sara Whittaker / Christina Gradowski	

12. ADDITIONAL DOCUMENTS

Links to other relevant material including names of authors / sources of additional information.

List to be further developed by March 2013. To include:

- *CQC Quality Risk Profiles*
- *JSNA*
- *Practice Profiles*
- *Quality Accounts*
- *Provider Annual reports*
- *LINks reports*
- *Learning Disabilities Health Self Assessment Framework*
- *Progress Report to Board on Transition: Safeguarding Children and Vulnerable Adults*

13. FACE TO FACE COMMUNICATION

Confirmation details of the verbal handover/discussions between key staff. This is to include dates, outline notes of issues discussed etc. In the event of confidential / sensitive material being shared with the receiving accountable officer a note should be made of the topic area without detail.

Subject area	Handover between	Date of meeting	Outline of issues discussed	Further actions / meetings
Safeguarding – process and function	Andrew Fenton (CSCSU), Julie Curtis (PCT Dir of Joint Commissioning), Jenny Selim (PCT Desig Nurse for CP), Sam Otorepec (PCT Head of Joint Commissioning), Sara Whittaker (PCT Quality Lead)	17 January 2013	Safeguarding Adults and Children: the function of CSU in relation to this area	
Safeguarding – operational	Ongoing discussions between Sam Otorepec and Quality Team staff (PCT/CSCSU)	January – March 2013		
Medical, Dental, Community Pharmacy and Optometry	David Buckle (PCT Med Dir), Helen Clanchy(PCT Cluster Dir of Commissioning) , Maureen McCartney, Jacky Walters (PCT Assistant Directors of Primary Care Commissioning)	Initial brief meeting (8 February 2013) followed by detailed meeting once new Head of Primary Care appointed for Thames Valley AT (imminent)	Commissioning, Contracts, Budgets, Quality and performance with risks. Contract performance follow up of visits and actions. Premises issues	To be confirmed
Primary Care Clinical Governance and Individual performer performance	David Buckle (PCT Med Dir), Geoff Payne (AT Med Dir)	7 February 2013	Clinical governance issues, Individual performer concerns, appraisal and revalidation and budgets	Detailed meeting to be arranged to discuss cases with Geoff Payne, Jacky Walters and Wendy McClure (PCT Lead for primary care performance) & GP Clinical Governance Leads
General handover process and oversight	Marian Andrews-Evans (Outgoing Director of Nursing for Berkshire Cluster) and Area Team Directors/CCG Leads	February CCG Assurance Meeting		

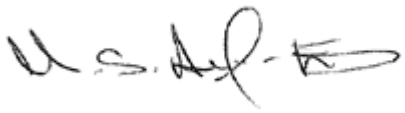
14. GLOSSARY

To be included in final version

15. DOCUMENT SIGN-OFF

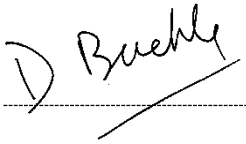
Signed by Transition Lead

Marion Andrews-Evans
PCT Cluster Director of Nursing



Approved by Medical and Nurse Directors

Dr David Buckle
PCT Cluster Medical Director



Marion Andrews-Evans
PCT Cluster Director of Nursing

NORTH & WEST READING 13/14 COMMISSIONING PLAN

"To identify and develop wholly integrated health services in conjunction with providers that are efficient, of high quality, easily accessible for our patients, whilst maintaining value for money and effective budget control."

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Introduction from the Chair

This is our first Commissioning Plan for North & West Reading CCG and covers the financial year from April 2013 to March 2014. The plan details our proposals for local healthcare services to meet the needs of our local population, and to drive improvement in health and health services. It is important for us to show that we are now leading the commissioning discussion and decision making for our local area. We firmly believe that placing clinicians at the heart of NHS commissioning will mean we can work with our partners and communities to make real improvements in local health and wellbeing.

North and West Reading is fortunate to have 10 excellent practices with a shared commitment to good patient care and this plan will be delivered locally in partnership with the other CCGs in the Berkshire West Federation, and with the local councils. This is to ensure that the healthcare services we provide are sustainable, effective and efficient and we reaffirm our duty to uphold the safety of our patients.

In order to provide services that meet the needs of our local communities, the CCG has based its plans on the findings of the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy (developed in partnership with the local councils), and from feedback received from patients and the public on local services.

It is our intention to deliver:

- The right care for patients, at the right time and provided in the right place
- Health and social care services that work more closely together wherever this is to the benefit of our patients and their carers
- Care closer to home for patients, recognising there are issues of access and travelling distances for our population.
- Innovative ways of providing care, through better use of technology, a wider skills-base and team support for individual members of staff, or development of shared care-planning with our patients

It is our intention to commission:

- Accessible, high quality, efficient patient care
- The best value for money in care from a wide range of providers
- Choice in providers wherever appropriate

There is no doubt, of course, that 2013/14 will be a tough year in terms of the decisions to be taken for the allocation of health and social care resources. We have worked closely with our providers and our partners in Reading and West Berkshire Council to achieve the fairest distribution that we

can, across the many priorities for funding that we face. We have also listened carefully and will continue to listen to the views of our patients and members of the public.

We have held several events to gain insight from members of the public, and local health professionals in developing this plan and though out 13/14 will give further opportunities to comment on how these plans are working in practice, and what changes we need to make to ensure a process of continuous improvement.

Dr Rod Smith
North & West Reading CCG Chair
West Berkshire Federation Chair

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

High Level Objectives	Strategic context	Priorities with target improved outcomes	What we will do in 2013/14		How it will look in 2015/16
To provide equitable, high-quality primary medical care To deliver more services in the community, with less patients being seen in hospitals To use finite NHS resources wisely, based on clinical evidence and need	A local CCG working in a Federation of 4 Our local population is ageing, with some older people living alone, and some deprivation across large rural areas 3,500 children live in poverty, and 6,000 households are in fuel poverty High performing primary care Historically low levels of emergency admissions, and GP referral rates Our predecessor PCT one of the lowest funded in the country CCG Budget for 2013/14: £108m Planned savings 2013/14: £1.3m	1. Delivery of 9 care processes for people with diabetes, to achieve best practice care for everyone ***Aiming for a 55% achievement in Year 1*** 2. Increase the uptake on invitations from the Bowel Screening Programme (60-75) ***Aiming for 57% in Year 1*** 3. Reduce the number of non elective hospital admissions due to COPD ***Aiming to bring admissions down to 107/100,000 population*** **General Practice** ▪ Quality & Efficiency visits ▪ Local prescribing QIPP initiatives ▪ Extended Hours Health Check service ▪ Innovative diabetes early warning programme **Partnership Working Safeguarding** ▪ Closer integration and collaboration between health, West Berks social care and all our statutory and voluntary partners ▪ Safeguarding for adults and children ▪ Health & Wellbeing Board & Strategy	**PLANNED CARE**	• Joint GP/Consultant working on best practise care pathways, to reduce clinical variation and ensure best use of diagnostics and referrals	• rimary care to make 'Care Closer to Home' a reality • Health and social care to work more closely together to provide seamless services for individuals and families, and improve the quality of the support they receive • Quality, outcomes and patient experience at the heart of decision-making
			URGENT CARE	• Efficient access and rapid assessment as alternatives to hospital admission • Continued investment and delivery via: rapid response and re-ablement teams; community geriatrician; 7-day access and single point of access to intermediate care • Improving patients' ability to access 'right care' through NHS 111 • Shorter ambulance response times and faster handovers in hospital • **In 2013/14, we aim to reduce non-elective admissions by 1 a day (£600K savings)**	
			LONG TERM CONDITIONS	• Embedding risk stratification and GP care management via new Case Coordinators • Investment in community nursing to provide 24-hour seamless care • Telecare investment for heart failure patients, and information websites for other conditions • Shared care planning as the norm • Early diagnosis of dementia and carer support	
			JOINT COMMISSIONING	• Joint working with social services to improve local support for people with Learning Disabilities • Reduce out-of-area placements • Better access to psychological therapies	

OUR PLAN ON A PAGE

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

OVERVIEW OF NORTH & WEST READING CCG

North West Reading CCG is comprised of 10 GP practices who have worked closely together for a considerable number of years with common values to develop services and share best practice. The practices have a track record of working together through fund-holding, training and Practice Based Commissioning to deliver improvements to services and education and make cost effective use of health resources. This requires close working of all the practices in terms of sharing learning points and ideas in order to benefit from any economies of scale and to implement effectively any new services for our patients

The CGG constitution is a Council, with an Elected Board which is supported by an Operational Management Team. Underpinning this close working is a strong and interactive Council of Member practices, with each practice represented by a GP and Practice Manager. Council Meetings and Forums form the basic working structure for this interaction but in between meetings, key messages are co-ordinated and introduced by the Council Chair. We have a strong culture of "name and explain" which helps drive forward a process of continuous improvement.

The geography of the CCG includes three practices within the neighbouring Local Authority and working relationships have existed with both Reading and West Berkshire Local Authorities for many years. Whilst relationships are required with both Local Authorities, patient flows for healthcare services are common and primarily focused around the Royal Berkshire NHS Foundation Trust for acute care and Berkshire Healthcare Foundation Trust for mental health and community services.

The CCG commissioning responsibility is for the registered populations of its member practices as well as any unregistered population within its geographic boundary.

The context for change is an environment of an ageing population, with the over 65"s proportion of the population increasing and with that increasing demand on healthcare, particularly in relation to long term conditions. This means that healthcare has to focus on prevention and productivity, whilst maintaining improving outcomes and quality for patients remain at the heart of what we do.

Dr George Boulos,
Chair of the Council of Practices

Our Member Practices

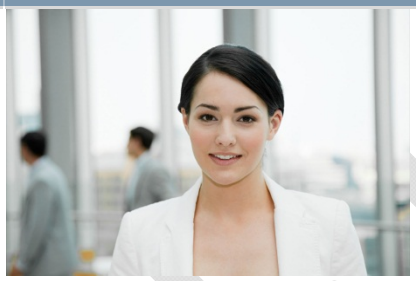
NORTH & WEST READING CLINICAL COMMISSIONING GROUP

Practice Name	Address	No of Patients	Chair of PPG*
Balmore Park Surgery	59a Hemdean Road Caversham Reading RG4 7SS	15,800	Gordon Summers
The Boat House Surgery	Whitchurch Road Pangbourne Reading RG8 7DP	10,500	Sir Neil McFarlane
Circuit Lane Surgery	The Surgery 53 Circuit Lane Reading Berkshire RG303AN	10392	*To be inculded*
Emmer Green Surgery	4 St Barnabas Road Emmer Green Reading RG4 8RA	9400	Martin Sykes
Mortimer Surgery	72 Victoria Road Mortimer Common Reading RG7 3SQ	11810	Chris Bardwell

Peppard Road Surgery	45 Peppard Road Caversham Reading RG4 8NR	2079	*To be included*
Priory Avenue Surgery	2 Priory Avenue Caversham Reading RG4 7SE	8500	Bernard Dominic
Theale Medical Centre	Englefield Road Theale Reading RG7 5AS	10431	*To be included*
Tilehurst Surgery Practice	Tylers Place Pottery Road Tilehurst Reading RG306BW	13200	Kirsten Willis
Western Elms Surgery	317 Oxford Road Reading Berkshire RG301AT	16600	Alan Porton

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

MEET THE BOARD

DR ROD SMITH CHAIR & JOINT COMMISIONING LEAD	DR ANDY CIECIESKI DEPUTY CHAIR & URGENT CARE LEAD	DR GEORGE BOULOS CHAIR OF THE COUNCIIL OF PRACTICES & PLANNED CARE LEAD
		
Biography	**Biography**	**Biography**

DR CATHERINE KELLY LONG TERM CONDITIONS LEAD	DR RUPPERT WOLLEY BOARD MEMBER	ALLWIN MERCER BOARD MEMBER
		
Biography	**Biography**	**Biography**

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

SALLY GIFFORD
PRACTICE MANAGER LEAD

Biography

MR DERECK FAWCETT
SECONDARY CARE CONSULTANT

Biography

DEBBIE DAILY
NURSE DIRECTOR

Biography

DR CATHY WINFIELD
CHIEF OFFICER

Biography

JANET MEEK
DIRECTOR OF FINANCE

Biography

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

MANAGEMENT TEAM

MAUREEN MCCARTNEY DIRECTOR OF OPERATIONS	PAVINDA THANDI COMMISSIONING MANAGER	SUSIE BACON ADMINISTRATOR
		

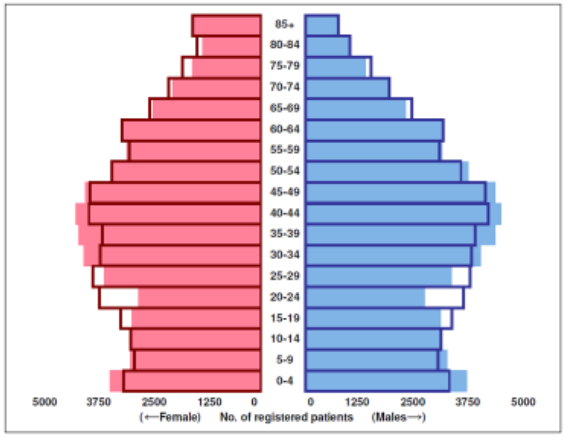
Our Populations Needs

JOINT STATEGIC NEEDS ASSESSMENT

This section sets out a summary of the Joint Strategic Needs Assessment, highlighting our priority areas for improvement. In particular it picks out life expectancy, mortality rates, admission rates, some long term conditions and child health. Learning disability and mental health are also highlighted.

North & West Reading CCG sits across two unitary boundaries and as a result we commissioned public health to do a further analysis of our population so we could fully understand the needs of our patients. This enables all our partners to take account of the broader social and environmental factors that shape our health and wellbeing.

Our Population



The England average population distribution is overlaid on the chart as an outline.
18.1% of CCG population are aged under 15 (England average 17.1%)
7.1% of CCG population are aged 75 and over (England average (7.5%)

Source: DH CCG data profiles

NWR has relatively little deprivation compared to other areas however we do have small amounts of rural deprivation within council estates and larger pockets of deprivation in some of the urban areas.

The age/sex breakdown of the population is similar to the national pattern, but with fewer younger adults (15-30) and more aged 30-45. The age breakdown is also different from our neighbouring CCG's of Newbury & South Reading.

Neither Reading UA nor West Berkshire UA's population is representative of North and West Reading however further analysis of the data suggested we have more similarities with Newbury CCG and West Berkshire than with the Reading population. Population projections suggest that the older population will increase proportionally more than the whole CCG population. This is similar to the national pattern.

The majority of residents in our CCG were either single or married for the first time.

This table shows how the CCG population is expected to grow by 2015, 2020 and 2025.

This indicates that N&W Reading will grow at a slightly higher rate than the national average and will have a similar age profile to the rest of the country.

N&W Reading CCG population projections

Year	Population	population 75+
Current (2011)	106,028	7,535
2015	109,836	8,133
2020	115,032	9,145
2025	119,842	10,946
Average annual growth rate 2011 to 2020	0.9%	2.2%
England average annual growth rate 2011 to 2020	0.7%	2.3%

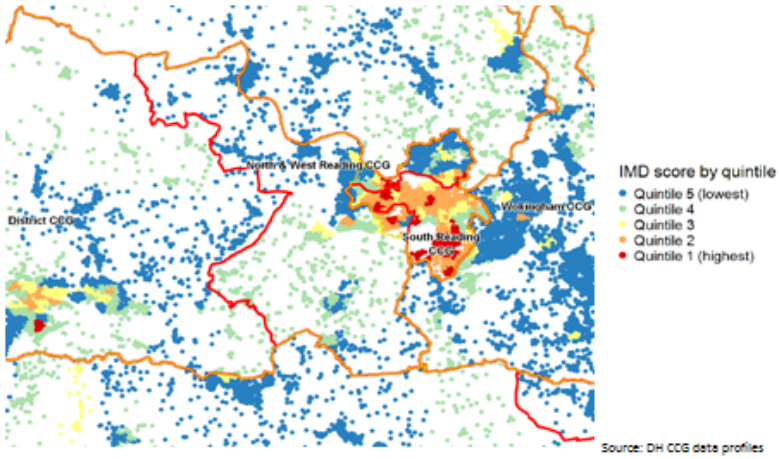
Source: DH CCG data profiles

North & West Reading's registered population is also spread widely outside of the CCG geographical boundaries with some parts of the population within Oxfordshire as well as a large population within Reading Borough and within West Berkshire. It was noted that the census population is 10% smaller than the actual population.

Pockets of deprivation and poverty

The majority of North & West Readings population is in the bottom quintile for deprivation and broadly the same across the CCG.

Index of multiple deprivation



Source: DH CCG data profiles

Our Health

Older People

The JSNA states that there is a certainty that the prevalence rate of dementia will increase across all areas. The current reported prevalence across our CCG is significantly lower than the South Central Strategic Health Authority area and national averages. The JSNA therefore suggests commissioning of services to increase assessment and diagnosis of both the expected growth and the current relative lower level of identification.

Long Term Conditions

The modelled prevalence of Chronic Obstructive Pulmonary Disease in North & West Reading is significantly higher than the reported prevalence. As COPD is the third most common cause of death in Berkshire West after cardiovascular diseases and cancer, the JSNA suggests a focus on identification and management of this disease.

The recorded prevalence of cardio-vascular disease is also significantly lower than the national and South Central averages however the rate of emergency coronary heart disease admissions per 100 people on the CHD register compares well with South Central and national averages. The JSNA suggests a focus on identification and a secondary focus on prevention and risk management. To be included

Children, Young People and Family Themes

The JSNA highlighted that North & West CCG priorities should be focused on early intervention (maternity care, breast feeding and immunisations), childhood obesity and long-acting reversible contraception. Current performance information shows that although performing well compared to the rest of the West Berkshire CCGs, the national targets for breast feeding and childhood immunisations are not being met. The rate of childhood obesity in Year 6 children is rising in particular in the Reading Local Authority side of the CCG geography also.

JSNA Summary

Another key finding from the JSNA was that our patient population overall perception of their health and limitations are better than national average, but there is a wide range across practices.

HEALTH & WELLBEING STRATEGIES

To be included

PATIENT & PUBLIC CONSULTATION

To be included

CCG Commissioning Priorities

DELIVERING QUALITY

To be refreshed

North & West Reading CCG recognises its responsibility in putting quality and safety at the centre of everything we do. One of the key objectives of this is to continuously improve the quality of services and therefore the experience of patients.

High Quality Care for All, the final report of the NHS Next Stage Review (2008) sets out commitments for making quality improvement across three dimensions: ensuring that care is safe, effective and provides patients with the most positive experience possible.

Our Quality Strategy has five objectives that will be addressed at every stage of the commissioning cycle. These objectives are:

1. To ensure that services being commissioned are safe, personal and effective
2. To ensure the right quality mechanisms are in place so that standards of patient safety and quality are understood, met, and effectively demonstrated
3. To provide assurance that patient safety and quality outcomes and benefits are being realised, and recommend take action if the safety and quality of commissioned services is compromised
4. To promise the continuous improvement and innovation in the safety and quality of commissioned services
5. To develop new and innovative ways of acting upon patient feedback to ensure real change happens.

We will ensure that the recommendations of the Winterbourne View Inquiry and Francis Report are embedded into our commissioning as key quality principles.

A quality report will be presented monthly to North & West CCG covering the three main measures of quality- Patient experience (including complaints and information form the NHS Choice website), Patient safety (including serious incidents, suicides and unexpected deaths and NSH Safety Thermometer information) and clinical effectiveness (including the Quality Schedule and CQUIN progress-see below).

In addition through our communications teams, Patient advice and liaison services , Health watch , our member practices, public website and various Patient engagement groups, such as North & West Reading Patient Voice and practice patient and participation groups , we will continue to be responsive to any concerns raised about a service we commission for the North & West population. We will assess the situation and take any necessary action to resolve issues, and communicate back, demonstrating our commitment to adopting the “You said we did” principle .

North & West Reading CCG is also actively involved in the Thames Valley Quality Surveillance Group which meets on a monthly basis to review the performance of our providers.

PLANNED CARE

Introduction from Dr George Boulos & Picture

The planned care programme will ensure that patients within North & West Reading CCG access services in the right place, at the right time, by the right healthcare professional and patients will have choice of providers.

The overall strategy for the Planned Care Programme is to redesign services to improve health outcomes for patients and to meet the five domains of the NHS Outcomes Framework, for healthcare services to be provided in the most appropriate location, quality is to be improved by offering patient choice and having robust contractual arrangements and for cost efficiencies to be achieved to allow for investment in innovative healthcare services.

The principles for commissioning services within the planned care programme are:

- Fewer inappropriate hospital admissions and shorter lengths of stay in hospital
- Efficient and appropriate number of outpatient visits
- Using more community-based health services rather than hospitals wherever possible
- Promoting the integration of health and social care services
- Commissioning care along a care pathway
- Supporting more people to care for themselves

A summary of the planned care programme of work for 2013/14 is shown below:

Area	Description	NHS Outcomes Framework Domain	Proposed Outcomes
End Of Life	To change the admission criteria for two beds at Duchess of Kent to enable them to admit 24/7 patients who are at the very end of life.	**Domain 5**	Patients placed in the most appropriate setting. Reduction in secondary care hospital admissions.
Long-Term Breast Follow-up Care	This service will be developed in line with the Survivorship programme which promotes patient-led follow-up and moving care out of secondary settings and closer to home.	**Domain 1,3,4**	To provide high quality, efficient, accessible, effective and safe follow up care for breast cancer patients who have completed active treatment. This will lead to reduction in hospital based follow up appointments.
Ophthalmology	An Integrated Eye Care Service with an	**Domain 4,5**	A cost effective service

Area	Description	NHS Outcomes Framework Domain	Proposed Outcomes
Service Development	appropriate level of follow-up activity undertaken within a community model, to agreed clinical protocols and a local tariff;		improving health outcomes.
Community Based Endoscopy Service	GPs will be appropriately referring patients requiring a routine gastroscopy or flexi-sigmoidoscopy to a community Tier 2 provider.	**Domain 4,5**	Generate capacity within main acute provider and achieving efficiencies for the Health Economy.
Reduction in Pathology variation	This project is to support the work begun by each clinical commissioning group in reducing avoidable usage of Direct Access Pathology at Royal Berkshire Foundation Trust.	**Domain 4,5**	Reductions in the avoidable usage of Direct Access Pathology at RBFT. Consistency of approach across the four CCGs
Reduction in Radiology Variation	This project is to support the work that has already begun by each clinical commissioning group in reducing avoidable usage of Direct Access Radiology at Royal Berkshire Hospital Foundation Trust.	**Domain 4,5**	Reduced inappropriate/avoidable referrals to providers radiology department and therefore reduced tests within the department
Musculo-Skeletal Service	A high quality, cost effective MSK service whereby parts of pathway are identified where efficiencies can be made, those that require decommissioning and those offering good value for money. Incorporation of Shared Decision Making for primary hip and knee replacement to enable patients to have informed decision on deciding to opt for surgery. Pro-formas for hips, knees, hand, ankles and shoulders surgery to ensure treatment in primary care is appropriate prior to referral into secondary care. Pain management and Shared Decision Making as part of MSK pathway ensuring patients are seen by right person, at the right time, in the right place.	**Domain 3,4,5**	A high quality, cost effective MSK service whereby parts of the pathway are identified where efficiencies can be made, those that require decommissioning and those offering good value for money. Incorporation of SDM for primary hip and knee replacement. Secondary Care CQUIN. Pro-formas for hips, knees, hand, ankles and shoulders surgery. QIPP for QOF QP for use of SDM tools for hip/knee

Area	Description	NHS Outcomes Framework Domain	Proposed Outcomes
			replacements. Pain management and SDM as part of MSK pathway.
Stroke Developments	To ensure that a Stroke patient in Berkshire West receives care in the appropriate place and that the long term outcomes for the patient are not compromised and do not incur further burden on the Health Care Economy. Part of an integrated service that is aimed to best meet the need of a wide range of patients following a stroke of varying severity. This will allow an integrated approach in providing patient specific rehabilitation while also allowing this to be the most cost effective, ensuring that the patient with the most benefit is in the right bed at the right time allowing providers to ensure the most effective and cost efficient model.	**Domain1.3.4.5**	Facilitate early discharge. Achieve stroke targets. Avoid readmissions. Reduced waiting times for CBNRT. Increased discharge from RBFT. Smooth transfer to Early Supported Discharge and Community based Neuro Rehab
Haematology DAWN	The DAWN system integrates with the pathology laboratory systems to pull out data for patients in its database and provides a patient-centric graphical timeline report on key patient parameters. It simplifies patient monitoring so that trends over time can be seen quickly. The reporting will be automated so that patients with test results moving outside the pre-determined parameters can be flagged. The system will also flag patients who miss regular blood tests, thereby building in a safety net for continued monitoring of patients.	**Domain 3,4,5**	Provide advanced reporting on patients who have missed a monitoring sample and provide an audit on the average drug usage for each condition. Provide a one stop shop for GPs to access advice on abnormal blood results. Reduction in follow-ups from 1:12.5 to 1:7.35
Surgical High Dependency Unit	The Royal Berkshire Hospital 11 critical care beds are often supplemented by managing surgical patients requiring	**Domain 1,3,4,5**	Patients been treated in a more appropriate setting. Reduction in mortality rates.

Area	Description	NHS Outcomes Framework Domain	Proposed Outcomes
	higher levels of monitoring in the Theatre recovery overnight. Managing patients in this environment ensures that patients are closely observed in the immediate post-operative phase prior to being discharged from the recovery area to the ward environment the next day, but it is recognised that this is not an ideal experience for the patients or their families. In addition no organ support can be provided in the theatre recovery. When the pressure of numbers is high it has meant that patients have been discharged back to the ward prematurely with anecdotal reports of patients outcomes being adversely affected. The development of a HDU will provide Level 2 care pre-operatively and post-operatively for surgical patients under the joint care of intensive care and surgical consultants. Typically patients in HDU will have single organ failure and are at a high risk of developing complications but the facility will be able to provide support for 2 and 3 organs for short periods of time. The HDU will have resources for immediate resuscitation and management of the critically ill. It will be equipped to manage short-term emergencies, e.g. the need for invasive mechanical ventilation.		

National policy on planned care is largely described as a set of national standards and in particular, focussed on equality of access to services, reducing unnecessary delays in accessing diagnosis and treatment, length of stay performance improvement and adopting the most clinically effective care pathways.

To be included

URGENT CARE

Introduction from Dr Andy Ciecierski & Picture

The Department of Health has consistently set policy to drive services and implement practice that means that whatever a person's urgent or emergency care need, whatever the location, they get the best care from the best person, in the best place and at the best time.

The CCG has a target of improving care for people at home, so that the number of emergency admissions reduces by the equivalent of one per day throughout 2013/14, commencing from April 2013. The following projects will support this objective.

The CCG aims to commission urgent care services which ensure patients are able to access the appropriate service first time, avoiding hospital admission unless clinically necessary. We plan to improve patient flow through the system, avoiding delay and to increase the capacity and develop the capability of community-based services. This reflects national guidance on moving towards 7 day availability of routine NHS services which support urgent and emergency care.

NHS 111

In line with national policy, an NHS 111 telephone service will operate throughout Berkshire in 2013/14. The Berkshire West CCGs have collaboratively commissioned a 2 year service from South Central Ambulance Service (SCAS) which goes live in April 2013. As well as close monitoring of the 111 service itself, the impact on the wider urgent care system will be monitored; including the Out of Hours (OOH) service provided by West Call and will inform future commissioning decisions.

Ambulance services

Commissioners are working with South Central Ambulance Service (SCAS) and the local acute hospital Trust to improve performance on ambulance handover times. A local trajectory was agreed which achieves 90% of handovers within 18 minutes by March 2013, which is an improvement in local performance. We will work with the ambulance service and the hospitals to achieve the national standard of 15 minutes during 2013/14. There will be contractual fines levied against the relevant organisation for delays of over 30 minutes and 60 minutes in both handover and readiness for new calls, in line with national guidance.

We will continue to use of the 'GP Triage' scheme to avoid conveyance to hospital where clinically appropriate. This means that when an ambulance attends a patient at home, they will assess the patient and if it is considered the patient does not need to attend hospital then the ambulance crew will contact the patients GP and discuss options for treating the patient to enable the patient to remain at home. Further work will be undertaken on the scheduling issues relating to transporting patients to hospital at the request of a GP that are deemed 'urgent' cases.

Care in Hospital

We will continue to monitor our acute hospital providers to ensure that they achieve the A&E 4 hour maximum wait target of 95%. There will be an additional contractual requirement in 2013/14 to ensure there are no patients waiting on trolleys longer than 12 hours.

A review of the way in which emergency care is delivered at RBFT is currently underway by the NHS Emergency Care Intensive Support Team (ECIST), at the request of the Urgent Care Programme Board (UCPB) to identify areas where there is scope for improvements to operational efficiency and patient experience. The UCPB will consider the findings from ECIST and determine an appropriate action plan in 2013/14.

The UCPB will also support the adoption of Enhanced Recovery principles, already operating successfully in elective care, in the care of patients who need urgent treatment or care.

System Resilience

The Urgent Care Programme Board oversees the operation of a robust system of monitoring pressures within the healthcare system and responding in line with escalation plans. Working collaboratively with the 3 Unitary Authorities, the CCGs have commissioned some work to inform demand and capacity planning across health and social care for the next 5 years. The CCG will manage a 24/7 on-call rota, in order to respond to any emergencies arising within the local system.

Quality, Innovation, Prevention & Productivity

A Quality Innovation, Prevention and Productivity (QIPP) programme has been agreed for unscheduled care which comprises a number of projects. Together these projects aim to achieve a target reduction in unnecessary emergency hospital admissions. An area wide Commissioning for Quality & Innovation (CQUIN) scheme will incentivise both our local acute hospital and community hospital Trust to support achievement of this objective.

Area	Description	NHS Outcomes Framework Domain	Proposed Outcomes
End Of Life	To change the admission criteria for two beds at Duchess of Kent to enable them to admit 24/7 patients who are at the very end of life.		Patients placed in the most appropriate setting. Reduction in secondary care admissions.
Enhanced Intermediate care services	Re-ablement and Rapid Response Services will be available throughout Berkshire West 7 days a week through locality based teams, via a Single Point of Access. All patients will have equality of access to a multidisciplinary team which will include Community Psychiatric Nursing, reflecting the national drive for mental health to be		To deliver 7 day a week access to both reablement and rapid response services across all 3 localities through the provision of locality based teams.

	as valued as physical health.		
24 hour community nursing	Additional resource and changed working patterns within community nursing will enable the provision of a comprehensive 24/7 service. This will enable more proactive management of patients with long term conditions		24/7 service with response within 2 hours of an urgent referral
COPD Pathway enhancements	Exacerbation Assessment service and targeted tele-monitoring		To enhance current service including supported discharge, tele-health and increased level of pulmonary rehab
ACG care co-ordination	Community based care co-ordinators will use the ACG risk stratification tool to identify patients who would benefit from proactive management through a multi-disciplinary team care co-ordination model (includes local authority social care)		High risk patients will have pro-active management plan. Less people will be admitted to hospital associated with disease progression
Heart Failure	To deploy an extra 25 tele-health units to patients with heart failure to further enhancing the ability of the Heart Failure team to provide more preventative support within the community setting		Reduced emergency admissions Improved quality of life for patients Increased medication compliance Reduced the need for face-to-face consultations
Paediatric Emergency Admissions	Building on the success of an existing project to reduce paediatric emergency admissions by implementing the 5 NHS Institute for Innovation pathways and supporting GPs to adopt the appropriate changes to their clinical practice, a further pathway for respiratory conditions will be implemented in 2013/14 following its publication.		Fewer children admitted in an emergency

National Context

To be included

LONG TERM CONDITIONS

Introduction from Dr Catherine Kelly & Picture

The Joint Strategic Needs Assessment (2012) predicts that North & West Reading will see a big increase in the numbers of older people in the future, which will also increase the prevalence of long term conditions.

A Long Term Condition (LTC) can be described as any condition which a person lives with all of the time, even though the impact of the disease may be only occasional or has not even manifested itself as a problem.

"*Long Term Conditions are those conditions that cannot, at present be cured, but can be controlled by medication and other therapies. The life of a person with a Long Term Condition is forever altered – there is no return to 'normal'* " (Department of Health 2008).

The CCG aims to educate and support patients in managing their own condition to optimise their health. Digital technology in particular telehealth will be utilised where appropriate and we will work towards the national target of offering online access to patients' own primary care medical record by 2015.

The CCG will develop its use of 'risk stratification' to improve the way it identifies patients who are at risk of hospital re-admission, ensuring their needs are addressed. We will design services which are person centred and integrated to improve the patient experience of care.

By using a risk prediction approach it is possible to identify those people who are the most regular users of hospital services (and are at risk of re-admissions), then identify their needs more effectively and commission cost effective interventions to meet those needs.

Long Term Condition (QIPP) projects planned for 2013/14 are described below. The initiatives in respiratory conditions (i.e., Chronic Obstructive Pulmonary Disease), Heart Failure, Epilepsy and Care co-ordination are expected to contribute to the overall reduction in emergency admissions in 2013/14 as well as improving relevant condition specific outcome indicators.

Dementia

In 2012/13 we invested in older people's mental health services to meet rising demand and additionally initiated 5 projects with Dementia Challenge funding:

- Care Home In-reach Team – to improve the quality of dementia care in care homes
- Cognitive Stimulation Therapy – to increase provision
- Domiciliary Care Training – to identify and address training needs
- Patient and Carers Information – to inform and empower
- Dementia Friendly Communities – to encourage local organisations to review and adapt their services
- Focus on implementing NICE guidance

- 4 dementia care advisors in place with agreement for on-going funding with UAs
- Expansion of Memory clinic capacity started in 2012/13 and increase in prescribing of medication to comply with NICE Guidelines
- Implementation of shared care on dementia medication prescribing
- Quality standards in BHFT contract about reducing prescribing of anti-psychotics
- Successful bid for £539,000 dementia national challenge funding to support 5 themes and improved care across the 4 CCGs in West of Berkshire
    - Care Home In-reach Team - £341,351
    - Cognitive Stimulation Therapy: Day Centres and Extra Care Housing - £37,910
    - Training for Domiciliary Providers - £33,660
    - Promoting Dementia Friendly Communities in the West of Berkshire - £100,980
    - Dementia: information for patients and carers - £25,000
- We will also be taking local action in North & West Reading on a number of local dementia priorities

In 2013/14 we will continue to increase our investment in older people's mental health services; expanding capacity in memory clinics and associated prescribing costs, and continue to roll out the local model of shared care. We have committed recurrent funding for the Care Home In-reach Team.

We currently diagnose less than the expected rate of dementia and aim to achieve an improvement in performance against this Outcome Indicator.

Integrated Care

In line with the evolving Health and Wellbeing strategy for West Berkshire and Reading Borough Council, the CCG is working with our partners on developing integrated community care

Diabetes and Care Planning

- Staged approach over 2 ½ years following Year of Care programme
- Launch to clinicians in July 2012 & enthusiastic response
- 3 local trainers - Clinical champion (GP), Clinical Project lead (PN) & DSN
- Clinician training from January to 2014
- Developing patient access to electronic records

<CAUTION: FORMATTING ISSUE IN THIS SECTION – TO BE RESOLVED>

Carers

A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who couldn't manage to live independently or whose health or wellbeing would deteriorate without this help. This could be due to frailty, disability or serious health condition, mental health or alcohol or substance misuse. It is estimated that 6,000 people take on caring responsibilities each day.

Being a carer comes at a physical and psychological cost.

- 40% of carers experience psychological distress or depression
- Carers have an increase rate of physical health problems
- Providing high levels of care is associated with a 23% higher risk of stroke
- Older carers who report strain have a 63% high likelihood of death in a year period for non carers or carers not reporting strain

In our engagement work with patients and the public we have heard that people would like us to do more for carers. We have agreed to review what we do for carers and enhance GP services to provide easier access and improved preventative healthcare. In addition, we will work with voluntary organisations to support carers in providing them with breaks.

The Department of Health has provided specific funding for CCGs to support carers have breaks. Some carers need time away from their caring responsibilities to recharge their batteries, enable them to undertake training, but other families just want to be supported to take a break together. It is important that this funding actually reaches carers and we will be working with local services and particularly voluntary organisations to ensure that this funding is spent on supporting carers.

National Context

Nationally, the Long Term Condition QIPP work stream seeks to improve clinical outcomes and experience for patients with long term conditions in England. It has focused on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their own.

The Operating Framework for the NHS in England 2012/13 documents the need to transform care for long term conditions driving the delivery for better quality and productivity. People with long

term conditions are significant users of NHS services and the aim is to reduce unscheduled hospital admissions by 20%, reduce length of stay by 25% and maximise the number of people controlling their own health through the use of supported care planning.

An essential component of any strategy to improve care and services for these patients is the development of a case finding mechanism to identify high risk patients as early as possible to enable interventions to be targeted before substantial preventable/avoidable expenditures have been incurred and health status has deteriorated further (Kings Fund 2006).

There is a growing body of evidence and experience suggesting that health care systems that combine multidisciplinary teams, self-management support and clinical information systems can lead to better management of patients with chronic illness. (Kings Fund 2007)

Area	What Will We Do?	How Will It Look?
Patient Education and support	We will work with our provider of Interventional Access to Psychological Therapies (IAPT) to develop 'Talking Health'; a model of education and support for patient self- management, to include face to face, telephone and group work with patients. It will include unlimited online access to 'SHaRON', a moderated online network.	Patients with long term conditions will feel more supported to manage their condition and will maintain their health-related quality of life
Area	**What Will We Do?**	**How Will It Look?**
Diabetes	A major redesign of the local diabetes service is underway to develop a primary care based service which ensures patients receive the nine care processes. It includes an education programme for health care professionals and the establishment of a Diabetes Specialist Nursing resource. Education for patients will be re-commissioned and a care planning approach (Diabetes Year of Care) will be introduced. We will invest in web based tools such as "Eclipse" to	Patients and their carers are well informed and know where to access information and support. 45% new Diabetics will have access to the 9 care processes, an increase of 9% locally. Diabetics will have their own Care plan with their results available electronically

	improve management of diabetics and promote self-care.	
Chronic Obstructive Pulmonary Disease (COPD) (See also urgent Care Programme)	Introduction of an Exacerbation Assessment service, enabling rapid outpatient assessment of a patient, avoiding admission. Implementation of the evidence based COPD Discharge Care Bundle, including follow-up phone calls Consultant input to the Early Supported Discharge scheme Telemonitoring of selected patients using an automated telephone messaging service Increasing Pulmonary Rehabilitation provision to establish a rolling programme in all localities, ensuring there is sufficient provision to meet the relevant national Outcome Indicator target.	Less people with Long term conditions requiring an emergency hospital admission associated with disease progression. Improved discharge arrangements, rehabilitation and on- going monitoring of patients. Improved long term under 75 years mortality rates from respiratory disease.
Heart Failure (See also Urgent Care Programme)	The existing telemonitoring scheme will be expanded to enable monitoring of additional patients with unstable heart failure at risk of re-admission to hospital. Care will be enhanced by the input of psychological therapy.	Improved monitoring of additional patients with unstable heart failure at risk of re-admission to hospital.
Neurological conditions	An Epilepsy Nurse Specialist will be funded, improving the quality of care and helping to avoid hospital admissions. Additionally information for patients and carers will be reviewed and developed to include a website, as part of the CCG's website for Long Term Conditions	An integrated specialist nursing service for neurological conditions. Patients and their carers are well informed and know where to access information and support.

Area	What Will We Do?	How Will It Look?
Care co-ordination (See also Urgent Care Programme)	Community based care co-ordinators will use the ACG risk stratification tool to identify patients who would benefit from pro-active management through a multidisciplinary team care co-ordination model (includes Local Authority social care.)	High risk patients will have a proactive management plan. Less people will be admitted as an emergency associated with disease progression.
Dementia	In 2012/13 we invested in older people's mental health services to meet rising demand and additionally initiated 5 projects with Dementia Challenge funding: • Care Home In-reach Team – to improve the quality of dementia care in care homes • Cognitive Stimulation Therapy – to increase provision • Domiciliary Care Training – to identify and address training needs • Patient and Carers Information – to inform and empower • Dementia Friendly Communities – to encourage local organisations to review and adapt their services In 2013/14 we will continue to increase our investment in older people's mental health services; expanding capacity in memory clinics and associated prescribing costs, and continue to roll out the local model of shared care. We have committed recurrent funding for the	We will improve our rate of diagnosis of people with dementia. Enhanced quality of life for people with dementia and their carers. Patients and their carers are well informed and know where to access information and support People with Dementia and their carers will feel more supported to manage their condition Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment

	Care Home In-reach Team. We will in May 2013 with North & West Reading Patient Voice hold a patient focused conference "Dementia and elderly care"	
Integrated Care (Also see Joint Commissioning Programme)	In line with the evolving Health and Wellbeing strategy for Reading we are working with Reading Borough Council on developing integrated community care in Long term Conditions.	Integrated care across health and social care for Long term conditions.

JOINT COMMISSIONING

Introduction from Dr Rod Smith & Picture

The commissioning of some services is done in partnership between the local authority, the CCG and the NHS Commissioning Board (NHS CB) in West Berkshire.

This will focus on the following key areas:

Mental Health

Full roll-out of the IAPT programme for Talking Therapies

The CCGs across the Federation have agreed significant additional funding to ensure that full roll out of the Improving Access to Psychological Therapies Programme (IAPT), to deliver services to 15% of the nationally predicted population for 2014/15 is achieved. Recruitment of additional staff to provide the necessary capacity commenced in December 2012.

Performance standards have been set for the Talking Therapies service for 13/14: Talking Therapies will deliver services to not less than 13.9% of the national predicted population for Berkshire West, while simultaneously exceeding the national requirement of 50% recovery rate and meeting the national 28 day waiting time KPI for the commencement of treatment.

Other key standards are:

- to continue the work to ensure access to people from BME and minority communities
- to increase the numbers of older people entering treatment
- to continue to develop competencies and the provision of psychological services to people with co-morbid clinical psychological illness and a physical long-term condition

The physical health of people with a mental illness or learning disability

The physical health of people with a learning disability or mental illness is addressed as an on-going quality standard through the delivery of physical health checks for people with severe mental illness, and feedback to GPs.

The delivery of health checks for people with learning disability will continue to be developed through implementation of the joint Learning Disability Self-Assessment standards, in partnership with the Unitary Authorities and the Learning Disability Partnership Boards.

Urgent and crisis services for people at risk of serious self-harm

A priority in 2013/14 will be the continuing improvement of NHS services' response to patients presenting with a risk of suicide or serious self-harm through CQUINs, Quality standards and development of specific outcomes and care pathways.

Key areas will be:

- the timely response and provision of services to patients presenting in a crisis or who are at risk, and
- the quality of the response back to those referring to NHS services patients perceived to be at risk

Improving services for people with a Personality Disorder

A specific project to expand treatment, reducing current waiting times for specialist psychotherapies, and develop outcomes for patients with personality disorder has commenced.

These patients are a significant proportion of those in specialist mental health care, including of those within forensic and non-forensic specialist inpatient services and are, nationally, identified as presenting a challenge to general mental health services.

Continuing expansion of Older People's Mental Health Services

In 2013/14 {NB cannot read Cathy's comments here} further expansion of Older Peoples Mental Health Services to increase the capacity of services to enable both the assessment and treatment of growing numbers of patients diagnosed with dementia and the delivery of the NICE guidelines on prescribing dementia medication. This action supports the Federation's Dementia Strategy.

Improved Services for adults with Autistic Spectrum Disorders (ASD) or Attention Deficit disorders (ADHD)

Building upon the work already implemented within Berkshire to create local NHS services for adults with ASD and ADHD, minimising the need for patients to travel to regional specialist services, the CCG will also continue to commission improvements in local services.

The key aims are:

- to reduce waiting times through increased capacity for diagnostic assessments
- to implement post-diagnostic support courses for both ASD and ADHD
- to develop joint strategies to provide medication for adults with ADHD
- to improve transition for young people from CAMHS services, where appropriate, to adult services offering a degree of specialist supervision
- to provide training for other health and social care services working with people with ADHD or ASD

Development of outcome and evidence-based care pathways for mental health & learning disability

The CCG will work with key stakeholders to develop outcome and evidence based care pathways for mental health and learning disability services. The involvement of social care commissioners, users and carers will also be an important part of developing these services.

Key outcomes for this work will include:

- The development of services based upon clinical and patient recorded outcomes
- Improved patient and carer involvement in the development of service outcomes
- Key quality standards, including those established in NICE Guidelines and policies
- Quality standards for liaison with other key services, such as primary care and physical health services
- Early intervention
- Improving the availability of outcome-based psychological therapies to all patients in specialist mental health services
- The delivery of services within Berkshire to minimise usage of out-of-area treatment and residential care
- Ensuring improved access to services for people from BME and minority groups, and for older people

Children and Young People

Children and Adolescent Mental Health Services (CAMHs)

There is a 4 tier structure for the delivery of CAMHs from April 2013, Tier 3 CAMHs will be commissioned by CCGs and Tier 4 CAMHs will be commissioned by NHS Commissioning Board (NHS CB)

Objectives for 2013/14

- To review the CAMHs urgent care pathway including the function of the Berkshire Adolescent Unit (BAU)
- To clarify gate keeping arrangements with NHS CB

- To consider opportunities for joint commissioning of a community intensive community support that:
  - Prevents admissions of young people to Tier 4 inpatient units
  - the length of stay of young people in Tier 4 inpatient units
- Prevents out of county fostering, community home and residential school placements for young people; and
- Prevents family breakdown, where a young person is likely to be placed out of county if this occurs
- Implement improved care pathways for anxiety and depression as part of IAPT for children and young people

Special Educational Needs (SEN)

Health and Wellbeing partners have a key role in ensuring safe and sustainable services for patients. A Government Green Paper advocates a single assessment across health, education and social care to identify those children with special educational needs or disabilities who could benefit from a personal budget.

Looked After Children

Health, educational and social outcomes for Looked after Children (sometimes called children in care) remains poor nationally with a high rate of teenage pregnancies, smoking and substance misuse, mental health problems, school drop-out rate with poor educational attainment and criminality. In conjunction with local authorities and other agencies, CCGs have a corporate parenting responsibility to try and improve the health and wellbeing of these children and young people.

Since 2000, there has been a series of Government initiatives to raise awareness of the needs of Looked After Children and to try and improve outcomes for them. A review of health services for Looked After Children in Berkshire was undertaken in 2012 and this resulted in a series of recommendations and an action plan which is being enacted.

- The capacity of the Looked After Children's team has been increased to improve quality and timeliness of service provision
- The system for providing initial health assessments needs to be improved
- There needs to be more robust assessment and follow up of emotional health and wellbeing in partnership with other agencies

Objectives for 2013/14

- Fully enact the action plan to improve the health of Looked After Children
- Implement a paediatrician led service to provide timely high quality initial health assessments

Community Paediatric Nursing

To ensure that the needs of ill and disabled children are met, four groups of children and young people have been identified as needing services:

- children with acute and short-term conditions
- children with long-term conditions
- children with disabilities and complex conditions, including those requiring continuing care and neonates; and
- children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care

Community children's nursing (CNN) services are the bedrock of the pathways of these children's care. The review aims to help both children's commissioners and providers of children's services improve services. A review of the community paediatric nursing pathway was undertaken in 2012/13 jointly with Royal Berkshire Foundation Trust (RBFT) and Berkshire Healthcare Foundation Trust (BHFT) community nursing teams. The objective was to reduce any duplication, improve integration and quality of services provided. Revised service specifications will be implemented in the 2013/14 contract.

Objectives for 2013/14

- To enact and monitor the revised service specifications resulting in improved quality of service
- To reduce spend on nursing agency packages of care by changing local commissioning arrangements

Area	What Will We Do?	How Will It Look?
Improved Access Psychological Therapy (IAPT) programme for Talking Therapies (Also see Long Terms Conditions Programme)	Significant additional funding will be used to increase the coverage of IAPT to population. We will continue the work to ensure access to people from BME and minority communities We will increase the numbers of older people entering treatment We will continue to develop competencies and the provision of psychological services to people with co-morbid clinical psychological illness and a physical long-term condition.	Talking Therapies service for 13/14 will deliver services to not less than 13.9% of the national predicted population for Berkshire West, while simultaneously exceeding the national requirement of 50% recovery rate and meeting the national 28 day waiting time KPI for the commencement of treatment. By 2014/15, 15% of the national predicted population will be receiving IAPT services.
The physical health of people with a mental illness or learning disability.	We will continue the work to ensure that the physical health of people with a learning disability or mental illness is addressed as an on-going	Improved mental health checks for people with severe mental illness, with mental health services measured on patient

	quality standard. The delivery of physical health checks for people with severe mental illness will be a continuing quality standard for mental health services, building upon the CQUIN developed and implemented from 2011onwards. The delivery of health checks for people with learning disability will continue to be implemented through the joint Learning Disability Self-Assessment standards, in partnership with the Unitary Authorities and the Learning Disability Partnership Boards.	outcomes. Improve patient satisfaction in mental health services from 25% to 50% Improved rates of health checks for people with learning disabilities.
Area	**What Will We Do?**	**How Will It Look?**
Urgent and crisis services for people at risk of serious self-harm	We will within our mental health contract focus as a priority on the continuing improvement of NHS services' response to patients presenting with a risk of suicide or serious self-harm through CQUINs, Quality standards and development of specific outcomes and care pathways.	Timely response and provision of services to patients presenting in a crisis or who are at risk. Improved quality of the response back to those referring to NHS services patients perceived to be at risk.
Improving services for people with a Personality Disorder	We will commence a specific project to expand treatment, reducing current waiting times for specialist psychotherapies, and develop outcomes for patients with personality disorder. These patients are a significant proportion of those in specialist mental health care, including of	Improved use of mental health and GP services for patients with Personality Disorder

	those within forensic and non-forensic specialist inpatient services and are, nationally, identified as presenting a challenge to general mental health services.	
Continuing expansion of Older People's Mental Health Services (Also see Long Term Conditions Programme)	We will increase investment in Older Peoples Mental Health Services to increase capacity of services to enable both the assessment and treatment of growing numbers of patients diagnosed with dementia.	We will improve our rate of diagnosis of people with dementia. Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment Increased prescribing of Dementia Medication in line with National Guidance (NICE)
Improved Services for adults with Autistic Spectrum Disorders [ASD] or Attention Deficit disorders [ADHD]	Building upon the work already implemented within Berkshire to create local NHS services for adults with ASD and ADHD, minimising the need for patients to travel to regional specialist services, we will continue to commission improvements in local services. We will develop joint strategies to provide medication for adults with ADHD and improve the transition for young people from CAMHS services, where appropriate, to adult services offering specialist supervision. We will provide training for other health and social care services working with people with ADHD or ASD.	Reduced waiting times through increased capacity for diagnostic assessments. Post-diagnostic support courses for both ASD and ADHD Seamless transition from CAMHS to adult ADHD services for young people as appropriate.
Area	What Will We Do?	How Will It Look?
Development of outcome and	We will work in partnership with key	Services based upon clinical and

evidence-based care pathways for mental health & learning disability.	stakeholders to develop outcome and evidence based care pathways for mental health and learning disability services. The involvement of social care commissioners, users and carers will be key. This will allow us to introduce Payment by Results [PBR] and allow future commissioning to focus on key outcomes and quality/performance standards. Key outcomes for this work will include: Quality standards for liaison with other key services, such as primary care and physical health services Early intervention Improving the availability of outcome-based psychological therapies to all patients in specialist mental health services	patient recorded outcomes Improved patient and carer involvement in the development of service outcomes Services provided where appropriate within Berkshire with minimal usage of out-of-area treatment and residential care Improved access to services for people from BME and minority groups, and for older people
Children's Services		
Area	What Will We Do?	How Will It Look?
(CAMHS) Children and adolescent mental health services	From April 2013 Tier 3 CAMHs will be commissioned by CCGs and Tier 4 (more complex needs) CAMHs will be commissioned by National Specialised Commissioning We will ensure there is a single care pathway so children and young people can seamlessly and safely access "step up/ step down" (repatriation) care. We will review availability of services locally over weekends and bank holidays and how these services interface with	Reduced admissions of young people to Tier 4 inpatient units. Shorter lengths of stay of young people in Tier 4 inpatient units. Reduced out of county fostering, community home and residential school placements for young people, reducing the potential for family breakdown as a result.

	emergency/ urgent care. We will review the provision of alternative Places of Safety for under 18s.	
Area	**What Will We Do?**	**How Will It Look?**
Special Educational Needs (SEN)	We will build an integrated therapy offer for early years, schools, and special schools. This would involve joint commissioning with local authorities) We will commission simple, single contact points where advice, guidance and information is given for all elements of children's development. We will increase the training, skills development and support of teachers and assistants, in ways that make functional and educational sense We will join up and simplify the assessment process and care planning, when more than one therapy is needed, agreed with education staff and parents	A more integrated, easy to understand service, with a single point of contact across health and social care. Reduced duplication and gaps in service provision. A more highly skilled workforce able to offer more influence and a more consistent service in children's learning development. A more integrating speech and language therapy and Occupational therapy service which is well received by families and partners
Safeguarding Children- Rapid Response to Child Death	Rapid Response arrangements currently in place will be enhanced by providing a "rapid response home visit" by a senior healthcare professional and police officer within 24 hours of death when deemed necessary.	Improved rapid response coverage 7 days a week, carried out by a senior healthcare professional and police officer. A service is provided to cover children who die outside of hospital and are not transported

	We will improve cover for rapid response to include weekends and bank holidays We will also commission a health led rapid response process for children who die outside hospital and who are not transported to hospital	to hospital.
Looked After Children	Health, educational and social outcomes for Looked After Children remain poor nationally with a high rate of teenage pregnancies, smoking and substance misuse, mental health problems, school drop-out rate with poor educational attainment and criminality. We will build upon work currently underway , working with our partner organisations, to improve the health of Looked After Children We will implement a paediatrician led service to provide timely high quality initial health assessments	Improved robust assessment and follow up of emotional health and wellbeing in partnership with other agencies. Improved quality and timeliness of service provision for Looked After Children. Timely and high quality health assessments routinely in place for Looked after children.
Area	**What Will We Do?**	**How Will It Look?**
Community Paediatric Nursing	To implement and monitor improvements to the current service . To improved commissioning arrangements so as to minimise the number of packages of care that are supplied by agencies.	Improved quality of services provided Fewer packages of care provided by agencies Increase number of packages of care provide within a formal service agreement.

Our Key Partners

PATIENT & PUBLIC GROUPS

Healthwatch Reading will be the new local consumer champion for both health and social care. It will aim to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided in Reading.

Healthwatch Reading will monitor the quality of the Social Care, Health Care and Public Health Care, being commissioned and provided in Reading; it will also monitor how all the people in Reading experience the quality of all aspects of the Care, which they receive.

Healthwatch Reading functions:

1. It has the power to enter and view services
2. Influence how services are set up and commissioned by having a seat on the local health and wellbeing board
3. Produce reports which influence the way services are designed and delivered by commissioners
4. Pass information and recommendations to Healthwatch England and the Care Quality Commission
5. Provide information, advice and support about local services, by providing advice and signposting to individuals regarding the services available in the local area

Healthwatch Reading will be a Charitable Incorporated Organisation supported by Reading Voluntary Action. It will have an elected Board, made up of local people, patient's and representatives from local organisations. The 'Board' will be responsible for ensuring that the contract, which it holds with the Local Authority to implement the Authority's statutory duty, is being managed to a high level of professional competence, with excellent outcomes for local people. Healthwatch Reading will ensure that patients and service-users contribute to the commissioning decisions of both the NHS and of the Local Authority, with regard to Social Care, Health Care and Public Health Care. It will seek to inform and to educate different groups within local communities, so as to enable them to participate in, and to contribute appropriately to, shared decision-making.

HealthWatch England (HWE)

Within the 2012 Health and Social Care Act, Healthwatch England came into statutory effect on October 1st 2012. Its Chair (Anna Bradley) is an independent Board member of the Care Quality Commission. HWE's role is to receive, and to respond to, information requests or reports or recommendations made by a Local Healthwatch and any of its sub-contractors. HWE will provide general advice and assistance to Local HWs and a route to influence national issues where necessary. HWE is not a regulatory body. Where a local Healthwatch has serious concerns, with the appropriate evidence, about any aspect of the commissioning or

of the provision of Health Care, Social Care or Public Health Care, it can and must refer these to the Care Quality Commission, as the appropriate regulatory body.

PROVIDERS

North & West Reading CCG are committed to maintaining the excellent diversity of provision and choice for our population and lead roles have also been set for provider relationship management (as set out below in contract negotiation) with responsibility for :-

- developing contracting strategies which deliver on current needs, but also create long term value with key providers via innovation, pathway restructuring, advanced cost management, risk management/business continuity;
- Ensure Provider Performance is evaluated encompassing:
  - Structured process, with measures on agreed key supplier goals and initiatives
  - Specific, transparent performance goals, measures and process understood by providers
  - Users actively involved
  - Regular formal feedback sessions on current performance and further improvement
  - "Voice of the provider" solicited for a balanced, two-way view of performance
  - Identifying and manage joint improvement efforts with the providers

We have also commissioned in partnership with Berkshire East and Buckinghamshire, Providers and social care partners a 5 year Capacity Modelling project to ensure sustainability across the wider health economy. The key findings of this report are:

To be included

We are also keen to increase the working relationships with the third sector by:

To be included

Any qualified Provider

CCGs must implement this approach to extending patient choice into community services. Providers must meet certain criteria and qualify to provide services. The CCG has agreed the following services to offer initially:

- Podiatry (adult)
- Ultrasound (non-obstetric)
- Audiology (over 55 hearing loss)

UNITARY AUTHORITIES

To be included from Reading & West Berkshire

HEALTH & WELLBEING BOARDS

West Berkshire Health & Wellbeing Board

The Health and Wellbeing Board for West Berkshire is responsible for transforming local health and social care services. The Board is a shared responsibility and is reflected in the membership which includes, the Leader of West Berkshire council, elected members of the local authority, GP leads of the North & West Reading CCG and Newbury & District CCG and the Director of Public Health.

A fundamental function of the Health and Wellbeing Board is to be responsible for leading the transformation of the local health and social care services to achieve improved population health and wellbeing for the people of West Berkshire and a collective focus of improving services for the whole community and individuals for the long term.

North & West Reading CCG has played a full part in the development of the Shadow West Berkshire Health and Wellbeing Board and the development of the Health and Wellbeing Strategy. The Health and Wellbeing Board has also endorsed the NWR Commissioning Plan.

For more information visit www.westberkshire.gov.uk

Reading Health & Wellbeing Board

Building on what we know from our JSNA and our local population characteristics, during 2012/13 we developed in conjunction with Reading Borough Council and South Reading CCG, and Reading Local Involvement Network (LINk, an independent body which promotes the interests of people using health and care services) our first Joint Health and Wellbeing Strategy for Reading. North & West CCG as a member of the Health & Wellbeing Board has tried to identify the most important issues to tackle to make Reading a healthier place. The Health & Wellbeing Board has also looked carefully at what local people have said health means to them and where their priorities lie.

Lots of things contribute to health and wellbeing - our environment, housing, schools, transport and leisure services as well as having good access to quality health and care services. And people who feel they belong to and can contribute to their community tend to enjoy better health than people who feel lonely or isolated. The Health & Wellbeing Strategy is based on four goals which describe what the Heath & Wellbeing Board feels it needs to focus on in order to make the biggest difference over the next few years.

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

The Health & Well-being Board have chosen four goals to aim for to help us achieve our vision:

1. *The health of communities is promoted and protected*
2. *Focus is increased on early years and the whole family*
3. *The impact of long-term conditions is reduced*
4. *Health-enabling behaviours and lifestyle are promoted*

Financial Plan

13/14 ALLOCATION & PLAN

The financial allocation for North & West Reading CCG has been notified by the NHS Commissioning board as £107,385k. This allocation has been based on a substantial data collection exercise carried out in the summer of 2012 and includes the 2.3% national growth uplift that has been applied to all CCGs in England. The total income for North & West Reading CCG for 2013/14 is £108,667k which includes Newbury and District CCG's share of the 2012/13 NHS Berkshire West surplus and a small non recurrent allocation due from NHS Berkshire East.

The financial plan for 2013/14 has been developed to support the CCG to deliver its Commissioning Plan within the resources available to it. It complies with the 2013/14 National Planning Guidance – Everyone Counts: Planning for Patients and the incorporated financial requirements which are summarised below:-

(i) Achievement of 1% surplus on Income and Expenditure
(ii) Commitment to spend only 98% of allocation recurrently ie to create 2% headroom to be spent non recurrently in year
(iii) Manage within an agreed cash limit
(iv) Hold at least 0.5% contingency

The plan also reflects an estimation of the potential impact of the demographic changes to the population in Newbury and District.

A summary of the financial plan is shown below:-

Financial plan - 2013/14	£k
Acute services	61,350
MH services	11,539
Community services	11,720
Continuing Care services	5,122
Primary Care services	14,523
Other Programme services	362
Contingency	789
2% Headroom	2,148
Total expenditure	107,552
Surplus	1,115
Allocation	108,667

NW READING QIPP ALLOCATION & PLAN

QIPP – Quality, Innovation, Productivity and Prevention – is a large scale transformational programme for the NHS, involving NHS staff, clinicians, patients and the voluntary sector. It is aimed at improving the quality of care the NHS delivers while making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care. Locally in North and West Reading we are working with our CCG federation colleagues, our provider organisations and social care on 4 work programmes (set out in Section 4),together with work on medicines management and through the application of contract business rules to deliver £1.265m savings in 2013/14. The levels of planned savings by programme are shown below:

	£ooo
Urgent / LT care	595
Business rules	224
Medicines management	224
Planned -Ophthalmology	35
Planned - MSK	103
Planned - Pathology/Radiology	46
Planned - other	37
Total QIPP savings	1,265

The achievement of these savings is already incorporated into our financial plan.

The CCG also plans to invest in healthcare services for its population and a summary of the planned investments (excluding known pressures) for2013/14 is shown below:-

Investments		**£m**
	Unscheduled care	0.22
	Long term conditions	0.22
	Planned care	0.10
	Joint commissioning & staying healthy	0.26
	QIPP schemes	0.80
	High Dependency Unit	0.30
	LD homes	0.04
	Patient Transport Service	0.07
Investments		**1.21**

LONG TERM FINANCIAL FORECAST

North & West Reading CCG has in place balanced financial plans for 2014/15 and 20115/16. The assumptions made are in line with national guidance provided at this time and achieve the required 1% surplus. Based on the income and expenditure assumptions made a QIPP gap of just over £743k was identified for 2014/15 and £844k for 2015/16. A summary of the plans for the 2 years are shown below:-

	2014/15'	2015/16'
	£m	£m
Baseline allocation	107.4	109.9
Growth	2.5	2.5
Non recurrent expenditure budget	-2.2	-2.2
Non recurrent adjustment	0.2	0.0
Total income	**107.9**	**110.1**
Recurrent cost base	105.5	107.9
Tariff changes	-0.1	-0.1
Demographics	0.7	0.8
Pressures/investments	2.5	2.3
Total expenditure	**108.6**	**111.0**
QIPP gap	**-0.7**	**-0.8**

The table below shows how we will close this gap in each of the 2 years. We have started to invest in a Berkshire/Buckinghamshire wide review of services in 2012/13 that we are confident will generate savings and better patient care in the following 2 years. We are likewise hoping to utilise some of our non-recurrent monies in 13/14 to start to transform our frail elderly care pathway across our healthcare providers and social care and have attributed savings to this work in both 14/15 and 15/16.

	14/15	15/16
	£'000	**£'000**
Business Rules	112	112
Medicines management	224	112
Berks/Bucks Review	224	448
Frail elderly pathway	72	144
Planned care -Ophthalmology	96	
Planned care - other	15	28
TOTAL QIPP SAVINGS	743	844

We will continue to develop QIPP plans in year to ensure that we achieve productivity and efficiency gains and to release funds for continued investment and innovation.

National Priorities

NHS CONSTITUTION

The NHS Constitution (Appendix 1) is core to the commissioning intentions for the CCG. The Constitution lays down the objectives of the NHS, the rights and responsibilities of the various parties involved in health care and guiding principles which govern the service. The Constitution covers access, quality of care and environment; access to treatments, medicines and screening programmes; Respect, consent and confidentiality; informed choice; patient involvement in healthcare and public involvement in the NHS; and complaints and redress.

EVERYBODY COUNTS

To be included

NHS OUTCOMES FRAMEWORK

To be included

EQUALITY ACT & EQUALITY DELIVERY SYSTEM (EDS)

North & West Reading CCG has had a statutory duty from 1st April 2013 to ensure compliance with the Equality Duty, showing we have had due regard to eliminate unlawful discrimination, advance equality of opportunity as well as foster good relations – between people who share a protected characteristic and people who do not. The protected characteristics we need to consider are as follows:age;

- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

Using the Equality Delivery System (EDS) tool designed by the Department of Health (DH) we will better understand how equality can drive improvements and strengthen the accountability of services to patients and the public. It will help ensure that everyone - patients, public and staff - have a voice in how organisations are performing and where they should improve. The EDS is all about making positive differences to healthy living and working lives. The EDS will help us analyses what is required by section 149 of the Equality Act 2010 (“the public sector Equality Duty”) in a way

that promotes localism and also helps us deliver on the NHS Outcomes Framework, the NHS Constitution and the Human Resources Transition Framework.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The four EDS goals are:

	Objective
1. Better health outcomes for all-	To embed the EDS and Equality Impact Assessments within commissioning processes ,which will be informed by engagement of representatives from the protected characteristics
2. Improved patient access and experie	To ensure our Engagement Strategy wi consultation with representatives from characteristics
3. Empowered, engaged and included staff	**Not applicable to CCG teams due to small size**
4. Inclusive leadership at all levels	To ensure designated equality leads are covered within a leadership role

We have adopted the objectives set in 12/13 and once our analysis is complete, we will update these to ensure they adequately reflect the needs of their own local population. Our progress in implementation of these actions will be monitored by the CCG Board, who will receive training in Feb 2013. We will be required to publish information to demonstrate compliance with the public sector Equality Duty at least annually, with the first publication being 31st January 2014.We will conduct an equality impact assessment on our Commissioning plan as part of its development.

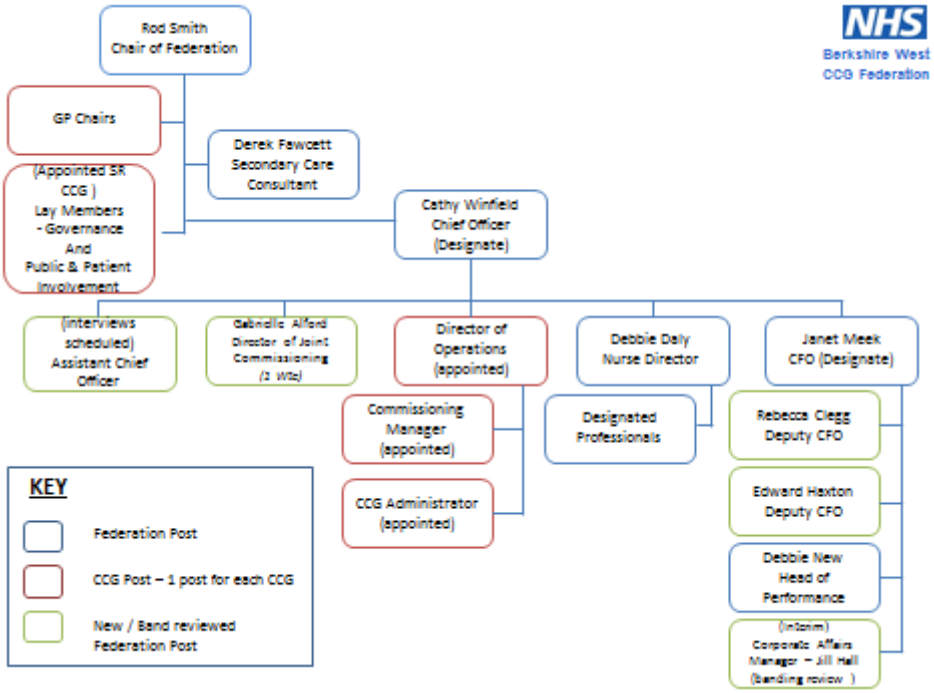
CCG OUTCOME INDICATORS

	Indicator Definition	Numerator	Denominator	Measure
Local Priority 1	People with diabetes who have received nine care processes. Performance to be assessed via local collection of NDA data which will be more current than the national dataset.	1961	3567	55.0%
Local Priority 2	Uptake on invitations from the Bowel Screening Programme (60-75)	4389	7700	57.0%
Local Priority 3	Rate of non-elective admissions per 100,000 population for COPD. Performance to be assessed on locally collected data from SUS	107	1	10700.0 %

Appendices

FEDERATED WORKING AND GOVERNACE STRUCTURE

Narrative to be included



CLINICAL SUPPORT UNIT

Securing robust and affordable Commissioning Support Services

The CCGs in the West federation have agreed to work together to develop the specification and secure the commissioning support services to support their operations. A nominated lead has been agreed to act for the CCG Federation supported by a GP in each CCG.

To date the Federation has, through a steering group, developed a view of the functions to operate within CCGs, in a federated fashion, and to be sourced from commissioning support. The CCG was actively involved in shaping the CSU prospectus with external support and has feed into the outline business case that the PCT cluster is producing. A Service Level Agreement for Commissioning Support along with outline Service Specifications are now in place.

The existing QIPP programme for 2012/13 has CCG specific targets and monthly reporting against targets and this will also continue as an established process in 2013/14. Both of these areas of finance and activity are performance managed (as set out below in Performance Management).

The CCG Board receives a monthly commissioning report detailing the position and a narrative of any variances and areas to address. Practice level information from the GP dashboard is also included in this report. The CCG is represented at the relevant contract performance meetings through the federated working arrangements and has access to analysis and interpretation of the information through the Commissioning Support Service Level Agreement.

NHS CONSTITUITON

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. the NHS provides a comprehensive service, available to all - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population

2. access to NHS services is based on clinical need, not an individual's ability to pay - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. the NHS aspires to the highest standards of excellence and professionalism - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. NHS services must reflect the needs and preferences of patients, their families and their carers - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being

6. the NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves

7. the NHS is accountable to the public, communities and patients that it serves - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: The NHS Constitution: The NHS belongs to us all (March 2012)

NORTH & WEST READING CLINICAL COMMISSIONING GROUP

Financial Strategy 2013/14 – 2015/16

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1. Introduction
2. National Economic Climate context
3. Key financial targets
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5. Sources of Funding
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7. QIPP and Efficiency Savings
8. Running Costs
9. Commissioning Intentions
10. Contract and Payment System
11. Financial Risk and Mitigation (including Risk Sharing)
12. Provider alignment
13. Arrangements with Commissioning Support Central Southern
14. Social Care Funding

1. INTRODUCTION

1.1 This financial strategy for the Berkshire West CCGs builds on the initial strategic, operational and financial planning that has already been developed for 2012/13 when the CCGs were operating in shadow form. It incorporates and takes into account the following guidance and policies that are currently in place:-

- *Operating plan 2012/13*
- *NHS South of England Operating Framework Guidance*
- *Draft Commissioning Intentions and Strategic plan 2013/14*
- *NHS Mandate (incorporating NHS Outcomes framework, NHS Constitution*
- *Prioritisation Framework*
- *JSNA for 2013/14*
- *National Planning Guidance 2013/14- Everyone Counts: Planning for Patients*

1.2 The objectives of the financial strategy are to ensure that collectively and individually the Berkshire West CCGs are in a strong financial position to:-

- *Implement efficient and effective clinical commissioning, including collaborative working where appropriate to ensure that high quality services are available to the CCG populations*
- *Maintain strong financial grip whilst delivering required non-financial performance standards and targets*
- *Achieve the required agreed financial surplus targets*
- *Identify, manage and mitigate financial risks which may include financial risk sharing across Berkshire West*
- *Support the development of provider healthcare services across Berkshire West (and beyond where appropriate)*
- *Support longer term financial sustainability and improved outcomes*

- *Demonstrate robust financial management and control and best value for taxpayers funds.*

2. NATIONAL ECONOMIC CLIMATE CONTEXT

The NHS in the last 10 years has benefitted from significant growth in funding and investment. This has now changed as a result of the current economic climate. Thiis has and continues to have both direct and indirect impact on the NHS and therefore presents financial challenges including:-

- *Minimal growth in funding over the next 3 years (assumed 2.6%)*
- *Nationally identified QIPP gap of £20bn*
- *Population growth and the ageing population demographic*
- *CIP and QIPP impact on local providers*
- *Increases in secondary care activity (volume) and costs (price)*
- *Impact of reduction in social care funding (estimated to reduce by 25% over 3 years)*
- *Private provider competition in the local market*

3. KEY FINANCIAL TARGETS

The current NHS financial regime includes a number of statutory and other key requirements that this strategy plans to meet:-

- *Achievement of a 1% I&E surplus*
- *Management within an agreed cash limit*
- *Achievement of agreed QIPP savings*
- *Commitment of only 98% allocation recurrently*
- *Payment to suppliers within 30 days unless agreed otherwise*
- *Demonstrating value for money*

4. KEY PLANNING ASSUMPTIONS

4.1 The table below shows the current national, regional and local planning assumptions:-

	Source	***2013/14***	***2014/15***	***2015/16***
I&E surplus	*SHA*	*1%*	*1%*	*1%*
Non recurrent spend	*SHA*	*2%*	*2%*	*2%*
Contingency	*Local*	*0.73%*	*0.73%*	*0.73%*
CQUIN	*National*	*2.5%*	*2.5%*	*2.5%*
Population Growth	*Local*	*1.2%*	*1.2%*	*1.5%*
Efficiency requirements	*National*	*4%*	*4%*	*4%*
Inflationary Uplift	*National*	*2.7-2.9%*	*3.2%*	*3.2%*
Prescribing Inflation	*Local*	*3%*	*3%*	*3%*
Continuing care growth	*Local*	*10%*	*10%*	*10%*
Allocation Changes	*Local*	*2.3%*	*2.3%*	*2.3%*

4.2 The CCG will invest to achieve national and local targets as determined nationally by the NHSCB (incorporating the Innovation, Health and Wealth recommendations) and locally derived from the Joint Strategic Needs Assessment (JSNA) . These include:-

Investments

	£k
Unscheduled care	*220*
Long term conditions	*220*
Planned care	*100*
Joint commissioning / staying healthy	*260*
High dependency unit	*300*

5. SOURCES OF FUNDING

5.1 The recurrent allocation given to the CCG for 2013/14 was announced in December at £107,384k, (including growth at 2.3% of £2,414k).This allocation was based on the data collection exercise undertaken in the summer of 2012, and does not attempt to move the CCGs towards any fair share allocation.

5.2 A number of adjustments have been made by the DH to the baseline data supplied relating to the funding transferred to Local Authorities and the NHSCB. These adjustments are still the subject of discussions with the AT.

5.3 The income projections for 2013/14 and beyond exclude income in respect of the functions that are transferring to other bodies such as Public Health to the Unitary Authorities and Public Health England, Specialist Commissioning and TVPCA (FHS) to the NHSCB (LAT) and Estates and Facilities to NHS Property Services.

6. INCOME AND EXPENDITURE SUMMARY

Summary of Budgets - 2013/14	***£k***
Acute services	*61,350*
MH services	*11,539*
Community services	*11,720*

Continuing Care services	*5,122*
Primary Care services	*14,523*
Other Programme services	*362*
Contingency	*789*
2% Headroom	*2,148*
Total expenditure	*107,552*
Surplus	*1,115*
Allocation	*108,667*

**note: allocation includes additional non recurrent allocations of £1,282k.*

7. QIPP AND EFFICIENCY SAVINGS

	£ooo
Urgent / LT care	*595*
Business rules	*224*
Medicines management	*224*
Planned -Ophthalmology	*35*
Planned - MSK	*103*
Planned - Pathology/Radiology	*46*
Planned - other	*37*
Total QIPP savings	*1,265*

8. RUNNING COSTS

8.1 The CCG was notified of its running cost allocation in December. These have been budgeted as follows:

Cost Area	***North & West Reading £000***
Federated Staff	*246*
CCG Staff	*186*
Clinical Teams	*303*
Non Pay	*418*
Charge from CSU	*1,162*
Contingency	*185*
Total = Running Cost Allocation	***2,500***

9. COMMISSIONING INTENTIONS

9.1 Commissioning intentions include compliance with all aspects of the National Operating Framework and support the delivery of QIPP.

9.2 Commissioning intentions include compliance with all aspects of the National Operating Framework and support the delivery of QIPP.

9.3 Commissioning intentions have been shared with providers and have been developed in collaboration with the other CCGs in Berkshire West with whom North and West Reading CCG is federated.

9.4 The intentions are premised on the key themes of

(i) Ensuring care takes place in the right setting

(ii) *Care is as close to the patients home as possible*

(iii) *Patients are empowered to manage their care in partnership with health professionals*

(iv) *Delivery of care will be as efficient as possible whilst maintain or improving quality*

9.5 Our commissioning intentions are set out in our document "Berkshire West CCGs – Commissioning intentions 201/14 which is available on our website.

10. CONTRACT AND PAYMENT SYSTEM

10.1 The CCG will use the 2013/14 NHS Standard e Contract

10.2 North & West Reading is the lead CCG for the South Central Ambulance Contract on behalf of Thames Valley CCGs

11. FINANCIAL RISK AND MITIGATION (INCLUDING RISK SHARING)

11.1 Significant Financial risks

	Risk	***Mitigation***
1	*CCG ability to manage and control activity*	*Agree activity levels in contract and performance manage effectively*
2	*CCG ability and influence in performance targets*	*Incorporate CQUIN gateway* *Investments planned In year*
3	*CCG ownership and delivery of QIPP schemes*	*Contingency established to cover non delivery*
4	*Allocations not based on fair shares or accurately reflect baseline exercise. Berkshire historically one of lowest funded/ head population in England*	*Allocation assumptions based on historic spend (prudent) Aim to be high level productivity and efficiency*
5	*Changes in policy*	*Horizon scanning to identify, use of reserves to finance.*
6	*Financial pressures and overspends with*	*Financial risk sharing with accountability and*

	risk sharing arrangements	*MoU between CCGs*
7	*Main provider financial position deteriorating*	*2% non-recurrent level budget included in planning assumptions*
8	*Pressures identified in relation to CHC retrospective claims are greater than anticipated*	*Provision based on realistic assumptions* *Downside case scenario modelling*
9	*Cost shunting from NHSCB and PH*	*Close monitoring and open communication with partners.*
10	*RBH EPR System*	*Monitor impact monthly through activity and finance* *Regular liaison with Trust*
11	*Uncertainty about 12/13 year end arrangements*	*Prudent planning assumptions* *Regular liaison with SHA/LAT*
12	*Potential impact of Winterbourne Review*	*Prudent planning assumptions* *Regular update and review*
13	*Likely reduction in social care funding*	*Establish reserve to support impact* *Horizon scanning for early warnings* *Realistic planning assumptions*

11.2 Risk Sharing Arrangements

The Constitution allows for an annual review of risk sharing arrangements. The areas that have been agreed for 13/14 are:-

(i) The BHCFT Community Contract - the contract is currently a block arrangement so there is no risk. Individual CCGs are allocated levels of activity against this contract through fair shares but this does not necessarily effectively equate to the levels of services individual CCGs are accessing/receiving eg South Reading look like they are spending more than they actually are but they are not receiving the same levels of

services as other CCGs Movement away from a block contract will create risk so CCGs will risk share this

(ii) The BHCFT Mental Health Contract – as above is currently a block contract with similar issues but the Mental health need in Reading is greater than (say) Newbury so fair shares is probably not representative –CCGs will risk share.

(iii) Unregistered patients in secondary care

(iv) CHC and FNC – whilst it will be possible to identify these patients on an individual CCG level the costs are high and volatile and could create cost pressures in individual CCGS that collectively may wish to mitigate, recognising there is little control over where these patients are ultimately taken care of. CCGs agree that an individual CCG should not be penalised for having a greater number of nursing homes in its patch and therefore agreed to risk share

(v) High Cost Out of hospital Placements – similar to above – tend to be small numbers and high cost

(vi) Critical care costs

(vii) High Cost drugs and Appliances

(viii) Bottom line surplus position – if one of the West CCGs has a cost pressure thereby preventing it from achieving its declared year end surplus position and another has too much surplus, CCGs have agreed that one CCG can support another non recurrently in year with repayment being made the following year. Criteria and governance arrangements will be developed in 13/14.

12. ALIGNMENT AND TRIANGULATION WITH LOCAL PROVIDERS

It is important that we align our positions with our providers and it is our aim to have a shared and agreed reported position on a monthly basis.

13. ARRANGEMENTS WITH COMMISSIONING SUPPORT CENTRAL SOUTHERN

13.1 All of the Berkshire West CCGs have committed to receiving services from Central Southern Commissioning Support Unit for 13/14. The capability and capacity of the CSU to provide the range of services agreed is critical to the delivery of the financial strategy. The charge is currently quoted at £10.75/head but it is anticipated that this will increase with the next iteration due imminently. CCG Running costs will need to be amended to reflect this.

14. SOCIAL CARE FUNDING

The impact of reductions in social care funding is starting to be felt in 2012/13. The likely reduction of 25% over the next 3 years is manifesting itself with increased delayed discharges in the acute and community sector. This is not only a threat to the achievement of targets but a real threat to patients care.

Glossary

Key definitions and explanation of terms / abbreviations

Acute care	Often referred to as emergency care, this is treatment or diagnosis needed so immediately or urgently that not to do so might be life threatening
Admission	When treatment or diagnosis requires someone to stay in hospital rather than be treated at home or in the community, they are "admitted" to that hospital
Admission rate	The number of people in a local population who are admitted to hospital in any year compared with the rest of the country
Aim	A medium to long term goal i.e. something that we plan to do over the life of our strategy. If you don't aim then you are likely to miss!
Ambulatory care	Rapid access, fast access, immediate and urgent care where the patent can walk in to a centre and be seen or be directly referred by a doctor, nurse or therapist to avoid the need to admit a patient
Assurance	The policies, procedures, systems and arrangements by which the public, those partners and external bodies to whom North & West Reading CCG is accountable, and its own Governing Body can be reassured that we are doing what we say we will do and in the way in which we said we would do it
Austerity and austerity measures	Long term savings plans and other changes brought in as a consequence of reductions in income
Baseline assumption	This is the money that an organisation will assume it has as a minimum
Business cycle	The annual timetable of plans, guidelines and publications. See also Commissioning Cycle

Care Quality Commission (CQC)	Reviews all providers to ensure that they meet the standards set out in law to provide safe healthcare of an acceptable quality. CQC has the power to close a service or to require immediate action to avoid closure, when their inspections find a service to be below standard
Chronic illness	A condition which a patient has for a considerable time and which can be referred to as a long term or even life-long condition. An illness that takes time from which to recover and/or can be permanently disabling
Clinical Commissioning Group (CCG)	An authorised body that is part of the NHS and has the responsibility for improving health and for planning and contracting for healthcare on behalf of a local population
Commissioning	The task of defining the health service needs of a local population and then contracting with an appropriate range of providers to allow both choice and the safe, effective, accessible and timely delivery of healthcare to meet those needs
Commissioning cycle	The annual process of strategic development, contract review, management and negotiations with key deadlines set by the Department Of Health each year, and informed by the annual publication of planning and priorities guidance, usually in December of each year.
Community care	Care delivered in a local neighbourhood and in the home.
Consensus building	where there is early disagreement on which of a number of change options is best, continuously refining the options until everyone is prepared to accept the same proposed solution
Constraints theory	A management theory that makes systems of care more effective and efficient by concentrating on where there are blocks or delays in progressing care and eliminating these
Consulting	providing people with information on a proposed change in services and its impact; encouraging them to comment and make alternative suggestions

Critical mass	A volume of care, activity or service that is sufficient to ensure that those who are providing care are sufficiently practised to offer safe care. Similar to the minimum number of air miles a pilot must do each year to retain a licence, usually only applied to specialist and rare healthcare
Demography	The analysis of population by age, gender and other factors that can influence health
Discharge Planning	The process of preparing for a patient to leave hospital
End state vision	What services or providers will look like once all proposed changes have been implemented fully. Important in ensuring there are no unintended consequences of individual changes
Engaging	actively seeking people to become informed and involved
Finished Consultant Episode	A completed episode of hospital care. This is one way of measuring the number of patients who have been admitted to hospital
Governance	The policies, procedures, systems and management arrangements by which North & West Reading CCG ensures we deliver our strategies and plans within the rules and regulations with which we must comply.
Governing Body	The Governing Body is the Board of a CCG comprising principally local clinicians drawn from general practice (GPs, nurses, and practice managers), and from local hospital and other health services. The Governing Body can also appoint lay members and experienced finance, strategy, commissioning or similar experts, but should remain predominantly clinical in its membership.
GVA or Gross Value Added	A way of measuring business growth in an area
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Health and Wellbeing Board	A joint committee of Reading Borough or West Berkshire Council, and North & West Reading CCG with the responsibility for developing a single "Health and Wellbeing Plan" for improving health across Reading or West Berkshire
Health economy or health system	The collection of health care organisations in an area which together represent the totality of healthcare and health service investment serving the same community. For example, all of the healthcare providers and the PCT/CCG in Reading would together be known as the Reading health economy or health system
Health services	Individuals, teams, departments or organisations whose role is to provide healthcare
Healthcare	The provision of nursing, therapy, medical, surgical diagnostic, drug, consultations, counselling and other care, intervention and treatment designed to improve health, prevent the onset of illness, address disease and illness, remedy harm and injury or recuperation following a period of poor health or injury
Healthwatch	To replace LINk (Local Involvement Network) from April 2013 but with additional powers and responsibilities including a place on the Health and Wellbeing Board, also taking on PALS (Patient Advice and Liaison Service) and ICAS (Independent Complaints Advisory Service)responsibilities, and with the ability to escalate local issues to Healthwatch England (who have direct links to Monitor, the NHS Commissioning Board, the Care Quality Commission and Secretary of State for Health)
Hospitalisation rate	Hospitalisation rate then measures if more or less patients than comparable elsewhere are being admitted to hospital
ICAS	Independent Complaints Advisory Service assists patients with complaints, especially those which are complex or where the complainant needs assistance in order to articulate their concerns
Informing	Giving people information
Innovation	A new approach or way of doing something

Intelligent commissioner	A body that plans and contracts for healthcare informed by the best information on health and health risks, provider performance, pathways of care, future workforce requirements, local population needs and the capacity needed to meet these local health priorities and the best means to respond
Involving	Providing people with the opportunity to be part of an activity (whether planning or designing services, choosing where money should be spent or reviewing the performance of local services)
Joint Strategic Needs Assessment	An analysis of our community's health and wellbeing, looking at life expectancy, life circumstances, diseases, employment, housing, poverty and other wider determinants of health in Reading or West Berkshire. Formulation of a JSNA helps to inform the creation of an agreed set of priorities for improvements in health shared by Reading Borough Council, West Berkshire Council and North & West Reading CCG
LEAN methodology	A management theory that removes variation in the way in which services are delivered and promotes the concept of "right first time". Successful in many other industries, it has seen the delivery of quality as an important factor for the delivery of value for money, (since much waste is due to the need to redo poor quality work)
LINk	Local Involvement Network. An independent network of thousands of individuals and local groups with the single and important aim of improving local health and social care (see also Healthwatch above)
Long term conditions	Illnesses which we have for long periods of time or even for the rest of our lives, for example diabetes. (See also Chronic Illness above)
MAU **Medical Assessment Unit**	A unit in a hospital where patients will be assessed for periods of usually up to 12 hours before either being admitted onto a ward, being referred to ambulatory care or being sent home with support.
Mission	One organisation's contribution towards delivering a Vision e.g. *we will be the first to put a man on the moon*

Monitor	Oversees the performance of NHS Foundation Trusts
NHS Commissioning Board	Responsible for planning and contracting for specialist services (specialist healthcare often not provided by local health services so planned for on a regional basis) and for the performance and conduct of CCGs, including their authorisation
NHS Trust	A provider of health care, either an NHS Trust (being phased out) or more commonly an NHS Foundation Trust. Trusts are separate legal bodies from CCGs but both are part of the NHS
Objective	A more detailed definition of an aim, setting out how the aim will be achieved, the timescales and the resources needed to do so
Out of Hospital care	An approach to providing care out of hospital and in community based clinics or the home
PALS	Patient Advice & Liaison Service. PALS role is to assist the public in finding or registering with the right service and to assist in the early handling of patients' concerns
Partners	Used in this document to cover those third parties with whom North & West Reading CCG is working towards a common agenda such as our shared health priorities or public and patient involvement and engagement. We do not use it to mean a formal partnership i.e. a legal entity in its own right, but rather a strong and mutually beneficial relationship
Patient Participation Group	A group set up to allow patients to become involved in the design and delivery of their healthcare or to become more informed about their condition and better able to deliver self care.
Planned care	Consultations, diagnosis, treatments and surgery where the attendance at hospital is pre-planned and an appointment is therefore made to be seen in clinic or to be admitted to a bed
Practice Participation Group	Similar to the above but set up at GP Practice level
Prevalence	The rate of incidence of a particular disease or condition in a

	community
Primary care	First point of contact with healthcare. Usually with your General practitioner but also includes dentists and pharmacists
Primary Care Foundation	An organisation which supports your local CCG with advice and audits
Primary Care Trust (PCT)	Currently responsible for planning and contracting for local health services but being phased out to be replaced by Clinical Commissioning Groups (CCGs)
Principle	Defines the *way* in which we will do things to ensure we deliver the benefits of what we set out to do
Priority	The outcomes, tasks or activities that are regarded to be most important and those which we will seek to achieve first
Productivity	Measuring how much activity per person or per £ invested in order to ensure & demonstrate that value for money is being provided
"Providerscape"	A description of the whole spectrum of providers in an area – a shorthand version of "the provider landscape"
Public Health	A department and discipline of healthcare that involves trained professionals, usually senior clinicians, researchers or doctors, in the analysis of health and health indicators and the development and delivery of programmes to address health concerns and improve health generally, including screening and surveillance programmes.
Quality	Definitions range from the standards expected of a service to that additional component that differentiates a good service from a bad service.
Recession	A period during which business growth, public sector finances and taxation are all standing still or reducing

ROPE	A locally developed healthcare feedback system that allows the continuous capture of patient, patient family, carers and visitors experience of GP, hospital and community services
Self-care	When we look after ourselves through accessing over the counter medication, following publicised advice for management of self-limiting illness.
Spell	Another method of measuring the number of patients who have been admitted into hospital
Supply induced demand	Where the demand for activity arises as a consequence of there being too much capacity in a local area
System simulation	A management technique that allows hypothetical patients to be run through computer software that mimics and reproduces the operational processing of a local health system. This allows changes to be tested for unintended consequences before implementation and also allows different healthcare solutions to be compared
Third sector	Voluntary, charitable and not-for-profit organisations and networks, so called as the private and public sector represent the first two sectors, but both are reliant on an active and coordinated voluntary and charitable sector.
Unemployment Stress	A measure of how much impact will be had on an area, authority or Borough due to unemployment
Urgent care	Care required to treat a condition, disease, harm or injury that requires rapid attention.
Vision	A long term aspiration or desired outcome that will benefit a community or society at large.
Voluntary sector	The collective term for voluntary groups and organisations. Voluntary groups and organisations are those where people have undertaken to support for or care for others without being employed. The Voluntary Sector provide their time and expertise at no cost (save sometimes for expenses and administrative support) and for no profit

Ward deprivation	A ward is the collection of households that vote for their local councillor. Ward deprivation measures the degree of local poverty and other indicators that might lead to a local community being less advantaged in terms of health, education, housing, employment, the environment, access to services and benefits, crime and fear of crime, the local economy
Well being	A contented state of being happy, healthy and prosperous

Other terms should be explained within the main body of this document but we welcome any queries regarding the terminology we have used, particularly if any terms are unclear. We will endeavour to update this document in response to all such feedback.

Draft 20 Feb 2013

NHS
South Reading
Clinical Commissioning Group

DRAFT SOUTH READING CCG COMMISSIONING PLAN 13/14

Introduction from the Chair

This document details the Commissioning Plan for 2013/14 and beyond, for South Reading Clinical Commissioning Group which will become a statutory organisation from 1st April 2013, through the NHS Commissioning Board authorisation process.

In South Reading, we are faced with the challenges of providing patient care to a relatively young patient population, ethnically diverse living and working in Reading. We also face the health challenges created by some significant pockets of deprivation.

With an ever increasing demand on health services, in order to ensure long term sustainability, our focus needs to be on prevention and increased efficiency whilst having quality services and improved outcomes for patients at the heart of everything we do.

Working in primary care GPs , Practice Nurses and other health care professionals are in the best place to follow our patients' journey through the healthcare system, and therefore also to influence that process. We will commission the highest quality services, working together with our patients, to maximise the efficient use of resources and to share and support best practice.

Alongside this we view our colleagues in the local Foundation Trusts and the Local Authority, as key partners, as we need to work in a more co-ordinated way to improve the patient experience and outcomes.

The input from our patient participation group, South Reading Patient Voice, and other patient groups, has so far been invaluable, and I would like to reflect on the key messages that they have given by them to the South Reading Commissioning Group so far:

"we *value the right care delivered in a timely manner, but would wish to see a more joined up approach in providing care for people with long term conditions and for older people"* ***South Reading Patient Voice Group***

We shall endeavour to keep listening to our patients, working together with our partner organisations, to deliver a service that we can all be proud to be a part of.

Dr Elizabeth Johnston, Chair South Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

VISION of SOUTH READING Clinical Commissioning Group (CCG) Working innovatively with patients and partners to improve the health of our local community				
High level Objectives	**Strategic Context**	**Priorities with target improved outcomes**	**"What will we Do?" in 13/14**	**"How will it look?" in 15/16**

2

To provide equitable, high- quality, primary medical care.

To deliver more services in the community, with less patients being seen in hospitals.

To use the finite NHS resources wisely based on clinical evidence and need

125,328 people registered with 20 GP practices.

South Reading CCG:
a **younger ethnically diverse population** (just 4.3% over 75 years; 27% ethnic minorities)

11% live in a ward in one of the 20% **most deprived** in England.

CCG Benchmarks well against national rates for GP referrals, elective and non-elective admissions.

CCG underperforms for childhood immunisations and cancer screening

Health inequality from mortality from cardiovascular disease (CVD) with an 8.5 year and 7 year difference in life expectancy for men and women respectively from the most to the least deprived areas of Reading.

87% of hospital care is from the **Royal Berkshire NHS Foundation Trust.**

Berkshire Healthcare Foundation Trust: main provider of community and mental health services.

Member of **Reading** Health and Wellbeing Board

Total Budget £115m with 1% Quality , Innovation, Productivity, & Prevention (QIPP) savings target for 13/14

National:
Hospital acquired infections e.g. C Diff and MRSA levels in line or less than nationally set targets.

Reduce avoidable emergency admissions by 1 patient per day.

Quality Premium:

Increase uptake of immunisations from 93% to 95%

Carry out an extra 804 CVD health checks

Achieve 45% coverage of the 9 care processes for diabetes , an increase of 9%

Improving Health inequalities in Children:

Reduce health impact of childhood obesity.

Increase uptake of Breastfeeding from 53% to 54%.

Increased input from Speech and Language Therapists into nurseries and schools

Other areas identified in our Joint Strategic Needs Assessment (JSNA)

Increase bowel cancer screening uptake from 44% to at least 54%
Increase numbers of smoking quitters

Commissioning priority
Improve patient satisfaction in mental health services from 25% to 50%

Increase Patient & Public Engagement across our diverse population
.

Planned Care	Increase the use of Shared Decision Aids for Hip and Knee replacement Review the Musculoskeletal (MSK) pathway Reduce routine follow-ups for Breast cancer with rapid access appointments to replace them	Improved Patient Reported Outcome measures for knees A Multidisciplinary Team (MDT) community pain clinic part of MSK pathway Improved patient experience .Royal Berkshire Hospital benchmarking Ratio for new: follow-ups improved
Urgent Care	Successfully implement NHS111 7 day admission avoidance service Reissue Paediatric Guidelines for GPs with training Organise Conference for patients on " Dementia & The Elderly"	An Integrated Urgent care system Reduction in avoidable emergency admissions Reduce numbers of children who attend A and E Functioning integrated " Frail Elderly Pathway"
Long Term Condition (LTC)	Increased Patient education to self-care and access to information Care-Co-ordinators to identify highest risk patients through the ACG tool and organise MDT meetings Training for Primary care to promote Care-planning Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment	Patients and their carers are well informed and know where to access information and support Less people with Long term conditions requiring an emergency hospital admission associated with disease progression Patients' "own " their Care plan with their results available electronically Enhanced quality of life for people with dementia and their carers
Joint Commissioning	Increased access to Talking Therapies and reduction in waiting times for Talking Therapies Development of further services for Personality Disorder	Over 15% of people with anxiety or depression receive Talking Therapies . Improved use of mental health and GP services for patients with Personality Disorder Mental Health services measured on patient outcomes Integrated health and social care with a single point of access.

"Working innovatively with patients and partners to improve the health of our local community"

Strategic High Level Objectives

- To provide equitable, high- quality, primary medical care.
- To deliver more services in the community with less patients being seen in hospitals
- To use the finite NHS resources wisely based on clinical evidence and need

South Reading CCG Workplan 13/14

- To ensure the Right Care happens at the Right Place at the Right time"
- To reduce health inequalities within South Reading"
- To improve health outcomes for children and families"
- To improve outcomes for people with Long Term Conditions

South Reading Clinical Commissioning Group (CCG), with a population of approximately 125,000, is made up of 20 GP practices (see appendix 3 for full list of our member practices) with an excellent track record of working together since 2006.

They have been actively involved in developing alternative pathways and service redesign projects locally as well as taking a lead role on Quality, Innovation, Productivity and Prevention (QIPP) projects across the local health economy.

The majority (87%) of patients registered within South Reading are predominately seen in local hospitals, including, Royal Berkshire NHS Foundation Trust for acute services and Berkshire Healthcare Foundation Trust for mental health and community services. It is therefore important for South reading CCG to ensure and promote sustainability of the local health economy so that we can commission high quality services for our local population close to home.

The CCG has a Board as its Governing Body, consisting of 5 GP members, a nurse director, chief finance officer, chief officer, 2 Lay members and a hospital consultant. . The board is supported by and accountable to its member practices in the form of a council of practices , with representatives from all 20 practices in South Reading ; as well as a management team made up of elected representatives and supported by commissioning management staff. South Reading CCG is one of four CCGs in Berkshire West and works in close collaboration (Federation) with the other three CCGs in Berkshire West. A similar “Federation” also exists covering the three CCGs in Berkshire East.

We also actively engage and work alongside with our public health colleagues, within the local authority and other health care professionals, such as speech and language therapists, physiotherapists, pharmacists etc., as well as social care professionals and the voluntary sector in our programmes. This collaborative working will supplement our local CCG team resources in implementing local initiatives. Further support will be provided by a comprehensive Commissioning Support Unit (see page 37) who will provide further capacity in supporting the implementation of QIPP. **(Quality, Innovation, Productivity and Prevention) at a federation level.**

We are currently developing a public website where you can find more information on the South Reading Clinical Commissioning Group, what our plans are and how you can help us shape health care locally.

You can find us at www.southreadingccg.nhs.uk

What are our responsibilities?

The NHS Commissioning Board is the new NHS body responsible for overseeing and supporting Clinical Commissioning Groups, such as South Reading CCG. "Everyone Counts" issued in December 2012, provides us with guidance, underpinned by the **NHS Outcomes Framework** and **NHS Constitution,** two key NHS documents which set out the goals and responsibilities of Clinical Commissioning groups within the NHS.

South Reading CCG will have a budget of £117.7 million and will be responsible for commissioning the following services form 1st April 2013:

Clinical Commissioning Group responsibility for Commissioned Services from 13/14 (for the registered populations of its member practices as well as any unregistered population within its geographic boundary)

- Urgent and emergency care (including 111, A&E and ambulance services) for anyone present in the CCG geographic area
- Out-of-hours primary medical services (for everyone present in the CCG area)
- Elective (Planned) hospital care
- Community health services (such as rehabilitation services, speech and language therapy, continence services, wheelchair services, and home oxygen services, but not public health services such as health visiting and family nursing)
- Other community-based services, including (where appropriate) services provided by GP practices that go beyond the scope of the GP contract
- Infertility services
- Rehabilitation services
- Maternity and newborn services (excluding neonatal intensive care)
- Children's healthcare services
- (mental and physical health)
- Services for people with learning disabilities
- Mental health services (including psychological therapies)
- NHS continuing healthcare

We will work in close collaboration with the local area team to support the development of primary care services as well as providing direct support within practice to enable programmes of work to be successfully implemented.

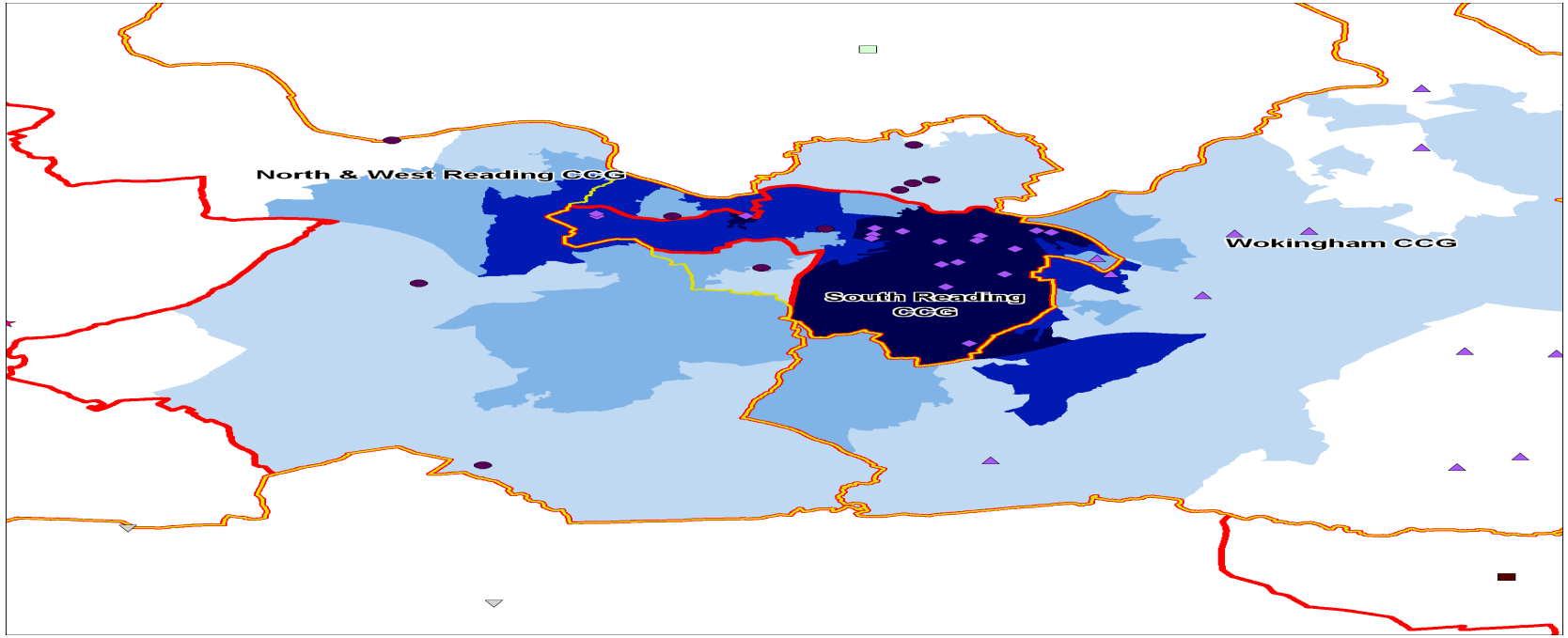
South Reading CCG has declared that we will have regard to and promote the **NHS Constitution**. The Constitution sets out the rights of NHS patients. These rights cover how patients access health services, the quality of care they will receive, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong. As a patient you the right to the following:

Referral to treatment waiting times for non-urgent consultant led treatment	Patients to start treatment within a maximum of 18 weeks from referral by the GP
Diagnostic test waiting times	Patients waiting for diagnostic tests (x-rays, scans etc) should have been waiting less than 6 weeks from referral by the GP
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
Cancer Waits – 2 week wait	A maximum two week wait for the first outpatient appointment for patients referred urgently with suspected cancer A maximum two week wait for the first outpatient appointment for patients referred urgently with breast symptoms (where cancer is suspected)
Cancer Waits – 31 days	A maximum of one month (31 days) wait from diagnosis to first definitive treatment for all cancers
Cancer Waits – 62 days	A maximum two month (62 days) wait from urgent GP referral to first definitive treatment for cancer
Category A ambulance calls	Category A calls resulting in an emergency response arriving within 8 minutes Category A calls resulting in an ambulance arriving at the scene within 19 minutes [Category A calls are '999' calls that are immediately life threatening. Where onward transport is required, life-threatening calls will receive an ambulance vehicle capable of transporting the patient safely within 19 minutes of the request for transport being made].
Mixed Sex Accommodation Breaches	Minimal number of mixed sex accommodation breaches in hospitals
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission (including the day of surgery) for non-clinical reasons will be offered another dated within 28 days, or the patients treatment funded at the time and hospital of the patients choice
Mental Health	Care Programme Approach (CPA). The proportion of people under adult mental illness specialties on CPA who are followed up within 7 days of discharge from psychiatric inpatient care

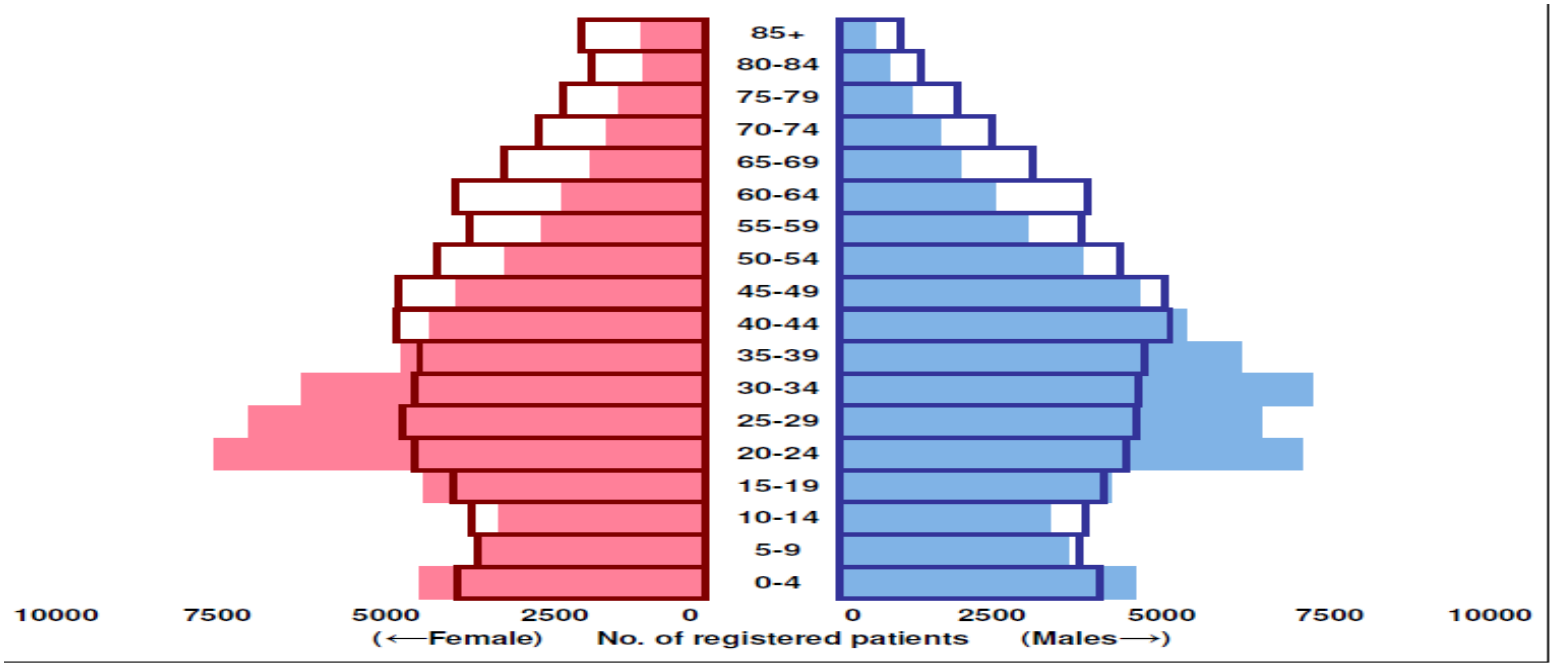
The Joint Strategic Needs Assessment (JSNA) is a statutory document produced jointly by Reading Unitary authority and local NHS commissioning organisations to enable all health and care partner agencies to take account of the broader social and environmental factors that shape people's health and wellbeing. It also provides information on the current picture of health and wellbeing in the local area. The JSNA helps inform our local commissioning and decision making by providing us with valuable information to allow us to commissioning quality health services now and in the future.

Our population

80% of South Readings registered population live within Reading Unitary Authority boundaries. (Shaded navy blue in the map below)



Age Profile of the Population



he England average population distribution is overlaid on the chart as an outline.

The chart below shows the age population pyramid for South Reading CCG.

17.1% of the CCG's registered population are under age 15 (England average 17.1%)
4.3% are age 75 or over (England average 7.5%).
48.5% are female (England average 50.2%).

South Reading CCG has the population profile that is different to the Berkshire West and England average. This difference mainly lies in the greater proportion of people in the 20 to 39 year old age group (*accounting for around 21% of South Reading CCGs total population*) and the relatively lower ageing population. Over the next 12 years the population of South Reading will grow on average by 0.8% per year (similar to the England annual average growth rate). However , the over 75 year old age group will only grow by 1.9% which is less than the England average of 2.3%. This means that there will be an ageing population with more people over the coming years who need support because of living with long term health conditions. It also tells us that South Reading will grow in size at a rate similar to the England average but will continue to have a higher proportion of younger people as its resident's than the rest of England.

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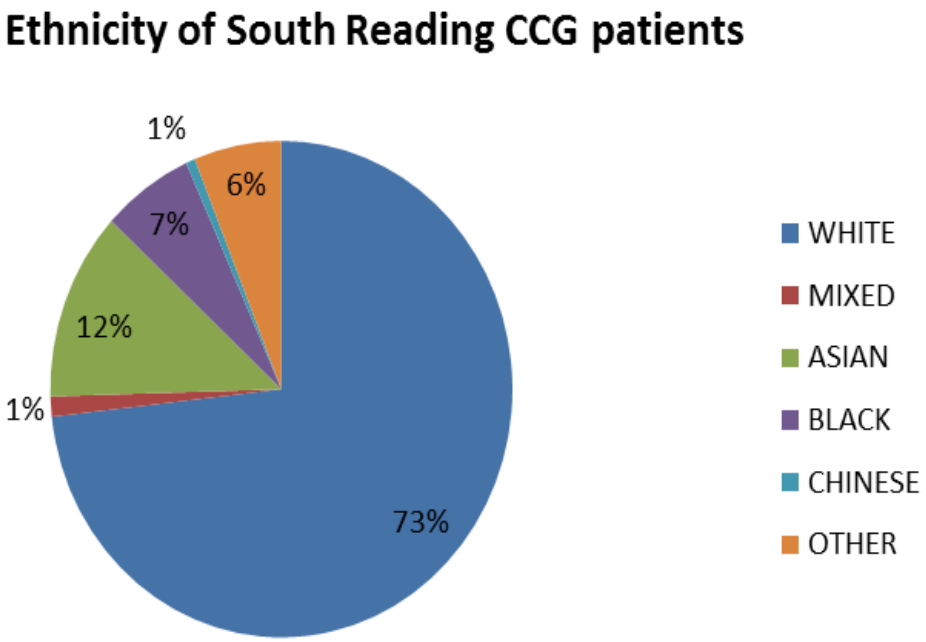
Ethnicity

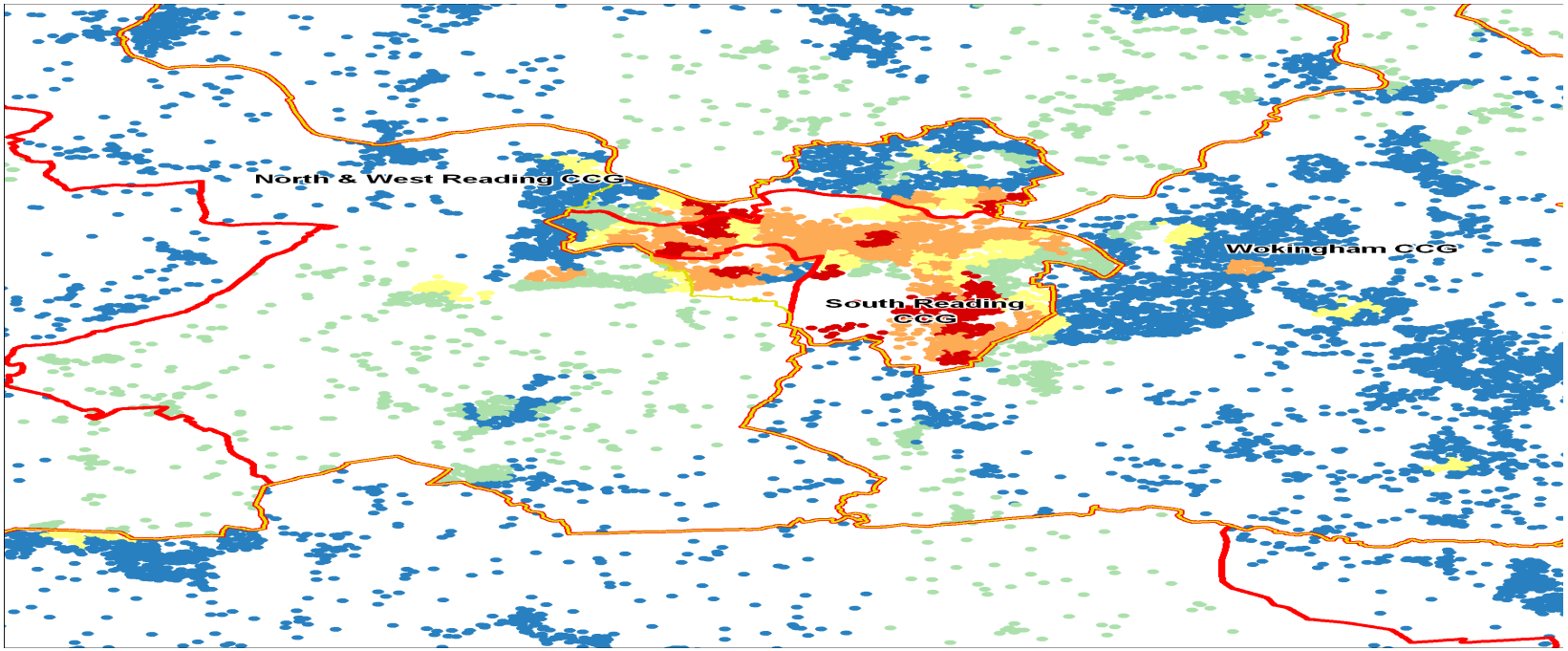


The ethnic minority population averages at 26% across South Reading CCG practices compared to 14% across Berkshire West as a whole. South Reading has a higher proportion of non-white residents than any other CCG in Berkshire West. The most represented ethnic minority groups in South Reading CCG is people of an Asian ethnic background (12% of all people) and people of a Black ethnic background (7%). 6% of the population is from other backgrounds including a growing number of people with a Nepalese background. This presents us with challenges in ensuring our services meet the need of the diverse population. We will need to take into account the different languages that may be spoken when considering access to services as well as any cultural barriers in promoting health and wellbeing.

Deprivation

- South Reading CCG is relatively more deprived than the NHS Berkshire West average and contains some of the most deprived wards in the County. These areas are shown on the map below. (red is highest level of deprivation)

INDEX OF DEPRIVATION 2010



There are some significant differences between different groups of people in Reading as to the quality of their health, including how long they can expect to live. For example there is an 8.5 year and 7 year difference in the life expectancy and death from cardiovascular disease (heart related disease) for men and women respectively from the most to the least deprived areas of Reading. These differences are known as health inequalities.

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Disease Prevalence versus Recorded Prevalence

The incidence or prevalence of specific diseases can be compared nationally and across south central, with local registers held within GP practices. (QOF registers). There are discrepancies in South Reading between the expected prevalence nationally and that which is recorded at practice level for a number of conditions including COPD (Chronic Obstructive Pulmonary Disease) , Cardio-vascular disease, including Heart failure, Atrial Fibrillation, Hypertension, Stroke, Dementia, Obesity and Diabetes. This suggests there are potentially more cases of these diseases in South Reading than is currently recorded. Further work is therefore needed to ensure we reach our population and meet their health needs appropriately.

Our Health and Wellbeing Strategy

Building on what we know from our JSNA and our local population characteristics, during 2012/13 we developed in conjunction with Reading Borough Council ,North & West Reading CCG, and Reading Local Involvement Network (LINk, an independent body which promotes the interests of people using health and care services) our first **Joint Health and Wellbeing Strategy** for Reading. South Reading CCG as a member of the Health & Wellbeing Board has tried to identify the most important issues to tackle to make Reading a healthier place. The Health & Wellbeing Board has also looked carefully at what local people have said health means to them and where their priorities lie.

Lots of things contribute to health and wellbeing - our environment, housing, schools, transport and leisure services as well as having good access to quality health and care services. And people who feel they belong to and can contribute to their community tend to enjoy better health than people who feel lonely or isolated. The Health & Wellbeing Strategy is based on **four goals** which describe what the Heath & Wellbeing Board feels it needs to focus on in order to make the biggest difference over the next few years.

The Health and Wellbeing Board has chosen four goals which align with the South reading CCG work plan for 13/14 and has approved the commissioning plan summaries.

Through a series of workshops with our GP members, practices events, public meetings and consultation we have been able to develop specific areas of focus that underpin and support the Reading Health and Wellbeing strategy and vision. These have been developed into local projects and in some instances work spanning across all four of the Berkshire West CCGs.

South Reading CCG Local Initiatives

HWBB Goal 1. The health of communities is promoted and protected

Immunisations

As South Reading CCG underperforms in attainment for childhood immunisations compared to other Berkshire west CCGs we are focussing on increasing the uptake our year 1 immunisations from 93% to 95%, recognising that this will also have future benefits by ensuring families with young children are identified and can be encouraged to attend for the rest of the vaccinations along with siblings requiring vaccination in line with the national immunisation programme.

Promote cervical, breast and bowel screening

As of November 2012 only 43% of those invited to participate in the Bowel Screening service within South Reading had done so – this is lower than the other areas of Berkshire West who are able to average 57%. We believe that the GP can be influential in encouraging our patients to take part in these cancer screening activities. We are starting with the bowel screening project, and supporting our GPs to record non-attendance and to write a letter to each patient encouraging them to participate. When we see how successful this is we may widen this to inviting non-attenders to the other screening programmes. The community health worker will work with different groups to educate and allay fears.

The Homeless Population

South Reading CCG is acutely aware of the needs of its homeless population and are working closely with our key stakeholders to improve health outcomes and access to care for this group of the population. This includes improved services for eye care, signposting to health professionals when necessary including treatments for mental health and alcohol related conditions. We will continue to invest annually £ 171, 000 in supporting homeless people to access healthcare.

HWBB Goal 2. Focus is increased on early years and the whole family

Breast Feeding

Nov 2012 figures show 91% recording of breast or bottle feeding at 6 weeks, and 53% uptake of breast feeding. We have worked with public health to have breast feeding advisors at the Delivery Unit. Each mother on discharge should know how to contact a local breast feeding advisor (often a trained volunteer) who can support her if difficulties arise. All midwives and health visitors have received training in breast feeding promotion. The CCG wishes to support the increased uptake of breastfeeding and is aiming for a 1% increase over 2013/14. We are investing in web tools to support this work and map services available.

Childhood Obesity

One third of 10-11 year olds are obese. Several of our local primary schools have a “Let’s Get Going” programme to encourage weight loss in obese children. We will promote sensible weight loss in overweight secondary school children by referring to dieticians and referring to the eat4Health Programme. The CCG will support the Local authority in addressing Childhood obesity

Children’s Speech & Language Therapy

There are a number of children who reach school age but who do not reach the threshold for a statement of special educational needs but do have a communication difficulty. As these children do not qualify for specialist speech and language therapy, we plan to work with Speech and Language specialists who will train and support local nurseries and pre-schools to help identify children with communication difficulties and provide them with strategies to address communication issues earlier. This is hoped to have a major impact on their lives and future educational employment opportunities in the future. It has also been shown that improved educational attainment reduced the healthcare burden in later life.

South Reading CCG will increase investment in Speech and Language provision, focussed on the most deprived wards.

HWBB Goal 3. The impact of long-term conditions is reduced

We will be working alongside out Berkshire West CCG colleagues through the Long Term Conditions Programme Board to support and implement the **Quality, Innovation, Productivity and Prevention** (QIPP projects) (see page 22). Examples include investment in care co-ordinators to work alongside practices and district nurses and to act as a point of contact and navigator through the health system, increased investment in diabetes education, and increased capacity in memory loss clinics.

In May 2013 we will be supporting our local patient focus group, South Reading Patient Voice to hold a conference for the public focusing on **Dementia and elderly care**. We will also continue to work with our local partners to develop a more co-ordinated pathway of care for frail, elderly patients.

Diabetes-“The Nine Care Processes”
People with diabetes will be offered access to the “9 care processes”. This is series of care options which help improved outcomes in diabetics and ensure appropriate on-going care and monitoring. We will increase by 9% to 45% of diagnosed diabetics receiving this level of care.

We will use web tools such as “Map of Medicine” and “Eclipse” and a new Long term Conditions website to support primary care in the improved management of Long Term conditions, starting with Diabetes and then expanding to include other long term conditions.

HWBB Goal 4. Health-enabling behaviours and lifestyle are promoted

Smoking cessation

This is one of the most cost effective lifestyle interventions that can make a real difference to health outcomes. We are aware that 21% of our population are currently smokers making them at increased risk of death from respiratory or cardiovascular diseases. We aim to promote smoking cessation services wherever possible and reduce smokers by 2%.

Cardiovascular Disease Health Checks

South Reading CCG has a higher death rate from cardiovascular disease in the under 75 year olds than the national average. There is good evidence that this risk can be decreased by focused intervention e.g. stopping smoking, increasing exercise, decreasing cholesterol and blood pressure. But to do this, the risk needs to be identified and where needed support given to enable change. We aim over a 5 year period to offer screening to all our 40-75 year olds. This was very much supported by our Patient Group. We will carry out an extra 804 health checks in 13/14.

This initiative along with increased year 1 immunisations and Diabetes "9 care processes" ,has been chosen by South Reading CCG as our three quality premium targets in line with NHS guidance "Everyone Counts".

Improving Health Outcomes –The NHS Outcomes Framework

The NHS Outcomes Framework 13/14 sets out measures to help the health and social care system to focus on health outcomes. The NHS Outcomes Framework details outcomes measures for Clinical Commissioning Groups into Five Domains:

- Domain 1– Preventing people from dying prematurely
- Domain 2 – Enhancing quality of life for people with long-term conditions
- Domain 3 – Helping people to recover from episodes of ill health or following injury
- Domain 4– Ensuring that people have a positive experience of care
- Domain 5 – Treating and caring for people in a safe environment; and protecting them from avoidable harm.

All our programmes of work help achieve the desired health outcomes.

A summary of how our programmes of work contribute to local (Health & Wellbeing and South Reading local work plan) and national (outcomes framework) targets can be found in Appendix 2.

Improving Health Outcomes- QIPP & the Four Programme Boards

QIPP (Quality, Innovation , Productivity and Prevention)

The CCGs in West Berkshire have been working together in a federated way to support South Reading and the other three CCGs in fulfilling their roles locally and to improve health outcomes. During 12/13 we embarked on a number of QIPP initiatives which generated savings which we have been able to reinvest in healthcare with new or extended projects. Our savings were carried forward into our baseline financial calculations. Examples include further expansion of Improved Access to Psychological Therapy (IAPT) and continued work further enhancing our end of life care, care for dementia and our work initiatives in Diabetes.

Our four main programmes of work across the federation are outlined below. These four major service areas covering a number of clinical change projects and other commissioning priorities, each overseen by a CCG Chair. Each programme monitors its progress through a programme board which then reports directly into the CCG Governing body. Our governance structure can be found in appendix 1.

LONG TERM CONDITIONS This programme has three core activities to roll our risk profiling, develop self care and integrate services. In addition the programme will deliver disease management programmes for specific conditions	**URGENT CARE** This programme will ensure a consistent and integrated response to patients with urgent care needs ensuring that the right part of the health and social care system responds to meet their needs and resources are optimised.
PLANNED CARE This objective of this programme is to ensure that patients can access the right care in the right place. This programme will ensure patients are seen by appropriate clinicians following redesigned care pathways.	**JOINT COMMISSIONING** This programme covers care groups, such as children and mental health, that are usually commissioned jointly with social care

1. Planned Care Programme-Improving Outcomes & being more efficient (Investment £110k)

The planned care programme of work focuses ensuring "The Right Care is delivered in the "Right Place" at the "Right Time" by the right healthcare professional and patients will have an appropriate choice of providers.

The principles for commissioning services within the planned care programme are;

- Using more community-based health services rather than hospitals wherever possible
- Fewer inappropriate hospital admissions and shorter lengths of stay in hospital
- Efficient and appropriate number of outpatient visits
- Promoting the integration of health and social care services
- Supporting more people to care for themselves
- Improved Patient reported outcomes for planned procedures

The Planned Care Programme will through these principles improve health outcomes for patients across the five domains of the NHS Outcomes Framework.

A summary of the key work within the planned care programme to promote **Quality, Innovation, Productivity and Prevention (QIPP)** during 13/14 and beyond are shown below:

Area	What will we do in 13/14?	How will it look by 14/15?
End Of Life	To change the admission criteria for two beds at Duchess of Kent to enable them to admit 24/7 patients who are at the very end of life.	Patients placed in the most appropriate setting. Reduction in secondary care admissions.
Long-Term Breast Follow-up Care	This service will be developed in line with the Survivorship programme which promotes patient-led follow-up and moving care out of secondary settings and closer to home.	To provide high quality, efficient, accessible, effective and safe follow up care for breast cancer patients who have completed active treatment. This will lead to reduction in hospital based follow up appointments and an improvement in new to follow up ratios.
Ophthalmology Service Development	An Integrated Eye Care Service with an appropriate level of follow-up activity undertaken within a community model, to agreed clinical protocols and a local tariff;	A cost effective service improving health outcomes.
Community Based Endoscopy Service	GPs will be appropriately referring patients requiring a routine gastroscopy or flexi sigmoidoscopy to a community Tier 2 provider.	Generate capacity within main acute provider and achieving efficiencies for the Health Economy.

Area	**What Will We Do in 13/14?**	**How will it look by 14/15?**
Reduction in Pathology variation	We will benchmark the use of pathology services by practice. We will agree with the Consultant Biochemist the most appropriate tests and identify any practice outliers.	Improved access to Direct Access Pathology at RBFT with efficiency savings of £151k across the four West CCGs.
Reduction in Radiology Variation	We will benchmark the use of direct access x ray and other radiology services by practice and agree with the Consultant radiologist the most appropriate use of radiology services.	Improved access to radiology with efficiency savings of £55k across the four West CCGs.
Stroke Developments	We will commission extra stoke care beds and increase investment for the Early supported Discharge team.	Stroke patients will receive care in the appropriate place Facilitate early discharge. Avoid readmissions. Reduced waiting times and ensure smooth transfer to Early Supported Discharge and Community Based Neurological Rehabilitation Team (CBNRT)
Musculo-Skeletal Service (MSK)	Review of the MSK pathway and agreement by the end of 2013/14 on its future state. Incorporation of Shared Decision Making (SDM) for primary hip and knee replacement as a must do prior to surgery to enable patients to have informed decision on deciding to opt for surgery. Pain management incorporated into the MSK pathway, as currently it is a separate service.	A high quality, cost effective MSK service whereby parts of the pathway are identified where efficiencies can be made, those that require decommissioning and those offering good value for money. Incorporation of SDM for primary hip and knee replacement. Pain management and SDM as part of MSK pathway.
Haematology DAWN	Commission the DAWN system which integrates with the pathology laboratory systems to simplify patient monitoring so that trends over time can be seen quickly..	Improved patient safety
Surgical High Dependency Unit	The Royal Berkshire Hospital's 11 critical care beds are often supplemented by managing surgical patients, requiring higher levels of monitoring, in the Theatre recovery area overnight. This ensures patients are closely observed in the immediate post-operative phase prior to being transferred to the ward environment the next day. This is not ideal for patients or their families, as specialist support can be provided. To prevent patients being transferred back to the ward prematurely a new High Dependency Unit (HDU) will provide care both pre and post operatively under the joint care of intensive	Patients been treated in a more appropriate setting. Reduction in mortality rates.

	care and surgical consultants. The HDU will have resources for immediate resuscitation and management of the critically ill. It will be equipped to manage short-term emergencies.	

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2. Urgent Care -Improving Outcomes (Investment £260k, saving £440k)

South Reading CCG is working closely with the three other Berkshire West CCGs on the urgent care programme. An Urgent Care Programme Board (UCPB) brings together the major local stakeholders.

The CCG aims to commission urgent care services which ensure patients are able to access the appropriate service first time, avoiding hospital admission unless clinically necessary. We plan to improve patient flow through the system, avoiding delay and to increase the capacity and develop the capability of community-based services. This reflects national guidance on moving towards 7 day availability of routine NHS services which support urgent and emergency care.

NHS 111

In line with national policy, an NHS 111 service will operate throughout Berkshire in 2013/14. The Berkshire CCGs have collaboratively commissioned a 2 year pilot from South Central Ambulance Service (SCAS) which goes live in April 2013. As well as close monitoring of the 111 service itself, the impact on the wider system will be monitored, including the Out Of Hours (OOH) service (West Call) and will inform future commissioning decisions.

Ambulance services

Commissioners are working with SCAS and the local acute Trust to improve performance on ambulance handover times. A local trajectory has been agreed which achieves 90% of handovers within 18 minutes by March 2013. We will work with providers to achieve the 2013/14 national standard of 15 minutes. There will be contractual fines levied from the relevant provider for delays of over 30 minutes and 60 minutes in both handover and readiness for new calls, in line with national planning guidance.

We will continue to incentivise the use of the 'GP Triage' scheme to avoid conveyance to hospital where appropriate. There will be further work on the scheduling issues relating to the conveyance of 'GP Urgent' cases.

Care in hospital

Redesign of the Urgent Care area at Royal Berkshire Foundation Trust (RBFT) is underway to improve operational efficiency and patient experience; a consultancy firm has been engaged to drive forward the changes.

RBFT remains on trajectory to achieve the 95% A&E 4 hour wait target. In 2013/14 there will be an additional contractual requirement to ensure there are no trolley waits longer than 12 hours.

A review of the emergency care pathway at RBFT by the NHS Emergency Care Intensive Support Team (ECIST) is currently underway, at the request of the Urgent Care Programme Board (UCPB) , to identify areas where there is scope for improvement and make recommendations based on national best practice. The UCPB will consider ECIST's report and determine an appropriate action plan.

The UCPB will support the adoption of Enhanced Recovery principles, already operating successfully in elective care, in the care of patients who present with an urgent care need.

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System Resilience (Managing services when demand is high)

The UCPB oversees the operation of a robust system of monitoring pressures within the system and responding in line with escalation plans. Working collaboratively with the 3 Unitary Authorities, the CCGs have commissioned Capita to undertake work which will inform demand and capacity planning across health and social care for the next 5 years.

Maternity Services

With a higher than average emergency caesarean section rate at Royal Berkshire Hospital and increasing demand on maternity services locally, improving maternity services is an important focus for South reading CCG and the other three CCGs in Berkshire West. A local steering group which includes patient representatives, midwives, and Local Authorities is in place to review and facilitate improvements in services. In addition, the Clinical Commissioning Groups (CCGs) have collectively commissioned Solutions for Public Health (SPH) to undertake an independent review of the existing maternity services capacity available to the population of Berkshire and to develop some options for improving the match of capacity to demand.

A draft report has been received and further work with stakeholders including the local Maternity Service Liaison Committee will commence and with a view to achieving the following outcomes:

- Commission maternity services which are high quality, safe, and women-centred.
- Plan future capacity across the whole health system in developing sustainable maternity care for the future.
- Optimise capacity from current maternity services by reviewing skill mix and care models.
- Women offered a genuine and informed choice of models of care and birth place.
- Progress initiatives to increase normal births where possible, to improve health outcomes, and reduce service demands.
- Management of pre-existing health conditions in pregnancy across clinical services.

Services for newborns requiring additional support in a Local Neonatal Unit or Neonatal Intensive Care will be commissioned by the National Commissioning Board, with whom we will work closely to ensure an appropriate interface with locally commissioned services.

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Our **Quality Innovation, Productivity and Prevention**, (QIPP) programme comprises a number of initiatives. **Together these projects aim to achieve a target reduction in emergency hospital admissions of One Admission Per CCG per Day.** A system-wide Commissioning For Quality Innovation (CQUIN) scheme will encourage both our local acute and community Trusts to support achievement of this objective.

Area	What Will We Do in 13/14?	How Will It Look by 14/15?
Enhanced intermediate care services	Re-ablement and Rapid Response Services will be available throughout South Reading and Berkshire West, 7 days a week through locality based teams, via a Single Point of Access. All patients will have equality of access to a multidisciplinary team which will include Community Psychiatric Nursing, reflecting the national drive for mental health to be as valued as physical health.	7 day a week service for South Reading with a single point of access. Rapid Access to a multidisciplinary team
24 hour community nursing	Additional resource and changed working patterns within community nursing will enable the provision of a comprehensive 24/7 service. This will enable more proactive management of patients with long term conditions.	24/7 service with response within 2 hours of an urgent referral.
ACG care co-ordination (also see Long Term Conditions Programme)	Community based care co-ordinators will use the ACG risk stratification tool to identify patients who would benefit from pro-active management through a multidisciplinary team care co-ordination model (includes Local Authority social care.)	High risk patients will have a proactive management plan. Less people will be admitted as an emergency associated with disease progression.
End of Life (also see planned care programme)	To change the admission criteria for two beds at Duchess of Kent to enable them to admit 24/7 patients who are at the very end of life. Increased GP education in end of life care.	Fewer emergency admissions at the end of life
COPD pathway enhancements (also see Long Term Conditions programme)	Exacerbation Assessment service and targeted telemonitoring	Fewer emergency admissions for respiratory disease

Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Heart Failure (also see Long Term Conditions programme)	*Expansion of Telehealth and psychological therapy*	Improved monitoring of additional patients with unstable heart failure at risk of re-admission to hospital.
Paediatric emergency admissions	Building on the success of the existing project to reduce paediatric emergency admissions by implementing the 5 NHS Institute for innovation pathways and supporting GPs to adopt the appropriate changes to their clinical practice, a further pathway for respiratory conditions will be implemented in 2013/14 following its publication.	Fewer children admitted in an emergency

3. Long Term Conditions Programme-Improving Outcomes (Investment £250k)

South Reading CCG is the lead for and continues to work closely with the three other Berkshire West CCGs on the commissioning programme for Long Term Conditions (LTC.) A programme board brings together multiagency stakeholders.

The Long Term Conditions Board aims to improve education and support patients in managing their own condition to optimise their health. Digital technology/ telehealth will be utilised where appropriate and we will work towards the national target of offering online access to patients' own primary care medical record by 2015.

We will develop the use of risk stratification (via an ACG tool) to better target interventions for LTC. We will design services which are person-centred and integrated to improve the patient experience of care.

Our **Quality Innovation, Productivity and Prevention, (QIPP) programme** comprises a number of initiatives planned for 2013/14 which are described below. The initiatives in Chronic Obstructive Pulmonary disease (COPD),Heart Failure, Epilepsy and Care co-ordination are expected to contribute to the overall reduction in emergency admissions in 2013/14 (see Urgent Care section above) as well as improving relevant condition specific outcome indicators.

Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Patient Education and support	We will work with our provider of Interventional Access to Psychological Therapies (IAPT) to develop 'Talking Health'; a model of education and support for patient self- management, to include face to face, telephone and group work	Patients with long term conditions will feel more supported to manage their condition and will maintain their health-related quality of life

	with patients. It will include unlimited online access to 'SHaRON', a moderated online network.	
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Diabetes	A major redesign of the local diabetes service is underway to develop a primary care based service which ensures patients receive the nine care processes. It includes an education programme for health care professionals and the establishment of a Diabetes Specialist Nursing resource. Education for patients will be re-commissioned and a care planning approach (Diabetes Year of Care) will be introduced. We will invest in web based tools such as "Eclipse" to improve management of diabetics and promote self-care.	Patients and their carers are well informed and know where to access information and support. 45% Diabetics will have access to the 9 care processes, an increase of 9% locally. Diabetics will have their own Care plan with their results available electronically
Chronic Obstructive Pulmonary Disease (COPD) (See also urgent Care Programme)	Introduction of an Exacerbation Assessment service, enabling rapid outpatient assessment of a patient, avoiding admission. Implementation of the evidence based COPD Discharge Care Bundle, including follow-up phone calls Consultant input to the Early Supported Discharge scheme Telemonitoring of selected patients using an automated telephone messaging service Increasing Pulmonary Rehabilitation provision to establish a rolling programme in all localities, ensuring there is sufficient provision to meet the relevant national Outcome Indicator target.	Less people with Long term conditions requiring an emergency hospital admission associated with disease progression. Improved discharge arrangements, rehabilitation and on-going monitoring of patients. Improved long term under 75 years mortality rates from respiratory disease.
Heart Failure (See also Urgent Care Programme)	The existing telemonitoring scheme will be expanded to enable monitoring of additional	Improved monitoring of additional patients with unstable heart failure at risk of re-admission to

	patients with unstable heart failure at risk of re-admission to hospital. Care will be enhanced by the input of psychological therapy.	hospital.
Neurological conditions	An Epilepsy Nurse Specialist will be funded, improving the quality of care and helping to avoid hospital admissions. Additionally information for patients and carers will be reviewed and developed to include a website, as part of the CCG's website for Long Term Conditions	An integrated specialist nursing service for neurological conditions. Patients and their carers are well informed and know where to access information and support.
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Care co-ordination (See also Urgent Care Programme)	Community based care co-ordinators will use the ACG risk stratification tool to identify patients who would benefit from pro-active management through a multidisciplinary team care co-ordination model (includes Local Authority social care.)	High risk patients will have a proactive management plan. Less people will be admitted as an emergency associated with disease progression.
Dementia	In 2012/13 we invested in older people's mental health services to meet rising demand and additionally initiated 5 projects with Dementia Challenge funding: • Care Home In-reach Team – to improve the quality of dementia care in care homes • Cognitive Stimulation Therapy – to increase provision • Domiciliary Care Training – to identify and address training needs • Patient and Carers Information – to inform and empower • Dementia Friendly Communities – to encourage local organisations to review and adapt their services In 2013/14 we will continue to increase our investment in older people's mental health	We will improve our rate of diagnosis of people with dementia. Enhanced quality of life for people with dementia and their carers. Patients and their carers are well informed and know where to access information and support People with Dementia and their carers will feel more supported to manage their condition Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment

	services; expanding capacity in memory clinics and associated prescribing costs, and continue to roll out the local model of shared care. We have committed recurrent funding for the Care Home In-reach Team. We will in May 2013 with South Reading Patient Voice hold a patient focused conference "Dementia and elderly care"	
Integrated Care (Also see Joint Commissioning Programme)	In line with the evolving Health and Wellbeing strategy for Reading we are working with Reading Borough Council on developing integrated community care in Long term Conditions.	Integrated care across health and social care for Long term conditions.

4. Joint Commissioning Programme-Improving Outcomes (Investment £300k)

The Joint Commissioning Programme Board encompasses Mental Health and Learning Disability services, in addition to children services. The programme aims to transform adult mental health and learning disability services, focussing on care pathways; the development and performance management of outcomes; patient safety; and the physical health of people with a mental illness or learning disability.

"In everything we do, mental health should have equality of esteem with physical health" (p 5 Everyone Counts: Planning for Patients 2013/14).

Keys areas of focus within **Mental Health** include:

Area	What Will We Do in 13/14?	How Will It Look by 14/15?

Improved Access Psychological Therapy (IAPT) programme for Talking Therapies (Also see Long Terms Conditions Programme)	Significant additional funding will be used to increase the coverage of IAPT to population. We will continue the work to ensure access to people from BME and minority communities We will increase the numbers of older people entering treatment We will continue to develop competencies and the provision of psychological services to people with co-morbid clinical psychological illness and a physical long-term condition.	Talking Therapies service for 13/14 will deliver services to not less than 13.9% of the national predicted population for Berkshire West, while simultaneously exceeding the national requirement of 50% recovery rate and meeting the national 28 day waiting time KPI for the commencement of treatment. By 2014/15, 15% of the national predicted population will be receiving IAPT services.
The physical health of people with a mental illness or learning disability.	We will continue the work to ensure that the physical health of people with a learning disability or mental illness is addressed as an on-going quality standard. The delivery of physical health checks for people with severe mental illness will be a continuing quality standard for mental health services, building upon the CQUIN developed and implemented from 2011onwards. The delivery of health checks for people with learning disability will continue to be implemented through the joint Learning Disability Self-Assessment standards, in partnership with the Unitary Authorities and the Learning Disability Partnership Boards.	Improved mental health checks for people with severe mental illness, with mental health services measured on patient outcomes. Improve patient satisfaction in mental health services from 25% to 50% Improved rates of health checks for people with learning disabilities.
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Urgent and crisis services for people at risk of serious self-harm	We will within our mental health contract focus as a priority on the continuing improvement of NHS services' response to patients presenting with a risk of suicide or serious self-harm through CQUINs, Quality standards and development of specific outcomes and care pathways.	Timely response and provision of services to patients presenting in a crisis or who are at risk. Improved quality of the response back to those referring to NHS services patients perceived to be at risk.

Improving services for people with a Personality Disorder	We will commence a specific project to expand treatment, reducing current waiting times for specialist psychotherapies, and develop outcomes for patients with personality disorder. These patients are a significant proportion of those in specialist mental health care, including of those within forensic and non-forensic specialist inpatient services and are, nationally, identified as presenting a challenge to general mental health services.	Improved use of mental health and GP services for patients with Personality Disorder
Continuing expansion of Older People's Mental Health Services (Also see Long Term Conditions Programme)	We will increase investment in Older Peoples Mental Health Services to increase capacity of services to enable both the assessment and treatment of growing numbers of patients diagnosed with dementia.	We will improve our rate of diagnosis of people with dementia. Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment Increased prescribing of Dementia Medication in line with National Guidance (NICE)
Improved Services for adults with Autistic Spectrum Disorders [ASD] or Attention Deficit disorders [ADHD]	Building upon the work already implemented within Berkshire to create local NHS services for adults with ASD and ADHD, minimising the need for patients to travel to regional specialist services, we will continue to commission improvements in local services. We will develop joint strategies to provide medication for adults with ADHD and improve the transition for young people from CAMHS services, where appropriate, to adult services offering specialist supervision. We will provide training for other health and social care services working with people with ADHD or ASD.	Reduced waiting times through increased capacity for diagnostic assessments. Post-diagnostic support courses for both ASD and ADHD Seamless transition from CAMHS to adult ADHD services for young people as appropriate.
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Development of outcome and evidence-based care pathways for mental health & learning disability.	We will work in partnership with key stakeholders to develop outcome and evidence based care pathways for mental health and learning disability services. The involvement of social care commissioners, users and carers will be key. This will allow us	Services based upon clinical and patient recorded outcomes Improved patient and carer involvement in the development of service outcomes Services provided where appropriate within

	to introduce Payment by Results [PBR] and allow future commissioning to focus on key outcomes and quality/performance standards. Key outcomes for this work will include: Quality standards for liaison with other key services, such as primary care and physical health services Early intervention Improving the availability of outcome-based psychological therapies to all patients in specialist mental health services	Berkshire with minimal usage of out-of-area treatment and residential care Improved access to services for people from BME and minority groups, and for older people
Children's Services		
Area	**What Will We Do in 13/14?**	**How Will It Look in 14/15?**
(CAMHS) Children and adolescent mental health services From April 2013 Tier 3 CAMHs will be commissioned by CCGs and Tier 4 (more complex needs) CAMHs will be commissioned by National Specialised Commissioning	We will ensure there is a single care pathway so children and young people can seamlessly and safely access "step up/ step down" (repatriation) care. We will review availability of services locally over weekends and bank holidays and how these services interface with emergency/ urgent care. We will review the provision of alternative Places of Safety for under 18s.	Reduced admissions of young people to Tier 4 inpatient units. Shorter lengths of stay of young people in Tier 4 inpatient units. Reduced out of county fostering, community home and residential school placements for young people, reducing the potential for family breakdown as a result.
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**
Special Educational Needs (SEN)	We will build an integrated therapy offer for early years, schools, and special schools. This would involve joint commissioning with local	A more integrated, easy to understand service, with a single point of contact across health and social care.

	authorities) We will commission simple, single contact points where advice, guidance and information is given for all elements of children's development. We will increase the training, skills development and support of teachers and assistants, in ways that make functional and educational sense We will join up and simplify the assessment process and care planning, when more than one therapy is needed, agreed with education staff and parents	Reduced duplication and gaps in service provision. A more highly skilled workforce able to offer more influence and a more consistent service in children's learning development. A more integrating speech and language therapy and Occupational therapy service which is well received by families and partners
Safeguarding Children- Rapid Response to Child Death	Rapid Response arrangements currently in place will be enhanced by providing a "rapid response home visit" by a senior healthcare professional and police officer within 24 hours of death when deemed necessary. We will improve cover for rapid response to include weekends and bank holidays We will also commission a health led rapid response process for children who die outside hospital and who are not transported to hospital	Improved rapid response coverage 7 days a week, carried out by a senior healthcare professional and police officer. A service is provided to cover children who die outside of hospital and are not transported to hospital.
Looked After Children Health, educational and social outcomes for Looked After Children remain poor nationally with a high rate of teenage pregnancies, smoking and substance misuse, mental health problems, school drop-out rate with poor educational attainment and criminality.	We will build upon work currently underway , working with our partner organisations, to improve the health of Looked After Children We will implement a paediatrician led service to provide timely high quality initial health assessments	Improved robust assessment and follow up of emotional health and wellbeing in partnership with other agencies. Improved quality and timeliness of service provision for Looked After Children. Timely and high quality health assessments routinely in place for Looked after children.
Area	**What Will We Do in 13/14?**	**How Will It Look by 14/15?**

Community Paediatric Nursing	To implement and monitor improvements to the current service. To improved commissioning arrangements so as to minimise the number of packages of care that are supplied by agencies.	Improved quality of services provided Fewer packages of care provided by agencies Increase number of packages of care provide within a formal service agreement.

A summary of how our programmes of work contribute to local (Health & Wellbeing and South Reading local work plan) and national (outcomes framework, CCG Indicators) targets can be found in Appendices 2 & 4 .

Improving and Maintaining the Quality & Safety of Services

South Reading CCG recognises its responsibility in putting quality and safety at the centre of everything we do. One of the key objectives of this is to continuously improve the quality of services and therefore the experience of patients.

High Quality Care for All, the final report of the NHS Next Stage Review (2008) sets out commitments for making quality improvement across three dimensions: ensuring that care is safe, effective and provides patients with the most positive experience possible.

Our Quality Strategy has four objectives that will be addressed at every stage of the commissioning cycle. These objectives are:

1. To ensure that services being commissioned are safe, personal and effective
2. To ensure the right quality mechanisms are in place so that standards of patient safety and quality are understood, met, and effectively demonstrated
3. To provide assurance that patient safety and quality outcomes and benefits are being realised, and recommend take action if the safety and quality of commissioned services is compromised
4. To promise the continuous improvement and innovation in the safety and quality of commissioned services

We will ensure that the recommendations of the Winterbourne View Inquiry and Francis Report are embedded into our commissioning as key quality principles.

A quality report will be presented monthly to South Reading CCG covering the three main measures of quality- Patient experience (including complaints and information form the NHS Choice website), Patient safety (including serious incidents, suicides and unexpected deaths and NSH Safety Thermometer information) and clinical effectiveness (including the Quality Schedule and CQUIN progress-see below).

In addition through our communications teams, Patient advice and liaison services , Health watch , our member practices, public website and various Patient engagement groups, such as South Reading Patient Voice and practice patient and participation groups , we will continue to be responsive to any concerns raised about a service we commission for the South Reading population. We will assess the situation and take any necessary action to resolve issues, and communicate back, demonstrating our commitment to adopting the “You said we did” principle.

Commissioning For Quality & Innovation (CQUIN)

The CQUIN (Commissioning for Quality and Innovation) framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables us to reward excellence by linking a proportion of healthcare income to the achievement of local quality improvement goals. The framework aims to embed quality within discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

Across Berkshire West, the four CCGs will set CQUIN schemes on a whole health economy basis, to incentivise collaborative community working to achieve the goal of improving quality through integrated working. For example we will introduce a CQUIN which all local provider organisations will work towards supporting our initiative to reduce emergency admission by one admission per CCG per day. (Four per day across Berkshire West). In order to be eligible for CQUIN payments providers must first meet nationally determined CQUIN targets as well as the National eligibility criteria, such as C Diff, etc. A quality schedule has been prepared for each provider identifying key areas for improvement.

South reading CCG chief officer will be an active member, alongside the regulatory bodies at the Area team Quality Assurance group.

Safeguarding Adults & Children

The CCG Board Lead for Safeguarding Adults and Children will be the responsibility of the Board Nurse across the four Berkshire West CCGs, in line with their responsibility for patient safety and quality. The nurse will be supported by two local GP Clinical leads on the CCG board with responsibility for children and adults safeguarding respectively.

South Reading CCG will have a statutory duty to make arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004. They are statutory members of Local Safeguarding Children Boards (LSCBs) under section 13 of the Children Act 2004 and have a statutory duty to cooperate under section 10 of the Act. We will have access to a Designated Doctor (a practicing Paediatrician) and Nurse, who have a strategic leadership role for child protection across the health system, and informing the commissioning of health services. The Designated Nurse & Doctor will support the CCG leadership regarding child protection, as well as providing leadership and support to the Named professionals in provider organisations throughout the local health system. All NHS trusts, NHS foundation trusts, public, third sector and independent sector, social enterprises providing services for children should identify a named doctor and a named nurse – and a named midwife if the organisation provides maternity services- for safeguarding children.

Adult Safeguarding is included within the job description of the CCG Board Nurse, along with Safeguarding for Children. The Board Nurse will be the representative on the Berkshire West Adult Safeguarding Board. There are significant advantages to the same person holding this responsibility, in terms of safeguarding issues affecting whole families – for example domestic abuse, as well as ensuring that good practice is shared between adult and children's arrangements. Reviews on safeguarding issues occur via the Quality Committee.

Equality Act & Equality Delivery System (EDS)

South Reading CCG has had a statutory duty from 1st April 2013 to ensure compliance with the Equality Duty, showing we have had due regard to eliminate unlawful discrimination, advance equality of opportunity as well as foster good relations – between people who share a protected characteristic and people who do not. The protected characteristics we need to consider are as follows:age;

- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

Using the Equality Delivery System (EDS) tool designed by the Department of Health (DH) we will better understand how equality can drive improvements and strengthen the accountability of services to patients and the public. It will help ensure that everyone - patients, public and staff - have a voice in how organisations are performing and where they should improve. The EDS is all about making positive differences to healthy living and working lives. The EDS will help us analyses what is required by section 149 of the Equality Act 2010 ("the public sector Equality Duty") in a way that promotes localism and also helps us deliver on the NHS Outcomes Framework, the NHS Constitution and the Human Resources Transition Framework.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The four EDS goals are:

	Objective
1. Better health outcomes for all-	To embed the EDS and Equality Impact Assessments within commissioning processes ,which will be informed by engagement of representatives from the protected characteristics
2. Improved patient access and experience	To ensure our Engagement Strategy will include consultation with representatives from the protected characteristics
3. Empowered, engaged and included staff	**Not applicable to CCG teams due to small size**
4. Inclusive leadership at all levels	To ensure designated equality leads are covered within a leadership role

We have adopted the objectives set in 12/13 and once our analysis is complete, we will update these to ensure they adequately reflect the needs of their own local population. Our progress in implementation of these actions will be monitored by the CCG Board, who will receive training in Feb 2013. We will be required to publish information to demonstrate compliance with the public sector Equality Duty at least annually, with the first publication being 31st January 2014.We will conduct an equality impact assessment on our Commissioning plan as part of its development.

Engagement with our Patients, The Public and Other Stakeholders

Providers of Hospital and community services

Each of the CCG's within Berkshire West , supported by the commissioning support unit, contracts, quality and finance divisions , has an identified a clinical lead for one of the main providers (hospital, community and other services we buy). South Reading CCG has the lead responsibility for the Berkshire Health care trust contract (community & mental health services). With each provider we will :

- develop contracting strategies which deliver according to need , but also create long term sustainability via innovation, pathway restructuring, advanced cost management, risk management/business continuity.
- Ensure Provider Performance is evaluated encompassing:
  - ✓ Structured process, with agreed goals and quality initiatives
  - ✓ Specific, transparent measures and process understood by the providers
  - ✓ Patients/Users actively involved in shaping care
  - ✓ Regular formal feedback sessions on current performance and further improvement
  - ✓ "Voice of the provider" solicited for a balanced, two-way view of performance
- Identify and manage joint improvements efforts with the providers

Work is also under way to inform a longer term view of sustainability in our health economy and we, collaboratively with the Unitary Authority and our main providers, commissioned work which will inform demand and capacity planning across health and social care for the next 5 years.

Reading Borough Council & The Health & Wellbeing Board

As a key member of the Reading Health & Wellbeing board, we will share responsibility for providing leadership to the local health and social care services. We will continue to develop our relationships with Reading Borough Council, in particular promoting the Integrated Care agenda. Work is already underway following a successful joint workshop exploring best practice options for integrated care in long term conditions. We continue to work with Reading Borough Council, our local providers, voluntary sector and patients to improve navigation throughout the health and social care and reduce duplication in existing service provision. Areas already identified include a single point of access for health and social care, integrated intermediate care and end of life care. Where appropriate efficiencies and improved quality of care will be facilitated through pooling of health and social care funds.

Voluntary Sector

Furthermore we have invested in partnership development , with the voluntary sector, who will support and help introduce initiates which will support our overall aim of providing care at the right place, at the right time and appropriate to the patient's needs, whilst promoting self-care and independence

Local Area team

We will work in close collaboration with the local area team to support the development of primary care services as well as providing direct support within practice to enable programmes of work to be successfully implemented. Examples include the provision of care co-ordinators to work alongside district nurses and practices, a variety of software tools, dementia advisers, diabetic specialist nurses and community geriatricians to offer advice and support when necessary.

Clinical Networks & Senates

The NHS Commissioning Board has recognised the value of Strategic Clinical Networks (SCNs) as 'engines for change' in the modern NHS. SCNs are therefore a further element in the wider system that will support CCG's to deliver quality improvements and outcomes benefits for patients.

The NHSCB has mandated four SCN groupings across England, as follows:

- Cancer
- Cardiovascular
- Maternity & Children

- Mental health, dementia and neurological conditions

Strategic Clinical Networks may also be bolstered on key work-programmes and disease groups identified by the Local Area Team, through Operational Delivery Network (ODNs).

Given the natural links between the CCG's priorities (including national priorities), South Reading CCG will endeavour to engage with SCNs to ensure a consistent and robust emphasis on quality improvements and patient outcomes at all times.

Patients & The Public, including Healthwatch

South Reading Clinical Commissioning Group's (CCG) will continue to talk and listen to our local community and work with them so that we can make sure we are doing the best we can to improve the health and wellbeing of the people we serve. We want to involve our local community in commissioning care and work with them to improve health and wellbeing. We fully recognise that this can't be a one-way or one –off process and as a CCG we are committed to informing and involving people by:

- Being open and transparent about what we are doing and our plans
- Explaining what we are doing regularly and in a way that is easy to understand
- Giving patients and representative groups the opportunity to be involved in decisions, have a voice and influence ideas and proposals
- Through our CCG and disease specific websites, help patients and their carers to access information about healthcare services.
- Reach out to all parts of our community and recognises the diverse nature of people served by South Reading CCG.
- Continue to engage and work closely with Healthwatch

We plan to do this in a number of ways:

- From April 2013, we will hold at least 4 Board meetings in public
- We have two lay members on the Board of the CCG with one leading on patients and public engagement and the other on governance.
- We have patient representatives attending and sometimes chairing many of our committees including;
    - Joint Commissioning Committee
    - QIPP and Financial Performance Committees
    - Quality Committee (Lay member chair)
    - Audit (Lay member chair)
    - Remuneration
    - Individual Patient Funding Review Committee (Lay member chair)

    - Appeals Committees
- CCG Clinical commissioning Committee
- Member Practices are encouraged to from a patient participation group
- Patient experience insights are a standing item on Council of Member Practices agendas
- Individual Programme Boards are required to ensure that business cases include 'demonstrable patient involvement'

Our Quality committee also reviews and reports from a Quality perspective, on patient experience including complaints and compliments. Every practice has an established feedback and complaints process and many practices have public suggestions boxes available in reception areas, posters in waiting areas. There will also be details of our CCG Complaints policy on our website advising of exactly how patients and public can provide feedback or make a complaint.

The South Reading Patient Voice is the CCGs patient participation group. It meets monthly and has agreed objectives and a constitution. As well as South Reading Voice, each GP practice within the CCG has or is developing patient participation groups – some of these involve face to face meetings and others are virtual and communicate and share information electronically.

We will build continuous and meaningful engagement with the public, patients and carers to influence and improve the health of people in South Reading, using the most appropriate means of communications for the requirements of the audience. We will use patient experience data and information to inform our work and to work with provider organisations to listen to patients more and act on their feedback 'Closing the loop' by reporting on the impact of public feedback on South Reading CCG decisions e.g. "You said , we did". We want people in South Reading to feel they have a voice in the decisions made by South Reading CCG and that they know how they have impacted local NHS services. We want patients to have an improved patient experience.

We have carried out a stakeholder analysis and have mapped out our wide range of stakeholders, with different needs and expectations. This includes not only the public, but also local media, Reading Borough Council, MPs, and our provider organisations such as the Royal Berkshire Hospital and Berkshire Healthcare Trust. We will make sure that the way we communicate and involve will be appropriate to each type of stakeholder.

We will involve patients and the public at each stage of the commissioning cycle. This commissioning plan and identification of our priorites has been developed and contributed to by patients, Healthwatch, Reading Borough Council, our providers and member practices throughout 12/13. This has been achieved using a number of different methods including a variety of public events and workshops, feedback from South Reading Patient Voice as well as contributions form patient attendance at key decision making meetings such as QIPP (Quality, Innovation, Productivity and Prevention) and our monthly Quality meeting. Our GP member practices, who are close to the on the group delivery of health services have also been actively involved in setting priorites and representing the interest of patients. Practice visits are undertaken across the CCG which provides an opportunity for as many GP's as possible, Practice Managers and Practice Nurses to meet with CCG Board members and share

feedback, experiences and best practice. Practice Managers also meet regularly with their administration and reception staffs to ensure all have an opportunity to provide feedback and participate in the development and delivery of healthcare across their practices and the CCG.

Patient Choice

In line with the NHS constitution we are committed to providing choice to patients and ensuring that they are active partners in their care. We promote the use of the Choose and Book system and have ensured that as many providers, including the independent sector and primary care services are published on the Directory of Services. This supports the offer of choice at the point of referral.

Any Qualified Provider

Any Qualified Provider (AQP) is a national programme which offers patients more choice and drives up standards of care alongside promoting innovation. CCGs are committed to diversity of provision for patient benefit, and thus have implemented this approach by extending patient choice into community services. By extending choice of provider into areas where it has not previously been available, patients will be able to choose, where appropriate, from a range of qualified providers and select the one that best meets their needs.

Following a rigorous and transparent selection process, alternative providers of adult hearing (over 55 hearing loss) , podiatry (adult) and non-obstetric ultrasound scan services have been chosen for Berkshire patients. Adult Hearing providers started to offer services from 2nd January 2013 and other providers will be operational by 1st April 2013.

Central Southern Commissioning Support Unit

Securing robust and affordable Commissioning Support Services

All of the Berkshire West CCGs have committed to receiving services from Central Southern Commissioning Support Unit for 13/14. The capability and capacity of the CSU to provide the range of services agreed is critical to the delivery of the commissioning plan including the financial strategy. We have developed with the CSU a series of service specifications. A Service Level Agreement for Commissioning Support along with Service Specifications is signed and in place. The CSU will fully support the delivery of QIPP initiatives across Berkshire West.

The CCG Board will receive monthly reports detailing the position and a narrative of any variances in any services we commission and identifying areas to address. The CCG is represented at the relevant contract performance meetings through the federated working arrangements and has access to analysis and interpretation of the information through the Commissioning Support Service Level Agreement.

South Reading CCG Financial Plan 2013/14 to 2015/16

The detail of our financial plan is incorporated into our financial strategy but below is a high level summary:-

2013/14 Allocation and Plan

The financial allocation for South Reading CCG has been notified by the NHS Commissioning board as £116,366k. This allocation has been based on a substantial data collection exercise carried out in the summer of 2012 and includes the 2.3% national growth uplift that has been applied to all CCGs in England. The total income for South Reading CCG for 2013/14 is £117,770k which includes South Reading CCG's share of the 2012/13 NHS Berkshire West surplus and a small non recurrent allocation due from NHS Berkshire East.
The financial plan for 2013/14 has been developed to support the CCG to deliver its Commissioning Plan within the resources available to it. It complies with the 2013/14 National Planning Guidance – Everyone Counts: Planning for Patients and the incorporated financial requirements which are summarised below:-

(i) Achievement of 1% surplus on Income and Expenditure
(ii) Commitment to spend only 98% of allocation recurrently ie to create 2% headroom to be spent non recurrently in year
(iii) Manage within an agreed cash limit
(iv) Hold at least 0.5% contingency

The plan also reflects an estimation of the potential impact of the demographic changes to the population in South Reading
A summary of the financial plan is shown below:-

Financial Plan- 2013/14	£'000
Acute services	65,385
MH services	13,243
Community services	13,452
Continuing Care services	5,864
Primary Care services	14,691
Other Programme services	415
Contingency	1,164
2% Headroom	2,327
Total expenditure	116,540
Surplus	1,230
Allocation*	117,770

2013/14 QIPP

QIPP – Quality, Innovation, Productivity and Prevention – is a large scale transformational programme for the NHS, involving NHS staff, clinicians, patients and the voluntary sector. It is aimed at improving the quality of care the NHS delivers while making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care. Locally in South Reading we are working with our CCG federation colleagues, our provider organisations and social care on 4 work programmes (set out in Section 4),together with work on medicines management and through the application of contract business rules to deliver £1.2m savings in 2013/14. The levels of planned savings by programme are shown below:

	£'000
Urgent Care	440
Contract Business Rules	257
Medicines management	257
Planned care -Ophthalmology	41
Planned care - MSK	119
Planned care- Pathology/Radiology	53
Planned care - other	44
Total QIPP savings	1,210

The achievement of these savings is already incorporated into our financial plan and the successes of our QIPPs in 12/13 are carried forward savings into QIPP baseline for 13/14.

The CCG also plans to invest in healthcare services for its population and a summary of the planned investments (excluding known pressures) for2013/14 is shown below:-

Investments		£m
	Unscheduled care	0.26
	Long term conditions	0.25
	Planned care	0.11
	Joint commissioning & staying healthy	0.30
	QIPP schemes	0.92
	High Dependency Unit	0.34
	LD homes	0.05
	Patient Transport Service	0.08
Investments		1.39

Long term Financial Forecast

South Reading CCG has in place balanced financial plans for 2014/15 and 20115/16. The assumptions made are in line with national guidance provided at this time and achieve the required 1% surplus. Based on the income and expenditure assumptions made a QIPP gap of just under £900k was identified for each of the years 2014/15 and 2015/16. A summary of the plans for the 2 years are shown below:-

	2014/15'	2015/16'
	£m	£m
Baseline allocation	116.4	119.0
Growth	2.7	2.7
Non recurrent expenditure budget	-2.4	-2.4
Non recurrent adjustment	0.3	0.0
Total income	**116.9**	**119.3**
Recurrent cost base	114.4	116.9
Tariff changes	-0.1	-0.1
Demographics	0.6	0.8
Pressures/investments	2.9	2.7
Total expenditure	**117.8**	**120.2**
QIPP gap	**-0.9**	**-0.9**

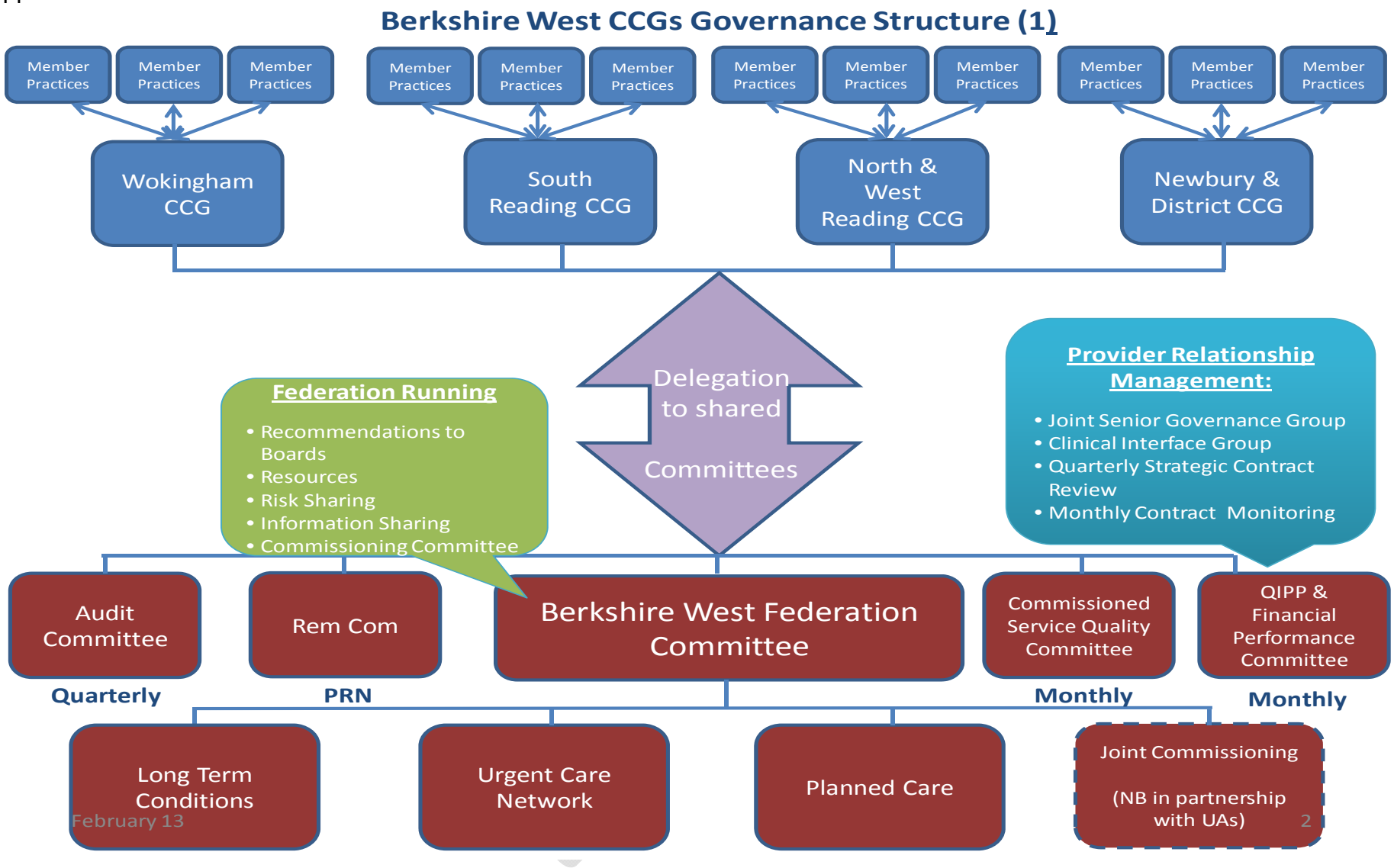
The table below shows how we will close this gap in each of the 2 years. We have started to invest in a Berkshire/Buckinghamshire wide review of services in 2012/13 that we are confident will generate savings and better patient care in the following 2 years. We are likewise hoping to utilise some of our non-recurrent monies in 13/14 to start to transform our frail elderly care pathway across our healthcare providers and social care and have attributed savings to this work in both 14/15 and 15/16.

	14/15	15/16
	£'000	**£'000**
Business Rules	128	128
Medicines management	257	129
Berks/Bucks Review	257	514
Frail elderly pathway	77	104
Planned care -Ophthalmology	108	
Planned care - other	48	14
TOTAL QIPP SAVINGS	875	889

+

We will continue to develop QIPP plans in year to ensure that we achieve productivity and efficiency gains and to release funds for continued investment and innovation.

Appendix 1


Berkshire West CCGs Governance Structure (1)
Member Practices
Wokingham CCG
South Reading CCG
North & West Reading CCG
Newbury & District CCG
Delegation to shared Committees
Federation Running
• Recommendations to Boards
• Resources
• Risk Sharing
• Information Sharing
• Commissioning Committee
Provider Relationship Management:
• Joint Senior Governance Group
• Clinical Interface Group
• Quarterly Strategic Contract Review
• Monthly Contract Monitoring
Audit Committee
Rem Com
Berkshire West Federation Committee
Commissioned Service Quality Committee
QIPP & Financial Performance Committee
Quarterly
PRN
Monthly
Monthly
Long Term Conditions
Urgent Care Network
Planned Care
Joint Commissioning
(NB in partnership with UAs)
February 13
2

Appendix 2

The following table summarises how the four programme board initiatives detailed above and maps these to the relevant National and local key indicator Groups, thus supporting the delivery of the National NHS Constitution Indicators and CCG indicators.

Planned Care QIPP Programmes	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
End Of Life	Domain 5	**Right care Right Place**	
Long-Term Breast Follow-up Care	Domain 1,3,4	**Right care Right Place**	**Health of community is promoted and protected (Goal 1)**
Ophthalmology Service Development	Domain 4,5	**Right care Right Place**	
Community Based Endoscopy Service	Domain 4,5	**Right care Right Place**	
Reduction in Pathology variation	Domain 4,5	**Right care Right Place**	
Reduction in Radiology Variation	Domain 4,5	**Right care Right Place**	
Musculo-Skeletal Service	Domain 3,4,5	**Right care Right Place** **Long term Conditions**	**Impact on Long term Conditions is reduced (Goal 3)**
Stroke Developments	Domain1.3.4.5	**Long term conditions**	**Impact on Long term Conditions is reduced (Goal 3)**
Haematology DAWN	Domain 3,4,5	**Right care Right Place**	**Impact on Long term Conditions is reduced (Goal 3)**
Surgical High Dependency Unit	Domain 1,3,4,5	**Right care Right Place**	

Urgent care QIPP Programmes	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
Enhanced intermediate care services	Domains 2, 3 & 4	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
24 hour community nursing	Domain 2	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
ACG care co-ordination (also see Long Term Conditions Programme)	Domain 2	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
End of Life (also see planned care programme)	Domain 5	**Right care Right place**	
COPD pathway enhancements (also see Long Term Conditions programme)	Domains 2 & 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Heart Failure (also see Long Term Conditions programme)	Domains 2.& 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Paediatric emergency admissions	Domain 3 & 5,	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**

Long term Conditions QIPP Programmes	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
Patient Education & Support	Domain 2	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Diabetes	Domains 1, 2 & 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Chronic Obstructive Pulmonary Disease (COPD) (See also urgent Care Programme)	Domains 2 & 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Heart Failure (See also Urgent Care Programme)	Domains 2.& 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
Neurological conditions	Domains 2 & 3	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
Care co-ordination (See also Urgent Care Programme)	Domain 2	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
Dementia	Domain 2	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
Integrated Care (Also see Joint Commissioning Programme)	Domains 2 & 4	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**

Joint Commissioning programmes (Mental Health)	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
Improved Access Psychological Therapy (IAPT) programme for Talking Therapies (Also see Long Terms Conditions Programme)	Domain 2 Domain 3	**Long term conditions** **Health Inequalities**	**Impact of Long Term Conditions is reduced (Goal 3)**
The physical health of people with a mental illness or learning disability.	Domain 1 Domain 2	**Health Inequalities**	**Health enabling behaviours & lifestyles are promoted (Goal 4)**
Urgent and crisis services for people at risk of serious self-harm	Domain 1, 3 and 4	**Right care Right Place**	
Improving services for people with a Personality Disorder	Domain 2, 3 & 4	**Right Care Right Place**	
Continuing expansion of Older People's Mental Health Services (Also see Long Term Conditions Programme)	Domain 2 & 4	**Long term Conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
Improved Services for adults with Autistic Spectrum Disorders [ASD] or Attention Deficit disorders [ADHD]	Domain 2 & 3	**Right care Right place**	**Impact of Long Term Conditions is reduced (Goal 3)**
Development of outcome and evidence-based care pathways for mental health & learning disability.	Domains 1, 2,3, 4 and 5	**Right care Right place**	**Impact of Long Term Conditions is reduced (Goal 3)**

Joint Commissioning programmes (Children's Services)	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
(CAMHS) Children and adolescent mental health services	Domain 1, 3,4,5	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Special Educational Needs (SEN)	Domain 3 and 4	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Safeguarding Children- Rapid Response to Child Death	Domain 1,4,5	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Looked After Children	Domain 3, 4, 5	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Community Paediatric Nursing	Domain 1, 2,3,4,5	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)** **Impact of Long Term Conditions is reduced (Goal 3)**

South Reading Local projects	NHS Outcomes Framework	South Reading Local Workstreams	Reading Health & Wellbeing Strategy Goal
Immunisations in year 1	Domain 5	**Health Outcomes in Children**	**Health of community is promoted and protected (Goal 1)**
Diabetes 9 Care Processes	Domains 2, 4 & 5	**Long term conditions**	**Impact of Long Term Conditions is reduced (Goal 3)**
Cardiovascular Health checks	Domain 1	**Health Inequalities**	**Health enabling behaviours & lifestyles are promoted (Goal 4)**
Keep people out of A & E	Domains 4 & 5	**Right care Right place**	
Speech & Language in early years	Domain 4	**Health outcomes in children**	**Focus is increased on early years and the whole family(Goal 2)**
Childhood obesity	Domain 1	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Breast Feeding	Domains 1 & 4	**Health outcomes in children**	**Focus is increased on early years and the whole family (Goal 2)**
Smoking Cessation	Domains 1 & 5	**Health inequalities**	**Health enabling behaviours & lifestyles are Promoted (Goal 4)**
Cervical , Breast & Bowel Screening	Domain 1 & 5	**Health Inequalities**	**Health of community is promoted and protected (Goal 1)**

Table Key:

NHS Outcomes Framework

Domain 1– Preventing people from dying prematurely

Domain 2 – Enhancing quality of life for people with long-term conditions

Domain 3 – Helping people to recover from episodes of ill health or following injury

Domain 4– Ensuring that people have a positive experience of care

Domain 5 – Treating and caring for people in a safe environment; and protecting them from avoidable harm.

South Reading Local Wokstreams

1. Right Care: Right place

2. Health Inequalities

3. Health outcomes in children.

4. Long term conditions)

Reading HWBB Strategy Goals

Goal1 –Health of community is promoted and protected;

Goal 2 Increased focus on Early years and the whole family

Goal 3 Impact on Long term Conditions is reduced

Goal 4 Health enabling behaviours & lifestyles are promoted)

Appendix 3   Our GP Practices

Practice name	Address
98be6c00-570f-4 Milman Road Hea Milman Road Health Centre - Lister	First Floor Milman First Floor Milman Road, Reading, Berkshire, RG2 0AR
d6eb8200-446b-4 Abbey Medical C Abbey Medical Centre	41 Russell Street 41 Russell Street, Reading, Berkshire, RG1 7XD
509e947f-03ba-4 Chatham Street S Chatham Street Surgery	121 Chatham Stre 121 Chatham Street, Reading, Berkshire, RG1 7JE
f7f0556e-0a74-4 Eldon Road Surge Eldon Road Surgery	10 Eldon Road, ¶ 10 Eldon Road, Reading, Berkshire, RG1 4DH
30526fa5-da53-4 Grovelands Medi Grovelands Medical Centre	701 Oxford Road 701 Oxford Road, Reading, Berkshire, RG30 1HG
4f39143a-0dcb-4 Kennet Surgery Kennet Surgery	30 Cholmeley Roa 30 Cholmeley Road, Reading, Berkshire, RG1 3NQ
9533626d-019d-4 London Street Su London Street Surgery	72 London Street 72 London Street, Reading, Berkshire, RG1 4SJ
57d27eb3-bafa-4 Longbarn Lane S Longbarn Lane Surgery	22 Longbarn Lan 22 Longbarn Lane, Reading, Berkshire, RG2 7SZ
e4380d03-dc82-4 Melrose Surgery Melrose Surgery - Dean	73 London Road, 73 London Road, Reading, Berkshire, RG1 5BS
f2bf704f-0b0b-42 Melrose Surgery Melrose Surgery - Williams	73 London Road, 73 London Road, Reading, Berkshire, RG1 5BS
fc1b5541-5db8-4 Milman Road Hea Milman Road Health Centre - Kumar	Ground Floor Miln Ground Floor Milman Road, Reading, Berkshire, RG2 0AR
0b0eac4e-2a48-4 Pembroke Surger Pembroke Surgery	31 Alexandra Roa 31 Alexandra Road, Reading Berkshire, RG1 5PG
0bc1f445-3efd-4 Reading Walk-In H Reading Walk-In Health Centre	First Floor, ¶103 First Floor, 103 Broad Street Mall, Reading, Berkshire, RG1 7QA

04ba612d-a6fc-4	Russell Street Su	Russell Street Surgery	The Surgery, ¶79	The Surgery, 79 Russell Street, Reading Berkshire, RG1 7XG
d0936b18-6f64-4	South Reading ar	South Reading and Shinfield Medical Centre	257 Whitley Woo	257 Whitley Wood Road, Reading, Berkshire, RG2 8LE
b1ff625f-33a5-48	The New Surgery	The New Surgery /London Road	172 London Road	172 London Road, Reading, Berkshire, RG1 3PA
70fc5818-ac01-4	Tilehurst Village S	Tilehurst Village Surgery	92 Westw ood Rc	92 Westwood Road, Tilehurst, Reading, Berkshire, RG31 5PP
107b8ac5-a3c2-4	University Medica	University Medical Practice	9 Northcourt Ave	9 Northcourt Avenue, Reading, Berkshire, RG2 7HE
5a3b7a57-844d-4	Westw ood Road	Westwood Road Surgery	66 Westw ood Rc	66 Westwood Road, Tilehurst, Reading, Berkshire, RG31 5PR
96c1aa47-07d4-4	Whitley Villa Surg	Whitley Villa Surgery	1 Chistchurch Ro	1 Chistchurch Road, Reading, Berkshire, RG2 7AB

Appendix 4 National & Local Indicators Mapped to the 4 Programme Board Areas

Indicator Grouping	Indicator Name	Programme Board
CCG Indicators Set	Mental Health Measure- Improved access to psychological services	Partnerships
CCG Indicators Set	Patient Experience Survey - Inpatients	Planned Care/Urgent Care
CCG Indicators Set	Emergency admissions for alcohol related liver disease	Urgent Care
CCG Indicators Set	Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes	Planned Care
CCG Indicators Set	Antenatal assessments <13 weeks	Planned Care
CCG Indicators Set	Maternal smoking in pregnancy	Planned Care
CCG Indicators Set	Maternal smoking at delivery	Planned Care
CCG Indicators Set	Breast feeding prevalence at 6-8 weeks	Planned Care
CCG Indicators Set	People with severe mental illness who have received a list of physical checks	Partnerships
CCG Indicators Set	Mortality within 30 days of hospital admission for stroke	Planned Care
CCG Indicators Set	One and five year survival from all cancers	Planned Care
CCG Indicators Set	One and five year survival from breast, lung & colorectal cancers	Planned Care

CCG Indicators Set	People with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 referred to a pulmonary rehabilitation programme	LTC
CCG Indicators Set	People with diabetes who have received nine care processes	LTC
CCG Indicators Set	People with diabetes diagnosed less than a year who are referred to structured education	LTC
CCG Indicators Set	People with diabetes who have an emergency admission for diabetic ketoacidosis	Urgent Care
CCG Indicators Set	Complications associated with diabetes	LTC
CCG Indicators Set	Lower limb amputation in people with diabetes	LTC
CCG Indicators Set	People with dementia prescribed anti-psychotic medication	LTC
CCG Indicators Set	Recovery following talking therapies for people of all ages	Partnerships
CCG Indicators Set	Access to community mental health services by people from black and minority ethnic groups	Partnerships
CCG Indicators Set	Access to psychological therapies services by people from black and minority ethnic groups	Partnerships
CCG Indicators Set	Estimated diagnosis rate for people with dementia	LTC
CCG Indicators Set	People who have had an acute stroke who receive thrombolysis	Planned Care
CCG Indicators Set	People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival at hospital	Planned Care
CCG Indicators Set	People with stroke who are discharged from hospital with a joint health and social care plan	Planned Care
CCG Indicators Set	People with stroke whoreceive a follow-up assessment between 4-8 months after initial admission	Planned Care
CCG Indicators Set	Patient experience of outpatient services	Planned Care
CCG Indicators Set	Responsiveness to in-patients' personal needs	Planned Care
CCG Indicators Set	Patient experience of A&E services	Urgent Care
CCG Indicators Set	Women's experience of maternity services	Planned Care
CCG Indicators Set	Patient experience of community mental health services	Partnerships
CCG Indicators Set	Incidence of venous thromboembolism (VTE)	Planned Care
CCG Indicators Set	Cancelled Operations on the day	Planned Care
Local	% spending 90%+ time on stroke unit	Planned Care
Local	TIA % high risk treat <24 hours	Planned Care

Local	Bookings to Services Where Named Consultant Led Team was Available (Even if Not Selected)	Planned Care
Local	Proportion of GP Referrals to First OP Appointments Booked Using Choose and Book	Planned Care
Local	Trend in Value/Volume of Patients Being Treated at non-NHS Hospitals	Planned Care
NHS Constitution	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	Planned Care
NHS Constitution	31-Day Standard for Subsequent Cancer Treatments-Surgery	Planned Care
NHS Constitution	31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	Planned Care
NHS Constitution	31-Day Standard for Subsequent Cancer Treatments-Radiotherapy	Planned Care
NHS Constitution	Ambulance Clinical Quality- Category A 8 Minute Response Time	Urgent Care
NHS Constitution	Ambulance Clinical Quality- Category A 19 Minute Transportation Time	Urgent Care
NHS Constitution	All Cancer Two Month Urgent Referral to Treatment Wait	Planned Care
NHS Constitution	62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service	Planned Care
NHS Constitution	62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority	Planned Care
NHS Constitution	Mental Health Measure- Care Programme Approach (CPA)	Partnerships
NHS Constitution	% of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	Planned Care
NHS Constitution	% of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	Planned Care
NHS Constitution	% of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	Planned Care
NHS Constitution	Diagnostic Test waiting times	Planned Care
NHS Constitution	A&E waiting time- Total Time in the A&E Department	Urgent Care
NHS Constitution	All Cancer Two Week Wait	Planned Care
NHS Constitution	Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	Planned Care
NHS Constitution	MSA Breaches	Planned Care/Urgent Care
NHS Constitution	HCAI measure (MRSA)	Planned Care
NHS Constitution	HCAI measure (Clostridium difficile infections)	Planned Care

Outcomes Framework	People with long-term conditions feeling independent and in control of their condition	LTC
Outcomes Framework	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	LTC
Outcomes Framework	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Urgent Care
Outcomes Framework	Emergency admissions for acute conditions that should not usually require hospital admission	Urgent Care
Outcomes Framework	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	LTC
Outcomes Framework	Under 75 mortality rate from cardiovascular disease	LTC
Outcomes Framework	Under 75 mortality rate from respiratory disease	LTC
Outcomes Framework	Cardiac rehabilitation completion	LTC
Outcomes Framework	Under 75 mortality from liver disease	LTC
Outcomes Framework	Under 75 mortality rate from cancer	Planned Care
Outcomes Framework	Health-related quality of life for people with long-term conditions	LTC
Outcomes Framework	Patient reported outcome measures for elective procedures: hip replacement	Planned Care
Outcomes Framework	Patient reported outcome measures for elective procedures: knee replacement	Planned Care
Outcomes Framework	Patient reported outcome measures for elective procedures: groin hernia	Planned Care
Outcomes Framework	Patient reported outcome measures for elective procedures: varicose veins	Planned Care
Outcomes Framework	Emergency admissions for children with lower respiratory tract infections	Urgent Care
Outcomes Framework	Emergency re-admissions within 30 days of discharge from hospital	Planned Care

Outcomes Framework	Patient experience of GP out-of-hours services	Urgent Care
Outcomes Framework	Friends and family test for acute inpatient care and A&E	Planned Care/Urgent Care
Supporting Measures	% of ambulance handovers completed within 15 minutes	Urgent Care
Supporting Measures	Non-elective FFCEs	Urgent Care
Supporting Measures	All First Outpatient Attendances	planned care
Supporting Measures	Elective FFCEs	planned care
Supporting Measures	Crew Clear	Urgent Care
Supporting Measures	Trolley waits in A&E	Urgent Care
Supporting Measures	Urgent operations cancelled for a second time	planned care
Supporting Measures	Number of 52 week Referral to Treatment Pathways	planned Care

Health and Wellbeing Board – Meeting 15 March 2013

Progress Report on Healthwatch

Since the last meeting I am pleased to report that RVA in conjunction with Reading Link (and on behalf of Healthwatch Reading) has been successful in its £20,000 bid to the PCT's Partnership Development Fund to establish and improve patient and public engagement in the GP practices located in N&W and South Reading CCGs. This funding available from 1 April 2013 will be invaluable in helping to improve awareness of health and social care issues in the area and will show how patients and the public can influence the extent and quality of services provided.

In addition Reading Link has been invited to provide observers to both CCG Board meetings and we attended our first meeting on 5 February 2013 at N&W Reading. This meeting, amongst other matters, discussed forthcoming practice visits by the a team from the CCG and Reading Link has been invited to attend selected visits to enable us to start to spread the message about improving the level of public engagement. It is hoped a similar approach will apply in South Reading.

Meetings continue to be held with the local authority to take forward the work of the Link's Task and Finish Group on Transition to Healthwatch Reading. The budget and funding for this is now agreed and RVA is taking steps to obtain new accommodation in the centre of Reading, where Healthwatch will be located. In addition staffing is being reviewed so that Healthwatch Reading will be up and running from 1 April.

In order to further engage with the local voluntary and community sector and incorporate their voices fully into Healthwatch Reading, Reading LINk will be establishing a forum for the local voluntary and community sector called 'Healthwatch Voices'. This will act a platform for dialogue with the sector to raise concerns, gather issues and priorities for their services users. This is intended to be a quarterly meeting and the first meeting will take place at the launch of Healthwatch Reading on April 17th. More details of this event will follow.

RVA have established a charity (Charitable Incorporated Organisation – CIO) which will be the vehicle to receive funding from the Local Authority and the payment of expenses incurred. The application for the Healthwatch Reading charity is now with the Charity Commission and hopefully will be approved in time for the start on 1 April.

Finally, steps are being taken to establish a Link Legacy document in accordance with advice supplied by the LGA and the DOH. Although the Link is continuing as Healthwatch Reading it is important that we identify all the work achieved over the last four years so that Healthwatch Reading has a sound basis on which to take its work forward. Sadly in other areas of Berkshire and farther afield this will not be the case.

DRAFT

READING BOROUGH COUNCIL

REPORT BY MONITORING OFFICER

TO:	**COUNCIL**		
DATE:	**26 MARCH 2013**	**AGENDA ITEM:**	**7**
TITLE:	**TRANSFER OF PUBLIC HEALTH – HEALTH & WELLBEING BOARD**		
LEAD COUNCILLOR:	**CLLR TICKNER**	**PORTFOLIO:**	**HEATH & WELLBEING**
SERVICE:	**ALL**	**WARDS:**	**BOROUGH-WIDE**
LEAD OFFICER:	**CHRIS BROOKS**	**TEL:**	**0118 937 2602 / 72602**
JOB TITLE:	**HEAD OF LEGAL AND DEMOCRATIC SERVICES**	**E-MAIL:**	**Chris.brooks@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report seeks approval to the changes required in consequence of the transfer of public health functions to the Council which will take effect on 1 April 2013. In particular, the report proposes the establishment of the Health and Wellbeing Board as a committee of the Council, for the remainder of the current Municipal Year.

1.2 The Health and Social Care Act 2012 ("the 2012 Act") provides for the transfer of public health functions from the NHS to local authorities. The relevant statutory provisions will come into effect on 1 April 2013. The 2012 Act requires the Council to establish a Health and Well Being Board ("the Board") and to appoint a Director of Public Health. The statutory functions of the Health & Wellbeing Boards are set out set out in Sections 195-196 of the 2012 Act, and para. 8.5 below.

1.3 In anticipation of these changes, the authority has had a shadow Health and Wellbeing Board for the past two years. This was set up by Cabinet on 14 March 2011 (Minute 182 refers), and by the Annual Council Meeting in May 2012. Its current terms of reference and operating arrangements are set out in **Appendix A**.

1.4 The transfer of public health functions in Berkshire will involve the abolition of the two Primary Care Trusts (PCTs) covering the county – for East Berkshire, and the West of Berkshire – and the transfer of relevant functions to the six Unitary Authorities. This process has been planned and coordinated by a Transition Board made up of officers from the six Unitary Authorities, and overseen by the Berkshire Chief Executives and Berkshire Leaders' Groups. They have agreed, in consultation with the Department of Health, that :

- there will be one Strategic Director of Public Health for Berkshire, who will be appointed jointly with the Department of Health and employed by a host authority
- each Unitary authority will have a Consultant in Public Health who will be accountable professionally to the Director.
- Bracknell Forest Borough Council will be the host authority for the Berkshire-wide public health service, and the employer of the Director of Public Health, and will provide a "core" public health service to all the Berkshire Unitary Authorities

- These arrangements will be the subject of a joint agreement between the six Berkshire Unitary Authorities.

1.5 The terms of the joint arrangement described above were approved by Cabinet on 18 March 2013. This included the arrangements for the transfer of existing PCT contracts to the Berkshire local authorities as successor authorities; unless these are specific to an individual authority, they will transfer to Bracknell Forest as host authority who will manage them on behalf of the successor authorities under the terms of the joint agreement (including payment).

1.6 The joint agreement also involves each Unitary Authority entering into a formal arrangement with Bracknell Forest under Section 113 of the Local Government Act 2013 to place the Director of Public Health, as Bracknell's employee, at the disposal of the other authorities for the purposes of their public health functions. This was also approved by Cabinet on 18 March 2013.

2 RECOMMENDATIONS

2.1 That the Council constitute the Health and Well Being Board as a committee of the Council under Section 102 of the Local Government Act 1972, for the remainder of the Municipal Year 2012/13, with the terms of reference and operating arrangements as set out in Appendix A and with membership that replicates the current composition of the shadow Health & Wellbeing Board, as follows:

- **The Leader of the Council**
- **The elected portfolio holders for Health, Community Care and Children's Social Care**
- **The Managing Director**
- **The Director of Education, Social Services and Housing**
- **Director of Public Health for the Local Authority (or the Reading Consultant in Public Health as the Director's named substitute)**
- **A representative from each of the commissioning consortia**
- **A representative from the Local Healthwatch organisation**

2.2 That the named membership, terms of reference and operating arrangements of the Board be reviewed and updated to reflect its new statutory role and functions, at the Annual Council Meeting in May 2013.

3. POLICY CONTEXT

3.1 The purpose of this report is to ensure that the Council complies with the provisions of the Health and Social Care Act 2012 relating to the transfer of public health functions from the NHS to local authorities from 1 April 2013.

3.2 Cabinet, on 14 March 2011, set up a shadow Health & Wellbeing Board to provide a basis for partnership working with the Primary Care Trust, the local Healthwatch, the local Clinical Commissioning Groups (CCGs) and other local health partners, to oversee the planning for this transfer. The Councillor membership comprised the Leader and the Lead Councillors responsible for health, children's services, and adult social care. The opposition Group Leaders have had the right to appoint one shadow lead councillor to attend Board meetings as observers.

3.3 The Annual Council Meeting, on 22 May 2013, will re-establish the Board, as a committee of full Council, for the Municipal Year 2013/14, and appoint all of its members for the new Municipal Year and agree its operating arrangements.

4. BACKGROUND AND PROPOSAL

4.1 **Health and Well Being Board**

4.1.1 Section 194 of the 2012 Act stipulates that the Council must establish the Board. The Board is regarded as a Committee of the Council. The main functions of the Board are:-

- overseeing the preparation of Joint Strategic Needs Assessments with relevant clinical commissioning groups, and

- approving a strategy for meeting, by the exercise of Council functions, needs identified in the Joint Strategic Needs Assessment.

The 2012 Act permits the Council to delegate other functions to the Board although that is not proposed by this report.

4.1.2 Section 194(11) of the 2012 Act states that the Board is a committee of the Council under Section 102 of the Local Government Act 2012 ("the 1972 Act"). However, the membership and operating arrangements of the Board, as specified elsewhere in Section 194, are incompatible with a standard local authority committee under Section 102 of the 1972 Act.

4.1.3 The membership of the Board is specified in Section 194(2) of the 2012 Act, as follows:

- Al least 1 Councillor
- The Directors of Adult Social Services and Children's Services
- The Director of Public Health
- A Local Healthwatch representative
- A representative of each relevant Clinical Commissioning Group (CCGs)
- Other co-opted members as the local authority thinks fit

4.1.4 This membership is problematic in terms of local government administrative law for a number of reasons:

- It permits a committee of one Councillor (not lawful under the Local Government Act 1972)
- It gives officers of the authority committee membership and voting rights (not lawful under the Local Government Act 1972)
- It gives partner representatives and co-opted members committee membership and voting rights
- It cuts across the proportionality provisions of the Local Government & Housing Act 1989

4.1.5 Under Section 197 of the 2012 Act, the NHS Commissioning Board must appoint a representative to join the Health & wellbeing Board for the purpose of participating in its preparation of its local health needs assessment and local Health & Wellbeing strategy.

4.1.6 In the summer of 2012, the Department of Health (DoH) consulted on the content of Regulations to govern the operation of the Board, to address these legal inconsistencies. The Council responded to this consultation. The DoH published its response to the consultation at the end of November 2012.

4.1.7 This statutory composition contains features which are not lawful for a committee of the Council appointed under section 102 of the Local Government Act 1972, in particular relating to having officers of the authority as members of a committee of the authority. As the Board will include non-Councillors, Section 194(12) of the 2012

Act provides that the Secretary of State may issue regulations disapplying or varying provisions of local government legislation which would otherwise be applicable.

4.1.8 These regulations were issued in February 2013, in the form of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2012. They disapply parts of the Local Government Act 1972 and the Local Government & Housing Act 1989 as follows:

- Members of the Board who are not Councillors will be able to vote, unless the authority directs otherwise (which it may only do after consultation with the Board)
- The statutory rules on political proportionality will not apply, and whether or not political proportionality will apply to the Councillor members of Boards will be left to local determination
- The law relating to disqualification for membership has been modified to allow officers of the Council to be members of the Board (and therefore with voting rights unless the authority directs otherwise as above)
- The Access to Information rules will apply

4.1.9 The provisions of the Localism Act 2011 regarding conduct, standards and the registration and declaration of interests will apply to all members of the Board (including non-Councillor members). The DoH had indicated that it was exploring a modification in relation to CCG participation in discussions and decisions where CCG representatives could otherwise be excluded because they have a pecuniary interest in the decision, but this has not appeared in the Regulations.

4.1.10 The Reading Health & Wellbeing Board will be established formally as a committee of the authority by full Council on 26 March 2013. As a committee of the authority, its establishment and membership will also be included each year in the Monitoring Officer's report to the May Annual Council Meeting (and therefore in May 2013), for the forthcoming Municipal Year.

4.1.11 This report is confirming that the membership and operational arrangements of the Board for the remainder of the current Municipal Year (2012/13) should be the same as for the shadow Board, as set out in Appendix A and recommendation 2.1.

4.1.12 For the Municipal Year 2013/14 and future years the Board will be re-established at each year's Council AGM, and its Members – both Councillors and other Members - appointed to it. All Member appointments will be on a named basis. Functions will be given to the Board as a committee of full Council. All members of the Board will have a vote – and decisions will be taken by majority vote of all Board Members – unless full Council, following consultation with the Board, decides otherwise.

4.1.13 With regard to standards and interests:

- The Council's local Member Code of conduct will apply to all voting Members of the Board.

- All voting Board members (including officers and partners) will have to complete and return to the Council's Monitoring Officer the standard Members' register of interests form. All voting Board members will have to register the statutory pecuniary (financial) interests of themselves and their spouse / partner. A failure to do this may prevent the member from taking part in Board meetings. The authority will publish on its website the returned forms for all voting Board members (as there is for Councillors).

- All voting Board members will have to declare at Board meetings any pecuniary (financial) interests held by themselves or their spouse / partner in any item of

business of the Board, and leave the meeting before it is debated and determined. These interests will be recorded in the minutes of the Board meeting.

- Meetings will be held in public, with a public agenda and reports published five working days before the meeting. Business may be considered in Part 2 (private) but only if the relevant exemptions under the Access to Information legislation come into play: this includes personal information relating to any individual.

4.1.14 Despite its new statutory status as a committee of the authority under Section 102 of the Local Government Act 1972, the shadow Board has acted as a partnership body, operating on a more informal basis, and this appears to be the underlying intention of the 2012 Act. Therefore it would be sensible for the Council and the Board to review the Board's operational arrangements for 2013/14, in the light of its new statutory status. This could include facilities for other stakeholders, who are not statutory members of the board, to participate in meetings and ask questions.

4.1.15 In this regard the Board, as a committee of full Council, will meet in public and will operate within the Council's Standing Orders for committees, which include a facility for members of the public to give notice to ask questions at a committee meeting (S036). The Standing Orders for Scrutiny offer further – and more flexible - opportunities to local people and stakeholders to be invited to attend and speak on relevant items (Scrutiny Procedure Rule 15.1) or to speak on individual agenda item (Scrutiny Rule 15.2), in both cases at the discretion and invitation of the Chair.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The proposals in this report contribute directly to the strategic aim of promoting equality, social inclusion and a safe and healthy environment for all

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

6.2 The Department of Health, in its response to the consultation on the Boards, sees Health and Wellbeing Boards as partnership forums for collaborative local leadership on health matters. The membership of the Health & Wellbeing Board is prescribed by Section 194 of the 2012 Act, with this in mind. It includes the ability for the Board to appoint such additional persons to be members of it as it thinks appropriate.

6.3 In this regard the Thames Valley Area Team of the NHS Commissioning Board have contacted all responsible local authorities in Berkshire, Buckinghamshire and Oxfordshire to indicate that they would wish to play a full part in the Health & wellbeing Boards of the successor local authorities, and that a named Director member of their Board should be in attendance.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 An equality impact assessment is not seen as relevant to the decisions in this report. This is because the report concerns the implementation of new legislation and Regulations. However, in conducting its business, the Board will be required to consider whether any decision that it makes will or could have a differential impact on: racial groups; gender; people with disabilities; people of a particular sexual orientation; people due to their age; people due to their religious belief.

8. LEGAL IMPLICATIONS

8.1 From 1 April 2013, the authority, as a Unitary Council and therefore a relevant body, will take on new public health responsibilities under the Health & Social Care Act 2012. This follows the abolition of the Primary Care Trusts, of which in Berkshire there were two (for East and West of Berkshire).

8.2 Under Section 28 of the National Health Service Act 2006, the authority must take such steps as it considers appropriate for improving the health of the people in its area.

8.3 Section 193 of the 2012 Act amends Section 116 of the Local Government & Public Involvement in Health Act 2007 ("the 2007 Act") to require the Council, as a relevant authority, to prepare, with its partner clinical commissioning groups, a Joint Health & Wellbeing Strategy to meet the health needs of area relating to the exercise of public health functions by the authority, the NHS Commissioning Board or the CCGs. Section 192 of the 2012 Act further amends Section 116 of the 2007 Act to place a duty on the CCGs to prepare the Joint Strategic Needs Assessment and Strategy for their area, in consultation with local people living or working in the area and the local Healthwatch. It further introduces a new Section 116B to the 2007 Act by which the local authority, and its partner CCGs, have a duty to have regard to these documents.

8.4 As mentioned above, under Section 194 of the Health & Social Care Act 2012, the authority must set up a Health & Wellbeing Board, to operate as a committee of full Council under Section 102 of the Local Government Act 1972 as amended by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2012. The more detailed implications of the legal tension between the 1972 Act and the operation of the board as prescribed by the 2012 act, and how the Regulations seek to resolve this, are set out in para. 4.1 above.

8.5 The principal functions of the Health & Wellbeing Boards, as set out in Sections 195-196 of the 2012 Act, are as follows:

- Duty to encourage integrated working in health and social care under the National Health Act 2006
- Power to encourage closer working in relation to wider determinants of health
- Power to give its opinion to the authority on whether the authority is discharging its duty to have regard to the Joint Strategic Needs Assessment and Strategy and Joint Health & Wellbeing Strategy for its area
- Duty to provide an opinion – to the authority and/or the NHS Commissioning Board - about whether the local commissioning plan has taken proper regard of the Joint Health & Wellbeing Strategy

8.6 The Board may also discharge any other health functions delegated to it by the authority. There is also a power for two or more Boards to exercise functions jointly.

8.7 The Department of Health, in advisory documents, refer to the Board having executive functions. This is inconsistent with the Board being set up as a committee of full Council under Section 102 of the Local Government Act 1972, which inconsistency the 2012 Regulations do not address. However, given that the public health functions that are being transferred to the local authority under the 2012 Act

have not, to date, been listed as functions which cannot be exercised by an authority's executive, under Section under Section 13 of the Local Government Act 2000 they are functions which only the executive of the authority can exercise. Therefore these health functions at present cannot be delegated to be exercised by a body that is a committee of full Council, and therefore not part of the executive. However, this inconsistency will be addressed in Reading from May 20123 when the authority moves to a committee system form of governance, and ends the artificial separation between executive and non-executive functions.

9. FINANCIAL IMPLICATIONS

9.1 Financial Implications

The report sets out the statutory Public Health responsibilities that will be transferring to the Council from the 1st April 2013. To meet these responsibilities each upper tier Council has received a ring fence grant from the Department of Health and for Reading this is £7.466 million for 2013/14.
This is a formula allocation based on a number of factors but starts from a baseline of the actual expenditure of the Berkshire West PCT in 2011/12. A review has been undertaken by the six Berkshire Council working together to understand how the services are being delivered across the East and West of the County. Many of these services as set out in the report have been commissioned on a PCT wide basis (e.g. west of Berkshire) and therefore can only be commissioned on that basis for 13/14.
By working together in this way the six Councils will be able to continue to provide these services and the costs will be apportioned on the basis on the share of the funding received. Reading received a 47.6% share of the total resources for the West of Berkshire to provided Public Health services.

The analysis of the funding allocation and the commitments indicates that the formula allocation will be sufficient to meet the Councils commitments in 13/14.

9.2 Value for Money (VFM)

It is not clear whether all of the services that are being inherited from the health service are value for money. The proposal through this joint agreement is to review the services and the outcomes during 2013/14 through the advisory board, to determine whether they are VFM.

9.3 Risks

This is a new area for the Council and the national resource allocation exercise has been a complex process. For the last eight months the Councils have been working closely together with the PCT to understand the services (and cost) that will be delivered from the 1st April 2013. Within the services there are some elements which are demand led (e.g. Sexual Health services) and others which have complex links into other services provided by the health service (e.g. Children services). The Council is aware of these potential issues and these will be monitored careful through the advisory board.

10. BACKGROUND PAPERS

10.1 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2012
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

APPENDIX A

HEALTH AND WELLBEING BOARD – TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

The Health & Wellbeing Board is a statutory Board of Reading Borough Council and will report directly to Cabinet. From time to time it may also be called upon to report to the NHS Commissioning Board.

Purpose

The Health and Well-Being Board (H&WB) acts as the high level strategic planning partnership to encourage the provision of integrated health and social care services in Reading Borough Council and surrounding areas which the consortia is responsible for. The H&WB for Reading is established to oversee the health improvement and well-being of those who live and work in the Borough.

Timing and meetings

The Board will, as a minimum, meet three times a year and may meet more often if the Board so decides.

The Board is committed to the principles of transparency and all meetings will be open to the public.

In order to accommodate confidential matters, particularly regarding commercially sensitive issues linked to commissioning and providers, the Board will hold two-part meetings with one part to consider any such matters. The Council's existing protocol for its Cabinet meetings will be adopted to ensure that the principles of transparency remain central to these arrangements.

Agendas and papers for Board meetings will be made public no less than 5 working days prior to the date of the meeting.

Key Responsibilities

1. Support the development of a joint strategic health needs assessment of the population covered by the GP consortia.
2. Support the development of the joint Health and Wellbeing Strategy and Action Plan.
3. Provide strategic and organisational leadership to ensure the delivery of the health and wellbeing strategy.
4. Mobilise and co-ordinate resources from its membership and from others to deliver shared priorities, including effective alignment or pooling of budgets where appropriate.
5. Communicate and consult with stakeholders and the wider community on the work of the Health and Well-being Board and its priorities – including residents, the Children's Trust, Safeguarding Boards, the Community Safety Partnership and existing health and social care networks.
6. Deliver cost effective solutions within a scarce resource base.

Key Functions

1. Develop an action plan related to the health and well-being strategy with clear priorities, objectives for delivery and measurable milestones.
2. Support the participation of the community and voluntary sectors, and other non-statutory agencies in the delivery of health and social care outcomes as a shared endeavour.
3. Ensure health & social care improvement in Reading is developed within the context of Best Practice and Clinical Governance.

4. Act as an independent reporting point for user led organisations and existing partnership groups e.g. the Older People's Partnership.
5. Establish time limited working groups to assist it to deliver any of its key responsibilities.
6. Work with key providers to provide strategic 'problem solving' to unlock potential, resources or improved practice.
7. Co-ordinate work with neighbouring H&WBs to ensure effective commissioning decisions that deliver value for money in support of improved outcomes.

Membership

The membership will include the following:

- The Leader of the Council
- The elected portfolio holders for health, community care and children's social care
- The Director and Council Manager
- The Director of Education, Social Services and Housing
- Director of Public Health for the Local Authority
- A representative from each of the commissioning consortia
- A representative from the Local Healthwatch organisation
- Until 2013 – a representative of the PCT

The H&WBB may appoint additional persons or representatives to be members of the Board as it thinks appropriate, provided that all parties agree to this.

The H&WBB may request a representative of the NHS Commissioning Board to join the Board to help in the preparation of the Joint Strategic Needs Assessment or Joint Health and Well-being Strategy

Chair

The Leader of the Council will act as Chair of the Board. The Leader of the Council may nominate another Board member to act as Chair in his or her absence.

Actions to be taken by Members of the Board

Delegated authority to make decisions and accountability should be clear, without superseding the responsibilities of any member agency. Representatives attending any working group should have the delegated authority to commit their agency to specific courses of action, including committing resources.

As a Statutory Board of Reading Borough Council the H&WB will report directly to Cabinet and support the alignment of the Council's plan's with the priorities identified in the Health and Well-being Strategy and Action Plan.

GP commissioning consortia will consult with the H&WB when drawing up their own annual plans.

The H&WB will include a statement in consortia's plans confirming or not that the consortia plans align with the JSNA and the priorities identified in the Health and Well-being Strategy and Action Plan.

The Board should receive the input and information it needs from member partners to support effective prioritisation and strategic decision making.

Members of the Board will hold themselves and partners to account for the delivery of agreed outcomes as set out in the action plan.

To inform the Joint Commissioning Partnership of key decisions that may impact on the provision of services or commissioning.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR AND COUNCIL MANAGER

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**15 MARCH 2013**	**AGENDA ITEM:**	**8**
TITLE:	**READING HEALTH AND WELLBEING STRATEGY**		
LEAD COUNCILLOR:	**COUNCILLOR LOVELOCK / COUNCILLOR TICKNER**	**PORTFOLIO:**	**HEALTH AND WELLBEING**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BROUGH-WIDE**
LEAD OFFICER:	**ASMAT NISA**	**TEL:**	
JOB TITLE:	**CONSULTANT IN PUBLIC HEALTH - READING**	**E-MAIL:**	**ASMAT.NISA@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To present to members the final draft of the Reading Health and Wellbeing Strategy, in preparation for sign off at Council on the 26 March 2013.

1.2 To outline next steps for developing a delivery plan and explain how the strategy and will be reviewed and refreshed.

1.3 Appendices with this report:

- Final Draft Health and Wellbeing Strategy (appendix 1);
- Consultation Feedback Incorporation Document (appendix 2);
- Strategy Questions and Answers (appendix 3).

2. RECOMMENDED ACTION

2.1 That members note the content of this report and give consideration to the final health and wellbeing strategy including the progress towards developing a delivery plan.

2.2 That members endorse the strategy, its arrangements for review and agree that it be presented to Council in March for full sign off.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 has given local authorities a much stronger role in shaping services and responsibility for local population health improvement. The Health and Wellbeing Board brings together local commissioners of health and social care, elected members and representatives of partners to agree an integrated way to improve local health and wellbeing.

3.2 Cabinet resolved at its meeting on the 14 March 2012 that a shadow local Health and Wellbeing Board be established. The board has since started work to ensure effective engagement between NHS and local authority commissioners, with GP consortia being at the heart of the new arrangements.

4. THE HEALTH AND WELLBEING STRATEGY

4.1 The Health and Wellbeing Strategy for Reading (**appendix 1**) has been developed using a broad range of data, knowledge and expertise. The combination of a firm evidence base and perception of relative importance from the public and service user viewpoint is a crucial element that underpins the production of the strategy.

4.2 Key stakeholders including the members of the Health and Wellbeing Board considered the evidence base on Health & Wellbeing in Reading and began initial work to start developing an outline vision and identifying key priorities for the HWB Strategy at a workshop on 25 May 2012.

4.3 Officers completed a full draft strategy and a summary version which was used for a consultation exercise with key stakeholders and partners as identified and agreed with the Health and Wellbeing Board. The results of that consultation were reported to council members at a briefing in January and a document explaining where changes have been made to the strategy as a result is at **appendix 2**. A number of questions were also submitted as a result of the consultation and discussions with officers and these have been pulled into a question and answer document (**appendix 3**) that is also planned for publication.

4.4 The strategy had been branded and will be submitted for full sign off at Councilon the 26th March and will then be published.

4.5 As we enter a period of rapid change within the health arena it will be important to ensure we have the appropriate opportunity to review where we are and check our strategy can be effectively delivered. A review within the first year is suggested once the public health function within the borough has had a chance to embed.

4.6 It is essential that we have robust delivery plans in place to take the strategy forward and work is taking place to map out existing work that contributes to the delivery within the existing work of the Council. A specific Health and Wellbeing delivery plan will be developed with partners over the next few months.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Health and Wellbeing Strategy will impact on the strategic aim of promoting equality, social inclusion and a safe and healthy environment for all

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Our ongoing commitment to engage and involve local people, communities and partners means that our strategy and future delivery plans represent the needs of Reading residents and how important we believe engagement in developing local health services is.

6.2 A recent example supporting the development of the strategy is the let's talk health programme, which included a survey and a range of community events, allowing participants own views and experiences to come to the fore.

6.3 Joint consultation and working with our voluntary sector to get feedback directly from service users is a key element to delivering an even better health service.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 The Reading Health and Wellbeing Strategy has been drafted using evidence from:

- The Public Health Outcomes Framework for England, 2013-2016
- The 2012/13 Adult Social Care Outcomes Framework
- Children and Young People's Plan 2011/2014
- Children's Health Profile 2012
- Reading Joint Strategic Needs Assessment
- Let's Talk Health Consultation
- The Draft Strategy Consultation Feedback

Which have identified the Health inequalities that need to be addressed in Reading. These inequalities are explicitly addressed throughout the strategy. (appendix 1)

8. LEGAL IMPLICATIONS

8.1 There are no legal implications associated with this report.

9. FINANCIAL IMPLICATIONS

9.1 There are no financial implications associated with this report.

10. BACKGROUND PAPERS

10.1 The Health and Social Care Act 2012, 14 March 2012 Cabinet Report titled Health and Wellbeing Board (Agenda Item 14), 25 January 2013 titled Reading Health And Wellbeing Strategy (Agenda Item 9).

Reading's Health and Wellbeing Strategy

2013-2016

NHS Berkshire

Reading Borough Council
Working better with you

Foreword

The Health and Social Care Act 2012 has given local authorities a much stronger role in shaping services and improving the health of local people. In Reading, the Health and Wellbeing Board brings together councillors, partner organisations and those responsible for commissioning health and social care services.

The Board's role is to set out an agreed, integrated health and well-being strategy for the Borough, which includes locally-determined priorities. This puts it right at the heart of activities to improve services and support Reading residents to live healthy lives.

The strategy will be used to inform the commissioning of services by the local Clinical Commissioning Groups and the Council. We will develop detailed delivery plans which will allow us to monitor and measure progress towards our key public health aims.

We plan to review the strategy after the first year. This will allow us to take account of any lessons learned as the Council's new public health function becomes embedded in the organisation. We will involve partners and residents in this process to ensure our priorities continue to be relevant to local needs.

Councillor Jo Lovelock
Leader, Reading Borough Council
Chair, Health and Wellbeing Board

Councillor Bet Tickner
Labour Councillor Abbey Ward
Lead Councillor for Health

Our vision – A healthier Reading

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

Goal One – Promote and protect the health of all communities particularly those disadvantaged

- **Objective 1 –** Protect health and reduce the burden of communicable diseases by targeting services more effectively
- **Objective 2 -** Ensure effective support is available to vulnerable and BME groups to protect their own health.
- **Objective 3 –** Increase awareness and uptake of Immunisation and Screening programmes

Goal Two – Increase the focus on early years and the whole family to help reduce health inequalities

- **Objective 1 –** Ensure high quality maternity services, family support, childcare and early years education is accessible to all
- **Objective 2 –** Reduce inequalities in early development of physical and emotional health, education, language and social skills
- **Objective 3 -** Improve identification and reduce the effects of domestic violence on emotional wellbeing for the whole family

Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups

- **Objective 1 -** Assist and support ability to self-care in all adults and young people with existing long term conditions
- **Objective 2 -** Ensure high quality long term condition services are available to all including those with a learning disability
- **Objective 3 -** Build on and strengthen the quality and amount of support available to adult and young carers in Reading

Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

- **Objective 1 –** Improve tobacco control and reduce harm due to alcohol and drug misuse in Reading
- **Objective 2 –** Enhance support and target causes of lifestyle choices impacting health for adults and children
- **Objective 3 –** Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes

1. Our vision

The Health & Wellbeing Board's vision is for:

A healthier Reading

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

2. Scope and purpose of this strategy

This is the first Joint Health and Wellbeing Strategy for Reading. It has been developed from plans to which organisations represented on the shadow Health & Wellbeing Board are already working, but sets out the local priorities which emerge from taking a much broader view of health and wellbeing across the partnership. The strategy has also been developed in the context of reduced funding for public services at a time when demographic changes, a worldwide recession and significant changes to the national welfare system are all likely to increase demand for health and care services, unless we take a fundamentally new approach.

Many aspects of life have an impact on our health and wellbeing: from what we traditionally recognise as 'health' issues or services through to the quality of our environment, access to housing, education, transport and leisure, and the wide range of formal and informal supports which help people feel involved with and part of their local communities. The extent to which people feel connected with others has been found to have health and wellbeing impacts comparable with smoking and alcohol consumption. Conversely, loneliness can pose a health risk even greater than factors such as physical inactivity and obesity.[1] Building on the capacity of local communities therefore underpins our approach, and we are conscious of the need to promote and develop services, including health and care support, which strengthen rather than weaken community connections. The role of the Health and Wellbeing Board is to set the strategic context in which local health and wellbeing services are commissioned, and to focus on those areas where the greatest influence can be exerted by working in partnership, particularly:

- sharing knowledge and data to identify the highest priority health and wellbeing needs locally;
- taking collective responsibility to ensure the most vulnerable are protected and included; and
- working collaboratively and creatively to maximise outcomes with limited resources.

[1] Holt-Lunstad [2010] - *Social Relationships and Mortality Risk: A Meta-analytic Review*

This strategy sets out how the Board will work across communities and partner agencies to ensure that everyone in Reading can live as healthily and independently as possible and has access to the services and support they need.

The Reading Health & Wellbeing Strategy will directly inform the commissioning of:

- acute health care services
- community health and care services
- adult social care services
- children's health and care services
- public health interventions

and will also influence the way other local services are resourced which cover the wider determinants of health.

We aim to ensure local services are high quality, integrated and accessible to all in order to improve the health and wellbeing of children, young people and adults in Reading and reduce the significant inequalities in health between the least and most deprived persons and communities in the borough. We recognise the Marmot[2] conclusions that health inequalities are neither inevitable nor immutable, but can be addressed by tackling underlying social inequalities.

In implementing our strategy, we will work to tackle risks to health and wellbeing, improve the determinants of health and deliver value for money. We will invest in and design quality health and care services that promote good health, increase life expectancy and reduce inequalities within our diverse communities.

The strategy focuses predominantly on reducing health inequalities in Reading through a life-course approach – addressing health and its determinants in maternity, early years, childhood, young adulthood, older adulthood and older age. We believe that every resident of Reading, whatever their age or background, deserves the best chances of living a healthy, happy and productive life.

3. How we developed the strategy

The Health & Wellbeing Board has an ongoing commitment to engaging and involving local people, communities and partners so that our strategy and future delivery plans represent the needs and priorities of Reading residents.

3.1. Public Engagement

At the beginning of 2012, Reading Borough Council led the 'Let's Talk Health' community involvement programme. Reading residents gave their feedback on what 'health' means to them and what they think needs to happen to make Reading a healthier place. This exercise demonstrated widespread

[2] Marmot [2010] – *Fair Society Healthy Lives*

recognition that a range of services are important to health and wellbeing, with Reading residents looking to statutory services to support them in taking care of themselves and their families. This support includes health advice and information, a greater range of options for accessing health services – particularly mental health services, affordable leisure and fitness opportunities, access to open spaces and opportunities for community involvement. When people do need to call on professionals for health and wellbeing support, they want to be treated with respect, compassion and empathy.

3.2. Engagement with the Board

The Health & Wellbeing Board has been and will continue to be informed by a range of Reading forums which give different groups the opportunity to comment on health and care services and contribute to their development.

These include:

- the Older People's Partnership
- the Carers Steering Group
- the Learning Disability Partnership
- the Physical Disability and Sensory Needs Network
- the Access Forum

These standing forums bring together people using health and care services, family or informal carers, and a range of community groups, some of which are also providers of community based 'preventative' services which play a vital role in keeping people well and living as full lives as they can. GP practices in Reading also gather and respond to the views of users of their services, for example through their Patient Participation groups and through the annual national GP patient survey. Joint consultation and working with our voluntary sector to get feedback directly from service users is a key element of delivering an even better health service.

3.3. Local Involvement

Reading LINk (Local Involvement Network) plays a key role in bringing a patient / service user voice to the Health & Wellbeing Board. LINk is an independent group with a remit to find out what local people want from health and care services, investigate issues and bring these to the attention of the people who commission and manage those services. Reading LINk carried out an extensive community engagement survey in 2010 to shape its work programme. This identified that mental health services, access to NHS dental services, and being seen on time for hospital outpatients and GPs appointments are priority issues that cut across different communities and affect individuals of all ages. The various projects which LINk has developed to explore these concerns further are now being reported through to appropriate members of the Health & Wellbeing Board. From the 1st April 2013 Reading 'Healthwatch' will be a voice for the community and act as a watch dog for local health and social care services.

3.4. Joint Strategic Needs Assessment

Our Joint Strategic Needs Assessment (JSNA) will underpin our Health and Wellbeing strategy. This analysis of the health and wellbeing of our local population is a joint responsibility of health and local authority partners, and is a fundamental tool to ensure that, in consultation with our communities and service users, we develop our understanding of the priorities issues affecting the health of our local population.

The Reading JSNA builds on a firm evidence base including feedback from members of the public, drawing particularly on their experiences of using services. The goals and objectives set out here reflect the priorities identified by the shadow Health & Wellbeing Board following a holistic review of information on local needs, services and aspirations.

Our Priorities

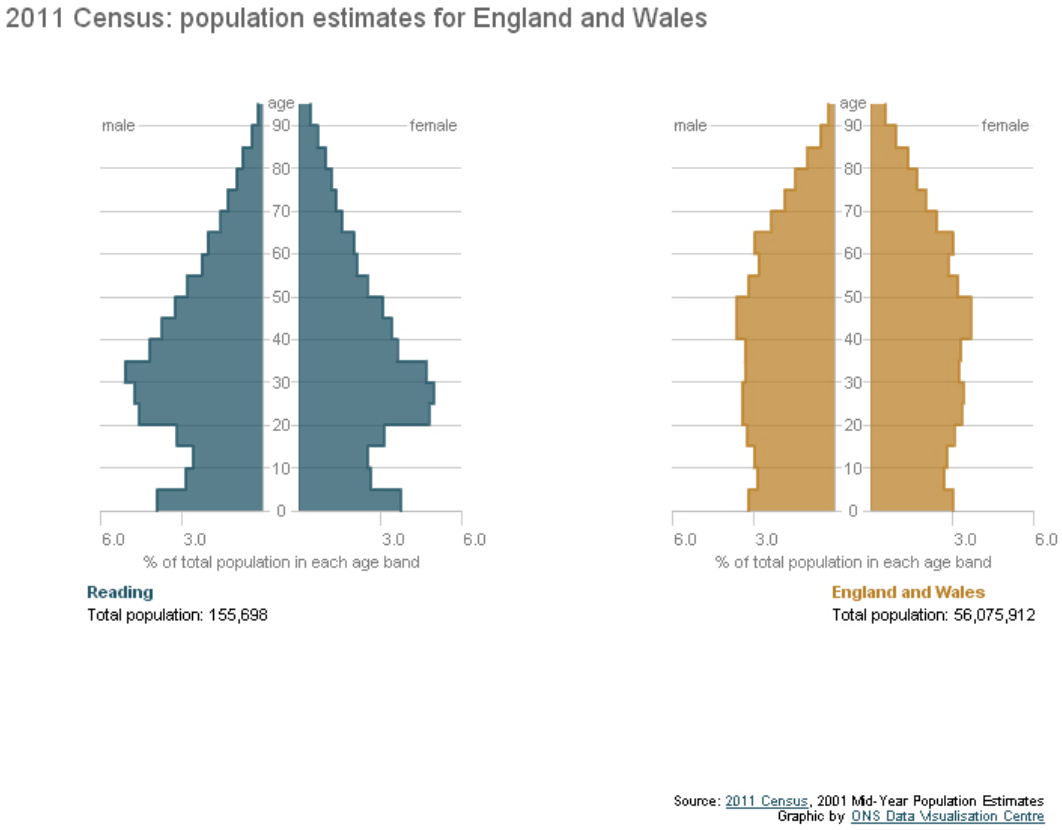
We have prioritised the achievement of four Goals to achieve our vision, as shown in Figure 1:

Goal One	Promote and protect the health of all communities particularly those disadvantaged
Goal Two	Increase the focus on early years and the whole family to help reduce health inequalities
Goal Three	Reduce the impact of long term conditions with approaches focused on specific groups
Goal Four	Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

Associated with each goal is a set of objectives (sub-goals) which are shorter-term measurable steps that will move us towards achieving the longer-term goals.

4. Context

4.1. Our population



The population of Reading is a younger one relative to the whole of Berkshire, the South East, and England and Wales populations. The overall population is expected to increase in size. Reading has some very affluent communities alongside some very deprived neighbourhoods. Reading is ranked 125 out of 326 local authorities nationally on the Index of Multiple Deprivation but some areas, mainly in the south of Reading, are among the 20% most deprived in the country. A number of wards - for example Whitley, Abbey and Church - have high proportions of older people living on low incomes.

Reading is ethnically and culturally rich and diverse with current population estimates probably not fully representing the ethnic mix within the population and the size of black and minority ethnic (BME) groups. As the data from the recent 2011 census becomes available we can use this to help us plan and support the needs of our population in a much more focused way. International migration into the area is high due to job availability and accessibility, but also relatively lower costs of living and better transport infrastructure, particularly public transport links. Internal migration figures suggest that more people move out of Reading to other parts of the UK then are moving in. In particular 0 to 15 year olds and 25 to 44 year olds are moving out of the area. More females than males are moving from within Reading to other parts of the UK.

As well as a relatively high BME and migrant population, the JSNA identifies other ways in which the Reading population is made up differently from national averages. There is a relatively large child population, particularly of those aged under five, which is also the population group expected to show the greatest increase over time. Almost 2,700 babies are born to families in Reading each year which represents a higher fertility rate than the national average. Specific groups of children are likely to have particular health and wellbeing needs as explored more fully in the JSNA - children looked after by the Local Authority, children subject to a child protection plan, children and young people not in education, employment or training, children with disabilities, and children living in poverty.

The number of older people in Reading is much smaller than in other areas of Berkshire. However, whilst Reading expects to see a relatively small increase in the total number of older people compared to most other areas, the biggest increase will be in the very elderly, aged 85 and over, who are at greater risk of experiencing long term health conditions than the newly retired. Just over a quarter of Reading residents over pension age are estimated to be living alone, and 80% of pensioner households are owner occupied properties. This means Reading has a significant number of older people at risk of social isolation with the negative impacts on physical and emotional wellbeing which this brings. There are also significant numbers of older people living in relative deprivation, making them especially vulnerable and therefore an appropriate population group to target, e.g. in focusing on reducing winter deaths amongst the elderly.

The 2011 census data shows that almost 8% of Reading residents provide informal or unpaid care to friends, family or neighbours. Research by Carers UK shows that, those providing high levels of care are twice as likely to experience ill health as members of the general population. The Health & Wellbeing Board is therefore committed to addressing the needs of carers alongside those of people who rely on carers, particularly as carer support is so often the crucial element which enables people with long term health conditions to remain in their own homes and communities.

4.2. Our achievements and assets

We know from the 2011 Residents Survey that the people of Reading have a commitment to their own health and wellbeing, with nearly three quarters participating in at least 30 minutes of sport and recreation on three or more days per week. People also report a commitment to their community: one in six local people volunteer at least weekly.

There is a strong voluntary and community sector in Reading which plays a key role in promoting the health and wellbeing of local residents. The VCS provides a wide range of community based 'preventative' services which help people to stay well and reduce the demand on statutory services. Local health and care commissioners invest in many of these services, but many more operate independently of such funding. The VCS draws in additional resource to provide health and wellbeing

support – through charitable donations or its use of volunteers – and so enhances local capacity to deliver our vision for a healthier Reading. The VCS is also a source of expertise on local communities and needs, and a valued partner at all stages of the commissioning cycle.

We already have a strong history of high quality care and good joint working across health and social care services on which to build. There are many examples where we have already made improvements together: in preventive services to help people stop smoking, eat more healthily and reduce their risk of cardiovascular disease; in services for young people to reduce rates of teenage pregnancy; and in providing more integrated care and support for older people to enable them to live healthier and more independent lives, particularly the intensive 're-ablement' service to help people regain maximum independence after an illness or injury. We have many highly skilled and experienced staff in our local health and social care commissioning teams and provider organisations who know Reading well and can use that knowledge for the benefit of our population.

All the partners in the Health and Wellbeing Board are committed to working together and building on our strengths to achieve positive changes for Reading.

4.3. Our existing challenges

We do however have many continuing challenges. Some areas of Reading have significant levels of deprivation, although there is a wide range with affluent areas alongside those where people are living in much more difficult circumstances. Overall, we are an economically thriving area. The health of people in Reading is mixed compared to the England average, and there are wide variations; life expectancy is 8.5 years lower for men and 7.0 years lower for women in the most deprived areas of Reading compared to the least deprived areas. Healthy life expectancy at age 65 is higher than the national average for both men and women, but lower than that for other areas of Berkshire West. Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen although the latter remains worse than the England average. An estimated 22.1% of adults smoke (slightly above the England average) and there are estimated to be about 173 deaths from smoking each year; however levels of obesity are below the England average at about 21.9% of adults. Rates of problem drug misuse are relatively high, and there were 1,774 hospital stays for alcohol related harm in 2009/10.

Poverty

The level of child poverty is worse than the England average with 23% of children under the age of 16 living in poverty, and about 7% of young people are not in education, employment or training, higher than the national average. Levels of childhood obesity are a concern particularly among year 6 children, 21% of whom are classified as obese. However 54% of pupils spend at least three hours each week on school sport. The level of teenage pregnancy is higher than the England average although it has declined significantly over the last few years.

Reading has long recognised the significance of poverty as an issue impacting negatively on the quality of life of many of its residents. This is explicitly recognised in Reading's Community Strategy that identifies 'breaking the cycle of inter-generational poverty' as a key priority. The Local Strategic Partnership has established a task and finish group to progress action against this priority over the coming year. In parallel the Council is committed to working with partners to develop an overarching anti-poverty strategy that highlights the pernicious impacts of poverty on children in particular and fulfils the statutory requirements to develop a Child Poverty Strategy (Child Poverty Act 2010) but takes a broader approach to the impacts across all generations.

4.4. Responsibilities for the implementation of this Strategy

Our Health and Wellbeing strategy is driven by the views of local people and our understanding of the needs and priorities for Reading, informed by the Joint Strategic Needs Assessment (JSNA), the analysis of the health and wellbeing of our local population. The strategy will also link with and inform the commissioning and strategic plans of each of the partner organisations that are members of the Health and Wellbeing Board. Each organisation will ensure that its own plans align with our jointly agreed priorities, so that each takes the action required, either individually or jointly, where that works best, to deliver our shared vision.

From 2013, Reading Healthwatch will be commissioned (by the local authority) as an independent body with statutory functions to promote the interests of local users of health and care services. Healthwatch will take over the existing role of LINk but take on some additional responsibilities to advocate for local patients and service users. Healthwatch will be open to all local people and community groups, and will be represented on the Health & Wellbeing Board (taking over the LINk seat on the shadow Health & Wellbeing Board).

4.5. The Reading shadow Health and Wellbeing Board (sHWB)

The role of the shadow Health and Wellbeing Board is to be the main forum where local leaders from the health and care system work together to understand their community's needs, agree priorities and promote more joined up commissioning of services for the local population. Our Health and Wellbeing Board was formally established in shadow form from April 2012, and will take on its statutory functions from April 2013.

The role of the Health and Wellbeing Board in developing a joint strategy which addresses locally agreed priorities in the most effective and cost-effective way will therefore be absolutely critical to ensuring that we can all work in a co-ordinated way to achieve the best outcomes for our population within the resources we have available.

A minimum membership for the Board has been mandated to include at least 1 local Councillor and a local Healthwatch

representative to strengthen local accountability, as well as representatives of the Clinical Commissioning Groups serving the local population, and the Directors of Public Health, of Adult Services and Children's Services.

The membership of the Reading shadow Health and Wellbeing Board includes:

- The Leader of the Council - Cllr Jo Lovelock (Chair)
- Lead Councillor for Health & Wellbeing - Cllr Bet Tickner
- Lead Councillor for Adult Social Care – Cllr Mike Orton
- Lead Councillor for Education & Children's Services – Cllr John Ennis
- The RBC Council Manager – Ian Wardle
- The Director of Education, Social Services and Housing - Avril Wilson
- Berkshire Director of Public Health – Lise Llewellyn
- A representative from each of the commissioning consortia - Dr Rod Smith Chair North & West Reading CCG and Dr Elizabeth Johnston Chair of South Reading CCG
- A representative from the Local Healthwatch organisation - David Shepherd from the Reading LINk
- Until 2013 – a representative of the PCT - Julie Curtis, Interim Director of Joint Commissioning

Participating observers

- Independent Chair, West Berkshire, Reading and Wokingham Local Safeguarding Children Boards - Stephen Barber
- Independent Chair, West of Berkshire Safeguarding Adults Partnership Board - Sylvia Stone

5. How we will measure success

We will develop a robust and proportionate performance management framework so that we can measure our progress and better understand where we may need to divert additional resources as we tackle the various challenges we face in the future.

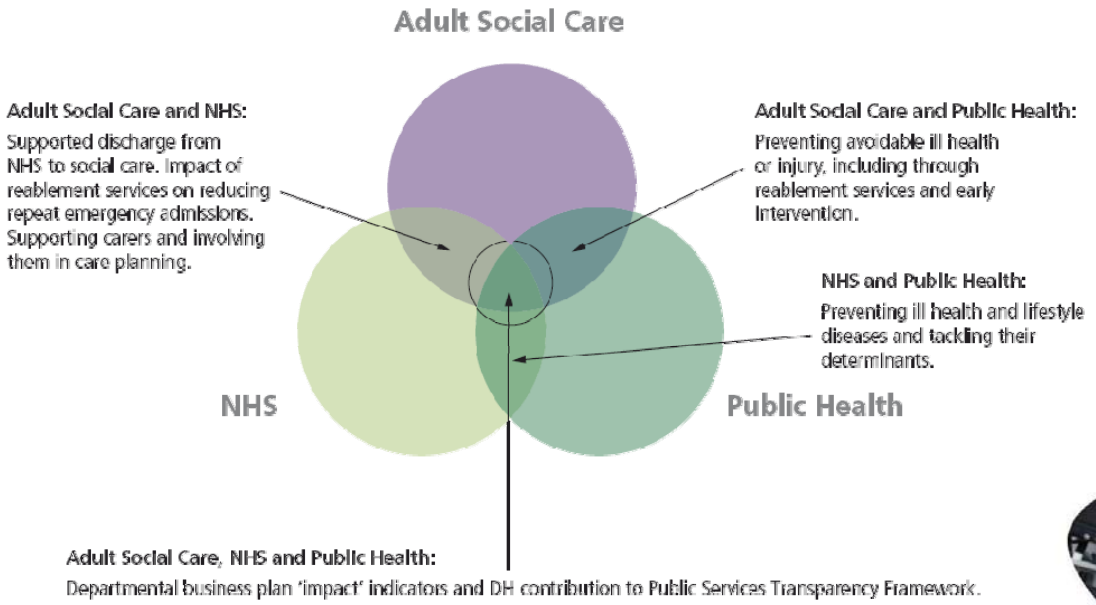
The framework will be based on the Outcomes Frameworks for Public Health, Adult Social Care and the NHS which have already been published by the Department of Health. Each includes outcomes in 4 or 5 domains (Table 1) and there is considerable overlap between them, as shown in Figure 2. Our approach to performance management will incorporate the links and interdependencies between these outcome frameworks.

We will also consider the outcomes frameworks for children's health and wellbeing and commissioning outcomes which are currenlty in development.

Table 1 - Outcomes frameworks domains

Adult Social Care	NHS	Public health
• Enhancing quality of life for people with care and support needs • Delaying and reducing the need for care and support • Ensuring that people have a positive experience of care and support • Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm	• Preventing people from dying prematurely • Enhacing quality of life for people with long-term conditions • Helping people to recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care • Treating and caring for people in a safe environment; and protecting them from avoidabel harm	• Improving the wider determinants of health • Health improvement • Health protection • Healthcare public health and preventing premature mortality

Figure 2 – Illustrating the Interplay between the 3 outcome frameworks



Source: Department of Health
NB: The Children's outcome framework was not available at the time this strategy was written.

Health and Wellbeing Goals and Objectives

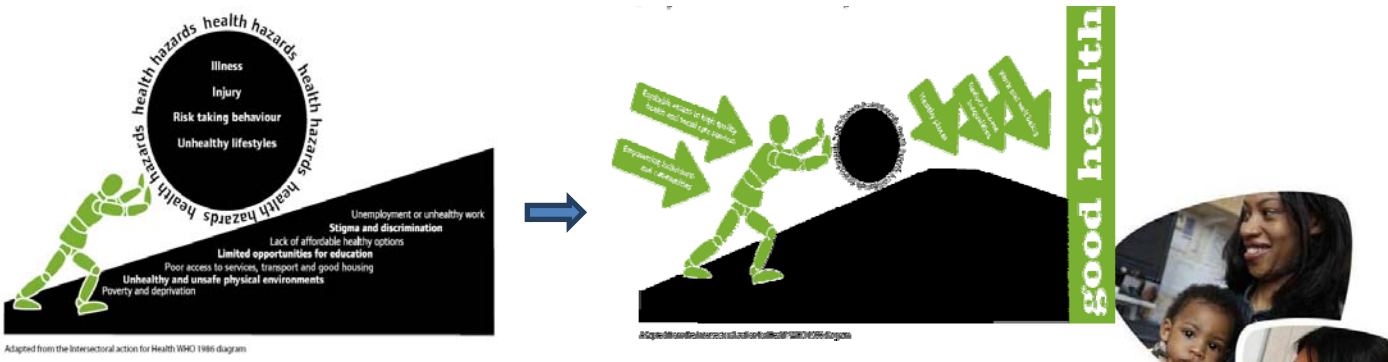
Goal One: Promote and protect the health of all communities particularly those disadvantaged

Introduction

Health is defined by the World Health Organisation as a state of complete physical, mental and psychological wellbeing and not merely the absence of disease. There are many factors outside the traditional remit of health care which determine the health of individuals and populations. These include less modifiable factors such as heredity and more modifiable wider determinants such as environment, housing, lifestyle and employment.

Health promotion is the process of empowering people to exert greater control over the factors that can improve their health. As illustrated in Figure 3 below, some individuals may face greater challenges than others in trying to achieve good health but a combination of individual empowerment (achieved by health promotion) and supportive environments makes better health a realistic goal for everyone. We want to see this strategy drive practical changes so that everyone has the opportunity to be as well as they can be.

Figure 3 – Illustrating the determinants of health and the influence of health promotion



Source: World Health Organisation 1986

In addition to the wider determinants that influence an individual's chances of achieving good health, there are external incidents or disease-causing agents that can directly or indirectly impair good health – infections, chemical incidents, radiation hazards. The public health arm of health protection reduces the dangers to health arising from such agents.

What the data tells us

Reading data tells us that:

- cancer and circulatory diseases cause relatively high numbers of deaths in people aged under 75, particularly for people living in deprivation, who smoke, have a poor diet or low levels of physical activity;
- more people are dying in winter than in the warmer months – and we also know that Reading has a relatively high number of older homes, which are more expensive to heat than modern homes, and that we have not managed to hit our targets recently in the number of older people having a seasonal flu vaccine;
- Tuberculosis rates have remained stable at high levels in Reading;
- the numbers of people with HIV have risen to a level at which we are recommended to run routine tests on everyone seeking to register for primary health care;
- significantly more young people aged 15 to 25 resident in Reading have been screened for chlamydia than the average number screened regionally, and across Berkshire;
- Reading school census figures from May 2012 show that 46% of the pupil population is from BME background;
- 15% of all adult social care clients in Reading are from a BME group.

What we want to see

We want to concentrate our health promotion efforts, e.g. immunisation and screening programmes, in a way which starts to break down health inequalities in Reading. In line with this, we want to see:

- a more targeted approach to health promotion so that support to make healthier lifestyle choices is accessible to people living in less affluent as well as more prosperous communities, and to groups historically under-represented in take-up figures;
- services equally as diverse and the particular health needs of different populations, including vulnerable and BME groups, being assessed;
- better access to health advice and treatment to help vulnerable and BME groups protect their own health and prevent disease;
- an increase in the numbers of older people taking up flu vaccines;
- a building on the success of the Winter Watch programme launched in 2011 to offer people practical support to keep warm and stay well during the colder months;
- lower transmission rates of TB and HIV through better education about risks and also ensuring treatments are started promptly and then completed;
- more young people being screened for Chlamydia within ‘core service’ settings for this screening programme, i.e. GP surgeries, pharmacies and contraceptive clinics;

Our three objectives in ensuring we promote and protect the health of all communities particularly those disadvantaged

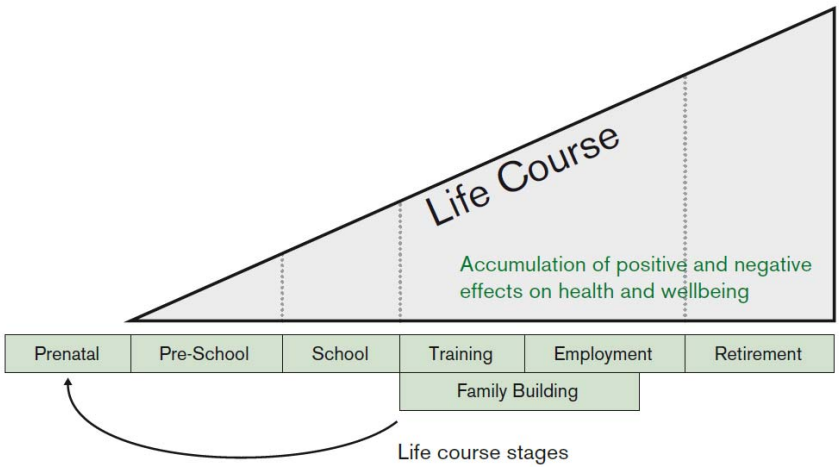
Objective 1 – Protect health and reduce the burden of communicable diseases by targeting services more effectively
Objective 2 - Ensure effective support is available to vulnerable and BME groups to protect their own health
Objective 3 – Increase awareness and uptake up of Immunisation and Screening programmes

Goal Two: Increase the focus on early years and the whole family to help reduce health inequalities

Introduction

The Marmot Review "Fair Society, Healthy Lives" sets out six policy objectives, two of which strongly relate to children and the whole family. Specifically, these are (1) Giving every child the best start in life, and (2) Enabling all children, young people and adults to maximise their capabilities and have control over their lives. These objectives are crucial to reducing health inequalities across the life course (see Figure 4 below). Achieving good health as early as possible in life will affect the chances of good health for the rest of a person's life. Indeed, exposures in the womb, such as maternal diet and overall health, as well as exposures in early life, such as breastfeeding and the socioeconomic environment in which a child grows up, can all affect health throughout the rest of a person's life. We know that intervening later in life can be less effective without good early foundations. This is why we are very keen to ensure we increase our focus on the early years.

Figure 4 – Stages of the life course and the accumulation of effects



Source: Fair Society, Healthy Lives (Marmot Review)

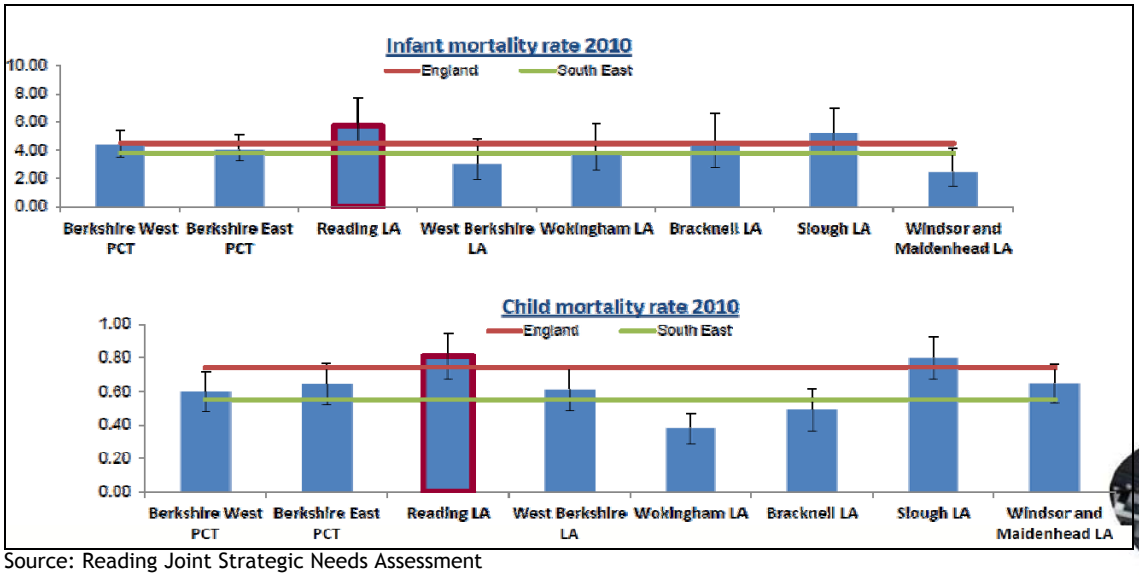
Crucially, strategies in the early years need to involve the whole family. For example, approaches to early and later childhood years that work across school-home boundaries and incorporate the provision of a range of extended services around schools to families and communities in their area have been particularly successful. Additionally, we know that very young parents, those who have significant challenges in their lives or who have little support from family or community may want to benefit from interventions which help with material, social or emotional needs. This is why we are very keen to focus on the whole family as well as children in the early years.

What the data tells us

Reading data tells us that:

- Reading has a higher-than-England-average proportion of NEETs and LAC and nearly 60/10,000 of our children were subject to a child protection plan in 2011, a rate that far outstrips that for England the South East region;
- Reading has relatively high rate of teenage pregnancy;
- a good proportion of new mothers in Reading start off breastfeeding, but only half are still breastfeeding their babies at 6-8 weeks of life;
- low child immunisation numbers in Reading mean children are at higher risk of avoidable, fatal, childhood diseases;
- Reading stood at 5.7 per 1000 live births while child mortality rate was 0.81 per 100,000 - rates which exceed the regional averages.
- In Reading there is a significantly higher rate of domestic abuse incidents than the Thames Valley average;
- 49% of domestic violence incidents in Reading occur in a house where a child is present.

Figure 5 – Infant and child mortality in Reading and surrounding areas, compared to nation and region



Source: Reading Joint Strategic Needs Assessment

What we want to see

In order to address the issues raised in the JSNA, we plan to focus on early years and the whole family. We want to see:

- that our communities have access to top quality maternity services that support women and their partners during pregnancy, birth and early parenthood, ensuring that we signpost those women who are more vulnerable, to specialist care at an early stage;
- high quality parenting and early intervention programmes that positively impact on inequalities in children's early years, education and health outcomes and parental health and well-being;

- a reduction in the infant and child mortality rates;
- an increase in breastfeeding rates and the take up of immunisation programmes;
- fewer pregnancies among teenage girls in Reading, and better life chances for teenage parents and their children;
- the gap, between deprived and affluent areas of the town, in early development of language, cognitive and social skills reduced or altogether removed;
- effective programmes to help people suffering with poor emotional health;
- better co-ordination of services to identify and address the needs of children and young people to promote emotional wellbeing and reduce the impact of violence and abuse.

Our three objectives in ensuring we increase the focus on early years and the whole family to help reduce health inequalities

Objective 1 – Ensure high quality maternity services, family support, childcare and early years education is accessible to all
Objective 2 – Reduce inequalities in early development of physical and emotional health, education, language and social skills
Objective 3 - Improve identification and reduce the effects of domestic violence on emotional wellbeing for the whole family

Goal Three: Reduce the impact of long term conditions with approaches focused on specific groups

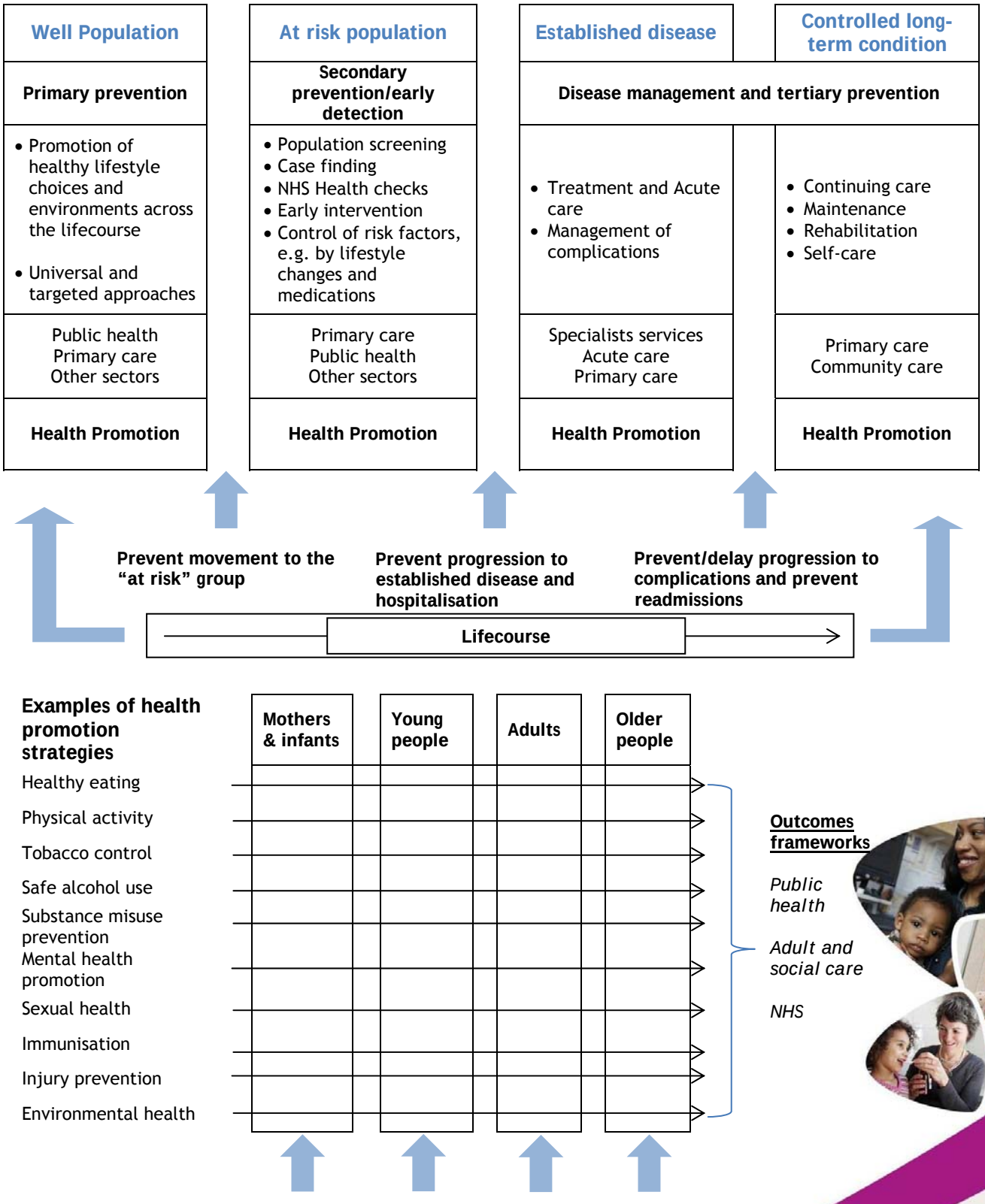
Introduction

Long-term conditions are health problems that require ongoing management over a period of years or decades (World Health Organisation). They include non-communicable diseases (e.g. cancer and cardiovascular disease), communicable diseases (e.g. HIV/AIDS), some mental disorders (e.g. schizophrenia, depression), and ongoing physical impairments (e.g. blindness, joint disorders). The Department of Health estimates that treatment and care of people with long-term conditions accounts for 69% of the total health and social care spending in England - almost £7 in every £10 spent. Although they can affect anyone, long-term conditions become more common as people advance in age. People living in relative deprivation are also more likely to be affected.

Long-term conditions can greatly impair the quality of people's lives and potentially place immense pressure on health and social care budgets. Increasing life expectancy and the growth in numbers of people living in poverty mean that the personal, social and economic impact of long-term conditions can be expected to grow. The rate of this growth will be rapid without concerted support to reduce the numbers developing long term conditions and then to delay the progress of such conditions amongst people who have developed them. In keeping with our vision to make the most efficient use of resources, the shadow Reading Health and Wellbeing Board is very keen to ensure that our strategy focuses attention on preventing long-term conditions and reducing their impact on people and budgets.

Figure 6 illustrates the health and wellbeing framework which we will adopt in reducing the impact of long term conditions in Reading. It highlights how a diverse set of health promotion and protection strategies in a variety of settings during the lifecourse can prevent onset of disease, identify disease early and manage it effectively in a way that prevents avoidable admission to expensive secondary/ tertiary care and maximizes independence for people living with those conditions.

Figure 6 – A health and wellbeing framework for reducing the impact of long term conditions in Reading (Adapted from National Public Health Partnership 2001)



What the data tells us

Reading data tells us that:

- we can expect to see a growth in the number of people living with long-term conditions as the Reading population ages, and also a growth in the number caring on an unpaid/informal basis for a friend or family member with a long term condition;
- the number of Reading residents living with diabetes is expected to rise year-on-year without primary preventive intervention, and although deaths from diabetes are not as common as from other long-term conditions like circulatory diseases and cancer, its complications and effect on quality of life, if not properly managed, can be catastrophic;
- update of diabetic eye screening in Reading is below the regional average;
- fewer people than expected are identified and recorded as having a long term condition within primary care, and local people have identified the need for improved identification and support at this stage;
- local people have said they want better access to prevention and long term condition management services for older people, and also carers given their vital role in helping people to manage long term conditions.

What we want to see

We want to see residents of Reading supported to stay healthy and avoid developing a long-term condition, where possible. However, where people do develop long-term conditions, we want them to be able to get an early diagnosis and treatment started as soon as possible. To do this, we want to see:

- more people taking up NHS Health Checks and other screening programmes;
- improved skills in primary health care for identifying and helping people to manage long term conditions;
- more integration across health and social care services around the needs of the individual, building on the success of the re-ablement service to help people achieve maximum independence after an illness or injury;
- greater use of patient-held or accessed records;
- development of Expert Patient Programmes across a range of conditions;
- increased take up of telecare and teleheath services;
- higher take up of carers' assessments;
- greater involvement of carers in developing individual care plans.

Our three objectives in ensuring we reduce the impact of long term conditions with approaches focused on specific groups

Objective 1 - Assist and support ability to self-care in all adults and young people with existing long term conditions
Objective 2 - Ensure high quality long term condition services are available to all including those with a learning disability
Objective 3 - Build on and strengthen the quality and amount of support available to adult and young carers in Reading

Goal Four: Health-enabling behaviours & lifestyle are promoted tailored to the differing needs of communities

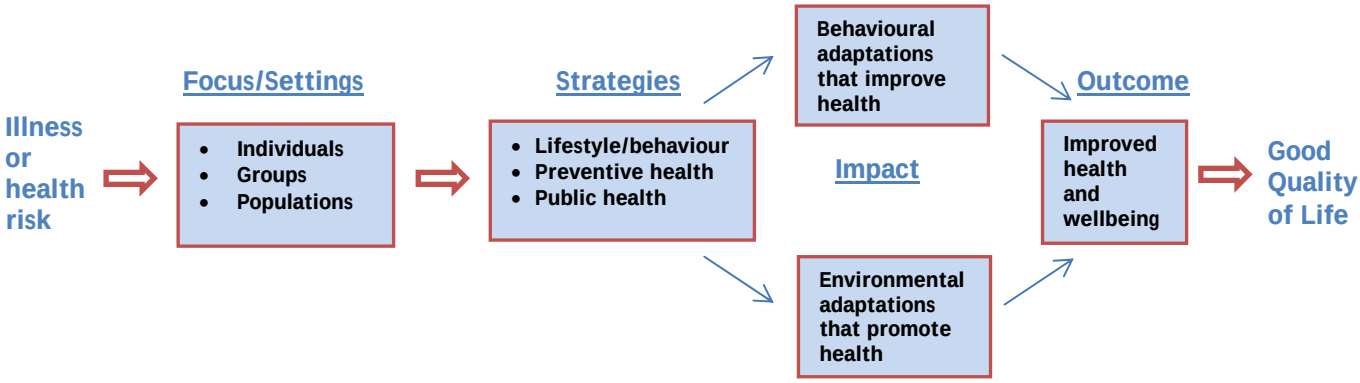
Introduction

We have already highlighted how the relatively high premature mortality rate in Reading is driven by circulatory diseases (in men) and cancer (in men & women). The incidence of these conditions across Reading also highlights the health inequalities between different parts of the community that we see in Reading. There is strong evidence linking increased likelihood of ill-health and premature death to lifestyle factors such as lack of exercise, unhealthy diets (typically high in fat, refined sugars and salt), stress, smoking, obesity, alcohol and drug abuse. Indeed a 10% increase in serum cholesterol due, for example, to a diet high in saturated fats, can result in a 50% increase in the risk of coronary heart disease. Smoking is associated with cardiovascular disease and lung cancer and alcohol misuse with liver cirrhosis, heart disease, social/domestic violence, suicide and mental ill health. In addition, unsafe sexual practices and intravenous drug use increase the risk of HIV/AIDS and other sexually transmitted infections.

Deprivation has direct adverse impacts on wellbeing and also limits people's options to mitigate the impact of stress and ill health. Those living on lower incomes may therefore need additional or more targeted support to make and maintain healthy lifestyle choices. Health promotion programmes are associated with lower levels of absenteeism from work and lower health care costs, and exercise and physical activity programmes with reduced health care costs. Specifically, exercise, cessation of smoking, healthy use of alcohol, eating a healthy (high-fibre, low-fat) diet, maintaining a healthy body weight, and learning to cope with stress, reduce the risk of circulatory diseases and cancer. All communities in Reading should have the opportunity to benefit from such programmes, and we are committed to delivering future health promotion on the basis of 'proportionate universalism' identified in the Marmot review as the most effective way of reducing the steepness of the social gradient in health, i.e. our actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage experienced by some groups.

Although lifestyle is generally considered a personal issue, it is significantly socially determined and reflects personal, group and socio-economic identities. The promotion of healthy lifestyles, being crucial to achieving improved population health and wellbeing, should therefore be directed to both the individual and the community in order to provide an infrastructural and social environment favourable to healthy lifestyle choices.

Figure 7 – A framework for promoting health-enabling lifestyles in Reading



What the data tells us

Reading data tells us that:

- just over 1 in 10 Reading residents achieve the recommended 5 sessions per week of 30-minutes sport/active recreation;
- nearly 2 in 5 children (36%) in Reading are either overweight or obese;
- over 11% of school age children consider themselves smokers, and 60% had drunk alcohol in the past year;
- an estimated 21% of the population aged over 18 years in Reading are increasing-risk alcohol drinkers, and there has been an increase in hospital admissions linked to alcohol plus a higher than average level of alcohol related crime;
- around 22% of Reading adults are smokers;

What we want to see

We want to see that healthy lifestyles are promoted vigorously in a variety of settings so that every Reading resident has a chance to maximize their health and quality of life. In particular, we want to see:

- local employers actively engaged in promoting health through workplace based schemes, including those to encourage physical activity;
- reductions in the prevalence of unhealthy weight in our children as a result of implementing this strategy;
- development on our successful school-based health promotion schemes to influence the health of young people, particularly in relation to tobacco, alcohol and drug use;
- support for a strategy to be developed focused on drug and alcohol;
- continued 'test purchasing' to reduce access to tobacco by young people;
- greater provision of 'stop smoking' support services for priority groups;
- good quality physical spaces in Reading which encourage people to be active, including family play areas;
- support for walking, cycling and public transport use.

Our three objectives in ensuring we promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

Objective 1 – Improve tobacco control and reduce harm due to alcohol and drug misuse in Reading
Objective 2 – Enhance support and target causes of lifestyle choices impacting health for adults and children
Objective 3 – Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes

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Consultation Feedback Incorporation Document

This document explains the changes that have been made to the draft Health and Wellbeing Strategy following a period of consultation. A written summary of the responses received is also available in the report 'Reading Health and Wellbeing Strategy: Consultation Response' which is published on the Reading Borough Council website.

Changes

Goals and Objectives
Feedback from the consultation has resulted in the following changes to the specific wording of the goals and objectives.

Changes within Goal One
Feedback suggested that issues of access to health, prevalence of health issues and attitudes to health in particular populations specifically the BME population be specifically included within the objectives for this goal. Objective 2 has been updated to take account of the feedback.

Objective 2 – Ensure effective support is available to vulnerable and BME groups to protect their own health.

Changes within Goal Two
Parenting programmes fall within a range of support offered to families and education in general is a key area that was felt to be an important aspect to supporting health improvement. Obesity appears in a number of the objectives and feedback provided supports a joining up and targeted effort in this area (now covered in Goal Four).

Objective 1 – Ensure high quality maternity services, family support, childcare and early years education is accessible to all.

Objective 2 – Reduce inequalities in early development of physical and emotional health, education, language and social skills.

Objective 3 – Improve identification and reduce the effects of domestic violence on emotional wellbeing for the whole family.

Changes within Goal Three
Feedback asked for further consideration for those with learning difficulties and disabilities. An importance around support available to carers, particularly young carers and the emotional health associated with being a carer was also expressed through feedback received.

Objective 1 – Assist and support ability to self-care in all adults and young people with existing long term conditions.

Objective 2 – Ensure high quality long term condition services are available to all including those with a learning disability.

Objective 3 – Build on and strengthen the quality and amount of support available to adult and young carers in Reading.

Changes within Goal Four
Feedback suggested that a number of objectives related to obesity actions and that these could be merged to create a more focused approach to this issue and specific activity should be used within an action plan.

Objective 2 – Enhance support and target causes of lifestyle choices impacting health for adults and children.

Objective 3 - Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes.

Specific Content
Feedback from the consultation has resulted in the following changes to specific content within the full strategy document.

Changes within 'How we developed the strategy'
Some concerns were raised around the lack of public involvement in developing the strategy and how people have the opportunity to help shape local services. Specific detail on how the views of local people, including services users, were gathered, this is covered in the strategy from the section on 'public engagement' onwards. More detail is now available on Healthwatch the community voice and additional information has also been included on this.

Changes within 'Context'
A population pyramid has been included in the 'our population' section and initial data is now available from the 2011 census which has been factored into this section.

Feedback suggested that Poverty is a theme that runs through all the goals within the strategy, Reading has completed specific analysis regarding the impacts and associated needs of those in poverty and plans to develop a strategy centred on reducing Poverty in Reading.

Changes within 'Health and Wellbeing Goals and Objectives' the detail
Each Goal is split into three sections 'Introduction', 'What the JSNA tells us' and 'What we want to see'

The section heading ‘What the JSNA tells us’ has been updated to ‘What the data tells us’ the goals and objectives have taken into account various information and feedback and not the sole use of the JSNA.

The highlighting of key facts using bullet points at consultation stage made each goal and objective easier to relate back to the specific objectives, the bullet point formatting for ‘What the data tells us’ and What we want to see’ has been incorporated into the final version of the strategy.

Strategy Questions and Answers

This document responds to a number of questions that were raised through the consultation on the draft Health and Wellbeing Strategy. A written summary of the responses received is also available in the report 'Reading Health and Wellbeing Strategy: Consultation Response' which is published on the Reading Borough Council website.

Question 1
How will the health needs of vulnerable populations, marginalised groups and health inequalities be identified and more specifically, how will local data be built around the needs of Black and Minority Ethnic and Refugee families?

Answer
The JSNA already identifies the needs of vulnerable and marginalised groups based on local data where that is available. Other needs assessments specifically focused on these population groups also highlight their specific health, healthcare and social needs. Having said this, there is some gap evident still in how thoroughly we understand the needs of these communities. Sometimes, information on ethnicity is poorly collected and exchange of information between health and social care is not as good as it needs to be. The Reading Health and Wellbeing Board is going to take on the crucial responsibility of driving integration of services in Reading where such integration is likely to improve the quality of health and social care individuals and communities receive. This will, in addition to driving up quality of care, provide a mechanism for collecting more complete local information on ethnicity and other social characteristics which might enable us understand in more detail the exact needs of these populations.

Question 2
Was the specific drug and alcohol JSNA consulted when drawing up this strategy?

Answer
Although the specific drug and alcohol JSNA was not used while developing this strategy, the health and wellbeing strategy does note the rates of problem drug misuse and hospital stays for alcohol related harm, it also supports the development of a specific drug and alcohol strategy to address the outcomes of the drug and alcohol JSNA. Although the specific mention of drug and alcohol misuse is mentioned within Goal Four this doesn't rule out specific activity within this area to support the achievement of the other three goals.

Question 3
Who is on the Health and Wellbeing Board at present and therefore making the decisions as to what is contained within the strategy and how those not represented can have an ongoing input?
Answer

The current membership of the Shadow Health and Wellbeing Board is included within the final strategy. The Board have agreed that as we enter a period of rapid change within the health arena it will be important to ensure we have the appropriate opportunity to review where we are and check our strategy can be effectively delivered. A review within the first year is suggested once the public health function within the borough has had a chance to embed.

Question 4
Community Safety Partnership include drugs and alcohol within their top ten priorities which we welcome and whilst we understand that that this group with have a different focus to the Health and Wellbeing Board we would like to understand how these groups will work together to ensure that priorities or targets work together and support delivery groups to succeed in delivering for both.

Answer
The Chair of the Community Safety Partnership is currently a member of the Shadow Health and Wellbeing Board in Reading. Board members attend represent the views of many groups and organisations, many of our members cover more than one group, partnership or association and have helped shape the development of the strategy.

Question 5
How does this strategy fit with the priorities of the Clinical Care Groups run by GPs?

Answer
The strategy will also link with and inform the commissioning and strategic plans of each of the partner organisations that are members of the Health and Wellbeing Board.

Question 6
Will funding will be apportioned to the four goals and if so how this will be done?

Answer
No, the strategy will inform commissioning and strategic plans of each of the partner organisations that are members of the Health and Wellbeing Board, the Board or the Strategy do not have any formal funding allocation associated with them.

Question 7
How will the strategy be performance managed?

Answer
Plans that will be outcome focused and measureable will be developed to support delivery of the strategy. A specific Health and Wellbeing delivery plan will be developed with partners over the next few months.

READING BOROUGH COUNCIL

REPORT BY HEAD OF COMMUNICATIONS

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**15 MARCH 2013**	**AGENDA ITEM:**	**9a**
TITLE:	**COMMUNICATIONS ACTION PLAN**		
LEAD COUNCILLOR:	**COUNCILLOR LOVELOCK / COUNCILLOR TICKNER**	**PORTFOLIO:**	**HEALTH AND WELLBEING**
SERVICE:	**COMMUNICATIONS**	**WARDS:**	**ALL**
LEAD OFFICER:	**DEREK PLEWS**	**TEL:**	**0118 937 2333**
JOB TITLE:	**HEAD OF COMMS**	**E-MAIL:**	**derek.plews@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To set out a communications Action Plan to support the Health and Wellbeing Communications strategy.

2. RECOMMENDED ACTION

2.1 The Board should note the content of the report and agree the action plan attached at Annex A.

3. COMMUNICATIONS STRATEGY.

3.1 The Board endorsed a report setting out a proposed communications strategy in November, and requested that a further report should be prepared, setting out an action plan for taking forward communications activities.

3.2 The November report, which included a narrative, messages and target audiences, highlighted the need to co-ordinate communications on public health across the whole of Berkshire in order to avoid confusing the public. It identified the Communications Workstream, involving all six local authorities and other partners, as the prime means of achieving a joined-up approach.

3.3 Unfortunately, since that meeting the Berkshire Public Health Transition Board disbanded the Communications Workstream, and a replacement co-ordinating group has only just been established. This has resulted in a delay in preparing the Action Plan.

4. THE PROPOSAL

4.1 The Action plan, attached at Annex A sets out proposals for Phase 1 of a two-phase communications strategy. The first phase is aimed at educating local people about the changes taking place in Public Health. The second phase, which will need to commence when the Health and Wellbeing Board assumes its formal 'live' status in April, will be designed to communicate the work of the Board and demonstrate its role in co-ordinating health and wellbeing across the Borough. An Action Plan for Phase 2 will be developed for discussion at the next Board meeting.

5. FINANCIAL IMPLICATIONS

9.1 No specific budget cover has been identified for health communications and any costs will have to be met from within existing resources.

DEREK PLEWS
HEAD OF COMMUNICATIONS

ANNEX A

HEALTH AND WELLBEING BOARD
COMMUNICATIONS ACTION PLAN – PHASE 1

ACTIVITY	TIMING	DETAILS	RESPONSIBILITY
Web page	w/c 18 March	Set up a new web page on the RBC site, setting out details of Health and Wellbeing Board, role, responsibilities, membership, inc link to Health and Wellbeing Strategy, FAQs stc.	RBC Communications
Media Briefing	w/c 25 March	Conduct a media briefing for local newspapers, radio and television news outlets. This is aimed at explaining the changes to Public Health in Reading as a result of the Health and Social Care Bill; the role of the H&WBB and how it will be conducting business. Briefing team should include: - H&WBB Chair – Cllr Jo Lovelock - DPH – Lise Llewellyn - Asmat Nisa – RBC PH Consultant. - Representative from CCG – tbc. Further details TBC.	RBC Communications DPH CCG
Social Media	w/c 25 March and on-going.	Set up Facebook, Twitter and You Tube accounts for Health and Wellbeing and establish protocol for use. Social Media is becoming a well-established channel for reaching and engaging with members of the public and it will be vital for the H&WBB to have a presence on these platforms.	RBC Communications

Publications	Under way	Produce a leaflet/poster setting out the role of the H&WBB for distribution via council offices, libraries, doctors' surgeries etc.	RBC Comms
Media activities	w/c 25 Mar	Invite broadcast media to interview H&WBB chair ahead of first 'live' Board meeting.	RBC Comms H&WBB Chair
		Issue invitations to all local media to attend future meetings of the Board.	RBC Comms
		Arrange for local media to receive Board papers in advance of meetings.	RBC Committee Services.
Internal briefings	w/c 1 April	Issue Councillors briefing pack	PH Team
		Introduction to the Public Health Team article in Inside Reading.	PH Team
		Consider holding a staff roadshow/soundbite session for staff across the council.	PH Team