READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	HEALTH AND WELLBEING BOARD		
DATE:	17 APRIL 2015	AGENDA ITEM:	5
TITLE:	READING INTEGRATION: UPDATE REPORT		
LEAD COUNCILLOR:	COUNCILLOR HOSKIN/ COUNCILLOR	PORTFOLIO:	HEALTH / ADULT SOCIAL CARE
SERVICE:	HEALTH / ADULT SOCIAL CARE	WARDS:	ALL
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report provides updates to the Health and Wellbeing Board on a number of key areas of work within the Health and Social Care Integration Programme as it relates to Reading. This includes an update on the Better Care Fund schemes, their progress and plans for implementation.

1.2 As part of the NHS planning process, the 2 Clinical Commissioning Groups (CCGs) in Reading have developed refreshed "*Plans on a Page*" and submitted drafts of these to NHS England. This report provides a summary of the updated Reading CCG priorities, many of which relate directly to the Integration Programme.

1.3 In reviewing the second year of the local CCG operating plans, NHS England has advised the CCGs to revise the target for reducing Non Elective Admissions to hospital (NEL) for 2015 – 2016. The need to revise this target relates to the pressures experienced over the winter period, alongside now having a clearer understanding as to how the Better Care Fund schemes are likely to impact on NEL activity. This report notes the progress that has been made in determining a new target.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes and supports:

(a) the progress which has been achieved in taking forward Reading's Better Care Fund schemes;
(b) the priorities set out in the Reading Clinical Commissioning Groups' 2 year plan refresh; and
(c) the further development of the Frail Elderly Pathway.

2.2 That the Health and Wellbeing Board notes the work that has been undertaken, and the work that is required, to develop a revised Reading Better Care Fund performance target in relation to Non Elective Admissions for 2015-16;

2.3	That the Board notes the receipt of guidance from NHS England "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16" and receives a report on this to the next meeting.

3. BACKGROUND

3.1 Integration of Health and Social Care has been identified as a key component of maintaining the sustainability of care services into the future. The need to address sustainability challenges is particularly pertinent given the increase in the older person's population and the number of people who are living with multiple and complex long term conditions.

3.2 Health and Social Care Integration has been promoted at a national level through recent legislation, including the Health and Social Care Act 2012. This Act was intended to safeguard the future of the NHS by addressing the challenges it faces, looking towards modernisation to ensure a sustainable National Health Service. The Health and Social Care Act 2012 aims to put clinicians at the centre of commissioning, free up providers to be innovative, empower patients, and give a new focus to public health.

3.3 The case for integrating health and social care was then developed in the NHS Five Year Forward View – published in 2014 - setting out how the health service needs to change if it is to close the widening gaps in the health of the population, quality of care and the funding of services. This partnership vision makes the case for stronger engagement between care providers, patients, carers and citizens to promote wellbeing and prevent ill-health. It also addresses the changes in patients' health needs and personal preferences. Long term conditions – rather than illnesses susceptible to a one off cure – now consume 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care needs, challenging the traditional divide between patient and professionals, and offering an opportunity for better health through increased prevention and supported self-care.

3.4 The Better Care Fund (BCF) provides for local funding for Health and Social Care services to be allocated in ways which explicitly promote integration. Specifically, in order to draw down the funding available through the BCF allocation, local authorities and clinical commissioning groups (CCGs) must submit agreed two-year plans for use of the BCF, which have been approved by their Health and Wellbeing Board. The funding is then made available within local poled budgets from 2015-16.

3.5 Reading's final Better Care Fund Plan was formally approved by the Health and Wellbeing Board on 10 October, 2014. Members had previously had sight of the Plan at an extraordinary Health and Wellbeing Board seminar on 27 August 2014. The Plan then received final approval from NHS England in November 2014. The Plan contains number of performance targets, including a 2.8% reduction in the number of non-elective admissions to hospital.

3.6 In reviewing their two year plans overall, the Reading CCG's have been working on a reviewed target for non-elective admissions. Reading aims to improve on what is already a strong baseline performance in terms of non-elective activity. Whilst this is to be celebrated, the strong baseline does make achieving further reductions particularly challenging. This along with the unprecedented rise in emergency admissions in the period from November 2014 – March 2015 has affected the system's ability to reach this target with a growth of 7% during this period.

3.7 NHS England issued guidance "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16" on 20th March 2015. This guidance sets out the reporting and monitoring requirements for the Better Care Fund, how progress against conditions of the fund will be managed.

Officers are undertaking work to determine the implications for these requirements. A further report will be brought to the next Health and Wellbeing Board to advise the board of its obligations.

4. UPDATE ON THE READING BETTER CARE FUND SCHEMES

4.1 A number of schemes were developed to achieve the key performance indicators within the BCF Plan. These have been approved in outline by the Board previously. How the various schemes have been developed and progressed is detailed below. The schemes within Reading's BCF plans are:

1 Hospital @ Home
2 Enhanced Support to Care Homes
3 Berkshire West Connecting Care (Interoperability)
4 Discharge to Assess / Time To Decide beds
5 Whole System / Whole Week (Neighbourhood Clusters, Health and Social Care Hub and 7 day working)

Table (1) describing each scheme and their go live dates:

Reading or West of Berkshire	Scheme	Go live date
West of Berkshire	Hospital at Home	Incremental: Soft launch May 2015 Full launch June 2015
West of Berkshire	Enhanced Support to Care Homes	Currently in situ
West of Berkshire	Connecting Care	Phase 1 – in place Phase 2 - Late 2015 Phase 3 - 2016
Reading specific	Discharge to Assess	1st April
Reading specific	Neighbourhood Clusters	To be determined
West of Berkshire	Health and Social Care Hub	Late 2015
Reading specific	7 day working	Incremental from 1st April.

Hospital at Home

4.2 Hospital at Home is a scheme that has received a lot of interest. Originally the Hospital at Home Service was intended to divert people from hospital by providing some lower level hospital interventions in the persons own home. An example would be for someone who is dehydrated and needing intravenous fluids. Usually this would be provided in hospital and the person would stay in hospital for 3 days or more. Similarly someone who has an infection, e.g. a urine infection, would also stay in hospital whilst they receive treatment. In both cases given the right level of care, including consultant oversight, this care could be provided at home. Being in hospital can lead to other complication such as falls, infection and creating levels of dependency, so providing care in the person's own home can improve recovery rates by avoiding these complications. There are, however, exceptions to this - such as if the person lives alone or has dementia, or has multiple conditions that counteract with each other.

4.3 In the autumn of 2014, the Hospital at Home model underwent a 'proof of concept' trial to test out the assumptions that had been made. This was an enlightening trial and evidenced that although there was a need for this service, the levels of demand were not as initially anticipated. The proof of concept did however, highlight that there was a group of patients that could have been discharged earlier by what is known is early supported discharge. This is where the patient is stable but still requiring medical intervention.

4.4 These findings have been built into a revised business case that has now been signed off. The revised and refined service is going to start in May 2015, with close scrutiny to ensure that any risks are reduced, with the aim of the service going fully live from June 2015.

Enhanced Support to Care Homes

4.5 Although developed within the Better Care Fund plan, Enhanced Support to Care Homes builds on a project which has already been in operation for a number of months. The current service has two key components.

GP-led Care Plans:
The target of achieving care plans for all residents of care homes over the age of 75 years has been met.

Training of care home staff:
The second element of the project has been support to raise the quality of care in care homes by providing expert clinical and therapeutic support, both around direct care and care planning. This has achieved good outcomes, particularly whilst the Inreach Team is actively working with a care home provider. However, a number of factors impact on how sustainable the improvements then are. This element of the scheme is therefore to be reviewed and re-scoped. The intention is to offer more targeted support to increase the impact, and also use the scheme to map out clearly other improvements which would help to reduce non elective admissions from care homes.

Berkshire West Connecting Care

4.6 A key enabler to more co-ordinated and integrated care is the ability to obtain access to timely information about an individual's care and support. Without this, care providers continue to ask for the same information, which at best is frustrating, but may also mean that professionals do not have all the information they need to make the best assessment or intervention.

4.7 There are three distinct phases to the Connecting Care Project:

1) Firstly, local authorities will adopt the NHS Number as the unique identifier for social care records. This has to be in place by 1st April 2015. Adult Social Care in Reading is on track to deliver this.

The first phase also includes a trial of primary care and out of hour GP services (delivered by Westcall) being able to view each other's records. This has been in place since early Autumn and already has demonstrated a positive impact on clinical decisions made by the out of hours GPs – for example, when they can see the medication someone is taking, whether they live alone or whether there is a carer.

2) The second phase will be access to records between primary care and community health. During this phase, Reading is interested in undertaking a pilot to measure the impact sharing records will have on our service users.

During this period it will be essential that a robust information governance agreement is put in place to safeguard service users' information.

3) The third and final phase will be to implement a solution that means that all relevant professionals across health and social care are able to access relevant information.

Discharge to Assess (including Time to Decide beds)

4.8 This scheme was designed to respond to a number of local issues, which include the length of time people stay in hospital unnecessarily (commonly known as Delayed Discharges), the number of people that move directly into a residential care home from hospital, and the fact that people have to wait in hospital over the weekend as providers are not willing to accept new packages of care or placements at the weekend.

4.9 The Discharge to Assess Service has two key elements. Primarily the focus is to provide the assessment of ongoing care needs outside of the hospital. This is because care needs identified on discharge may not lead to the most suitable longer term solution when the assessment is undertaken in a chaotic hospital environment. The aim of the Discharge to Assess scheme will always be to enable the person to return to their own home if it is safe for them to do so. Community support will be provided via Reading's Full Intake model Community Reablement Team that, via BCF funding, is being expanded to provide broader patient/service user access criteria that supports a wider remit of need, aids more timely discharge from hospital and supports the move to assessment in the community, rather than an acute setting. The Full Intake CRT is an integrated function containing a range of Health and Social Care professionals including social care workers, physiotherapists, occupational therapists and clinical nurses. Professionals will work closely with the individual and their carers to make sure that if there are any long term care needs, they are properly understood and met.

4.10 The second element of the Discharge to Assess service is commonly described as a Step Down Service. This supports people to make the transition from more intensive care to more independent living. This element will be delivered from the assessment flats at the Willows Care Home and a range of Step Down flats in Extra Care Housing schemes. Again, the aim will be to re-able the individual so that they can return home. A dedicated social worker will support the individual to make informed life choices about the next stage.

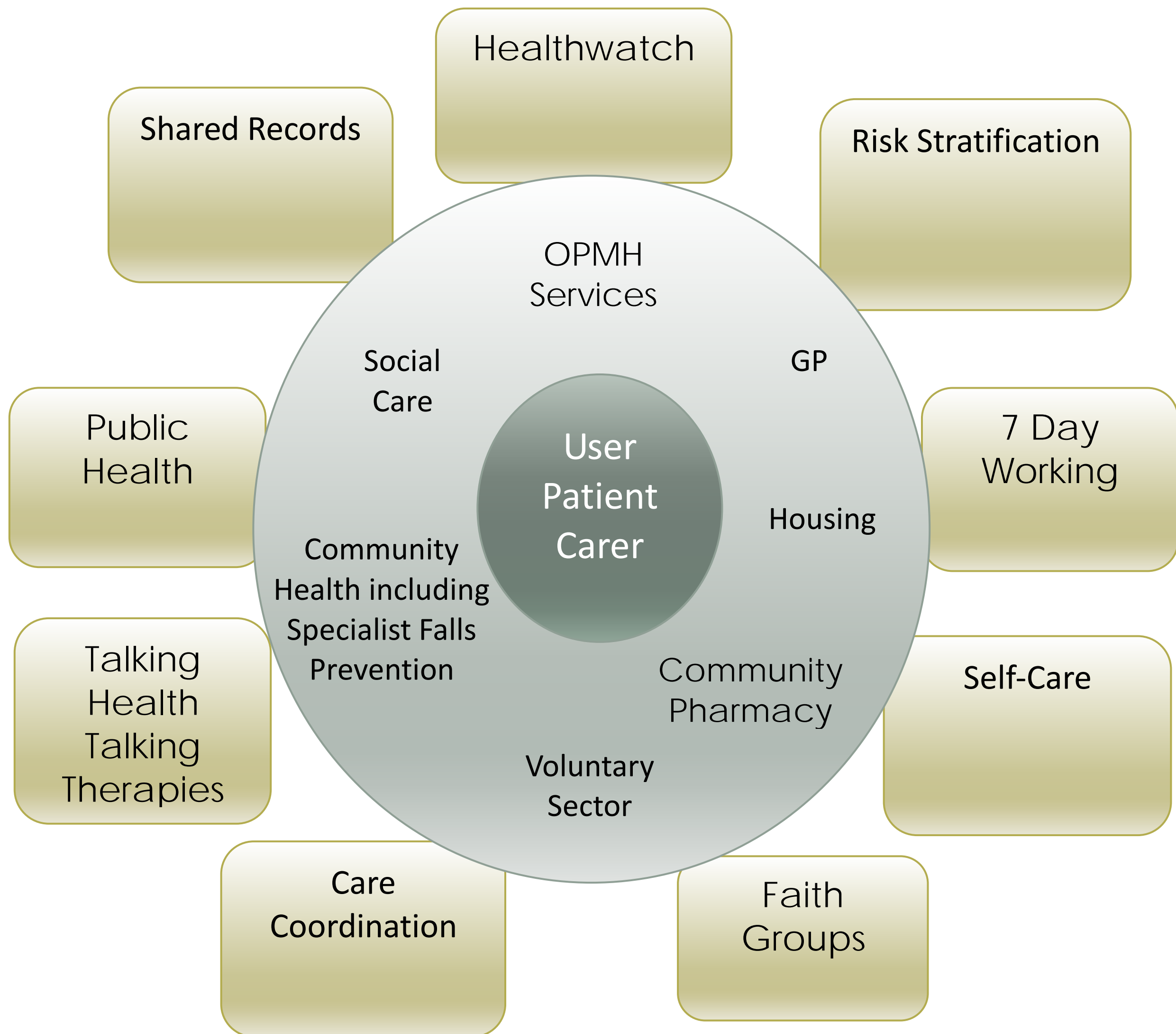
4.11 Both elements of the Discharge to Assess Scheme will be available 7 days per week, which will improve the "flow" through the system and ultimately reduce the time that people spend in hospital unnecessarily.

Whole System, Whole Week

4.12 Whole System, Whole Week encompasses a number of schemes, some unique to Reading and some that span the whole of the West of Berkshire. The three schemes are: Neighbourhood Clusters, Health and Social Care Hub and 7 day working.

Neighbourhood Clusters

4.13 Unique to Reading, the Neighbourhood Clusters schemes will integrate Health and Social Care with support from other partners to achieve better outcomes for the individual.



This picture describes the key partners/services within the neighbourhood network that will be available to the individual, and also the enablers those partners are working towards.

4.14 The Neighbourhood Clusters scheme is being developed through a steering group composed of Health, Social Care, voluntary sector, community pharmacy and housing representatives. A model for Reading will be disseminated for wider discussion and engagement from later this month.

Health and Social Care Hub

4.15 Across the whole of Berkshire, Berkshire Healthcare Foundation Trust provides a Health Hub, offering one single number for professionals to use for health referrals (except mental health referrals, which are managed through a separate system – the Common Point of Entry).

4.16 However, referrals for social care are currently more complex, as is the range of contact points for members of the public. Across the West of Berkshire, there are ten key care partners including 3 local authorities, 4 clinical commissioning groups, one acute trust, one community trust and one ambulance trust. This makes for a complex health and social care landscape which is difficult to navigate. This complexity can often lead to delays due to confusion about where to make referrals. In Reading alone there are 26 different places that referrals are made.

4.17 In its first phase, the Health and Social Care Hub will link existing social care contact points into one number that will be managed across the west of Berkshire for professionals.

4.18 The second phase will be to open this co-ordinated contact point up to all patients / service users and carers. It is anticipated that this will reduce confusion in navigating the right care. The service will also be available 7 days per week, extending the current offer of a 5 day service. This extension is part of Reading's improved offer to family / unpaid carers, who often report feeling at a loss at weekends when it is commonly difficult to access services.

Seven day working

4.19 The final element of the Whole System, Whole Week offer sets out Reading's response to the Better Care Fund focus on 7 day working. Local partners have recognised that the whole system needs to move away from a 5 day a week, office hour only service. These are not the only times that people have their long term condition or their illness or emergency. Recent media attention surrounding access to Primary Care has evidenced this further, showing how people are using Accident and Emergency departments as a default options for accessing out of hours support.

4.20 As described above, the Discharge to Assess scheme will operate 7 days per week, as will the Health and Social Care Hub once this is in place. Weekend access to GPs is already available at some surgeries, with plans in place to extend this to more surgeries. The development of 7 day Health and Social Care will be incremental but is already well underway.

5. THE CLINICAL COMMISSIONING GROUPS' 2 YEAR PLAN RE-FRESH.

5.1 The two CCGs covering the Reading area (South Reading CCG and North and West Reading CCG) submitted summary refreshed plans ("Plan on A Page") to NHS England on 27 February 2015. Feedback is awaited before a subsequent submission is made on 1 April 2015. These refreshed plans should be read in conjunction with the existing 2014/16 "Plans on A Page" and the 2014/16 2 year operational plans previously presented to the Health & Wellbeing board in February 2014.

5.2 South Reading CCG has identified the main areas to receive greater focus in 2015/16 as follows:

Increasing the number of people taking part in physical activity from 15,074 in 2014/15 to 22,500 in 2015/16 - through expansion of the **Beat the Streets** initiative - to support increasing life expectancy across the population.

Developing an **acute Alcoholic Liver Disease Liaison Service** and an MDT outreach approach - aiming to have 20 fewer non elective admissions related to alcohol harm.

Opening a new local integrated **ambulatory cardiology unit** in April 2015 - to improve the quality of care for people with heart failure, and aiming to lead to 15 fewer non-elective admissions in its first year.

Improving **diagnosis of dementia** from 58.2% towards the national target of 67% by July 2015, including adopting a technological solution to streamline coding of patients directly from the Memory clinic to practices.

Expanding diabetes care to include **pre -diabetes screening and identification, and** replicating diabetes focused schemes for people with respiratory disease with the aim of reducing emergency admissions for COPD and Emphysema by 13 in 2015/16.

5.3 North and West Reading CCG have identified the main areas to receive greater focus in 2015/16 as follows:

Ensuring that **all GP practices conduct risk stratification and care planning for patients aged 75 and over** (including all care home residents)

Ensuring that at least 80% of practices provide **enhanced access** for their patients.

Implementation of a three plan to **increase walking/cycling via the "Beat the Street" initiative.** There will be a specific focus on encouraging those with long term conditions to take part and we aim to ensure that at **least 15% of patients with long term conditions will take part in 15/16.**

Increase **dementia diagnosis rates** from 62.4% to 67% by July 2015.

Increase **uptake of bowel cancer screening** to 62% by the end of March 2016

Focus on **cardiovascular disease** by working closely with Public Health to achieve increased uptake in health checks from 61% to 66% of our eligible population by end of March 2016.

"Upstream" intervention for patients aged 75 plus. We will work with Age UK to pilot a scheme whereby 2 Personal Independence Co-Ordinators will be funded to guide and support patients not currently requiring medical or nursing intervention to help reduce their future dependency on health and social care.

Working with partners to identify and address gaps in local GP services to support carers.

6. THE CHANGE TO THE NON ELECTIVE TARGET

6.1 The 2 CCGs have reviewed their most recent non elective (NEL) admission data during the process of reviewing and refreshing their 2 year plans as requested by NHS England. This then revises the baseline denominator from which the % change in activity is calculated. The calculations include, as they did last year, all those improvement intervention schemes which are expected to have an impact on reducing NEL activity, including the better care fund, but also schemes that have been directly commissioned by the CCG's, for example, the community respiratory service.

6.2 On 27th March 2015, Health and Wellbeing Board members were contacted via email for their views of a revised target from 2.8% to 0.6%. As this timing did not coincide

with a Health and Wellbeing Board, it has been necessary to seek an "in principle" agreement by Board members outside of the scheduled meeting. An email was sent out to board members on 27th of March seeking such approval. No adverse comments were received from board members.

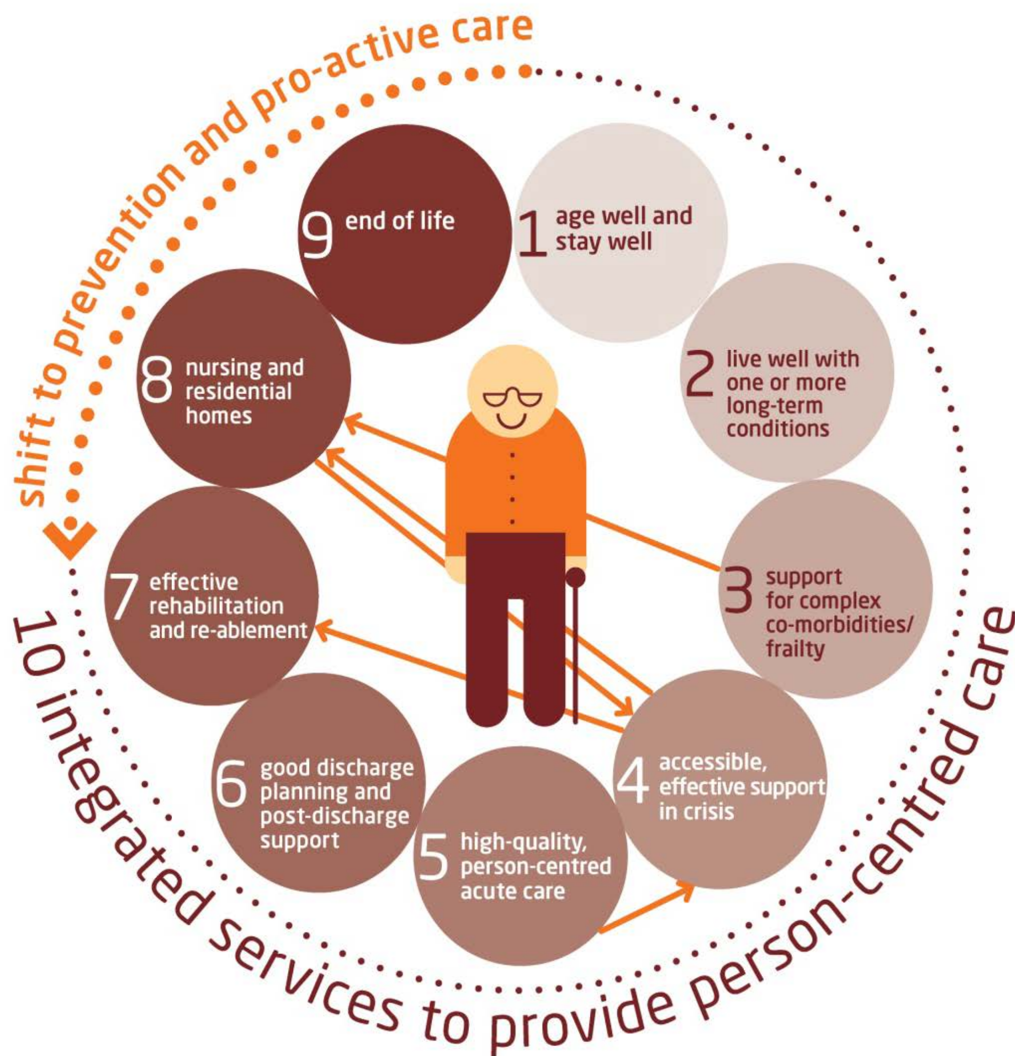
6.3 However, since this point further analysis of the data has been conducted to secure an accurate and realistic figure. It is imperative that the impact both financially for the whole system and against capacity and service delivery are considered and any areas of risk identified and mitigated where possible. For this reason, the board is asked to note the work to date, with the assurance that once this has been fully analysed, a final recommendation will be put to the board members for agreement. As the timescales for approval again are not conducive with the Health and Wellbeing Board meetings, a plan will be put in place to achieve an agreement before the NHS England final submission deadline of 14 May 2015.

7. FRAIL ELDERLY CARE PATHWAY

7.1 Work on the Frail Elderly Care Pathway started in 2012 (preceding the Better Care Fund) in recognition of the need to improve older people's experience of services and mitigate – from the patient/ user perspective – against the complex arrangements of care services across the system.

7.2 The drivers for this piece of work were the demographic pressures across the system; the scale of the costs of frail elderly care, the austerity across the system, as well as a long established aspiration for health and social care to be integrated.

7.2 The Frail Elderly Care Pathway came out of a number of stakeholder workshops, facilitated by the King's Fund, which enabled the whole system to develop a local model. This model is centred round the needs of Sam, as described in Sam's Story, rather than by which services are in place. Berkshire West care partners chose to work towards a model of what "good" looks like for an older person at various stages of health and wellbeing, from "Ageing and living well" to "end of life". The work created a commitment for the whole system to be integrated in its approach.



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7.3 In the final King's Fund Report, a number of overarching themes were identified to inform future development. There were:

- Establishing a generic care worker role with identified skills and competencies
- An underpinning training and development process to enable the transition of the existing workforce into the new generic roles
- Information systems and IT requirements which communicate and share information across all the practitioners working with patients at any stage of the pathway.
- Development of a centrally-held care record to which all have access, which is shared and updated within a centrally-located information hub

7.4 A Frail Elderly Steering Group with senior leadership across the West of Berkshire has been established with the sole purpose of driving the development of a model and acting as the accountable forum for taking this work forward on behalf of the Berkshire West Partnership. This Group will be chaired by a single Senior Responsible Officer for the partnership, and the first task of this group will be to clarify expectations, identify the supporting roles required, and agree key priorities and proposed objectives and key milestones.

7.5 It is anticipated that the models that come out of this work will create greater opportunities for integration beyond those already in place. Once this work has been completed, it will be presented to the Health and Wellbeing board for discussion.

8. CONTRIBUTION TO STRATEGIC AIMS

8.1 Reading's integration plans are articulated within its BCF Plan, which in turn draws on and develops the strategic priorities set out in Reading's Health and Wellbeing Strategy (2013-16) and Prevention Framework (first published in 2011 and refreshed in 2015). The BCF Plan also supports the vision outlined in the Berkshire West Strategic plan 2014-2019 and the Reading CCGs operating plans 2014-2016 to 'keep people well and out of hospital in partnership'.

8.2 The proposals and schemes outlined in this report contribution to meeting the following priorities set out in the Council's Corporate Plan 2015-18:It

- Ensuring that all vulnerable residents are protected and cared for;
- Enabling people to live independently, and also providing support when needed to families;
- Ensuring care and support provision is effective and of good quality;
- Building capable communities for local people to become more involved and help themselves;
- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the Council is financially sustainable and can continue to deliver services across the town; and
- Co-locating services with partners to have better joined up services and community hubs so that residents have better access to services.

8.3 The Council's 3 – 5 year plan for Adult Social Care approved by Policy Committee in September 2014 also includes consideration and participation in these integration projects.

9. COMMUNITY ENGAGEMENT AND INFORMATION

9.1 Reading's integration plans have drawn on patient, service user and public feedback gathered across a range of Health and Social care involvement channels, and continue to do so, for example through regular presentations at Reading's Care and Support Conferences and to Patient Participation Groups. Feedback continues to evidence that maintaining independence and having choice and control over how they receive care is very important to the people of Reading.

9.2 Patient / service user and carer representatives are being recruited to steering and project groups to inform the development of individual schemes and keep their perspective at the centre.

9.3 As the plans around neighbourhood clusters develop, there will be a number of engagement events with the public, and with key stakeholders including GP Council's. These are expected to take place during April and May 2015.

10. EQUALITY IMPACT ASSESSMENT

10.1 As integration plans are developed and the need for specific policy or service change identified equality analyses will be carried out so that conscious and open minded consideration can be given to the impact of the equality duty in relation to the integration of health and social care locally.

10.2 With plans now in place for most schemes previous Equality impact assessments will be reviewed during April 2015.

11. LEGAL IMPLICATIONS

11.1 There are no direct legal implications arising from this report.

12. FINANCIAL IMPLICATIONS

Revenue Implications

12.1 The report sets out a number of schemes that will have revenue implications. The funding for these schemes has been identified and approved in the Council's main budget report and in previous reports to the Health and Wellbeing Board, but the key elements of funding that are provided are:

- Previous Health funding (through what was called the "Section 256 transfer") - this is funding existing Council services that support health outcomes (such as part of the intermediate care and the reablement team costs).
- Funding which protects investment in Adult Social Care service and also provides support to the costs of the implementation of the Care Act.
- Funding to cover the new schemes identified in section 4.

12.2 All of the above funding requires a formal agreement between the Council and the Clinical Commissioning Groups to establish a pooled fund (in the form of a Section 75 NHS Act 2006 Agreement). The details of this are set out Section 12.3 below.

12.3 This paper proposes a change to the Non-elective target which impact on the "performance" revenue that supports this. As the BCF is currently only a one year scheme, the partners to Reading's BCF submission agreed previously that this element should stay with the CCGs, but monitored through this Board which would take recommendations around the use of this element.

Capital

12.4 This report does not contain any specific capital implications. However, as identified in previous papers there are two main capital issues in relation to the Integration Programme: these are the Adult Social Care Capital Grant and the Disability Facilities Grant. These will continue to be used and work is ongoing in terms of how these can be better integrated into the joint working across partners.

Pooled Fund Arrangements

12.5 It is a requirement of the Better Care Fund that Clinical Commissioning Groups and the Council establish a pooled fund for the delivery of the local plan, and it is a condition of securing the funding that such agreements are in place with effect from 1 April 2015.

12.6 Section 75 of the NHS Act 2006 gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

12.7 Utilising the best practice S75 agreement template issued by NHS England, the Council and CCGs (the Partners) have drafted the terms on which they have agreed to collaborate and to establish a framework through which they can secure the future position of Health and Social Care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners and as defined in the Reading BCF submission.

12.8 The Berkshire West 10 Finance Sub-Group have been working collectively to finalise the agreement, which is now with Council solicitors for scrutiny prior to formal sealing by the Council and NHS South Reading CCG for 1 April.

12.9 Delegated authority to enter into the Section 75 agreements was sought and awarded at the Adults Social Care, Children's Services and Education Committee on 4 March 2015.

Risks

12.10 Integration with Health is a significant undertaking and the range of Section 75 agreements required is a complex undertaking. The volume of work required to establish these this would normally be expected to cover more than one year. A large amount of work has been undertaken by the Council and its partners across the West of Berkshire to arrive at a point that it is hoped that the Section 75 agreements can be signed prior to 1 April. That said, within all these agreements there are risks that are going to have to be managed and overspends on any particular scheme will be the responsibility of the named lead organisation.

12.11 For Reading mechanisms are being established to support the implementation of the various schemes and to manage the risks, future reports to the Board will update on progress and how (if required) risks are being managed.

13. BACKGROUND PAPERS

13.1 The full Reading August 2014 BCF submission is contained in the following documents:

Better Care Fund Planning Template – Part 1
Better Care Fund Planning Template – Part 1 – Annex 1
(Appears as Appendix 1 to this report)
Better Care Fund Planning Template – Part 1 – Annex 2
Better Care Fund Planning Template – Part 2
Better Care Fund Library of Supporting Documents

These documents are all available at www.reading.gov.uk/meetings/details/3694.