Ian Wardle
MANAGING DIRECTOR

Civic Centre, Reading, RG1 7AE
☎ 0118 937 3737

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

Direct: ☎ 0118 937 2112
e-mail: nicky.simpson@reading.gov.uk

13 June 2013

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 21 JUNE 2013

A meeting of the Health & Wellbeing Board will be held on **Friday 21 June 2013 at 2.00pm in the Kennet Room, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

Cont/..

CIVIC CENTRE EMERGENCY EVACUATION: Please familiarise yourself with the emergency evacuation procedures, which are displayed inside the Council's meeting rooms. If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble at the Hexagon sign, at the start of Queen's Walk. You will be advised when it is safe to re-enter the building.

../Cont

6. HEALTH & WELLBEING STRATEGY ACTION PLAN 26

A report on the progress to develop an action plan that underpins the delivery of the Health and Wellbeing Strategy.

7. UPDATE REPORT ON PROPOSALS FOR STANDARDISED PACKAGING OF TOBACCO PRODUCTS 35

A report on progress in relation to Department of Health and the Devolved Administration's national consultation on policy proposals to require cigarettes packs and other tobacco packaging to conform to a standardised format.

8. PHARMACY ROLE IN HEALTH & WELLBEING 40

A report on the role of pharmacy in Health and Wellbeing and on work with this key group to improve services within Reading.

9. DEMAND & CAPACITY MODELLING 43

A report giving the highlights of a recent report into demand and capacity within the adult social and health care economy across the west of Berkshire, setting out some short term actions that will help to manage demand in Accident & Emergency services and unplanned hospital admissions, and on proposals to pursue a bid to become 'pioneers' on an integration programme.

10. CLINICAL COMMISSIONING GROUPS UPDATE REPORTS

Reports giving updates from the two CCGs in Reading.

a) NORTH & WEST READING CCG 56

b) SOUTH READING CCG verbal/ to follow

11. HEALTHWATCH READING UPDATE 70

A report giving an update from Healthwatch Reading.

12. JOINT STRATEGIC NEEDS ASSESSMENT VISION FOR REDESIGN 74

A presentation on proposals to develop a redesigned Joint Strategic Needs Assessment for Reading.

Cont/..

../Cont

13. DELIVERY OF THE WINTERBOURNE VIEW CONCORDAT AND REVIEW COMMITMENTS 77

A copy of a letter from Norman Lamb, Minister of State for Care and Support about delivery of the Winterbourne View Concordat and review commitments – for information.

14. BRINGFORWARD LIST 80

To consider the Board's bringforward list of items for future meetings.

15. DATE OF NEXT MEETING – Friday 20 September 2013 at 2pm -

READING SHADOW HEALTH & WELLBEING BOARD MINUTES – 15 MARCH 2013

Present:

Councillor Lovelock (Chair)	Leader of the Council, Reading Borough Council (RBC)
Elizabeth Johnston	Chair, South Reading Clinical Commissioning Group (CCG)
Lise Llewellyn	Berkshire Director of Public Health
David Shepherd	Board Member, Reading LINk
Councillor Tickner	Lead Councillor for Health & Wellbeing, RBC
Ian Wardle	Managing Director, RBC
Avril Wilson	Director of Education, Social Services and Housing, RBC

Also in attendance:

Stephen Barber	Independent Chair, Reading Local Safeguarding Children Board
Helen Clanchy	Director of Commissioning, Thames Valley Area Team, NHS Commissioning Board
Zoë Hanim	Head of Policy, Performance & Community, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Director of Operations, South Reading CCG
Rob Poole	Head of Finance & Resources, Housing & Community Care, RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Sara Whittaker	Assistant Director of Quality, NHS Berkshire West
Cathy Winfield	Chief Officer, Berkshire West CCG Federation

Apologies:

Councillor Ballsdon	RBC
George Boulos	North & West Reading CCG
Catherine Kelly	North & West Reading CCG
Karen Reeve	Head of Children's Social Care, RBC
Rod Smith	North & West Reading CCG
Sylvia Stone	Independent Chair, West of Berkshire Safeguarding Adults Partnership Board

1. MINUTES

The Minutes of the meeting held on 25 January 2013 were confirmed as a correct record and signed by the Chair.

2. HEALTH MANAGEMENT & STRATEGY DEVELOPMENT PROGRAMME PLAN

Zoë Hanim submitted the latest version of the Health Management 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, RAG status, progress and risks/issues for each work stream.

AGREED: That the Plan be noted.

3. TRANSFER OF PUBLIC HEALTH – JOINT ARRANGEMENT

Zoë Hanim submitted a copy of a report which would be considered by Cabinet on 18 March 2013 seeking authority for the Council to enter into an agreement with the other Berkshire Unitaries for a joint arrangement concerning the Public Health function which would transfer to local authorities from the NHS on 1 April 2013. The proposed arrangement would cover:-

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

(b) the vesting in Bracknell Forest 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.

The report also covered:

(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; and

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

The report stated that there would be a report to full Council on 26 March 2013 to establish the Health & Wellbeing Board for Reading, as a committee of full Council (see Minute 7 below).

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

The transfer of public health functions in Berkshire would 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 had 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, which had agreed, in consultation with the Department of Health:

- there would be one Strategic Director of Public Health for Berkshire, appointed jointly with the Department of Health and employed by a host authority;

- each Unitary authority would have a Consultant in Public Health, accountable professionally to the Director;

- Bracknell Forest Council would be the host authority for the Berkshire-wide public health service, and the employer of the Director of Public Health, and would provide a "core" public health service to all the Berkshire Unitary Authorities;

- These arrangements would be the subject of a joint agreement between the six Berkshire Unitary Authorities, and in March 2015 authorities could choose to review arrangements and give a year's notice to withdraw. The arrangement was not time limited but any authority would have the ability to withdraw from the arrangement after two years giving a year's notice.

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

The joint arrangement would be overseen by a Joint Advisory Board which would report through the Berkshire Chief Executives to the Berkshire Leaders, and would comprise the Director of Public Health, a Berkshire Chief Executive, and a senior officer from each authority.

The report recommended to Cabinet:

(1) That a joint agreement be entered into with the other Berkshire Unitary Authorities for the provision of public health services in Berkshire, as described in Paragraph 4 of the report, from 1 April 2013;

(2) That the Head of Legal & Democratic Services be authorised to enter into the joint agreement on behalf of the Borough Council;

(3) That the Director of Education, Social Services & Housing (or in her absence the Head of Policy, Performance & Community) be appointed to 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 required the exercise of functions by the Borough Council, and subject to the decisions and actions being published in the Decision Book;

(4) That the appointment by Bracknell Forest 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 Council under Section 113 of the Local Government Act 1972 by which Bracknell would 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;

(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;

(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 be given delegated authority for those matters for which they were required to be responsible under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) as specified below:

- 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 required 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 included 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.

(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 NHS 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.

AGREED: That the the report be noted.

4. BERKSHIRE PCT CLUSTER QUALITY HANDOVER DOCUMENT

Sara Whittaker submitted a report which presented the draft Berkshire PCT Cluster Quality Handover Document "Maintaining and improving quality during transition". The document provided an overview of healthcare services in Berkshire and set 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 had been drawn up to meet the quality and patient safety needs of the receiving organisations and provided information that was needed by other organisations, such as in relation to public health. The document covered:

- The context of transition
- The organisation of the local healthcare system
- Key personnel
- Governance arrangements
- Provider Quality Profiles
- Patient Experience
- Risk Register
- Communication of plan

The report summarised the key quality areas that had been identified in the document in relation to the three key providers, Royal Berkshire NHS Foundation Trust, Heatherwood & Wexham Park NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust.

The document would be approved by the PCT Cluster Board before the final handover to receiving organisations. Sara reported at the meeting that there was now a fuller section on the roles and destinations of key staff members.

The meeting discussed a possible joint project to provide an "SOS Bus" in Reading, to reduce admissions to Accident & Emergency, which had been discussed at the Local Strategic Partnership and Commissioning for Quality and Innovation (CQUIN) meetings and it was noted that officers needed to discuss this further.

The meeting noted that the report focused on quality in the specific sectors which had been monitored by the PCT. The HWB Board would need to consider the role it would play in quality monitoring in the future, using a whole system approach, and how partners would work jointly on quality issues. It was reported that there was a seat for an officer level HWB Board representative on the Quality Surveillance Group, and an officer representative needed to be arranged.

AGREED:

(1) That the report be noted;

(2) That officers discuss further outside the meeting possible proposals for providing an SOS bus for Reading and arranging an officer HWB Board representative for the Quality Surveillance Group;

(3) That, when the Management Group were looking at forward planning for the HWB Board, they include the Board's role in quality monitoring.

5. DRAFT NORTH & WEST READING AND SOUTH READING CCG COMMISSIONING PLANS 2013/14

Further to Minute 6 of the last meeting, Maureen McCartney and Elizabeth Johnston submitted the latest drafts of the 2013/14 North & West Reading and South Reading CCG Commissioning Plans respectively. Copies of an amended North & West Reading CCG Commissioning Group "Plan on a Page" were tabled at the meeting. Maureen and Elizabeth said that they would welcome any further comments, so that the Plans could be finalised over the next few weeks.

The Plans detailed the CCGs' proposals for local healthcare services to meet the needs of the local population and to drive improvement in health and health services. They had been developed using the findings of the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and from feedback received from patients and the public on local services. The Plans included the CCGs' visions, strategic aims and objectives and set out specific commissioning plans to meet these.

David Shepherd noted that the South Reading CCG plan on a page contained a reference to patient and public involvement, but the North & West Reading CCG plan on a page did not. Maureen McCartney said that this could be amended.

Elizabeth Johnston reported that the South Reading CCG website was due to go live in April 2013 and that the CCG was looking at long term conditions, in order to provide a resource for the whole community. There would also be a series of public workshops to find out what patients would like for their long term conditions, especially in relation to self-care and access to information.

It was noted that the focus on the websites tended to be on long term conditions and it was suggested that it might be useful also to provide information on the websites

giving people advice on how to stay well, in order to prevent them becoming patients.

Helen Clanchy noted that a number of initial NHS Commissioning Board plans on a page for their commissioning plans had also been circulated separately to members of the Board.

AGREED:

(1) That the latest draft Commissioning Plans be noted;

(2) That Maureen McCartney add in a reference to patient and public involvement in the North & West Reading CCG plan on a page;

(3) That any further comments on the draft plans be submitted to the appropriate CCGs as soon as possible.

6. PROGRESS REPORT ON HEALTHWATCH

David Shepherd submitted a report which gave details of the progress in establishing Healthwatch Reading.

The report stated that Reading Voluntary Action (RVA), in conjunction with Reading LINk (and on behalf of Healthwatch Reading), had been successful in a £20,000 bid to the Primary Care Trust's Partnership Development Fund to establish and improve patient and public engagement in the GP practices located in North and West and South Reading CCGs. This funding, available from 1 April 2013, would be invaluable in helping to improve awareness of health and social care issues in the area and would show how patients and the public could influence the extent and quality of services provided. Reading Link had also been invited to provide observers to both CCG Board meetings.

The budget and funding for transition to Healthwatch Reading had now been agreed and RVA was taking steps to obtain new accommodation for Healthwatch in the centre of Reading. In addition, staffing was being reviewed so that Healthwatch Reading would be up and running from 1 April 2013.

In order to further engage with the local voluntary and community sector and incorporate their voices fully into Healthwatch Reading, Reading LINk would be establishing a forum for the local voluntary and community sector called 'Healthwatch Voices'. This would act as a platform for dialogue with the sector to raise concerns and gather issues and priorities for their services users. This was intended to be a quarterly meeting, with the first meeting taking place at the launch of Healthwatch Reading on 17 April 2013.

RVA had established a charity which would be the vehicle to receive funding from the Local Authority and the payment of expenses incurred. The application for the Healthwatch Reading charity was with the Charity Commission and David reported at the meeting that the Commission seemed to be happy with what was proposed and final approval was now awaited, hopefully in time for 1 April 2013.

Steps were also being taken to establish a LINk Legacy document in accordance with advice supplied by the Local Government Association and the Department of Health,

to identify all the work achieved over the last four years so that Healthwatch Reading had a sound basis on which to take its work forward.

AGREED: That the report be noted.

7. TRANSFER OF PUBLIC HEALTH – HEALTH & WELLBEING BOARD

Further to Minute 8 of the last meeting, Zoë Hanim submitted a draft report for submission to Council on 26 March 2013 setting out the changes required as a consequence of the transfer of public health functions to the Council which would take effect on 1 April 2013 (see Minute 3 above); and proposing the establishment of the Health and Wellbeing Board as a committee of the Council, for the remainder of the current Municipal Year.

The Health and Social Care Act 2012 ("the 2012 Act") provided for the transfer of public health functions from the NHS to local authorities. The relevant statutory provisions would come into effect on 1 April 2013. The 2012 Act required the Council to establish a Health and Well Being Board ("the Board") as a committee and to appoint a Director of Public Health. The statutory functions of Health & Wellbeing Boards were set out in Sections 195-196 of the 2012 Act, and paragraph 8.5 of the report.

The report stated that, in anticipation of these changes, the authority had had a shadow Health and Wellbeing Board for the past two years. Its current terms of reference and operating arrangements were set out in Appendix A to the report.

The report explained that there were a number of problems in terms of local government administrative law caused by the following statutory membership of the Board as a committee specified in the 2012 Act:

- At least one 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 thought fit

The report also explained how regulations issued in February 2013 had disapplied parts of the relevant Local Government Acts to deal with these problems, as follows:

- Members of the Board who were not Councillors would be able to vote, unless the authority directed otherwise (which it could only do after consultation with the Board)
- The statutory rules on political proportionality would not apply, and whether or not political proportionality would apply to the Councillor members of Boards would be left to local determination
- The law relating to disqualification for membership had been modified to allow officers of the Council to be members of the Board (and therefore with voting rights unless the authority directed otherwise as above)
- The Access to Information rules would apply

The report noted that the shadow Board had acted as a partnership body, operating on a more informal basis than a formal committee, and that appeared to be the underlying intention of the 2012 Act. It therefore recommended:

(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 replicated 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) 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.

The report noted that the 2012 Act required the NHS Commissioning Board to appoint a representative to join the Board for the purpose of participating in its preparation of the local Joint Strategic Needs Assessment and local Health & Wellbeing Strategy.

Zoë explained that this was the opportunity for the Board to be consulted on those matters where the authority could only direct regarding voting by members of the Board if it had consulted with the Board. She said that it was proposed that officers were not given voting rights on the Board, even if they were statutory members of the Board, and that the only members of the Board to have voting rights should be:

- The Leader of the Council;
- The three elected portfolio holders for Health, Community Care and Children's Social Care;
- The two representatives from the CCGs;
- The representative from the Local Healthwatch organisation.

The meeting noted that it was hoped that the Board would continue to run as a collaborative partnership meeting, without the need to bring issues to a vote, but that it was best to be clear on voting in case a matter required a vote. It was also proposed that the voting members on the Board should be named representatives, with named substitutes. Zoë noted that the Member Code of Conduct would apply to all voting members of the Board and they would have to complete a register of interests form and declare any pecuniary interests at Board meetings, as set out in the report.

Councillor Lovelock said that applying political proportionality to the committee would make it unmanageable in terms of the number of Councillors required, and

operating as a partnership more difficult, hence the proposal to retain the existing Councillor membership instead, but that it was intended to continue to extend invitations to opposition spokespersons to attend Board meetings as observers with speaking rights.

It was noted that officers from the health organisations as well the Council would be able to attend to give advice and contribute to meetings, but would not have a vote.

AGREED:

(1) That the report be noted;

(2) That the Board recommend to the Council that at the Annual Council Meeting in May 2013 it agree:

(a) That the following named members of the Health & Wellbeing Board (or their named substitutes) be given voting rights:

- The Leader of the Council;
- The three elected portfolio holders for Health, Community Care and Children's Social Care;
- The two representatives from the CCGs;
- The representative from the Local Healthwatch organisation.

(b) That the following members of the Health & Wellbeing Board not be given voting rights:

- 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).

(c) That Opposition Group Spokespersons and officers continue to be invited to attend Health & Wellbeing Board meetings and speak but not vote.

8. READING'S HEALTH & WELLBEING STRATEGY

Further to Minute 9 of the last meeting, Lise Llewellyn submitted a report by Asmat Nisa, Consultant in Public Health - Reading, presenting the final draft of Reading's Health & Wellbeing Strategy 2013-16 in preparation for sign off by Council on 26 March 2013, outlining the next steps for developing a delivery plan and explaining how the strategy would be reviewed and refreshed. The report had appended:

Appendix 1 – Final Draft of Reading's Health & Wellbeing Strategy
Appendix 2 – Consultation Feedback Incorporation Document
Appendix 3 – Strategy Questions and Answers

The report stated that, as a result of the consultation exercise carried out with key stakeholders and partners, changes had been made to the draft Health and Wellbeing Strategy and Appendix 2 explained where changes had been made. A number of questions had also been submitted as a result of the consultation and discussions with

officers and those had been pulled into a question and answer document attached at Appendix 3.

The strategy had been branded and would be submitted for full sign-off at Council on 26 March 2013 and would then be published. A review within the first year was suggested, once the public health function within the authority had had a chance to embed. Lise explained that she would be working on the refresh of the Joint Strategic Needs Assessment which would produce information for the review of the strategy.

The report noted that it was essential that a robust delivery plan was put in place to take the strategy forward. 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 the draft strategy still had the old NHS Berkshire logo on its front page, instead of the CCG logos.

AGREED:

(1) That the report be noted;

(2) That the logo used on the front of the strategy be updated from NHS Berkshire to the appropriate CCG logos;

(3) That, subject to (2) above, the final draft Health & Wellbeing Strategy 2013-16 be endorsed for submission to Council on 26 March 2013, and the arrangements for review of the Strategy and development of a delivery plan be endorsed.

9. COMMUNICATIONS ACTION PLAN

Zoë Hanim submitted a report by the Head of Communications which set out a Communications Action Plan to support the Health and Wellbeing Communications Strategy agreed at the meeting on 2 November 2012 (Minute 9 refers).

The Action Plan was appended at Annex A and set out proposals for Phase 1 of a two-phase communications strategy. The first phase was aimed at educating local people about the changes taking place in Public Health. The second phase, which would need to commence when the Health and Wellbeing Board assumed its formal 'live' status in April 2013, would 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 would be developed for discussion at the next Board meeting.

AGREED: That the report be noted and the Communications Action Plan set out at Annex A be agreed.

10. HEALTH & WELLBEING BRIEFING PACK

Zoë Hanim reported that officers were working on producing a health information pack for Councillors and other stakeholders to include explaining the roles and accountability for the management and delivery of Health and Wellbeing services in

Reading from 1 April 2013. Once the briefing pack had been drafted, it would be circulated to partners for comments before its distribution.

AGREED: That the position be noted.

11. OTHER BUSINESS

a) Health & Wellbeing Board Development - Offer of Bespoke Support from the LGA

Further to Minute 12 (b) of the last meeting, Zoë Hanim reported that officers were still discussing with the Local Government Association consultants the best format for a workshop to help the Board focus on the HWB Strategy and its objectives and to plan its next steps. The DoH funding would run out at the end of April 2013, so it was now proposed that a workshop be held in April 2013, and Zoë suggested five possible dates.

AGREED:

That a workshop for the Health & Wellbeing Board be held at 9.30am-12.30pm on Friday 12 April 2013.

b) Summary of Board meetings

It was queried whether a summary for the public of the output of Board meetings could be produced after each meeting.

AGREED:

That the Head of Communications be asked whether it was feasible to produce a summary of the output of Board meetings for the public after each meeting.

12. DATES AND TIMES OF FUTURE MEETINGS

AGREED:

That the meetings of the Health & Wellbeing Board for 2013/14 be held at 2.00pm on the following dates:

- Friday 21 June 2013 (Kennet Room, Civic Offices)
- Friday 20 September 2013 (Conference Room G29/30, 57-59 Bath Rd)
- Friday 13 December 2013 (Conference Room G29/30, 57-59 Bath Rd)
- Friday 21 March 2014 (Kennet Room, Civic Offices)

(The meeting started at 12.30pm and closed at 1.53pm)

Health and Well Being Board 21 June 2013

This document sets out the updated terms of reference and operational arrangements for the Health and Well Being Board for agreement.

HEALTH AND WELL-BEING BOARD

TERMS OF RERERENCE AND OPERATIONAL ARRANGEMENTS

READING BOROUGH COUNCIL

This is set up under section 194 of the Health and Social Care Act 2012. Under section 194(11), the Board must be treated as a committee appointed by the authority under Section 102 of the Local Government Act 1972.

The profile of Reading Health Wellbeing Board

The Health and Well-being Board (HWB) aims to improve health and well-being for people in Reading. It is a partnership that brings together the Council, NHS and the local Healthwatch organisation.

By working together on the delivery of national and local priorities, the Board's purpose is to make existing services more effective through influencing future joint commissioning and provision of services. The Board will be responsible for overseeing the production of a Joint Strategic Needs Assessment (JSNA) for Reading, and for developing a Health and Well-being Strategy and Delivery Plan as the basis for achieving these aims. The focus will be on reducing health inequalities, early intervention and prevention of poor health and promotion of health and well-being.

The Board is responsible to the Council and will reflect the need to promote health and well-being across health and Council departments, including housing, social care, schools, community services, environment, transport, planning, licensing, culture and leisure.

The Board will be expected to improve outcomes for residents, carers and the population through closer integration between health services and the Council. Stronger joint commissioning offers scope for more flexible, preventative and integrated services for children and adults with long-term conditions and those living in vulnerable circumstances.

The Joint Strategic Needs Assessment (JSNA) provides the framework for considering the wider determinants of health, including employment, education, housing and environmental factors that impact on the health and well-being of people in Reading. The JSNA will inform the development of the Health and Well-Being Strategy and Action Plan and alongside other intelligence, especially the views of local people, help define priorities for the strategy that in turn will influence commissioning priorities.

The powers and duties of the Board are set out in Article 8 of the Council's Constitution, and are attached as an appendix to this Terms of Reference. The Health & Wellbeing Board is a Committee of Reading Borough Council. It is subject to Article 8, and the Standing Orders for Council and Committees and the Access to Information Procedure Rules in Part 4, of the Council' Constitution. Subject to Standing Order 23, it has

delegated authority from the Council to discharge the functions set out in the Appendix to these terms of reference.

ROLE AND PURPOSE OF THE BOARD:

The Health and Well-Being Board (H&WB) acts as the high-level strategic planning partnership to develop the provision of integrated health and social care services in Reading Borough. The H&WB for Reading is established to oversee the health improvement and well-being of those who live and work in the Borough.

1. To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes

2. To provide the collective leadership to improve health and well being across the local authority area, enable shared decision making and ownership of decisions in an open and transparent way

3. To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making

4. To address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the local area.

KEY FUNCTIONS

1. Ensure the preparation and publication of a JSNA for the area.

2. Develop an action plan to deliver the health and well-being strategy with clear priorities, objectives for delivery and measurable milestones.

3. 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.

4. Ensure health & social care improvement in Reading is developed within the context of Best Practice and Clinical Governance.

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 where appropriate to ensure effective commissioning decisions that deliver value for money in support of improved outcomes.

TIMING AND MEETINGS

The Board will, as a minimum, meet four times a year and may meet more often if the Board so decides.

The Board is subject to the access to information provisions of Section 100A of the Local Government Act 1972. It is committed to the principles of transparency and all meetings will be open to the public.

In order to accommodate confidential and exempt matters, particularly regarding commercially sensitive issues linked to commissioning and providers, the Board will hold two-part meetings with such matters being considered in Part 2 (without the press and public present) as necessary. The Council's Access to Information Procedure Rules will apply, 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.

Quorum

The quorum of the board will be no fewer than three of its voting membership; if fewer voting Members than this attend, then the meeting will be deemed inquorate.

Decision Making

Decisions at meetings will be achieved by consensus of those present. If a vote is required then, if there is an equal number of votes for than against the proposal, the Chair will have a second, casting vote**.**

MEMBERSHIP

The Council may co-opt additional persons or representatives to be members of the Board as it thinks appropriate, either as voting or non-voting Members, subject to the Council consulting beforehand with the Board.

The statutory membership of the Board is as follows:

- The Leader of the Council
- The Lead Councillors for Health, Adult Social Care, Children's Services and Families
- The Director of Education, Social Services and Housing *
- Director of Public Health for the Local Authority or his/her representative *
- A representative from each of the two commissioning consortia
- A representative from the Local Healthwatch organisation

(* the Members asterisked will not have voting rights, as explained below)

Voting rights

Under the provision of Regulations 6 and 7 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, the Council, following consultation with the shadow Health & Wellbeing Board, has decided as follows:

- To disapply the duty to allocate seats to political groups under Sections 15 and 16 of the Local Government & Housing Act 1989

- To treat the following as non-voting members of the Board:
    - The Director of Education, Social Services & Housing (or her representative)
    - The Director of Public Health (or her representative)

The voting membership of the Board must be named by the body they are representing. It will therefore be as follows:

- 4 Councillors by relevant office, i.e. the Leader of the Council, and the Lead Councillors for Health, Adult Social Care, and Children's Services and Families
- 1 named Local Healthwatch representative
- 2 named local CCG representatives

The bodies appointing voting Members to the Board may, in addition, appoint named substitute Members who may attend as voting Members in the place of their named Member.

Voting Members will be subject to the Council's local Member Code of Conduct, and will be required, under the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012 to register with the Monitoring Officer, and to declare at meetings, any disclosable pecuniary interest that both they and/or their spouse/partner has in the business of the Board.

Co-opted Members

The following will be co-opted as non-voting additional members:

- The Managing Director of Reading Borough Council (or his representative)

Observers

The following observers may attend and participate but not vote at Board meetings:

Chair - Local Safeguarding Adults Board
Chair - Local Safeguarding Children Board

One relevant shadow Lead Councillor for each opposition group on the Council (up to three in total).

A named representative of the NHS Commissioning Board will 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 Chair the Board.

VICE-CHAIR

The Lead Councillor for Health will be the Vice-Chair of the Board.

ACTIONS TO BE TAKEN BY MEMBERS OF THE BOARD

The Board is a decision-making body of the Council. Therefore the voting Members from other organisations must have authority from the bodies that they represent to make decisions at Board meetings. Accountability should be clear, without superseding the responsibilities of any participating agency. Board Members attending any working group should have the delegated authority to commit the body they represent to specific courses of action, including committing resources.

As a Statutory Board of Reading Borough Council the H&WB may report to Council as appropriate including recommending the Health and Well Being Strategy for approval and support the alignment of the Council's plans 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 whether or not 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 partner bodies 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.

The Board will inform local commissioners of key decisions that may impact on the provision of services.

Appendix

The Powers and Duties of the Health and Well Being Board were agreed at the Council's annual general meeting on the 22 May 2013 in line with statutory requirements.

Powers and duties of the Health and Well Being Board

(1) To discharge the functions of the Health & Wellbeing Boards as set out in Sections 195-196 of the 2012 Act, ie:

- Duty to encourage integrated working in health and social care under the National Health Service 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 its partner clinical commissioning groups CCGs and/or the NHS Commissioning Board - about whether the local commissioning plans have taken proper regard of the Joint Health & Wellbeing Strategy

(2) To discharge any other health functions delegated to it by the authority.

(3) To ensure that the authority meets its duties as a relevant authority, under Section 116 of the Local Government & Public Involvement in Health Act 2007 ("the 2007 Act"), as amended by Sections 192 and 193 of the Health & Social Care Act 2012:

(a) to prepare, with its partner CCGs, and publish a Joint Strategic Needs Assessment for the area, involving the local Healthwatch and local people living or working in the area;

(b) to prepare, with its partner CCGs, and publish a Joint Health & Wellbeing Strategy to meet the health needs of the area included in the Joint Strategic Needs assessment, relating to the exercise of public health functions by the authority, the NHS Commissioning Board or the CCGs, involving the local Healthwatch and local people living or working in the area;

(c) to ensure that the local authority, and its partner CCGs, have regard to these documents.

(4) To ensure that the authority complies with its duty, under Section 28 of the National Health Service Act 2006, to take such steps as it considers appropriate for improving the health of the people in its area, with particular reference to:

- any public health functions of the Secretary of State which s/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 Service 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

(5) To ensure that the authority complies with its duties to improve public health as set out in Sections 2B and 111 of the National Health Act 2006 (as amended by Section 12 of the Health & Social Care Act 2012), including:

(a) under Section 2B(3):
- Providing information and advice
- Providing services or facilities designed to promote healthy living (including helping individuals address behaviour that is detrimental to health or in any other way)
- Providing services for the prevention, diagnosis or treatment of illness
- Providing financial incentives to encourage individuals to adopt healthier lifestyles
- Providing assistance (including financial) to help individuals minimise any risks to health arising from their accommodation or environment
- Providing or participating in the provision of training for persons working or seeking to work in the field of health improvement
- Making available the services of any person or any facilities

(b) Under Section 2B(4), providing grants or loans on such terms as the local authority considers appropriate.

(c) Under Section 111 and Schedule 1:
- Dental public health (S111)
- Medical inspection of pupils (Paras 1-7B)
- Research for any purpose connected with the exercise of the authority's health functions (Para 13)

(6) To oversee the following joint arrangement and partnerships in which the authority is involved:

- Berkshire Public Health Joint Arrangement
- Berkshire Public Health Joint Advisory Board

(7) To make representations to the Adult Care, Children's Services and Education Committee as the authority's health scrutiny committee.

READING BOROUGH COUNCIL

REPORT BY COUNCIL MANAGING DIRECTOR

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**21 JUNE 2013**	**AGENDA ITEM:**	**5**
TITLE:	**NEW HEALTH STRUCTURE**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BROUGH-WIDE**
LEAD OFFICER:	**ASMAT NISA**	**TEL:**	**0118 937 3623**
JOB TITLE:	**CONSULTANT IN PUBLIC HEALTH - READING**	**E-MAIL:**	**ASMAT.NISA@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the basis of the new health structure and provides an overview of the key organisations and their new responsibilities following the implementation of the Health and Social Care Act 2012.

1.2 Appendices with this report:

- Outline roles on responsibilities of health organisations (appendix 1);
- Diagram showing key organisations (appendix 2).

2. RECOMMENDED ACTION

2.1 Consider and confirm the detail within the report and appendices.

2.2 Agree to the content being used to help explain the new structure more widely.

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. From 1st of April 2013 Public Health functions, resources and commissioning responsibilities transfer from the NHS into Local Government. Reading now makes up one of six unitary authorities that will be responsible for Public Health across Berkshire.

3.2 The new health and care system became fully operational on 1 April NHS England, Public Health England, Healthwatch England and Health Education England have taken on their full range of responsibilities.

3.3 Locally, clinical commissioning groups – made up of doctors, nurses and other professionals – will buy services for patients, while local councils formally take on

their new roles in promoting public health. Health and wellbeing boards will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

4. NEW STRUCTURE

4.1 Clarity on who has the responsibility for specific activity within the complex new make up of health is essential so we can ensure Reading gets the best service for the people that live and work in the borough.

4.2 Officers across the council including members of the public health team across do, and continue to, develop relationships with key stakeholders as the new system embeds. Ways of working with Regional and national stakeholders are also being explored within this new health structure.

4.3 The roles and responsibilities of a number of key stakeholders and commissioners are outlined at appendix 1, it also details links to service provision for public health functions that are provided by working in partnership with a number of organisations.

4.4 A diagram is also provided at Appendix 2 which also helps to illustrate the complex structure.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The new health structure and the councils new public health functions 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 working with other local health services, partners, communities and local people in the work we do reflects the how important we believe engagement in developing local health services is.

7. EQUALITY IMPACT ASSESSMENT

No equality impact assessment has been undertaken for this report.

8. LEGAL IMPLICATIONS

There are no legal implications associated with this report.

9. FINANCIAL IMPLICATIONS

There are no financial implications associated with this report.

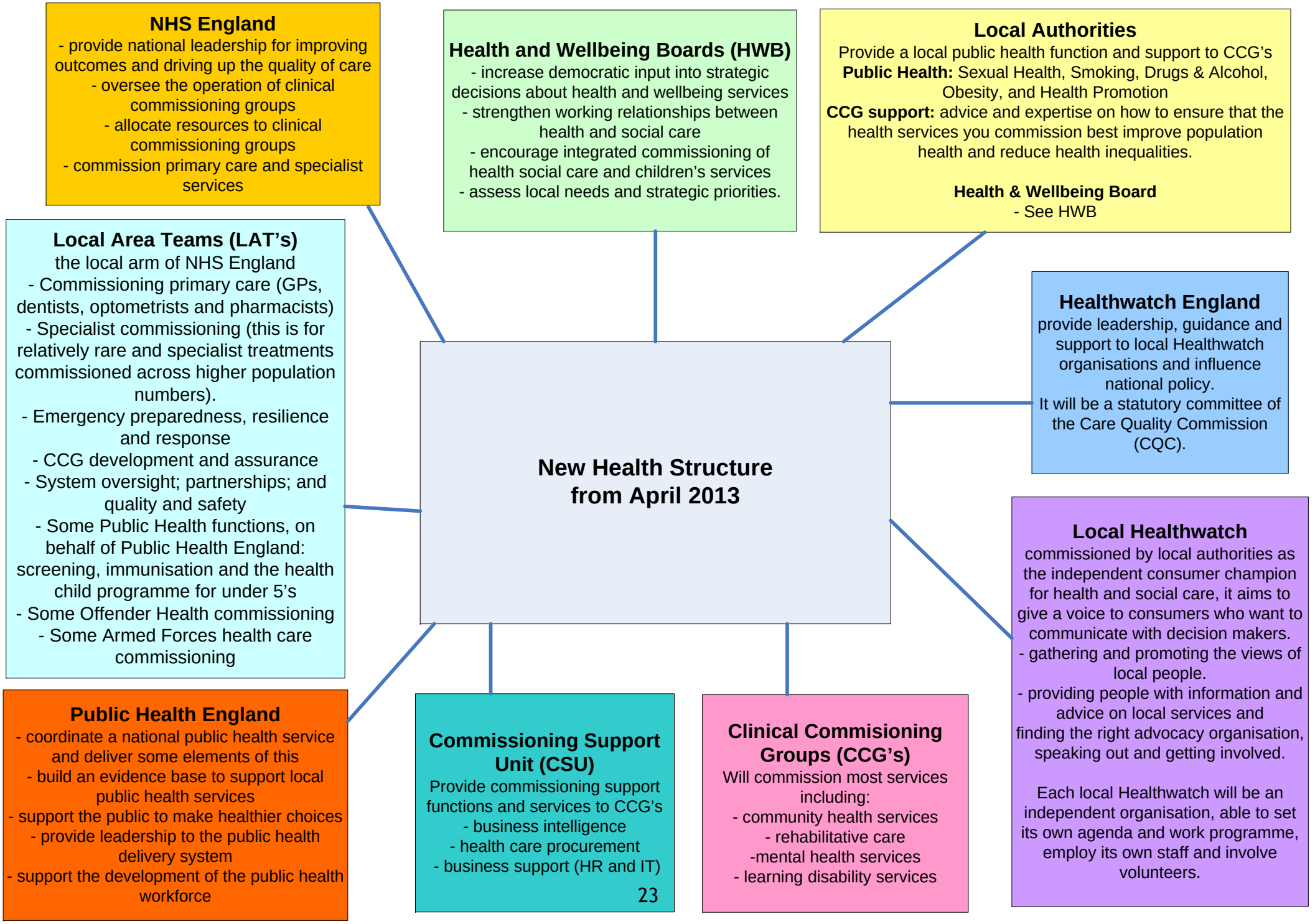
10. BACKGROU ND PAPERS

The Health and Social Care Act 2012,

Health Organisations and their New Responsibilities

Area	Organisations & Responsibilities
Commissioning	**NHS England** (previously the NHS Commissioning Board) with national, regional and local area teams (LATs) which operate within a **single operating model.** It will directly commission the primary health care provided locally by GPs, nurses and other health professionals as well as some specialist national services. **Local Area Teams (LATs)** will have direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services. They will also the following core functions: CCG development and assurance, emergency planning, resilience and response, quality and safety, system oversight. **Clinical Commissioning Groups (CCGs)** have the freedom to innovate and commission services for their local community from any service provider which meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers. **Commissioning Support Units (CSUs)** provide support to NHSCB and CCGs with a range of services including contracting and procurement.
Public Health	**Public Health England (PHE)** provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies. **Local Authority Public Health Teams (PH)** will be responsible for improving public health, empowering people and local communities and commissioning care. They will use their knowledge of the local community to tackle public health

	challenges such as smoking, alcohol and drug misuse and obesity. Local authorities will lead **HWBs**.
Local Leadership and Planning	**Health & Wellbeing Boards (HWB)** will bring together local agencies to plan services according to the health needs of the local community. They will produce needs assessment and health and well being strategy and promote integration.
Information and Involvement	**Healthwatch England** ensure that the overall views and experiences of people who use health and social care services are heard and taken seriously at a local and national level. **Healthwatch** (hosted by LAs) will collect and collate evidence from people using local health and care services and bring this to the attention of local health and wellbeing boards and local commissioners. **Health and Social Care Information Centre** supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers.
Workforce	**Health Education England** makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards. **Local Education and Training Boards** plan education and training of the workforce to meet local and national needs.


NHS England
- provide national leadership for improving outcomes and driving up the quality of care
- oversee the operation of clinical commissioning groups
- allocate resources to clinical commissioning groups
- commission primary care and specialist services
Health and Wellbeing Boards (HWB)
- increase democratic input into strategic decisions about health and wellbeing services
- strengthen working relationships between health and social care
- encourage integrated commissioning of health social care and children's services
- assess local needs and strategic priorities.
Local Authorities
Provide a local public health function and support to CCG's
Public Health: Sexual Health, Smoking, Drugs & Alcohol, Obesity, and Health Promotion
CCG support: advice and expertise on how to ensure that the health services you commission best improve population health and reduce health inequalities.
Health & Wellbeing Board
- See HWB
Local Area Teams (LAT's)
the local arm of NHS England
- Commissioning primary care (GPs, dentists, optometrists and pharmacists)
- Specialist commissioning (this is for relatively rare and specialist treatments commissioned across higher population numbers).
- Emergency preparedness, resilience and response
- CCG development and assurance
- System oversight; partnerships; and quality and safety
- Some Public Health functions, on behalf of Public Health England: screening, immunisation and the health child programme for under 5's
- Some Offender Health commissioning
- Some Armed Forces health care commissioning
New Health Structure from April 2013
Healthwatch England
provide leadership, guidance and support to local Healthwatch organisations and influence national policy.
It will be a statutory committee of the Care Quality Commission (CQC).
Local Healthwatch
commissioned by local authorities as the independent consumer champion for health and social care, it aims to give a voice to consumers who want to communicate with decision makers.
- gathering and promoting the views of local people.
- providing people with information and advice on local services and finding the right advocacy organisation, speaking out and getting involved.
Each local Healthwatch will be an independent organisation, able to set its own agenda and work programme, employ its own staff and involve volunteers.
Public Health England
- coordinate a national public health service and deliver some elements of this
- build an evidence base to support local public health services
- support the public to make healthier choices
- provide leadership to the public health delivery system
- support the development of the public health workforce
Commissioning Support Unit (CSU)
Provide commissioning support functions and services to CCG's
- business intelligence
- health care procurement
- business support (HR and IT)
Clinical Commisioning Groups (CCG's)
Will commission most services including:
- community health services
- rehabilitative care
-mental health services
- learning disability services

Health Organisations and their New Responsibilities

Area	Organisations & Responsibilities
Commissioning	**NHS Commissioning Board (NHSCB)** with national, regional and local area teams (LATs) which operate within a **single operating model.** It will directly commission the primary health care provided locally by GPs, nurses and other health professionals as well as some specialist national services. **Local Area Teams (LATs)** will have direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services. They will also the following core functions: CCG development and assurance, emergency planning, resilience and response, quality and safety, system oversight. **Clinical Commissioning Groups (CCGs)** have the freedom to innovate and commission services for their local community from any service provider which meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers. **Commissioning Support Units (CSUs)** provide support to NHSCB and CCGs with a range of services including contracting and procurement.
Public Health	**Public Health England (PHE)** provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies. **Local Authority Public Health Teams (PH)** will be responsible for improving public health, empowering people and local communities and commissioning care. They will use their knowledge of the local community to tackle public health

	challenges such as smoking, alcohol and drug misuse and obesity. Local authorities will lead **HWBs**.
Local Leadership and Planning	**Health & Wellbeing Boards (HWB)** will bring together local agencies to plan services according to the health needs of the local community. They will produce needs assessment and health and well being strategy and promote integration.
Information and Involvement	**Healthwatch England** ensure that the overall views and experiences of people who use health and social care services are heard and taken seriously at a local and national level. **Healthwatch** (hosted by LAs) will collect and collate evidence from people using local health and care services and bring this to the attention of local health and wellbeing boards and local commissioners. **Health and Social Care Information Centre** supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers.
Workforce	**Health Education England** makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards. **Local Education and Training Boards** plan education and training of the workforce to meet local and national needs.

READING BOROUGH COUNCIL
REPORT BY COUNCIL MANAGING DIRECTOR

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**21 JUNE 2013**	**AGENDA ITEM:**	**6**
TITLE:	**HELATH AND WELLBEING STRATEGY ACTION PLAN**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKINS**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BROUGH-WIDE**
LEAD OFFICER:	**ASMAT NISA**	**TEL:**	**0118 937 3623**
JOB TITLE:	**CONSULTANT IN PUBLIC HEALTH - READING**	**E-MAIL:**	**ASMAT.NISA@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report updates the board on the progress to develop an action plan that underpins the delivery of the health and wellbeing strategy.

1.2 Appendices with this report:

- the draft Health and Wellbeing action plan (appendix 1);
- the outcomes of the health and wellbeing board workshop (appendix 2);

2. RECOMMENDED ACTION

2.1 The Board consider how the information is presented and the level at which information is included within the draft action plan.

2.2 Partners agree how they wish to contribute to the development of the action plan.

3. POLICY CONTEXT

3.1 Health and Wellbeing Boards are a statutory requirement which 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 The board has since started work to ensure effective engagement between NHS, local authority commissioners, and GP consortia in readiness for this new statutory role. This includes producing the health and wellbeing strategy for Reading.

4. DELIVERING ACTIVITY

4.1 As a first step in developing an action plan (appendix 1) to support the delivery of the key goals set out in the Strategy, service areas within the council have been approached and asked to provide information on key supporting strategies and programmes of work that will take place during 2103/14, which directly contribute to the delivery of the Health and Wellbeing Strategy goals and objectives. Input from key stakeholders outside of the council including CCG's is also being sought.

4.2 It is important to note that the action plan is still in development, the plan captures existing local authority activity as well as some the new responsibilities that the council have in relation to its new public health function. Work across the county and locally is taking place to consolidate understanding of the range of services that are being commissioned and provided and how they relate to this plan.

4.3 Members of the Board as well as a range of health professionals and advisory officers attended a workshop in April 2013 to explore a partnership approach to shaping what delivery might look like for the objectives within the strategy. Suggestions for high impact and high influence activity, which could contribute to the delivery of the strategy vision and goals, were identified.

4.4 A number of the suggestions were examined in more detail to establish what partnership activity could take place to help contribute to the delivery of the strategy objectives. The outcomes of the workshop are attached at appendix 2, some of which are already captured within the draft action plan.

4.5 The process has highlighted the need for any proposals for new developments which support improvements in population health and wellbeing to have a clear business case with identified success measures and robust mechanisms to evaluate performance to ensure that we allocate public resources appropriately. As the action plan finalised and we develop an approach to dealing with resource requests a further report will be presented to the board.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The new health structure and the councils new public health functions 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 working with other local health services, partners, communities and local people in the work we do reflects the how important we believe engagement in developing local health services is.

7. EQUALITY IMPACT ASSESSMENT

No equality impact assessment has been undertaken for this report.

8. LEGAL IMPLICATIONS

There are no legal implications associated with this report.

9. FINANCIAL IMPLICATIONS

9.1 The financial implications of the Strategy must be contained within current resources, including the Public Health grant that is due to transfer to the Local Authority from 1 April 2013. The ring fence grant from the Department of Health for Reading this is £7.466 million for 2013/14.

9.2 HWB members will need to consider any financial implications arising from the development of commissioning plans to deliver the strategy which will be the subject of further reports to the Board.

10. BACKGROUND PAPERS

15 March 2013 Health and Wellbeing Board titled Reading Health and Wellbeing Strategy (Agenda Item 8).

Draft Health and Wellbeing Action Plan 2013/14

Goal 1 : Promote and protect the health of all communities particularly those disadvantaged

	Strategic Objective	What Do We Want To Achieve	What Will We Do	Who Will Lead This Work	What Outcomes Does This Help Us Achieve
	Protect health and reduce the burden of communicable diseases by targeting services more effectively	Assess the need, demand and service provision for sexual health services across Reading and identify gaps.	Undertake a sexual health needs assessment	Public Health	PHOF 3.3; PHOF 2.20; PHOF 3.4; PHOF 4.8
		Increase HIV testing and HIV prevention awareness within BME communities	Commission a community based HIV needs assessment to map Reading based African community groups and to assess the acceptability and feasibility of approaches to increase HIV testing	DESSH/Public Health	
		To reduce transmission of HIV	Increase awareness and information about HIV and HIV services (including eleigibility, confidentiality, treatment and what it means to live with HIV); and promote preventative services	Public Health	
		To reduce late HIV diagnosis	Primary community prevention	Public Health	
		To provide high quality care/treatment	Increase opportunity to and uptake of testing and disseminate information about opportunities for testing to targeted/vulnerable groups	Public Health	
		To promote testing for hepatitis B and hepatitis C	Increase opportunity to and uptake of testing and disseminate information about opportunities for testing in high risk groups	Public Health	

Goal 1 : Promote and protect the health of all communities particularly those disadvantaged					
	Strategic Objective	**What Do We Want To Achieve**	**What Will We Do**	**Who Will Lead This Work**	**What Outcomes Does This Help Us Achieve**
	Ensure effective support is available to vulnerable and BME groups to protect their own health.	Respond to local needs for vulnerable people	Safe Place scheme in the town Centre providing support of people with a LD	Community Safety	PHOF 3.3; PHOF 2.20; PHOF 3.4; PHOF 4.8
			ASB Risk assessment leads to enhanced response for vulnerable people and communities	Community Safety	
		Improve living conditions for vulnerable and disabled residents	Improve dwellings for Category 1 hazards under the Housing Health & Safety Rating System	Housing & Environmental Protection	
			Undertake enforcement action for overcrowding in private sector housing	Housing & Environmental Protection	
	Increase awareness and uptake of Immunisation and Screening programmes	Increase uptake of bowel and breast screening screening in low take up areas of Reading	To work with CCGs and Public Health England to provide support and oversight to local screening programmes	Public Health	
		Increase the consistent up take of immunisations across Reading to ensure national coverage targets are achieved	Provide advice to PHE Immunisation leads as appropriate to ensure effective evidence based interventions are developed to meet local needs	Public Health	
		To promote MMR vaccine uptake	Scutinise vaccine uptake results and provide leadership	Public Health	
		Increase uptake of screening in people with a learning disability	Reading Learning Disability Partnership Board to advise on targeted improvements	Partnership and Development (Debra Cole)	

Goal 2 : Increase the focus on early years and the whole family to help reduce health inequalities					
	Strategic Objective	**What Do We Want To Achieve**	**What Will We Do**	**Who Will Lead This Work**	**What Outcomes Does This Help Us Achieve**
	Ensure high quality maternity services, family support, childcare and early years education is accessible to all	Improve maternity pathways and parenting support for all family types.	Participate in the maternity working group and work jointly with the midwifery team.	Early Years & Extended Schools	PHOF 1.1 - Children in poverty; PHOF 2.1 - Low Birth Weight of term; NHSOF1.6i-ii - Reducing deaths in babies and young children; NHSOF 4.5 - Women's experience of maternity services; 1.16 - Utilisation of green space for exercise/health reasons; 2.2 - Breastfeeding; PHOF 2.4 - Under 18 conceptions; PHOF 2.5 - Child development at 2-2.5 years; PHOF 2.6 - Excess weight in 4-5 and 10-11 year olds; PHOF 2.7 - Hospital admissions caused by unintentional and deliberate injuries in under 18s; PHOF 2.8 - Emotional wellbeing of looked-after children; PHOF 4.1 - Infant mortality
		Increase the availability and accessibility of antenatal education opportunities	Review and scope out existing provision of antenatal education from statutory and voluntary providers. Develop plans and where necessary commissioning proposals to implement Birth and Beyond (DH 2001)	Public Health	
		Increase access to childcare.	Provide 15 hours free early education childcare to all two year olds meeting the free school meals criteria.	Early Years & Extended Schools	
	Reduce inequalities in early development of physical and emotional health, education, language and social skills	Increase support to available to parents	Deliver the Early Years Foundation Stage framework	Early Years & Extended Schools	
			Provide impartial support to parents seeking assessment for children with special educational needs or disabilities through the parent partnership service	Early Years & Extended Schools	
			Influence decisions for the early intervention panel for support children aged 0-5 with SEN	Early Years & Extended Schools	
		Reduce speech and language inequality	Implement the language strategy and deliver supported projects	Early Years & Extended Schools	
			Provide access to speech and language therapies within the EY settings	Early Years & Extended Schools	
		Increase the prevalence of breastfeeding across all areas of Reading but with a particular focus on the low rate wards	Continued implementation of the Unicef Baby Friendly Initiative	Lynn Aubrey-Jones Infant Feeding Co-ordinator (BHFT)	
			Continued implementation of the Breastfeeding Peer Support Project	Katy Hughes Breastfeeding Netwrok	
		Improved Oral Health in the <5s	Mid term evaluation of the Brushing for life project.Continued Implementation of the Brushing for Life intervention	Public Health	
		Reduce the prevalence of unplanned teenage pregnancies	Continued implementation of designated young people friendly drop-in clinics and promotion of the Young people's health website (JUICE).	Janice Burnett RBHFT	
			Improve the accessability and promotion of the Pharmacy EHC scheme	Public Health	
	Improve identification and reduce the effects of domestic violence on emotional wellbeing for the whole family	Increase the number of victims of domestic abuse identified and referred by GP.	Implement the IRIS project as a Pilot in 12 of the Reading practices (6 in each CCG)	Bernadette Adams Berkshrie Women's Aid	

Goal 3: Reduce the impact of long term conditions with approaches focused on specific groups					
	Strategic Objective	**What Do We Want To Achieve**	**What Will We Do**	**Who Will Lead This Work**	**What Outcomes Does This Help Us Achieve**
	Assist and support ability to self care in all adults and young people with existing long term conditions	Facilitate access to appropriate treatment(s) and support in managing long term conditions independently	Offer preventive health checks in community locations to adults aged 40-74 who are at risk of developing vascular disease.	PDSN Network	PHOF 1.6i: People with learning disabilities in settled accommodation; PHOF 1.6ii People receiving secondary mental health services in settled accommodation; PHOF 1.8 - Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness; PHOF 4.16 - Dementia and its impacts; NHSOF 2.1 - Proportion of people feeling supported to manage their condition 2.2 – Employment of people with long term conditions; NHSOF2.3i - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); NHSOF 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under19s
			Extend opportunities for accessible confidential testing for HIV, and ensure information is available and accessible in a range of formats appropriate to at-risk HIV groups.	PDSN Network	
	Ensure high quality long term condition services are available to all including those with a learning disability	Increase public say in support available	Deliver activity within the Learning Disability Plan - A Big Voice	Partnership and Development (Debra Cole)	
		Increase engagement for planning LTC services for those with learning disabilities	Support the Reading Learning Disability Partnership Board to engage with LTC projects	Partnership and Development (Debra Cole)	
	Build on and strengthen the quality and amount of support available to adult and young carers in Reading	Strengthen the quality of support provided for carers in Reading.	Review National Carers Strategy against local provision	Partnership and Development (Debra Cole)	
		Increase take up of service from marginalised groups.	Deliver activity within the Reading Carers Action Plan. Including: Reading Carers Communication	Carers Steering Group (Ifty Ahmed)	
		Support carers of adults with long term conditions – including young carers - to access support services and identify other services which can ease the burden of caring	Respite opportunities	PDSN Network	
		Service provision and needs are better matched.	Review future commissioning plans against the needs of carers	Carers Steering Group (Ifty Ahmed)	

Goal 4: Promote health enabling behaviours & lifestyle tailored to the differing needs of communities					
	Strategic Objective	**What Do We Want To Achieve**	**What Will We Do**	**Who Will Lead This Work**	**What Outcomes Does This Help Us Achieve**
	Improve tobacco control and reduce harm due to alcohol and drug misuse in Reading	Dectect and take action against illegal tobacco suppliers	Implement/enhance the Berkshire-wide Tobacco Control Plan	Consumer Protection	PHOF 2.9 - Smoking; prevalence – 15 year olds; PHOF 2.11 - Diet (Placeholder); PHOF 2.12 - Excess weight in adults; PHOF 2.13 - Proportion of physically active and inactive adults; PHOF 2.14 - Smoking prevalence – adult (over 18s); PHOF 2.17 - Recorded diabetes; PHOF 2.18 - Alcohol-related admissions to hospital; PHOF 2.19 - Cancer diagnosed at stage 1 and 2; PHOF 2.20 - Cancer screening coverage; PHOF 2.21i-vii - Access to non-cancer screening programmes; PHOF 2.22 - Take up of the NHS Health Check Programme – by those eligible; PHOF 2.24: Falls and fall injuries in the over 65s;
		TBC	Identify area where there is known underage drinking for targeted licensing response.	Community Safety	
		Reduction in drug related deaths	TBC (long term substance misusers)	Drug and Alcohol Action Team	
			Introduce SOS Bus in the Town Centre		
	Enhance support and target causes of lifestyle choices impacting health for adults and children	Increased active travel	Deliver a programme of personalised travel planning, incentives, fare discounts and concessionary fares, workplace challenges, cycle training, new infrastructure and reallocating road space	Transport Team	
		GP Practice targets for health checks are achieved and a wide range of community interventions ensure access to health checks though alternative settings	Continue to implement the Health Checks Programme across Reading through GP practices and targetted community interventions	Public Health	
		TBC	Review Health Trainer Service and Activity		
	Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes	Improved access to good quality information and advice on nutrition	Promote good quality information and advice on nutrition through our childrens' centres	Early Years & Extended Schools	
			Provide family learning for cooking on a budget and healthy eating	New Directions	
			Introduce Eat Well Get Well initiatives such as BHF Healthy hearts scheme to tackle obesity	Consumer Protection	
		Ensure a minimum of 90% Reception Children and Year 6 children are weighed and measured each year.	Continued implementation of the National Childhood Measurement Programme	Penny Cooper - School Nursing Locality Lead	
		Increase access to specialised healthy weight interventions for primary school children	Continued implementation of the Lets Get Going Project in 2 Reading Primary Schools (Katesgrove and Newtown)	Holly Raeby - Lets Get Going Co-ordinator	
		Develop a joint obesity strategy and action plan for Reading (to include adults and children and maternal obesity)	Scope out the existing services commissioned across Reading that translate as "assets" in a strategy and action plan to reduce obesity in adults and children in Reading and identify gaps and needs.	Public Health	
			Hold a stakeholder workshop as the starting point for developing an obesity strategy and action plan	Public Health	
			Establish an obesity strategy group	Public Health	
			Develop an obesity strategy and action plan	Puclic Health	

		Increase access and availability of specialist healthy lifestyle courses (exercise and nutrition)	Continued promotion and implementation of Eat for Health Programme with the opportunity being extended to include adolescents.	Melanie Benford??	

UPDATE REPORT ON PROPOSALS FOR STANDARDISED PACKAGING OF TOBACCO PRODUCTS

Purpose of Report

This report provides an update on progress in relation to Department of Health and the Devolved Administration's national consultation on policy proposals to require cigarettes packs and other tobacco packaging to conform to a standardised format.

Background

A review of research evidence (Moodie et al, 2011)[1] indicated that there is strong evidence to support the propositions set out in the Framework Convention on Tobacco Control relating to the role of plain packaging in helping to reduce smoking rates.

Specifically; the review suggests that plain packaging would reduce the attractiveness and appeal of tobacco products, increase the effectiveness of health warnings.

In addition, the studies in the review show that plain packaging is perceived by both smokers and non-smokers to reduce initiation among non-smokers and cessation-related behaviours among smokers.

A government consultation on proposals relating to plain packaging was held in the summer of 2012. A letter of response to the consultation was endorsed by the Cabinet on 16th July 2012. The consultation closed in August 2012.

Update on progress

At the time of this report, no information has been released summarising the contributions to the consultation or its findings. In May 2013 there was no mention of plain tobacco packaging in the Queens Speech.

A BBC interview by Jeremy Hunt on the day of the speech confirmed that no decision has been taken as yet.

Also in May 2013, a collaboration of professional bodies including the Royal College of General Practitioners, the Faculty of Public Health and the British Medical Association wrote an open letter to the Prime Minister expressing concern over the lack of progress (see attached letter)

In the meantime, the Scottish government have published a strategy that includes plain packaging. However they are awaiting the findings of the Coalition's consultation before making firm plans for legislation.

Dr Lisa McNally, Consultant in Public Health, Bracknell Forest Council

---

[1] Moodie et al 92011) Plain Tobacco Packaging: A Systematic Review, University of Stirling, 2011 http://phrc.lshtm.ac.uk/project_2011-2016_006.html

Smokefree ACTION
IT'S ABOUT HEALTH AND IT'S ABOUT TIME

Rt Hon David Cameron MP
Prime Minister
10 Downing Street
London SW1A 2AA

Thursday 2nd May 2013

Dear Prime Minister

Standardised "Plain" Packaging of Tobacco Products

We are writing to you on behalf of the Smokefree Action Coalition, an alliance of over 100 health and welfare organisations committed to reducing the harm caused by tobacco. We are extremely disappointed to read reports in the Sun newspaper (Thursday 2nd May 2013) that, at your initiative, the Government has abandoned proposals for legislation requiring tobacco products to be sold in standardised packaging. Such a step would seriously undermine the Government's credibility on public health issues.

Cigarette packaging is designed to be as attractive as possible to the tobacco industry's target markets, including young adult women and teenagers of both genders. The General Lifestyle Survey shows that two out of three smokers become addicted before the age of 18, and almost two in five before the age of 16. Cancer Research UK has used a government commissioned annual survey of youth smoking habits to calculate that in 2011 more than 200,000 children started to smoke. The number of new teenage smokers rises by an estimated 570 a day. Half of all lifetime smokers will die from disease related to their addiction.

Standardised packaging, as envisaged in the Department of Health's consultation document, would make tobacco packaging less attractive, increase the effectiveness of health warnings, prevent the use of misleading design to promote mistaken consumer beliefs about strength and quality, and remove any positive association with specific cigarette brands and images. The latest polling evidence suggests that nearly two thirds of the English public would support a standardised packaging. Experience of legislation on smokefree public places and the retail display ban also shows that public support would be likely to grow after the legislation came into force. The evidence overwhelmingly backs the case for standardised packaging.

The Sun story suggests that two factors may have influenced the reported decision not to proceed, first, the possible impact on the UK packaging industry, and secondly concerns about a possible rise in cigarette smuggling.

On the impact of standardised packs on the packaging industry, we understand from the British Printing Industries Federation that tobacco cartons account for less than 5% of all folding cartons produced in this country, and the total value of tobacco cartons

manufactured in the UK in 2011 was less than £50 million, so it is a very small part of our packaging industry (see enclosed brief for references). Standardised packaging would still of course need to be manufactured, so the actual impact on the packaging industry would be negligible and more than counteracted for by the positive effect on public health.

On the impact on illicit trade, all independent evidence, and in particular successive "Measuring Tax Gaps" publications from HM Revenue and Customs, shows that the level of illicit tobacco in the UK is falling, and not rising as industry funded reports regularly claim. The key security features present on existing packaging would also be present on standardised packaging, including covert anti-counterfeit marks and printed codes on packs. This argument is therefore also specious.

The UK Government has in recent years achieved a justified international reputation as a leader on tobacco control issues. This reputation could now be lost, as other countries follow the Australian example and introduce standardised packaging. Instead, the Government will be seen as having bowed to pressure from a well funded and mendacious tobacco industry campaign. It should be noted that one of the big four tobacco manufacturers, Japan Tobacco International, has announced that it is spending at least £2 million on this campaign, and the other three manufacturers are also heavily engaged.

Abandoning standardised packaging would be to miss a golden opportunity to take a further big step to cut smoking rates and the awful toll of death and disease that smoking causes would also have been missed. Many thousands of young people now starting to smoke will face painful and debilitating illnesses and shortened lives as a result. We cannot believe that this is an outcome that the Government is prepared to accept.

We therefore hope very much that the Sun report will prove inaccurate and that this important public health measure will not simply be abandoned in the face of tobacco industry lobbying. However, if you are not minded to proceed with the introduction of standardised packaging as Government policy, we would strongly suggest that Parliament be given the opportunity to determine this issue in a free vote. A clear precedent for this exists, since this was how comprehensive smokefree legislation was introduced, a measure which you have subsequently accepted has been a great success. We believe that Parliament would back standardised packaging if given the opportunity.

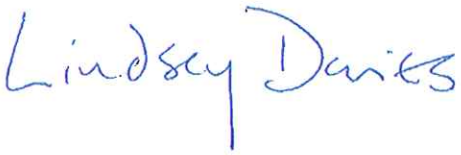
We would be happy to meet Ministers or your officials to discuss the matter further or to supply you with any further information or evidence you might require. We look forward to receiving your reply.

Yours sincerely

Dr Clare Gerada
Chair of Council
Royal College of General Practitioners

Janet Atherton
President
Association of Directors of Public Health

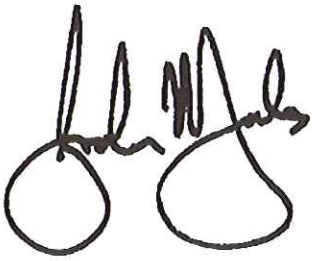
Harpal Kumar
Chief Executive
Cancer Research UK



Professor Lindsey Davies
President
Faculty of Public Health

Dr Peter Carter
Chief Executive and General Secretary
Royal College of Nurses

Dr Mark Porter
Chair of Council
British Medical Association



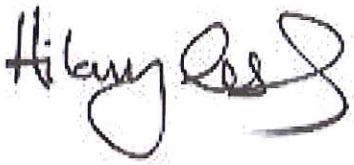
Graham Jukes
Chief Executive
Chartered Institute of Environmental Health

Penny Woods
Chief Executive
British Lung Foundation

Simon Gillespie
Chief Executive
British Heart Foundation

Francine Bates
Chief Executive
The Lullaby Trust

Sir Richard Thompson
President
Royal College of Physicians



Dr Hilary Cass
President
Royal College of Paediatrics and
Child Health

Deborah Arnott
Chief Executive
Action on Smoking and Health

Please respond c/o ASH, New House, 67-68 Hatton Garden, London EC1N 8JY

Pharmacy role in Heath and well being

1 Introduction

The purpose of this paper is to briefly explain the role of pharmacy in Health and well being and to inform the Health and Wellbeing Board how we are working with this key group to improve services within Reading

2 Contractual arrangements

Every day about 1.8 million people visit a pharmacy in England. The latest information shows that 99% of the population - even those living in the most deprived areas - can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport.

Community pharmacy plays a key role in delivering main line heath services through the dispensing of medication to the community. They represent a local focus for health care and the new contract that has been developed tries to develop a wider role for the highly skilled professional and the wider team.

Community pharmacy is contracted by NHS England and the local commissioner is the Thames Valley Area Team. Under the contract your community pharmacy will provide the following

Essential Services:

- The Dispensing Service - the number of prescription items dispensed by community pharmacies in England in 2008-09 was 771.5 million.
- The Repeat Dispensing Service - regular repeat prescription medicines direct from your local pharmacy for an agreed period of time,
- Disposal of Unwanted Medicines -.
- Promotion of Healthy Lifestyles - *pharmacy will also take part in local health promotion campaigns such as taking care in the sun and understanding the risks of long term conditions such as diabetes.*
- Signposting to other Services –
- Support for Self-Care -
- Medicines Use Reviews (MURs**)**. (An MUR is a consultation between the pharmacist and a patient that lasts approximately 10-20 minutes. It provides an opportunity for the patient to discuss how they use their medicines and to find out more about them; and the service is designed to supplement (and not replace) the more in depth clinical reviews that are conducted at GP practices.) Almost any patient can have an MUR consultation providing they have been using the pharmacy for more than 3 months and the pharmacist feels that the patient will benefit from the review.

Enhanced services

Similar to other primary care practitioners (e.g. GPs) in addition to the core service pharmacies have the opportunity through extra elements in their contract to provide additional services, these include first medicines review,

As well as national services provided by all pharmacies, the pharmacy contract also includes Enhanced services that are commissioned at a local level by the Primary Care Trust (PCT). Local examples of these services are:

- Emergency hormonal contraception services to reduce the incidence of unwanted teenage pregnancy;
- Minor Ailments Services to reduce waiting times in GP practices;
- Stop smoking services;
- Supervising consumption of Methadone and provision of Needle Exchange Schemes for drug users.

In the new system local enhanced services can be commissioned by the Area Team, the Drugs and alcohol commissioners or the public health team. Where the services were in place prior to the re organization the funds for these services were transferred to the new commissioners.

3 Opportunities for Health and Wellbeing

1) As part of Cross Berkshire Health promotion campaigns

Across Berkshire we have similarities in key heath promotion issues. The new arrangements for public health provides the opportunity for us to develop major campaigns for health promotion messages across Berkshire which will maximise the visibility of these issues by combining media, professional and community approaches, coupling this with local approaches . Part of the core services in pharmacy provides for them to deliver part of these key health promotion massages e.g. flu vaccination campaigns

2) Local enhanced services to tackle local issues

Within Reading pharmacies are commissioned to deliver a range of local services e.g. stop smoking, flu vaccination but we plan to work with pharmacist to develop opportunities for other services e.g. provision of NHS health checks, promotion of childhood immunization

3) In addition we aim to develop closer links between services and community pharmacies e.g. care of frail elderly - integrated care teams and the repeat medication services, new medication, self care and long term conditions.

4 Pharmacy Needs assessment

From 1st April 2013, every Health and Wellbeing Board (HWB) in England will have a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. These services are part of local health care and public health and affect NHS budgets.
PNAs are also relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies.
Applications are keenly contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly.

Firstly the HWB board will have a legal duty to check the suitability of existing PNAs, compiled by primary care trusts (PCTs), and publish supplementary statements explaining any changes. For example, since the boundaries of the PCT and HWB are not the same we will need to do a supplementary statement this summer.
We will need to ensure that that the NHS Commissioning Board and its Area Teams have access to their PNAs.
The HWB will need to publish its own revised PNA for its area by 1st April 2015. This will require board-level sign-off and a period of public consultation beforehand.
Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.

5 Delivery of opportunities

Within Berkshire the community pharmacists work together through the Local pharmaceutical committee, the DPH now attends this meeting to ensure that existing and opportunities for additional services are taken forward in Berkshire and also that local issues are addressed and taken forward for each Unitary Authority. This will allow us to develop common approaches to awarding of contracts, contract management and sharing of new approaches.

6 Summary

This paper briefly outlines the opportunities and duties in respect of pharmaceutical services and the approach to including this provider in our ongoing work. The HWB board is asked to note this update and agree to the approach for engaging with this professional group

Dr Lise Llewellyn

Strategic Director of Public Health for Berkshire

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, SOCIAL SERVICES AND HOUSING

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**21 JUNE 2013**	**AGENDA ITEM:**	**9**
TITLE:	**DEMAND AND CAPACITY MODELLING**		
LEAD COUNCILLOR:	**COUNCILLORS HOSKIN & EDEN**	**PORTFOLIO:**	**Health & adult social care**
SERVICE:	**HEALTH AND ADULT SOCIAL CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**AVRIL WILSON**	**TEL:**	**0118 937 4053**
JOB TITLE:	**CATHY WINFIELD DIRECTOR OF EDUCATION, SOCIAL SERVICES AND HOUSING** **CHIEF OFFICER**	**E-MAIL:**	**Avril.wilson@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report seeks to inform the Board of the highlights of a recent report into demand and capacity within the adult social and health care economy across the west of Berkshire. The report sets out some short term actions that will help to manage demand in Accident & Emergency services and unplanned hospital admissions. The report also seeks a delegated authority from the Board to pursue a bid to become 'pioneers' on an integration programme.

2. RECOMMENDED ACTION

2.1 Notes the results of a report on demand and capacity modelling across the local health and social care economy.

2.2 Notes and supports those actions already agreed to manage demand pressures within accident and emergency services and the numbers of unplanned admissions into hospital.

2.3 That the Director, acting in consultation with the Lead Members for Health and Adult Social Care, be delegated to coordinate a bid to become a 'pioneer' under the newly announced integration agenda. That the Chief

Officer for the CCGs similarly co ordinate activity on behalf of health partners.

2.4 To note that a range of partner organisations represented on the Health and Wellbeing Board have a key interest in this work and therefore delegates operational responsibility for delivery to the Berkshire West Partnership Board.

2.5 Requests that a further report on the Care Bill and integration agenda be submitted to the Board in due course.

3. POLICY CONTEXT

3.1 Over the spring period a number of local health and social care partners commissioned a major piece of work from Capita to:

- model the demand for health and social care over the next 5 years at Unitary Authority level
- build on the modelling work undertaken by Berkshire Health Care Trust
- provide a 5 year view of demand in the economy
- provide evidence based strategic service redesign options for health and social care commissioners.

3.2 The subsequent report is a lengthy document which is attached herewith at Appendix A.

3.3 The report identifies some trends at local level:

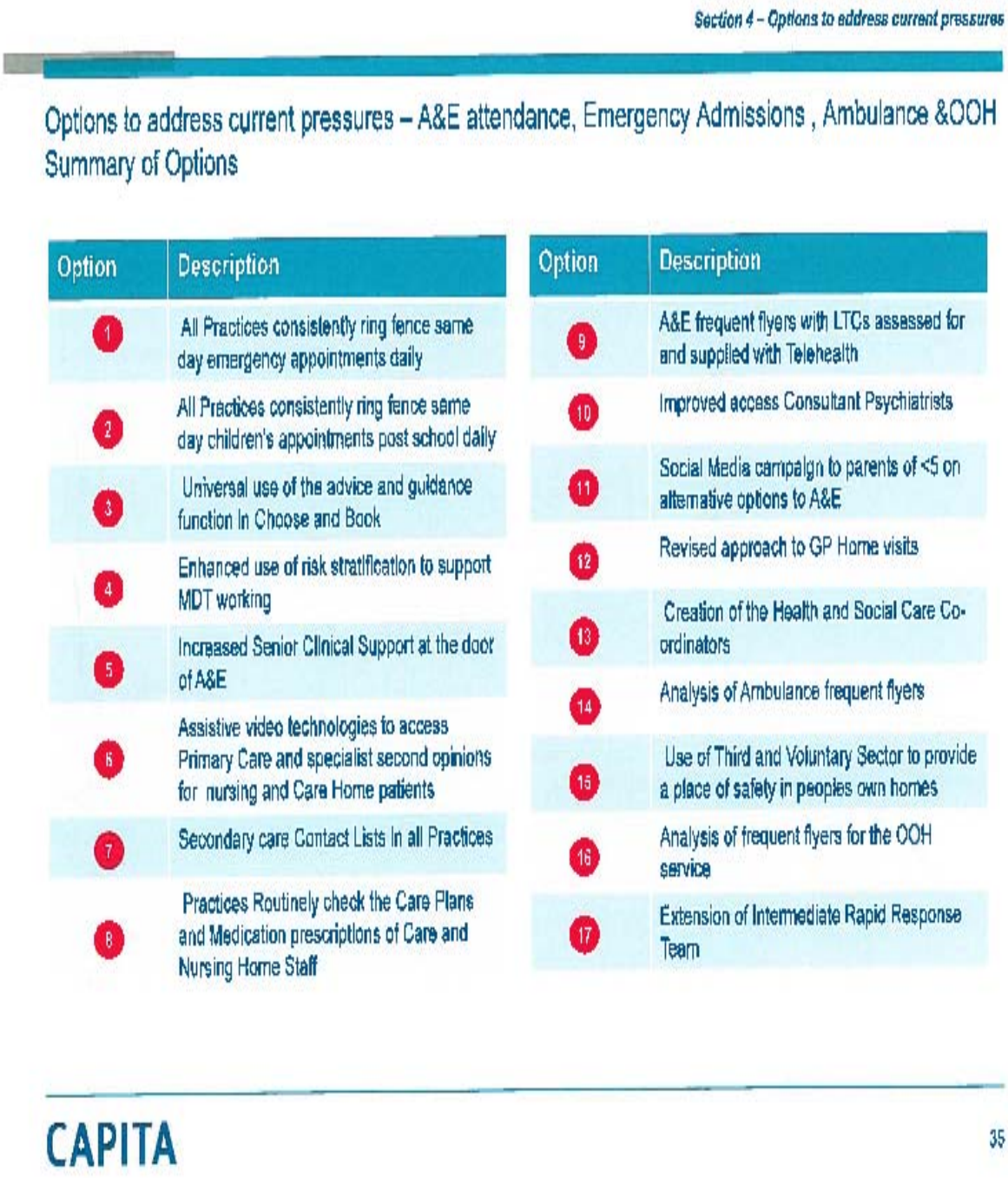
- Increased A& E attendances
- Increased use of OOH provision
- Increased demand for Ambulances
- Pressure on A&E capacity
- Increased demand for non-elective procedures

Many of these issues are not particular to the Reading area and reflect a national pattern of stresses at the 'front door' of A&E that has been subject of considerable debate.

3.4 The report goes on to conclude:

- The 'Do Nothing' option is untenable with demographic pressures alone likely to account for >7.5% average increases across services
- Current Demand and Capacity pressures (many of which concern emergency and unplanned care) must be addressed although the long and short term solutions are not necessarily the same
- The cultural and behavioural pre-conditions exist for fairly advanced levels of collaboration within and across the economy
- The economy is in a position to adopt a Whole System approach to working if the will can be marshalled

3.5 Partner agencies have met at executive level and have agreed 17 short/medium term actions to alleviate pressure in the system. These are set out below:



Section 4 – Options to address current pressures

Options to address current pressures – A&E attendance, Emergency Admissions , Ambulance &OOH
Summary of Options

Option	Description
1	All Practices consistently ring fence same day emergency appointments daily
2	All Practices consistently ring fence same day children's appointments post school daily
3	Universal use of the advice and guidance function in Choose and Book
4	Enhanced use of risk stratification to support MDT working
5	Increased Senior Clinical Support at the door of A&E
6	Assistive video technologies to access Primary Care and specialist second opinions for nursing and Care Home patients
7	Secondary care Contact Lists in all Practices
8	Practices Routinely check the Care Plans and Medication prescriptions of Care and Nursing Home Staff

Option	Description
9	A&E frequent flyers with LTCs assessed for and supplied with Telehealth
10	Improved access Consultant Psychiatrists
11	Social Media campaign to parents of <5 on alternative options to A&E
12	Revised approach to GP Home visits
13	Creation of the Health and Social Care Co-ordinators
14	Analysis of Ambulance frequent flyers
15	Use of Third and Voluntary Sector to provide a place of safety in peoples own homes
16	Analysis of frequent flyers for the OOH service
17	Extension of Intermediate Rapid Response Team

CAPITA

35

3.6 On 13 May 2013 the Government published 'Integrated care and support; our shared commitment'. This document sets out an expectation that there will be an integrated health and social care system in every locality by 2018. The document is not prescriptive as to how that is achieved but does set out an outcome framework against which organisations will be measured. Linked to

this initiative the Government has also called for bids to become a 'pioneer'. Pioneer status does not bring any additional moneys but would allow the local economy to draw down expert help and advice e.g. workforce development and financial modelling.

3.7 Partners are committed to developing a bid in order to take advantage of additional expert support. However, the simple fact of developing the bid will also help members of the Health and Wellbeing Board to, at single agency level and collective level, clarify and determine what vision they have for integration and their appetite for collective working.

3.8 The complexity of working across three Councils – with their separate HW Boards, with four CCGs and with the two provider trusts the HW Board is asked to delegate coordination of the bid to:

- The Director (in consultation with the lead Councillors for Health and Adult Social Care) on behalf of the Council
- The Chief Officer for the 4 CCGs

and to coordinate the work through the West of Berkshire Partnership which includes representatives from Wokingham and West Berkshire Councils and the two provider Trusts. Regular reports will then be made to the HWB Board in Reading.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Meeting the needs of vulnerable people as part of the strategic aim 'To promote equality, social inclusion and a safe and healthy environment for all'.

5.2 One of the main themes of the Sustainable Community Strategy is '*a fairer Reading for all*'.

5.3 '*Healthy People and Lifestyles*' as part of the Reading Local Strategic Partnership.

6. FINANCIAL IMPLICATIONS

6.1 Adult Social care is a demand led service. The Directorate has focussed on the development of preventative services that are designed to promote independent living and reduce the need for costly interventions such as residential care and acute hospital care. The Council's overall budgetary position is such that it cannot sustain a substantial increase in numbers of people residential care.

7. BACKGROUND PAPERS

Draft Care and Support Bill July 2012
Demand and Capacity Modelling report April 2013
Letter seeking bids for Pioneer status – 13 May 1023

LETTER INVITING EXPRESSIONS OF INTEREST FOR HEALTH AND SOCIAL CARE INTEGRATION 'PIONEERS'

To:

Local authority chief executives
Chairs of Health and Wellbeing Boards
CCG clinical leads
Provider CEOs across the social care and health system – public, private and voluntary

Dear colleagues,

The Government is encouraging all areas to develop their own reforms to public services. This approach involves all services and builds on experience from the community budget pilots supported by the Department for Communities and Local Government. A collaborative of national partners[1] has now set out an ambitious vision of making person-centred coordinated care and support the norm across the health and social care system in England over the coming years. ***Integrated Care and Support: Our Shared Commitment*** published today, signals how this national partnership will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better integration for the benefit of patients, people who use services, and local communities.

All localities need to develop plans for integration. There is no blueprint. While elements of different models will be transferable, every locality is unique and needs to develop its own model of integration to suit the needs of local people. But we know that delivering better coordinated care and support, centred on the individual, is difficult and that there are barriers at national and local level that are getting in the way.

The national partnership is therefore inviting expressions of interest from local areas to become integration 'pioneers' as a means of driving forward change at scale and pace, from which the rest of the country can benefit. We are looking for pioneers that will work across the whole of their local health, public health and social care systems and alongside other local authority departments and voluntary organisations as necessary, to achieve and demonstrate the scale of change that is required. The local area could comprise of the area covered by a particular CCG or local authority, or a larger footprint in which different authorities and health bodies work together to enable integrated services. What is important is that it would be at a scale at which a real difference can be made.

[1] Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

We will provide tailored support to pioneers. In return, we expect them to be at the forefront of disseminating and promoting lessons learned for wider adoption across the country.

National partner organisations are already working to clarify the scope and extent of the freedoms and flexibilities in the system. These will allow localities to innovate and develop their chosen models for integrated care and support. We will seek to address at local level any additional barriers that emerge as pioneers and other local areas push forward on integrated care and support, and we will assess whether any rules should be changed at the national level, as a result.

The attached annex sets out our vision for pioneers, the criteria and process for selecting them, and the offer of support from national partners, helping us succeed together in meeting our shared aspirations. As we want to enable and encourage local innovation[2], we would be interested to receive expressions of interest from commissioners and providers. This includes any that might not yet have all of the prerequisites in place but nevertheless have innovative ideas and proposals worthy of further consideration. Any gaps against the criteria could be addressed during the process of pioneer selection for inclusion in the first, or subsequent, cohorts.

If you would like to be considered to become a pioneer, please send an expression of interest, addressing the required criteria on no more than 10 pages, to pioneers@dh.gsi.gov.uk by 28 June 2013. This is the first call for expressions of interest, and we expect there will be further calls in future years as momentum builds and progress is made across England.

We are working closely with the Department for Communities and Local Government and the Public Service Transformation Network – a multi-agency organisation with secondees from across national and local government and local public services - to ensure that the health and social care pioneers programme is closely aligned and integrated with support that the Network will provide to local public services. If you have already submitted an expression of interest to work with the Network and wish also to be considered as a health and social care pioneer, please send an expression of interest. We will work with the Network to ensure that we take account of this as part of the pioneer selection process.

If you have any queries, please contact us at pioneers@dh.gsi.gov.uk.

We look forward to receiving your proposals.

[2] Innovation: "*An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied."* **Innovation, Health and Wealth (2011)**

Annex

Pioneers in integrated care and support: Selection criteria, process and national support offer

1. Introduction

In our joint publication today, ***Integrated Care and Support: Our Shared Commitment,*** a collaboration of national partners[3] has set out an ambitious vision of making person-centred coordinated care and support the norm across England over the coming years. We have signalled how we will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better person-centred, coordinated care for the benefit of patients and people who use services, their carers and their local communities more generally.

For the most ambitious and visionary localities, we will provide additional bespoke expertise, support and constructive challenge through a range of national and international experts to help such pioneers realise their aspirations on integrated care. This approach builds on the community budget pilots, which provided insights into co-designing integrated health and care at scale and pace. The pioneer programme will link directly with the development of a Public Service Transformation Network extending across government and participating localities.

We want everyone to innovate and we have highlighted in our publication today the freedoms and flexibilities in the system. We will seek to address at local level any additional barriers that emerge as pioneers push forward and we will assess whether any rules should be changed at the national level, as a result.

We aim to stimulate successive cohorts of pioneers, supporting them for up to five years. In return, we expect them to contribute to accelerated learning across the system.

[3] Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

2. Our expectations from pioneers

Within five years, we expect pioneers to:

- ➔ **be regarded as exemplars**:
    - deliver improved outcomes, including better experiences for patients and people who use services
    - tackle local cultural and organisational barriers
    - realise savings and efficiencies for re-investment

- ➔ **have used the Narrative developed for us by National Voices, in association with *Making it Real***, to help shape good, person-centred coordinated care and support for individuals in their area

- ➔ **have demonstrated a range of approaches and models involving whole system transformation** across a range of settings

- ➔ **have demonstrated the scope to make rapid progress**

- ➔ **have tested radical options**, including new reimbursement models and taking the risk of 'failure to integrate' in some cases

- ➔ **have overcome the barriers to delivering coordinated care and support**

- ➔ **have accelerated learning across the system to all localities**

- ➔ **have improved the robustness of the evidence base** to support and build the value case for integrated care and support

3. Selection criteria

Against this background, we are requesting expressions of interest from areas that wish to become pioneers. We will announce the first of these in late summer 2013.

We will not be prescriptive about the specific models for local adoption; it will be for localities to decide, based on their own judgements and circumstances. However, to be selected as a pioneer, we would expect a locality to satisfy six key criteria:

Primary criterion	Supporting considerations
Articulate a clear vision of its own innovative approaches to integrated care and support	This should include how it will: • adopt the Narrative developed by National Voices, aligned with *Making it Real*; • integrate around, and deliver better outcomes, including experiences for, individuals, families, carers and communities; • align with outcome frameworks; and • identify potential financial efficiencies for reinvestment; and identify potential measures of success.
Plan for *whole system* integration	This should encompass mental and physical health, social care and public health, as well as other public services, such as education, involving the community and voluntary sectors, as appropriate, across their local areas. The plan should include how the locality will deliver greater prevention of ill health and deterioration of health and personalisation through better integrated care and support. The plan should include those who would benefit most from person-centred, coordinated care and support, such as intensive users of services who repeatedly cross organisational boundaries or who are disproportionately vulnerable. It should also take into account how public services should be integrated with the unpaid contributions of families and communities.

Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area	This should include local executive and political leadership, staff groups, including clinicians, patient groups, people who use the services, carers and families. Areas will also need to demonstrate robust governance structures, including for information sharing, to sustain the approach, as well as a robust plan for engaging local Healthwatch, people who use the services, all staff groups and the public in local service reform. **The involvement and support of Health and Wellbeing Boards** (as a minimum, by the end of the selection process) will be an **essential prerequisite** for any area to become a pioneer.
Demonstrate the capability and expertise to deliver successfully a public sector transformation project *at scale and pace*	This might be evidenced by: • a proven track record in this area, strong local leadership and accountability; and/or • demonstrable and robust plans to address key local barriers to integrated care and support; and • risk management mitigation strategies, to maximise the likelihood of the area delivering its vision for integrated care and support across its locality.
Commit to sharing lessons on integrated care and support across the system	This would be expected to include involvement in peer to-peer (including clinicians) promotion, dissemination and learning networks.
Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence	This will include: • plans that have taken account of the latest available evidence; • understanding of the potential impact on the relevant local

	providers and intended outcomes; • a commitment to work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support across sectors; and • a commitment to participate actively in a systematic evaluation of progress and impact over time

4. Selection process

The selection process will be fair and transparent, whilst avoiding unnecessary bureaucracy. It will involve the following steps:

- Potential pioneers have six weeks to develop and return their Expressions of Interest, addressing the selection criteria above and not exceeding 10 pages in length. Expressions of interest can be submitted as joint applications, such as from a CCG and its local authority.

- In early July, the national partnership organisations will undertake an initial review of the Expressions of Interest. We will draw on additional sources of information, including the perspectives of local representatives of people who use services; information provided through the NHS planning round; information from CQC; any relevant information from Monitor and National Trust Development Authority; the recent ADASS/NHS Confederation survey of local authorities; and the selection of the new phase of community budget sites being run by the Department for Communities and Local Government as part of the wider Public Service Transformation Network.

- In mid-July, a Selection Panel made up of representatives from the national partners, three UK and three international experts will consider the Expressions of Interest and any additional information. The Panel will be chaired by Jennifer Dixon, Chief Executive of the Nuffield Trust (other panel members are being confirmed). The Panel will select any areas that meet the evaluation criteria in full or sift in any prospective candidates subject to receiving further information and clarification. National partners will obtain any additional information that might be necessary for the Panel to reach its view.

- The Selection Panel will make final recommendations to the national partners by the end of August, for their approval.

- The first cohort of pioneers will be announced in September 2013.

5. National support for pioneers

During the process of selection, national partners will discuss with pioneers their specific needs and proposed models of integration, and tailor their support accordingly. Based on what the system more generally has told us it needs from national organisations, the support that we envisage providing specifically to pioneers could include some or all of the following:

Capability Need	Support available
Changing the strategic/executive level culture	Organisational development Priority setting Action Learning sets Workshops, including peer-to-peer and champion support
Developing local payment systems	Payment design Contract design and models Cost collection Risk underwriting
Understanding the framework of rules on choice, competition and procurement	Clarification of rules and how integrated solutions can comply with them
Workforce flexibility	Employment law advice Workforce development
Public and professional opinion and engagement	Implementation of the Narrative National political support Engagement expertise
Analysis and evidence	Data and service audits Analytical support Financial modelling and health economics expertise to build the value case Evaluation expertise

In addition, we will:

- provide a dedicated ‘account manager’ as the main day-to-day point of contact with each pioneer to help them access the specialist support they need;

- draw together the current learning from literature and sites where integrated care has already been successfully adopted and other related initiatives, such as Year of Care implementer sites; and
- connect the pioneer sites through a strong community of practitioners to enable rapid and real time sharing of best and emerging practice across the pioneers, as well as more generally across the rest of the country.

Please submit your applications to pioneers@dh.gsi.gov.uk by 28th June 2013
If you have any queries or questions about the process these can also be submitted to pioneers@dh.gsi.gov.uk

Report from Dr Rod Smith, Chair of the CCG to the Health and Well Being Board Meeting June 2013

1. Introduction

I am delighted to present this report to the Health and Well Being Board.

The CCG formally assumed its statutory responsibilities on behalf of our local community in North& West Reading on 1 April. We are responsible for planning and commissioning hospital, community health and mental health services on behalf of our local community. The members of the CCGs are our 10 GP practices and we are committed to bringing the benefits of clinical commissioning to our local community. CCGs are a vital foundation of a new, clinically-led NHS that is focused on delivering improved health outcomes, quality, patient safety, innovation and public participation.

2. Board Meetings in Public

The CCG will hold Board meetings in public every second month. We have held two in public to date and were very pleased to have members of the public attend both meetings. I was also pleased to welcome Councillor Bet Tickner to the first meeting and Councillor Graham Hoskin to the second. At the end of each meeting we have an open question and answer session which I think has proved very helpful. I hope all members of the HWWB will be able to attend one of our future meetings this and look forward to welcoming you there.

3. Launch of NHS 111

NHS 111 was launched in Berkshire West on 15th M ay. The Berkshire service continues to be one of the strongest performing NHS 11 services in the country. The average number of calls answered within 60 seconds is above the national standard of 60 seconds.
The numbers of 999 dispatch numbers are also below the national average.
Daily conference calls are held with all stakeholders to monitor performance and resolve any operational issues. Weekly clinical governance group meetings also take place.

DR Andy Ciecierski, a GP Board member of North and West Reading CCG is the Clinical Lead for 111 across Berkshire.

4. Urgent and Emergency Care

North and West Reading lead on the Urgent Care Programme work on behalf of the 4 West Berks CCGs. There has been a lot of national publicity about urgent and emergency care recently and in response to this we have reviewed all of the joint work that we do with the

Royal Berkshire Foundation Trust, Berkshire Health Care Foundation Trust and the three Local Authorities to provide assurance to NHS England that we are taking the right measures across a patients journey through the emergency system. This focuses on three elements of the patient journey:

- Prior to arrival at A&E
- Whilst in hospital
- The discharge from hospital

A copy of the plan that was submitted to the Area Team of NHS England at the end of May is attached.

5. Introduction of Risk Stratification.

Dr Catherine Kelly, one of our GP Board members is the CCG Clinical Lead for the Long Term Conditions Programmer Board work which is led by South Reading CCG. Catherine is leading the work we are doing in N&W Reading on the identification and case management of patients identified as seriously ill or at risk of hospital admission. Catherine is also leading on a COPD project and details of this will be provided at a future Health and Well Being Board meeting.

6. Health and Social Care Integration Pioneers

On 14thMay the Government made an announcement about health and social care integration pioneers. We are preparing a joint bid with the other CCGs in the Berks West Federation, Wokingham, Reading and West Berks Unitary Authorities and our 2 major Providers, Royal Berks and Berkshire Healthcare Foundation Trusts to become a “pioneer”. This provides an excellent vehicle for us to take forward the work we have been doing with our health and social care partners and we look forward to having further discussion about this at the Health and Well Being Board in future.

7. Patient and Public Groups Engagement.

The majority of our practices have PPG's and these are strongly supported by the practice managers. At practice visits we also talk to clinicians and practice managers about what they are doing locally to ensure that their patient groups have the opportunity to influence services locally.

On 14th May, we jointly hosted with NHS South Reading CCG a conference to explore and share areas of best practice across the country in Dementia and Elderly care and to identify any gaps in services. The event was very well attended with representation from Local Health Services, charities, the voluntary sector, patients and carers.

We were also very pleased to support Carers Week and attended both information events on 19th and 12th June at Broad Street Mall and the Civic Centre.

8. Launch of Health Watch

I was delighted to be at launch of Health Watch on 17th April and give a presentation on the work of the CCGs. The event was very well attended and I look forward to our continuing engagement with Health Watch in future. We are encouraged by the way Health Watch is developing locally and see them as an important partner in helping us improve local health and healthcare.

9. Diabetes Care

We are working closely with our Federation Partner CCGs to improve diabetic care. We held a major educational event for our Clinicians at Wokefield Park and are providing training for all our practices in care planning, have a Diabetic Specialist Nurse for the CCG to support practices and patients and have improved training opportunities for diabetic patients to improve their own care. Results from the Diabetes Outcomes versus Expenditure Tool for 2011-12, published by Yorkshire Public Health Observatory show that North and West Reading CCG's outcomes for HbA1c compare favourably with other CCGs nationally and we have some of the best outcomes in the Country for cholesterol management in Diabetics. We expect these improvements to continue as all the improvements we are making to diabetes services feed through to the next DOVE survey and to the National Diabetes Audit.

10. Bowel cancer screening

One of the CCGs three local priorities for 13/14 is to increase the response uptake to invitations from the Bowel Cancer Screening Programme. Our practices are now sending out personalised letters to patients from their own known GP to those who fail to respond to invitations from the National Bowel Cancer screening program. We are aiming to increase uptake of this important National Screening campaign by at least 3% to exceed the National target of 60% by involving GPs in this way. Early detection of bowel cancer has massive benefits for individual patients in whom it is found.
The 12 month position for our practices up to Nov 12 is as below:

	Nov-11	Jun-12	Aug-12	Nov-12	3% target aimed for
BALMORE PARK SURGERY	56.7%	56.9%	59.3%	63.3%	62.3%
CIRCUIT LANE SURGERY	49.0%	55.3%	58.8%	60.0%	61.8%
MORTIMER SURGERY	62.5%	60.9%	63.5%	64.6%	66.5%
EMMER GREEN SURGERY	59.6%	58.1%	62.1%	66.4%	65.1%
PEPPARD ROAD SURGERY	54.8%	51.9%	54.0%	56.5%	57.0%

PRIORY AVENUE SURGERY	53.1%	55.1%	57.8%	58.9%	60.8%
THE BOAT HOUSE SURGERY	59.8%	59.4%	62.7%	64.6%	65.7%
THEALE MEDICAL CENTRE	48.0%	52.0%	56.5%	59.9%	59.5%
TILEHURST SURGERY PARTNERSHIP	52.8%	55.2%	56.6%	60.2%	59.6%
WESTERN ELMS SURGERY	46.3%	44.6%	46.2%	49.4%	49.2%
CCG Total	54.6%	55.5%	58.4%	61.1%	61.4%

This shows that we have already exceeded the end of year target agreed with the NHS Commissioning Board and we hope to build on this over the next 9 months as the impact of personalised letters from our GPs increases uptake further.

11. CCG Prospectus

The CCG has produced a Prospectus for 2013/14. This is a short guide that explains to our local community what the CCG is and the ambitions we have for our local population. It states our key priorities and outlines how the budget we have is spent.

12. CCG Website:

The CCG website is now up and running at www.nwreadingccg.nhs.uk.

Dr Rod Smith
7th June 2013

Annex A

Berkshire West Federation Urgent Care Programme Board
A&E Recovery & Improvement Plan
June 2013
V2.2

Ref	Action	Lead	Deadline	RAG Status	Comments
PRIOR TO A&E					
1	**Strengthening primary and community care for frail and elderly patients**				
1.1	Single Point of Access operating across the 3 localities ensuring ease of access to the most appropriate service.	Fiona Slevin-Brown	1-8-13	A	Single number available to RBFT by Jul-13
1.2	Enhanced Intermediate Care services: providing extended capacity and services 9am to 8pm 7 days per week.	Fiona Slevin-Brown	1-4-13	G	Service in place and being covered by interim staff whilst recruitment takes place. UCPB to monitor capacity.
1.3	Integrated care with community nurses/matrons in LTC management (includes 24 hour DN service).	Fiona Slevin-Brown	1-4-13	G	Part of the LTC model of care which includes risk stratification, integrated care and support to self-care.
1.4	ACG Care Co-ordination linked to new Directed Enhanced Service "*Risk Profiling and Care Management Scheme*" to be commissioned from GPs. This requires practices to have at least quarterly multidisciplinary meetings to review the management of patients who are predicted of becoming or who are at significant risk of emergency admission now or in the future. Patients must be identified using a risk stratification tool. These meeting will be held on a monthly basis.	Fiona Slevin-Brown & the 4 CCG Operations Directors	Jul-13	A	Start date Jul-13.

1.5	Enhance current respiratory and COPD pathway and introduce ESD for COPD patients, telehealth and increase pulmonary rehab provision.	Fiona Slevin-Brown	1-4-13	G	
1.6	Deployment of 25 extra telehealth units in the care of patients with heart failure providing preventative support in community settings.	Carolyn Lawson	1-4-13	A	Contract in place. Delay from provider in placing units – being escalated.
1.7	Improved access to EoL beds	Duchess of Kent (DoK)	31-10-13	G	Additional capacity at Duchess of Kent House.
1.8	Provision of disease specific EoL education to primary care and Nursing Homes. .	Fiona Slevin-Brown / DoK		G	Planning for education events commenced.
2	**Use of community diversion schemes**				
2.1	Expansion of Rapid Response services to provide 7 day a week access via a Single Point of Access.	Part of Enhanced Intermediate Care services (ref. 1.2)			
2.2	Extension of Specialist Community IV services to 7/7.	Fiona Slevin-Brown	1-4-13	G	In place
2.3	Development of pathway for Cellulitis and UTI.	Debbie Milligan and Fiona Slevin-Brown	30-09-13	G	
2.4	Pathway for subcutaneous hydration.	Fiona Slevin-Brown	30-09-13	G	Pathway for palliative care patients delivered by the Hi Tech team.
2.5	Pathway for oral vitamin K infusion.	Fiona	30-09-13	G	Pathway for patients to have

		Slevin-Brown			vitamin K infusions delivered by the Hi Tech team.
2.6	Pathway for rehydration via intravenous infusions.	Fiona Slevin-Brown	30-09-13	G	Scope to develop a pathway for patients not on the palliative care pathway who would benefit from this service.
2.7	Maintenance of 'App' and webpage providing details of all alternatives to acute admission.	Maureen McCartney	Ongoing	G	
2.8	Red Cross admission avoidance service operating extended hours from A&E – supporting the frail elderly in their own homes preventing avoidable admissions.	Red Cross	Funded for 13/14	G	
3	**Strengthening GP out of hours services**				
3.1	NHS 111 outcomes to be used to inform 'intelligent commissioning' of OOH Primary Care services.	Andy Ciecierski and Maureen McCartney	**Ongoing**	A	In addition to current quarterly monitoring of activity and outcomes with the aim of moving to outcome based commissioning model.
4	**Use of virtual wards in the community**				
4.1	Various 'Hospital at Home' initiatives in place including 7 day IV antibiotic service, 24/7 DN service, integrated Intermediate Care with extended opening hours.	Fiona Slevin-Brown	In place	G	
4.2	Wokingham CCG project on piloting a virtual ward linking in with the Community Geriatrician.	Debbie Milligan /LA/ Fiona Slevin-Brown	tbc	A	
5	**Support to care homes to avoid emergency referrals**				

5.1	Care Home work stream across BHFT/LAs/PC to co-ordinate the support to care homes bringing together provision of falls/dementia/continence and end of life care.	Fiona Slevin-Brown /LAs/PC	Rolling programme	G	
6	**Peer review of GP emergency admissions and A&E attendances**				
6.1	The Quality and Productivity Indicators in QOF have 48 points assigned to GPs reviewing data on emergency admissions, taking part in peer review of this data and the management and treatment of patients in three care pathways aimed at avoiding emergency admissions.	Maureen McCartney	Ongoing	A	
6.2	The QP and QOF indicators also have 31 points allocated to GPs reviewing data on A&E attendances, taking part in peer review of this data and each Practice developing an improvement plan that aims to reduce avoidable A&E attendances.	Maureen McCartney	Ongoing	A	
7	**Reducing ambulance conveyance rates**				
7.1	Continue focus on GP Triage scheme.	Keith Boyes	Rolling programme	G	Incentivised by CQUIN and recently re-launched by SCAS Berkshire.
7.2	Continue to ensure SCAS maintains links with BHFT and UAs and has direct access to alternatives to conveyance.	Keith Boyes	Ongoing	G	SCAS Berkshire have high rates of non conveyance.
7.3	NHS 111 will support process of directing patients to the most suitable service provider as per the comprehensive Directory of Services.	Keith Boyes	Ongoing	G	
7.4	Scoping work with Primary Care around same day access in General Practice and potential role of SCAS in supporting this.	Andy Ciecierski and Maureen McCartney	Scoping	A	

7.5	As part of the 13/14 contract SCAS are incentivised to deal with upto 30% of calls via 'Hear and Treat'. This will be achieved through employing GPs in their call centres to triage and where possible close calls with advice and providing improved training to staff.	Keith Boyes	13/14	G	
8	**Flow of GP Urgents**				
8.1	Use of the SCAS Urgent Care desk with dedicated resources to support the timely flow of GP Urgents into the acute.	Keith Boyes	Ongoing	G	Supporting rapid assessment and same day turnaround where possible.
9	**Patient education and support on alternatives to admission**				
9.1	Choose Well campaign run annually to coincide with seasonal pressures. Learn from best practice, in particular, Exeter.	CSU	Oct-13	G	
9.2	NHS 111 public launch (locally in addition to national launch scheduled autumn 13).	Keith Boyes	Jul-13	G	Patients requiring urgent care encouraged to call NHS 111 before accessing services.
9.3	South Reading CCG A&E project: work with A&E to collect data on inappropriate attendances, signpost/leaflets for patients and RAG rate attendances for practice follow up.	Elizabeth Johnston	Ongoing	A	
10	**Roll-out arrangements for NHS 111**				
10.1	Successful soft launch Berkshire West (high performance against KPIs and high levels assurance NHS England).	CS CSU/ CCGs	May-13	G	
10.2	NHSD switch off.	""	Jun-13	G	
10.3	Berkshire Public launch.	""	Jul-13	G	
10.4	Maintenance of comprehensive and robust Directory of Services.	""	Ongoing	G	
FLOW WITHIN THE HOSPITAL AND A&E					
11	**Prompt booking of patients to reduce ambulance turnaround delays.**				
11.1	New handover process and Standard Operating Procedures	Sue	Ongoing	G	SCAS reporting much improved

	in place at RBFT for ambulance handover	Edees/ Keith Boyes			position and RBFT meeting contractual target.
12	**Full see and treat in place for minors**				
12.1	Nurse led see and treat well established in A&E.	Sue Edees	Ongoing	G	
12.2	Nurse led see and treat to be established in AAU (Acute Assessment Unit).	Sue Edees			Pending approval of Business Case (28.5.13)
13	**Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed**				
13.1	Consultant delivered triage 0800 – 2200, 7 days per week.	Sue Edees	Ongoing	G	
14	**Prompt initiation of blood and radiological tests with rapid delivery of test result**				
14.1	Part of the STAR process: See, Treat and Refer, implemented at RBFT.	Sue Edees	Ongoing	G	
15	**Prompt access to specialist medical opinion**				
15.1	Develop fully functioning pathway with additional Acute Physician capacity on AAU.	Sue Edees			Pending approval of Business Case (28.5.13)
15.2	Functioning Elderly Care Physician of the Day model on AAU.	Sue Edees	In place	G	
16	**Full use of computer aided patient tracking and system for progress chasing**				
16.1	Part of functionality of new EPR system.	Sue Edees	30-09-13	R	Date of bed management functionality becoming operational to be confirmed.
16.2	Effective computerised patient tracking system in A&E.	Sue Edees	In place	G	
17	**Regular seven day analysis should be in place for rapid identification and release of bottlenecks**				
17.1	Expansion of Service Navigation Team to support team attending daily board rounds, next step plans for all patients, use of patient pathways and discharge check lists, early day discharge and increased use of discharge lounge.	Sue Edees	30-09-13	G	
17.2	System Resilience overview and Sitrep on a daily basis,	Carolyn	Ongoing		

	supplemented by system wide teleconference calls twice weekly.	Lawson/ Maureen McCartney			
17.3	Daily analysis of internal delays and blocks at RBFT.	Sue Edees	In place	G	
18	**Bed base management**				
18.1	Bed Management team in place and undertaking regular reviews of bed status and overview of patient flows.	Sue Edees	Ongoing	A	
19	**Daily Consultant ward rounds**				
19.1	Daily Board rounds in place on the majority of wards under Consultant supervision. Daily on AAU.	Sue Edees	Ongoing	A	
19.2	SNT Co-ordinators will work with doctors when planning treatments taking into account treatment and discharge schedules. They will drive the 'to do' list on each ward to reduce delays in diagnostics and referrals.	Sue Edees	30-09-13	G	Part of SNT Business Case
20	**Provision of specific services for patients groups such as those with mental health problems**				
20.1	Acute Mental Health Liaison Team commissioned to work with RBFT to support patients with a mental health need.	Maureen McCartney	Ongoing	G	
20.2	Scoping of strengthening support for dementia under way.	Fiona Slevin-Brown			
21	**Re-admissions**				
21.1	RBFT to share details of re-admissions with BHFT to enable a pro-active approach to preventing further re-admissions.	Sue Edees	30-06-13	G	
DISCHARGE AND OUT OF HOSPITAL CARE					
22	**Designation of expected date of discharge (EDD) on admission**				
22.1	Expansion of Service Navigation Team to support all patients	Sue	30-09-13	G	

	having discharge plan and EDD within 24 hours of admission (CQUIN)	Edees			
22.2	EDD shared with community and social care 48 hours in advance.	Sue Edees			
23	**Maximisation of morning and weekend discharges**				
23.1	SNT 'Safe Day of Discharge' – overseeing discharge, identifying potential problems on day of discharge, explaining medications, working with transport services	Sue Edees	30-09-13	G	
24	**Full use of discharge lounges**				
24.1	Discharge Lounge is open from 1000 to 1800 and staffed from 0945 Mon to Fri.	Sue Edees	In place	A	SNT works with the wards to identify patients suitable for the Discharge Lounge and book transport as required.
25	**Minimisation of outliers**				
25.1	RBFT have recently undertaken a bed configuration review and have ringfenced elective and non elective bed pools.	Sue Edees	In place	A	Rated amber as demand for NEL has led to medical outliers since the bed reconfiguration.
26	**Delayed transfers of care reduced**				
26.1	Service Navigation Team (SNT) commissioned to monitor delayed discharges of care and liaise with UAs to facilitate discharge.	Carolyn Lawson and Maureen McCartney	Ongoing	A	Rated amber as DToCs above target.
26.2	Daily 'Fit to Go' list generated by SNT detailing all patients awaiting discharge to another provider (including official delays). List widely circulated and system resilience escalation linked to triggers in terms of numbers on list and "days lost".	Carolyn Lawson and Maureen McCartney	Ongoing	A	Rated amber as DToCs above target.

26.3	RBFT project with West Berkshire UA on improvements to discharge flow.	Sue Edees / WBBC	30-06-13	G	
27	**Flexing of community service capacity to accept discharges**				
27.1	Additional flexible winter community bed escalation capacity to form part of BHFT contract 13-14.	Elizabeth Johnston	31-12-13		Planned rather than reactive opening of additional community inpatient capacity.
27.2	Community inpatient and CRT capacity reviewed on System Resilience teleconference when system escalated and capacity flexed to meet demand where possible.	Fiona Slevin-Brown	Linked to SR status	A	
28	**Reviewing continuing care processes**				
28.1	Implementation of report on CHC processes.	Gabrielle Alford / UAs			
29	**Assessment of use of reablement funding by local authorities**				
29.1	Regular monitoring and assurance via performance monitoring of Rapid Response and Reablement services.				Services offering extended hours and 7/7 working accessed via SPA.
30	**Patient Transport Services**				
30.1	In 12/13 the PCT/CCGs invested in a dedicated discharge crew for patient transport for the Royal Berkshire to manage on the day bookings and discharges. This service runs from 1000 to 1000 Mon-Fri and 1000 to 2000 Sat and Sun.				
SYSTEM RESILIENCE AND ESCALATION					
31.1	New process for determining internal system resilience status at RBFT and escalation actions required.	Sue Edees	May-13	G	
31.2	System status report and escalation status circulated daily.	Sue Edees	Ongoing	G	
31.3	List of patients clinically fit for discharge and awaiting onward care by another agency prepared by SNT and circulated 3 times per week ('Fit to Go list').	Sue Edees	Ongoing	G	

31.4	Escalation triggers based on numbers and beddays lost on Fit to Go list proposed and to be agreed.	UCPB	May-13	G	
31.5	Twice weekly system wide SR teleconference calls in response to escalation status – one operational and one strategic.	All	Ongoing	G	
CAPACITY AND DEMAND PLANNING					
32.1	Establish Steering Group and action plan based on the Capita work: Demand & Capacity modelling for the Berkshire West Health and Social Care economy April 2013.	Cathy Winfield	30-06-13	G	
EVIDENCE BASED BEST PRACTICE					
33.1	Complete ECIST programme of visits to Berkshire West and agree action plan based on recommendations.	Maureen McCartney and Carolyn Lawson	30-06-13	G	
33.2	Complete baseline assessment against best practice checklist contained within Urgent and Emergency Care: A review for NHS South of England, The King's Fund, March 2013.	Maureen McCartney and Carolyn Lawson	30-06-13	G	

Update for Health and Wellbeing Board

David Shepherd, Chairman-Healthwatch Reading Trustee Group

Transition to Healthwatch and Healthwatch Launch

The launch of Healthwatch Reading took place on April 17th. Over one hundred people attended the event and we received very good feedback. Healthwatch will be holding its Annual General Meeting on Monday 1st July. At the AGM Healthwatch will elect a new Board made up of twelve people. Healthwatch has also recruited two new part time Development Officers to join the team. We also have a new website, which can be found at www.healthwatchreading.co.uk.

Healthwatch Voices Forum

Healthwatch will be piloting a new forum for engagement and feedback with the voluntary sector called Healthwatch Voices. This will be a quarterly forum to engage with local voluntary sector organizations, support groups and community organisations.

The aim of the forum is to:

- A stronger collective voice
- Influence Policy making and decisions
- Better services delivered, owned and shaped by its users

It will have the following objectives:

1. Get feedback on key local issues in health and social care
2. Provide an interface for Providers and Commissioners
3. Deliver workshops or seminars
4. Provide a platform for networking and greater information sharing

Voluntary Sector Commissioning

A meeting was organised by representatives of the Voluntary Sector to discuss input into Healthwatch and the Health and Wellbeing Board and to highlight any current issues. Two key issues arose from discussions. Firstly the number of and level of support services that is available in the voluntary sector that can be utilised to assist in saving costs. Secondly the engagement of local people that can be achieved through greater involvement of the voluntary sector. Healthwatch will meet with voluntary sector representatives ahead of all Health and Wellbeing Board Meetings to discuss any issues that they would like to raise.

Healthwatch Workplan Plan 2013-2014

The projects that Healthwatch will be focusing on this year are laid out in the workplan below.

Project	Aim
1. The physical care needs of people with mental health issues, are they recognised and treated appropriately?	Gain a better understanding of how mental health services in the new health landscape and explore avenues for greater user involvement in shaping these services.
2. The transition from children's mental health services to adult mental health services.	Gain an understanding of the scope of this issue in Reading and make recommendations for service improvement.
3. The role school nurses play in mental health for young people	Engage with young people and understand the level of support for young people available in schools.
4. Promoting and distributing the Support after Suicide Booklet.	Support families and individuals dealing with suicide.
5. Health and Social Care integration. The emerging relationship between Health and Social Care e.g. Delayed transfers of care	Gain an understanding of the scope of the issue on Reading and make recommendations based on feedback.
6. Home Care Service User project	To involve users in shaping Home Care Services.
7. A&E co-design project with RBH	Improve Emergency Services at the RBFT through user involvement and engagement.
8. Outpatient Appointments	Improve the Outpatient Experience of users by working with the Outpatient Working Group at RBFT
9. Transport	Explore & Understand transport arrangements for residents who are visiting patients, who have out-patient appointments and being discharged from hospital. Including the mapping of transport services provided by community organizations across Reading which potentially provide extra transport for vulnerable people and highlight any geographical gaps.

healthwatch Reading

PPG Project

This project aims to support the development of local patient participation groups in GP surgeries across Reading. To engage members of the community in having an active voice in shaping local health and social services and explore ways to network the groups and work more closely with Healthwatch Reading. This is a one-year project from 1st April 2013, funded through the Partnership Development Fund.

Project Objectives	Project Outcomes	What will we do
1. PPG or patient feedback mechanism set up in every GP Surgery in Reading	Improved channels of communication between patients, commissioners and providers of services.	Development meetings with existing PPGs and identify areas for development. Carry out engagement events to encourage interest from the local population. Measure number of PPG/Patient Feedback mechanisms. Measure the number of people involved (at different levels).
2. Development of a mechanism to share information & ideas across PPG's, Healthwatch & Healthwatch Voices.	Improved health outcomes through patient focused provision.	Build ongoing relationships with N&W Reading Chairs Group and South Reading Patient Voice Group. Identify challenges and come up with responses & solutions. Measure the number of issues raised or feedback given.
3. Identify, collect and share best practice in PPG's.	Increased input of good quality feedback from the community to allow the shaping of services around patient needs.	Compile good practice documents. Measure the number of good practice resources developed.
4. Development of a toolkit with support information for PPG's.	Increased input of good quality feedback from the community to allow the shaping of services around patient needs.	Compile toolkit.

Suicide Support Information Booklet

Healthwatch Reading worked in partnership with local support organisations to produce a booklet for members of the general public who have been affected by the suicide of a member of their family. The booklet is currently going through final checks and will be ready for distribution in the next two months. The booklet was produced as part of a two-year project working with families who have been affected by the suicide of a family member. The feedback received highlighted the lack of support families received through this process. The booklet navigates families through the process highlighting where they can access support at each stage.

Home Care Users Research Project

We have just completed the project on Home Care Services in partnership with Reading Borough Council (RBC). In total we interviewed 57 people in their homes who receive Home Care. The aim of this project was to use service user input to shape the commissioning of these services. Their feedback will directly be used to shape Key Performance Indicators to be used by RBC in future commissioning. A summary report is in its final stages.

Joint Strategic Needs Assessment
Vision for Redesign

Public Health Services for Berkshire
Working together for the health and wellbeing of Berkshire

Background

- The Health and Social Act (2012) requires all Health & Wellbeing Board's working through local authorities and CCG's to produce a JSNA of the health and wellbeing of their local community.
- The Reading JSNA was developed in 2011/2012
- The JSNA needs to be refreshed in 2013

Current JSNA Feedback

Constructive

- Provides a comprehensive data source
- Provides clear overarching priorities
- Provides basis to commission services
- Provides information for the Health & Wellbeing Board

Challenging

- Cumbersome document
- Not "user" friendly
- Clinically focussed
- Confusing data (relevance of data to local area)
- Unable to "tell the local story" – snap shot of needs

Vision

The transfer of Public Health into Local Authority presents a new opportunity to create a new style JSNA.

The vision is to develop a JSNA that has the ability to:

- *Be accessible and web based*
- *Provide relevant, easy to disseminate data*
- *Tell the local story*
- *Use Ward data as a tool to plan for localised services*
- *Provide key stakeholders with data for commissioning intentions.*

Proposal for redesign

To adopt a phased approach for the redesign

Phase 1:
Develop a web based JSNA which tells the local story with refreshed data and newly created ward profiles

Phase 2:
Further develop the web based JSNA to link to key strategies across the Council

Phase 3:
Build on other local information/data to provide details of health and wellbeing inequalities

Phase 4:
Review and update

Time frame for Phase 1

- JSNA Workshop — 12th June 2013
- JSNA development & redesign — July - Oct 2013
- Web JSNA — Mid Nov 2013
- Formal launch of JSNA — By 1st Dec 2013

Proposal action for redesign

To develop an accessible web design:

- To provide information which is three clicks from a front web page
- To be clear and "user" friendly
- To simplify the navigation to access information and data

To provides relevant, easy to disseminate data:

- Refreshed data
- Clear data tables
- A range of options of viewing data i.e. script, graphs, tables, pictures

Proposal action for redesign

To have the ability to tell the local story:

- Which is easy to read and understand
- Evidenced based outcomes linked to the Health and Wellbeing Strategy
- Provides a snap shot of current activities/services and future plans

To present Ward Data as a tool to :

- Promote Ward level conversations based on evidence of needs
- Provides the facility to utilise Ward Data in promoting and planning localised services

Proposal action for redesign

To provide key stakeholders with refreshed data for commissioning intentions:

- Which has the ability to access detailed reports on specific issues, conditions and inequalities
- Provides comparison data
- Provides links to data source

JSNA Ward Profiles

- Use Ward data as a tool to plan for localised services
- Promotes Ward conversations based on evidence of needs
- Provides the facility to utilise Ward Data in promoting and planning localised services
- **Cautionary note on the use of Ward level data**

Suggested inclusions for Ward Profiles

- Population
  - Age/gender, ethnicity, population groups with specific needs
- Social and place wellbeing
  - Economy, environment, education, housing, crime
- Lifestyles and health improvement
  - Physical activity, alcohol, smoking, health improvement
- Health and wellbeing
  - Feelings of wellbeing, life expectancy, disability, cardio-vascular and respiratory health
- Service utilisation
  - Social care, health care
- Inequalities

Comments and Questions

Next Step

To agree the proposed phased approach to redesign the JSNA

Berkshire Public Health Shared Team
Working together for the health and wellbeing of Berkshire

From Norman Lamb MP
Minister of State for Care and Support

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,

NORMAN LAMB

We hope to publish progress around the country in reaching the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

Reading Health and Well Being Board Bringforward List

20 September 2013

- Changes in Dental Health Services (Dr Paul Batchelor from Public Health England to attend and give a presentation about the changes in dental health services for residents in Reading)
- Health & Wellbeing Strategy Action Plan – Update (Asmat Nisa)
- Update on Cancer Screening Group (Chris Cook - NHS England Area Team)
- Update on Immunisations (Chris Cook – NHS England Area Team)
- High Energy Drinks (Asmat Nisa/Kim Wilkins)
- Involvement of Children's Trust in HWB Board (Avril Wilson/Karen Reeve)

13 December 2013

- ?Health Premium Incentive Scheme – 2015 funding – once information is known (Rob Poole)
- Health & Wellbeing Strategy Action Plan – Update (Asmat Nisa)

21 March 2013

- Health & Wellbeing Strategy Action Plan – Update (Asmat Nisa)