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

10 July 2014

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 18 JULY 2014

A meeting of the Health & Wellbeing Board will be held on **Friday 18 July 2014 at 2.00pm in the Kennet Room, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

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

5. BETTER CARE FUND AND WIDER INTEGRATION AGENDA: UPDATE 34

A report on: the work of the Berkshire West Integration Programme and in particular developments with the Reading–specific projects which are described in the Reading Better Care Fund Submission; on the transfer of funds from the NHS to the Council and on how the Fund will help enable further integration.

6. SOUTH READING & NORTH & WEST READING CCG QUALITY PREMIUM TARGETS 2014/15 88

A report on the South Reading and North and West Reading Clinical Commissioning Group (CCG) Quality Premium Targets for 2014/15 and seeking retrospective formal approval of four of the six targets.

7. HEALTH & WELLBEING STRATEGY & ACTION PLAN 94

A report giving an update on the review of the Health and Wellbeing Strategy and action plan following a joint workshop on 2 April 2014 and subsequent feedback from local commissioners of health and social care, Councillors and representatives of partners.

8. WINTERBOURNE VIEW PROGRAMME UPDATE 107

A report giving details of the progress made on the joint improvement programme to support the discharge of people with a learning disability and/or autism from NHS in-patient settings, initiated in response to the Department of Health report "Transforming Care; A National Response to Winterbourne View". The report has appended a draft Joint Commissioning Plan for Services for People with Learning Disabilities and Challenging Behaviour.

9. BRIEFING ON REVIEW OF FUTURE NEED FOR SERVICES CURRENTLY DELIVERED AT THE READING WALK-IN HEALTH CENTRE 110

A report outlining the review and evaluation process of the Reading Walk-In Health Centre in Broad Street Mall being undertaken jointly with Reading Clinical Commissioning Groups prior to a decision on whether to re-commission the service provision post-August 2016.

Cont/..

../Cont

10. PROTOCOL AGREEMENT BETWEEN READING LOCAL SAFEGUARDING CHILDREN'S BOARD, HEALTH AND WELLBEING BOARD AND CHILDREN'S TRUST BOARD 114

A report presenting a protocol setting out the expectation of the relationship and working arrangements between Reading Local Safeguarding Children's Board (LSCB), Reading Health and Wellbeing Board and Reading Children's Trust.

11. ROYAL BERKSHIRE NHS FOUNDATION TRUST'S STRATEGIC PLAN 2014-19 122

John Taylor, Commercial Director at the Royal Berkshire NHS Foundation Trust will give a presentation on the Trust's Strategic Plan 2014-19. A copy of the summary of the Plan and the presentation slides are attached.

12. ROYAL BERKSHIRE NHS FOUNDATION TRUST – CQC INSPECTION REPORT 150

A report on the outcome of a CQC inspection of the Royal Berkshire NHS Foundation Trust and the Trust's plans for implementing a CQC Improvement Plan in response to the findings within the inspection report.

13. DATE OF NEXT MEETING – Friday 10 October 2014 at 2pm -

READING HEALTH & WELLBEING BOARD MINUTES – 21 MARCH 2014

Present:

Councillor Lovelock (Chair)	Leader of the Council, Reading Borough Council (RBC)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Hoskin	Lead Councillor for Health, RBC
Elizabeth Johnston	Chair, South Reading Clinical Commissioning Group (CCG)
Lise Llewellyn	Director of Public Health for Berkshire
David Shepherd	Board Member, Healthwatch Reading
Rod Smith	Chair, North & West Reading CCG
Ian Wardle	Managing Director, RBC

Also in attendance:

Hannah Budnitz	Senior Transport Planner, RBC
Helen Clanchy	Director of Commissioning, Thames Valley Area Team, NHS England
Zoë Hanim	Head of Customer Services, RBC
Eleanor Mitchell	Operations Director, South Reading CCG
Maureen McCartney	Operations Director, North & West Reading CCG
Clare Muir	Acting Policy Manager, RBC
Asmat Nisa	Consultant in Public Health, RBC
Rob Poole	Head of Finance & Resources (Financial Planning), RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Suzanne Westhead	Head of Adult Social Care, RBC

Apologies:

Councillor Rye	RBC
Councillor Williams	RBC

50. MINUTES & MATTERS ARISING

The Minutes of the meetings held on 13 December 2013 and 14 February 2014 were confirmed as correct records and signed by the Chair.

Further to Minute 33 of the meeting held on 13 December 2013, Lise Llewellyn reported that she had not yet circulated an update on the progress of the programme to offer screening for Abdominal Aortic Aneurysm (AAA) to all eligible men, but would do so.

Resolved – That Lise Llewellyn circulate an update on the progress of the AAA screening programme to members of the Board.

51. BETTER CARE FUND SUBMISSION UPDATE

Further to Minute 47 of the last meeting, Suzanne Westhead submitted a report on progress to date in developing an agreed plan for Reading for use of the Better Care

Fund (BCF), and seeking approval to a delegation in order to meet nationally determined timescales for the final BCF submission.

The report explained that the BCF provided for local funding for health and care services in ways which would take forward the integration agenda. The BCF provided an opportunity to improve the lives of some of the most vulnerable people in Reading who used health and social care services and the report reiterated the five schemes in the BCF submission.

Funding would be made available from NHS England in 2014-15 and then as local pooled budgets in 2015-16. In order to draw down the funding available through the BCF allocation, Local Authorities and Clinical Commissioning Groups (CCGs) had to submit agreed two-year plans for use of the BCF, which had to be approved by the appropriate Health and Wellbeing Board. The original submission had been approved at the last meeting and had been submitted by the 14 February 2014 deadline to NHS England and the Local Government Association (LGA). The final revised submission had to be submitted by 4 April 2014 but, at the time of writing the report, no formal feedback had been received on the original submission, making it impossible to produce an updated document for the Board to approve at this meeting. The final version would need to address any issues raised in the feedback.

The report therefore proposed that the Accountable Officer for the Berkshire West Clinical Commissioning Groups, jointly with the Director of Education, Adult and Children's Services, be authorised to approve the final BCF proposal for submission by the deadline of 4 April 2014, in consultation with the appropriate Lead Councillors. It stated that a copy of the submission would be circulated to all members of the Board in order to take into account any views or comments prior to the final submission of the BCF.

Suzanne Westhead reported at the meeting that formal feedback from NHS England had been received on 19 March 2014, which had indicated that Reading's five proposed schemes would be able to go ahead and had suggested areas in which more work needed to be carried out on the submission. This work was being undertaken currently.

Resolved -

(1) That the progress to date in developing an agreed BCF submission for Reading be noted;

(2) That the Accountable Officer for the Berkshire West Clinical Commissioning Groups, jointly with the Director of Education, Adult and Children's Services, be authorised to approve an updated Reading BCF Proposal for submission, in consultation with the Lead Councillor for Health and the Lead Councillor for Adult Social Care.

52. UPDATE ON JOINT WORKING TO SUPPORT CHILDREN & FAMILIES

Further to Minute 17 of the meeting held on 20 September 2013, Councillor Gavin submitted a report giving an update on the work of the sub-group set up at that meeting to progress opportunities identified across the Council's Children's Services and Public Health teams, the two Clinical Commissioning Groups and local health

services to strengthen joint working to improve health outcomes for children and families.

The report set out key achievements over the last six months and further developments planned, against the following four key themes, as well as areas of work where longer-term input was required:

1. Improved Awareness of Children's Services for GPs and Health Care Professionals
2. Education and Resources for Families
3. Opportunities for Awareness Raising and Making Contact with Families
4. Promotion of Immunisations

The report stated that an Action Plan had been developed to progress the identified opportunities (attached at Appendix A). The Action Plan identified leads for each of the actions, and individual agencies would be responsible for delivering against these and ensuring progress continued. It had been recognised that a number of the actions required dedicated resource to make progress and so South Reading CCG had employed a project manager on a short term contract to jointly support the sub-group. The project manager had begun in February 2014 and would work part-time for two months to drive forward work on a number of the priority actions.

The report proposed that the sub-group continued to meet on a quarterly basis, to maintain strategic oversight of progress against the Action Plan and monitor collective impact. The group could also ensure that any further opportunities identified by the Board could be aligned with existing work and included in the Action Plan as required.

Councillor Gavin proposed that the sub-group present a further update report to the Board in six months' time.

Resolved -

(1) That the progress made to date be noted and the further development of the work, as set out in the report, be supported;

(2) That the sub-group continue to meet quarterly to maintain oversight on ongoing progress against the Action Plan;

(3) That a further progress report be submitted to the Board in six months' time.

53. BEAT THE STREET UPDATE

Further to Minute 9 (2) of the meeting held on 21 June 2013, Hannah Budnitz submitted a report giving feedback on the 'Beat the Street' Caversham project that had been funded by a Transport service grant awarded to the company Intelligent Health to run a community-wide walking challenge throughout Caversham in summer 2013. The report also provided an outline of a proposed further 'Beat the Street' project for May 2014. Hannah gave a presentation on the Beat the Street projects, copies of the slides for which were appended to the report.

The report explained the background to Beat the Street projects as challenges to promote walking for health, using technology involving radio frequency identification

cards or keyfobs and strategically located on-street readers called 'beatboxes' to foster competition and record participants' walks. It gave details of the two previous projects in Reading, in three primary schools in Whitley in June/July 2012 and in three Reading secondary schools as part of a global schools competition in October 2012. In January 2013, the Council's transport team had launched a Challenge Fund to give grants for ideas to promote and increase sustainable transport and Intelligent Health had won a grant of £49,700 to run Beat the Street in Caversham.

The Caversham project had been run from June to September 2013 and had aimed to engage the entire community to collectively 'walk around the world'. It had included training for local GP practices to encourage participation of their at-risk patients, and individual prizes donated by local businesses and £3,000 worth of books donated to local schools and the library had been available.

There had been a high degree of engagement (20%), with 5,650 participants in total, both children and adults, who had collectively walked twice around the world in the three-month period, and the report gave details of the positive feedback received from schools, GPs, press and local businesses and of the post-project survey results. Both walking and cycling had been increased during the challenge and people had said that they intended to continue their behaviour changes after the end of the challenge. The evaluation of the Caversham project had not been able to provide evidence of sustained behavioural change or health outcomes, as these had not been measured, but the project's success in terms of participation, community engagement and enthusiasm had been undeniable and had caught the attention of local GPs.

The report provided an outline of a further 'Beat the Street' project which had therefore been proposed by the North & West Reading CCG, and was being funded mainly by the North & West and South Reading CCGs. The project board included representatives from the Council's transport and public health teams. The further project had been developed based on the positive reception of the Caversham project and a workshop provided by Intelligent Health to the CCGs, and was planned for May 2014 for the entire areas covered by the two CCGs (all of Reading Borough and parts of West Berkshire covered by North & West Reading CCG – a total population of around 180,000). It would be open to all, although children under 12 and certain categories of high risk patients would be targeted, and was intended as a preventative project to change habits and behaviours and increase physical activity in patients. The aim was to engage 20% of the total local population to participate in the event. A more thorough scope for evaluation was being developed based on the lessons learned from the Caversham project, to reflect the additional health goals and to enable an understanding of the longer-term outcomes. The potential for legacy projects in the future, using the beatboxes and/or back-office system, was also being investigated.

Hannah reported that the transport team was also working with the school expansion team to look at how the Council could best use the beatboxes it owned after the project and at how safer routes to school could be developed in conjunction with the school expansion programme.

Resolved -

(1) That the background to the Beat the Street walking challenges and the feedback and evaluation results for the Caversham Beat the Street Project, as summarised in the report, be noted;

(2) That the proposal for a further expanded Beat the Street challenge, funded primarily by the North & West Reading and South Reading CCGs with support from the Transport Strategy and Public Health teams within the Council, be noted.

54. TACKLING POVERTY IN READING

Clare Muir submitted a report on a Tackling Poverty in Reading Event which had been held on 19 November 2013 in order to give an insight into the current situation on poverty in Reading and identify specific practical actions that could be taken.

Appendix 1 provided a report on the event and Appendix 2 provided a list of the priorities for action identified and the pledges made through the event.

The report gave details of the event, which had presented key current local data, testimonies of people in poverty in Reading and perspectives from organisations working with people in poverty in Reading. Ten workshops had been held, including one on Health and Wellbeing; each workshop had been asked to come up with three priority actions and pledges had also been made. In most cases the workshops had been led by a partnership or organisation that would be a natural lead for each theme so that the actions would be taken forward as a matter of course by each partnership. Clare reported that Rod Smith, Chair, North & West Reading CCG and Kim Wilkins, Public Health Programme Manager, had led the Health and Wellbeing workshop. The report proposed that the Health and Wellbeing Board be the lead on the Health and Wellbeing theme of the Tackling Poverty Strategy.

The three Health and Wellbeing priorities for action had been identified as:

1. Health and wellbeing – to more effectively work together across sectors.

2. To promote closer working between agencies.

3. To improve access to information on health services, eg homeless.

Appendix 2 to the report listed all the priorities for action identified and pledges made, which had included seven Council pledges and over 50 community and partner pledges, and the report gave details of the implementation of the Council pledges.

The report explained that a draft Tackling Poverty in Reading Strategy and Action Plan would be prepared based on the priorities and pledges. The Tackling Poverty Delivery Partnership would oversee and monitor the development of the strategy and action plan, as well as the delivery of the priorities and pledges made at the event.

The report invited the Board to recommend health service representatives to join the Tackling Poverty Delivery Partnership.

Resolved -

(1) That the report be noted;

(2) That the Health & Wellbeing Board be the lead on the Health and Wellbeing theme of the Tackling Poverty Strategy;

(3) That Karen Grannum, CCG Manager for South Reading CCG, and a representative from North and West Reading CCG to be confirmed, be recommended as the health representatives on the Tackling Poverty Delivery Partnership;

(4) That, once the Tackling Poverty Strategy and Action Plan had been developed, it be brought back to a future meeting of the Board.

55. SEXUAL HEALTH PROCUREMENT

Lise Llewellyn submitted a report giving an update on the sexual health services procurement process being led by Public Health Berkshire on behalf of the six public health teams in the six Berkshire unitary authorities. The report had appended:

- Appendix 1 – a general description of sexual health/genitourinary medicine (GUM) services
- Appendix 2 – Sexual Health Needs Assessment - key facts about sexual health in Reading and details of the current pattern of services and providers
- Appendix 3 – some key findings from a Reading sexual health stakeholders workshop

The report stated that, following the transfer of public health functions to local government, the sexual health services contract had been reviewed, along with all public health contracts, and it had been agreed to put the contract out to tender in a collaborative approach across Berkshire, on the basis that a contract would be entered into with each unitary authority on the same terms and conditions, but with tailored specifications for each authority. Procurement and administration of the contracts would be undertaken by the core Public Health team based at Bracknell Forest Council, and the report gave further details of the governance of the procurement. Decisions relating to the procurement, clienting and monitoring of public health contracts applying to Reading had been delegated to the Director of Education, Adult & Children's Services, in consultation with the Lead Councillor for Health and the Public Health Consultant, at Policy Committee on 17 March 2014 (Minute 97 refers).

The report explained that a Sexual Health Needs Assessment had been completed, which had been presented to Reading stakeholders at one of six local stakeholder workshop events, where the current service had been reviewed and gaps and issues to be incorporated into the specification had been identified. A Berkshire-wide stakeholder event had been held on 26 February 2014 involving voluntary and community groups and the outcomes of all the events would be fed into the draft specifications, which would be circulated and consulted upon and the pan-Berkshire procurement would then be progressed. A timetable for the procurement and a summary of the risks relating to the procurement process, service disruption and finance were set out in the report.

Resolved – That the report be noted.

56. HEALTH & WELLBEING BOARD TERMS OF REFERENCE AND POWERS & DUTIES

Zoë Hanim submitted a report seeking approval to the following changes to the terms of reference and powers and duties of the Reading Health & Wellbeing Board:

(1) To give the Board additional powers and functions, concerning the local pharmaceutical needs assessment and the integration of health and social care functions.

(2) To agree that the Chair of the Board be transferred to the Lead Councillor for Health from the Leader of the Council, and that the Vice-Chair be appointed from the remaining councillors who were members of the Board.

The updated terms of reference and powers and duties of the Board were set out at Appendix A, with the new text shown in italics. The report explained that, if agreed, they would be introduced at the Annual Council Meeting on 11 June 2014.

Resolved -

That the amended terms of reference and powers and duties of the Board as set out in Appendix A be agreed, incorporating the following amendments:

(a) To give the Board additional powers and functions, concerning the local Pharmaceutical Needs Assessment and the integration of health and social care functions;

(b) To agree that the Chair of the Board be transferred to the Lead Councillor for Health from the Leader of the Council, and that the Vice-Chair be appointed from the remaining councillors who were members of the Board.

57. DATES AND TIMES OF FUTURE MEETINGS

Resolved –

That the meetings of the Health & Wellbeing Board for 2014/15 be held at 2.00pm on the following dates:

- Friday 18 July 2014
- Friday 10 October 2014
- Friday 30 January 2015
- Friday 17 April 2015

(The meeting started at 2.00pm and closed at 2.56pm)

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT & CHILDREN'S SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**18 JULY 2014**	**AGENDA ITEM:**	**4**
TITLE:	**UPDATE ON CHANGES TO SPECIAL EDUCATIONAL NEEDS PROVISION 2014 - 2016**		
LEAD COUNCILLOR:	**CLLR ENNIS/ CLLR HOSKIN**	**PORTFOLIO:**	**EDUCATION/ HEALTH**
SERVICE:	**INCLUSION AND SEN**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**CHRIS STEVENS**	**TEL:**	**0118 9372351**
JOB TITLE:	**SEN SERVICE MANAGER**	**E-MAIL:**	**Chris.stevens@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 At its meeting on 24 April 2014, the Adult Social Care, Children's Services and Education (ACE) Committee received the attached report (Appendix 1) on the position with regard to changes to Special Educational Needs (SEN) provision 2014-16 in relation to national changes due to start from September 2014, which will take up to three years to implement, and outlining the direction of travel required in order to meet the short and medium requirements of the Children and Families Bill. ACE agreed that the report be submitted to the Health and Wellbeing Board and that representatives of the Reading Families' Forum be invited to attend the meeting (Minute 33 refers).

1.3 The opportunity for improved partnership with parents will be at the heart of the work to implement the local systems which will be developed to meet the needs of local children and comply with national requirements. Ramona Bridgeman and Tara Robb, of Reading Families' Forum, gave a presentation on the parental perspective of having a child with special needs at ACE on 24 April 2014, and they will attend this meeting and repeat the presentation.

1.5 At its meeting on 7 July 2014, the ACE Committee received the attached update report (Appendix 2) on progress that has been made with regard to the development of the Special Educational Needs (SEN) strategy. There has been extensive consultation and the four priority areas have been agreed by Parents Forum, Schools, Practitioners and the Independent and Voluntary sector. An Action Plan has been drafted with LA officers and representatives of Parents Forum. This has been signed off by the SEN strategy group. The fully populated SEN strategy Action Plan will be circulated for information during September 2014.

2. RECOMMENDED ACTION

2.1 That the report/s and presentation be noted.

3. POLICY CONTEXT

3.1 It is imperative that the SEN strategy represents the holistic needs of children, young people (CYP) and their families. If CYP with SEN are to leave schools emotionally and physically healthy and able to transfer to either further training or employment, then both schools and communities need to work together to support and develop expert provision to meet needs.

4. THE PROPOSAL

Changes to Special Educational Needs (SEN) provision 2014-16

4.1 ACE agreed that the report attached at Appendix 1 should be submitted to the Health and Wellbeing Board because Education, Health and Care (EHC) plans will replace the current Statements of Special Educational Need (SEN) and Section 139a assessments and offer a single integrated plan from birth to 25. The plan will offer the same statutory protection to parents as the statement of SEN and will include a commitment from all agencies to provide their services. Implementation for this begins from 1st September 2014 with a three year transition period during which all current Statements will be re-written as Education, Health and Care (ECH) plans.

Presentation

4.2 The ACE Committee also recommended that representatives of the Reading Families' Forum be invited to attend the meeting to give the presentation on the parental perspective of having a child with special needs which was given at the ACE meeting.

Joint Commissioning Strategy

4.3 A joint health/council commissioning strategy for health provision for children with additional needs will need to be developed and a task group is working to establish a system for joint commissioning. It is anticipated that this work will be completed by April 2016.

The Local Offer

4.4 The Local Offer is a term introduced in the legislation and is used to describe a concept of both information and services that help families understand what provision is available to them in the local area. It has the following elements:

- early years
- school and college provision and transport to and from it;
- social care services available, including short breaks;
- health services, including speech and language therapy;

- how to access specialist support; and special and specialist school provision available – including training providers and apprenticeships.

4.5 The Local Offer is well on track for being in place by 1st September 14. All Reading's schools, Colleges, Nurseries are currently in the process of completing our on line questionnaire that will become their Local Offer as published within the Reading Local Offer website. They will complete this exercise by 7 July 2014. Similar on line questionnaires have been sent for completion to the Family Information Service, colleagues in Health, Voluntary Organisations and teams within RBC.

Education, Health & Care Plans

4.6 The national changes require Statements of Special Educational Need to be converted into Education, Health and Care plans by September 2017 and the Council has taken a phased approach to this, maintaining existing statements until their conversion.

4.7 The Education, Health and Care plan has been completed. Parents Forum and SEN /LDD leads across Berkshire have been involved with the creation of this plan. This has been led and coordinated by Reading. The agreed format has come after extensive discussions with families and with representatives from Local Authorities who have been appointed as Pathfinders to develop the Plan, the Local Offer and the process for the allocation of Personal Budgets.

4.8 The Education, Health and Care Plan has been signed off by our Health colleagues. Currently a trial is under way with two families and the SEN team to complete the Plan. This process will help to iron out any last procedural or content issues by 1 September 2014.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 As identified in the attached report/s to ACE.
The success of the SEN strategy will have a direct bearing on the future health and develop of these CYP. This will include both emotional and physical health.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 As attached. As will be noted there has been extensive consultation with community groups, families, Independent and Voluntary sector and Schools and Practitioners

7. EQUALITY IMPACT ASSESSMENT

7.1 As attached

8. LEGAL IMPLICATIONS

8.1 As attached

9. FINANCIAL IMPLICATIONS

9.1 As attached

10. BACKGROUND PAPERS

10.1 Report to ACE, 24 April 2014 - Update on Changes to SEN Provision 2014-16 (Appendix 1)

Report to ACE, 7 July 2014 - Update on Special Educational Needs Provision 2014 – 2016 (Appendix 2)

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT & CHILDREN'S SERVICES

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE**		
DATE:	**24 APRIL 2014**	**AGENDA ITEM:**	**2**
TITLE:	**UPDATE ON CHANGES TO SEN PROVISION 2014-16**		
LEAD COUNCILLOR:	**COUNCILLOR ENNIS**	**PORTFOLIO:**	**EDUCATION**
SERVICE:	**SPECIAL EDUCATIONAL NEEDS**	**WARDS:**	**ALL**
		TEL:	**0118 937 2094**
LEAD OFFICER:	**AVRIL WILSON**		
		E-MAIL:	**Avril.wilson@reading.gov.uk**
JOB TITLE:	**DIRECTOR OF EDUCATION, ADULT & CHILDREN'S SERVICES**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report follows from reports made in July 2013 and March 2014 which outlined four strands of a strategic approach to providing education support for children with additional needs. For ease of reference these priorities are as follows:

Priority 1: To ensure that Children and Young People with Statements of Special Educational Needs/Education, Health and Care Plans will have their education, health, social and emotional needs met from provision within the locality of Reading or neighbouring Local Authorities whenever possible.

Priority 2: Develop provision within Reading or in partnership with our neighbouring Local Authorities which reduces reliance on the most expensive and remote options.

Priority 3: Work with families to enable them champion better outcomes for their children.

Priority 4: Work with schools and other providers to make best and transparent use of the finances available to narrow the achievement gap for SEN children.

1.2 Following Royal Assent of the Children and Families Bill, this report provides an update of the current position in relation to national changes which are due to start from September 2014 and will take up to three years to implement. It outlines the direction of travel required in order to meet the short and medium term requirements of the Bill.

1.3 The national changes require statements to be converted into Education, Health and Care plans by September 2017 and the council will take a phased approach to this, maintaining existing statements until their conversion.

1.4 The opportunity for improved partnership with parents will be at the heart of the work to implement the local systems which will be developed to meet the needs of local children and comply with national requirements.

2. RECOMMENDED ACTION

2.1 Committee reaffirms its commitment to providing opportunities for children and young people with additional needs and recognises that children and parents must be at the heart of these changes.

2.2 Instructs the Director (DCS), acting in consultation with the Lead Member for Education, to ensure that Reading Council is able to meet the statutory requirements of the Children and Families Act that must be in place by September 2014. This includes a process for generating Education, Health and Care plans is in place and that RBC has published a Local Offer.

2.3 An action plan is written, co-produced with parents, setting out the direction of travel for officers, schools and parents to follow, this may require further decisions to be taken at policy level which will be reported to the Adult Services, Children's Services and Education committee in due course.

2.4 A short life working group of school staff, officers and parents publishes recommendations by the end of July 14 that define a system that ensures that SEN finances are delegated, allocated and monitored in a transparent way that meets the needs of the pupils and is understood and 'owned' by both schools and parents.

3. POLICY CONTEXT

3.1 Following consultation and feedback the Children and Families Bill was published in February 2013. The resulting Act received Royal Assent on 21 March 2014. The new legislation can be summarised thus:

1) *Education, health and care (EHC) plans* will replace the current Statements of Special Educational Need (SEN) and Section 139a assessments and offer a single integrated plan from birth to 25. The plan will offer the same statutory protection to parents as the statement of SEN and will include a commitment from all agencies to provide their services. Implementation for this begins from 1st September 2014 with a three year transition period during which all current Statements are re-written as Education, Health and Care (ECH) plans.
2) *Personal budgets* will become a legal right for families with an approved EHC plan if they request it so they can directly buy the support identified

in the plan. No date for implementation has been given but it is expected that this needs to be in place by September 2017.

3) *Joint commissioning* between Local Authorities and Clinical Commissioning Groups (CCGs) will be required for services for disabled children and young people and those with SEN. No date for implementation has been given but it is expected that a system for joint commissioning needs to be in place by September 2017.
4) *The "Local Offer"* has to be published so parents know exactly what is available including details of: early years, school and college provision and transport to and from it; social care services available, including short breaks; health services, including speech and language therapy; how to access specialist support; and special and specialist school provision available – including training providers and apprenticeships. This should be accessible from 1st September 2014.
5) Joint assessment procedures established across professional groups. This is a development issue with the expectation that professionals agree a format for carrying out outcome focused assessments that are based on the aspirations of a family and their child.

4. THE PROPOSAL

Current Position – National Requirements

4.1 The Berkshire SEN / LDD lead officers have been working together, along with parents and Berkshire Health agencies, to plan the operational delivery of the five requirements of the Children and Families Bill (as set out in section 3 above) across the geographic area to ensure a common approach as far as possible. The progress of that operational group is summarised below:

- There is an agreed format for the Education, Health and Care plan (EHCP). This is subject to minor local variations. It has been co-produced with families from Readings Parents Forum and Parents' forum across Berkshire. A process and timetable for producing these plans has been agreed. It is proposed to trial the new EHCP in Reading in May to seek operational feedback.
- A process for allocating Personal budgets is being developed with clarification of a process to be agreed by Christmas 2015.
- Similarly a task group is working to establish a system for joint commissioning. It is anticipated that this work will be completed by April 2016.
- Berkshire SEN / LDD lead officers have agreed to use one common system to 'operate' the Local Offer. This system is called Open Objects and allows all Local Authorities to populate a database platform that will allow families and professionals to both interrogate the system to seek answers to queries around Special Educational Needs and find information about what services are available. Reading is already using this system for information about Adult services.

4.2 The Department for Education has provided a one-off, grant allocation of £250k for the three years 2014-2017 to support the process of transition in the SEN system. This is in addition to the £75k provided in 2013-14 for support.

In order to meet our statutory obligation to convert, over three years, each current Statement into Education, Health and Care plans it is proposed that EHCPs will be created via the Annual Review process at the point of transition within the three years where possible. The new requirements build regular meetings with families into the Statutory Assessment process to ensure that they are more effectively involved in the process. The final meeting, chaired by the SEN team Officer (to be renamed Assessment Co-ordinator) will require parents and assessing professionals to co-produce the EHCP.

4.3 It is anticipated that the capacity of the current SEN team will need to be increased by 2 additional team members to meet the new requirements of the Statutory Assessment process and will need to be in place for the 1st September 2014.

4.4 The Local Offer is a term introduced in the legislation and is used to describe a concept of both information and services that help families understand what provision is available to them in the local area. It has the following elements:

- early years
- school and college provision and transport to and from it;
- social care services available, including short breaks;
- health services, including speech and language therapy;
- how to access specialist support; and special and specialist school provision available – including training providers and apprenticeships.

4.5 In order to have a published Local Offer by 1st September additional work needs to be carried out to create "pathways" for families to follow when they are seeking information. Currently the Local Offer database is being populated. Questionnaires have been sent to all providers for them to complete online and return. Schools have been provided with a system for completion of the questions and are expected to complete this by 7th July. Health Authority colleagues have also been asked to complete and return a questionnaire.

4.6 An additional project officer has been appointed to work with parents to complete the 'problem solving' pathway. These will be based on the most frequently asked questions that parents will be asked to generate and will be accessible from the 'Local Offer' service.

Current Position – Local Requirements

4.7 The Council has led a broad consultation exercise during late 2013 / early 2014 to collate the views and ideas of parents, schools, colleagues in health and the Private, Voluntary and Independent sector that would improve the effectiveness of the local SEN systems and approaches. Feedback from this exercise has focussed on:

- increased information sharing,
- common learning, and
- effective discussion forums underpinned by strong relationships.

4.8 A review of the local SEN funding approach by an external consultant has indicated that greater clarity is required in order to ensure that parents and

schools have a good understanding of how Special Educational Needs funding is allocated and the impact that it has on the child. To achieve this, we will have to establish systems for reviewing and monitoring both the cost and outcomes for our wide range of existing provision. It is anticipated that a short life working group of officers, schools and parents will propose recommendations for achieving this by the end of July 2014. The scope of the review will include both mainstream and special schools; formula funding factors; and the operation of the "top up" funding system. This will include a review of the quantum allocated to SEND in the mainstream school funding formula, along with the indicators used. Consideration will be given to introducing 'prior attainment' as an indicator of need alongside the more traditional 'deprivation' factor.

4.9 The Council will consider introducing the concepts of 'predictable and exceptional needs'. This will help schools understand more clearly the range of needs that they are expected to meet and identify more consistently, while those whose needs are less common or particularly significant and complex may still merit additional funding. The Council will also need to identify more transparently the budget it proposes to retain for exceptional needs and develop a collective approach to allocation/prioritisation. The budget could cover both individual allocations and additional support to 'inclusive schools' that need to draw more significantly on their delegated budget to meet the first element of funding for exceptional needs pupils.

4.10 The combination of both of these activities and the national changes will enable a strategic Action Plan to be drafted that outlines the broad direction of travel to follow. It is suggested that the action plan should include sections which cover the following areas:

- The implementation of the national requirements including statement conversion, starting in September 2014.
- Communication about the Local Offer and how families access provision from September 2014.
- Creating effective forums with schools and parents to share information and ideas which reports on the quality of provision for young people with additional needs.
- Create a leading partnership to shape local policy and provision over time which improves the outcomes for children with additional needs aged from 0-25.
- Develop an objective approach to the funding of effective provision to drive demonstrably improved value for money.

4.11 All the above activity areas, including the work on the assessment format has been co-produced with families represented by the various cross Berkshire Parent Forums. This has proved invaluable as the creativity of ideas and their engagement has been inspiring. This includes Colleges and Early Years settings. We will seek to build on the engagement so far in all future work.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This report directly contributes to a healthy population and the development of good educational attainment.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 There have been specific consultation events which have informed the proposals in this paper. Meetings have been held with families, mainstream schools, SENCO's and special schools along with colleagues from Health and the Voluntary sector, to seek their views on the organisational and financial aspects of the changes.
This culminated in a workshop attended by about 30 schools in early February and a schools and Special Educational Needs Co-ordinator and parents conference in March. At these events delegates were given an update on the national position, feedback on the required impact of the proposed strategic strands, asked to describe whet a good system would feel like to them and were provided with some tools to assess how aligned they are already to the new requirements.

6.2 The Schools Forum has been engaged in the development of this work and has appointed a sub-group to be part of the development of the funding approach required for improved clarity.

7. EQUALITY IMPACT ASSESSMENT

7.1 This report does not require an EIA as it deals with those people who already share a protected characteristic. An EIA will be undertaken as part of the development of the detailed action plan referred to in the main body of the report.

8. LEGAL IMPLICATIONS

8.1 There are no specific legal implications arising from this report.

9. FINANCIAL IMPLICATIONS

9.1 A grant of £250k has been allocated by central government to support the implementation of these changes and to ensure the effective communication with parents, carers, schools, voluntary organisations and young people themselves.

9.2 A number of the financial decisions required will either be: made by, or consulted on with, the Schools Forum as the expenditure is predominantly from the Dedicated Schools Grant. Recent regulatory changes require that more decision making is devolved to this group which reports in public.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT AND CHILDREN'S SERVICES

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE.**		
DATE:	**7 JULY 2014**	**AGENDA ITEM:**	**8**
TITLE:	**UPDATE ON CHANGES TO SEN PROVISION 2014 – 16**		
LEAD COUNCILLOR:	**CLLR ENNIS**	**PORTFOLIO:**	**EDUCATION**
SERVICE:	**INCLUSION AND SEN**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**CHRIS STEVENS**	**TEL:**	**0118 9372351**
JOB TITLE:	**SEN SERVICE MANAGER**	**E-MAIL:**	**Chris.stevens@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report follows the ACE Committee meeting April 24th 2014 at which the committee reaffirmed its commitment to providing opportunities for children and young people with additional needs and recognised that children and parents must be at the heart of these changes.

1.2 The local authority has to meet a number of statutory requirements of the Children and Families Act by September 2014 as set out in the ACE committee papers of April 24th 2014.

1.3 The council set out two immediate actions in April and this paper updates on progress towards those actions:

- A SEND strategy action plan is co-produced with parents and the Local Authority.
- A short life working group of Head Teachers and parents is established to agree a system for ensuring that SEN finances are delegated, allocated and monitored in a transparent way.

1.4 Appendix 1 details the current draft "Special Educational Needs and Disability Action plan" as co-produced so far and Appendix 2 contains the leaflet sent to all parents who have a child with a Statement of Special Educational Needs. It has also been distributed to all schools and preschool settings.

2. RECOMMENDED ACTION

2.1 That the Committee notes the progress made to date with regard to the actions previously agreed by the Committee.

3. POLICY CONTEXT

3.1 The national policy context was set out in section 3 of the previous report to the ACE committee in April 2014.

3.2 The ACE committee, in April 2014, noted that the first requirement for the local authority was to have systems in place for 1st September 2014 for both "the local offer" and for "Education, Health and Care plans for new claimants".

3.3 The Council committed to engage families as close partners in the development of both SEND strategy and provision and officers are expected to work actively to achieve this co-production.

4. PROGRESS

Action Plan

4.1 Based on the SEND strategy consultation document produced via a process of lengthy consultation with all stakeholders, a SEND action plan has been drafted by representatives from Parents Forum and Local Authority Officers. The draft action plan is currently being reviewed by officers, parents and schools ahead of completion and the version as at 13th June is included in Appendix 1.

4.2 This Action plan includes what needs to be done to meet the Statutory requirements of the Children and Families Bill. It also describes the objectives that need to be completed in order to meet the agreed 4 SEND strategy priority areas.

4.3 The Action Plan will be populated with owners and dates once the tasks listed under each priority area have been finalised. The Action Plan will then be circulated to stakeholders for information, an SEND action planning operations group will be formed and progress will be reported to both the SEND strategy group and ACE.

Mainstream Funding

4.3 A short life working group has been established to report, by the end of July, on a transparent system for the allocation of SEN funding beyond that provided in base budgets. This group consists of five primary school head teachers, one secondary school head teacher, three SENCOs, two Councillors and the external consultant who worked with schools and parents to seek their views around allocation of SEN finances. The group meetings are chaired by the SEN Service Manager.

4.4 The group have agreed to produce a draft procedure for consultation by 1st September 14. This procedure will initially introduce a process for the distribution of 'Top up' SEN funding for children and young people who have a current Statement of Special Educational Need. Over time it is envisaged that there will be a reduction in children with statements or plans, with this procedure offering additional resources for schools facing exceptional

demands. The budget reserved for the High Needs Block will not alter but it is expected that the working group will suggest a model of allocation that has greater Head Teacher accountability and ownership.

4.5 This group have representatives on the Schools Forum funding formula group who are considering changes to the formula for April 2015 and the representatives have already requested consideration of "prior attainment" be part of the next discussion.

Local Offer

4.6 The Local Offer is well on track for being in place by 1st September 14. All Reading's schools, Colleges, Nurseries are currently in the process of completing our on line questionnaire that will become their Local Offer as published within the Reading Local Offer website. They will complete this exercise by 7th July. Similar on line questionnaires have been sent for completion to the Family Information Service, colleagues in Health, Voluntary Organisations and teams within RBC.

Education, Health and Care Plans

4.7 The Education, Health and Care plan has been completed. Parents Forum and SEN /LDD leads across Berkshire have been involved with the creation of this plan. This has been led and coordinated by Reading. The agreed format has come after extensive discussions with families and with representatives from Local Authorities who have been appointed as Pathfinders to develop the Plan, the Local Offer and the process for the allocation of Personal Budgets.
The Education, Health and Care Plan has been signed off by our Health colleagues. Currently a trial is underway with two families and the SEN team to complete the Plan. This process will help to iron out any last procedural or content issues by September 1st 2014.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This report directly contributes to a healthy population and the development of good educational attainment.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 There have been specific consultation events which have informed the proposals in this paper. Meetings have been held with families, mainstream schools, SENCO's and special schools along with colleagues from Health and the Voluntary sector, to seek their views on the organisational and financial aspects of the changes.

7. EQUALITY IMPACT ASSESSMENT

This report does not require an EIA as it deals with those people who already share a protected characteristic. An EIA will be undertaken as part of the development of the detailed action plan referred to in the main body of the report.

8. LEGAL IMPLICATIONS

There are no specific legal implications arising from this report.

9. FINANCIAL IMPLICATIONS

9.1 A grant of £250k has been allocated by central government to support the implementation of these changes and to ensure the effective communication with parents, carers, schools, voluntary organisations and young people themselves.

9.2 A number of the financial decisions required will either be: made by, or consulted on with, the Schools Forum as the expenditure is predominantly from the Dedicated Schools Grant. Recent regulatory changes require that more decision making is devolved to this group which reports in public.

10. BACKGROUND PAPERS

10.1 ACE Committee paper – April 2014 – SEN Update
10.2 SEND Consultation Report – RBC – April 2014

Special Educational Needs and Disabilities (SEND) Action plan to address:-

The requirements of the Children and Families Act.
The 4 priority areas of the Special Educational Needs strategy post consultation.

The four priority areas are:-

Priority 1.
Every child including those with SEND in Reading should have their needs met, in Reading if possible, but the priority is to ensure that each child's needs are me.

This priority refers to establishing a range of specialist provision for CYP with Statements or EHCPs.

Priority 2. Develop provision within Reading, or in partnership with our neighbouring Local Authorities which reduces reliance on the most expensive and remote options.

This priority refers to establishing a range of provision and resources to intervene to support families and their children at Universal, Targeted and Individual levels (usually within the context of mainstream, college or preschool provision) and preventative / early intervention provision such as training programmes and working with young mothers. Both assume that interventions will include how we develop social capitol and community wealth as a way of developing skills and resilience.

Priority 3. Work with families to enable them champion better outcomes for their children.

Priority 4. Work with schools and other services to provide resources (this includes financial) in order that all children, including those with SEND, are given the opportunity to reach their full potential. This includes the development of their academic, social, emotional and communication skills.

This priority makes reference to clarity of resource allocation which includes 'SEN finances'.

Context. This draft action plan needs to incorporate both the changes required by the Children and Families Bill and RBC SEND strategy post the consultation process.

The consultation requests that the SEND Action plan include:-

1. The implementation of the national requirements
2. How we create effective forums with schools and parents to share information and ideas which report on the quality of provision for CYP with additional needs
3. The creation of a leading partnership to shape local policy and provision over time which improves the outcomes for children and young people with additional needs aged from 0 – 25.
4. How we develop an objective approach to the funding of effective provision to drive demonstrably improved value for money, raised standards and inclusion.

The consultation process has identified four recommendations.

1. There needs to be a much more coherent and joint up approach to pulling various initiatives together to avoid duplication and ensure information is fairly and easily accessible to all.
2. Develop neighbourhood SEND initiatives which will include all agencies including Private and Voluntary sector and incorporate the skills of the families within neighbourhoods.
3. To create more collaborative approaches to learning, development and capacity building based on audits of local need and strengths and RBC wide audits of trend.
4. That every child is in receipt of their entitlement to a full time education once they reach statutory school age.

Objective	Actions	lead	Evidence of Success / Outcome	Milestones	Comments
Meet the requirements of the Children and Families Act 2014					
Short and Medium national requirements resulting from Children and Families Act are met	1. Confirm the role of Assessment Co-ordinator. 2. Develop the skills to carry out this role. 3. Agree new statutory assessment process and timelines including role of Annual Reviews and where Personal budgets are initiated. 4. Convert all Statements into Education Health	CS CS CS CS	Current SEN team plus two additional members are renamed Assessment Co-ordinators. They chair AR and EHCP meetings. Timeline published and shared and agreed with parents (especially Personal budget decision making process) By August 2017 all current Statements converted	1st September August 2017	

	and Care plans. 5. Work with Practitioners to agree common assessment format with outcome focused assessments. 6. Resource allocation system agreed for allocation of Personal budgets. 7. Joint commissioning process and criteria for allocation of personal budgets agreed with Social Care, Health and Education. 8. Letters and information about the planned changes to be sent to schools and families who have a child with a Statement of Special educational need	CS CS and TF CS and TF JT CS	By December 14 all Practitioners use the same format Resource Allocation System agreed and practiced and implemented. Criteria for allocation of personal budgets agreed with all agencies. Resource management process in place in all school settings Letter and Booklet sent	December 2014 January 2015 March 2015 December 2014 May 2014	
Local Offer in Place by 1st September	1. Schools, providers and agencies(including Health) complete the statutory questions and send 'on line' to G.S. 2. Project officer to work with parents and G. S to develop pathways on the Open Objects data base based on the most commonly asked	CS TF	Local Offer in place via RBC website.	1st September 2014	

	questions regarding SEND issues. 3. LA sends schools document outlining what should 'normally be made available' at Universal, Targeted and Individual levels. 4. Annual reviewing cycle process agreed	CS CS and JT		November 2014	

Priority 1. Every child including those with SEND in Reading should have their needs met, in Reading if possible, but the priority is to ensure that each child's needs are me.

Objectives	Actions	Lead	Evidence of success/outcome	Milestones	Comments
To complete an audit of current needs and provision (including SPLD) against overall achievement, patterns and trends of exclusion rates, population trends and destination once leaving school. (via NEET information)					
Draft recommendations recorded in an action plan.					

Priority 2. . Develop provision within Reading, or in partnership with our neighbouring Local Authorities which reduces reliance on the most expensive and remote options.

Objectives	Actions	Lead	Evidence of success/outcome	Completion/review date	Comments
To establish 'wrap around' preventative services for children and families with a			(Need to make sure we link with Health, Housing and Transport)	)	

neighbourhood bias (such as via Children Centres) as appropriate and record in the Local Offer when established.			(Developing a commissioning strategy		
A lead is commissioned to coordinate the development of resources and provision to promote emotional health and social skills for those children who present with Social, Emotional and Mental Health issues leading to challenging behaviours.					
To work with all agencies, including Health, to ensure the correct level of skill and expertise is available to schools and families to assist in meeting the holistic needs of children with SEND.					
To create a spectrum of provision and a philosophy of practice that ensures full time education for all children with SEND, with the commitment that no children with a Statement /EHCP is					

excluded.					
Based on the Audit of need, develop the spectrum of provision and resource to meet the needs of CYP with ASD and with Social, Emotional and Mental Health issues.					
For schools to develop a range of skills and service to promote inclusion such as Move, TEACCH and PECS. This is to ensure that there are the skills to meet the predictable needs of children including those with ASD, SPLD, SEMH issues and Social Interaction and Communicatio n difficulties.					

Priority 3. Work with families to enable them to champion better outcomes for their children.

Forums for partnership working between Schools, Families and RBC are established	1. Parent / school's charter drafted. 2. Through Reading Families Forum to create parent support groups attached to every school via the work of a School Group Facilitator by May 15 3. LA and Parent's	CS CS and RB CS and RB	Charter in place and forums in place.	September 2014 January 2015 November 2014	

	Forum have agreed procedures for co-production and engagement				
Strategic Partnership responsible for shaping policy and provision for those between 0 – 25 who have additional needs is in place	Members to be identified with renewed terms of reference agreed at first meeting	CS	Dates of meetings agreed along with membership and chair	September 2014	
Communication strategy written, including improvements to RBC website					
Via the Local Offer and coproduced with families to provide clear consistent information for families of children with SEN.					
To develop a training strategy for all school staff and Governors that covers the spectrum of needs encountered in mainstream schools.					
Brochure written for families that describes Short Break provision available (including holiday clubs), criteria for entry and carers assessments.					
Priority 4. Work with schools and other services to provide resources (this includes financial) in order that all children, including those with SEND, are given the opportunity to reach their full					

potential. Potential means the development of their academic, social, emotional and communication skills.					
Procedures for communication, allocation and review of resources to meet the needs of CYP with SEN are in place	Short life working group of HT, Parents, LA is set up with timescales and terms of reference agreed at first meeting.		Communication strategy agreed and published. Leaflet written for schools and parents outlining allocation and reviewing process for all SEND funding both within schools and within specialist provision and specialist teams	October 2014	
Schools to agree a provision mapping and resource allocation process for all those children with SEND					

Your Child's Statement & the new Education Health & Care Plans

Reading Borough Council
Working better with you

The Government is reforming the way we work together to support children with Special Educational Needs and/or Disabilities (SEND).

The vision:

1. Children's Special Educational Needs (SEN) are picked up early and support is routinely put in place quickly.

2. There is greater control for parents and young people over the services they and their families use.

3. Parents know what they can reasonably expect their local school, college, Local Authority and local services to provide without having to fight for it.

4. Practitioners have the knowledge, understanding and skills to provide the right support for children and young people who have SEN or are disabled.

5. Aspirations for children and young people are raised through an increased focus on life outcomes, including employment.

6. For more complex needs practitioners will work together with families. This can lead to a single Education, Health and Care Plan that can be in place from birth to 25.

Special Educational Needs & Disabilities (SEND) 2014

How will this effect your child's Statement?

- From the 1st September 2014 we will not be writing Statements. We will be writing Education, Health and Care plans.
- We have three years (by September 2017) to change all our current Statements into Education, Health and Care plans.
- Education, Health and Care plans will have the same legal status as Statements.
- While we alter our Statements into Education, Health and Care plans your child's Statement will not change and will remain a legal document.

What are we going to do next?

- We have over 900 Statements to change into Education, Health and Care plans.
- We will change all these over three years.
- We will rewrite your child's Statement at their Annual Review to become an Education, Health and Care plan.

Therefore:

- Between September 2014 and July 2015 all the Statements for children with ***dates of birth before and including 31/08/00*** will be changed via their annual review
- Between September 2015 to July 2016 all the Statements for children with ***dates of birth between and including 1/9/00 - 31/8/04*** will be changed via their annual review
- Between September 2016 to July 2017 all the Statements for children with ***dates of birth including and after 1/9/04*** will be changed via their annual review

You do not need to do anything now.

- When we change your child's Statement into an Education, Health and Care plan we will contact you and your child's school. This will be done through the annual review process.
- We will be asking your child's school to arrange an Annual Review and will be sending them and you the new Education, Health and Care plan form that will be completed, with you, at the Annual Review.
- This will replace your child's Statement.
- The new Education Health and Care plan will be a legal document.

For more information please discuss with the Special Educational Needs Coordinator at your child's school.

Special Educational Needs & Disabilities (SEND) 2014

Reading Borough Council
Working better with you

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT AND CHILDREN'S SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**18 JULY 2014**	**AGENDA ITEM:**	**5**
TITLE:	**BETTER CARE FUND AND WIDER INTEGRATION AGENDA - UPDATE**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**MELANIE O'ROURKE / JEANETTE LONGHURST**	**TEL:**	**0118 937 4053**
JOB TITLE:	**RBC INTEGRATION PROGRAMME MANAGER / BERKSHIRE WEST INTEGRATION PROGRAMME DIRECTOR**	**E-MAIL:**	**Melanie.o'rourke@reading.gov.uk Jeanette.longhurst@wokingham.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this paper is to ensure that the Reading Health and Wellbeing Board is kept up to date with the work of the Berkshire West Integration Programme and in particular developments with the Reading – specific projects which are described in the Reading Better Care Fund Submission.

1.2 The report also notes the revised submission of the Better Care Fund based on the fact that Reading has been identified as a possible exemplar site.

1.3 Appendix A sets out the full schedule of Health and Social Care integration projects and work streams which Reading is part of.

1.4 This report is for the Reading Health and Wellbeing Board to agree to the transfer of funds from the NHS to Reading Borough Council. The report also set out how the fund will help enable further integration. See Appendix B.

2. RECOMMENDED ACTION

2.1 For the Health and Wellbeing Board to:

(a) Note progress to date on the development of Reading's Integration Programme;

(b) To note the content of the more recent submission as of 9 July 2014;
(c) Support the further integration work proposed; and
(d) For the Health and Wellbeing Board to agree to the transfer of funds from the local NHS to the local authority in order to deliver the integration projects described pursuant to Section 256 of the National Health Service Act 2006.

3. POLICY CONTEXT

3.1 The Better Care Fund (BCF) is intended to provide local funding for integrated Health and Social Care services and replace several funding streams previously directed into either the Health or Social Care system separately. The precise timing of how the BCF will proceed is currently under review nationally. However, Reading remains committed to the proposals approved in outline by its Health & Wellbeing Board in February 2014 and based on earlier work to integrate Health and Social Care locally.

3.2 While each locality in Berkshire West has submitted its own Better Care Fund plan, a number of the projects within the plans are shared across Berkshire West and are based on some earlier planning for integrated Health and Social Care coming out of the frail elderly pathway work. In addition, some of the enabling projects within the Berkshire West Programme include the Reading locality and will benefit the Reading specific projects.

3.3 In the summer of 2013 Reading Borough Council and the Reading Clinical Commissioning Groups (CCGs) responded to a Government call to become health and social care Integration Pioneers. The pioneer application was made as a bid across Berkshire West and included the other all four CCG which serve this area, Wokingham and West Berkshire Councils as well as the Royal Berkshire Hospital, the Berkshire Healthcare Foundation Trust and the South Central Ambulance Service.

3.4 Although Berkshire West was shortlisted, it was not chosen as one of the 14 pioneer sites nationally. However, preparing the pioneer bid generated a momentum around working together for better outcomes for individuals within a sustainable whole systems economy. The partners to the Berkshire West bid therefore agreed to establish the Berkshire West Integration Programme. This programme is intended to deliver integrated services for three distinct client groups: older people; children; and users of mental health services. The client group programmes are to be supported by a number of enabling projects such as workforce development and shared IT solutions.

3.5 The development of BCF bids for each of the localities covered by the Berkshire West Integration Programme has strengthened and focused the programme. The BCF drives joined up health and care services around the needs of vulnerable or elderly patients, so that people can stay at home more and be in hospital less. BCF proposals are required to meet certain national conditions and also to outline the specific projects intended to achieve agreed local objectives.

3.6 The Health and Wellbeing Board will also be aware of the enormous task the local authority has to meet its new statutory responsibilities within the Care Act. The synergies between the Integration Programme and preparation for Care Act implementation are being closely monitored and the opportunities to find added value and more effective solutions through integrated working are actioned.

3.7 In order to help other areas achieve deliverable and affordable plans and to demonstrate the importance Ministers, NHS England and Local Government attach to the Better Care Fund, agreed to fast track a number of plans for sign off and announcement in early July. NHS England and LGA have reviewed the plans received in April and identified 14 localities which are very close to meeting all the criteria for sign off. The Reading plan is among these. Following the success of this submission it is possible that Reading will be seen as one of the 7 exemplar sites.

3.8 Within the local integration agenda there is a commitment for close working across the whole of the West of Berkshire. For this reason, submissions for each locality across the West of Berkshire are to be submitted.

3.9 Given the level of work that has been undertaken across Health and Social Care since the initial submission officers across Health and Social Care have been able to provide NHS England with a greater level of detail, include a sense of delivery timeframes. We await to hear the outcome.

4. THE PROPOSAL

4.1 The Projects that sit under the Reading Better Care Fund proposal can be found in Appendix (A).

4.1.1 There are three Health and Social Care projects that are exclusive to Reading, all of which will have "Sam's Story" at the heart of the planning. Sam's Story is a tool developed by the Kings Fund to illustrate the potential and value of integrated care from the perspective of the patient/service user.

4.2 Increased Access to Intermediate Care (Full Intake Model).

4.2.1 Reading's current Intermediate Care Service focuses on the needs of people new to care services within Reading. The Full Intake Model is designed to offer a more inclusive service. The Service will:

1) Support people already known to Social Services who have a long term condition, and who would benefit from Intermediate Care. This would extend the service to people who may have had an increase in their level of need due to deteriorating health. They would have access to professionals who can reassess their needs and evaluate the benefits of providing equipment or helping the person to cope with a change in their condition so that they are able to remain as independent as possible. The multi-disciplinary team would then also determine a bespoke package of care to meet ongoing need.

2) At present, it is not always possible for someone to go home from hospital on a Friday, Saturday or Sunday due to difficulties in being able to secure appropriate care packages. By ensuring that all people leaving hospital receive Intermediate Care they will be able to leave hospital 7 days per week. Once the care needs have been properly defined, care agencies will be approached if ongoing care is required.

4.2.2 By utilising the Intermediate Care Service in this way, Adult Services will be able to support discharges from hospital through the week. This has two benefits - firstly, the individual will be able to return home as soon as they are well enough; and, secondly, this will free up the Royal Berkshire Hospital beds. We have now undertaken a scoping exercise and built up the details of this project. We hope to be able to help those existing service users by September of this year, and to provide a 7 day service from April 2015.

4.3 Time To Decide Beds

4.3.1 Choosing the right residential or nursing home placement is a very stressful event both for the person themselves and their families/carers. People can remain in hospital for longer than they have a medical need to be there whilst care homes are viewed, assessments are carried out by visiting care home staff, and financial arrangements are being set up.

4.3.2 This project aims to support people to move out of the hospital to a care home as an interim arrangement *whilst* these things are **explored** long term choice for the individual. By using a care home rather than a ward the individual will have a more comfortable environment with their own bedroom and bathroom whilst arrangements are made.

4.3.3 The aspiration across Health and Social Care is for the continuation of support from Physiotherapists and Occupational Therapists during this period to enable the individual to achieve their optimum independence when they eventually move on.

4.4 Full Integration of Intermediate Care

4.4.1 Reading has an established Intermediate Care and Reablement Service. The team works closely across different disciplines and one of the major benefits of the team is that staff are co-located. However, there are two organisational structures that are in effect. Some staff are employed by Reading Borough Council, with the associated management structures, terms and conditions and computer recording systems. The remaining staff are employed by Berkshire Healthcare Foundation Trust, again with different management structures, terms and conditions and computer recording system. This can make the service not as efficient and streamlined for the person receiving support and at times not as coordinated as it could be.

4.4.2 By fully integrating the teams, this would reduce the duplication of management structures, terms and conditions and computer recording systems, all of which will mean more time for the person receiving care. By doing this TUPE would apply.

4.4.3 Our first stage of work is to undertake a series of scoping exercises to explore the feasibility of this project.

4.5 Funding transfer from NHS England to Social Care - 2014/15

4.5.1 The report has established that the Better Care Fund is a substantial change for both the Health Service and local councils. To support this change the Government has made available to Reading Borough Council £2.513m which is an increase of £475k compared to 2013/14.

4.5.2 This funding is to support the Council and the CCG in the delivery of the BCF objectives in 2015/16. The summary of how this will be spent is as follows:

- Intermediate Care Team – additional capacity to support the Full Intake Model
- Additional staffing for the Reablement Team
- Project support for the CCG and the Council to model the new time to decide beds and the full integration of the Intermediate Care Service.

Detail of which can be found in Appendix B.

4.6 These objectives link back to the Better Care Fund plan submitted by the Council and the CCGs in April.

4.7 The reminder of the funding is planned to be allocated on much the same basis as in 2013/14 and the summary of this expenditure can be found in Appendix B.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 To develop services which keep the patient/service user experience at the heart of our planning, Health and Social Care need to work alongside people with direct experience of Health and Social Care services, their families, and other interested stakeholders. The recruitment to a new post of Community Engagement Officer to support Reading's integration proposals will be a huge benefit.

5.2 Reading's BCF submission has drawn on patient, service user and public feedback gathered recently across a range of Health and Social Care involvement channels, including the Home Carer User Interview Project (a joint RBC and Healthwatch initiative), the NHS Call to Action event and the 2013 Dementia and Elderly Care Conference. This feedback indicates a strong appetite for better integrated Health and Social Care, and also illustrates that maintaining independence and having choice and control over how they receive care is very important to the people of Reading.

5.3 There are several standing forums and mechanisms operating across Reading which bring together people using Health and Social Care services. Some of these focus on individual services, some on geography and some on particular health conditions or needs so that peer support is an integral part of the

group's function. The development of integrated care services will need to draw on all of these and facilitate sharing amongst them.

6. FINANCIAL IMPLICATIONS

6.1 Revenue Implications

6.1.1 The report sets out the key revenue issues for the Council and partners and also sets out the use of the Health Funding for 2014/15. As stated in paragraph 4.5.1 above, in 2014/15 Reading will receive a funding transfer of £2,513,343. The report sets out that the majority will continue to support the schemes identified in 2013/14, with the extra amount supporting the Council and the CCGs to develop plans and schemes to deliver the objectives and outcomes from, the Better Care Fund.

6.2 Capital implications

6.2.1 There are no capital implications for the 2014/15 funding allocation.

6.3 Value for money

6.3.1 In the review of any service, there needs to be a consideration of whether value for money is being delivered. The Council has undertaken over the last few years a number of transformational programmes which have improved outcomes for clients and the Council (e.g. Reablement Service).

6.3.2 With funding reductions for both Health and Social Care there will be a need to work jointly to determine effectively ways of services delivery which the closer integration of services should support.

6.4 Risk Assessment

6.4.1 For 2014/15 and beyond there are significant challenges in managing demand for services with an increasing elderly population against a backdrop of reducing resources. Integration of services will help to support this challenge but this comes with substantial challenges in two very different services coming together. This will require resources to deliver the change and some potential difficult issues to be tackled when funding is transferred in 2015/16.

7. LEGAL IMPLICATIONS

7.1 Under section 256 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) the Secretary of State has power (through NHS England) to make payments to a local authority towards expenditure in connection with any social services functions. Conditions can be attached to these payments. The two conditions applying in 2014-15 are that the payments be used to support adult social care services which also have a Health benefit; and that local authorities demonstrate how the transfers they receive will make a positive difference to services and outcomes. Beyond

these two conditions there is intended to be local flexibility in the way the funds are used.

7.2 These transfers are the first stage of introducing the Better Care Fund, which was announced in June 2013 and aims to promote integration between Health and Social Care, and will lead to a pooled Health and Social Care budget in 2015-16.

8. BACKGROUND PAPERS

8.1 NHS England Guidance

http://www.england.nhs.uk/2014/05/21/social-care/

Appendix A

Integration Projects	
Reading Specific Projects	
Time to Assess Service	Improved rate of discharge from acute care; improved experience of care; widening the options for older people when decisions need to be made; allows for appropriate plans to be made.
Full Access to Intermediate Care	An inclusive model of Reablement and Intermediate Care which will support those with long term conditions as well as those awaiting discharge from hospital. This will mean less unnecessary delays in hospital.
Full Integration of Intermediate Care and Reablement	This will be an enhancement on our current service and reduce duplication whilst at the same time creating a service that is more able to flex with the demands across Health and Social Care.
Berkshire Wide Projects	
Hospital at Home	Improved healthcare experience for Berkshire West patients; an integrated approach to care; reduction in unnecessary admissions; reduction in outpatient attendances; improved access to Intravenous Therapy; improved quality of life for patients; improved coordination of crisis management
Enhanced Service in Care Homes	The expected outcomes of this intervention are to avoid unnecessary acute admissions from nursing and care homes; to increase knowledge and continuity of health care for nursing and care home residents; reduced unnecessary non-elective admissions; reduced number of prescriptions; improved co-ordination of crisis management and improved end of life experience for patients through advanced care planning. There will be a reduction in acute hospital activity and associated costs. Providing proactive care and avoiding unplanned admissions for vulnerable people in Primary Care. Improve practice availability for all patients at risk of unplanned hospital admission; other clinicians /professionals will be able to easily contact the practice to support decisions relating to hospital transfers or admissions; regular risk profiling of at least two per cent of patients will result in a more proactive care management; one-to-one discussions with patients and their carers will enable holistic care planning that reflects their individual needs and wishes; proactive care and support, ensuring that patients have a named accountable GP and care coordinator; timely follow up by an appropriate professional when a person is discharged from hospital, ensuring that they receive coordinated care upon discharge.

Locality based integrated working	Patients will benefit from an integrated approach to care, care coordination and closely aligned, expertly led teams of professionals providing care closer to home. Establishing the neighbourhood teams will facilitate the development of resource targeting based on the ACG risk stratification tool described above, and combining this with local intelligence. The integrated team will identify and target patients most likely to benefit from a coordinated approach to their care as determined by practice profile and needs analysis. This community-based and pro-active approach will identify individuals at high risk of hospital admission, assess their needs, produce a personal care plan, agree a lead professional and ensure co-ordination of that plan, whilst caring for the patient at home.
Integrated Short Term Teams	Reduction in care home placements; decrease need for further intervention beyond Reablement; prevent admissions to hospital; facilitate timely discharge. Direct commissioning of Social Care by Health staff (West Berkshire only). Health staff are able to deliver efficient health and social care where changes in individuals needs require a rapid response; likely to reduce numbers of admissions to hospital.
Enabling Projects **In addition to the older peoples projects the programme is also running a number of enabling projects. These are seen to have a wider impact than just older people's services and will influence the shape of integrated arrangements.**	
Health and Social Care Hub	Active management of cases preventing people being lost between services due to differing referral criteria or lack of capacity. One single point of access.
Interoperability IT solution (shared care record)	Reduction of clinical errors; reduction in Duplication of work; reduction in Marginal Admissions; improved concordance with preferred place of care and use of NHS number by Social Care.
7 day access to Primary and Social Care	Greater access to Primary Care; Primary Care at the centre for managing long term conditions and frail elderly; 7 day access to Social Care; better patient experience; timely discharges; admission avoidance by access to appropriate care.
Market Management	Efficient use of market potential through integrated management; integrated innovative approaches to commissioning residential, nursing and domiciliary care; decreases in spend on commissioning.

Integrated Carers Commissioning	One approach to providers of carers support; making best use of integrated funding to meet agreed outcomes in each locality.
Engagement and Communication	Common engagement process; agreed internal and external communications; public and staff awareness leads to positive take up.
Whole Systems Organisational Development	An agreed understanding of the nature, structure and future direction of the integrated arrangements in Berkshire West; one target operating model one forward plan.
Finance & Personal Health and Social Care Budgets	Agreed joint protocols around whole system funding to include pooled budget arrangements; budget holder criteria; allocation of whole system savings; funding options; savings on whole systems work identified. One system of choice for patients and Social Care users.
Integrated Workforce Development	Shared understanding across all staff in all organisations of the benefits of working together and their role within the new arrangements; plan for appropriate recruitment and retention across the Health and Social Care sector; specific development of the generic care worker; the keyworker or case co-ordinator and whole system leadership; workforce capability to deliver new models of care.

Appendix B

Table 1 – Use of the remainder of the 2014/15 Health Transfer Allocation

	14/15 (£)	**NHS Analysis Area**
The Willows - Intermediate Care Services	347,812	Bed-based Intermediate Care services
Christchurch Court Assessment Flat	7,000	Bed-based Intermediate Care services
Charles Clore Court Assessment Flat	24,000	Bed-based Intermediate Care services
Intermediate Care Team	264,375	Integrated crisis and rapid response services
Community Reablement Team	923,975	Reablement services
Specialist Nursing Placements	109,494	Early supported hospital discharge schemes
Mental Health Reablement Team	150,000	Mental Health Services
Long Term Conditions	176,687	Other preventative services
Community equipment and adaptations	35,000	Community equipment and adaptations
Total to support Whole Systems Health Activity	2,038,343	

Remaining £475,000 to be allocated as per Section 4.5.2 of the main report

TRANSFORMING CARE

JOINT COMMISSIONING PLAN FOR SERVICES FOR PEOPLE WITH LEARNING DISABILITIES & CHALLENGING BEHAVIOUR

Wokingham Borough Council

Reading Borough Council

West Berkshire District Council

&

NHS Berkshire West Clinical Commissioning Groups (CCGS)

Final Draft

29th April 2014

Contents

Summary of Actions			
Improving Information			
Future JSNAs should separately identify people with learning disabilities with challenging behaviour/autism and mental health issues.	The local authorities and CCGs will collect information about services provided to children with challenging behaviour to inform planning and commissioning of services	The local authorities and CCGs will identify and collate information about people with challenging behaviour supported in the community to inform service provision and development.	
Improving Support Planning and Delivering Outcomes			
Health and Social services will ensure that all people who show challenging behaviour have appropriate support plans with clear outcomes and that services provided are appropriate to meet and achieve these.	Each local authority and health commits to reviewing all out of borough placements that they fund with a view to understanding if people wish to come back into the Berkshire area.	We will undertake more structured co-ordinated and integrated contract monitoring and service review process will be established to ensure services are meeting individual needs and outcomes and to inform wider commissioning activities.	
Improving Services			
The lack of behavioural specialists within CTPLD team will be addressed	NHS Berkshire West CCGs to examine need for and resourcing of case management for health funded placements.	Health and Social Care services will work together to develop integrated health and social care pathways to ensure timely access to appropriate services.	Each local authority and CCG will support the further development of service user led reviews and audits of services in their areas.
Improving Commissioning			
Transition arrangements between adults and children's services will be reviewed to ensure that challenging behaviour is clearly identified to inform future commissioning.	An integrated Berkshire West commissioning team will be established to ensure that gaps and overlaps between services to support children transitioning into adult services are removed and this group will ensure that people with learning disabilities have more choice and control over their lives.	Local Health and Social Care services will work together to develop clear joint health and social care commissioning pathways to ensure that appropriate services are commissioned to meet the needs of people with challenging behaviour.	Each Local authority and CCG will adopt clear criteria to identify when it is appropriate for an individual to remain in an out of locality placement. For those who wish to stay in that locality but who are in registered care settings we should also assess suitability for transfer supported living within that locality.
New Services and Market Development			
The CCG will aim to develop a multi-disciplinary team able to respond rapidly to provide crisis support in residential, supported living and domestic settings to reduce the need for hospital admissions.	The local authorities and CCGs will investigate commissioning of small, short term intermediate unit as a way of reducing hospital admissions and delayed discharges across the Berkshire health and social care economy.	The local authorities and health services will establish a project to plan for increasing capacity in the locality to meet increased need for supported living for people with challenging behaviour including availability of appropriately skilled staff.	
Improving Funding Arrangements and Value for Money			
Health and social care will collaborate to review the interpretation to the national eligibility criteria. Berkshire West has the lowest number of CHC funded patients with learning disabilities and challenging behaviour.	We will explore the possibility of developing the use of pooled budgets to enable easier commissioning of integrated packages of care which ensure that health and social care elements are co-ordinated to achieve agreed outcomes and deliver value for money.	High cost placements which do not achieve worthwhile outcomes for the individuals concerned should be identified and reviewed and, where necessary re-commissioned.	
Improving Support for Carers and Providers			
The local authorities and health services will seek a better understanding of carers supporting people with challenging behaviour through reviews and engagement and explore the availability of intensive community health input for carers support.	Health and social care will collaborate to understand the need for workforce development highlighting key issues.	A Provider engagement/forum/network will be established to enable providers, commissioners and other stakeholders to share good practice.	

Introduction

This strategy covers the three local authorities and Clinical Commissioning Groups which provide services in the west of Berkshire; Reading, West Berkshire and Wokingham, and has been written in response to the Department of Health's final report into the abuse at Winterbourne View - Transforming care: A National Response to Winterbourne View Hospital, which was published in December 2012.

The aim of the strategy is to ensure that we understand and are able to meet the needs of people within the area who have challenging behaviour. The strategy sets out common principles, aims and actions for the local authorities and CCGs but also indicates where particular local considerations or issues apply.

Table 1: Projecting Adult Needs and Service Information (PANSI) projections for people aged 18-64 with challenging behaviour for the three authorities is as follows.

Local Authority Area	2012	2014	2016	2018	2020
Reading	47	47	47	47	47
West Berkshire	42	43	43	43	44
Wokingham	44	45	46	47	48
Total	133	135	136	137	139

Although the numbers of people are relatively small and are not predicted to grow significantly we know that services for people with challenging behaviour can be difficult to commission in the immediate locality and that if we are to achieve our aim of enabling more people with challenging behaviour to be supported in the community we will need to improve our understanding of the needs of the individuals affected and extend and enhance services in a number of key ways.

There is a significant amount of literature on how services can be better designed, commissioned and delivered and there is also extensive expert knowledge locally which will inform how we develop services to ensure that people with challenging behaviour are appropriately supported and able to live as ordinary lives as possible in their communities.

The local stocktaking exercise required by the Department of Health following the Winterbourne View report showed that there are very few people placed in hospitals by the three local authorities and the local CCGs, and these people were all actively being assessed or receiving treatment. There were no people inappropriately in hospital as a long term residential option. It is our aim to maintain our good record on providing support, care and treatment in the right locations and avoid long term hospital stays where this is not appropriate.

This strategy was developed by a joint group comprising officers from the three borough councils, the Berkshire West CCG Commissioning Support Group, and the Berkshire Healthcare Foundation Trust to ensure that we work together to achieve this ambition.

Executive Summary

Despite the positive results from the Winterbourne View stocktakes there are a number of key areas where we have identified scope to further develop and improve services. These have formed the basis of an action plan set out in full on pages 31 to 32. In summary our findings are as follows:

Improving Information

We need to know more about the people with challenging behaviour that we support to better understand the needs of this group. This will be addressed through the local Joint Strategic Needs Assessments and collating information from reviews.

Improving Support Planning and Delivering Outcomes

Good support planning is key to delivering good outcomes. We will work to ensure that everyone has a person centred support plan with clear outcomes based around the principles set out in the Model of Care set out in the Transforming Care report. All placements will be reviewed and reviews will be better planned and co-ordinated.

Improving Services

We have a well-established Community Learning Disability team providing specialist support across the West of Berkshire but their ability to support people with challenging behaviour would be improved by the addition of a behavioural specialist. We also need to look at case management for heath cases and developing integrated care pathways to ensure people receive the right services.

Improving Commissioning

Identifying needs early is an important aspect of commissioning the right services. Commissioning services for younger people transitioning to adults' services offers a prime opportunity for this. We will also work to establish joint commissioning pathways to ensure we have the right services in place. Out of area placements will be reviewed to ensure that where appropriate people are supported to move back to the area.

New Services and Market Development

We have identified a gap in the availability of intensive support and will develop a multi-disciplinary team to provide this. A local short term intermediate support unit may also help reduce unnecessary hospital admissions and this option will be explored. We are also aware of the general need for more supported living options within the area.

Improving Funding Arrangements and Value for Money

Social Care and NHS agencies will work together to ensure that we share a common understanding of health and social care funding criteria. We will also look at using pooled budgets to deliver better integrated care. High cost placements will also be reviewed to ensure they provide value for money by delivering high quality outcomes.

Improving Support for Carers and Providers

People caring for a family member who has challenging behaviour are a vital and valued part of the support available. We need to ensure carers are properly supported. We also need to look at how better to support providers and customers. In this respect workforce development initiatives through training, advice and peer support networks will be developed.

Background

Transforming care: A National Response to Winterbourne View Hospital (The DH final report into the abuse at Winterbourne View) stated that:

> "By April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care (Page 9 Para 13)
>
> By April 2014: CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially 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) processes. (Timetable of Actions – 57)

This strategy has been developed in response to the above requirements to ensure that we have a clear and sustainable approach to the provision of care and support to people with challenging behaviour, built on agreed values and principles, and identifying specific actions to ensure all services are planned, commissioned and provided in accordance with the Transforming Care report Model of Care. This strategy draws on a number of other national reports and guidelines in addition to the Transforming Care Report as listed in Appendix 1.

Purpose and Scope

Purpose of the strategy is to set out how best Berkshire West local authorities and the CCGs will ensure that we have the right range of health, social care and housing services to meet the needs of Adults and Children with challenging behaviour to maintain the current position that no persons are inappropriately placed in inpatient settings on a long term basis and ensure that people in this group are supported to have lives that are as full and independent as possible.

The focus of the strategy will be on those people most at risk of admission to hospital or out of area specialist placements and how they will be supported to live as ordinary lives as possible in the community of their choice.

The strategy will set out commissioning principles, aims and actions and will identify the actions we need to take to ensure that assessment, care planning and commissioning activities will enable us to achieve this, together with the steps to be taken to develop the local care market and workforce to ensure the necessary services are available locally.

Values

The strategy is based on the principle that people who have challenging behaviour are entitled to live as "ordinary" lives as possible within their local communities, and should be at the heart of all planning and decisions concerning their housing, care and support. This means our focus will be on community based services which support people to remain in their local communities and services which reduce or prevent the need for higher level clinical and crisis intervention.

Principles, Aims and Intentions

This strategy is built on the Key Principles set out in the Model of Care in the Department of Health's report on Winterbourne View (Transforming Care). This is set out in full in Appendix 2.

The key elements of this model are that the individual and their family are at the centre of all support with the aim of 100% of people living in the community, supported by local services.

Services should be for all, including those individuals presenting the greatest level of challenge and services should plan and intervene early, starting from childhood, and including crisis planning. Services should be integrated and should focus on improving quality of care and quality of life and be provided by skilled workers. Where inpatient services are needed, planning to move people back to community services should start from day one of admission.

Services should deliver outcomes that result in people with challenging behaviour being able to say they are safe, treated with compassion, dignity and respect and be involved in decisions about their care. They should be protected from harm, but also have freedom to make choices and take risks.

People should get the right treatment for their conditions as well as being able to access good quality general healthcare. Where they have additional care needs, they get the support in the most appropriate setting and their care is regularly reviewed.

What do we mean by challenging behaviour?

In this strategy we have adopted the definition of "challenging behaviour" as used as in the Mansell Report which said:

> "The phrase "challenging behaviour" is used in this report to include people whose behaviour presents a significant challenge to services, whatever the presumed cause of the problem. Wherever it is used, it includes behaviour which is attributable to mental health problems.
>
> "As a working definition, that proposed by Emerson et al has been used
>
> > 'Severely challenging behaviour refers to behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities.'
>
> "When the term 'challenging behaviour' was introduced, it was intended to emphasise that problems were often caused as much by the way in which a person was supported as by their own characteristics. In the ensuing years, there has been a drift towards using it as a label for people. This is not appropriate and the term is used in the original sense."

The Royal College of Psychiatrists' Report on Challenging Behaviour (A Unified Approach) also proposed the following modified version of Emerson's definition

> "Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

The National Development Team for Inclusion (NDTI) Commissioning Guide further noted that

> "Some people prefer to use the term 'people who services label as challenging' to make this point about placing the responsibility with services rather than the individual".

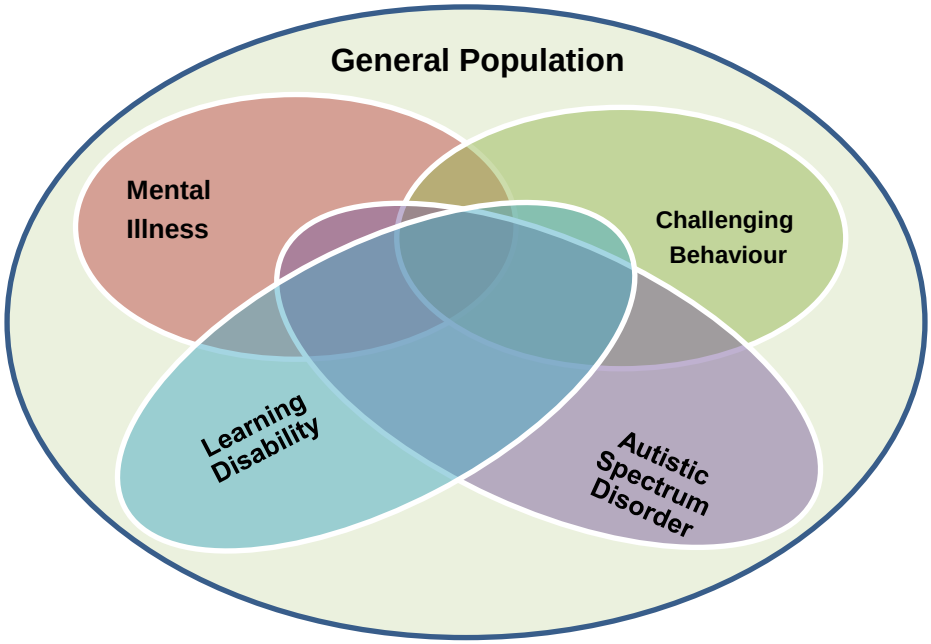
The Royal College of Psychiatrists' Report also noted that

> "..the term 'challenging behaviour' is socially constructed. The term represents the interaction of both individual and environmental factors, and the relationship between them"

The principles and aims of this strategy apply to all clients with learning disabilities but the main focus will be on this smaller group of people with challenging behaviour for whom appropriate services are difficult to find locally and where support needs to be more intensive and multi-disciplinary in nature. People in this group are at greater risk of admission to hospitals and other therapeutic settings, or to be placed in services outside the locality.

The Joint Commissioning Panel for Mental Health Guidance illustrates the relationship between challenging behaviour, learning disabilities and metal health problems as follows

Fig 1 Relationship between Learning Disability, Mental Illness, Autism and Challenging Behaviour



Although people with a learning disability are more likely to suffer mental health problems than the general population the numbers of people exhibiting challenging behaviour remain relatively small and a Royal College of Psychiatrists Report on Challenging Behaviour indicated that only between 10% and 15 % of people with a learning disability exhibit challenging behaviour which is likely to threaten their safety and quality of life and that of others.

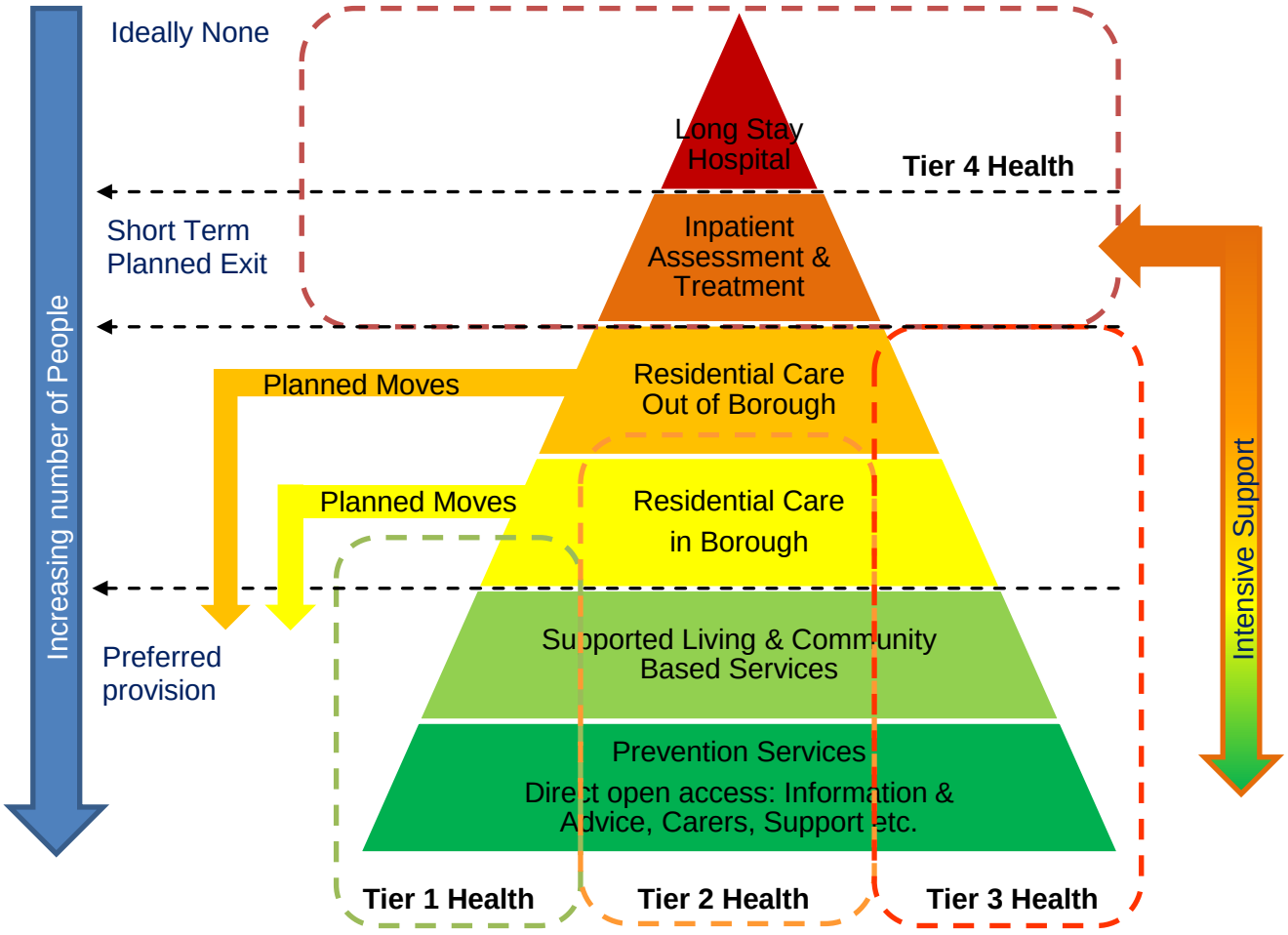
Despite individuals requiring high levels of need there is good evidence that people whose behaviour challenges services can be supported in the community in supported living settings with very good outcomes in terms of enhancing their quality of life and in many cases resulting in reducing the incidence of challenging behaviour. "Be Bold" published by NDTI and Think Local Act Personal (TLAP) includes a number of case studies which demonstrate this.

Accommodation, care and support therefore needs to be planned creatively across a wide range of professional disciplines and to be capable to responding to a wide range of fluctuating needs which may change dramatically at short notice, such as, for example, specialist multi-disciplinary intervention and crisis support to prevent admission or facilitate early discharge.

Accordingly we aim to develop joined up integrated services in which social care, health and independent service providers work closely together to a shared set of values and principles, and to ensure that each person's needs are well understood and that services are appropriate and responsive to those needs.

Local Model of Provision

Fig 2 Berkshire West planned model of provision



Health Services

- **Tier 1**: Primary care and other mainstream services meeting general health, social care and educational needs. There is some limited direct involvement by the community learning disabilities team and the psychiatrist.

- **Tier 2:** General community learning disability services. This includes specialist learning disability services. Services are mostly provided jointly between health and social services.

- **Tier 3**: Highly specialised community learning disability services. This includes areas of specialised needs such as challenging behaviour, pervasive developmental disorders and out-patient forensic services.

- **Tier 4:** Specialist in-patient services. It includes all specialist in-patient services for people with learning disabilities, ranging from local assessment and treatment services to high security forensic services.

Further details of health services in each tier are set out in Appendix 3

Patients who are currently living in the assessment and treatment units have been reviewed by Berkshire healthcare Foundation Trust to plan appropriate care in the community and these reviews have provided information about gaps in service to develop a joint health and social care strategic plan that will be submitted to NHS England in April 2014.

The evidence from the various reports following Winterbourne View indicate that the quality and models of service throughout the country vary widely and there has been an over reliance upon specialist services which may often be out of area, assessment and treatment hospitals.

The overall aim of the joint plan will be to provide better outcomes for people with learning disabilities with an assessed need, including mental health, by facilitating improved access to appropriate accommodation, opportunities for fulfilled and meaningful lives and access to healthcare services.

The plan will address gaps in the current provision of services in Berkshire and will focus towards the development of integrated and community based models of care thus making best use of joint working and networks of provision particularly in respect of supporting people to access mainstream services, including mental health services.

NHS Assessment and Treatment (A&T) units should only be for short term therapeutic needs and MUST not be used as a substitute for a residential provision. Residential care should only be required in a small number of cases and people in residential care should be supported to maintain and regain independent living skills and should be regularly reviewed with a view to moving into community based settings. Residential Care should not be arranged out of the locality except in exceptional circumstances and there should be a plan in place to facilitate relocation to local provision where this is the wish of the individual or the result of a formal Best Interest decision.

Where are we now?

Local Stocktaking

Stocktaking for the "Winterbourne View" review for each of the CCG area was as follows:

Reading

- For Winterbourne reporting purposes the return in September 2013 was **3**. One of these people has since been discharged. Of the 2 remaining people, **1** is placed within Southern Health NHS Foundation Trust assessment and Treatment services, **1** is placed in a rehab service in an independent hospital having been stepped down through the forensic pathway.

- During the period 2012/13, **1** person remained in an out or area independent rehab service (noted to be the responsibility of Wokingham CCG but Reading LA).

- During the period 2012/13, **2** people remained in out of area medium secure placements and 1 person remained in a high secure placement.

- During the period 2012/13, **8** people were treated within BHFT's assessment and treatment services and **5** were discharged. The average length of stay was 219 days which included a person a total stay of 529 days of which 148 days were noted as a "delayed discharge".

West Berkshire

- For Winterbourne reporting purposes the return in September 2013 was **1**. This person is placed within BHFT's assessment and treatment services.

- During 2012/13, **8** people were treated with BHFT's assessment and treatment service. A further person was admitted from the area but the responsibility of Slough LA. **6** people were discharged within 2012/13 and the average length of stay was 155 days. This included one person who was noted to as a "delayed discharge for 54 days.

- During 2012/13, **1** person was placed in an independent hospital out of area rehab placement.

- During 2012/13, **1** person remained in a low secure and **1** person remained in a high secure placement out of area.

Wokingham

- For Winterbourne reporting purposes (i.e. numbers of people who placed in hospital who are **not** receiving active treatment) the return in September 2013 was **nil**.

- During the period 2012/13, **2** people continued in an out of area long term rehabilitation placement remaining under Section 3 of MHA Both are Wokingham CCG's responsibility; the Local Authorities responsible were Hillingdon and Reading.

- During the period 2012/13, **1** person remained out of area in medium secure and **1** person in a low secure setting.

- During the period 2012/13, **6** people were treated within BHFT's assessment and treatment services and **5** were discharged during this time. The average length of stay for Wokingham people was 404 days which included a person with a total stay of 822 days of which 423 days were noted as a "delayed discharge".

Joint Strategic Needs Assessments

The Local JSNAs have little data on prevalence of people with learning disabilities and mental health problems or challenging behaviour. This needs to be addressed. The development of registers as proposed in the Winterbourne Report should help to address this and future JSNAs should look at the needs of this group separately from the larger group of people with learning disabilities as their needs are in many ways significantly different and require higher levels of specialised support.

West Berkshire Council's JSNA for People with Learning Disability 2012/11 indicated that there were 69 people who exhibited behaviour that challenged services and 86 people with complex needs. This document also notes that there were 71 young people in the Transition group (13 -17 yrs) who were placed in schools outside area. (Not all of this group however will exhibit challenging behaviour).

ACTION: Future JSNAs should endeavour to identify people with learning disabilities with challenging behaviour/autism and mental health issues.

Local Health Services

Health Services for Children and Young People

Current commissioning arrangements

There are currently no young people aged 14+ in Berkshire who meet Winterbourne View criteria and are funded by health. There are a number of young people who are placed out of area by Local Authorities whose CAMHs treatment is funded by CCGs under Responsible Commissioner rules and provided in the locality where the child is placed. However none of these young people currently meet the WV criteria.

Looked After Children's teams in Berkshire are responsible for maintaining the health care plan for each Looked After Child, even when a child is placed out of area. BHFT are commissioned to carry out all Looked After Children's reviews within a 20 mile radius of the Berkshire border. Outside this radius, the local community provider is commissioned to carry out the review.

Psychiatric adolescent inpatient care is now commissioned by NHS England. There are no Tier 4 units in Berkshire. Some young people in such provision in the future may meet the WV Criteria. Although the CCGs are no longer statutorily the 'Responsible Commissioner' they continue to maintain an overview of cases via a weekly report provided by BHFT and Specialised Commissioning. BHFT remain involved in cases to ensure efficient repatriation processes across Health, Education and Social Care. Case management sits with NHS England specialised commissioning- this function ensures the placement continues to meet the young person's needs and plans for re integration back into community

In Berkshire, Children's Continuing Healthcare funding is accessed via an assessment process in line with national guidance and a multiagency CHC panel in each area. Applicants are assessed by trained nurse assessors. The team includes Learning Disability Nurses.

How young people are involved in planning services in Berkshire

CAMHs service users are currently being asked to provide feedback as part of the CAMHs review. Engagement tools have been developed by a panel of young people, including those with disabilities, and include Widget and symbol software. A CAMHs service user forum is in place.

Looked After Children took part in a similar engagement exercise 2 years ago. Additionally, health workers meet regularly with Children in Care Councils and Independent reviewing officers. The Looked After Children's service has been heavily modified due to feedback from young people in recent years. Health passports for care leavers have been developed and implemented.

Future plans- SEND reforms

The Children's commissioners are working closely with Education colleagues in order to ensure that we are able to deliver improved and effectively joined up services as part of the proposed SEND Reforms. A key element of this is the implementation of a joint Health, Education and Social Care Plan for every child with learning disability who was formerly the subject of a statement of Special Educational Needs. This will include all children included in the WV criteria.

Future Plans- CAMHs commissioning

A review of CAMHs provision is currently under way in Berkshire. The review seeks to identify options for delivering high quality integrated services that can be delivered within resources available to meet the needs of the Berkshire population, taking into account equality and diversity issues.

This work builds on the Berkshire Tier 3 to Tier 4 pathway work which was undertaken in 2013.

The review considers the question

“Does CAMHS provide timely, effective and efficient services to the population of Berkshire?”

An engagement exercise is underway with service users, families, carers, stakeholders and service providers. This part of the review is being led by an external expert in Children’s Rights and participation.

The review is due to report to CCGs in May 2014 and it will include any recommendations from the Tier 4 review which is currently underway, led by NHS England.

Future Plans- developing technology

CCGs in Berkshire are considering the potential of extending the SHARON (Support Hope and Recovery Online) project to young people. It may be possible for young people who are placed out of area to stay in touch with a local care coordinator through a secure online network, both in hours and outside conventional working hours.

Health Services for Adults

Assessment and Treatment Centres

There are two NHS assessment and treatment centres within the West of Berkshire Area. The Campion Unit based in Prospect Park Hospital, in Reading, which has 9 beds and Little House in Bracknell, which has 7 beds. The physical environment of the Campion Unit enables it to support people with most extreme challenging behaviour but people with challenging behaviour are also supported at Little House when risks can be appropriately managed .The Campion Unit tends to provide for more challenging behaviour. Both units are managed by the Berkshire Healthcare Foundation Trust.

About half of patients in the units are admitted due to a primary presentation of challenging behaviour and the remainder have a complex presentation of mental illness. There is a 12 week assessment period and the average stay in the units for people from the 4 West of Berkshire CCG’s is currently around 192 days, which is below the national average. Delayed discharges are becoming an increasing reason for longer stays. Few patients admitted to these services return for subsequent admission indicating that treatment is effective and individuals are able to hold onto improvements. There are objective measurements of pre and post treatment with a six month post discharge follow up which evidence that significant changes for people are made and maintained.

Community Based Health Services

Joint Community Teams For People With Learning Disabilities (CTPLD). –

LD specialist community services are part of the health and social care systems that support people with LD. Working within a person centred approach, professionals will link into all aspects of a person’s support plan as needed, networking and working across a wide range of agencies.

The teams comprise

- 3.4 fte nurses
- 0.6 Health Team manager
- 0.8 fte support worker
- 1 fte psychologist
- 1 fte OT,
- 0.8 fte OT helper
- 0.8 fte physiotherapist
- 0.4 fte speech and language therapist per week
- 0.2 fte dietician
- 0.8 fte Consultant psychiatrist
- 0.6 fte Specialty Doctor

The team is supported by a consultant psychiatrist.

Learning Disability psychiatry and psychology work as part of the Community Learning Disability Teams to provide specialist health input to service users in their homes. There is a named psychiatrist and psychologist for each CTLD.

The health professionals work with people over 18 with a severe learning disability (IQ under 70).

The team does not however work with people with Asperger's, forensic needs or acquired brain injury. The eligibility criteria ensure the specialist work is correctly targeted and enables support to be focussed on those people who cannot be supported by other services.

The support includes assessments and direct and indirect interventions to understand the function of the behaviour and minimise the impact.

This team provides partnership working for high quality, evidence based services, which promote good, measurable outcomes for service users and their family carers which continuously improve these services through access to joint information systems

- The CTPLD provides specialist assessments and therapeutic interventions and provides direct intervention and support for people with most complex needs. Where there is a need for intensive treatment, this may include support for people in inpatient services but always with least restrictive option being considered first. The intention of the Berkshire CCGs and local authorities is to reduce the need for inpatient admission.

- This team supports partner agencies to ensure smooth transition for young people from children's services into this service

Each CTLD (West Berks, Reading and Wokingham) receives approximately 50 referrals a year between nursing and psychology

It is recognised with the team that some specialism are not fully represented. This includes in particular behavioural specialist and any drama, art or music therapists.

ACTION: The lack of behavioural specialists within CTPLD team will be addressed.

Enhanced Support Service

An enhanced support service (ESS) has been commissioned from Berkshire Healthcare Foundation Trust to provide specialist assessments and interventions as part of a multidisciplinary person centred support to people with learning disability to improve the person's well-being and quality of life. Its key objectives are to

- Work in partnership with service users/families/carers, statutory and independent services to enable a person centred approach to support the individual to maximise the quality of life in the least restrictive environment.
- Provide teaching/education to service users and their supporters to improve their understanding of maintaining good mental health and appropriate interventions.
- Work collaboratively with primary care and secondary care services to raise their understanding of LD specific issues and to support access to mainstream health services.
- Review specialist LD out of area placements to ensure good quality services are provided that meet the needs of the service users and to support agreed transitions to less restrictive environments in a timely manner.
- Participate in the research and audit that contributes to the knowledge of specialist LD services.

The service is part of the pathway for admission to Assessment and Treatment Units to explore options for community based support, and is delivered by a multi-disciplinary team. The service interfaces between the in-patient services and the community teams for people with learning disability. The care management process for the service users is led by the local authority working closely with health professionals to ensure seamless support for the service user. The service is underpinned by a person centred and holistic approach to encompass all aspects of support in daily living, personal development and health and wellbeing with consideration to balancing risk management and providing opportunities/choice.

Protocols are in place to work collaboratively across MH and LD services ensuring that the most appropriate support is provided.

This service area provides a seamless service for the service user, working closely with colleagues in the six CTPLD's, in-patient services family groups/carers and partnership agencies. Protocols are in place to work collaboratively across MH and LD teams.

The care pathways for access to health services are included at appendix 4.

ACTION: Health and Social Care services will work together to develop integrated health and social care pathways to ensure timely access to appropriate services.

Reviews and Contact Monitoring

Case Management and Reviews of Health Cases

Health professionals within the CTPLD's do not case manage or review health funded cases (either CHC, S117, or MHA) which can leave a care management gap. An identified cohort of people are care managed through ESS but people now leaving BHFT's assessment and treatment services with health funding attached do not have a health case manager to support and review the care. This can also impact on service and contract monitoring for this group of people. A specialist health care manager would address this issue and establishing such a post should be considered as part of the development of our services in response to the Transforming Care (Winterbourne View) Report.

i) Block contract reviews – The contract with the main provider is reviewed on a quarterly basis but continuous monitoring is carried out to ensure patient safety.

ii) Clinical reviews – BHFT case manager reviews all out of area placements. The Enhanced Support Service have a case load of 25 people maintaining links with all people placed in forensic services and an identified cohort of people with health funding (MHA/ S117) . The capacity of the case manager is under review due to an increased demand.

ACTION: NHS Berkshire West CCGs to examine need for and resourcing of case management and reviews for health funded placements.

Social Care Services

Children's, Young People's and Transitions services

Transitions teams within the local authorities work closely with children's services to identity and track young people from the age of 16 who may need services on becoming 18. This includes children with learning and physical disabilities as well as vulnerable care leavers.

Reading

Reading has recently established a Children and Young Peoples Team (0-25). It brings together the children and adult social care support function. This allows for better planning and preparation of young people as they approach adult hood and a more seamless transition. The Team has a transitions coordinator who gathers data on future needs of young people and also supports social workers in their planning and support of the young person. Currently the Team have identified 6 young people between the ages of 14 and 18 who present with challenging behaviour.

West Berks

In West Berkshire 395 young people were in Transition in 2012/13. Not all will be eligible for Adult services and only a small number will present with challenging behaviour. Within CTPLD in West Berkshire, there is a specialist transition social worker and there is also assistant SEN Manager with specific responsibility for transition in children's services. Children's and adults service work together via a virtual transition team.

Wokingham

WBC currently manages commissioning for young people transferring from children's to adults' services within a dedicated transitions team comprising 2.5 fte social workers.

Each term any children with Special Educational Needs who will become 16 that term will be assessed to establish whether they are likely to have needs as adults to enable longer term planning of services. At any one time there are around 30 young people allocated to the transitions waiting list for assessment of these, between 5 and 10 are likely to be aged 17-18.

There are relatively few out of area placements in the 16-18 group, generally around 4-5 and historically most of these have been happy to return to the borough for ongoing long term support.

In many cases a direct payment is taken so that families can take more control of the support provided.

ACTION: The local authorities and CCGs will collect information about services provided to children with challenging behaviour to inform planning and commissioning of services

Adult services

Assessment and Support Planning

Good services for individuals start with a good understanding of their needs and their capabilities and aspirations. This requires careful, sensitive and comprehensive assessment of needs and a good, co–produced person centred support plan. All three Councils use person centred planning approaches and allocate personal budgets to allow maximum choice and control for individuals over the services they require.

For people with challenging needs we must ensure that Individuals and their families are supported through this process by clear information and open and honest communication families should be fully involved in the assessment and support planning process. Families' expertise and knowledge of the individual should be understood and respected and should inform the process. Advocacy should also be provided where requested or appropriate to ensure that the individual's voice is heard throughout the process.

ACTION: Social services will ensure that all people who show challenging behaviour have appropriate support plans with clear outcomes, and that services provided are appropriate to meet and achieve these and enable them to live "as normal a life as possible".

General situation in relation to people with a learning disability supported by the three local authorities

The findings of the Winterbourne View stocktake are, however, no reason to be complacent. The three councils still fund a significant number of people in residential care outside the borough. Many of these are in services in each other's or neighbouring authorities, with whom the three local authorities have links dating back to when the six Berkshire Unitaries were a single County Council. Nevertheless the information suggests there is clearly a need for greater provision within or close to the three authorities' areas.

Residential Placements

Table 2 Current Local Authority funded learning disability placements as at January 2014

Local Authority	Service	Within borough	Out of borough	Out of borough placements in neighbouring authorities
Reading	Residential	47	78	45
	Supported Living	140	2	1
	Total	**187**	**80**	**46**
West Berks	Residential	36	58	10
	Supported Living	180	2	3
	Total	**216**	**60**	**13**
Wokingham	Residential	27	60	33

	Supported Living	81	2	2
	Total	**108**	**62**	**31**

In addition the following residential placements are fully funded with Continuing Health Care (CHC) funding:

Table 3 Current 100% health funded learning disability placements as at January 2014

Local Authority	Within borough	Out of borough	Out of borough placements in neighbouring authorities
Reading	0	3	1
West Berks	5	8	1
Wokingham	2	7	3

Action: Health and social care will collaborate to review the interpretation to the national eligibility criteria. Berkshire West is one of the lowest numbers of CHC funded patients with learning disabilities and challenging behaviour.

Out of Area Residential Provision

Overview

The main reason for out of area placements was the perceived lack of local provision deemed appropriate when registered residential care homes providing high levels of support were seen as the most appropriate service. The success of supported living as an option was not as well established as it is now. Moving people back into their local communities however can prove difficult to arrange for a number of reasons, including, lack of suitable registered provision or supported living accommodation, individuals becoming used to the existing provision and the establishment of local links by the individual and/or their families.

Many out of area placements are highly successful and provide good services that people benefit from. Many families have relocated to be nearer to these services. However we need to ensure that each such placement is appropriate given the general preference for provision of services close to each individual's community.

Reading

Reading Borough Council has 80 people placed out of area and 18 of these people are considered to have challenging behaviour. One of these 18 placements is a specialist mental health/learning disability supported living placement made in 2011 with the remainder all being residential care and having been made prior to 2006.

RBC undertook a comprehensive review of all residential service placements in 2011 with a view to bringing people back to Reading. It was clear then that the majority of the people had lived in the residential care homes upwards of 5 years and in several cases their family is living locally. Therefore Reading concluded it was not in people's best interests to return to the Reading area. However, the authority remains concerned that distant placements reduce the ability to robustly monitor the quality and outcomes of these out of area placements. Therefore Reading are introducing a protocol for comprehensive out of area reviews which will include consideration of return to Reading.

Reading are in the process of building 10 new supported living flats and will be considering whether this provision can meet the needs of those who are considered to challenge services.

West Berkshire

Of the 68 people from West Berkshire Council currently placed in residential care out of area 33 are known to have challenging behaviour.

The people in out of area placements tend to be historical Section 28a transfer placements or young people who have been placed out of area into residential schools and colleges and for whom there has been no local placement. The younger group tend to be people with challenging behaviour but a number of the older ex-long stay hospital group are also challenging. Two years ago West Berkshire Council opened a 4 unit bespoke supported living service in Newbury for this younger group who either were or were at risk of being placed in expensive out of area specialist residential care. This service with a good care provider has worked well but it was very resource intensive to set up.

West Berkshire reviewed all its out of area placements in the year up to September 2013. These were reviews of the quality of the placement as well as the needs of the individual and a recommendation was made that either confirmed that the placement continued to appropriately meet the needs of the individual, or that the person needed different care. We are currently working actively with 9 people to move them on to supported living either back in West Berkshire or in the area where they are currently placed and have established networks. We have also worked over the past year with BHFT to bring one young man back from an out of area hospital to his own bespoke supported living accommodation locally.

Wokingham

The main reason for out of area placements is a legacy one; such placements were made due to lack of local provision for the services deemed appropriate at that time. This was generally in residential homes offering high levels of support as the success of supported living as an option was not as well established as it is now. Whilst the Council has sought to find local accommodation of a suitable type it can sometimes prove difficult to arrange moves back to the borough or the local area as individuals have become used to the existing provision.

Of the 27 people currently placed outside the immediate locality (Wokingham and neighbouring authorities) 10 have been identified as having both learning disability and mental health needs or challenging behaviour. A further 9 people in placements in authorities bordering on Wokingham but outside Berkshire have been identifies a having challenging behaviour.

Action: Each local authority commits to reviewing all out of borough placements with a view to understanding if people wish to come back into the Berkshire area.

Local Residential Provision

Currently the number of CQC registered residential homes within each of the three local authorities specialising in learning disability or mental health is as follows

Table 4: Registered Residential Care Provision within the area

Local Authority	Number of CQC Registered Care Homes	Number of Beds
Reading	23	153
West Berks	29	195
Wokingham	42	384
Total	**94**	**732**

The registered provision in Wokingham includes a large complex at Ravenswood village, providing services to around 130 people. Very few are funded by Wokingham Council, most are self-funded or not Borough residents.

Local residential homes are able to support many people with challenging behaviour but there is no collated or systematic review or understanding of each services capacity to do this and what their needs might be in terms of additional support.

Local Community Based Services Including Supported Living.

Table 5: Accommodation type for people supported in the community

People supported 2012/13 (source: HSCIC ASC-CAR L2)	**Living independently (inc supported living schemes)**	**Settled accommodation with family or friends**	**Total**
Reading	175	145	**320**
West Berkshire	185	130	**315**
Wokingham	165	170	**335**
Total	**525**	**445**	**970**

People living in the community receive a range of community based services including professional support, home care, and day opportunities which can offer support to people with a range of needs.

Reading Council has a mix of in house provision where a dedicated 1:1 worker is provided for a small number of people who are able to be supported in a day centre environment, There are 2 main providers of external day care building based and then a number of people who are supported during the day as part of their supported living or residential support package.

West Berkshire Council has 3 pan disability Day Service resource centres. These can work with a small number of people with challenging behaviour on specific days. We purchase a small number of day care places from independent sector day care and residential providers but generally for people who challenge services we need to commission additional staffing to support the individual.

Specialist learning disability day support in Wokingham is commissioned from Optalis, the Council's social care trading company and operates in 3 locations across the borough. In the last year the service has invested in two proact scip trainers. This allows the organisation to train support workers not only in

the principles but on a customer by customer basis to deliver a person centred whole approach to people management. By using proact scip it gives staff the skills to use a less restrictive approach and allows those who challenge to be supported in a much more positive way and to lead a fulfilling life.

Despite his however, it is recognised that there are gaps in our knowledge about people with challenging behaviour supported in the community and what services they receiving.

ACTION: The local authorities and CCGs will identify and collate information about people with challenging behaviour supported in the community to inform service provision and development.

Social Care Services Reviews and Contract monitoring

Regular reviews should take place but there is a gap in aggregating the information to inform commissioning in both local authority and CCGs.

It is acknowledged that contract monitoring and reviews have not to date enabled us to systematically evaluate which services best deliver the required outcomes for the individual. Anecdotally we are aware that that services which work well for some do not work well for others even within the same placement of provider.

As a part of our service development we will undertake more structured approach to monitoring service performance. This will include clear guidance on scheduling reviews, especially out of area placements, assessing services against placements and actions to be taken where services appear not to be delivered according to service specifications or meeting the individual's needs or achieving the desired outcomes.

ACTION: We will undertake more structured co-ordinated and integrated contract monitoring and service review process will be established to ensure services are meeting individual needs and outcomes and to inform wider commissioning activities.

Commissioning

Developing a Commissioning Pathway

NHS Berkshire West CCG and local authorities can develop opportunities to develop an integrated health and social care team with delegated lead responsibilities for commissioning, safeguarding, performance managing and reviewing all Berkshire West health and social care spot commissioned out of borough placements for adults with global learning disabilities (Global learning disabilities is defined as a person who has an IQ below 70).

Meeting needs in a joined up and integrated way would involve commissioning "wrap around" services to support the person to remain in the community. It is important that we clarify how these services are planned and commissioned and how they are funded. Some may be commissioned by and based in individual authorities and others Berkshire wide and Thames Valley wide.

An integrated Berkshire West commissioning team approach would help to ensure that gaps and overlaps between services provided or funded by different agencies are removed and that a holistic view can be taken of each individual's needs. **A joint health and social care integrated team approach can ensure that people with learning disabilities have more choice and control over their lives. This can be achieved through the roll out of personalised budgets.**

ACTION: An integrated Berkshire West commissioning team will be established to ensure that gaps and overlaps between services are removed and to can ensure that people with learning disabilities have more choice and control over their lives.

Given the nature of services required it is inevitable that most services will be commissioned on an individual level based on personalised care plans, and commissioners will need to develop skills that enable them to identify and secure services to meet needs on an individual level whilst also delivering value for money. This will include co-production, awareness and understanding of local provision and best practice, as well as the ability to work closely with individuals and their families.

We therefore see a need to establish clear commissioning pathways covering all elements of the commissioning cycle and which identify responsibilities in relation to service planning, finance, procurement routes, outcomes and service monitoring.

ACTION: Local Health and Social Care services will work together to develop clear joint health and social care commissioning pathways to ensure that appropriate services are commissioned to meet the needs of people with challenging behaviour.

Commissioning Children's and Transitions services

Each local authority has established processes by which it manages the planning and commissioning of services for children transitioning from children's to adults' services.

As indicated above all three local authorities' Adult Care services work closely with Children's Services to identity and track young people from the age of 14 who may need services on reaching 18. This includes children with learning and physical disabilities as well as vulnerable care leavers. Each term any children with Special Educational Needs who will become 16 that term will be assessed to establish whether they are likely to have needs as adults to enable longer term planning of services. Those who are likely to need services are allocated to a worker.

The Children and Families Bill will place requirements on Social Care Health and Education services to work together to jointly plan and commission service for young people with Special Educational Needs and work is currently being done across social care, health and education to enable us to fulfil this duty.

- Support to individuals to continue in education and training or find employment
- Support to access services in the community
- Building independence
- Support to carers including supporting carers so that they can continue to work as well as more tradition support such as short respite breaks

There are a small number of transitions cases that pose problems for services due to lack of any formal diagnosis or clear understanding of the underlying issues. Appropriate services to support individuals in this category after the age of 18 can be difficult to find and individuals are often unwilling or unable to engage with services, which can give rise to problems such as homelessness and offending behaviour.

Transition arrangements between adults and children's services will be reviewed to ensure that challenging behaviour is clearly identified to inform future commissioning.

Commissioning Adults Services

Out of Locality Placements

As a matter of principle our view is that supported living should be the first choice option even for those with challenging behaviour. Only in extremely rare cases should it be necessary to commission registered residential care, and where it is there should be a plan in place which identifies steps towards supporting transfer to supported living and community based alternatives. Support in the home is a preferred option for many but may not promote the independence of the individual and may also place a strain on carers.

As three relatively small authorities it may be unrealistic and unnecessary to insist on all provision being within each of the boroughs. Historical links with other parts of what was Berkshire County, and the proximity of population centres in the neighbouring boroughs coupled with good transport links together, with the boundaries of the main NHS provider of specialist health care (the Berkshire Healthcare Foundation Trust) being based on the old county boundary, suggest that placements in neighbouring authorities would in most cases be sufficient to meet the underlying principle of placements being close to each individual's own community.

The question of out of area placements needs to be addressed by each authority as a matter of policy. There are issues in terms of whether to preserve individual choice and allow people to stay where they are if they choose to do so, irrespective of location or cost effectiveness and accept that this may result in many such placements continuing, or commit to the model of support within the individuals locality and arrange appropriate transfers. In order to take account of each individual's preferences and balance choice against location of provision, it would seem appropriate for each local authority to consider whether to offer every person currently placed out of the locality the opportunity to moving back to the local authority area or a nearby location.

It is recognised however that there are significant barriers to achieving the aim of supporting people within or close to the borough, especially for those with a high level of need or who require specialist support. Many people currently being supported outside the immediate locality are likely to be genuinely happy and settled in their current placements, which achieve good outcomes for them and it may not be apparent what they would gain from a move. Others may be less happy or receiving services that fail to meet their needs and outcomes but be unable to make an informed decision about moving to an alternative service even if this would be to similar or better provision.

In order to address these issues clear criteria are needed to identify when remaining in an out of locality placement is appropriate. This will include quality of care, achievement of outcomes, the individual's links with the locality and their personal preferences. Where a person indicates a preference to remain but it appears that services are not meeting the individuals needs the service will be regularly reviewed against clear outcomes and should there be no improvement in provision a decision may be made to re-commission a more appropriate service closer to the local authority area.

For those who wish to and stay in their current locality but who are in registered care settings we should also assess suitability for transfer supported living within that locality. This may be particularly appropriate for those people whose families have moved out of the borough in order to live near to their residential placements. This would have the effect of transferring responsibility for funding support to the local authority under Ordinary Residence arrangements. Local authorities are bound by Ordinary Residence regulations which require them to take on financial responsibility for people moving into their areas. This does not apply to residential care placement arranged and funded by the local authority but does apply to supported living provision. This can make it difficult to commission supported living in other areas

Individuals and their carers would be fully involved in any reviews and planned transfers with advocacy support where necessary.

ACTION: Each Local authority and CCG will adopt clear criteria to identify when it is appropriate for an individual to remain in an out of locality placement. For those who wish to stay in that locality but who are in registered care settings we should also assess suitability for transfer supported living within that locality.

In order to fulfil the ideal of support being provided in supported living (as opposed to registered care) accommodation in the locality, sufficient additional provision within or close to each of the three boroughs will need to be commissioned (see Action below)

Local Registered Residential Provision

Given the significant level of registered residential provision within the three boroughs as recorded above, it is not anticipated that additional residential is required. Generally the preferred option will in future be for supported living placements and it is likely that some existing registered provision will be de-regulated to offer supported living provision.

As mentioned above on page 14, CCGs and social care will review how much of the existing local residential provision has the capacity to support people with challenging behaviour.

Each local authority has access to specialist capacity to support people with challenging behaviour. However, it is recognised that a number of people returning from out of area will require enhanced services through joint working**.**

All the local authorities have addressed the need for local residential provision to have capacity to support people with challenging behaviour. This has included seeking specilaised training from staff based at Prospect Park hospital and training in PROACT SCIP.

Supported Living Services and Community Based Services

All clients are allocated a personal budget and supported to develop person centred support plans detailing how this will be spent. Plans and final budget amounts are moderated and signed off before services are commissioned ensuring that both the support plan and the budget amount are sufficient to meet the identified eligible needs.

Commissioning supported living arrangements is dependent on three key factors

1. Finding compatible tenants
2. Finding suitable housing
3. Finding suitable support

These can be especially difficult to meet when commissioning services for people who demonstrate challenging behaviour. For this reason such placements tend to be on an individual basis with bespoke care packages involving high levels one to one support.

The main requirement therefore is the availability of skilled staff to support individuals in a community setting. Care staff providing such support require specialised training and close management support. There must be good relations with statutory agencies and additional support should be readily available when needed to prevent escalation of incident of challenging behaviour.

Where people are supported in community settings such as supported living it is also important that we also have in place appropriate care and opportunities in the community provision to meet their needs and this should include support to access mainstream services whether to meet health or social care needs. Such services are important to ensure people are supported to be a visible and accepted part of their local communities and are able to engage fully in local community life.

ACTION: The local authorities and health services will work together on a joint plan for increasing capacity in the locality to meet increased need for supported living for people with challenging behaviour including availability of appropriately skilled staff.

Intensive Support and Crisis Intervention

The provision of ongoing intensive support is likely to result in decreases in the number of crises resulting in hospital admission. There are known hot spots for recurring crises and most patients involved are well known to services. This means that preventative specialist support can be targeted and over time will assist both the individual and care staff to better cope with potential crisis situations.

It is inevitable that there will be a need for intervention in crisis situation and good rapidly available crisis support will enable both families caring for someone at home and services such as supported living and residential care schemes to better manage crises and so prevent unnecessary escalation of support or hospital admission. Support should be multi-disciplinary involving clinical psychology, behavioural specialists, and speech and language therapists, with access to OT and psychiatry and social care professionals and should be able to respond rapidly. However the size of each borough and numbers of potential people may be too small to justify a dedicated service for each authority. A Berkshire wide service would offer a more viable solution whilst retaining local links enabling staff to become familiar with and work more closely with local families and people. More remote services, operating on a regional basis would be unlikely to achieve this.

ACTION: The CCG will aim to review the current arrangements to support the development of a multi-disciplinary team able to respond rapidly to provide crisis support in residential, supported living and domestic settings to reduce the need for hospital admissions.

Managing crises in domestic or supported living settings can however be difficult as the environment is not always appropriate especially where violent behaviour may be an issue. However it is also recognised that hospital admission (in some cases under the MHA) for what might be a short lived episode may not be the most appropriate option.

Where a hospital admission is required it can sometimes be difficult to arrange timely discharge, especially for those admitted under the MHA as providers are sometimes unwilling to take such referrals. An intermediate service would also be able to take people ready for discharge and provide a more appropriate setting that the hospital until a more permanent placement can be found.

A small intermediate unit specially adapted or designed for short term support in such cases would therefore fill an identified gap in current provision. To help preserve continuity of care support into the unit should ideally be provided by the community team with some additional resources.

Capacity for around 6 beds and this could be funded by having fewer short term funded beds. Further consideration will therefore be given to the possibility of commissioning such provision.

ACTION: The local authorities and CCGs will investigate commissioning of small, short term intermediate unit as a way of reducing hospital admissions and delayed discharges across the Berkshire health and social care economy.

Open Access (Prevention) Services

The CCGs and the local authorities fund a range of services which individuals and their families and carers can access directly. These services are generally provided by the third sector and are free. Although no statutory social care need or assessment is required the services may operate their own criteria and will of course want to ensure that services are targeted where they are most needed. Services include drop in day services and advice and support for individuals and families with a child or adult with Autistic Spectrum Condition.

Direct Payments

The Council supports a number of families to have direct payments to employ personal assistants to support adults and children with very profound needs. Many families find using direct payments for this a good way of being in control of their support and tailoring it to meet their individual needs. The money is used to fund a variety of services including personal assistants to help with personal care as well as community based support to access the community and respite.

All three local authorities are keen to increase the take up of direct payments generally and we should establish whether there is specific additional support which would enable more people with challenging behaviour and their families to use these.

Support for Carers

Caring for someone with challenging behaviour is highly time consuming and stressful and we are committed to supporting carers in this situation. Social Care Institute of Excellence has produced a guide for family carers on getting the right support to cope with challenging behaviour which indicates the need for a range of information, advice and practical support to be available, and providing these services is a key part of our overall approach.

The Care Bill will change the statutory definition of a carer and will also place a duty on Councils to provide carers with services to meet their eligible needs. Each Council already commissions a range of services for carers including respite breaks, information, training, support groups and practical help into the home to support carers in their caring role. Access to third sector support services provided by organisations with specific expertise is also an important part of the wider support networks which families and carers need. It is however recognised that more capacity for respite and short break options within the borough are required.

As part of our service development we will engage with carers of people who have challenging behaviour to establish what additional support services support services would most benefit them in continuing in their role. This can be linked in to development of carers' services resulting from the proposed changes in the Care Bill.

ACTION: The local authorities and health services will seek a better understanding of carers supporting people with challenging behaviour through reviews and engagement and explore the availability of intensive community health input for carers support.

Market Development

Model of Local Provision

The Mansell Report suggested the model of provision should include 4 key elements

Fig 3 Model of Local Provision for People with Challenging Behaviour

To achieve this we will need to take active steps to develop both the local market for services and the local workforce.

Developing Local Provision

It will continue to be the aim to commission services for individuals from a wide range of providers based on co-produced and person centred plans using focused procurement exercises in which the individual and their family is fully engaged. We know that one size fits all services block purchased from a small group of providers does not deliver the variety and choice required. Commissioning services from more providers including small scale enterprises not only increases choice but reduces the potential impact if a provider should fail.

The overall aim of the joint plan will be to provide better outcomes for people with learning disabilities with an assessed need, including mental health, by facilitating improved access to appropriate accommodation, opportunities for fulfilled and meaningful lives and access to healthcare services

Outcomes and Performance Indicators

All support plans must include clear outcomes agreed with the individual and their families where appropriate indicating what the service is aiming to achieve and it should be clear how this will be achieved.

Outcomes should be co-produced with the individual and where appropriate their families and agreed with the service provider through clear service specifications and support plans. They should be based on the principles and aims of the Winterbourne Report model of care and SMART principles to ensure that they are deliverable in way that all involved can see and understand. They should be regularly monitored and action taken to adjust services where outcomes are not being achieved.

Contract Monitoring

It is important that we regularly review the performance of providers against the terms and outcomes of the contacts and service specifications. Lack of monitoring by commissioners was highlighted in the Transforming Care Report. Commissioners should ensure that contracts and specifications include clear and readily understood monitoring requirements and performance indicators which are relevant to the service and the outcomes to be achieved. This should involve at least an annual visit to the service. This has to go beyond simple inputs and outputs such as support hours and should focus on the quality of provision and the impact the service is making on the wellbeing of the customer.

As indicated above this has not always happened in a planned and co-ordinated way and this has sometimes hindered evaluation of the quality of cost effectiveness of individual services and our overall understanding of what services work best and finding good examples of sustained where best practice. This will be addressed through a more structured, co-ordinated and integrated contract monitoring review process as indicated on page 20.

Monitoring provides an opportunity to collate and feedback on services from a range of sources and to agree where services are performing well or need to improve. It should be based on an open and honest partnership between the commissioner and provider. Where action is agreed it is important that this should result in clear action plans and commissioners should provide appropriate support where this may be required to help a provider address particular issues.

It is recognised that people with challenging behaviour often need high levels of support in specialised environments. This can lead to high costs. We do however need to make sure that these costs are linked to high quality services which deliver the right outcomes for people and high cost is not in itself seen as a the solution to high needs. Some high cost placements may no longer reflect best practice in supporting people with challenging behaviour. And resources might be better used to deliver more appropriate services to meet the individual's needs and outcomes. Such will therefore need to be reviewed.

ACTION: High cost placements which do not achieve worthwhile outcomes for the individuals concerned should be identified and reviewed and, where necessary re-commissioned.

Workforce Development

We need to ensure that appropriate training is provided to support people who display challenging behaviour to minimise escalation into the crisis pathway. There is a need staff skilled in both LD and MH

Employers and staff should be aware of the Guidance issued by Skills for Care and the NDTI on supporting staff who work with people who challenge services and should have in place appropriate training, support and management to ensure that staff are properly skilled, trained and supported to carry out this work.

Local Authorities and Health Services will work with professionals and providers in their areas to identify workforce development issues.

Commissioners will take into account the level and training of support staff when commissioning services and where this needs to be specified or enhanced to meet needs this will be highlighted.

Information about skills and training in the workforce will be collected and collated to ensure that the right skills are available.

ACTION: Health and social care services will collaborate to understand the need for workforce development highlighting any recruitment, retention, training support and development issues.

User Audits and Customer/Carer Feedback

Customer and carers' feedback on individual services is routinely recorded during individual service reviews and reviewing officers will raise issues with providers directly and will also report concerns both through safeguarding and Care Governance Procedures.

It is also recognised that involving service users in more formal and structured reviews of services offers a uniquely powerful insight into the value and performance of those services.

Attempts have been made to establish user audits of services but these have not so far been successful in establishing a sustainable service. This an area in which we will continue to look to develop in the future, alongside user and carers groups in the borough.

ACTION: Each local authority and CCG will support the further development of service user led reviews and audits of services in their areas.

Safeguarding

We seek to ensure the safety and wellbeing of customers through a double handed approach using a Berkshire wide safeguarding protocol that provides a clear structure and process for concerns to be reported, recorded and investigated, and escalated where appropriate.

Regular training sessions are provided on the safeguarding process and providers are contractually required to ensure they have their own safeguarding procedures which comply with the Berkshire protocol and also have whistleblowing policies and procedures.

Each authority has quality assurance or care governance process aimed at identifying issues with providers and supporting providers to address these and information from these is shared across the authorities as well as with a range of official agencies including CQC, local health services and neighbouring authorities to enable those organisations to contribute to any investigations and be part of any co-ordinated response. Where the issues are serious this may also involve a suspension of new placements while action is taken to address the issues.

All health and social care staff and staff employed by providers to support customers will be expected to have an understanding of Deprivation of Liberty Safeguards and the purpose and process for making Best Interest decisions.

Advocacy

Independent advocacy is available from a locally based specialist third sector advocacy services which provides individual issue based advocacy to all vulnerable people and their cares. Commissioners of advocacy services will ensure that such services are able to support people with challenging behaviour and will advise and support advocacy services where appropriate to enable this.

IMCA & IMHA Services are commissioned across Berkshire to ensure appropriate access to these statutory advocacy services. All staff involved in supporting people with challenging behaviour should be aware of these services and the role they lay. Information about the services should be readily available to staff, customers and carers and customers should be supported to access these services as required.

Provider support

In order to ensure that all services meet the aims expectations of this strategy it is important that commissioners and other professionals actively engage with independent and third sector providers involved in supporting people with challenging behaviour. Providers will equally be able to provide feedback on the effectiveness and capacity of services in dealing with challenging behaviour, where there are gaps and scope for improvement and what works well and might be further developed. Providers can also form an important peer support group to share good practice.

It is therefore acknowledged that a structured setting in which providers can come together with commissioners, other health and social care professionals and stakeholders including carers and customers could provide a valuable opportunity to share ideas for the improvement and development of services.

ACTION: A Provider engagement/forum/network will be established to enable providers, commissioners and other stakeholders to share good practice.

Funding and Finances

The Transforming Care Report stated that “the strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements”.

ACTION: We will explore the possibility of developing the use of pooled budgets to enable easier commissioning of integrated packages of care which ensure that health and social care elements are co-ordinated to achieve agreed outcomes and deliver value for money.

Identifying and Understanding Costs

Adult Social Care

A recent costs analysis undertaken by each of the three local authorities indicated that the 5 most expensive learning disability placements commissioned by each one was as follows

Table 6: Highest cost LD placements for each local authority

Reading	Weekly Cost	Service type
1	**£4,618**	Residential - out of Reading but in Berkshire
2	**£2,869**	Residential - out of Reading but in Berkshire
3	**£2,405**	Residential - out of Reading but in Berkshire
4	**£2,358**	Residential - in Reading
5	**£2,260**	Residential - out of Reading but in Berkshire
West Berks		
1	**£5,073**	
2	**£3,548**	
3	**£2,856**	
4	**£2,844**	
5	**£2,415**	
Wokingham		
1	**£3,360**	Residential - in Wokingham
2	**£2,851**	Residential - out of Wokingham but in neighbouring authority
3	**£2,698**	Supported Living - out of Wokingham but in Berkshire
4	**£2,415**	Residential College - out of Wokingham
5		TBC

Governance

A Steering Group will be established including senior representatives of the three local authorities and local health services to oversee the delivery of the action plan.

The Steering Group will meet at least quarterly and will report regularly to the local Health and wellbeing Boards.

ACTION: Establish Steering Group to oversee delivery of action plan. The steering group will include representatives of key stakeholder groups (customers, carers, health, social care, providers and third sector organisations) and will report to the relevant health and Wellbeing Boards on the delivery of this strategy.

Action Plan

Action	Lead	Deadline
Future JSNAs should separately identify people with learning disabilities with challenging behaviour/autism and mental health issues.		
The lack of behavioural specialists within CTPLD team will be addressed		
Health and Social Care services will work together to develop integrated health and social care pathways to ensure timely access to appropriate services.		
NHS Berkshire West CCGs to examine need for and resourcing of case management for health funded placements.		
The local authorities and CCGs will collect information about services provided to children with challenging behaviour to inform planning and commissioning of services		
Social services will ensure that all people who show challenging behaviour have appropriate support plans with clear outcomes, and that services provided are appropriate to meet and achieve these and enable them to live "as normal a life as possible".		
Health and social care will collaborate to review the interpretation to the national eligibility criteria. Berkshire West has the lowest number of CHC funded patients with learning disabilities and challenging behaviour.		
Each local authority commits to reviewing all out of borough placements with a view to understanding if people wish to come back into the Berkshire area.		
The local authorities and CCGs will identify and collate information about people with challenging behaviour supported in the community to inform service provision and development.		
We will undertake more structured co-ordinated and integrated contract monitoring and service review process will be established to ensure services are meeting individual needs and outcomes and to inform wider commissioning activities.		
An integrated Berkshire West commissioning approach with a view to setting a team will be initiated to ensure that gaps and overlaps between services are removed and to can ensure that people with learning disabilities have more choice and control over their lives.		
Local Health and Social Care services will work together to develop clear joint health and social care commissioning pathways to ensure that appropriate services are commissioned to meet the needs of people with challenging behaviour		
Transition arrangements between adults and children's services will be reviewed to ensure that challenging behaviour is clearly identified to inform future commissioning.		

Each Local authority and CCG will adopt clear criteria to identify when it is appropriate for an individual to remain in an out of locality placement. For those who wish to stay in that locality but who are in registered care settings we should also assess suitability for transfer supported living within that locality.		
The local authorities and health services will work together on a joint plan establish a project for increasing capacity in the locality to meet increased need for supported living for people with challenging behaviour including availability of appropriately skilled staff.		
The CCG will aim to develop a multi-disciplinary team able to respond rapidly to provide crisis support in residential, supported living and domestic settings to reduce the need for hospital admissions.		
The local authorities and CCGs will investigate commissioning of small, short term intermediate unit as a way of reducing hospital admissions and delayed discharges across the Berkshire health and social care economy.		
The local authorities and health services will seek a better understanding of carers supporting people with challenging behaviour through reviews and engagement and explore the availability of intensive community health input for carers support.		
High cost placements which do not achieve worthwhile outcomes for the individuals concerned should be identified and reviewed and, where necessary re-commissioned.		
Health and social care services will collaborate to understand the need for workforce development highlighting any recruitment, retention, training support and development issues.		
Each local authority and CCG will support the further development of service user led reviews and audits of services in their areas.		
A Provider engagement/forum/network will be established to enable providers, commissioners and other stakeholders to share good practice.		
We will explore the possibility of developing the use of pooled budgets to enable easier commissioning of integrated packages of care which ensure that health and social care elements are co-ordinated to achieve agreed outcomes and deliver value for money.		
Establish Steering Group to oversee delivery of action plan. The steering group will include representatives of key stakeholder groups (customers, carers, health, social care, providers and third sector organisations) and will report to the relevant health and Wellbeing Boards on the delivery of this strategy.		

Appendix 1

Selection of Relevant Policies, Guidance, Reports and Resources

ADASS: Finding Common Purpose - Developing strategic commissioning relationships to support people with learning disabilities

Challenging Behaviour Foundation: Guidance and Fact sheets

Challenging Behaviour National Strategy Group: Challenging Behaviour Charter

DH: Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report

DH: Winterbourne View -Transforming Care One Year On

DH: Services For People With Learning Disabilities And Challenging Behaviour or Mental Health Needs, Revised Edition 2007 (Mansell Report)

DH: Learning Disabilities Good Practice Project

Driving Up Quality Alliance: Driving Up Quality Code

Improving Health and Lives, RCGP and RCPsych: Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs)

Joint Commissioning Panel for Mental Health: Guidance for commissioners of mental health services for people with learning disabilities

Mencap: Charter for Clinical Commissioning Groups

Mencap: Out of Sight; Stopping the neglect and abuse of people with a learning disability

NDTI: Guide for commissioners of services for people with learning disabilities who challenge services

NDTI, SCIE: Be Bold - developing the market for the small numbers of people who have very complex needs

NDTI, Skills For Care – Supporting Staff Working With People Who Challenge Services

Public Health England: Wokingham Learning Disabilities Profile 2013

Raising our Sights: Services for adults with profound intellectual and multiple disabilities; Professor Jim Mansell

The Royal College of Psychiatrists - Challenging behaviour: a unified approach - Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices.

Appendix 2

The model of care

There are too many people challenging behaviour living in inpatient services for assessment and treatment and they are staying there for too long.

The closure of most long-stay hospitals in the 1980s and 1990s, and the recent closure of NHS campuses, means most people with learning disabilities, including those with behaviours that challenge now live in the community with support. But some still live (for short or longer periods) in NHS funded settings. Assessment and treatment units emerged as the most likely solution to meeting the needs of people with learning disabilities and complex mental health/behavioural issues post-institutional closure. However, there were opposing views between 'building based' services and increasing support to people in their natural communities as the preferred option.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge includes the 1993 Mansell report, updated and revised in 2007. Both emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour; and
- that services/support should be provided locally where possible.

Evidence shows that community-based housing enables greater independence, inclusion and choice and that challenging behaviour lessens with the right support. The Association of Supported Living's report *There is an Alternative* describes how 10 people with learning disabilities and challenging behaviour moved from institutional settings to community services providing better lives and savings of around £900,000 a year in total.

The CQC *Count me in* 2010 census showed only 2 learning disabled patients on Community Treatment Orders compared to over 3,000 mental health patients – suggesting a greater reliance on inpatient solutions for people with learning disabilities than for other people needing mental health support.

CQC found some people were staying many years in assessment and treatment units. Annex B estimates that, in March 2010, at least 660 people were in A&T in Learning Disability wards for more than 6 months.

This report sets out how the model of care set out in the Mansell reports fits with the new health and care system architecture focusing on key principles, desired outcomes for individuals, and a description of how the model should work in practice.

Key principles

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out below:

For people:

1. I and my family are at the centre of all support – services designed around me, highly individualised and person-centred;
2. My home is in the community – the aim is 100% of people living in the community, supported by local services;
3. I am treated as a whole person;
4. Where I need additional support, this is provided as locally as possible.

For services:

5. Services are for all, including those individuals presenting the greatest level of challenge;
6. Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning;
7. Services are provided locally;
8. Services focus on improving quality of care and quality of life;
9. Services focus on individual dignity and human rights;
10. Services are provided by skilled workers;
11. Services are integrated including good access to physical and mental health services as well as social care;
12. Services provide good value for money;
13. Where inpatient services are needed, planning to move back to community services starts from day one of admission.

Outcomes

A high quality service means that people with learning disabilities or autism and behaviour which challenges will be able to say:

1. I am safe;
2. I am treated with compassion, dignity and respect;
3. I am involved in decisions about my care;
4. I am protected from avoidable harm, but also have my own freedom to take risks;
5. I am helped to keep in touch with my family and friends;
6. Those around me and looking after me are well supported;
7. I am supported to make choices in my daily life;
8. I get the right treatment and medication for my condition;
9. I get good quality general healthcare;
10. I am supported to live safely in the community;
11. Where I have additional care needs, I get the support I need in the most appropriate setting;
12. My care is regularly reviewed to see if I should be moving on.

This is about personalisation, starting with the individual at the centre, living in the community. The first level of support for that individual includes the people, activities and support all people need in their everyday lives – family, friends, circles of support, housing, employment and leisure.

Most people with learning disabilities or autism will need more support from a range of sources: their GP or other primary care services, advocacy, a care manager or support worker and could include short breaks. That support may change as needs change, and this will involve assessments of physical or mental health needs or environmental needs (such as loss of a parent, a relationship breakdown, unemployment) to identify what support should be provided.

For people who need further support – including where they have behaviour which challenges – the intensity of support should increase to match need. That should include intensive support services in the community, assessment and treatment services (which could be provided in a safe community setting), and, where appropriate, secure services. But the aim should always be to look to improvement, recovery, and returning a person to their home setting wherever possible.

Responsibility for safety and quality of care depends on all parts of the system working together:

i. **providers** have a duty of care to each individual they are responsible for, ensuring that services meet their individual needs and putting systems and processes in place to provide effective, efficient and high quality care;

ii. **commissioners** (NHS and local authorities) are responsible for planning for local needs, purchasing care that meets people's needs and building into contracts clear requirements about the quality and effectiveness of that care;
iii. **workforce,** including health and care professional and staff who have a duty of care to each individual they are responsible for; and
iv. **system and professional regulators** who are responsible for assuring the quality of care through the discharge of their duties and functions.

To achieve these outcomes a revised model of care as set out below needs to be delivered.

Roles and responsibilities Good services meeting the needs of everybody must include:

Information

- **Councils, elected councillors, health bodies and all care providers, whether from the public, for-profit or not-for-profit sectors** should provide good quality, transparent, information, advice and advocacy support for individuals, families and carers.

Community based support

- **Councils and health commissioners** should ensure that general services (GPs, hospitals, libraries, leisure centres etc.) are user-friendly and accessible to people with learning disabilities/autism so they can access what everyone else can access.
- **Community based mental health services** for this group should offer assertive outreach, 24-hour crisis resolution, a temporary place to go in crisis and general support to deal with the majority of additional support needs at home.
- **Housing** authorities should include a wide range of community housing options - shared, individual, extra care, shared lives scheme, domiciliary care, keyring, respite.
- **Social care commissioners** should ensure the availability of small-scale residential care for those who would benefit from it (e.g. because they have profound and multiple disabilities).
- **Councils and employment services** should offer support into employment.
- **Councils and providers of services** should enable a range of daytime activities.
- **Councils** should roll out personal budgets for all those who are eligible for care and support including those with profound and multiple disabilities and/or behaviours seen as challenging. Where appropriate, **health commissioners** should fund continuing health care.
- **Health and social care commissioners** should focus on early intervention and preventive support to seek to avoid crises (e.g. behavioural strategies). Where crises occur, they should have rapid response and crisis support on which they can call quickly.

Commissioning, assessment and care planning

- **Health and social care commissioners** should develop personalised services that meet people's needs. Key factors include;
- involving individuals - with support where needed - and families at all stages;
- planning for the whole life course, from birth to old age, starting with children's services; ☐ developing expertise in challenging behaviour;
- developing partnerships and pooling resources to work together on joint planning and support with integrated services – including:

    - multi-disciplinary teams to perform assessments, care planning, care assessment, care management and review
    - joint commissioning – ideally with pooled budgets, and
    - shared risk management;

- **Health and social care commissioners** should use all available information from joint strategic needs assessments (JSNAs) and local health and wellbeing strategies to commission strategically **for innovation** and to develop person-centred community based services;
- **Health and social care commissioners** should commission personalised services tailored to the needs of individuals, ensuring a focus on improving that individual's health and well-being and agreed outcomes. Progress towards delivering outcomes should be regularly reviewed;
- **Health and social care commissioners** should start to plan from day one of admission to inpatient services for the move back to community;
- **Health and social care commissioners** should ensure close coordination between the commissioning of specialised services including secure services, and other health and care services;
- **Social care bodies** have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, including working with all partners to develop and work towards delivering a discharge plan;
- **Health and social care commissioners** should audit provision to assess which services are good at supporting people with challenging behaviour (the Health Self-Assessment Framework is an effective way to monitor outcomes);
- **Health and social care commissioners** should develop effective links with children's services to ensure early planning at transition and joint services. The SEND Green Paper proposal for an integrated health, education and care plan from 0-25 will also help to ensure that children's services are similarly thinking about a young person's transition to adult services at an early stage.

Service Providers

- **All service providers** (community, residential, health, care, housing – public, for-profit and not-for-profit providers) have a duty of care to the individuals for whom they provide services and a legal duty to refer. This includes ensuring that:
    - people are safe and protected from harm;
    - their health and well-being are supported;
    - their care needs are met;
    - people are supported to make decisions about their daily lives;
    - people are supported to maintain friendships and family links.

Providers should:

- provide effective and appropriate leadership, management, mentoring and supervision. Good leadership is essential in setting the culture and values;
- have a whole organisation approach to Positive Behaviour Support training;
- recruit for values and ensure that staff have training for skills - mandatory training which can include training on value bases when working with people with learning disabilities, positive behaviour support, types of communication including non-verbal communication, active support and engaging in meaningful activities and Mental Capacity requirements. Best practice includes involving people with learning disabilities and families in the training;
- operate good clinical governance arrangements;
- monitor quality and safety of care;
- work with commissioners to promote innovation – new and different ideas, especially for the most challenging.

Assessment and treatment services

- **Health and care commissioners** are responsible for commissioning assessment and treatment services where these are needed. The focus should be on services (which can be

community based) rather than units**.** Where a person is at risk (or is putting others at risk) in a way that community support cannot help and needs to be moved to a safe place, **commissioners** should focus on this being provided close to home.

- **Health and care commissioners** should look to review any placement in assessment and treatment services regularly, and focus on moving the individual on into more appropriate community based services as soon as it is safe for the individual to do so.
- **Social care services** should be closely involved in decisions to admit to assessment and treatment services.
- All **assessment and treatment services providers** must comply with statutory guidance on the use of physical restraint.

Prisons and secure services

- **Social care services** should work closely with prison and secure services to ensure person centred planning and health action planning and to plan for appropriate provision when people move on from prison or secure services.
- **Offender management processes** should include health screening programmes that identify an offender's learning disability and any physical and/or mental health issues.

Workforce should demonstrate that they are providing quality care and support which includes:

- personal and professional accountability;
- training in working with people with complex needs and behaviour which challenges;
- developing good communication and involving advocates and families'
- monitoring an individual's progress and reviewing plans; and good understanding of the legislative framework and human rights;
- Taking action to report any concerns identified.

System and professional regulators

As a regulator, the Care Quality Commission (CQC) should:

- monitor whether services are meeting essential standards;
- take enforcement action if a provider is not compliant;
- monitor the operation of the Mental Health Act 1983.

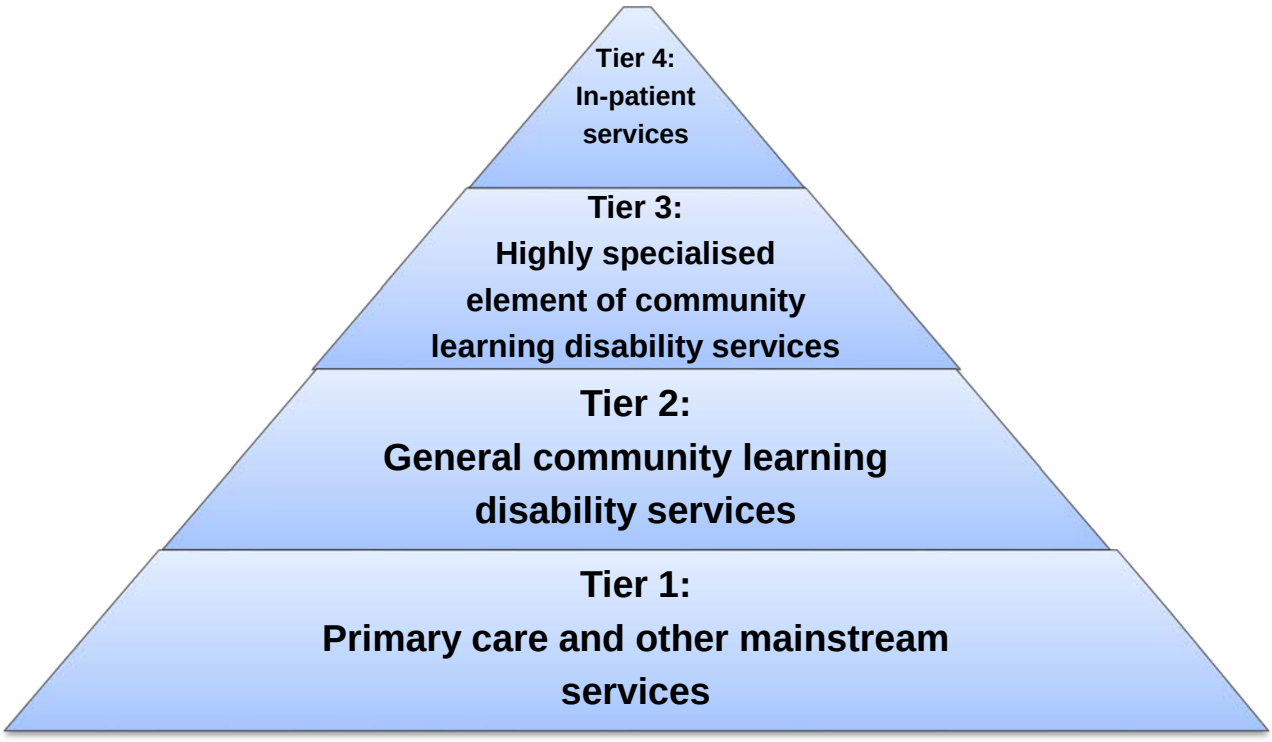
Professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), have a role to play to protect and promote public safety. They do this by:

- setting and maintaining professional standards; and
- investigating and taking appropriate action where concerns are raised about registrants, which can include the registrant being removed from the register and where appropriate being referred to the Independent Safeguarding Authority (ISA).

The professional regulators have produced a leaflet to help the public to ensure that they receive the care and treatment from professionals who meet the right standards.

Appendix 3

Tiered/stepped model of care for learning disability services (adapted from Royal College of Psychiatrists)



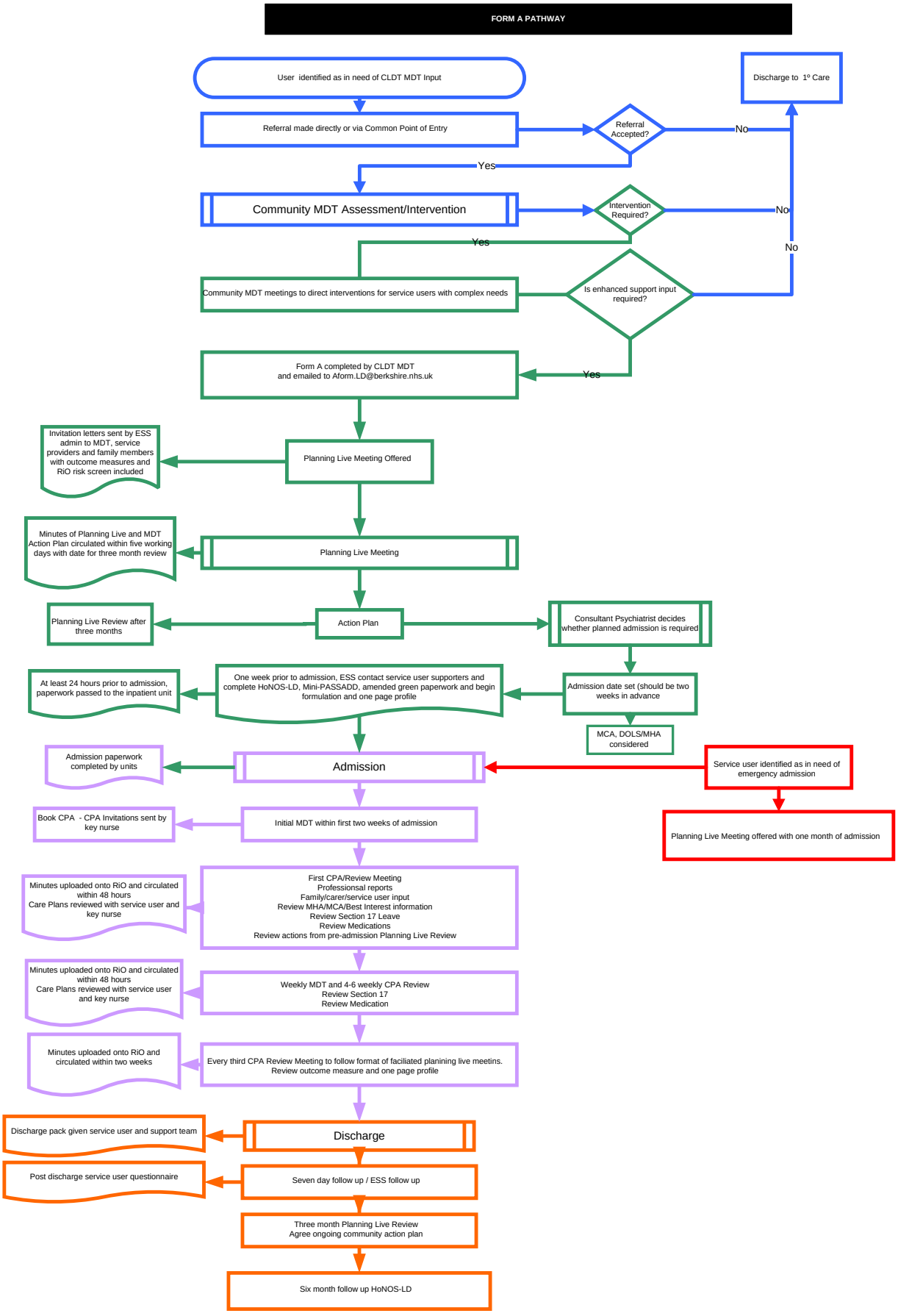
Tier 1 encompasses primary care and other mainstream services. It is the tier of service provision that serves the general health, social care and educational needs of people with learning disability and their families. The community learning disabilities team and the psychiatrist have limited direct clinical contact in this tier. Nevertheless, they are involved in activities which may influence patients' care and interacting with this tier is essential to the training of learning disability psychiatrists.

Tier 2 is general community learning disability services. At this level the person with learning disability starts to use specialist learning disability services. Most specialist services are provided jointly between health and social services or are moving towards such a model.

Tier 3 is a highly specialised element of community learning disability service. This includes areas of specialised needs such as epilepsy, dementia, challenging behaviour, pervasive developmental disorders and out-patient forensic services.

Tier 4 is specialist in-patient services. It includes all specialist in-patient services for people with learning disabilities, ranging from local assessment and treatment services to high secure forensic services.

Campion Ward and Little House Care Pathway



REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP (SRCCG) & NORTH & WEST READING CLINICAL COMMISSIONING GROUP (NWRCCG)

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**18th July 2014**	**AGENDA ITEM:**	**6**
TITLE:	**SOUTH READING & NORTH & WEST READING QUALITY PREMIUM TARGETS 2014/15**		
LEADS:	**DR ELIZABETH JOHNSTON**	**TEL:**	**0118 921 3827**
	DR ROD SMITH		**0118 982 2917**
JOB TITLE:	**CHAIR, SOUTH READING CCG**	**E-MAIL:**	**ejohnston@nhs.net**
	CHAIR, NORTH & WEST CCG		**rodsmith1@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England has the power to make payments to Clinical Commissioning Groups (CCGs) to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities. NHS England has produced "Quality Premium Guidance" for CCGs for 2014/15. The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The Quality Premium measures agreed in 2014/15 will be paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – and will be based on **six** measures that cover a combination of national and one local priority. **Four** of these measures are required to be signed off by the health and Wellbeing Board. This paper outlines the measures and the targets that have been set by the individual CCGs.

RECOMMENDED ACTION

To note and agree the following four quality premium measure targets set for North & West Reading CCG and South Reading CCG for 2014/15:

1. **Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people. Target 10.2% (NWRCCG) and 16.2% (SRCCG) reduction from baseline.**
2. **Improving access to Psychological Therapies: A 3% increases to 17.1% (NWRCCG) and 18.2% (SRCCG).**
3. **Patient experience: Chosen indicator "Improved Patient experience of Hospital care"**
4. **Medication Errors: A 10% increase in reporting at Royal Berkshire Hospital (RBFT)**

2. POLICY CONTEXT

a) NHS England issued planning guidance to Clinical Commissioning Groups (CCGs) "Everyone Counts: Planning for patients 2014/15 to 2018/19" on 20th December 2013. Alongside this guidance, NHS England produced "Quality Premium Guidance" for 2014/15 which was further revised on 13th March 2014.

b) NHS England has sought to design the quality premium to ensure that it:

rewards CCGs for improved outcomes from the services they commission against the main objectives of the NHS Outcomes Framework and the CCG Outcomes Indicator (see Background Papers for more detail)

c) The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

d) The value of this reward is a maximum of £650,000 for South reading CCG and £540,000 for North & West Reading CCG, which can be invested in improvements in the quality of services that patients receive.

e) The Quality Premium measures agreed in 2014/15 will be paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on **six** measures that cover a combination of national and one local priority.

f) A CCG will not receive a quality premium if it:

a) Is not considered to have operated in a manner that is consistent with Managing Public Money1 during 2014/15; or

b) Incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or

c) Incurs a qualified audit report in respect of 2014/15.

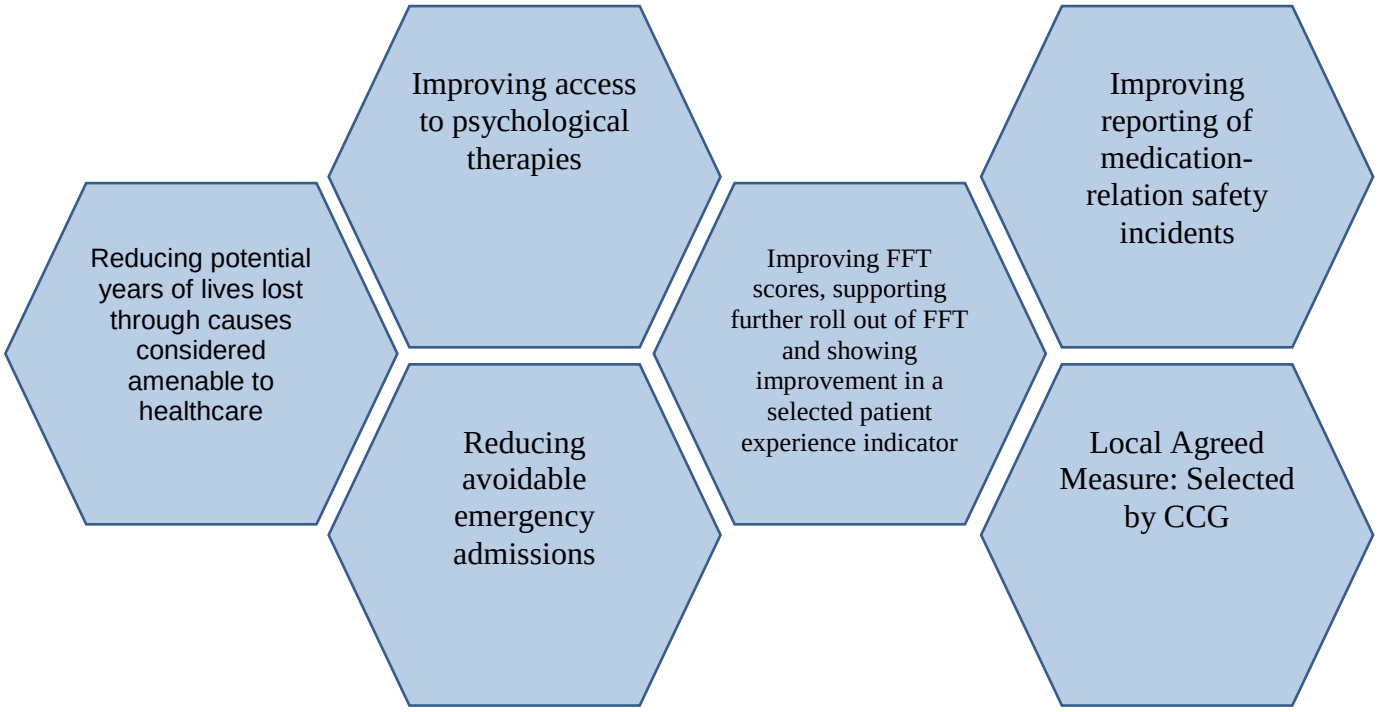
g) NHS England also reserves the right not to make any payment where there is a serious quality failure during 2014/15.

h) The total quality premium payment for a CCG will be **reduced** if its providers do not meet the **NHS Constitution rights or pledges** for patients in relation to (a) **maximum 18-week waits from referral to treatment**, (b) **maximum four-hour waits in A&E departments**, **maximum 14-day wait from a urgent GP referral for suspected cancer**, and (d) **maximum 8-minute responses for Category A red 1 ambulance calls.**

i) Regulation 2 sets out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities

j) The CCG's 2 Year Operational Plans and the 5 Year Strategic Plan supports the delivery of Quality Premium, the NHS Outcomes Framework and the Outcomes ambitions, through our knowledge of local health needs as identified in the Joint Strategic Needs Assessment (JSNA) and the Reading Health & Wellbeing Strategy.

k) The Six National Measures (including one local measure) are shown below:



3. PROPOSED TARGET MEASURES for 2014/15

Four of the above measures are required to be signed off by the Health & Wellbeing Board:

3.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people (The overarching objective for Domain 1 of the NHS Outcomes Framework)

To earn this portion of the quality premium, each CCG will need to:

a) agree with Health and Wellbeing Board partners and with the relevant NHS England area team the percentage reduction in the potential years of life lost (adjusted for sex and age) from amenable mortality for the CCG population to be achieved between the 2013 and 2014 calendar years. This should be no less than 3.2%.

North & West Reading CCG Trajectory for 2014/15	South Reading CCG Trajectory for 2014/15
Baseline of 1948 **10.2% reduction** planned across 5 years to give a plan of 1936 per 100,000 population in 14/15	Baseline of 2293 **16.2% reduction** planned across 5 years to give a plan of 2278 per 100,000 population in 14/15

As the two CCG populations are starting from different baselines, the stretch target for South Reading is consequently higher than that for North and West Reading CCG and is weighted towards greater reduction in the later years as schemes begin to deliver longer term outcomes. The measures proposed were established by comparing benchmarking data for the whole of England and calculating a revised % which would allow the individual CCGs to improve on their current performance relative to the proposed stretch recorded for the rest of England.

3. 2 Improving Access to Psychological Therapies (IAPT) (A major contributing factor to Domain 2 of the NHS Outcomes Framework)

To earn this portion of the quality premium, each CCG needs to achieve an increase in access to psychological therapies in Quarter 4 2014/15. The increase needs to be a minimum of 3% increase.

North & West Reading CCG Trajectory for 2014/15	South Reading CCG Trajectory for 2014/15
Baseline run rate – 14.1% Quarter 4 run rate – 17.1%	Baseline run rate – 15.2% Quarter 4 run rate – 18.2%

Both North & West and South Reading CCG have high baseline level of access to IAPT compared to the other CCGs in England who are below 13% currently and are only required to reach the 15% national target. Both CCGs in Reading are required to further improve by 3% (as measured at quarter 4 2014/15).

3.3 Patient Experience (A major contributing factor to Domain 4 of the NHS Outcomes Framework)

There is a requirement to have an improved average score achieved between 2013/14 and 2014/15 for one of the patient improvement indicators set out in the CCG Outcomes Indicator Set. The specific indicator is to be agreed by the CCG with the Health and Wellbeing Board, the NHS England area team and the relevant local providers. CCGs should be assured that NHS providers have plans in place to reduce the proportion of people reporting a poor experience of care in line with the locally set level of ambition.

The CCG proposes that the below indicator is selected from the Outcomes Indicator Set for this component of the quality premium.

- Patient Experience of Hospital Care

This would be based on the national CQC inpatient survey for RBFT.

3.4 Medication Errors (A major contributing factor to Domain 5 of the NHS Outcomes Framework)

A CCG will earn this portion of the quality premium if:

• it agrees a specified increased level of reporting of medication errors from specified local providers for the period between Quarter 4, 2013/14 and Quarter 4, 2014/15 and these providers achieve the specified increase.

The following measure should be agreed by the CCG with its local Health and Wellbeing Board;

- Numbers of medication errors reported at RBFT will increase by x%, as a demonstration of an open culture of reporting and learning.

- This % is yet to be agreed with RBFT but is likely to be a 10% increase and the HWBB is therefore asked to support this on the basis that 10% is agreed.

The Two Additional Measures (not required be signing off but included for information only)

3. 5 Reducing Avoidable Emergency Admissions. (A composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework)

This measure is nationally pre-determined and CCGs and local partners do not have the ability to set either partially or fully the level of improvement to be achieved. The measures for the Reading CCGs are shown below:

We have a target of a 2.8% and 3.9% decrease over 2014/15, in avoidable emergency admissions (certain specific conditions only) for North & West Reading and South Reading CCGs respectively.

3.6 Local Clinical Commissioning Group (CCG) Priorities

The local priority for South Reading CCG is to ensure 25% of Diabetics have care plans in place by 31st March 2015, from a baseline of 0%.

In North & West Reading CCG, the local priority is to increase the number of patients with an End of Life Care Plan in place by 10%.

These local priorities have previously been presented to the HWBB on 14th Feb 2014.

4. NEXT STEPS

4.1 Following feedback from NHS England a revised submission took place on 20th June 2014 to NHS England for approval. In view of the timescales for submission, we are now seeking retrospective agreement on the measures that have been submitted.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 Both the 2 year and 5 Year Strategic Plans have been shared with key stakeholders including Providers, HWBB, Local Authority, Healthwatch, Patients and carers and with NHS England between January and end of March 2014. This has included details of quality premium targets and has helped inform any alterations that were made to plans before the final submission on 20th June 2014.

6. BACKGROUND PAPERS

6.1 NHS England "Quality Premium Guidance 2014/15" 13 March 2014.

6.2 NHS Outcomes framework 2014-15

NHS Outcomes Framework 2014/15

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5 –	Treating and caring for people in a safe environment; and protecting them from avoidable harm

The Seven Improving Outcome Ambitions

1.	Securing additional years of life for people of England with treatable mental health and physical conditions
2.	Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health
3.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital
4.	Increasing the proportion of older people living independently at home following discharge from hospital
5.	Increasing the number of people having a positive experience of hospital care
6.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community
7.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

READING BOROUGH COUNCIL

REPORT BY MANAGING DIRECTOR

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**18 JULY 2014**	**AGENDA ITEM:**	**7**
TITLE:	**HEALTH AND WELLBEING STRATEGY AND ACTION PLAN**		
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 updates the Board on the review of the Health and Wellbeing Strategy and action plan following a joint workshop and subsequent feedback from local commissioners of Health and Social Care, elected members and representatives of partners.

1.2 Appendices with this report:

- The outcomes of the Health and Wellbeing action plan workshop (Appendix 1);
- The updated Health and Wellbeing action plan (Appendix 2);

2. RECOMMENDED ACTION

2.1 To note the updated Health and Wellbeing Strategy Action Plan.

2.2 To agree that the action to deliver the Health and Wellbeing Strategy is managed and monitored centrally by the Public Health Team in Reading.

2.3 That the Board receive an update on overall progress on the action plan every six months.

3. POLICY CONTEXT

3.1 The Reading Health and Wellbeing Board has been working collaboratively with Health partners since it was established in response to our statutory obligation. The Board is responsible for ensuring effective delivery of health programmes and initiatives across the Borough and this work is influenced by the jointly produced Health and Wellbeing Strategy for Reading.

4. HEALTH AND WELLBEING STRATEGY AND ACTION PLAN

4.1 The outcomes of the workshop show that there is still a way to go in the development of robust ways to plan and monitor activity across the health provision where many organisations contribute to delivery. Each organisation has their own methods of managing a tracking progress with areas of delivery. Delivery has continued without there being firm joint arrangements in place.

4.2 An overall outcome of the workshop and specific feedback from stakeholders attending was that the action plan required clear leads and a better understanding of roles and responsibilities. This was a main theme throughout the workshop and is one of the key actions that will take place as detailed in the 'how we will respond' table on page 1 of Appendix 1.

4.3 The following key areas were highlighted in the overall feedback from the session and subsequent feedback received. Actions and timescales to respond to each of them have been outlined in Appendix 1.

- Action plan needs ownership, names, role, leads & agencies;
- Stakeholders understanding their roles and responsibilities;
- Greater need to involve the public and voluntary sector;
- SMART targets and clear measures should be included;
- Achievements need to be publicised to raise awareness.

4.4 Feedback on each of the goals gave general areas where development could take place to improve outcomes and although the goals are broad no specific recommendation was made to update or review them.

4.5 The action plan has also been updated (Appendix 2) and now includes a RAG status, areas for improvement and what the first step might be to achieving that improvement. A plan with timescales to respond to feedback on the goals and the activity within the action plan will be developed once leads have been identified.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Health and Wellbeing Strategy and action plan 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

7.1 No equality impact assessment has been undertaken for this report.

8. LEGAL IMPLICATIONS

8.1 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. The ring fence grant from the Department of Health for Reading is £8.212 million for 2014/15.

9.2 H&WB 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

10.1 No background papers.

Outcomes of the Health and Wellbeing Action Plan Workshop

Key health partners in Reading came together to review the health and wellbeing action plan for Reading at a workshop on 2nd April 2014. The workshop was attended by 25 representatives from across Health and Social Care including attendees from Healthwatch and the voluntary sector.

Each of the four goals were reviewed and some overall feedback was also captured. Where possible the activity for each objective was ranked with a red, amber and green status and improvements in some areas were also highlighted.

Some areas of the action plan didn't fall within the remit of local health partners and although an opinion on progress could be given, it was decided that in some areas without input from representatives from NHS England and the like it was difficult to make an informed judgement. The landscape and range of organisations which make up the new health structure make it difficult for us to monitor and track the very wide remit of our strategy and goals. However, the information from the workshop has since been circulated giving those not at the workshop an opportunity to respond.

Overall Feedback

- Action plan needs ownership, names, role, leads and agencies;
- Stakeholders understanding their roles and responsibilities;
- Greater need to involve the public and voluntary sector;
- SMART targets and clear measures should be included;
- Achievements need to be publicised to raise awareness.

How we will respond

Feedback	Response	Timescale
Action plan ownership	PH will take a clearer lead role for the overall strategy and action plan. Named leads will be identified for each activity.	Ongoing Aug 14
Stakeholder role	Clear roles and responsibilities will be set out and agreed with stakeholders.	July 14
Greater involvement	Existing engagement opportunities will be mapped out to identify and gaps An engagement plan will be developed.	Aug 14 Dec 14
SMART targets	Work with named leads to review activity within the action plan, remove completed activity, and introduce SMART targets and clear measures.	Dec 14
Achievement communication	Work closely with stakeholders and the communications team to develop a better way to share success.	Mar 15

Public Health will lead the response above, but will need the support of stakeholders and officers across the Council to deliver to the timescales detailed in the plan above.

Specific Feedback on the Goals

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

- Better co-ordination with voluntary sector
- Tackling poverty strategy correlation
- A planned approach to allow meaningful involvement

Goal 2 Increase the focus on early years and the whole family to help reduce health inequalities

- Join up groups/initiatives
- Better links to Reading University to build activity/capacity
- Specify who will lead on initiatives. Not a service, but in that context and review current leadership

Goal 3 Reduce the impact of long term conditions with approaches focused on specific groups

- Information sharing across the whole system
- Supporting integration to reduce duplication and make the best use of resources
- Joint Working/Commissioning across the system & to build community capacity and empowerment

Goal 4 Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities

- Implement effective & tailored pathway for each of the areas in this objective
- What don't we know because it's not in the JSNA?

Feedback on Action Plan Activity

The following feedback from stakeholders was captured at the workshop.

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

- Clarity needed on roles and responsibility for HIV testing
- Work better with partners on messages around Flu and MMR vaccines
- Work more closely with the Trust

Goal 2 Increase the focus on early years and the whole family to help reduce health inequalities

- Need to engage the correct stakeholders for maternity services
- Domestic Violence work needs a clearer focus
- Joined up work is already taking place, need to build on this

Goal 3 Reduce the impact of long term conditions with approaches focused on specific groups

- Review the language used and where activity sit
- Link up and support integration work to reduce duplication
- Invest in voluntary sector and develop better community capacity

Goal 4 Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities

- Wide range of services covered by this goal makes it difficult to get a clear picture on where we are
- Common themes and clear progress required

- Deliverables and measures need to be confirmed

Stakeholders that attended the workshop and those who have since responded to the information circulated have updated areas of the action plan. The action plan now has RAG status updates, areas for improvement and what the first step might be to achieving that improvement.

How we will respond

Once named leads have been identified for the action plan Public Health will work alongside them to review the feedback above and respond, as well as review the areas for improvement and first step actions captured on the action plan as a result of the review exercise.

Draft Health and Wellbeing Action Plan 2014/15

Goal	What Do We Want To Achieve	What Will We Do	Who Will Lead This Work	RAG Status	What needs to improve?	What would be the first step to achieve this?
Promote and protect the health of all communities particularly those disadvantaged	**OBJECTIVE: 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 (Extended).	Undertake a sexual health needs assessment	Public Health	Green	Consultation method was paper. Why not on line? Also too long. Needs to be more user friendly (extend consultation to all risk groups).	Early community engagement with the process. For example, Asking Youth Cabinet to help design questions.
	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	Adult Social Care /Public Health	Red	We need to do this.	Clarify responsibility for HIV testing in community and primary care. Needs ownership. Need to talk to Thames Valley Positive Support.
	To reduce transmission of HIV (to be linked with Late Diagnosis - Below)	Increase awareness and information about HIV and HIV services (including eligibility, confidentiality, treatment and what it means to live with HIV); and promote preventative services	Public Health in LA, CCGs/NHS England, voluntary organist	Amber	Increased awareness and at earlier stage. Co-ordinated work -> To identify gaps & clarity of respective roles.	Co-ordinate with RAHAB & Thames Valley Positive Support. Consultant in Public Health to provide clarity of responsibilities. Clear briefing about what is currently happening.
	To reduce late HIV diagnosis (to be linked with Transmission - Above)	Increase opportunity to and uptake of testing and disseminate information about opportunities for testing to targeted/vulnerable groups	NHS England, who commission GPs & in Secondary Care Blood Donation Service	?	As above.	As Above
	To provide high quality care/treatment	Primary Community Prevention	Secondary care/Hospital	Red	?	Review objective so it accurately reflects what we want to achieve.
	Anything Missing?	Other comm, diseases, e.g.. TB & measles	Public Health	?		
	OBJECTIVE: 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		Report on user feedback to Access & Disabilities Working Group	Suggest agenda item to working group. Need to have appropriate representation.
		ASB Risk assessment leads to enhanced response for vulnerable people and communities	Community Safety	?	? - Don't know, but need to find out.	
	Improve living conditions for vulnerable and disabled residents	Reduce the number of Category 1 hazards under the Housing Health & Safety Rating System, to improve living conditions.	Regulatory Services	Amber	Under reporting by tenants, intimidation & lack of compliance by landlords, targeting the most vulnerable.	Work with partners to ensure greater understanding of risk and enforcement activities. Widen use of evidence to target the most vulnerable.
		Undertake enforcement action for overcrowding in private sector housing	Regulatory Services	Amber	Under reporting by tenants, intimidation & lack of compliance by landlords, targeting the most vulnerable.	Work with partners to ensure greater understanding of risk and enforcement activities. Widen use of evidence to target the most vulnerable.
	Anything Missing?	Travelling communities	DEACS			
	Anything Missing?	Need to have specific reference to BME				
	Protect the vulnerable from aggressive doorstep selling, rogue traders and scams	Support the National Scams Hub and provide advice to victims. Provide a rapid response and full investigation of doorstep selling offences.	Regulatory Services	Green	Improved links/joint working with police. Education of vulnerable consumers. Successful prosecutions of offenders	Raise with PCC and TVP at Community Crime Group
		Provision of Grants & Loans (inc Disabled Facilities Grants)	Regulatory Services	Green	Further improve processing times.	Provision of surveying support.
	OBJECTIVE: 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, CCGs, PHE (B/screening)	Green	Are there culture sensitivities? Cultural diversity re bowel screening. Need to increase awareness across the board.	More engagement, BME groups, community groups. Appropriate publicity in different langs. Targeted awareness. Weekend & evening appointments.
	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 & CCGs	Amber	Increased uptake in some GP practices & ethnic groups.	Continue to prioritise at CCG & practice level. More effective communication via midwives. More targeted work in relation to flu uptake.
	To promote MMR vaccine uptake - Develop to increased uptake of MMR	Scrutinise vaccine uptake results and provide leadership. Campaign - Primary Health/CCs/Health Visitors	Public Health England - Needs to be localised to practice level	Green/Amber	Still myth busting re autism link. Recall systems/health visitors delivering.	Communication/publicity.
	Increase uptake of screening in people with a learning disability	Reading Learning Disability Partnership Board to advise on targeted improvements	Partnership and Development (who are they?)	?		Ask the board what is happening.
	Anything Missing?	*Needs better communication between all services/agencies to ensure no duplication or gaps & to inform better practice.				

Draft Health and Wellbeing Action Plan 2014/15

Goal	What Do We Want To Achieve	What Will We Do	Who Will Lead This Work	RAG Status	What needs to improve?	What would be the first step to achieve this?
Increase the focus on early help strategy and the whole family to help reduce health inequalities	**OBJECTIVE: 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	Insufficient knowledge	Improve communication on impact & effectiveness. Review who leads this work - to join up work of LA & Health	
	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)	NHS England	Insufficient knowledge	Improve communication on impact & effectiveness. Review who leads this work - to join up work of LA & Health	
	Increase access to good quality & affordable childcare.	Provide 15 hours free early education childcare to all two year olds meeting the free school meals criteria (will need to review given change in FSM).	TBC - LSP?	Amber	Need to have data to inform the debate. Links to economic development & poverty agenda.	Is both access to free early education & general access.
	Improve quality of provision in PVI sector		Early Years & Extended Schools			
	Provision of childcare for older children aged five and over	Joint working - engagement with schools.	Early Years & Extended Schools			
	OBJECTIVE: Reduce inequalities in early development of physical and emotional health, education, language and social skills					
	To engage with single plan, local offer, joint commissioning, personal budgets. *N&W SEN framework, so this needs reworking to address new requirements.	Provide impartial support to parents seeking assessment for children with special educational needs or disabilities through the parent partnership service	SEN/CSC & Health	Amber	Get report to HWB. Target sources to implement C&F action at parents, to ensure **Aggenton** NDI & strategic level	Update objectives & refresh
		Influence decisions for the early intervention panel for support children aged 0-5 with SEN	Early Years & Extended Schools	Green/Amber		
	Reduce speech and language inequality	Implement the language strategy and deliver supported projects	Early Years & Extended Schools	Green	Achieved - END	
		Provide access to speech and language therapies within the EY settings	Early Years & Extended Schools	Green	Achieved - END	
	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	BHFT	Green	Improve information on the impact this work has had & if we need to improve/change targeting	Report needed to HWB board. Accredit action achieved? When achieved, maintain.
		Continued implementation of the Breastfeeding Peer Support Project	BFN	Green	Do we know stats worked elsewhere? If so, can we do better?	
	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/ BHFT	Insufficient Information	Improve communication so we know.	Review outcomes. Continue to review number of toothbrushes & packs distributed via children's centres.
	Reduce the prevalence of unplanned teenage pregnancies (refresh needed)	Continued implementation of designated young people friendly drop-in clinics and promotion of the Young people's health website (JUICE).	RBH	Green	Improve real-time information available to all partners.	
	Improve/develop use of technologies to get information to parents on H&WB information& support					
	Children's Centres as a 'hub' to access support to children & families (L 5 years)	Mental Health Issues	BHFT		Identifying major issues	Monitor Outcomes
	Beat the Street initiative	Looked after children	CCG			Monitor Outcomes
	Anything Missing?	Infant mortality			Tackling risk factors of prematurity like smoking during pregnancy	
	OBJECTIVE: 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. Needs to cover whole health professional	Implement the IRIS project as a Pilot in 12 of the Reading practices (6 in each CCG). Higher referral rates to police & early help services.	Berkshire Women's Aid	Red		
	Outcomes family choice project		Housing, Neighbourhoods and Community Services		Improve quality of referral information from all agencies Communication with DV strategy group (including governance links)	professionals are confident and can manage risk appropriately Two half day tips training (for primary health care team)
	Anything Missing?	Review DV commissioning strategy	Housing, Neighbourhoods and Community Services			Report to partnership board
	Anything Missing?	Better links with Reading University to build activity & capacity in these areas.			Identifying vulnerable children & mapping access/health outcomes e.g. Children with diabetes/ on CP plans. Something on Health Visitor transition to LA & how this could support Goal 2	

Draft Health and Wellbeing Action Plan 2014/15

Goal	What Do We Want To Achieve	What Will We Do	Who Will Lead This Work	RAG Status	What needs to improve?	What would be the first step to achieve this?	
Reduce the impact of long term conditions with approaches focused on specific groups	**OBJECTIVE: Assist and support ability to self-care in all adults and young people with existing long term conditions**						Improved communication & information sharing across health & social care. (MIG) smart cards/apps etc.
	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. Target specific groups better.	Public Health	Amber	Improve recording & delivery of health checks across health & social care	Community Health Checks to be developed by Public Health. Move to goal 1 as screening	
		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. Care planning, diabetes/care homes. Directory of signposting services to support self care.	PDSN Network. Goal One.	Amber	Need to extend to other LTCs		
	Self Care	Expert patient programmes. Not commissioned.	We have 'Talking Health', CDM/COPD, eggs		Recruitment of 'patients'/commission jointly		
	Anything Missing?	NHS Health Checks & other screening checks (HIV, dementia/depression etc.)	Public Health		Identify specific groups	Goal one	
	Anything Missing?	Telecare & Telehealth	Adult Social Care		COPD/HF, Also evaluation of work		
	Co-Production with PT groups	For pathway & support	Adult Social Care				
	Support the work of the Home Improvement Agency	Enable the ability for people to remain living in their own homes by reducing accidents in the home	Regulatory Services	Amber	Ability to assist a greater number of people through the handyperson service	Additional funding to enable more vulnerable residents to have small handyperson jobs carried out to reduce slips and trips and costs associated with hospital stays, rehabilitation and home care	
	OBJECTIVE: Ensure high quality long term condition services are available to all						
	Increase public say in support available	Deliver activity within the Learning Disability Plan - A Big Voice. 2014 end date. Refresh of LD plan ongoing	Adult Social Care	Amber	Susses to date, but some actions remain. Areas identified in joint health & social care assessment need to be actioned & take forward.		
	Increase engagement for planning LTC services for those with learning disabilities	Support the Reading Learning Disability Partnership Board to engage with LTC projects	Adult Social Care		Use frail elderly pathway to set strategy for Goal 3		
	Anything Missing?	Access to services for LDs. Health & Social Care Joint Assessment	Adult Social Care				
	Anything Missing?	LD Liaison Nurse in RBFT	Adult Social Care				
	Anything Missing?	LD Health Checks	Adult Social Care	Amber			
	Anything Missing?	Identify those who do not access services who we should target	Adult Social Care				
	OBJECTIVE: 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. Plan in plan & resource in place across West Berkshire. Now needs to be implemented.	Adult Social Care	Amber			
	Increase take up of service from marginalised groups.	Deliver activity within the Reading Carers Action Plan. Including: Reading Carers Communication. Gaps identified.	Carers Steering Group	Amber	Implement the carer's action plan.		
	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. Some respite available. Lack of capacity. Strict criteria needs to be met.	PDSN Network	Amber/Red			
	Service provision and needs are better matched.	Review future commissioning plans against the needs of carers	Carers Steering Group				
	Anything Missing?	Support for carers in a wider sense. E.g.; support at home etc.	Carers Steering Group				
	Anything Missing?	Development of the sector to provide community capacity.	Adult Social Care		More involvement in voluntary sector.		
	Anything Missing?	*Needs to be refreshed in line with BCF	Adult Social Care				

Draft Health and Wellbeing Action Plan 2014/15

Goal	What Do We Want To Achieve	What Will We Do	Who Will Lead This Work	RAG Status	What needs to improve?	What would be the first step to achieve this?
Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities	**OBJECTIVE: Improve tobacco control and reduce harm due to alcohol and drug misuse in Reading**					
	Detect and take action against illegal tobacco suppliers	Implement/enhance the Berkshire-wide Tobacco Control Plan	Regulatory Services	Not Known	Further communicate re content & status of plan	Request circulation of plan & update. Consider future report to H&WBB
	Detect and take action against illegal alcohol consumption/supply	Identify areas where there is known underage drinking for targeted intelligence led enforcement response.	Regulatory Services	Amber	RAMEG protocol updated and agreed by TVP and partners. Further communicate re content & status of plan	Request circulation of plan & update. Consider future report to H&WBB. Report through DADG
	Detect illegal and potentially unsafe alcohol products, illicit tobacco and NPS	Intelligence led enforcement visits	Regulatory Services	Amber	Identifying sources	School Survey
	Ensure businesses are complying with marketing requirements of tobacco products including display bans and plain packaging.	intelligence led enforcement visits	Regulatory Services	Amber	Resources to conduct checks provided by CAP officer	Recruit CAP officer
	Reduction in drug related deaths	TBC (long term substance misusers)	Drug and Alcohol Action Team	Green	Clarification as to whether work will be driven locally or Berkshire wide. Consistency/clarity of what is a DPD	
	Reduction in drink and drug related harm/injury	Run First Stop Bus in the Town Centre	Regulatory Services	Amber	Decision over commissioning of service and replacement of Coordinator. Clarification over reporting lines. Greater buy in from NHS. Assessment of outcomes. Further funding.	Report to Project Board/CSP
	Successful completion of treatment & indicator around prevention	Re-commission drug & alcohol services	DAAT community safety	Amber	More emphasis on prevention education. Further/affective use of resources via recommissioning	Ensure robust monitoring of new arrangements benchmarking performance with statistical neighbours
	Reduce alcohol consumption in young people	Introduce Community Alcohol Partnerships across Reading	Regulatory Services	Green	Recruit 1 year fixed term coordinator and produce implementation project plan	Complete recruitment process and project plan
	Provide national and local information to smokers on a Smoke free homes and cars campaign	Provide information to smokers via doctors surgeries, pharmacies libraries and work place newsletters on smoke free homes and cars main messages	Tobacco Control Alliance Coordinator	Amber	Better links to National schemes, better publicity of what we do locally.	Project plan, lists of premises to be targeted, press release or press briefing ref this work. Partnership working with local businesses
	Secondary School pupils smoking and drinking habits survey	Survey as many 11-18 year olds in full time education in Reading on their smoking and drinking habits.	Tobacco Control Alliance Coordinator	Amber	Better information regarding this project to partners and Cllrs	Getting the schools to sign up to the project before July 2014,.
	Peer mentoring of year 10 pupils in secondary schools-to provide stop smoking support to those in year 10 or younger	Following smoking survey report provide as required a peer mentoring programme for Reading Secondary schools. Provide mentor training and refresher training through the year.	Tobacco Control Alliance Coordinator	Amber	Being provided with survey statistics regarding potential use of the peer mentoring programme	Provision of data base of peer mentor trainers, full support of the scheme from secondary schools
	Better intelligence sharing between Tobacco Control Alliance Partners	Share intelligence regarding illegal tobacco and non compliance of tobacco related legislation between Police/HMRC/ UA/PH/RBFR	Tobacco Control Alliance Coordinator	Amber	All partners share intel via IDB, or via secure mail links	Providing overarching template regarding the sharing of data and ensuring data sharing is done so timely and securely
	OBJECTIVE: 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	Green/Amber	More focus on health/leisure walks	Respond to outcomes of cycle strategy. Create capacity around health walks.
	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 targeted community interventions	Public Health	Amber	Awareness targeted & community Access	Understanding current levels of activity
	Access to wider workforce, community, peer support role	Review Health Trainer Service and Activity	Public Health	Red	Could link to VCO service B	Review need for any future provision re MT or alternative models
	Key pathways for risk factors e.g. diabetes, obesity, CHD etc.	Develop /renew pathways	Public Health		GAP Analysis. More co-ordination **bln** services	

OBJECTIVE: 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 children's' centres	Early Years & Extended Schools	Not Known		
	Provide family learning for cooking on a budget and healthy eating	New Directions	Not Known		
	Introduce Eat Well Get Well initiatives such as BHF Healthy hearts scheme to tackle obesity	Regulatory Services	Red	Funding stream needs to be secured in order to progress a healthy eating award	Set up action plan and review whether support can be obtained through LSP.
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	BHFT - School Nursing Locality Lead	Amber	Finalise Healthy Weight Strategy	
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)	Public Health Berkshire Youth - Lets Get Going Co-ordinator	Green		
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	Amber	Finalise Healthy Weight Strategy	
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.	Public Health		Work through tendency process. Check re adolescents with scope of tender	
Increase access to physical activity programmes	GAP Analysis & mapping	Public Health / Environment, Culture and Sport			Development of Berkshire PA Framework
Increase take up of your Reading Passport		Environment, Culture and Sport			

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT AND CHILDREN'S SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**18 JULY 2014**	**AGENDA ITEM:**	**8**
TITLE:	**WINTERBOURNE VIEW PROGRAMME UPDATE**		
LEAD COUNCILLORS:	**COUNCILLOR HOSKIN/ COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ADULT CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**BRIGID DAY / SUZANNE WESTHEAD**	**TEL:**	**0118 937 3207**
JOB TITLE:	**HEAD OF COMMISSIONING AND IMPROVEMENT / HEAD OF ADULT CARE**	**E-MAIL:**	**Brigid.day@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To update the Board on the position of Reading residents placed in assessment And treatment hospital provision, reviewed under the Winterbourne View programme.

1.2 To agree the joint commissioning plan drafted by the Berkshire West councils and CCGs to address the needs of people with Learning Disabilities and challenging behaviour.

1.3 See attached draft Joint Commissioning Plan 'Transforming Care'.

2. RECOMMENDED ACTION

2.1 That the Board notes the progress made.

2.2 That the Board agrees the draft commissioning plan.

3. POLICY CONTEXT

3.1 In December 2012 the Department of Health published its final report Transforming Care: A National Response to Winterbourne View. The report plus the Winterbourne View Review, Concordat: Programme of Action set out steps to respond to the failings that led to the abuse at Winterbourne View and a programme of action to transform services to ensure people no longer live in hospital settings which are inappropriate.

3.2 **Transforming Care: a national response to Winterbourne View:**

In summary the main national recommendations from the Department of Health were:

- All current placements reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014.

- By April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with a prescribed model of good care.

4. CURRENT POSITION

4.1 **Progress made to support the discharge of people with a learning disability and / or Autism from NHS in patient settings:**

The following information is provided as an update to that provided in September 2013. This information was also submitted to Department of Health in May 2014. There now only remain 3 people from the 8 people initially identified in Reading at the start of the programme in 2012. There has been some fluctuation in numbers of people admitted and discharged through assessment and treatment and changes in circumstances of individuals. However, the following demonstrates our progress in ensuring patients are assessed and plans made for them to move to settled accommodation at the earliest opportunity.

Client	CCG	LA	Current placement	Update on situation	Comment
1	South Reading	Reading	Out of area in specialist NHS long term rehab provision	Expected to remain detained under Mental Health Act. Needs long term hospital placement. Family would prefer move nearer to Reading.	No long term hospital beds nearer Reading identified, that meets client's highly complex needs. Likely to remain in current placement with regular reviewing of situation with family re moving back closer to Reading area.

2	South Reading	Reading	NHS local Assessment and Treatment Service	Discharged to Supported Living unit in Reading.	Target date achieved.
3	South Reading	Reading	Independent Hospital Rehab unit out of area	BHFT and social worker identified potential providers.	Client detained long term under Mental Health Act. Accommodation and support provider identified and progessing. Funding application in progress. Statutory MHA meetings ongoing re discharge planning.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The strategy contributes to the council's strategic aim of *promoting equality, social inclusion and a safe and healthy environment for all.*

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 It is planned to have a consultation on the draft strategy across the participating organisations. In Reading council this will be led by the service manager for disability and will include the Learning Disability partnership board and the Disability Strategy group.

7. EQUALITY IMPACT ASSESSMENT

7.1 The draft strategy is targeted on meeting the specific needs of people with a learning disability who have challenging behaviour, which aims to improve their equality of opportunity. An impact assessment will be required as part of the implementation plan to ensure any different needs are met of people within this group.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications arising from the update or draft strategy.

9. FINANCIAL IMPLICATIONS

9.1 Individuals placed detained in hospitals and assessment/treatment units are funded by the NHS. When those people move to placements in the community there could be cost implications for local authority social care funding.

READING BOROUGH COUNCIL

REPORT BY NHS ENGLAND

TO:	**Health and Wellbeing Board**		
DATE:	**18th July 2014**	**AGENDA ITEM:**	**9**
TITLE:	**Briefing on review of future need for services currently delivered at the Reading Walk-in Centre**		
LEAD COUNCILLOR:	**Councillor Hoskin**	**PORTFOLIO:**	**Health**
SERVICE:	**Primary Care**	**WARDS:**	**Boroughwide**
LEAD OFFICER:	**Nicky Wadely**	**TEL:**	**01865 963896**
JOB TITLE:	**Contract Manager NHS England**	**E-MAIL:**	**england.tvatmedical@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Reading Walk in Centre in Broad Street Mall opened in August 2009 providing an 8am to 8pm, 7 days a week service to registered patients (like a conventional GP practice) and a walk-in service for registered and non-registered patients. The Centre opened following a competitive tender process that offered a contract on a 5 year term with the option to extend for a further 2 years. The initial 5 year term expires in August 2014 and discussions are currently taking place with the Provider, Assura Reading LLP, to extend the contract until August 2016. This briefing outlines the proposed review and evaluation process being taken jointly with Reading Clinical Commissioning Groups prior to a decision on whether to recommission this service provision post August 2016.

1.2 The review will also need to be considered in the context of the CCG primary care strategy and proposal for delegated authority from NHS England for the CCG to co-commission aspects of primary care.

2. RECOMMENDED ACTION

2.1 ***The Reading Health and Wellbeing Board is asked to note the review process of the Reading Walk in Centre as part of the needs assessment and engagement as a key stakeholder in the proposed consultation on the future of the service***

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 has given local authorities a much stronger role in shaping services and responsibility for local population health improvement. The Health and Wellbeing Board brings together local commissioners of health and social care, elected members and representatives

of partners to agree an integrated way to improve local health and wellbeing, which has resulted in the development of a joint Health and Wellbeing Strategy.

3.2 The provision of services at the Walk in Centre helps contribute to the aims of the Health and Wellbeing Strategy, especially Goal One - Promote and protect the health of all communities particularly those disadvantaged.

3.3 The Council's Housing, Health & Community Care Scrutiny Panel received a report on the first six months of service provision at the Walk in Centre on 11 March 2010 (Minute 49 refers).

4. THE PROPOSAL

4.1 Background

The Reading Walk-in Centre, located in the Broad Street Mall, Reading, opened in August 2009 providing an 8 to 8, 7 days a week service to registered patients (like a conventional GP practice) and a walk-in service for registered and non-registered patients. The Centre opened following a competitive tender process that offered a contract on a 5 year term with the option to extend for a further 2 years. The 5 year term expires in August 2014 and discussions are currently taking place with the Provider, Assura Reading LLP, to extend the contract until August 2016.

Assura Reading LLP is a joint venture between established local GP practices across Reading and a health provider organisation.

In the last year 38,085 walk-in consultations have taken place and as at 1st April 2014 6,632 patients have registered with the Centre.

4.2 Responsibilities and need for review

NHS England (Thames Valley) is responsible for commissioning primary medical care services for registered patients and Clinical Commissioning Groups (CCGs) are responsible for primary care services for non-registered patients, such as urgent care centres like the Reading Walk-in Health Centre. NHS England (Thames Valley) currently holds the contractual liabilities for the whole service. In the run-up to contract end NHS England (Thames Valley) needs to evaluate the case for re-commissioning the list-based service for registered patients, whilst the CCGs need to decide whether to re-commission the 'open access' element of the service. It has been decided that this evaluation should be conducted as a whole, led by NHS England (Thames Valley) with the involvement of all key stakeholders

4.3 Process

An assessment is being made of:

- Patient and population need (current and future)
- Value for money of the current contract
- Impact assessment if the service were decommissioned at the end of the contact period, including capacity of current services to meet the needs of the population

- Quality of service provision and Patient experience of current services
- Strategic Alignment with CCG and NHS England commissioning plans and the Local Authority's JSNA, gap analysis of services and Health & Wellbeing strategy
- Alternative service models to meet the needs of the population resulting in the development of a consultation proposal and paper to be presented to appropriate decision-making forums.

4.4 **Timeline**

Needs Assessment	January – July 2014
Development of the Consultation	July – September 2014
Consultation on options	October 2014 – December 2014
Decision making	December 2014
Re-procurement commencement	in early 2015
Or De-commissioning of service	

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The review will support the strategic aim to promote equality, social inclusion and a safe and healthy environment for all

5.2 The Review will also contribute to development of Health of the people of Reading

6. COMMUNITY ENGAGEMENT AND INFORMATION

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

6.2 Patients who use the Walk in Centre will be asked to take part in a survey to help understand how the service is utilised and also their views of the current service provided. In addition, as part of the consultation phase of the review, views of wider stakeholders will be collected and considered.

The list of stakeholders to be engaged in this process will include:

- Berkshire West CCGs
- Berkshire West Urgent Care Board
- Public Health
- Health and Wellbeing Board
- Overview & Scrutiny Committee
- Local Medical Committee
- GP Practice patient and public groups
- Healthwatch
- Local healthcare providers

7. EQUALITY IMPACT ASSESSMENT

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

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

7.2 An Equality Impact Assessment (EIA) will be considered as part of the process to determine the options for consultation considering the differential impact on: racial groups; gender; people with disabilities; people of a particular sexual orientation; people due to their age; people due to their religious belief

8. LEGAL IMPLICATIONS

8.1 In accordance with Health and Social Care Act 2012 the NHS Commissioning Board (otherwise know as NHS England) is responsible for direct commissioning of services beyond the remit of clinical commissioning groups, including primary care services. Therefore NHS England is responsible for commissioning this service, in partnership with the Reading CCGs.

9. FINANCIAL IMPLICATIONS

9.1 Each option developed will consider the financial implications and Value for Money (VFM).

10. BACKGROUND PAPERS

10.1 NHS England policy on managing time limited medical contracts
http://www.england.nhs.uk/wp-content/uploads/2013/07/mng-end-tmlim-con-pms.pdf

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT AND CHILDREN'S SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**18 JULY 2014**	**AGENDA ITEM:**	**10**
TITLE:	**PROTOCOL AGREEMENT BETWEEN READING LOCAL SAFEGUARDING CHILDREN'S BOARD, HEALTH AND WELLBEING BOARD AND CHILDREN'S TRUST BOARD**		
LEAD COUNCILLOR:	**COUNCILLOR GAVIN**	**PORTFOLIO:**	**CHILDREN'S SERVICES**
SERVICE:	**CHILDREN'S SERVICES**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**ESTHER BLAKE**	**TEL:**	**01189 373269**
JOB TITLE:	**BUSINESS MANAGER FOR READING LSCB AND CHILDREN'S TRUST PARTNERSHIP**	**E-MAIL:**	**esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The attached protocol sets out the expectation of the relationship and working arrangements between Reading Local Safeguarding Board (LSCB) Reading Health and Wellbeing Board and Reading Children's Trust.

1.2 It is a statutory requirement that agencies working with children and young people work closely in partnership to ensure the best outcomes are achieved effectively. All statutory agencies with responsibility for providing services for children and young people, plus the voluntary sector and young people themselves, are represented on one or more of these three partnership boards. It is therefore vital that these three boards communicate effectively to ensure a joined up approach and avoid duplication.

1.3 The Health and Wellbeing Board are asked to endorse the protocol, which has already been agreed by both the LSCB and the Children's Trust.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board endorse the attached protocol agreement.

3. POLICY CONTEXT

3.1 There has been a protocol agreement in place between Reading LSCB and Reading Children's Trust for 5 years. This has ensured that reports or concerns have been disseminated or discussed at the most appropriate board. It has also ensured that priorities have been discussed and consulted with each partnership group, plus the annual reports for each board have been presented to the other for discussion and challenge where necessary.

3.2 With the introduction of the Health and Wellbeing Board, the protocol needed to be reviewed and rewritten to ensure the inclusion of all three boards.

4. THE PROPOSAL

4.1 The Reading LSCB and Children's Trust Boards have already endorsed this protocol, acknowledging that it represents best practice. It is recommended that the Reading Health and Wellbeing Board also endorse the protocol.

4.2 The shared principles for this working protocol are:

- The boards will work together to minimise the duplication of reports and actions, and that there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.
- The boards share a commitment to a strategic approach to understanding needs, in a way that includes analysis of data and effective engagement with frontline practitioners, with children and young people, with families.
- The Partnerships are committed to developing a joined up approach to understanding the effectiveness of current services (what difference does it make) and identifying priorities for change – including where services need to be improved, reshaped or developed.
- All three Boards will work together to provide constructive challenge to one another and partners.

4.3 The protocol lists the key responsibilities of each board, and how each one should interact with the other. This includes ensuring that each board is consulted when one of the related strategic plans is re-written, such as the Health and Wellbeing Strategy and the Children and Young People's Plan, plus any annual reports from one board are presented to the others, such as the LSCB Annual Report.

4.4 The protocol details the key lines of communication between the boards and describes the interconnectedness of senior management representation on each board which ensures key topics for discussion/concern are made aware across the partnerships.

4.5 It also describes the route by which concerns highlighted by one board can be raised with one of the other boards.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This protocol contributes to the following Council strategic aims:

- To establish Reading as a learning City and a stimulating and rewarding place to live and visit.
- To promote equality, social inclusion and a safe and healthy environment for all.

5.2 It also contributes to the Local Strategic Partnership delivery themes of Community Safety and Health.

5.3 The protocol itself does not refer specifically to these strategic aims and delivery themes, but the strategic plans produced by each board (the Health and Wellbeing Strategy, the LSCB Business Plan and the Children and Young People's Plan) do detail the aims and priorities of the work undertaken by board partners. These strategic aims and delivery themes are clearly embedded within each document.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Consultation on this protocol has been carried out within the membership of the boards concerned.

6.2 The strategic plans of the Health and Wellbeing Board and the Children's Trust are consulted on within the community, including children and young people. A current aim of the LSCB is to ensure we listen and respond to our children and young people in relation to their safeguarding needs, and be able to evidence this.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EIA) is not relevant to the recommendation of this protocol. The protocol itself will not have a differential impact on: racial groups; gender; people with disabilities; people of a particular sexual orientation; people due to their age; people due to their religious belief. However, equality and diversity are key themes for the all three boards, ensuring that any changes to practice or service recommended by the boards will not disadvantage any particular group.

8. LEGAL IMPLICATIONS

8.1 There is no legal requirement to have a protocol in place, but the statutory framework listed below requires that partners work effectively together to safeguard and provide appropriate services for children and young people.

8.2 The statutory framework for the protocol is:

- Section 10, 11, 13 and 14 of the Children Act 2004

- Local Safeguarding Children Board Regulations 2006/2010
- Working Together to Safeguard Children 2013
- Health and Social Care Act 2012
- Apprenticeship, Skills, Children and Learning Act 2009

9. FINANCIAL IMPLICATIONS

9.1 None.

10. BACKGROUND PAPERS

- Reading Health and Wellbeing Board Terms of Reference
- Reading LSCB Business Plan
- Reading LSCB and Children's Trust Protocol Agreement
- Reading Children and Young People's Plan

Appendix 1

Protocol agreement between Reading Local Safeguarding Children Board, Health and Wellbeing Board and Children's Trust Board

Introduction

This document sets out the expectations of the relationship and working arrangements between Reading Local Safeguarding Children Board (RSCB), Reading Health and Wellbeing Board (H&WB) and Reading Children's Trust (RCT).

Statutory Framework for this Protocol

- Section 10, 11, 13 and 14 of the Children Act 2004
- Local Safeguarding Children Board Regulations 2006/2010
- Working Together to Safeguard Children 2013
- Health and Social Care Act 2012
- Apprenticeship, Skills, Children and Learning (ASCL) Act 2009

Local Safeguarding Children Board	Health and Wellbeing Board	Children's Trust
Statutory Framework RSCB is a statutory partnership under the Children Act 2004 with statutory guidance on making arrangements to safeguard and promote the welfare of children. It has responsibility for agreeing how relevant local organisations will co-operate to achieve this.	**Statutory Framework** The Health and Social Care Act 2012 includes the establishment of a Health & Wellbeing Board to undertake joint strategic needs assessments. The Board must adopt and operate under a Joint Health and Wellbeing Strategy which identifies the top priorities where working together can make a real difference in promoting the health and wellbeing of the people of Reading.	**Statutory Framework** Although statutory guidelines have been removed, the Children's Trust in Reading continues to work together as an effective strategic partnership, ensuring that the lives of children and young people are improved by the delivery of better services, including for their health and wellbeing.
Role RSCBs role is to monitor and evaluate the effectiveness of local arrangements for safeguarding children and young people and promoting their welfare.	**Role** The 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.	**Role** The RCT vision is to create a positive and ambitious environment for Reading children and young people so that they: • are happy, healthy, safe and coping with change and challenge • are enthusiastic and skilled learners • value themselves and others.

Shared Principles for this working protocol

- The boards will work together to minimise the duplication of reports and actions, and that there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.
- The boards share a commitment to a strategic approach to understanding needs, in a way that includes analysis of data and effective engagement with frontline practitioners, with children and young people, with families.
- The Partnerships are committed to developing a joined up approach to understanding the effectiveness of current services (what difference does it make) and identifying priorities for change – including where services need to be improved, reshaped or developed.
- All three boards will work together to provide constructive challenge to one another and partners.

Reading Safeguarding Children Board Responsibilities

1. The core objectives of the Safeguarding Children Board which are prescribed in Working Together are to:

    - Co-ordinate what is done by each agency to safeguard and promote the welfare of children and young people in Reading.
    - Ensure the effectiveness of that work.
    -

2. The RSCB is the decision making body for multi-agency arrangements for safeguarding of children within Reading. It is a statutory partnership and its work is directed by statutory guidance. This guidance dictates the functions to be undertaken by Safeguarding Children Boards and the criteria/functions against which they will be measured during Ofsted Safeguarding Inspections.
3. The Chief Executive of the Council has the statutory responsibility for ensuring that an effective Safeguarding Children Board is in place for the Local Authority area.
4. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under Section 14 of the Children Act 2004, are as follows:

    1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

    (i) the action to be taken where there are concerns about a child's safety or Welfare, including thresholds for intervention;
    (ii) training of persons who work with children or in services affecting the safety and welfare of children;
    (iii) recruitment and supervision of persons who work with children;
    (iv) investigation of allegations concerning persons who work with children;
    (v) safety and welfare of children who are privately fostered;
    (vi) cooperation with neighbouring Children's Services authorities and their board partners;

    (b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
    (c) monitoring and evaluating the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority;
(e) undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

5. The RSCB is responsible for challenging each relevant partner, as defined by the Children Act (2006) on their effectiveness in safeguarding children and ensuring their welfare.
6. The RSCB may request the Health and Wellbeing Board to consider issues for development, action or scrutiny.

Reading Health & Wellbeing Board Arrangements and Responsibilities

7. The H&WB aims to improve health and well-being for people in Reading. It is a partnership board that brings together the Council, NHS and the local health watch organisation. By working together on the delivery of national and local priorities, the Board aims to make existing services more effective through integrating provision and influencing future joint commissioning and provision of services.
8. The H&WB will be responsible for developing a Health and Well-being Strategy and Action 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.
9. The H&WB will be expected to improve outcomes for residents, carers and the population through closer integration between Health 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.
10. Underpinning the work of the H&WB is the Joint Strategic Needs Assessment (JSNA) which 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.
11. The H&WB will ensure that RSCB and RCT are formally consulted during the development of the Health and Wellbeing Strategy.
12. The H&WB may request RSCB or RCT to consider issues for development, action or scrutiny.

Reading Children's Trust Responsibilities:

13. The purpose of the CT is to consult with and bring all partners with a role in improving outcomes for children together to agree a common strategy on how they will co-operate to improve children's wellbeing and to help embed partnership working in the partners' routine delivery of their own functions. Delivering the strategy, the Reading Children & Young People's Plan, is the responsibility of the partners, both individually and together. This means each partner's existing lines of accountability are unchanged, i.e. each partner of the CT retains its existing formal lines of accountability for delivering its own functions. This avoids any confusion or blurring of lines of accountability.

14. The CT will contribute to the priorities for children and young people within the Health and Wellbeing Strategy (priorities agreed following the Joint Strategic Needs Assessment). The H&WB will provide constructive challenge and support to the CT.
15. The H&WB and RSCB will be formally consulted by RCT when the Children & Young People's Plan is being drafted, allowing sufficient time for both Boards to provide support and challenge.
16. RCT will maintain responsibility for the overall performance monitoring of the indicators, data and targets and outcomes identified within the Children and Young People's Plan but also provide challenge to RSCB and the H&WB as necessary when scrutinising its performance information.
17. RCT will ensure that any advice and information provided by the H&WB is appropriately disseminated within the CT member organisations.

Lines of Communication

18. The Independent Chair of RSCB is an invited attendee at RCT Board meetings. The Chair of RCT (the Lead Member for Children's Services) is a member of both the RSCB and H&WB. The Director of Children's Services is a member of all three Boards. The interconnectedness of senior level membership ensures key issues are discussed in the appropriate meeting.
19. The RSCB Annual Report is presented to both the RCT and H&WB.
20. The Children and Young People's Plan Annual Report is presented to both the RSCB and H&WB.
21. Any particular issues or concerns raised by one Board for consideration by either or both of the other boards will be scheduled onto the next appropriate agenda via the LSCB & RCT Business Manager or Principal Committee Administrator. A written report will be presented to the Board which details the issue/concern with and expectation of the outcome. Please note that H&WB meetings are public and due consideration must be made regarding report content.

Formal agreement of this protocol

22. This protocol will be agreed at full Board meetings of:

	Meeting Date
Reading Safeguarding Children Board	18 June 2014
Reading Health and Wellbeing Board	18 July 2014
Reading Children's Trust	8 April 2014

23. A review of this protocol will be undertaken annually.

Royal Berkshire NHS Foundation Trust

Summary of Strategic Plan

2014/2019

Strategic context and objectives

- Anticipate broadly the same range of services as we have today
- In later years anticipate significant changes in the health economy - integrated community-based systems of care.
- Recognition of the impact that these models of care could have on our sustainability.
- High degree of uncertainty exists currently as to what form these changes will take whether the changes are affordable for the health economy.
- In response to this uncertainty, individual services will continue to focus on achieving and sustaining the highest clinical standards, while also meeting target efficiency gains.

Our strategic objectives will be based on the following overarching aims:

- A commitment to **high quality care** that is safe, compassionate, effective and provides a positive experience for patients through **better integration**.
- Meeting the **needs** of the local population: a) by aligning and influencing **commissioner's intentions** and local developments; and b) improvement of our **capability, capacity and leadership**.
- Ensuring **financial stability, resilience and sustainability** in the longer term, allowing for **investment** in frontline services that are fit for the future

Summary aims:

- ***Remain a major provider of A&E and medical and surgical emergency access services on the RBH site.***
- ***Committed to development of more integrated care across both local hospital, community-based and primary health services.***
- ***Focus on prevention, early intervention and keeping people healthy, as well as to provide excellent care for people who need treatment.***
- ***Continue to develop as a centre of excellence for cancer, critical care, heart attack management, stroke, trauma, spinal surgery, paediatric and neonatal services.***
- ***Retain and develop a range of planned diagnostic and treatment services (which are clinically and financially viable, and support the wider provision of services in the Trust).***

Key changes: IBP July 2013 to Strategic Plan June 2014

July 2013

Activity growth over 5 years:
- A&E - 20-33%
- Outpatients -11-17%
- Non-elective -10%
- Day case – 26%
- Inpatient – 8%
- Maternity – move to 8000 births, 1:32

Income:
- Grow to £380m

Capacity:
- 126 additional beds needed across the health economy by 2019

Focus:
- Expansion of the specialist centre and working towards integration

- Stakeholder consultation and feedback
- Alignment with CCG growth assumptions
- Greater quality emphasis
- Greater development of integration schemes
- Deterioration in RBFT financial position
- RBFT CIP programme
- Better care fund and CCG QIPP
- CQC Inspection
- Increase in uncertainty

June 2014

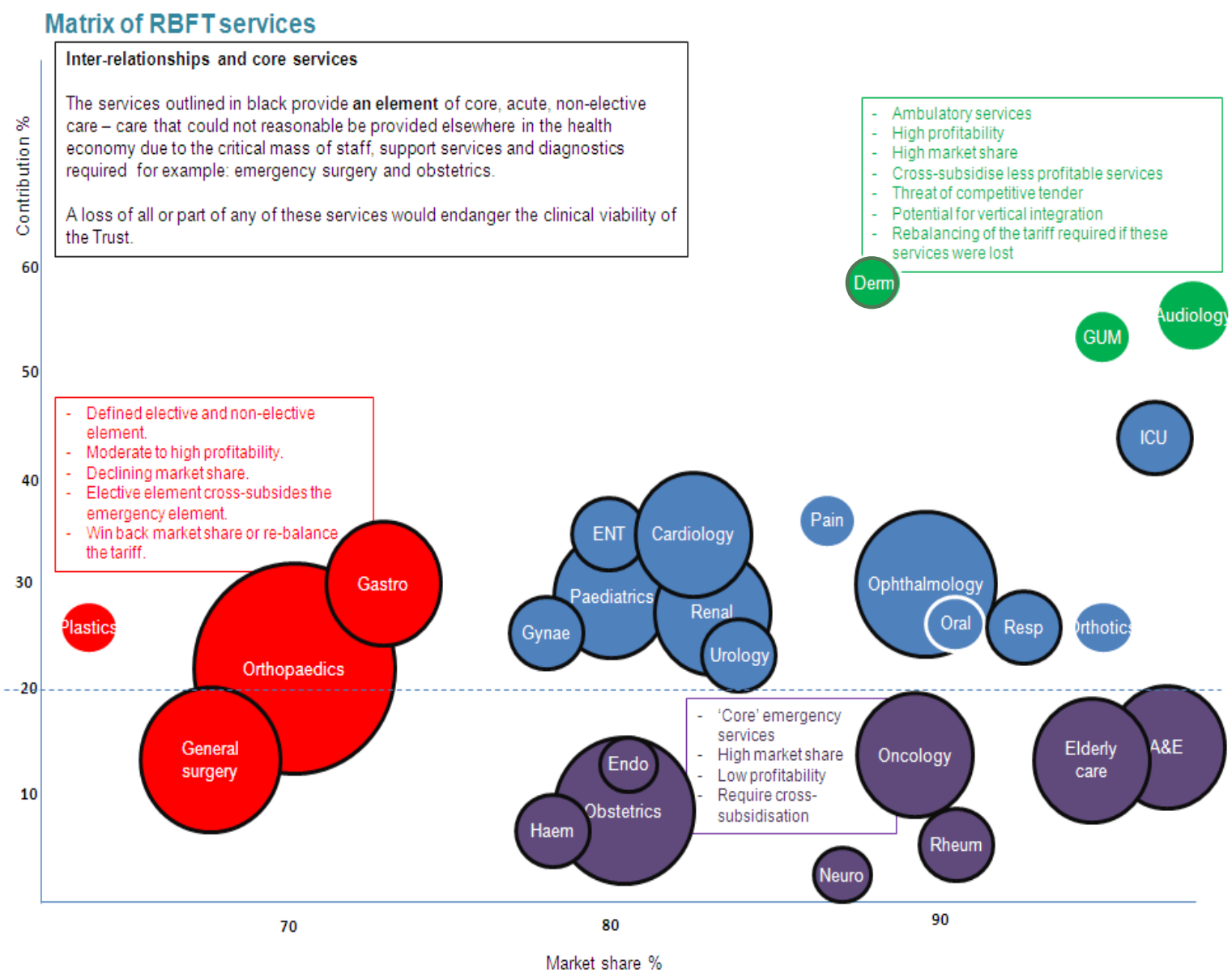
Activity growth over 5 years:
- A&E - 7%
- Outpatients -5%
- Non-elective -17%
- Day case – 7%
- Inpatient – 12%
- Maternity – stay at 6000 births; 1:28

Income:
- Grow to £380m

Capacity:
- 70 additional beds needed across the health economy by 2019

Focus:
- Consolidation of the specialist centre, improving quality of care and working towards integration.

Review of services



- Small number of services could be considered 'non-core'.
- Small in terms of income so the loss of these services would not help the overall health economy financial situation (cost of re-provision).
- Substantial contribution to overall Trust overheads (subsidising less profitable specialities).
- Loss of these services would have a significant impact on the financial viability of the Trust.
- Trust would need to 'buy in' the proportion of these services that support the core services.
- **Downsizing not a viable option as it does not benefit patients, the Trust or the wider health economy.**

Service developments

Elective orthopaedic centre

- Aim: to improve safety, efficiency and productivity.
- 2 additional laminar flow theatres.
- Additional ward area.
- Will increase theatre and bed capacity across planned care.
- Will drive reduction in waiting list and increase in market share.
- Supporting marketing plan to be developed.
- £10.5m income projected with 43% surplus.

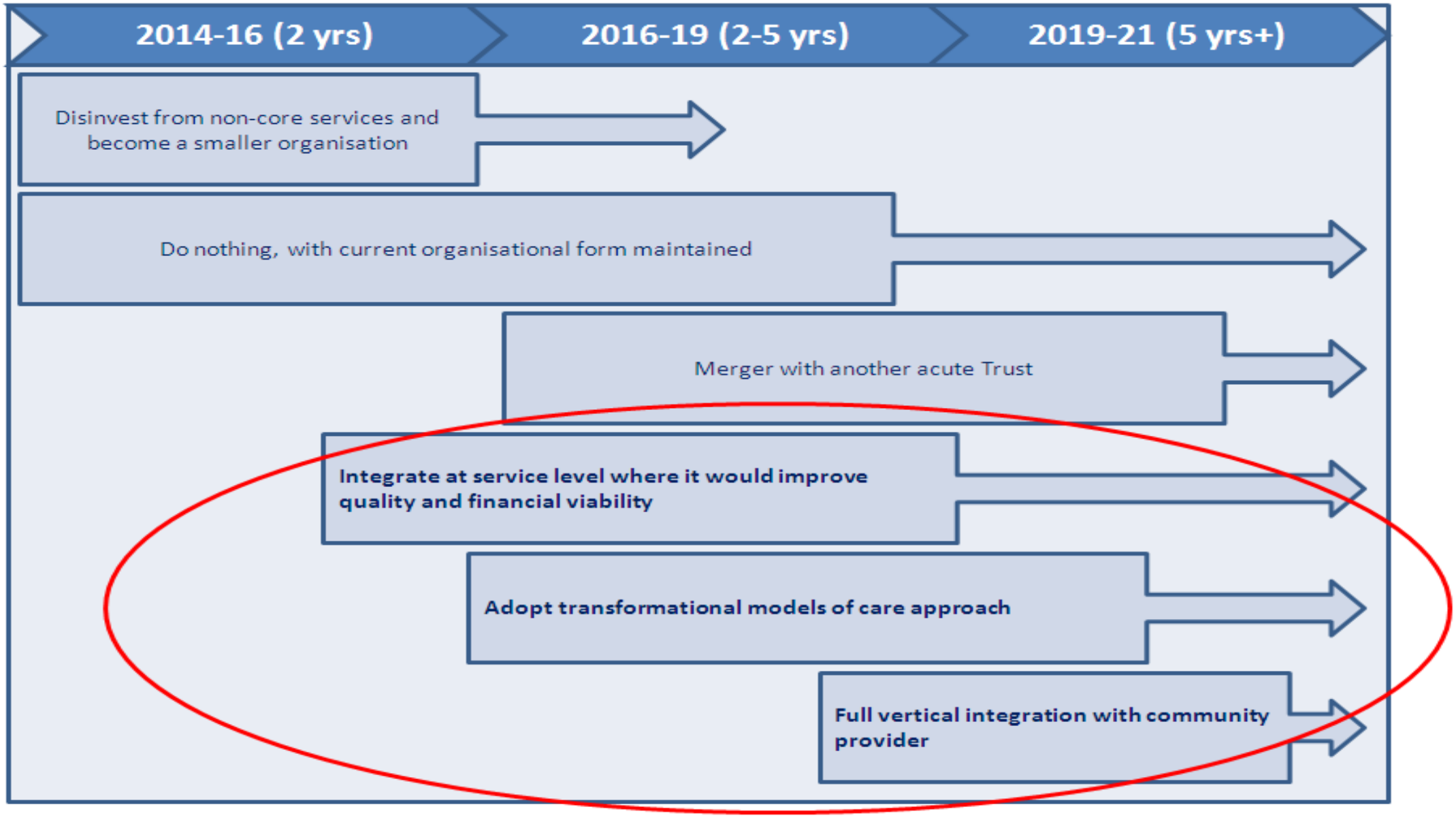
Urgent care floor

- Aim: to increase capacity in ED so current and future demand can be accommodated.
- Aim: to increase ICU capacity so all patients requiring ICU care can be cared for in appropriate area.
- Preferred option is a phased approach over 5 years costing circa £30m.
- Unclear how this will be funded at present.

Other plans

- Frail elderly pathway – integrated care
- Pathology consolidation
- Integrated eye service
- Potential endoscopy expansion – RBBC
- Potential for horizontal expansion in some service – therapies, audiology.
- Potential for inpatient plastic surgery

Strategic options – growth, integration, transformation

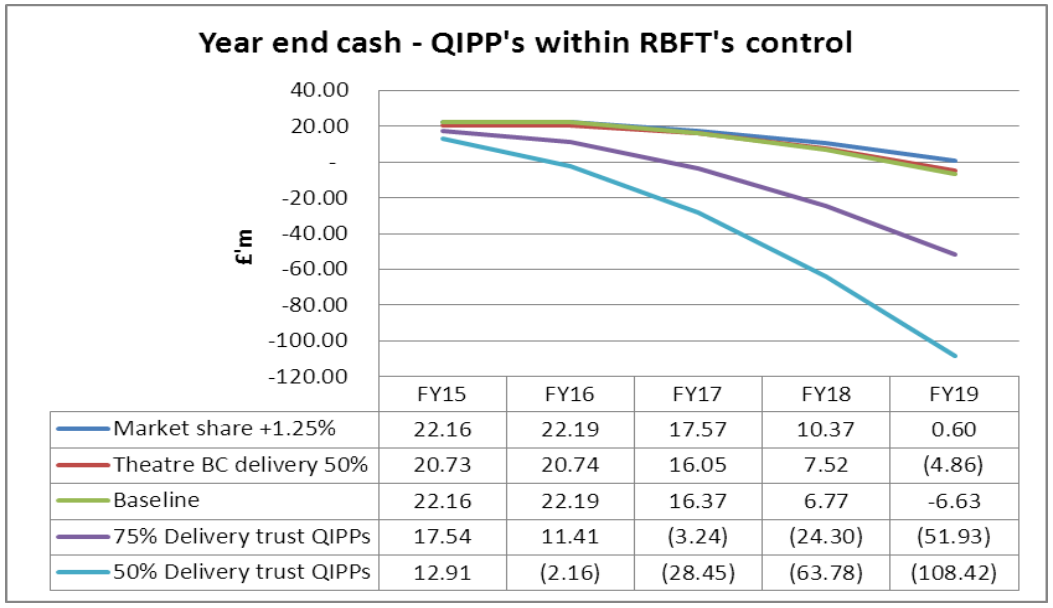


5 Year Financial Plan

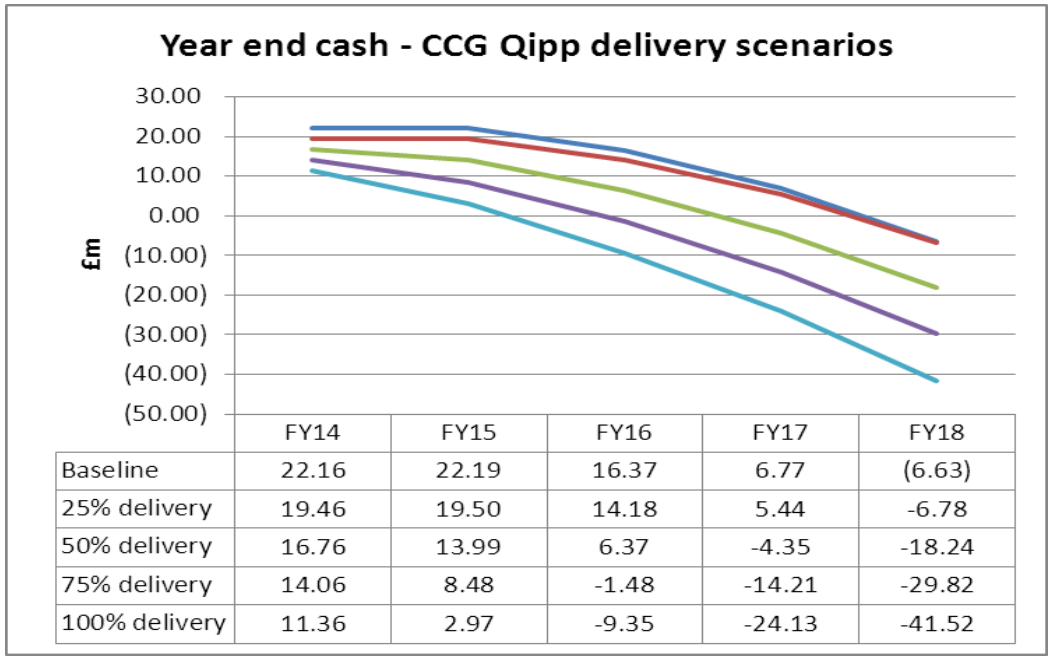
	2014/15 IBP	2015/16 IBP	2016/17 IBP	2017/18 IBP	2018/19 IBP
Income					
PCT Activity	297.7	306.2	314.1	319.3	324.2
Drugs	28.0	29.7	31.4	33.3	35.2
Other	23.1	23.1	23.1	23.1	23.1
Total income	**348.8**	**359.1**	**368.7**	**375.7**	**382.5**
Pay	(202.3)	(203.1)	(216.2)	(226.8)	(237.4)
Drugs	(33.6)	(36.3)	(38.7)	(41.2)	(43.8)
Clinical Supplies	(44.4)	(46.6)	(48.6)	(50.9)	(53.3)
Non Clinical Supplies	(7.0)	(7.9)	(8.1)	(8.3)	(8.4)
Other Operating Exps	(38.5)	(40.1)	(35.4)	(30.5)	(25.5)
Total Costs	**(325.8)**	**(334.0)**	**(346.9)**	**(357.7)**	**(368.4)**
EBITDA	**23.0**	**25.1**	**21.7**	**17.9**	**14.1**
Depreciation	(17.7)	(17.9)	(17.9)	(17.9)	(18.0)
PDC	(5.1)	(5.1)	(5.1)	(5.1)	(5.1)
Interest	(1.0)	(1.0)	(1.0)	(0.9)	(0.9)
Surplus (pre impairmer	**(0.9)**	**1.1**	**(2.3)**	**(6.1)**	**(9.9)**
QIPPs	18.5	16.9	9.2	9.4	9.6
Year end cash	22.16	22.19	16.37	6.77	(6.63)
Capital expenditure	12.5	15.3	17.8	17.8	17.8

- Return to surplus in 2015/16, with cash broadly flat.
- Thereafter Trust QIPPs cover inflation only, so cash falls
- Planning assumptions reflect CCG guidance for 2.5 year on year growth (excl theatres business case)
- We assume CCG Qipps not delivered.
- Impact of CCG QIPP delivery evaluated as downside scenario.
- Trust QIPPs remain high and pose significant cash risk if not delivered.

Downside scenarios



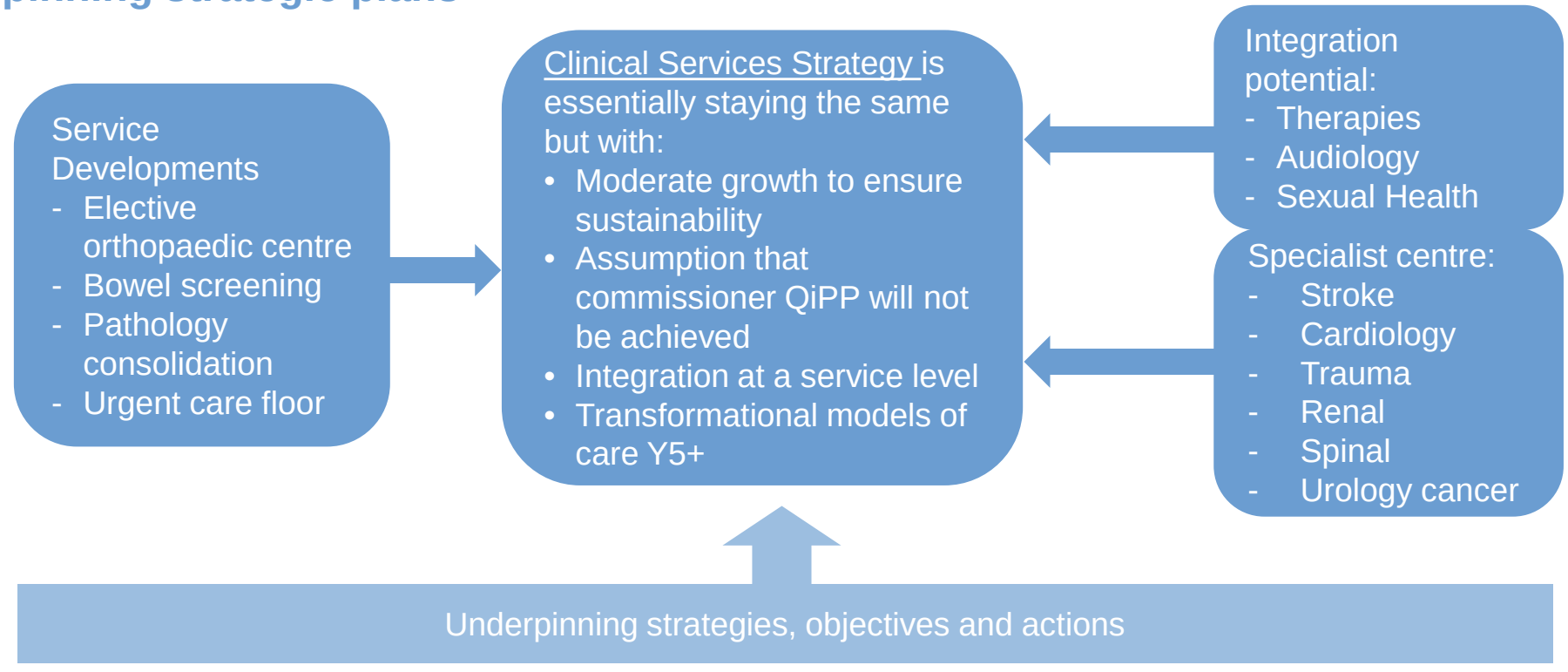
	FY15	FY16	FY17	FY18	FY19
Market share +1.25%	22.16	22.19	17.57	10.37	0.60
Theatre BC delivery 50%	20.73	20.74	16.05	7.52	(4.86)
Baseline	22.16	22.19	16.37	6.77	-6.63
75% Delivery trust QIPPs	17.54	11.41	(3.24)	(24.30)	(51.93)
50% Delivery trust QIPPs	12.91	(2.16)	(28.45)	(63.78)	(108.42)



	FY14	FY15	FY16	FY17	FY18
Baseline	22.16	22.19	16.37	6.77	(6.63)
25% delivery	19.46	19.50	14.18	5.44	-6.78
50% delivery	16.76	13.99	6.37	-4.35	-18.24
75% delivery	14.06	8.48	-1.48	-14.21	-29.82
100% delivery	11.36	2.97	-9.35	-24.13	-41.52

- Biggest risk is non delivery of Trust QIPPs
- To help mitigate on downside scenarios capex would be restricted to £12.5m in FY15 and FY16 and £15.0m thereafter.
- Cost of transition under CCG delivery of QIPP scenarios ranges from £11m to £44m

Underpinning strategic plans



Estates
- Significant backlog maintenance
- North Block and West Drive – decisions required over future
- Maternity/South block/ eye block improvements
- A&E/ICU works
- Car park mgt plan (Long term – expansion into TEC)

Informatics
- Data quality
- Data warehouse
- Improve basic management information
- Business intelligence
- Information governance forum
- Improved training on how to use information

Quality
- Patient safety thermometer – reducing harm
- Reduction in c.diff
- Improve weekend mortality
- Improve medical records quality and availability
- Improve complaint process
- Staff attitude and behaviour

Workforce
- OD strategy
- Workforce strategy
- Appropriate staff levels
- Leadership and governance
- Performance and assessment
- Development
- Payroll costs
- Improved governance and leadership

Royal Berkshire NHS
NHS Foundation Trust

Strategic Plan Document for 2014-19
Summary

Royal Berkshire NHS Foundation Trust

Summary version: 30 June 2014

Contents

1. Signature page - Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

Name	Craig Anderson
Job Title	Director of Finance
e-mail address	craig.anderson@royalberkshire.nhs.uk
Tel. no. for contact	0118 322 7298
Date	**30 June 2014**

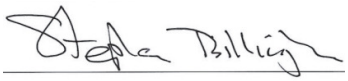
The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

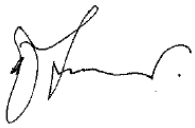
Approved on behalf of the Board of Directors by:

Name *(Chair)*	Stephen Billingham

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Alistair Flowerdew

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Craig Anderson

Signature 

2. Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.	***~~Confirmed~~ / Not confirmed***

The Royal Berkshire NHS Foundation Trust's Strategic Plan 2014-19 is dominated by the pressing need to achieve affordability and sustainability of healthcare provision both in the shorter and in the longer term. The most immediate challenge for the acute setting is the need to deliver and respond to significant internal and external cost saving pressures in light of continued growth in demand. Efficacy of demand management is therefore the critical factor in achievement of both clinical and financial sustainability.

Our Strategic Plan is based on responding to the current levels of predicted activity growth and related income and the need to ensure delivery of high quality patient care. It excludes commissioner QiPPs and demand management initiatives. On that stated basis and subject to the concerns highlighted below, the Board can confirm that the Trust will be operationally and clinically sustainable over the five year period of this Strategic Plan.

The Board can confirm that the Trust will be financially sustainable in one year's time, based on an assumption that the Trust delivers on its own cost CIPs in both 2014/15 and 2015/16. In addition, the Board can confirm that it expects to be financially sustainable over a period of three years, based on the assumption that, in addition to delivering the Trust's own cost CIPs, that the CCG is not successful in delivering all of its own QiPPs within that period. However, in light of this uncertain and changing background, the Board cannot confirm that the Trust will be financially sustainable over the five years of the Strategic Plan. The key reasons for this are:

- there is a need for the CCGs to deliver their QiPPs to ensure the financial sustainability of the sector as a whole and there is concern as to the impact that this will have on the Trust; and
- there is concern that beyond the next two years, the Trust will not be able to deliver sustainable cost CIPs much higher that 2% to 2.5%. Whilst the Trust would look to mitigate this partly through reducing capital expenditure, the Trust would also expect to see an alignment of Trust and Regulator expectations as to ongoing level of efficiencies and a consequent adjustment to the tariff deflator.

Given the overall level of risk within the local health sector we are working closely with Berkshire West CCGs, Berkshire Healthcare FT, and local social services to look at areas where we need to amend the provision of local health services to significantly reduce costs. This work involves exploring models of delivery from health sectors elsewhere. This is likely to result in the need to change local contractual arrangements but may also require some funding to deliver the necessary changes in a timely manner.

3. Strategic context and the local health economy

3.1 Context

This strategy sets out a realistic assessment of the future for the Royal Berkshire NHS Foundation Trust over the next three to five years. It maps a clear assessment of the risks to achieving financial stability, taking account of the anticipated impact of both demographic change and the vision for re-balancing between hospital and community-based care. In particular this strategy sets out the Trust's assessment of and approach to a significantly constrained financial environment. Importantly, it consolidates and builds on the Trust's commitment to high quality care, secured through a focus on specific areas of service improvement, and supported by organisation-wide developments in the estate, informatics and the workforce. The future range of services described in this plan is broadly similar to today's Trust portfolio.

However, in the later years of this plan and beyond, we anticipate the possibility of significant changes in the health economy, specifically the development of better integrated community-based systems of care, capable of supporting many more people in the community. This strategy recognises the high degree of uncertainty that exists currently as

to which form of service delivery these changes will take and whether the models themselves are affordable for the health economy.

3.2 Challenges

The Royal Berkshire NHS Foundation Trust provides hospital and community based health services across Berkshire and neighbouring areas. The Trust's outlook for the next three to five years is dominated by the twin challenges of improving quality and responding to changing demands on the service, while managing this within a static or reducing budget.

The issue of affordability of healthcare into the future has compelled us to review and revise how we achieve our vision for our community in the fast changing and uncertain socio-economic environment. We are anticipating the potential for system-wide changes which will be needed to sustain affordable and effective health and care services over the coming years. There are two significant factors that are relevant to our plans:

- There is a need to re-shape local health and care services, to provide much more prevention, early intervention and care in the community, keeping people out of hospital wherever that is possible. This includes developing, with commissioners, local pricing and tariffs that reflect the costs and necessary investment for the services we deliver.
- External consultants have been commissioned by the Berkshire West CCGs to review the models of hospital care across the health economy. This work is aimed at helping secure financially and clinically sustainable services across the area and includes: a financial assessment of the health economy; analysis of core pathway pilots to assess effectiveness and efficiency across the entire system; and model of the attributes of the healthcare system that can deliver and enable change.

The above conversations are at an early stage and the Trust's strategic plan is deliberately modelled to allow flexibility and responsiveness across the whole health economy whilst the consultation and development of the above plans continues. This document sets out to describe a viable and strong future for this organisation, and how the Trust will respond these strategic challenges.

3.3 Our objectives

Our vision to provide sustainable, and improving, high quality care for our local community has not changed. What has changed is how we intend to achieve this. There is an acknowledged uncertainty as to how the local health economy will develop and the challenges faced by, not only the Trust, but also our partner providers, including primary care and our commissioner. We are therefore refreshing both our vision and our strategic objectives to reflect the ongoing changes in our local health economy. Nonetheless, there is a clarity underpinning our objectives that is based on the following overarching aims:

- A commitment to high quality care that is safe, compassionate, effective and provides a positive experience for patients through better integration.
- Meeting the needs of the local population: a) by aligning and influencing commissioner's intentions and local developments; and b) improvement of our capability, capacity and leadership.
- Ensuring financial stability, resilience and sustainability in the longer term, allowing for investment in frontline services that are fit for the future.

Central to our strategy is our view of the range of services we will be providing over the next three to five years. The Trust is clear that it aims to:

- Remain a major provider of A&E and medical and surgical emergency access services on the RBH site.
- Being committed to development of more integrated care across both local hospital, community-based and primary health services in order to deliver, with our partners, best care for patients throughout their healthcare journeys.
- Focus on prevention, early intervention and keeping people healthy, as well as to provide excellent care for people who need treatment.
- Continue to develop as a centre of excellence for cancer, critical care, renal, heart attack management, stroke, trauma, spinal surgery, paediatric and neonatal services.

- Retain and develop a range of planned diagnostic and treatment services (which are clinically and financially viable, and support the wider provision of services in the Trust).
- The Trust will act in partnership with other organisations to provide and sustain high quality care, when this is the most appropriate solution.

3.4 Strategic direction of our services

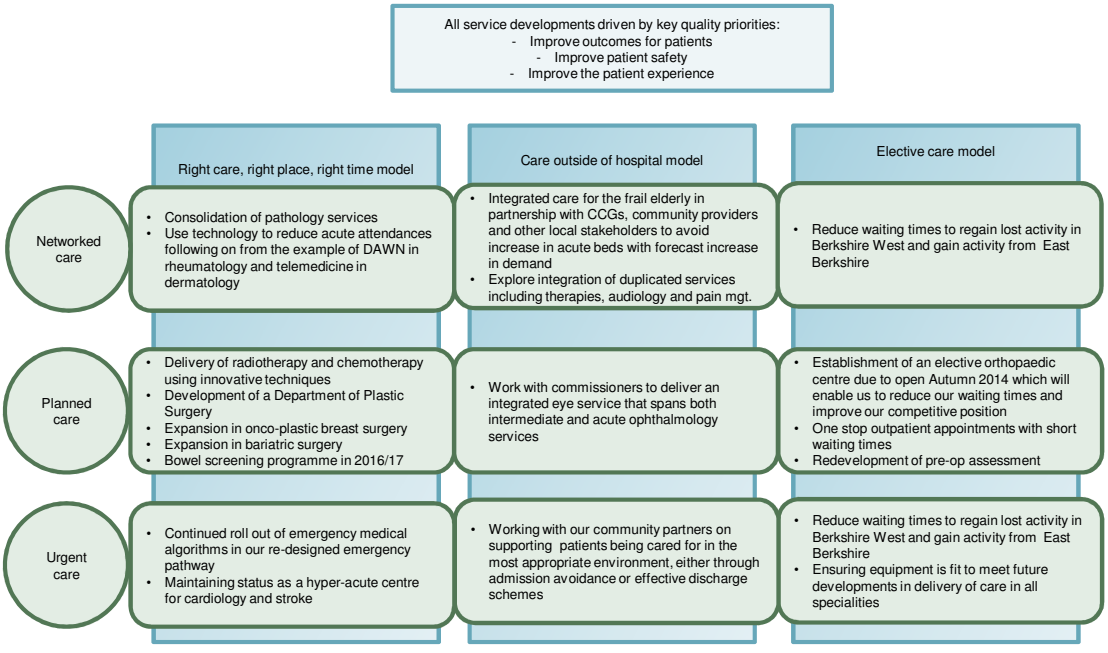
Transformative patient care

This strategy describes our intention to adopt a transformational approach. This will underpin our vision in the face of the competing demands on the shrinking resources available to us and to the local health and social care economy as a whole. We believe that this will give us the flexibility to respond to the changing needs of our patients and the local health and social care environment in order to bring maximum benefits to our patients and at the same time remain affordable to our commissioners. By 2018/19 we believe we will be working towards the implementation of a transformative approach to healthcare delivery in partnership with other providers locally. This will ensure long term sustainability but will require flexibility including a balanced review of services and consideration of:

- multiple application of options across specialities;
- not taking a 'one size fits all' approach to services; and
- review of partnership approach with other providers including the independent sector.

Our transformative model of integrated care is largely based around the six models of care identified by NHS England, Monitor and the NTDA. We envisage the development of a mixed model as depicted in Figure 1 below:

Figure 1: Transformative model of care



Achieving and maintaining financial health

The five-year financial plan that supports the delivery of the Trust's strategy demonstrates the challenges that are faced by the Trust in achieving its financial aims. We are clear that this can only be achieved through whole system solutions. Our current strategy is to aim to achieve the right balance in the services we provide and how we are paid in order to secure the following key goals:

- Return to surplus in 2015/16: the pressures of ongoing cost efficiencies and assumptions around the tariff deflator are likely to result, if nothing changes, in a return to deficits in 2016/17 and beyond.
- Achieve a continuity of service rating of two in 2014/15, maintaining this in 2016/17: the pressures referred to above are likely to see this decline thereafter.
- Achieve sufficient surplus to finance a robust Estates Strategy consistent with our objectives above.
- Achieve sufficient surplus to finance a fit for purpose IT Strategy.
- Effectively manage downside risks.

3.5 Historic performance

Finance

Over the past three years (from 2011/12 to 2013/14) our income has grown progressively from £317m to £344m, representing an 8.7% increase. Tariff deflators have reduced the price paid for our services over this period so the growth in revenue is largely attributable to increased activity rather than increase in prices. Over the same period the cost of providing care has increased at a higher rate than the rate of increase in revenue. Our pay costs in particular have increased steadily, by 10.5% over the past three years.

In spite of income increasing, our financial position has steadily deteriorated over the three years. This trend is indicative of the threat to the sustainability of the Trust's services. Ensuring our pay is controlled is a key objective as we aim to return to a surplus position by 2015/16. Delivery of a surplus is also contingent on the delivery of a challenging CIP programme.

Activity

There has been a steady growth in activity over the past three years. The key growth areas are A&E attendance and non-elective admissions. During this period there has been a 13% increase in attendances at our main A&E department. Non elective admissions have increased by 6% over the same period. Despite demand management schemes we are seeing a year on year growth in referrals and growth in additions to our outpatient and surgical waiting lists. Our waiting times for both admitted and non-admitted patients are longer than we would like in some areas and this is negatively impacting our competitive position.

Quality

Our overriding focus has always been to provide high quality care; care that is safe, effective, compassionate and which gives our patients a positive experience from their contact and interaction with our services. Since 2009/10 our journey of quality improvement has been underpinned by continuing to pay particular attention to the issues that meant a lot to our service users and on those areas of care that did not meet the high standards that we sought to achieve. Although improving how we communicate with our patients has been a more challenging aim for the Trust to achieve success in, over the past five years we have been successful in reducing:

- harm from falls to our patients;
- pressure ulcers;
- harm from sepsis;
- venous thromboembolism;
- incidence of clostridium difficile infections; and
- mortality.

3.6 Key challenges facing the Trust

Our local health economy

We provide general medical and surgical services to a local core population of around 500,000 who live in Berkshire West and South East Oxfordshire. We also provide specialist services to a wider population of around 1,000,000 across East and West Berkshire and areas of Oxfordshire, North Hampshire and Buckinghamshire These services include heart attack, stroke, cancer, renal and ophthalmology.

Our services are primarily commissioned by four CCGs who between them account for over 75% of our patient care related income. These CCGs are: South Reading; North and West Reading; Wokingham; and Newbury and District. Our assessment of the demographic changes and changing health needs profile comes primarily from analysis of the Joint Strategic Needs Assessments produced by local authorities and CCGs.

In the context of the national picture, the key challenges facing our local health economy are:

- increasing demand caused by an increasingly ageing population with multiple long term co-morbidities;
- increase in lifestyle induced morbidities within the growing population;
- increasing patient expectations and affordability of health and social care as a result of the increasing gap between rising demand and reducing funds.

If demand continues to rise as predicted and services continue to be provided in the same way (e.g. a 'do nothing scenario') the health economy faces a funding gap of circa £157m by 2018/19, with approximately £78m attributable to the Royal Berkshire NHS FT. This figure does not include any capital that would be required to increase capacity to deal with the additional demand. As a Trust we are already experiencing capacity problems within our accident and emergency department and approximately 40-50 of our non-elective beds are occupied by patients who are medically fit for discharge.

Impact of population growth and the ageing population

The population in Berkshire West is forecast to grow by circa 25,000 over the next five years but the growth rates in different age bands and locations varies. Berkshire West has a lower proportion of older people than the South East average. However the population of older people is increasing at a rate that is higher than the national average. This growth is higher in the West Berkshire and Wokingham local authority areas. There is therefore likely to be an increase in age-related and chronic conditions including dementia, diabetes, stroke, respiratory and coronary heart diseases with a corresponding increase in healthcare demand.

The over 65 population is growing at a faster rate than other segments of the population and this group typically has higher health needs than other age groups. In particular the high levels of growth predicted in the over 85 population are a key indication that demand for frail elderly services will rise. As people age they are more likely to have multiple co-morbidities which mean that admission to hospital is more likely and length of stay is longer. They also tend to require more robust hospital to home packages required to allow them to stay well and avoid readmission.

Long term conditions

There has been an increase in the proportion of people living with long term conditions in Berkshire West, partly due to increased survival rates following stroke and heart attack. This trend is predicted to continue due to the ageing population and the impact of lifestyle choices on health.

The incidence of cancer nationally and in Berkshire West is rising. This is due to a number of factors including the ageing population and lifestyle factors including smoking, drinking alcohol and obesity. Our commissioners intend to enhance the screening programmes for breast, bowel and cervical cancer and we predict that this, together with awareness schemes, will lead to a further increase in patients referred with suspected cancer.

The incidence of cardiovascular disease in Berkshire West is predicted to rise over the next five years due to the increased age profile of the population. We are a specialist centre for interventional cardiology and we are expecting demand for this service to increase. We are designated as a hyperacute stroke centre, delivering thrombolytic treatment 24/7. The incidence of stroke in our area is predicted to increase over the next five years.

Impact of lifestyle on health

The majority of the population in Berkshire West is healthier than the England average. However there are significant concerns about the impact that unhealthy lifestyles and behaviours are having on the health of the population including:

- 22% of the adult population in Berkshire West engage in higher risk drinking which contributes to alcohol related mortality and increased A&E attendances and hospital admissions.

- Rates of smoking are better than the England average however 19% of the adult population across Berkshire West smoke, with 22% of the adult population of Reading smoking.
- Obesity is a predisposing factor to many health problems and is a growing problem in Berkshire West with one quarter of the adult population being obese along with 20% of reception age children.
- Teenage pregnancy rates have improved in recent years though Reading remains worse than the England average.
- Chlamydia positivity is higher than the South East average and the incidence of HIV in Reading is higher than the national average.

Growth in the black and minority ethnic (BME) population

The BME population in Berkshire West is predicted to rise over the next five years. It is estimated that 34% of the population of Reading are of BME origin and analysis of school registrations suggests that this will rise. This increase is relevant to planning future health needs as specific diseases are more prevalent within the BME community, including diabetes; prostate cancer; respiratory diseases; and coronary heart diseases.

3.7 Competitor analysis

Our local health economy has become increasingly competitive in recent years with:

- the arrival of a third major private provider in central Reading;
- the introduction of the Any Qualified Provider 'AQP' scheme; and
- increased competition in border areas with other NHS Trusts.

Competition presents a large risk to the Trust's income as independent sector providers tend to target the more profitable elective procedures. The independent sector also targets a simpler case mix leaving the Trust to provide more complex surgery on patients with greater co-morbidities and operative risk.

In central Reading there are three independent sector providers offering NHS services. There are also private providers in Hampshire and East Berkshire who treat NHS patients within our core catchment. These providers are targeting high margin elective surgery. The key drivers for the significant increase in the share of private sector provision of elective activity in general and Orthopaedic services in particular include; shorter waiting lists and quicker access, relatively smoother administrative and booking processes, greater capacity, aesthetic attraction of their estates and facilities and astute marketing of their services.. We aim to address this in 2014/15 by installing two additional laminar flow theatres and additional elective beds, creating an elective orthopaedic centre with a significant reduction in waiting times for surgery.

3.8 Market share

Market share trends and implications for RBFT

Over the past three years we have lost significant market share of elective surgery (both inpatient and daycase) to the private sector. This erosion in market share has an effect on the sustainability of the Trust both clinically and financially. We need to ensure that we perform a critical mass of elective surgical procedures in order that we:

- Ensure we continue to provide high standards of training for junior doctors
- Ensure financial viability
- Maintain sufficient operational balance between elective and emergency work

Despite the loss of market share our overall elective surgical activity has grown suggesting that thus far the private sector has primarily benefited from growth in the market, rather than simply gaining activity from RBFT.

In 2014/15 the Trust will develop its commercial strategy which will set out its approach to regaining lost market share and ensuring continued clinical and financial viability. This strategy will focus on the quality of the services we provide, in terms of patient experience, patient safety and patient outcomes, and how we ensure that patients and referrers are aware of the quality of our services. It will also address the investment required to achieve this.

Our outpatient market share has remained relatively steady despite the decrease seen in day cases and elective inpatient share. This suggests that we are a relatively more attractive choice for patients who have ambulatory care needs and are not likely to require surgery.

3.9 Strengths, Weaknesses, Opportunities and Threats (SWOT)

Our SWOT (figure 2) analysis identifies that our strengths as an organisation can be applied to exploit the opportunities on offer and also to mitigate against the threats we face.

Figure 2: SWOT analysis

Strengths	Weaknesses
• Highly motivated and trained staff: Will deliver innovative services. • Range of specialist services: Develop centres of excellence • Access to community facilities: Deliver care closer to homes • Excellent partnerships: Redesign pathways and joint initiatives • Positive reputation and public support: Facilitate patient information and choice	• Long waiting times and access problems: Reduction in outpatient and surgical waiting times. • CQC and Monitor observations: Implement improvement plans • Quality/age of estates: Develop sustainable strategy. • Inadequate capacity in A&E: Increased capacity • Administrative weaknesses: Dedicated project to manage appointments • Financial impact of historic investments: Increased utilisation of Bracknell and EPR solution plan • Adverse impact of poor pay control: focus on managing agency spend and pay QIPP • Poor management of medical records: Priority project to resolve
Opportunities	**Threats**
• Deliver and develop more services at the community sites: Utilise our strengths in community delivery • 7 day working: Service development plans to address implementation • Exploit the benefits of digital technology: Wider roll out of technology solutions • Increase private provision: Additional theatre capacity to facilitate provision • Expand specialist services: Attract patients from other areas.	• Competition, tenders, AQP: Optimise service quality and reduce waiting lists • Rising demand for healthcare: Collaborative working on integrated pathways • Centralisation of specialist work: Set up networked arrangements • Commissioner QIPP: Contingency in place • Contract penalties: Enhanced contract monitoring • Increased regulatory oversight: Enhanced executive and Board governance capability

3.10 Commissioner intentions

Our local CCG's joint strategy for 2014-19 sets out their vision for how enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. The strategy centres around care at the right place at the right time with a key theme that patients should only attend the acute hospital when they require services that cannot be delivered elsewhere.

The CCGs key priorities over the next 5 years are:

- placing a greater emphasis on prevention;
- putting patients in control of their own care planning;
- better use of technology;

- better integration between health and social services;
- implementation of hospital at home;
- developing the role of primary care services as part of a more integrated system and ensuring that the CCG role in commissioning enhanced services is used to maximum effect;
- commissioning hospital services delivered through new modes of care – fewer centres of excellence, one stop shops, combining hospital and community services; and
- using tariff flexibilities and new models of contracting to deliver these priorities.

We fully support the strategy and we recognise that a different approach to demand management is needed across the health economy if we are to avoid increasing acute capacity over the next 5 years and we believe that integration will play a crucial role in ensuring continued financial viability of the health economy. We want to work with commissioners to further develop these schemes for the benefit of the health economy.

Our commissioners also intend for specialist services to be increasingly provided at tertiary centres. Whilst we recognise that patients deserve to be treated in centres where critical mass is sufficient to ensure the best possible outcomes we believe that decisions to transfer care to specialist centres need to be evidence based at a local level.

4. Strategic options and risks to sustainability

4.1 Internal risks to sustainability

There are a number of areas where we know we need to make significant improvements over the next two years or where we need to consolidate and embed improvement work that has been carried out in the past year. These over-riding improvements centre on the need to provide an infra-structure, management and a workforce that is fit for the future and that can support the Trust's quality and clinical services strategies aimed at improving the quality, safety and the experience of patients.

Real Estate priorities

With significant uncertainty over the future model of service delivery, a long-term transformative estate strategy is not realistic. However, a short to medium term plan focussing on good stewardship of the Trust estate still remains essential. The Trust has clear sight of the pressing and urgent priorities that must be addressed as the estate is ageing, with a number of clinical services housed in accommodation that is either unfit for purpose or requires significant work to maintain fitness for purpose:

- The Trust has significant backlog maintenance. This is heightened as a risk by the limited capital programme in place over the next 5 years.
- We need to develop better facilities for urgent and emergency care. Progress in this is beginning with a modest expansion of the emergency department in 2014/15 to support short-term viability.
- We are also considering options for delivering a greater range of activity at our community sites, particularly West Berkshire Community Hospital and Royal Berkshire Bracknell Clinic. This will provide a better service for patients living in these areas and will also reduce pressure on the main Royal Berkshire Hospital site.

Informatics priorities

There is a critical need to improve the quality, timeliness and usage of data within the organisation. We have experienced problems with data quality since we migrated to our electronic patient record in 2011/12 with a proportion of our data requiring validation before it is useable. We aim to improve our approach to information quality by:

- Creating an information governance forum to give business leadership
- Redeveloping the data warehouse
- Empowering the Informatics and Data warehouse leads
- Improve basic management reporting
- Evaluate and provide a 'fit for purpose' Business Intelligence website
- Improve training, including how to exploit information

We will continue to exploit available technology to deliver efficiencies and improvements to the patient experience such as DAWN and telemedicine, to support the patient activation agenda.

Workforce and Leadership priorities

The Trust has been clear about the challenges it faces and the need to revise its vision and strategic objectives in light of uncertainty. Nonetheless, the Trust has not deviated from its belief that good quality and adequately supported front-line staff are essential for quality improvement. The most powerful tool that we have in achieving our goals and objectives are our staff.

We are in the process of enabling detailed Organisational Development and Workforce Strategies designed to ensure the development of a responsive and flexible workforce that will reflect the integration agenda and the need to utilise health economy resources more cleverly. This will be supported by a programme covering:

- improving management and clinical leadership;
- improving governance and leadership of the Trust
- developing the qualifications and career prospects of the workforce;
- installing a strong performance assessment framework;
- staffing levels commensurate with needs of patients;
- controlling payroll costs including agency costs; and
- developing roles and contracts of employment to meet service need.

Quality priorities

The Trust was awarded an overall rating of "Requires Improvement" by the CQC following their inspection in March. Although we were disappointed that we did not achieve a rating of "good" in all aspects of our service the report does recognise our compassionate approach and the respect and dignity shown to patients. Two categories received a rating of outstanding: the critical care team was recognised for its caring interventions to support patients, families, friends and staff, while end of life care received an outstanding rating for their responsiveness to patient needs. Services for children and young people also achieved a 'good' rating against all five measures.

In addition, as part of our quality strategy we have identified urgent quality priorities that we will focus on in the short-term:

- minimise the number of patients acquiring CDI;
- promoting a harm free environment through e.g. reducing falls and pressure ulcers;
- maintaining and improving mortality;
- improving the quality and availability of medical records;
- reducing patient complaints relating to staff attitudes and behaviour; and
- Reduce the number of rescheduled outpatient appointments and cancelled operations.

4.2 External risks to sustainability

Demand growth and management

As discussed in the market assessment section above, the growth in the frail elderly population and growth in long term conditions will increase demand for healthcare services. We have noticed that the acuity of patients who are being admitted is higher than previously and we are also admitting increasing numbers of patients who have dementia as a co-morbidity. We have modelled the impact of an additional 1.25% activity growth on top of our base-case to illustrate the impact of continued growth across the health economy.

Commissioner QIPP

The health economy faces a significant challenge in dealing with rising need and demand against a backdrop of flat funding for the NHS. In a 'do nothing' scenario a £157m affordability gap is predicted for the health economy by 2018/19. We are working closely with our colleagues across the health economy, particularly our CCG colleagues to understand how we can meet these challenges together and continue to provide the services that our patients require in a sustainable way.

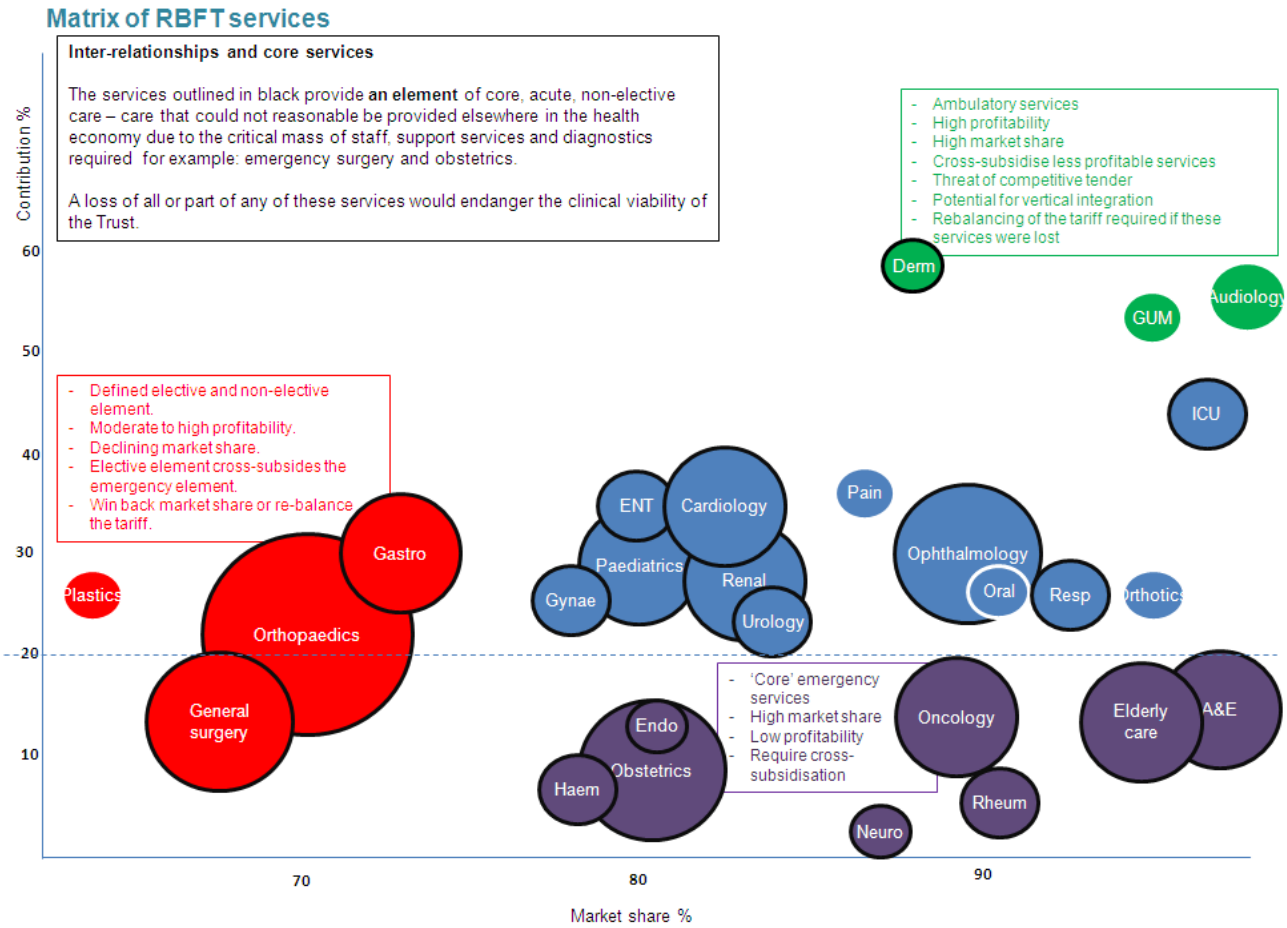
Berkshire West CCG has commissioned external consultants to work with all partners in the local health economy to carry out a detailed review of three high volume healthcare pathways that cut across different parts of the healthcare economy. The aim of the review was to find improvements in efficiency, patient experience and outcomes and identify a sustainable model of healthcare for the local economy.

As an organisation the Trust has a substantial CIP target to achieve and we face the challenge of delivering this whilst absorbing the potential reduction in income as a result of CCG QIPP. If CCG QIPPs are delivered we would need to reduce acute capacity (and would face significant transition costs). We do not believe it is in the best interests of patients or the health economy if we were to plan to reduce capacity before these schemes have been evaluated and proven to be effective.

Competition

We have seen a substantial decrease in our market share for elective surgery, particularly in orthopaedics over the past three years. Competitive tender and AQP also pose a challenge. Our experience locally and the trend nationally is for commissioners to run tender processes for the services that deliver the biggest financial margin for the acute Trust. Generally these are ambulatory care services that do not have the cost of inpatient beds apportioned to them. These services act to cross-subsidise services that make much lower margins and therefore when such services are lost, or the income available reduced through the tender process, it affects the overall viability of the Trust (illustrated in Figure 3 below). Therefore there is a pressing need to revisit the payment methods underpinning services to reduce perverse incentives or disincentives.

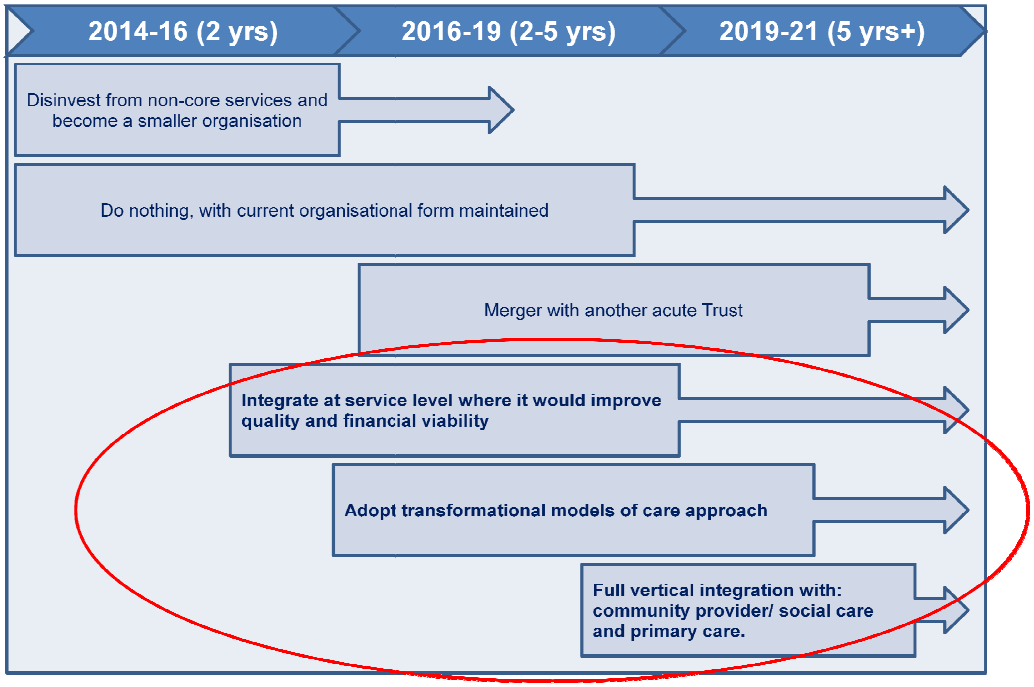
Figure 3: Comparison Matrix of Service Contribution v Market Share



4.3 Strategic options for 2014/15 – 2018/19

The strategic options available to RBFT can be categorised into three groups – options for growth, integration and organisational form. They can be considered as a chronological set of options with growth options being immediately pertinent, integration options crystallising at around year three of the plan and options around organisational form requiring a health economy wide transformation and therefore being considered at year five onwards.

Figure 4: Strategic 'Likely' Option Appraisal



The strategic options the Trust believes will be most likely over the next 5 years are:

1) moderate growth to ensure sustainability; limited growth in other areas; and
2) integration at a service level where it would improve quality or financial viability.

However, as we anticipate that by 2018/19 the Trust will be moving towards models of care aligned with elements of NHS England and Monitor's "Transformative Ideas for the Future NHS" additional integration becomes more likely. This is at present an emerging vision for us with the implication for organisational forms within the healthcare economy unclear. Therefore for our activity and financial projections we have assumed organisational form remains the same until 2018/19.

Moderate growth to achieve sustainability

We have chosen to actively plan for moderate growth in elective surgery to achieve sustainability. In recent years we have lost significant share of the elective orthopaedic market as we have not had sufficient theatre capacity to offer patients an acceptable waiting time. We therefore plan to add an additional two laminar flow theatres increasing our theatre capacity for both orthopaedics and other specialities.

Based on our assessment of patient need and demand we are predicting a low but steady rate of growth over the next five years (Table 1). Our commissioners are broadly in agreement with our assessment of activity growth across outpatient, A&E and non-elective service lines.

Table 1: Activity growth predictions 2014/15 – 2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
A&E	114,839	119,433	120,627	121,833	123,051
NEL	35,473	36,910	38,404	39,960	41,578
OPN	155,550	157,743	159,936	161,903	164,056
OPF	211,041	214,016	216,990	216,648	219,529
OPP	47,251	47,917	48,583	49,181	49,835
DC	36,672	38,036	38,481	38,905	39,332
EL	9,502	10,369	10,472	10,577	10,683

Integration

We have considered a number of options for integration over the next five years. Our immediate plan is to maintain the status quo and 'stand alone' for the next 2 years, working via collaborative arrangements with other organisations, without formal integration at service or organisational level. The first step towards integration could involve the merger or cross-working of suitable acute and community services and pathways to improve quality or to create efficiencies

There is the potential, in the future for integration at an organisational level within our health and social care economy. This could involve RBFT merging with Berkshire Healthcare NHS FT or could go further and involve a merger with primary or social care. We have not included this option in our strategic plan at present as we are yet to have the health economy wide debate as to what this merged entity would involve and what organisational form it would take.

Merger with another NHS acute trust is unlikely as our geographical position and proximity to other Trusts does not lend itself to an obvious option for merger.

Alternatives options for growth

Alternatives to our plans for moderate growth include planning for very limited growth or actually going a step further by disinvesting in services and shrinking. A further alternative would be to disinvest in some services and become a smaller organisation, focusing on core acute services which cannot reasonably be provided by another provider in the locality. It is difficult to draw a clear demarcation between core and non-core services not least because our terms of authorisation as a Foundation Trust

5. Strategic plans

5.1 Strategic Plan: Moderate activity growth to maintain sustainability

Emergency and non-elective care

We predict a 4% year on year growth in demand for non-elective admissions which is in line with commissioner predictions of underlying growth before application of their QIPP.

Whilst we believe that integration provides optimum care and is the way in which the health economy can best tackle the rising demand we are concerned about the impact should the current QIPP schemes not deliver the expected reduction in acute activity and hence the level of savings that commissioners anticipate over the next 2 years. We have therefore not included the achievement of commissioner QIPP in our plans although we continue to actively engage with the commissioners and work collaboratively to support the achievement of the QiPPs.

Elective care

Our projections for elective surgery – both day case and inpatient surgery - are broadly in line with CCG projections for growth in demand. We are however forecasting a higher rate of growth for activity carried out by the Trust which reflects our intentions to increase our market share both in Berkshire West and beyond. We are not forecasting a higher elective spend for the CCG overall, rather we are forecasting that a higher proportion of that spend will come to us.

Outpatient attendances

Our projections for outpatient first attendances are broadly in line with CCG projections for growth in demand. We aim to reduce our outpatient waiting times to improve our competitive position. We also intend to improve the range and volume of activity carried out at our community sites. We particularly intend to grow activity from the Berkshire East market from our facility in Bracknell.

Our projections for outpatient follow-up are aligned to CCG projections. We have made progress in reducing follow-ups in a number of specialities including rheumatology and we aim to carry this work on over the next 5 years.

Capacity analysis – Beds and theatres

Apart from an increase of 8 surgical beds in 2014/15 as part of the elective orthopaedic centre development we are not currently in a position to plan any increases or decreases in our bed base over the next five years due to the need to determine how CCG plans to reduce non-elective admissions will crystallise.

When carrying out our detailed operational planning for 2016/17 we will have more evidence on the likely impact of integrated care schemes on admissions and can take a decision as a healthcare economy as to whether additional capacity is required and, if so, where it should be located.

Table 2: Bed requirement based on activity plan

		Bed requirement based on activity plan				
	Current bed base	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Medical Non elective	397	384	397	410	424	438
Surgical	197	209	217	220	223	226
Total beds	**594**	**593**	**613**	**630**	**647**	**664**

We carried out a detailed review of theatre capacity as part of the planning stage for our elective orthopaedic centre development. We currently have 22 theatres and our elective orthopaedic centre will add another two laminar flow

theatres to this total and will ensure that we have sufficient capacity to perform surgery in an acceptable waiting time for patients.

Workforce

Our goal is for every member of staff to understand their role in delivering high quality care and be capable to continually strive to improve quality. A trust wide training programme in quality improvement methodologies, tools and techniques is being implemented to ensure that all staff have the necessary skills, support and time to participate in quality improvement projects and ongoing professional development training.

In light of the recommendations of the Francis Report, the Berwick report and the Keogh review, the Trust has undertaken a skill mix review of nursing staff requirement based on safer staffing models. This has the impact of increasing the projected staffing levels for 2014/15 by 193 WTE. However, we anticipate that the combined benefits of reducing agency spend, service remodelling, pathway redesigns and other improvement and efficiency arrangements would lead to reductions in headcount in the following years beginning with a moderate reduction of circa 36 WTE from 2015/16.

Estates

Uncertainty over the future approach to and modelling of service delivery constrain the Trust's ability to set out a truly strategic view of the development of our estate. However our long-term plan is to ensure delivery of an Estate Strategy designed to achieve three objectives:

- To have an estate which is fit for the future, supporting the Trust's service strategy
- To have an estate which enhances the quality and safety of care and the experience of patients and staff
- To have an estate which enables best value for money.

The key elements of our long-term plan are the refurbishment and modernisation of existing blocks, expansion of care parking facilities, ensuring that all buildings are fire compliant and the development of the Orthopaedic centre and Preoperative assessment building:

Quality

In the latter part of 2013/14 we refreshed our Quality Strategy for the next five years. This underpins our aim to deliver the highest quality healthcare services to our patients and sets out our action plan for making measurable improvements to the quality of our services. Our improvement strategy addresses both our immediate requirement for change, whilst prioritising that improvement to ensure consistency with resource limitations and ensuring that we embed a wider cultural and organisational transformation. Our short term improvement priorities are highlighted in the 2014/15-15/16 Operational Plan. Our longer-term goals for quality improvement are included within our five year quality strategy and include:

- Culture: We will develop our Organisational Development Strategy to align all the components of our organisation that define us, our culture and how we approach quality of
- Patient Safety: We are committed to striving to achieve harm free care. In 2014/15 we will focus on reducing harm as measured by the Patient Safety Thermometer
- Clinical Effectiveness: The immediate focus of our attention will be improving understanding of mortality indicators and how these are used with the hospital.
- Patient Experience: How we communicate with patients and waiting times will form the central themes of our patient experience improvement. We will particularly focus on how we address complaints.

5.2 Key service line initiatives

Elective orthopaedic centre development

A priority in 2014/15 is the creation of a dedicated elective orthopaedic centre with ring-fenced beds to improve safety, efficiency and productivity of the orthopaedic pathway ensuring an excellent patient experience.

The key project risks relate to technical building issues, increased project costs, maintaining 'business' as usual throughout construction and recruitment of staff. Building issues will be managed via our contractor and we are working to resolve any issues with build and design before works start. We are mitigating against increased costs for ground works by going back out to tender and we also have some contingency built into the business case. Failure to recruit sufficient theatre and ward staff is one of our highest risks. We are planning to undertake an overseas recruitment programme to recruit specialist theatre staff and based on previous experience we believe this will be successful.

Urgent care floor

Our ambition over the next five years is to secure funding to redevelop our urgent care floor. The 'urgent care floor' refers to three departments with current capacity constraints which work in interdependent way and provide better quality and safety of care when co-located. These departments are: the emergency department (ED), the ambulatory medical unit and emergency care unit (AMU/ECU) and the intensive care unit (ICU).

The aims of the urgent care floor development would be to:

- Continue to embed and improve quality and safety of services for our patients
- Provide highly reliable care to give our patients the best experience
- Enhance the clinical outcomes for patients e.g. mortality rates
- Enable on-going achievement of the A&E 4-hr target and quality indicators

5.3 Financial model

The financial model for our planned activity growth is consistent with CCG planning assumptions (with non-delivery of CCG QIPPs). We plan to return to a surplus position in 2015/16. This requires a significant cost savings programme (CIP) of circa £33.5m in two years, representing in excess of 10% of our current cost base. This is supported by a combination of internal plans and external benchmarking that we have undertaken.

Beyond 2015/6 it is unlikely that the Trust will be able to continue to make savings at this level. We have assumed at best that we will be able to drive cost efficiencies of around 2.5% per annum, essentially covering annual inflation increases. We have modelled this in our baseline scenario and the impact is that cash remains flat at circa £22m until the end of 2015/16. Our cash position then has the potential to fall, unless mitigating actions are taken, until we enter a negative cash scenario in 2018/19. Despite the moderate growth in our revenue over the next five years, our earning before interest, depreciation and amortisation (EBITDA) increases in 2015/16 but begins to fall afterwards and we enter into a deficit position.

Trust CIPs

The Trust faces a significant CIP challenge of £18.5m in 2014/15 and £16.9m in 2015/16. This level of CIP is required to reverse our underlying deficit of circa £11.5m in 2013/14.

Whilst we have identified key programmes for 2015/16 our plans are less well developed. We have identified £14m of potential efficiencies which are summarised below. These are in addition to the normal base level of efficiencies we would expect to deliver.

- Consolidation of Trust pathology service: The Trust is working in partnership with four other Trusts to consolidate their pathology services into one large service offering. *Target savings 2015/16 - £1m.*
- Corporate Services (including IT): A key programme of work is to reduce corporate spend by 25% over the next two years. *Target savings 2015/16 - £3m*
- Administration: A full review of how the administration function is provided across the organisation is underway.. *Target savings 2015/16 - £1m*
- Consultant Productivity: aimed at achieving improved efficiency and value from our consultant body, whether that be productivity from theatre and clinic sessions, or outputs from non clinical duties *Target savings 2015/16 - £2m.*
- Inventory and Logistics Management: we will be reviewing our whole logistics function to ensure we are operating as effectively as possible. We are currently working with external partners to identify innovative new ways of working in this area. *Target savings 2015/16 - £1m*

- Procurement : Ongoing drive to achieve best pricing but supported by a move to greater partnerships with key suppliers such as NHS Supplies and other local NHS procurers of services. *Target savings 2015/16 - £3m*
- Service Line Reporting / Patient Level Costing : Ongoing in depth review of specialties and HRG's using service line reporting and patient level costing to identify areas for improved operational and financial performance using reference costing and benchmarking at a specialty/HRG level. *Target savings 2015/16 - £3m.*

We have modelled the impact of achieving 50% and 75% of our CIP programme. Not achieving our CIP in full is the biggest risk to our financial position and to the delivery of our strategic plan.

5.4 Local Health Economy mitigation of financial risk.

Our own plan assumes cost CIPs of circa £64m by the end of 2018/19, whilst Berkshire Healthcare FT face a similar cost challenge, and the CCGs are looking for a reduction in spend in excess of £100m. Collectively this adds up to a significant financial challenge to the local health economy. Recognising this we have begun to work as a sector with Berkshire West CCGs, Berkshire Healthcare FT and local social services to pursue a sector solution. We are collectively supported by Ernst & Young.

All parties across Berkshire West are committed to work together to arrive at a sector solution which delivers effective and modern patient care whilst mitigating our collective financial risk and ensure long term sustainability. The output of this work will have an inevitable, and possibly fundamental impact on this strategic plan and Monitor and other stakeholders will be kept updated as this work progresses.

Royal Berkshire NHS Foundation Trust

Reading Health & Wellbeing Board

Title: **CQC Inspection Update**

Date: **9th July 2014**

Lead: **Caroline Ainslie, Director of Nursing**

Purpose: This paper informs the Board of the outcome of the CQC inspection and the Trust's plans for implementing a CQC Improvement Plan in response to the findings within the inspection report.

Key Points:

- Following the CQC formal inspection 24th – 26th March, the Trust has now received the final report detailing the findings (attached in Appendix 1).
- An overall rating of 'Requires Improvement' has been given to the Trust, with separate ratings given for each CQC domain (safe, effective, caring, responsive, and well-led) and ratings for each core service.
- The Trust was able to challenge many of the findings within the report that were felt to be inaccurate or out of context, and the majority of these were successfully upheld by the CQC and reflected in the final report.
- The report findings include a total of 13 actions the Trust must take and a further 14 actions that the CQC suggest the Trust should take. These actions have been amalgamated into 7 'Compliance Actions' (regulatory legal actions that confirm the essential standards the Trust must meet through delivery of the action plan).
- The Trust is now finalising a detailed Improvement Plan to address all of the key actions within the report and will be submitted to the CQC for sign off by the deadline of 18th July.
- Governance of the Plan internally will be via the Trust's monthly Quality Performance and Learning Committee, and externally with the CCG via the Quality Review and Joint Senior Governance Groups. Updates will be provided to the Trust's CQC liaison lead and Monitor.
- An overall Trust Improvement Plan has been developed pulling all of the Improvement projects together, including the Board Evaluation and Quality Governance Framework action plans. Oversight of the Improvement Plan will be undertaken by Head of PMO. Additional project management resource has been agreed to support staff in delivering the actions over the next few months.

Royal Berkshire NHS Foundation Trust

Quality report

Royal Berkshire NHS Foundation Trust
Craven Road
Reading
RG1 5AN

Tel: 0118 322 5111
www.royalberkshire.nhs.uk

Date of inspection visit:
24 to 26 March 2014

Date of publication:
June 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Overall rating for this trust	**Requires improvement**
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Letter from the Chief Inspector of Hospitals

Royal Berkshire NHS Foundation Trust provides acute services to a population of 600,000 people across Reading, Wokingham and West Berks, and specialist services to a wider population across Berkshire and the surrounding borders. Royal Berkshire Hospital is the main inpatient site, with five other sites including West Berkshire Community Hospital, Windsor Dialysis Unit, Prince Charles Eye Unit, Royal Berkshire Bracknall Clinic and Townlands Hospital Outpatients.

During the inspection, we visited the Royal Berkshire Hospital, West Berkshire Community Hospital (Day Surgery Unit and Outpatient services), Windsor Dialysis Satellite Unit and Prince Charles Eye Unit.

We carried out this comprehensive inspection because the Royal Berkshire NHS Foundation Trust was initially placed in a high risk band 1 in CQC's intelligent monitoring system. Immediately prior to the inspection the intelligent monitoring bandings were updated and the trust was placed in a low risk band 5. The inspection took place between 24 and 26 March 2014 and an unannounced inspection visit took place on 29 March and 2 April 2014.

Overall, this hospital requires improvement. We rated it good for being caring and effective but improvement was required in providing safe care, being responsive to patients' needs and being well-led.

We rated the A&E service, end of life care and services for children and young people as good, but we rated outpatients, medical, surgical, maternity and critical care as requiring improvement.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The hospital was clean and well maintained; although there were some examples where cleanliness fell below expected standards.
- The workforce were committed and we noted an open culture during the inspection.
- Infection control rates in the hospital were similar to those of other trusts except the C.Difficile rates, which were higher than average and the trust was taking steps to improve.
- Staffing levels were not always sufficient to meet the needs of patients on all ward areas, with a consequent reliance on bank and agency staff.
- Medical records and the electronic patient record system and processes were not robust, which resulted in patient records not being available, reliance on temporary records and inability to access records as required in a timely manner, impacting on the ability to deliver care.
- ICU capacity was insufficient and operations were going ahead when no ICU bed was available, resulting in patients being cared for in the recovery area overnight.
- The observation ward in A&E was a room with three beds but it was not included in the four-hour decision to discharge, admit or treat A&E target as it was used as a ward, although it did not have any shower facilities. There were concerns about appropriate use and care of patients in this observation area.
- The major incident process associated with decontamination was not appropriate because of the distance and journey for patients through the hospital.
- Safeguarding processes and knowledge of the Mental Capacity Act was not sufficient.
- DNACPR forms were not consistently completed.
- The end of life care team worked collaboratively with key stakeholders.
- Paediatric care was generally positive.

We saw several areas of outstanding practice including:

- Caring interventions and support for families in in the Intensive Care Unit.
- The Children's A&E department.
- Consultant geriatricians worked in the A&E department 8am to 8pm seven days a week.
- The responsiveness of the Palliative Care team.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that medical records are kept securely and records can be located and accessed promptly when needed to appropriately inform the care and treatment of patients.
- Maintain the privacy and dignity of patients placed in the observation bay in the A&E department.
- Ensure that the design and layout of the emergency department protects patients and staff against the risks associated with unsafe or unsuitable premises.

- Take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to care for patients' needs, and safeguard their health, safety and welfare.
- Accurately complete 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and document the discussions about end of life care with patients.
- Take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe by planning the delivery of care and appropriate treatment to meet patients' individual needs, and have procedures in place to deal with emergencies which are reasonably expected to arise.
- Review the ICU capacity across the trust; employ suitably qualified, skilled and experienced staff; and have necessary equipment available to care for patients who require intensive or high dependency care.
- Ensure that planning and delivery of care meets patients' individual needs, and ensure the safety and welfare of all patients.
- Increase staff knowledge of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding.
- Improve contemporaneous record keeping by all staff to avoid misplacing records of care and observations.
- Ensure the staffing levels and admission criteria in the Rushey Midwife-led unit is maintained to ensure safe care is provided to all women.
- Ensure that at all times there is a sufficient number of suitably qualified, skilled and experienced staff employed to provide safe midwifery care in all areas.
- Take action to improve the ventilation system on the delivery suite, to protect patients and others who may be at risk from the use of unsafe equipment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Background to Royal Berkshire NHS Foundation Trust

Royal Berkshire NHS Foundation Trust has been a foundation trust since June 2006. It employs around 5,000 staff and has 745 beds and 22 operating theatres (across three surgical sites). The trust's turnover is £330 million with a £2.68 million deficit in 2012/13.

The Royal Berkshire NHS Foundation Trust's inpatient site is the Royal Berkshire Hospital. The trust also provides services at West Berkshire Community Hospital (Day Surgery Unit and Outpatient services), Windsor Dialysis Satellite Unit and Prince Charles Eye Unit, Bracknall Clinic and Townlands Hospital Outpatients.

The former chief executive left the trust in December 2013 and the medical director became interim chief executive until a formal appointment was made. The executive team comprised of six permanent executive positions and five interim executives. The trust had adopted a clinically led model with three of the executives holding positions as Care Group Directors of urgent care, planned care and networked care. At the time of the inspection the trust did not have a chief operating officer (COO) post, but an interim COO was starting immediately post inspection. The significant number of interim appointments presented challenges for consistent leadership.

The Chairman had been in post since July 2012 and four of the five non-executive directors had joined following his appointment, with the most recent being in December 2013.

The trust had recently been under enforcement action from Monitor because its A&E consistently failed to meet the four-hour target, its financial stability, its quality governance, and *C. difficile* rates. At the time of the inspection concerns had been signed off by Monitor and the trust was rated as green, with no evident governance concerns. The trust continued to face financial challenges with a financial stability rating of 2 from Monitor, meaning that there was a material level of financial risk. The trust had also recently faced concerns in the media regarding its radiology waiting times.

Our inspection team

Our inspection team was led by:

Chair: Professor Kay Riley, Chief Nurse, Barts Health
Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 45 included CQC inspectors and analysts, consultants, junior doctors, senior nurses, a student nurse, a senior physiotherapist, patients and public representatives, experts by experience and senior NHS managers. Some team members were present at the inspection for one of the two days on site.

The Patients Association was also part of our team to review how the trust handled complaints.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at the Royal Berkshire Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

In addition, the inspection team also inspected the following core services at other locations linked to the Royal Berkshire Hospital:

- Medical provision at the Windsor Dialysis Satellite Unit
- Day surgical and outpatient services at West Berkshire Community Hospital
- Surgical services at Prince Charles Eye Unit.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event, in Reading on 24 March 2014, when 128 people shared their views and experiences of the Royal Berkshire Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 24 and 26 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections on 29 March and 02 April 2014. We looked at how the hospital was run out of hours and at night, the levels and type of staff available and the care provided.

What people who use the trust's services say

- We held a listening event, which 128 people attended. Some people told us about us that they had good care at Royal Berkshire Hospital. However, people had concerns about the long waiting times in A&E particularly for care of older people.
- The Adult Inpatient Survey in 2012 Royal Berkshire Hospital NHS Foundation Trust scored 'about the same' as other trusts for all 10 areas. The trusts performance had reduced in one area and improved in three areas. Of the 60 questions asked the trust performed better than other trust in one question.
- The results from the Friends and Family Test (FFT) between September 2013 to December 2013 show the trust has scored below the England average for all four of the months, achieving the lowest in October. Response rates are fairly consistent over the four months. A&E scores compared to the England averages were higher in two months and lower in two months.
- The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that out of 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings, the trust was rated by patients as being in the bottom 20% of all trusts nationally for 14 of the 69 questions and performed better in 9 questions.
- CQC's Survey of Women's Experiences of Birth 2013 showed that under the 'Care during labour and birth' that the trust is performing better than other trust's for one of the three areas of questioning. Comparison with the 2010 results highlighted an upward trend in one of the eight questions. The other seven questions saw no change in the results.
- Between January 2013 and February 2014, Royal Berkshire Hospital had 294 reviews from patients on the NHS Choices website. It scored 4 out of 5 stars overall, with 91 comments with a rating of 5 stars and 34 with a rating of one star. The highest ratings were for cleanliness, staff co-operation, dignity and respect, involvement in decisions and same sex accommodation. The lowest ratings were for staff being rude, breach of confidentiality, patient aftercare, pain management and communication.
- Patient-Led Assessment of the Care Environment (PLACE) is self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. In 2013, Royal Berkshire scored greater than 92% for all four measures, with cleanliness scoring the highest at 99.2%.
- The patients association attended the inspection and will publish their report independently.

Facts and data about this trust

Context

- Foundation trust since June 2006
- Approximately 745 beds
- Population 600,000
- Staff approximately 5,000
- Annual turnover: 330 million
- Deficit: £2.68m in 2012/13

Activity (2012/13)

- Inpatient admissions 94,755
- Outpatient attendances 449,627
- A+E attendances 101,497

Intelligent Monitoring – Low risk (March 2014)

	Items	Risks	Elevated	Score
Safe	8	1	0	1
Effective	31	0	1	2
Caring	18	0	0	0
Responsive	10	0	0	0
Well led	26	2	0	2
Total	**93**	**3**	**1**	**5**

Safety

- 4 never events (Dec 2012-Jan 2014)
- STEIs 93 SI's (Dec 2012-Jan 2014)

- NRLS Deaths 13
  Severe 5
  Abuse 14
  Moderate 680

Caring:

CQC inpatient survey (10 areas): Average for all 10 areas

Cancer patient experience survey (69 questions):
Above for 9 questions
Average for 46 questions
Below for 14 questions

Responsive:

Bed occupancy	89.1%
A&E: four hour standard	Below average
Cancelled operations	Similar to expected
Delayed discharges	Similar to expected
18 week Referral to treatment (RTT)	Similar to expected
Diagnostic target	Below average

Well-led:

Staff survey (28 questions)	Above average for 18 questions Average for 6 questions Below for 4 questions
Sickness rate 3.5 %	Below national average

Summary of findings

Are services at this trust safe?

Requires improvement

Overall we rated the safety of services in the trust as 'requires improvement'. For specific information please refer to the report for Royal Berkshire Hospital.

Nursing staffing levels were insufficient on many wards and consequently there was a significant reliance on agency and bank staff. The agency and bank staff were appropriately checked and had an induction checklist carried out. The trust was taking steps to recruit nurses internationally due to the difficulty in recruiting. Midwifery staffing was a concern in the Rushey unit, however, immediately after our inspection the trust closed two beds until further staff were recruited. Consultant presence in obstetrics was not in line with national standards. Medical staffing out of hours was a concern, particularly in medicine. Due to capacity pressures and workload, medical staffing needed improvement in some areas and in particular the critical care unit as consultants regularly needed to stay in overnight when they were on call.

Clinical data was not always easily accessible due to the fragmented structure of the trust's electronic patient record (EPR) and patient records were not easily accessible or well-maintained with an over-reliance on 'temporary' records. This affected patient care as significant information was not available and in some instances patients had more than one test as the initial result was not available. The trust recognised the safety concerns relating to medical records and set up a working group led by the interim medical director to address the issues as a priority.

Medical equipment checks were not consistently completed or recorded and staff reported difficulties in being able to get equipment checked or replaced.

Are services at this trust effective?

Good

Overall we rated the effectiveness of the services in the trust as 'good'. For specific information please refer to the report for Royal Berkshire Hospital.

Most patients were treated according to national evidence-based guidelines and clinical audit was used to improve practice. There were good outcomes for patients and mortality rates were within the expected range. Seven-day services were in development and there were good examples of seven-day working. There were good examples of robust ward rounds and multi-disciplinary team working with input from allied health professionals. There were examples of clear documented pathways of care.

Are services at this trust caring?

Good

Overall we rated the caring aspects of services in the trust as 'good'. For specific information please refer to the report for Royal Berkshire Hospital.

Overall, patients received compassionate care and were treated with dignity and respect. The Critical Care service provided some excellent caring interventions both for the patients and their families, with positive feedback about their bereavement service. Patients and relatives we spoke with said they felt involved in their care. There were examples of patients not feeling appropriately cared for in A&E and some ward

areas where staff were busy. Staff acknowledged that, at times, workload pressures could prevent the level of care and support patients needed. Staff were extremely committed and aimed to put the needs welfare of patients as their priority.

Are services at this trust responsive?

Requires improvement

Overall we rated the responsiveness of services in the trust as 'requires improvement'. For specific information please refer to the report for Royal Berkshire Hospital.

The trust faced significant capacity pressures. The A&E department was not consistently meeting the four-hour target for treatment, admission or discharge. The department was designed for 65,000 attendances but had around 100,000 attendances a year at the time of the inspection. This resulted in patients waiting in corridors to be seen and, in some instances, spending longer than 12 hours in A&E.

The flow throughout the trust was not robustly managed, with patients who were clinically fit for discharge not being discharged in a timely manner. There were significant waiting times for radiology diagnostic procedures, which impacted on both inpatients and outpatients. The trust was taking steps to improve the radiology waiting times and looking at other ways of providing diagnostic treatment.

The critical care capacity was not sufficiently meeting the demand and resulted in either patients' operations being cancelled or patients staying in recovery overnight. The trust did not have clear robust plans to address the capacity and flow issues. However the appointment of the interim chief operating officer was intended to concentrate on addressing them.

Are services at this trust well-led?

Requires improvement

The trust's leadership was rated as 'requires improvement'. Many of the executive team were interim positions and the former chief executive had left in December 2013. The trust had proactively commissioned a review into its leadership and governance processes and we had confidence that they were beginning to take appropriate steps to address some of the trust wide issues found during the inspection. They were aware of the potential risks associated with interim posts and were in the process of appointing a new chief executive. This recent instability in leadership has resulted in front line staff not feeling fully informed about the recent changes and unclear on the overall vision for the trust. Staff did not feel the executive team were visible enough, although many staff told us that the Director of Nursing was more visible and had 'made a difference' in the relatively short time she had been in post since June 2012.

Whilst the trust board was aware of the improvements that were required, they were facing a legacy of some areas of governance not being standardised or robust and systems and process being inconsistently applied, which would take some time to address. During the inspection there was some evidence of improvement starting, but it was too soon to establish the impact. There were some areas that needed stronger leadership from the board to the ward to realise the required changes.

Vision and strategy for this service

- The trust had been through significant change at board level and was awaiting recruitment of a permanent chief executive.
- The trust was managing the capacity pressure as a priority and the longer term vision was being reviewed awaiting new leadership.
- The impact of numerous interim directors being in post resulted in staff not feeling they were clear on the future vision of the trust given the financial pressures.

Governance, risk management and quality measurement

- The overall governance structures lack standardisation and clear performance management, which

impacted on the board holding to account in a timely manner.

- Whilst the care group structure has some inevitable benefits through the clinical leadership model the trust aimed to achieve, each care group was operating primarily independently of each other in 'silos' without robust standardisation of reporting to the board on performance and quality.
- The care group directors were accountable to the board for performance and quality of their care group, however they were not consistently held to account on delivery of their targets and key performance indicators. Furthermore, it was not clear how the corporate functions were structured to work with the care groups and where the lines of accountability were in all cases.
- The trust had recognised there were significant improvements needed in their quality governance structure and had commissioned work from an external company to commence work within the immediate few weeks following the inspection.
- During the inspection it was evident that there were significant data quality issues across the trust, which, at times, resulted in the board taking assurance from data that could not always be relied on. Whilst the majority of the board recognised there was a data quality concern, the care groups were not interrogating the data consistently in the reports they presented to the board.
- The levels of incident reporting were a concern as there was a theme that staff members did not always report incidents because they did not always see resultant changes when they had reported in the past.
- The care group 'silo' working had meant that learning from incidents and complaints was not shared effectively trust wide. Whilst themes and aggregated data was, at times, discussed at the trust board, this communication of learning was not fed back to the clinical staff delivering care to patients in a robust manner.
- The care groups had recently recognised the lack of formal information sharing as an issue and consequently set up a new formal meeting where each care group shared learning and discussed performance and quality with the aim to eradicate the 'silo' working and encourage 'trust-wide' operational working where appropriate. However, it remained unclear how the corporate functions linked into this approach.

Leadership of service

- The leadership of the trust had been through some significant changes in the preceding months of the inspection as the chief executive left in December 2013, which left some resultant confusion among staff at all levels.
- The board was made up of a significant number of interim positions with more commencing in post following the inspection. At the time of the inspection the executive team comprised of six permanent executive positions and five interim executives. The significant number of interim appointments, presented challenges for consistent leadership.
- Under the leadership of the former chief executive, a clinically-led model had been adopted with three of the executives holding positions as Care Group Directors of urgent care, planned care and networked care. The care group directors worked clinically and were ultimately accountable for their care group performance, however the amount of time allocated specifically for the care group director role was not consistent.
- Development of board members had not been a priority and it was apparent that the executives were not, at times, joined up in their approach. When the three care group directors were appointed there was limited formal support and development provided in relation to the new roles.
- At the time of the inspection the trust did not have a Chief Operating Officer (COO) post but an interim COO was starting immediately post inspection.
- Feedback from staff highlighted that many staff members did not know who the members of their executive team were and there was a consistent theme that executives were not visible enough. One main exception was that many staff members knew the director of nursing and felt she was

visible, although they would like visibility to still increase.

- The consistent leadership of the trust was an issue raised by staff at all levels, particularly given the financial pressure the trust faced.

Culture within the service

- The trust wide culture was one of pride and commitment among staff who were very positive about the trust as a place to work, with many clinical staff having worked at the trust for the majority of career.
- The staff focus groups were very well attended and, whilst there were many issues raised regarding staffing and systems and processes, the overriding message received was that that they were proud to work for the trust and they felt well supported by managers in their development.
- The recent resignation of the former chief executive had impacted on the culture as a consequence of staff not feeling they were aware of the plans for the trust and what changes might occur with new leadership.
- There was an open and transparent culture among staff at all levels.

Public and staff engagement

- Staff consistently stated they felt involved in the development of their work and in particular more locally in their clinical areas.
- The care group structure meant that staff often felt involved in their 'care' group' rather than the trust overall.
- Patient feedback was obtained through the Friends and Family test and the NHS Choices website and inpatient feedback captured by volunteers.

Innovation, improvement and sustainability

- Staff were encouraged to improve standards of care through innovation and felt support in developing their own practice locally, however capacity and staffing pressure meant that they did not feel they were able to improve the standards of care proactively in all cases as time constraints prevented them doing so.
- The sustainability of the trust was a concern to staff given the instability at the executive level and to compounding financial pressure and staff were awaiting the commencement of the new chief executive and a permanent executive team to secure a sustainable future for the trust.

Overview of ratings

Our ratings for Royal Berkshire Hospital are:

	Safe	Effective	Caring	Responsive	Well-led		Overall
Accident and emergency	Good	Inspected but not rated[1]	Good	Requires improvement	Good		Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Critical care	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement		Requires improvement
Maternity and family planning	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Children and young people	Good	Good	Good	Good	Good		Good
End of life care	Good	Good	Good	Outstanding	Good		Good
Outpatients	Requires improvement	Inspected but not rated[1]	Good	Requires improvement	Requires improvement		Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement

	Safe	Effective	Caring	Responsive	Well-led		Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement

Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both accident and emergency and outpatients.

Outstanding practice

We saw several areas of outstanding practice including:

- Caring interventions and support for families within in the Intensive Care Unit.
- The Children's A&E department.
- Consultant geriatricians worked in the A&E department 8am to 8pm seven days a week.
- The responsiveness of the Palliative Care team.

Areas for improvement

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that medical records are kept securely and records can be located and accessed promptly when needed to appropriately inform the care and treatment of patients.
- Maintain the privacy and dignity of patients placed in the observation bay in the A&E department.
- Ensure that the design and layout of the emergency department protects patients and staff against the risks associated with unsafe or unsuitable premises.
- Take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to care for patients' needs, and safeguard their health, safety and welfare.
- Accurately complete 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and document the discussions about end of life care with patients.
- Take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe by planning the delivery of care and appropriate treatment to meet patients' individual needs, and have procedures in place to deal with emergencies which are reasonably expected to arise.
- Review the ICU capacity across the trust; employ suitably qualified, skilled and experienced staff; and have necessary equipment available to care for patients who require intensive or high dependency care.
- Ensure that planning and delivery of care meets patients' individual needs, and ensure the safety and welfare of all patients.
- Increase staff knowledge of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding.
- Improve contemporaneous record keeping by all staff to avoid misplacing records of care and observations.
- Ensure the staffing levels and admission criteria in the Rushey Midwife-led unit is maintained to ensure safe care is provided to all women.
- Ensure that at all times there is a sufficient number of suitably qualified, skilled and experienced staff employed to provide safe midwifery care in all areas.
- Take action to improve the ventilation system on the delivery suite, to protect patients and others who may be at risk from the use of unsafe equipment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of the needs of the services user and the planning and delivery of care and, where appropriate, treatment to meet the needs and ensure the safety and welfare of the service users. Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostics and screening	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: The registered person had not ensured that equipment was properly maintained and available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. Regulation 16 (1) (a) (2) Safety, availability and suitability of equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The registered person had not, so far as reasonably practicable, made suitable arrangements to ensure the privacy and dignity of service users. Regulation 17 (1) (a) Respecting and involving people who use services

Regulated activity	
Treatment of disease, disorder or injury Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: The registered provider must ensure service users are protected against the risks associated with unsafe or unsuitable premises by means of- suitable design and layout and adequate maintenance of the premises in connection with the regulated activity. Regulation 15 (1) (a) (ii) (c) (i) Safety and suitability of premises
Regulated activity	
Treatment of disease, disorder or injury Surgical procedures Maternity and midwifery services	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 Consent to care and treatment
Regulated activity	
Treatment of disease, disorder or injury Surgical procedures Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all tine there were sufficient numbers of suitably qualified and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Staffing
Regulated activity	**Regulation**
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Service users were not protected against the risk of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of the maintenance of: an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided. The registered provider must ensure that records are kept securely and can be located promptly when required. Regulation 20 (1) (a) (2) (a) Records