Bracknell Forest Council

# NOTICE OF MEETING

## Health and Wellbeing Board
## Thursday 4 June 2015, 2.00 pm
## Council Chamber, Fourth Floor, Easthampstead House, Bracknell

## To: The Health and Wellbeing Board

Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning, Bracknell Forest Council
John Nawrockyi, Director of Adult Social Care, Health & Housing
Rachel Pearce, South Central Sub Region NHS
Mary Purnell, Bracknell & Ascot Clinical Commissioning Group
Lise Llewellyn, Director of Public Health
Mark Sanders, Healthwatch
Dr William Tong, Bracknell & Ascot Clinical Commissioning Group
Timothy Wheadon, Chief Executive, Bracknell Forest Council

ALISON SANDERS
Director of Corporate Services

**EMERGENCY EVACUATION INSTRUCTIONS**

1 If you hear the alarm, leave the building immediately.
2 Follow the green signs.
3 Use the stairs not the lifts.
4 Do not re-enter the building until told to do so.

If you require further information, please contact: Katharine Simpson
Telephone: 01344 352308
Email: katharine.simpson@bracknell-forest.gov.uk
Published: 27 May 2015

# Health and Wellbeing Board
# Thursday 4 June 2015, 2.00 pm
# Council Chamber, Fourth Floor, Easthampstead House, Bracknell

Sound recording, photographing, filming and use of social media at meetings which are held in public are permitted. Those wishing to record proceedings at a meeting are however advised to contact the Democratic Services Officer named as the contact for further information on the front of this agenda as early as possible before the start of the meeting so that any special arrangements can be made.

## AGENDA

Page No

1. **Election of Chairman**

2. **Appointment of Vice-Chairman**

3. **Apologies**

   To receive apologies for absence and to note the attendance of any substitute members.

4. **Declarations of Interest**

   Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

5. **Urgent Items of Business**

   Any other items which the chairman decides are urgent.

6. **Minutes from Previous Meeting**

   To approve as a correct record the minutes of the meeting of the Board held on 5 March 2015. 1 - 6

7. **Matters Arising**

   To consider any matters arising on the minutes of the previous meeting that are not already on the agenda.

8. **Public Participation**

   **QUESTIONS:** If you would like to ask a question you must arrive 15 minutes before the start of the meeting to provide the clerk with your name, address and the question you would like to ask. Alternatively, you can provide this information by email to the clerk Katharine Simpson: Katharine.simpson@bracknell-forest.gov.uk at least two

hours ahead of a meeting. The subject matter of questions must relate to an item on the Board's agenda for that particular meeting. The clerk can provide advice on this where requested.

**PETITIONS:** A petition must be submitted a minimum of seven working days before a Board meeting and must be given to the clerk by this deadline. There must be a minimum of ten signatures for a petition to be submitted to the Board. The subject matter of a petition must be about something that is within the Board's responsibilities. This includes matters of interest to the Board as a key stakeholder in improving the health and wellbeing of communities.

9. **Actions taken between meetings**

Board members are asked to report any action taken between meetings of interest to the Board.

10. **Xenzone Presentation**

To receive a presentation from Xenzone, the organisation providing Bracknell Forest's online mental health support for young people, to learn about their experiences of working in Bracknell Forest and to provide the Health and Wellbeing Board with an opportunity to help shape the service's development.

11. **Co-commissioning of Primary Care and the Implications for the Health and Wellbeing Board**

To consider a report providing an update on the introduction of co-commissioning of primary care services and the role of the Health and Wellbeing Board in this work. 7 - 18

12. **Child and Adolescent Mental Health Services Review Update**

To receive a report providing an update on review of the Child and Adolescent Mental Health Services and a draft action plan. 19 - 42

13. **Bracknell and Ascot Clinical Commissioning Group Operational Plan**

To consider a report setting out Bracknell and Ascot Clinical Commissioning Group's operational plans for 2015/16. 43 - 54

14. **Infrastructure Group Update**

To consider a report setting out the work carried out by the Health and Wellbeing Board's Infrastructure Group to examine the projected growth and demographic changes in the Borough and the impacts that these will have on the Borough's health infrastructure. 55 - 62

15. **Health and Wellbeing Board Review Implementation Update**

To receive an update on the progress made to implement the changes arising from a recent review of the Health and Wellbeing Board's structures. To follow

16. **Forward Plan**

Board members are asked to make any additions or amendments to the Board's Forward Plan as necessary. 63 - 64

# HEALTH AND WELLBEING BOARD
# 5 MARCH 2015
# 2.00 - 4.00 PM

Bracknell Forest Council

**Present:**
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing
Dr William Tong, Bracknell & Ascot Clinical Commissioning Group
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Helen Clanchy, Thames Valley Area Team
Dr Janette Karklins, Director of Children, Young People & Learning, Bracknell Forest Council
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Mary Purnell, Bracknell & Ascot Clinical Commissioning Group
Mark Sanders, Healthwatch

**In Attendance:**
Zoë Johnstone, Chief Officer: Adults & Joint Commissioning
Lynne Lidster, Head of Joint Commissioning
Dr Lisa McNally, Consultant in Public Health
John Nawrockyi, Interim Director of Adult Social Care, Health and Housing
Alex Tilley, NHS England
Nicky Wadeley, NHS England

**Apologies for absence were received from:**
Rachel Pearce, South Central Sub Region NHS
Lise Llewellyn, Director of Public Health

121. **Declarations of Interest**

There were no declarations of interest.

122. **Urgent Items of Business**

There were no urgent items of business.

123. **Minutes from Previous Meeting**

**RESOLVED** that the minutes of the meeting of the Health and Wellbeing Board held on 17 September 2014 be approved as a correct record and signed by the Chairman.

124. **Matters Arising**

There were no matters arising.

125. **Public Participation**

In response to the following question, submitted by Mr Ed Glasson on behalf of People's Healthwatch:

*Leaving aside the conspicuous failure of the Board to respond seriously to the first part of the question tabled at its 17.09.2014 meeting, please may we have a response to the second part of the question? Namely, when will the Board consider the dire findings of the Public Health England 2013/'14 peer local authority mortality study?*

Lisa McNally, Consultant in Public Health, expressed surprise at the view that the outcomes of the Public Health England Longer Lives survey were considered to be dire particularly in light of the fact that Bracknell Forest's rankings had improved significantly across all measures when compared with the findings of the previous Longer Lives survey which had placed Bracknell Forest bottom in most categories.

In addition, Health Profiles for the Borough showed that Bracknell Forest had the lowest number of red indicators in the Thames Valley and the recently published life expectancy data showed that Bracknell Forest had experienced the second highest rise in male life expectancy nationally.

It was stressed that whilst the Board would not be considering the survey as a separate substantive item it would be kept abreast of any developments that were considered to be relevant to the Health and Wellbeing Board as they arose.

126. **Actions taken between meetings**

It was noted that no substantive actions had taken place since the Board's last meeting.

127. **Child and Adolescent Mental Health Services (CAMHS) Commissioning Update**

The Director of Children, Young People and Learning presented a report providing an update on the work taking place to review each tier of the Child and Adolescent Mental Health Services (CAMHS) and the work that was taking place to prepare for the re-commissioning of the service from April 2015.

The multi-agency review of CAMHS was progressing well against a changing national landscape and a joint CAHMS Action Plan would be developed to take the emerging recommendations forward. The recently published NHS Planning Guidance 2015/16 had placed an increased emphasis on achieving parity for mental health including CAHMS provision. It had therefore been agreed that work on the action plan's development would be delayed to enable the full implications of this guidance to be clarified. Notwithstanding this delay, work was progressing inside all agencies to improve CAHMS provision.

The Public Health Team was working to develop an online resource to provide help and guidance to young people. The service had been match funded by the Clinical Commissioning Group and a twelve month contract had been entered into with a specialised provider. The service would commence on 1 April 2015 and it was hoped that this resource would not only provide young people with an opportunity to access help and advice at an early stage before more intensive interventions might be required but also act as an on-going step down support service for those children and young people reaching the end of treatment programmes.

It was recognised that there was a stigma attached to accessing mental health diagnostic services and that the online resource should help to address this. It had been acknowledged that schools would be central to the success of the online resource and the service provider would be working closely with schools to raise awareness of the resource and help train staff to recognise those children and young

people who might be at risk and those young people who could be considered to be 'Quiet at risk' i.e. those who struggled to cope but just got on with things in particular.

The Clinical Commissioning Group (CCG) had used funding received through the Winter Operational Resilience Fund to improve the interface between Tiers 2 and 3 and early intervention services. Work was also taking place to raise awareness amongst schools and GPs of the help available.

It was recognised that for many young people the transition from Children's Services to Adult Services could be an issue, with adult services requiring different thresholds for intervention and in CAMHS for example some specialist services not being provided at all in the adult health sector. To combat this work was being started to transform the transition between the two areas into a continuous on-going process.

It was also noted that the transfer of commissioning responsibility for 0 – 5 year-olds public health services (health visitors and Family Nurse Partnerships) into local councils in October, alongside the existing 5 – 19 services, would give further opportunities over time to create more continuity.

Arising from the Board's questions and comments the following points were noted;

- It was requested that schools be asked to provide anonymised feedback on the work that they were doing to support young people and the impact that this work was having on their students' life and performance at school
- Services were already being provided out of the Berkshire Adolescent Unit in Wokingham. However the transformation of the unit to a Tier 4 provider had been included in the service specification for the new financial year with implementation expected during quarter 2
- The additional funding used by the CCG to reduce waiting times had enabled the backlog of urgent cases to be dealt with and further work was taking place with Tier 2 providers to reduce waiting times for the non-urgent cases
- A list of named contacts in schools which GPs could use to discuss specific cases would be available by 11 March 2015
- The imminent transfer of responsibility for the care of 0-5 year olds from the NHS to local authorities would provide the Borough with the opportunity to develop the support given in the area of post natal mental health
- It was requested that future update reports include specific dates and deadlines for the completion or delivery of work packages

**RESOLVED** that:

i. The latest national guidance and response to the local review of CAMHS be noted
ii. The commissioning plans and arrangements for children and young people at each tier be noted
iii. The renewed emphasis on early intervention and prevention especially at Tier 2 and the expected impact of this work on higher levels of support be endorsed
iv. The changes that are being made to improve provision at Tier 4 in Berkshire be noted.
v. The planned review of the workforce training and support needs for improved transition between CAMHS and Adult Mental Health Services be endorsed
vi. The work to review the workforce training and development needs for better identification of post natal mental health issues, to receive swift and early help, and to better understand the reasons why women do not take up the

provision of Adult Mental Health Services for pregnant women and for the first year after birth be endorsed

vii. A joint CAMHS action plan for all tiers of support be developed and to be brought to the Board's June meeting

128. **Review of the Health and Wellbeing Board**

The Board considered a report detailing the outcomes of a recent review of the Board's processes and setting out proposals for the future membership, meeting cycle, priority setting and performance monitoring of the Board.

It was noted that the Board was reaching the end of its second year in operation (the first year operating as a shadow board and the second as a functioning committee) and that although the Board had initiated and driven forward a number of positive pieces of work for example the multi-agency review of CAMHS and the development of improved synergies and understanding between the agencies represented at the Board there were still areas for development for example:

- Expanding the Board's membership to include key providers representing health, social care and housing and the voluntary sector as well as the local NHS Foundation Trusts
- Establishing priorities for the Board that focus on four or five key areas
- The establishment of task and finish groups with a wider membership to work on the Board's priorities
- The development of a dashboard of performance indicators with measurable targets and parameters

It was stressed that the Board must make it clear what level of commitment would be required from new Board members as well as their expectations in relation to accountability.

It was stressed that when expanding the Board's membership and developing priorities that the wellbeing aspect of the Board's remit must not be lost.

It was agreed that a report setting out proposals for a new structure, expanded membership list and draft priorities and performance measures would be brought to the Board's June meeting.

**RESOLVED** that the proposed membership, meeting cycle, priority setting and performance monitoring detailed in the Director of Adult Social Care, Health and Housing's report be approved.

129. **Pharmaceutical Needs Assessment**

The Board considered a report setting out the Pharmaceutical Needs Assessment (PNA) for Bracknell Forest.

Responsibility for the development and updating of PNAs passed to Health and Wellbeing Boards following the implementation of the Health and Social Care Act 2012. The PNA provided a statement of the needs for pharmaceutical services of a population setting out information on the pharmaceutical services currently provided and identifying gaps in the current service provision. Once approved the PNA would be used by NHS England, local Clinical Commissioning Groups and Public Health functions to help inform future commissioning decisions.

The PNA had been informed by public events and a survey. Across the Berkshire area, Bracknell Forest had received the highest per capita return rate of all the Berkshire unitary authorities with 390 completed questionnaires being returned.

Feedback from the recent Self Care Week promotional work had identified that obtaining access to information relating to out of hours pharmacies was an issue for local residents. It was agreed that the Public Health Team would work with the local pharmaceutical committee to develop an up to date resource and this would then be made available online and publicised by the Clinical Commissioning Group and Healthwatch.

Hospital based pharmacies were not classified as community pharmacies and did not offer the same range of over the counter services as community pharmacies. It was acknowledged that patients taking prescriptions issued by hospitals to community pharmacies was causing a resource issue and these concerns would be taken up with the appropriate advisory committees.

**RESOLVED** that the Pharmaceutical Needs Assessment, attached as an annex to the Strategic Director for Public Health's report, and its associated recommendations be approved.

130. **Development of Community Based Services in Bracknell Forest**

Mary Purnell, Nicky Wadely and Alex Tilley gave a presentation in respect of the changes taking place to transform the delivery of primary care services. The presentation included an overview of the new joint approach to co-commissioning, an overview of the primary care transformation programme and a summary of work to increase the future capacity of primary care services in the Borough. Arising from the subsequent discussion the following points were noted:

- Bracknell and Ascot CCG had received formal approval of their request to enter into co-commissioning with NHS England on 4 March 2015
- A bid for funding to support the transformation programme in the local area had been submitted to the Prime Minister's Challenge Fund. It was stressed that even if the bid was not successful the CCG would still take the transformation programme forward
- Under the terms of any co-commissioning work NHS England would retain responsibility for contract maintenance
- Six GP surgeries in Bracknell Forest had submitted bids for Primary Care Infrastructure Funding to increase the capacity of their surgeries. A total of £2billion would be available from the Fund and there would be three further annual funding cycles to which bids could be made in the coming years
- The invitation to submit bids to the Primary Care Infrastructure Fund had been sent directly to GP surgeries and there had been limited input from the CCG and other agencies

The Board recognised that in order to improve the chances of success for any future funding bids that a pro-active approach must be taken and that a comprehensive plan setting out the Board's strategic vision for its health and wellbeing services and detailing where new housing developments would be built, spatial planning matters and the range of health and wellbeing services that would be needed to meet demand in the future should be developed. This could then be used to support any future bids and commissioning decisions. It could also be used to support engagement with the Department of Health at a political level.

It was agreed that this piece of work should be taken forward by a sub-group of the Health and Wellbeing Board. The Sub-group would be led by the CCG with representation from the Director of Adult Social Care, Health and Housing, Planning Policy and NHS England in the first instance. It was agreed that a report setting out the scope of the Sub-group's work would be brought to the Board's June meeting for consideration.

The Board thanked Mary Purnell, Nicky Wadely and Alex Tilley for their update.

131. **Forward Plan**

The Board noted the following additions to the Forward Plan:

- CAMHS Update (Janette Karklins)
- Review of Health and Wellbeing Board (John Nawrockyi)
- Development of an Infrastructure Group (Mary Purnell)

**TO: HEALTH AND WELLBEING BOARD**
**4 JUNE 2015**

---

**BRACKNELL AND ASCOT CLINICAL COMMISSIONING GROUP TRANSFORMATION OF PRIMARY CARE & THE INTRODUCTION OF CO-COMMISSIONING OF PRIMARY CARE**

## 1 PURPOSE OF REPORT

1.1 This report advises the Board on the introduction of Primary care co-commissioning and the role of the Board in participating in the governance of this. An update will also be provided by presentation at the meeting of the plans under development by Bracknell and Ascot Clinical Commissioning Group (CCG) for the transformation of primary care services "Better Futures for All".

## 2 RECOMMENDATIONS

**2.1 The Board is advised of the introduction of co-commissioning and the participation of the Board in the governance arrangements for this.**

**2.2 The Board is asked to comment on the proposals for the transformation of primary care, with particular regard to the contribution this can make to the delivery of JHWS priorities**

## 3 REASONS FOR RECOMMENDATIONS

3.1 The success of these initiatives is dependent on the whole system working together towards shared priorities, therefore the input and support of the Board to shape these is important

## 4 ALTERNATIVE OPTIONS CONSIDERED

4.1 Not applicable.

## 5 SUPPORTING INFORMATION

5.1 **Co-commissioning -** The draft terms of reference for the Co-commissioning Board are attached.. A presentation will be made to the HWBB on the latest position with both co-commissioning and primary care transformation ("Better Care for All"). The Board's attention is drawn to the requirement for a non-voting representative to sit on the Co-commissioning Board.

5.2 **Primary care transformation -** Following the successful draw down of the CCG surplus from 2013/14 of £2.1m the CCG Governing Body agreed to invest these funds in the delivery of the programme designed around the principles of Prime Minister Challenge Fund (PMCF).

The B&A programme of work, named "Better Futures for All" is summarised below. There are four work streams in this programme, these being;

- Co Operative Working – establishment of legal entity for practices and the implementation of EMIS enterprise to support the sharing of good practice and enabling centralised data collection for commissioning by the CCG
- Extended Access – the provision of extended general practice Monday to Friday 8am to 8pm, and weekends. This service is being driven through a process of co design with patient and our provider partners.
- Enhanced Patient Support – delivering alternative access and support for patients around elf management, such as Healthmakers, group consultations, health street teams and ensuring high standards of motivation skills for our professionals to use supporting better engage their patients.
- Workforce – developing capacity and ensuring high quality skill mix for the future of primary care. This includes a GP Fellowship pilot programme, nurse revalidation and leadership, and advanced community nursing pilot developed with our community and primary care providers.

## 6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not applicable

Borough Treasurer

6.2 Not applicable

Equalities Impact Assessment

6.3 Will be applied to each project within the overall programme

## 7 CONSULTATION

Principal Groups Consulted

7.1 the primary care transformation programme 'Better Futures for All' is committed to co-design as a principle.

Method of Consultation

7.2 Workshops and patient group involvement

Representations Received

7.3 n/a

Background Papers

Contact for further information
Alex Tilley
Alex.tilley@nhs.net

# Model terms of reference for joint commissioning arrangements including scheme of delegation

*November 2014*
*Revised March 2015*

# MODEL TERMS OF REFERENCE FOR JOINT COMMISSIONING ARRANGEMENTS INCLUDING SCHEME OF DELEGATION

## Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

2. The NHS England and Bracknell and Ascot CCG joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Bracknell and Ascot.

### Statutory Framework

3. The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

4. As permitted by section 14Z9 of the NHS Act 2006 (as amended) Bracknell and Ascot CCG will delegate the following statutory functions to the joint committee:

- Management of Locally Commissioned Services (formally known as LESs)
    a. Value: 2015/16 budget of £312,000

- Management of any PMS Premium funds released through the PMS review
    a. Value: 2015/16 Not applicable

**Role of the Joint Committee**

5. The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.

6. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

7. In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Bracknell and Ascot CCG, which will sit alongside the delegation and terms of reference.

8. There is a requirement for the CCG Governing Body to engage with the Primary Care Commissioning Joint Committee on all key strategic areas that have an impact on Primary Care

**Geographical coverage**

9. The Joint Committee will comprise NHS England Thames Valley Area Team, and the Bracknell and Ascot CCG. It will undertake the function of jointly commissioning primary medical services for Bracknell and Ascot CCG

**Membership**

10. **The Joint Committee shall consist of:**

Voting Membership:

**NHS England**

a) Director or Programme Manager – co-commissioning

b) and Lay member

**Bracknell and Ascot CCG**

a) Accountable Officer (can be deputised by the Executive Director)

b) And Lay Representative for Governance (or deputy: lay representative for patient engagement) from CCG Board

a) The membership will meet the requirements of **Bracknell and Ascot** CCG's constitution.

11. The Chair of the Joint Committee shall be the **Lay Representative** of the **Bracknell and Ascot CCG**

12. The Vice Chair of the Joint Committee shall be the **Lay Representative** appointed by **NHS England**

13. Non voting attendees will be:
    - Representative from each of the 2 local HealthWatch organisations
    - Representative from each of the 2 local Health and Wellbeing Boards
    - 2 x CCG GP Directors
    - Patient Representative
    - CCG Head of Operations (or Deputy)
    - CCG Governing Body Executive Nurse or Deputy

The Chair will indicate when attendees are required to leave the room at decision points.

14. Other attendees will be invited to support discussions as defined by the items on the agenda including finance support, LMC representation and other subject matter experts

**Meetings and Voting**

15. The Joint Committee shall adopt the Standing Orders of Bracknell and Ascot CCG insofar as they relate to the:

    a) Notice of meetings;

    b) Handling of meetings;

    c) Agendas;

    d) Circulation of papers; and

    e) Conflicts of interest

16. Each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by (a simple majority of members present, but with the Chair having a second and deciding vote, if necessary).

17. For the Committee to be quorate, there must be at least 2 voting members of the committee in attendance; to include the Chair or Vice Chair of the Committee and the lay representative (or deputy).

18. The meeting frequency is quarterly.

19. Meetings of the Joint Committee:

    a. Shall, subject to the application of 7(b), be held in public.

    b. The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

20. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

21. The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

22. Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

23. Bracknell and Ascot CCG will provide the secretarial support for the meetings of the Joint Committee.

24. The secretariat to the Joint Committee will:
    a) Circulate the minutes and action notes of the committee with 1 week of the meeting to all members.
    b) Present the minutes and action notes to Thames Valley Area Team of NHS England and the Governing Body of Bracknell and Ascot CCG.

25. These Terms of Reference will be reviewed annually, reflecting experience of the Joint Committee in fulfilling its functions and the wider experience of NHS England and CCGs in primary medical services co-commissioning.

**Decisions**

26. The Joint Committee will make decisions within the bounds of its remit.

27. The decisions of the Joint Committee shall be binding on NHS England and Bracknell and Ascot CCG.

28. Decisions will be published by both NHS England and Bracknell and Ascot CCG.

29. The secretariat will produce an executive summary report which will presented to Thames Valley Area Team of NHS England and the Governing Body of Bracknell and Ascot CCG each month for information.

**Key Responsibilities**

The key responsibilities of this committee are to work together to:

a) plan, including needs assessment, primary medical care services in the Bracknell and Ascot CCG area;

b) undertake reviews of primary medical care services in the Bracknell and Ascot CCG area

c) co-ordinate a common approach to the commissioning of primary care services generally;

d) manage the budget for commissioning of primary [medical] care services in Bracknell and Ascot CCG area.

**Review of Terms of Reference**

30. These terms of reference will be formally reviewed by Thames Valley Area Team of NHS England and Bracknell and Ascot CCG in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between Thames Valley Area Team of NHS England and Bracknell and Ascot CCG at any time to reflect changes in circumstances which may arise.

**Signature provisions**

Chair of the Joint Committee (Bracknell and Ascot CCG)

Name:…….. Signature:……..

Date: ……

Vice Chair of the Joint Committee (Area Team)

Name:…….. Signature:……..

Date: ……

**Schedule 1 – Delegation by CCG to joint committee – CCG functions**

As permitted by section 14Z9 of the NHS Act 2006 (as amended) Bracknell and Ascot CCG will delegate the following statutory functions to the joint committee:

- Management of Locally Commissioned Services (formally known as LESs)
    a. Value: 14/15 budget of £312,000

- Management of any PMS Premium funds released through the PMS review
    a. Value: 2015/16 Not applicable

**Schedule 2 - List of Members – populate once membership agreed**

- Representative from each of the 2 local HealthWatch organisations
- Representative from each of the 2 local Health and Wellbeing Boards
- 2 x CCG GP Directors
- Patient Representative
- CCG Head of Operations (or Deputy)
- CCG Governing Body Executive Nurse or Deputy

This page is intentionally left blank

Unrestricted

**TO: HEALTH AND WELLBEING BOARD**
**4 JUNE 2015**

---

# UPDATE ON CHILD AND ADOLESCENT MENTAL HEALTH (CAMHS) SERVICES TIERS 1-4

**Joint report of the**
**Director of Children, Young People & Learning, Bracknell Forest Council**
**Director of Adult Social Care Health & Housing, Bracknell Forest Council**
**Bracknell & Ascot Clinical Commissioning Group**
**Berkshire Healthcare Foundation Trust and**
**NHS England**

## 1 PURPOSE OF REPORT

1.1 At the last HWBB meeting a full update report was presented on progress with each tier of CAMHS with the intention to finalise a joint action plan in the summer across all tiers of support. This report provides an update on national developments which are quite fast moving and details the draft action plan.

## 2 RECOMMENDATIONS

**That the Health and Wellbeing Board (HWBB):**

**2.1 Notes the latest new national guidance on CAMHS.**

**2.2 Endorses the joint (draft) action plan which is contained in Appendix 1.**

**2.3 Receives an annual update on progress against the joint action plan.**

## 3 REASONS FOR RECOMMENDATIONS

3.1 The HWBB is concerned that children and young people are able to access the emotional and mental health services that they require in a timely manner, and where possible at the lowest level possible to prevent escalation to higher tiers of support.

## 4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

## 5 SUPPORTING INFORMATION

### National perspective

5.1 The last meeting of the HWBB was in March 2015. In the intervening period of approximately three months there have been numerous relevant national announcements and a wealth of new national guidance and advice. This illustrates well the challenge for us all of making sure our actions keep abreast of the latest recommendations. It therefore means that the joint action plan should be a dynamic document which will continue to evolve and develop as we progress through the year.

5.2 NHS England published 'Future in Mind – promoting, protecting and improving our children and young people's mental health and well-being' which is a very helpful document which promotes five themes. We have used these themes to shape our

Action Plan and focus attention on the joint nature of our endeavours across the tiers of support.

5.3 NHS England also published two important background papers from the Children and Young People's Mental Health and Wellbeing Taskforce which both informed the 'Future in Mind' report. They are the Coordinated System: Task and Finish Group Report and Data and Standards Task and Finish Group Report. All the national reports mentioned are available on line.

5.4 The Department for Education are also active in publishing new guidance and information. The DfE is leading work to improve the quality of teaching about mental health within Personal, Social and Health and Economics (PSHE) lessons in schools. This covers guidance for pupils aged 5-16 years old and for older pupils addresses issues directly concerned with school life, like managing anxiety and stress around exams. The new Ofsted inspection framework 'Better Inspection for All' also includes a new judgement on personal development, behaviour and welfare of children and learners. Further DfE guidance on using counsellors in schools is also planned as part of a school's counselling strategy.

5.5 Public Health England has also produced 'Improving young people's health and wellbeing - a framework for public health'. This document also includes a list of questions with six questions for the Health and Wellbeing Board to consider. These are included as Appendix 2 for information. The Health and Wellbeing Board are proposing a summit on EHWB / CAMHS in the summer and these questions could provide a useful basis for future discussion.

**Bracknell Forest update**

5.6 There can be no doubt that emotional health and wellbeing and the mental health of young people is topical and there is no shortage of relevant advice, guidance and information. There is widespread recognition that there is a need to raise the profile of this work and also provide a spotlight and focus on improving current provision. This is exactly what we are doing in Bracknell Forest and in the Children and Young People's Plan 2014-17 one of our six priorities across the partnership is: Improve physical and emotional health and wellbeing from conception to birth and throughout life. In support of achieving that priority we have developed a joint action plan which describes the actions for all providers under key themes/headings.

5.7 The joint action plan focuses on:

- Improving young people's emotional health and wellbeing in educational settings
- Promoting resilience, prevention and early intervention so young people and their families know what they can do to help themselves and where to go for additional help
- Improving access across all service providers to effective support at all levels of need
- Care for the most vulnerable which is timely and where thresholds are understood
- Special focus on addressing perinatal mental health for new mothers
- Accountability and transparency through effective data and information collection and reporting of key measures
- Developing the workforce so that they are better able to meet needs

5.8 The Board will be aware that at the last meeting the finalisation of the Joint Action Plan by all parties for the HWBB deadlines for the June meeting was anticipated to be a challenge. The Action Plan at Appendix 1 is currently draft as the actions proposed by the CCG are subject to endorsement by the CCG Board and it is anticipated that there could be a refresh of some CCG outcomes. An updated copy will be circulated if this is the case.

5.9 NHS England has prepared new protocols contained in the Specialised Mental Health Services Operating Handbook (please see Appendix 3) setting out the referral and access assessment process for children and young people into inpatient services.

5.10 A joint sub group of the HWBB and the Children and Young People's Partnership has been established to oversee the delivery of the joint action plan.

## 6. Conclusion

6.1 The focus on children and young people's emotional health and wellbeing and recognising the important role that all partners play in delivering good outcomes for this group of more vulnerable young people. The strong link between physical and mental health is reinforced and there can be no doubt that the HWBB has created the space for greater discussion, awareness raising and joint actions on good mental health and getting people better informed about how to keep mentally and emotionally healthy. The conversation will continue as there is much to do.

## 7 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Treasurer

7.1 The financial impact of any re-commissioned services will need to be established and implications agreed with the responsible funding body prior to effecting any changes.

Contact for further information
Dr Janette Karklins, Director, Children, Young People & Learning - 01344 354183
janette.karklins@bracknell-forest.gov.uk

Dr William Tong, Chair, Bracknell & Ascot Clinical Commissioning Group
w.tong@nhs.net

**Appendix 1**

**DRAFT Action Plan for 2015 – 16**
**Emotional Health and Wellbeing/CAMHS**

**The Action Plan has not yet been approved by the CCG Board and therefore the CCG actions remain draft.**

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | **Improving young people's emotional health and wellbeing in educational settings** | | | | |
| **1** | Develop a consistent level of awareness of how to promote an emotionally healthy school | Communications campaign with regular mailings to schools<br><br>Half termly focus events promoted through PSHE network | CYPL | September 2015 and ongoing | HTs and COGs can demonstrate an awareness of factors impacting on emotional health and well being.<br>Focus events are promoted and used in schools |
| **2** | Improve support in schools for mental health issues like ADHD, self harm etc | Learn from a local pilot project on school based management of ADHD. Pilot started in January in a single school in the South of Reading. | BHFT and LA (children's services) | Dec 2015 | Share good practice from the project and apply the learning as appropriate. |
| | | Provide regular training opportunities for school staff in the general field of mental health as well as specific topics such as self-harm or anxiety. For example:<br>• Regional conference on self-harm took place on 27-2-15.<br>• PEPP Care training to be offered to GPs, schools and LA staff | LA (children's services)<br>LA (Public Health)<br>BHFT | Ongoing | Training programme meets EHWB focus.<br>Case study evidence 50% of schools have developed their practice in promoting resilience in children and young people to develop resilience. |
| **3** | Review of healthy schools programme to focus on promoting EHWB | Promote new healthy schools scheme to schools and support to implement and assess impact | CYPL and schools | April 2016 | Evidence of new actions to promote emotional health and wellbeing in 30% of schools |
| | **Promoting resilience, prevention and early intervention so young people and their families know what they can do to help themselves and where to go for additional help** | | | | |
| **4** | Work with young people, | Provide clear communications | Emotional | September | Wider understanding of the pathways |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | parents and services to co-design and review the pathways work started by Slough PH | pathways and information so young people and parents experience a smooth journey through the appropriate care pathway | Health & Wellbeing Group/CYP/CSC | 2015 | and thresholds.<br>Relevant leaflets and communications about the pathways. |
| **5** | Engagement with the youth council on EHWB | Engage with the youth council on EHWB<br>• Young people to be trained as 'peer listeners'<br>• Campaign to raise awareness of EHWB and mental health mirrors that in schools | CYPL Youth Service | April 2015 and ongoing | Youth Council promote and have developed skills in building resilience.<br>10 young people trained<br>10 using skills to support peers<br>Feedback of training that over 80% thought it useful |
| **23** | **Improving access across all service providers to effective support at all levels of need** | | | | |
| **6** | Reduce waiting times for help and increase resources to meet the increased demand. | Berkshire East CCGs have secured additional winter resilience funding from NHS England for 2014/15 to provide enhanced CAMHs help that reduces the number of young people whose needs escalate to crisis point. | CCGs | Dec 2014 | Some posts have been recruited to. BHFT working proactively to fill all vacancies.<br>Service partially up and running since Dec 2014. Monthly update reports being provided. |
| | | Redesign the CAMHs care pathway so that more help and advice is available at an earlier stage, meaning that fewer children and young people will need a service from specialist CAMHs. | Local Authority (children's services), LA (Public Health), CCGs, BHFT | Dec 2015 | More self help available at earliest point<br>Waiting list for CAMHS reduces so that less than 12 week wait is achieved by January 2016. |
| **7** | | Consideration of business case to increase investment into Tier 3 CAMHs. | BHFT and CCGs | July 2015 | Initial business case received by CCGs from BHFT- Feb 2015.<br>Commissioners and provider will useful learning from additional winter resilience funded projects to shape investment. |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | Work with schools, children's services voluntary sector and CAMHs to develop a more integrated approach to accessing help when ASD is suspected or diagnosed. Access to help should be based on the child's needs not just the presence/ absence of a diagnosis. | Local Authority (children's services), CCGs, BHFT, schools | March 2016 | Discussed in principle by CCG and BHFT March 2015<br>Business case submitted to CCGs includes additional resources to support Tier 3 ASD diagnostic pathway. |
| **8** | Seek consent from parents and young people at an early stage to sharing information | All services to check that information consent is in place as a first stage. | All services lead LA CYPL | April 2016 | No barriers to sharing information |
| **9** | Services to work together to ensure effective transition where necessary Tier 2 to 3 and Tier 3 to 2 services. | Establish greater clarity of thresholds across the system CAMHS Common Point of Entry to discuss thresholds<br>Tier 2 CAF referrals and multi agency team to include reps from partner agencies regarding interdependence<br>Regular case reviews and liaison Tier 2/3 and 3/2. | CYPL and CCG/CAMHS | June 2016 | Clear understanding of thresholds by all partners.<br>Good transition between tiers.<br>Evidence of fewer inappropriate referrals to Tier 3<br>Increased demand on Tier 2 services |
| **10** | Ensure that young people are seen in a timely manner and non attendance is followed up, especially where children are dependent on an adult to access appointments | Risk assessment for any 'did not attend' cases and re-engagement arrangements for dependent children | All agencies | April 2016 | Children receive help and keep at least 90% of appointments. |
| **11** | Increase Tier 2 provision, to ensure timely 'early intervention', reducing escalation of mental health problems and reducing the need for specialist Tier 3 and 4 services. | Discuss how existing and new resources and services at Tier 2 become a shared Early Help responsibility across the partnership. | Local Authority (children's services) with partners | July 2016 | Good communications between partners.<br>Reduced waiting lists for CAMHS.<br>Timely access to services.<br>Improved user satisfaction. |
| | | Commission and publicise the new on-line systems of self help and | Public Health | March 2015 | Young people get access to appropriate help at an early stage |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| 25 | | support for emotional health and wellbeing.<br>• Develop a publicity campaign to advertise the on-line counselling service<br>• Develop suitable metrics around referrals and take up<br>• A CAMHs app to be finalised following engagement with service users. | | June 2016 | EHWB concerns are dealt with at an early point and the vast majority do not escalate to higher tiers<br><br>Metrics being developed.<br><br>CAMHs App being trialled in 3 Slough schools to then refined prior to national launch. |
| | | Specialist Tier 2 targeted services for family issues, mild emotional and behavioural disorders, child behaviour problems, conduct disorder, bereavement, bullying, anger management etc<br><br>• Clear understanding of the pathways and access routes and escalation processes<br>• Care plan in place | CYPL Targeted Services | September 2015 | Relaunch of Tier 2 provision to schools and pathway maps.<br>New SLA from April 2016.<br>At least 90% buy back. |
| | | Enhance existing maternal, perinatal and early year's health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.<br>Link with the Thames Valley Strategic Clinical Network lead for perinatal mental health to establish opportunities to improve services | TVSCN linking with midwives, BHFT<br>Public Health<br>CCG<br>CYPL | March 2016 | • TVSCN perinatal mental health lead has been appointed |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | locally. | | | |
| **12** | Provide more detailed information about services and how to access them. | Make sure that up to date information is on key websites including the local offer. | LA (children's services)<br>LA (Public Health)<br>BHFT | September 2015 | • Local authorities have compiled lists of services that are available at Tier 2 and this is improving signposting within CAMHs. This directory of services supports teachers, GPs and others working with CYP, detailing where services are available and how to access them easily.<br>• BHFT have launched a new CAMHs website which will include a 'Supporting You' section. This section will contain information and links to other agencies offering local support to families, as well as links to online resources and top tips. |
| | | Following engagement with BHFT service users, BHFT to update information, resources and the website. | BHFT | June 2015 | • Engagement with service users to develop website and resources underway |
| **13** | Improve the environment where CYP are seen or are waiting including more privacy for confidential conversations and availability of resources for activities | Service users suggestions to improve clinical spaces and waiting rooms are<br>• Artwork, produced by service users, to be displayed throughout CAMHs buildings.<br>• Positive and inspiring messages within CAMHs buildings.<br>• Uplifting posters.<br>• Access to helpful and reliable information on the issues they are experiencing within the waiting areas.<br>• Fidget toys and stress balls | BHFT | March 2015<br>March 2015<br>March 2015<br>March 2015<br>April 2015<br>April 2015 | • 2 art workshops held to date. Plans to continue this as part of ongoing service user engagement<br>• Materials ordered<br>• Materials ordered<br>• Materials ordered<br>• Materials ordered<br>• Materials ordered |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | as distraction aids.<br>• A selection of up-to-date magazines.<br>• Annuals and other books to 'dip into' whilst they are waiting for their appointment.<br>• Less "gloomy" information and publicity on issues that are not directly related to young people's mental health. | | April 2015<br><br>March 2015 | • Materials ordered |
| **14** | Better post-diagnostic support, particularly for children with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). | To discuss how existing and new resources and services that support children with ASD and ADHD can be better coordinated across the partnership. | Local Authority (children's services)<br>CCG<br>BHFT<br>Voluntary sector | March 2016 | Discussed in principle at Pan Berkshire CAMHs meeting Jan 2015 |
| **15** | Provide better access to services in a crisis and out of hours. | Secure additional resources to extend the availability of CAMHs help in a crisis into the evening and over weekends and Bank Holidays. | CCGs | Jan 2015 | • Finance has been secured using mental health operational resilience funding. |
| | | Secure staff to be able to offer the service. | BHFT | Feb 2015 | • Partial delivery due to vacancies |
| | | Evaluate effectiveness of the service with a view to mainstreaming this with recurrent funds. | BHFT and CCG | May 2015 | |
| | | Enhance the Early Intervention in Psychosis service for young people.<br>Evaluate this with a view to mainstreaming the enhanced service. | BHFT | June 2015 | • Finance has been secured using mental health operation resilience funding Dec 2014.<br>• Partial delivery due to vacancies (Feb 2015)<br>• Evaluate service |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | Evaluate the new Psychological Medicines Service for young people under the age of 18 years that has opened at Wexham Park Hospital, providing rapid response mental health assessments for people who are being treated for physical conditions. | BHFT with WPH | June 2015 | • This service works across the hospital, including in A&E, so that children and young people who are in hospital for physical health problems can be assessed for any mental health issues without a further referral. This enables more rapid access to mental health services when required. The service started in Jan 2015. Monthly reporting. |
| | | CCG is working with the police, ambulance service, Local Authorities, Public Health, hospitals, Drug and Alcohol Teams and BHFT to develop and implement the Crisis Care Concordat action plan. | BHFT<br>CCG<br>LA<br>SCAS<br>Police<br>Acute hospitals | May 2015 | • Action plan published following consultation with service users<br>• Crisis Care Concordat Declaration was signed off Dec 2014. |
| **16** | Provide a local 24/7 inpatient service for those CYP with the most complex needs. | To increase opening hours of the Berkshire Adolescent Unit from 4 nights per week to 7 nights per week. | NHS England<br>BHFT | Dec 2015 | Since September longer term plans have been agreed in principle with the CCGs and NHS England to change the Berkshire Adolescent Unit, based in Wokingham from a Tier 3 unit (with some Tier 4) into a Tier 4 provision so that it can be open for 7 days, 52 weeks per year. It will eventually be expanded (7 beds currently) to form a larger in-patient residential unit (12-15 beds) as well as catering for day patients. This unit could also provide some crisis intervention beds. Under this new proposal a proportion of the funding for running the provision will transfer to NHS England. The remaining Tier 3 resources for the community based Eating Disorders service and Early Intervention in Psychosis will be included within the Tier 3 CAMHs service specification.<br>Other centrally funded grants will be considered and applied for as and when |
| | | To increase the number of Tier 4 beds available in Berkshire | NHS England<br>BHFT | March 2017<br>TBC | |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | | | | opportunities arise |
| | **Care for the most vulnerable which is timely and where thresholds are understood** | | | | |
| **17** | More vulnerable young people eg looked after and care leavers, learning disability and CSE victims to be prioritised and specialist appointments within 10 days of referral | | CAMHS/CYPL dependent on support needs | | |
| **18** | Transition between CAMHS and Adult Mental Health Services and it is recommended that a review of the workforce training and support needs for improved transition be undertaken | Improve transition between CAMHS and Adult Mental Health Services | BHFT and CCG LA Adult Services | Ongoing | • CQIN in 15/16 contract measuring the satisfaction of service users<br>• Review of workforce training needs around transition to inform training programme |
| **19** | Free Tier 3 CAMHS staff to work more collaboratively with partner agencies. | Consider service redesign to increase investment into Tier 3 CAMHs to enable this to happen. | BHFT and CCGs | July 2015 | • Initial business case received by CCGs from BHFT- Feb 2015.<br>• Commissioners and provider will use learning from additional winter resilience funded projects to shape investment. |
| **20** | Deliver improved communications and administration | Engage with service users and their families to find out what they want to know about the service<br>• Service leaflet on what to expect from BHFT CAMHs.<br>• Review service letters to be clear on wait times and service offer.<br>• Improve website, add a section called “Our service”. Site to be available as an | BHFT | March 2015<br>March 2015<br>July 2015 | • Process in place for service users to be consulted on all forms of communication and publicity.<br>• “CAMHs web” and new website under development |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | App for smart phones and tablets<br>• Improve information in waiting areas.<br>• Text reminder system to be set up.<br>• Implement online tool "CAMHs web" which will facilitate shared decision making with young people- they will be able to access their own care plans which they have jointly agreed and developed with their clinician using tablets and smart phones. This will facilitate the self-reporting of outcomes. | | May 2015<br><br>May 2015<br><br>April 2015 | |
| **21** | **Specialist Tier 4** Provide clarity on the referral routes and process of referral to highly specialised mental health services at Tier 4 | Follow the protocol as set out in the Specialised Mental Health Services Operating Handbook see Appendix 3 | NHS England | April 2015 | • Clarity on the referral routes, process and access to Tier 4 which can be assessed against the protocol |
| **22** | Specialist pathways for crisis and urgent referrals/care | Follow the protocol as set out in the Specialised Mental Health Services Operating Handbook see Appendix 3 | NHS England | April 2015 | • Clarity on the referral routes, process and access to Tier 4 which can be assessed against the protocol |
| | **Special focus on addressing perinatal mental health for new mothers** | | | | |
| **23** | Support for post natal mental health, particularly for young pregnant women | Link with the Thames Valley Strategic Clinical Network lead for perinatal mental health to establish opportunities to improve services locally. | TVSCN linking with midwives, BHFT<br>Public Health<br>CCG<br>CYPL | March 2016 | • TVSCN perinatal mental health lead has been appointed |

| No. | Area of Need | Actions | Lead agency | When | Outcomes |
|---|---|---|---|---|---|
| | | | | | |
| | **Developing the workforce so that they are better able to meet needs** | | | | |
| **24** | Clear workforce development plan to ensure that staff are well trained and supported in their work | Identify and commission key training for staff, promote training | CYPL | Ongoing<br>By April 2016 | 20% of staff skilled to promote EHWB in the workplace |
| | | Develop the workforce, including GPs, Early Years, schools, children's centre staff, school nurses, youth workers | LA (Public Health) with CCGs | Ongoing | • Training is taking place on an ongoing basis. |
| | | Strengthen the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND)<br>Consider further integration of children's therapies and community nursing with mental health services | BHFT | April 2016 | • March 2015- BHFT scoping opportunities |
| | **Accountability and transparency through effective data and information collection and reporting of key measures** | | | | |
| **25** | Establish clear and joint management information and reporting standards for CAMHS and EHWB for service improvement. | Develop and maintain an accurate data set so that cases can be overseen and progressed<br>Establish wait times for Tier 2 and 3<br>Establish baseline data for those who do not meet the threshold for Tier 2 and 3 who have been referred | CYPL<br>BHFT | Annually from 2016 | • CCG working with BHFT on data accuracy as part of 2016 contract |

**Appendix 2**

**Questions for Health and Wellbeing Boards from Public Health England**

1. Is the Board setting aspirations for health and wellbeing outcomes for young people based on the best performing local authorities? How is it using national and regional comparative benchmarks?

2. How does the joint strategic needs assessment demonstrate a specific focus on 10-24 year olds? Does this include disadvantaged groups such as looked after children, children adopted from care and care leavers? If it doesn't, what plans are there to address this?

3. How is the Board assured that services are working together to ensure those vulnerable to poor outcomes or whose safety is at risk, including sexual exploitation, are identified and supported as early as possible?

4. How does the Board identify local health inequalities and inequity of provision for this age group?

5. How is the Board assured that there is sufficient investment in youth provision to meet universal, targeted and specialist needs?

6. How do young people help shape the Board's plans and review progress?

Appendix 3



# Specialised Mental Health Services Operating Handbook Protocol

**Referral and Access Assessment Process**
**For Children & Young People into Inpatient Services**

| |
|---|
| ***Date of issue: 20 October 2014*** |
| ***Date of review: February 2015*** |

## 1. Specialised Area

The service specifications developed by the Clinical Reference Group (CRG) for Inpatient Services for children & young people describe in detail the specialist area.

*Child and Adolescent Mental Health Inpatient Services (CAMHS) deliver tertiary level of care and treatment to young people with severe and/or complex mental disorders. This could include inpatient units, learning disability units, secure forensic adolescent units and eating disorder units. Young people and children who are admitted to CAMH Inpatient Services have complex needs, often with co-morbidity that cannot be adequately treated by community CAMH services and where the risk identified cannot be managed. The purpose of treatment in these specialist services is to reduce risk using a variety of evidence-based therapies, whilst increasing the young person's psychological wellbeing and enabling discharge from CAMH Inpatient Services at the earliest possible opportunity with the support of community services. Where possible all children and young people should be treated as close as possible to their home area and in the least restrictive environment.*



**Key issues which can influence or contribute to poor mental health in young people include**:

- Living in a family where there is a lone parent
- Where both parents are unemployed
- Where a parent has mental illness
- Where a parent has substance misuse problems
- Where a child is 'looked after' by the Local Authority
- Where a child has a learning disability
- Young offenders or children from an offending background
- Chronic physical illness
- Where there are prolonged difficulties at school, including special educational needs and exclusion; and children who are refugees.

The young person's capacity to consent to be admitted into hospital must be assessed. For the young person (or parent / carer) to make an informed decision; information, where possible, should be explained in terms of expectations of the admitting hospital re engagement, observation practices, treatment programme etc.

Considerations also to take into account:

1. Competent child or young person can consent to admission

2. Parent can consent on behalf of a child who is not competent and falls within zone of parental control

3. Over 16 who lacks capacity and where admission does not involve deprivation of liberty can be under provisions of Mental Capacity Act.

4. If a competent child/young person refuses or there are reasons not to rely on consent or if parental consent not applicable or reasons not to rely on parental consent then consider admission under the Mental Health Act 1983 (NB: only young people detained under the Mental Health Act may be considered for Psychiatric Intensive Care Units PICU).



## *2. Access Assessment*

*The following section describes the arrangements for referral, assessment and admission into CAMHS in-patient services. The service specifications developed by the Clinical Reference Group (CRG) for CAMH Inpatient Services describe in detail additional requirements / referral response times for each specialised service.*

*Mental Health Case Managers (MHCM) will work collaboratively with local services, access assessors and CAMH Inpatient Services taking into consideration local issues and geographical differences. Where a young person is approaching their eighteenth birthday MHCM's will work with local clinicians to ensure the most appropriate pathway is identified.*

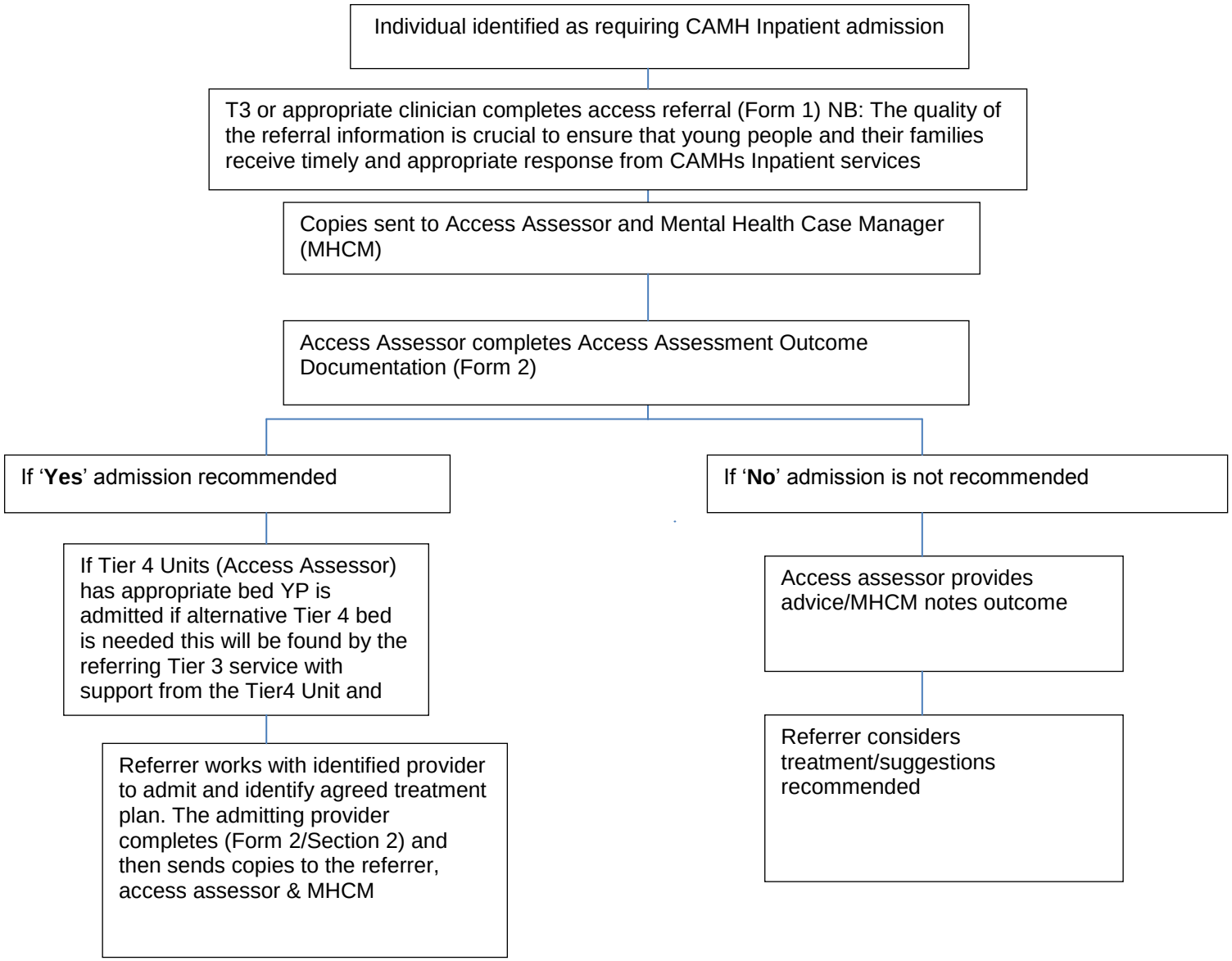
*Admission must operate within a pathway of care, involving the local community teams. It is essential to avoid protracted length of stay and the development of dependency on inpatient treatment, or loss of contact by the young person with their family and community. It is the role of T3 services and the Access Assessor to explore alternatives to admission and assess the suitability of an individual for inpatient treatment. The young person's strengths and the protective factors within the family environment must be considered. It is important to balance the need for admission against the disruption to school attendance and the young person's social and local environment.*

*The quality of the referral information is crucial to ensure that young people and their families receive timely and appropriate response from CAMHs Inpatient services.*

*Where there is overwhelming evidence, within the referral and associated documents, that the young person requires admission there may be no need for a face to face assessment. The access assessment may be completed as a "table top" exercise using the available clinical information.*

*Best practice indicates that access assessments are completed by a CAMH's Inpatient clinician wherever possible. In some areas identified CAMHs T3 will provide this resource. Practitioners who undertake access assessments need to be skilled, trained professionals who know how to engage and work with children, young people and their families and elicit vital information. The Tier4 team should liaise closely with the referring team and any other agencies involved in conducting the assessment and formulating an agreed care plan. The clinician carrying out the access assessment could be a senior member of the team and this will depend on available resources and the clinical picture of the referral. The assessing clinician should be empowered to make a decision regarding need for admission to CAMH Inpatient Services. In conjunction assessing clinicians may find the use of structured assessment tools useful in completing the access assessment. Whatever assessment framework is used it should be structured and systematic and services should be able to describe how they are able to achieve threshold consistency, reliability and validity in the assessments they undertake.*

*Following receipt of (Form 1) Referral, the Access Assessor will need to complete Access Assessment Documentation (Form 2) and follow the flow chart set out below. The Referrer works with identified provider to admit and identify agreed treatment plan. The admitting provider completes Section 2 (of form 2).*


Individual identified as requiring CAMH Inpatient admission
T3 or appropriate clinician completes access referral (Form 1) NB: The quality of the referral information is crucial to ensure that young people and their families receive timely and appropriate response from CAMHs Inpatient services
Copies sent to Access Assessor and Mental Health Case Manager (MHCM)
Access Assessor completes Access Assessment Outcome Documentation (Form 2)
If 'Yes' admission recommended
If 'No' admission is not recommended
If Tier 4 Units (Access Assessor) has appropriate bed YP is admitted if alternative Tier 4 bed is needed this will be found by the referring Tier 3 service with support from the Tier4 Unit and
Referrer works with identified provider to admit and identify agreed treatment plan. The admitting provider completes (Form 2/Section 2) and then sends copies to the referrer, access assessor & MHCM
Access assessor provides advice/MHCM notes outcome
Referrer considers treatment/suggestions recommended

*The following descriptions are taken from the service specifications and describe the expected timeframe for each specialist area to respond to a referral.*

**i. Tier 4 CAMH General Adolescent Services**

Referral routes - *referral to a Tier 4 CAMHS General Adolescent Service will be from Tier 3 CAMH services and endorsed by a consultant psychiatrist- T3 CAHMS or Adult Consultant (if out of hours).*

- Emergency referrals will be reviewed and responded to by a senior clinician within 4 hours; emergency assessment will be offered within 12 hours.
- Urgent referrals will be reviewed and responded to within 48 hours.
- Routine referrals will be reviewed and responded to within 1 week.

**ii. Tier 4 Children's Units**

Referral routes- *referrals will be accepted from or supported by Tier 3 CAMH services and endorsed by a consultant psychiatrist- T3 CAMHs or Adult Consultant (if out of hours).*

- Emergency referrals will be reviewed and responded to by a senior clinician within 12 hours; emergency assessment will be offered within 24 hours.
- Urgent referrals will be reviewed and responded to within 48 hours.
- Routine referrals will be reviewed and responded to within 1 week and assessment offered within 4 weeks

**iii. Tier 4 CAMH In Patient Learning Disability Service**

Referral Routes- referrals should be from Tier 3 CAMHS/Community Learning Disability Services or other Tier 4 CAMHS Services. Response times are as detailed above.

- Emergency admissions are not usually possible due to the need to assess the young person before admission. However it may be possible in some instances when the young person resides near the Tier 4 CAMHS Specialist Learning Disability Unit. Advice can be given to referrers on management pending assessment.

**iv. Tier 4 CAMH Specialist Eating Disorder Service**

Referral routes- Referrals will be accepted from Tier 3 CAMHS, Tier 4 General Adolescent Units and Children's Units.

- Response to emergency referrals will be within 24 hours
- Response to urgent referrals will be within 48 hours
- Response to non-urgent referrals will be within 5 working days.

**v. Tier 4 Psychiatric Intensive Care Units (PICU)**

Referral process–referrals will be accepted from Tier 4 Adolescent Services or occasionally directly from Tier 3 CAMHS where it is evident that the young person's needs could not be met within the Tier 4 general CAMH service.

- Response to referrals will be within 2 hours.

**vi. Referral for Access Assessment into Medium or Low Secure Inpatient Services for Children & Young People Refer to Form 1 Additional Considerations for Referrers**

It is important to note that each referral is unique and the receiving clinician/clinical team will determine the urgency of the referral on receipt. In some cases discussions between referrer, access assessor and the MHCM will be required to enable consideration of clinical, geographical and appropriate use of available capacity.

**Referral and Access Assessment process for potential admission for Children & Young People**

**Process for routine referrals:**

1. Referral for access assessment (form 1) to be completed and sent to the appropriate access assessor and copy to MHCM. This will identify the significant Mental Health needs.

2. The access assessment will explicitly address the following issues;

   - Whether inpatient admission will address the mental health needs of the young person.
   - The best environment/level of service in which the care should be provided including Level of security required
   - Identify risks
   - Comments on the ability of the holding/referring organisation to safely care for the young person until transfer can be arranged
   - The wishes and feelings of the child and parents/ carers should always be sought as part of the assessment.

3. Where after the access assessment it is agreed the child does not require a CAMH Inpatient Service, an access assessment (form 2) should be provided including advice to the referrer/Tier 3 team on the young person's management.

4. If it is agreed the child requires in-patient admission, in an appropriate setting as identified by access assessor (form 2 completed) and MHCM.

5. If Tier 4 Units (Access Assessor) has appropriate bed (Form 3 completed) YP is admitted.

6. Where a bed is not available locally discussions need to take place between the referrer, MHCM. The most appropriate CAMHs Inpatient Service will be identified by the referring Tier 3 service with support MHCM.

7. Where a bed is required but the local Tier 4 service feels unable to meet the needs of the child or young person then the reasons for this must be communicated and clearly to the referrer, and discussion with the MHCM is required to determine the most appropriate service.

   Access assessor and the CAMH Inpatient Service must maintain communication with the referrer throughout the process.

   - Where an initial access assessment determines the child requires care from a more specialist CAMH Inpatient Service, the access assessor will provide advice on the type of unit required and discussions will take place with the MHCM and the referrer.

**Process for emergency/urgent referrals (including out of hours):**

1. Initial referral to be made to access assessor as identified (see local access arrangements and list of services below)
2. Referral discussed with CAMH Inpatient Service immediately
3. Agreement reached between referrer and access assessor re degree of urgency
4. Outcome of access assessment to be communicated to referrer as soon as possible
5. Where admission is indicated, a bed should be offered as soon as clinically appropriate
6. Access Assessment Form 2 (out of hours section) completed

**Note: where referral / admission takes place out of hours, at the weekend or on a bank holiday the MHCM will need to be made aware on the first working day after the urgent admission of a child or young person to a CAMH Inpatient Service**

## 3. Case Management Arrangements

MHCM will work collaboratively with local services, access assessors and CAMH Inpatient Services taking into consideration local issues and geographical differences. Where a young person is approaching their eighteenth birthday MHCM will work with local clinicians to ensure the most appropriate pathway is identified. Contact details are included in the last section of this document.

## 4. Arrangements for Access Assessments

Inpatient Access Assessment for Tier 4 (using Form 1) will be provided by:-

Leigh House Hospital, Winchester (For Hampshire, IOW, Portsmouth, Southampton referrals)
Pebble Lodge, Dorset (For Dorset referrals)
Berkshire Adolescent Unit, Wokingham (For Berkshire referrals)
Highfield, Oxford (For Oxfordshire, Buckinghamshire referrals)

If the referral raises concerns regarding risk of harm to others, then the Forensic CAMHS Service can be contacted for advice as follows:-

Hampshire, IOW, Portsmouth, Southampton, Dorset - Jonathan.Bigg@nhs.net

Berkshire, Oxfordshire, Buckinghamshire – Nick.Hindley@oxfordhealth.nhs.uk

## 5. For Information: Local CAMH Inpatient Services

Huntercombe Manor Hospital, Maidenhead
Highfield, Oxford
Berkshire Adolescent Unit, Wokingham
Pebble Lodge, Dorset
Leigh House Hospital, Winchester,
Priory Hospital Southampton

## 6. Contact Details

Queries regarding the process can be directed to:-

Gareth Davies, Mental Health Case Manager
Garethdavies2@nhs.net

Louise Doughty, Head of MH & Programme of Care Lead
Louisedoughty@nhs.net

This page is intentionally left blank

**TO: HEALTH AND WELLBEING BOARD**
**04 JUNE 2015**

---

**BRACKNELL AND ASCOT CLINICAL COMMISSIONING GROUP**
**OPERATING PLAN 2015/16**

## 1 PURPOSE OF REPORT

1.1 To appraise the Board of operating plan proposed by Bracknell and Ascot Clinical Commissioning Group (CCG) for 2015/16 and seek the views of the Board on the plans. The Board is particularly asked to comment on the Collaborative Commissioning for the Older Citizen programme.

## 2 RECOMMENDATION

**2.1 The Operating plan is recommended to the Board for approval**

## 3 REASONS FOR RECOMMENDATION

3.1 There is a requirement for the CCG to bring its operating plan to the Health and Wellbeing Board. But in any case, there is a dependency between the CCG operating plan and the JHWS, as the CCG plan is a delivery mechanism for the JHWS, and the JHWS is a cornerstone of the CCG plan. The Board will wish to be assured that these links are evident in the plan

## 4 ALTERNATIVE OPTIONS CONSIDERED

4.1 Not applicable

## 5 SUPPORTING INFORMATION

5.1 The executive summary of the 2015/16 operating plan is attached. The full plan is available and will be posted on the BACCG website. A presentation summarising the plan and giving more detail on the Collaborative Commissioning for the Older Citizen programme will be made at the HWBB meeting

## 6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not applicable

Borough Treasurer

6.2 Not applicable

Equalities Impact Assessment

6.3 Applied to each programme of work as appropriate

Strategic Risk Management Issues

6.4 It is important for the overall delivery of the JHWS that the CCG plans are aligned with shared priorities. The CCG operating plan offers assurance of this

Other Officers

6.5 Dr Lisa McNally, Consultant in Public Health

## 7 CONSULTATION

Principal Groups Consulted

7.1 Public and patients, key stakeholders and partners through the annual planning process

Method of Consultation

7.2 various

Representations Received

7.3 nil

Background Papers
None.

Contact for further information
Mary Purnell
Mary.Purnell@nhs.net

Anshu Varma
anshuvarma@nhs.net

## Operating Plan 2015-16 : Executive Summary

**Our Commissioning Intentions are:-**

1) The delivery of all the constitutional standards sustainably in year and to have in place recovery or improvement plans for those that are currently not achieving the standard.
2) To continue to build on the improvement in outcomes achieved 2014/15 as demonstrated in the 7 outcome measures.
3) To improve integrated working and unplanned care through the delivery of our BCF plans
4) We will continue to progress our major programmes of service improvement
5) In line with the intentions in our 5 year plan we will develop and implement new urgent care working arrangements.
6) We will work with Frimley Health to improve the quality of local services following the acquisition and system wide transformation through the Collaborative Care for Older Citizen.
7) Work with Public Health colleagues to prevent ill health and empower individuals to improve their own health.
8) We will drive quality and incentivise service improvements through robust and enforceable contractual levers.
9) We will work together with member practices to deliver sustainable improvement to primary care and support the development of co-commissioning.
10) We will continue to ensure that patient is at the centre of all that we do and continue to involve the public and patients in commissioning services.

**Delivery Priorities and Objectives**

Our five year plan set out the following Improvement Interventions:-

- Transform Primary Care
- Transform Integrated Care
- Transform Urgent Care
- Transform Elective Care
- Transform Collaborative Care for the Older Citizen

We have now separated out mental health as a work programme in its own right. To support the development of these programme areas we have reviewed the commissioning for value packs and are analysing the opportunities presented within the 'deep dive' packs to confirm and redefine our programmes of work using the NHS Right Care methodology. In addition to these we have used benchmarking provided by local networks, cancer peer review, national cancer patients survey, ECIST, Local Authority data packs and the Public Health Observatory to prioritise areas of improvement.

**Table 1 - The major programmes of service improvement**

| Delivery Priorities | Outcomes |
|---|---|
| Cardio Vascular Disease | - Deliver the optimum pathways for Heart Failure, Arrhythmia, AF and cardiac rehabilitation with our partners<br>- Increase the number of people getting an early diagnosis of hypertension in line with the commissioning for value pack indicators<br>- Work with Public health and primary care around prevention in partnership with our patients<br>- Commission the optimum Stroke pathway within the programme for CVD |
| Mental health services & Learning Disabilities. (See Maternity , Children & Young people | - Deliver the Mental Health concordat<br>- Increase dementia diagnosis to national recommendations as a minimum<br>- Deliver the national target for IAPT as a minimum and continue to target those with a long term condition<br>- Be assured of parity of esteem for people with mental illness<br>- An east Berkshire LD steering group with representation from all partner agencies has been initiated and meets monthly. The terms of reference include development and improvement of LD specific services, development of a strategy to improve all health and social services interface with LD clients, ensure multiagency governance |

| | |
|---|---|
| | and ensure full implementation of the Transforming Care agenda |
| Diabetes | - Reduce the number of hospital admissions for diabetes related conditions such as cellulitis<br>- Improve the knowledge of and support to diabetics to enable them to remain well and free from complications |
| Cancer | - Improve early diagnosis by improving the uptake of screening.<br>- Improve clinical pathways for early assessment and treatment |
| Better Care Fund | "*Our population will be happier, healthier and active for longer; through having better information, access to expert health and care services when required; and support to make the right choices."*<br><br>This high level vision for Bracknell Forest has three key elements:<br><br>• **Prevention:** Our focus will be on health, not illness. The population will be happier, healthier and active for longer; through having access to better information and support to make the right choices.<br><br>• **Personalisation:** Our care and support will respond to the individuals' choices and needs. This will begin with ensure that people only have to tell their story once. We will then support them and their carers to achieve the outcomes that are important to them.<br><br>• **Partnership:** An integrated system across health and social care will develop with the individual at its centre. Improvement will also be driven by partnership with local people and learning from what they tell us about their health and experiences of using services.<br><br>People will only have to tell their story once, as there will be integrated, shared records based on the NHS number as a unique identifier. People's needs will be met with the minimum time spent in hospital or travelling to access the services they need. Care and support will respond to the individual's choices as well as their needs.<br>The full Bracknell Forest plan can be viewed at http://www.bracknell-forest.gov.uk/bracknell-forest-better-care-fund-plan.pdf<br><br>A similar approach is being taken for our Ascot residents via the RBWM Better Care Fund. |
| Referral Management | Reduce clinical variation to deliver the optimum levels of referrals to secondary care in line with best practice, meeting the target of 119 referrals per 1,000 weighted population |
| Respiratory pathway | Continuing the work started in 2014/15 to deliver a redesigned pathway to better support people in and out of acute care and reduce length of stay in acute hospitals |
| Self care and prevention programme | Based on the JHWS and targeted using the Commissioning for Value pack, establish a joint programme focusing on prevention, early intervention and self-care running throughout the year. A comprehensive programme will deliver the following outcomes:<br>- Increased reported confidence by people to manage their own health and wellbeing<br>- Increase in people feeling supported to manage their own condition<br>- Increase in recorded prevalence of hypertension<br>- Increase in numbers of women taking up breast screening and cervical smear tests<br>- Testing and evaluation of the 'Healthmaker' concept |

| | |
|---|---|
| Urgent & Emergency Care | As indicated in our 5 year plan we will have a system plan to develop and implement new urgent care working arrangements across the wider system. During 2014/15 this will be developed through the follow areas of work:-<br>- Build on the success of the Bracknell UCC with additional pathways and use of Patient Education Centre.<br>- Collaborate with Frimley Health on the clinical vision to underpin the major rebuild of Wexham Park Emergency Department.<br>- Re-procurement of 111<br>- Re-procurement of OOHs service to incorporate Sandhurst<br>- Work as part of the Frimley South SRG to deliver a system resilience plan across all partners, building on the success of the OCRP plans |
| Primary Care | Primary care transformation began with a large scale event in Feb 2014. Since then a programme board has delivered the steer for co-commissioning of primary care and supported the member's practices working closer together.<br><br>The 7 day primary care programme designed around the needs to the population linking with the Prime Ministers Challenge Fund, include:<br>• 7 day Primary Care provision model<br>• Extending Access to the population<br>• Workforce Development<br>• Focus on Quality Outcomes, via a new local quality outcomes scheme which will address priorities including;<br>o end of life care planning,<br>o reducing clinical variation in referrals,<br>o engagement in multi-disciplinary integrated care teams |
| Pathway redesign<br>• Parkinson's<br>• Community IV & DVT<br>• Gastroenterology<br>• Urology<br>• ENT<br>• Spinal<br>• End of Life Care<br>• Respiratory | ➢ Pathways are being redesigned and developed collaboratively with our secondary care, community & primary care.<br>➢ The CCG is collaborating with Frimley Health on the clinical vision to underpin the building of a state of the art cold elective centre on the Heatherwood site.<br>➢ These have been established as service improvement plans in our contracts for 15/16.<br>➢ These will support the following outcomes:<br>• Better prevention,<br>• Earlier diagnosis<br>• Better treatment<br>• Improve access<br>• Reduction in NEL admissions. |
| Maternity , Children & Young people | - CCG plans to develop a women's and children and young people's strategy with their partners and take part in NHS England review for maternity services and develop action plan on the recommendation to provide appropriate choice for mothers without compromising on safety.<br>- Collaborate with Frimley Health on the capital refresh of Wexham Park Maternity and Gynaecology facilities to improve patient flow and experience.<br>- The CCG will work with Local Authorities, Public Health, midwives, schools and primary care to identify and treat emerging mental health issues earlier, before difficulties escalate. This includes Early Intervention In Psychosis.<br>- Additional capacity will be provided to tier 3 CAMHs to meet the growth in demand and complexity of cases.<br>- The CCG will continue to work with NHSE and BHFT to improve access to local Tier 4 CAMHs provision |
| Collaborative Care for the Older Citizen | Through this project, the east Berks CCGs, with Chiltern CCG will work in partnership with Frimley Health and Berkshire Healthcare Foundation |

| | |
|---|---|
| | Trusts and Local Authorities to transform the model of care for older people. The new model will cover the population of people aged over 65 who are registered with one of the four CCGs. |

**Finance & Resources**

The total funding allocation for Bracknell & Ascot CCG in 2015/16 is £148.5m. Last year the CCG was 6.4% below the "target" funding calculated by NHS England, but for 2015/16 this has reduced to 4.5%. Overall the CCG has received an increase in programme funding of £9.3m, but is still £6.7m below its "target" funding allocation.

The CCG is meeting the key NHS England financial business rules with delivery of a surplus of £2.3m (1.5%), non-recurring expenditure of £1.5m (1%) and holding a contingency of £3.3m (2.1%) – some of which will be require for system-wide risk sharing. There is a QIPP and Savings Plan of £3.0m and the CCG has adopted the NHS Right Care methodology in identifying and managing key opportunities. NHS England has provisionally agreed that £2.1m of the surplus from 2014/15 can be used for new primary care developments. Delays in agreeing the National Tariff for acute providers impacted on the local timescales for agreeing contracts, but these are now very close to finalisation. The risk of contract over performance has been mitigated by the earmarking of contingencies and Better Care Fund reserves. Our budget for 2015/16 is summarised below:

**Budget Summary**

| | 15/16 £m | 15/16 % |
|---|---|---|
| Funding Allocation | 148.5 | |
| Other Adjustments | (0.9) | |
| Previous Year Surplus | 5.7 | |
| | **153.4** | |
| | | |
| Secondary Acute | | |
| - Frimley Health (North) | 15.3 | 10.0% |
| - Royal Berkshire | 12.3 | 8.0% |
| - Frimley Health (South) | 34.7 | 22.6% |
| - Other | 14.3 | 9.3% |
| Mental Health | 13.7 | 8.9% |
| Community Health | 12.1 | 7.9% |
| Other Programme | 2.9 | 1.9% |
| Primary Care | | 0.0% |
| - Prescribing | 15.2 | 9.9% |
| - Other | 6.4 | 4.1% |
| Out of Hospital | 9.5 | 6.2% |
| Corporate | 3.0 | 2.0% |
| Earmarked Reserves (incl. Better Care Fund) | 8.3 | 5.4% |
| Contingency | 3.3 | 2.1% |
| | **151.1** | |
| Surplus | 2.3 | 1.5% |
| | **153.4** | 100.0% |

**Alignment of our plans with our providers**

The CCG has been working together in collaboration with other CCG to agree contracts with our main providers and London. Contact with NHS England specialist commissioners has been minimal during this planning round and further work is needed in year to improve this position. The SRG have reviewed the impact of all schemes commissioned during the 2014/15 with stakeholders and have agreed the retention of a number or schemes to support system flow for 2015/16 and have implemented a system wide real time urgent care summary dashboard to support daily resilience and planning across the health economy to manage surge in demand.

Main Provider contracts for 2015/16 are now agreed with final documentation under production with the intention of signing on the 21 May 2015. Where the CCGs is an associate to externally hosted contracts there have been no areas of dispute and signing timelines will be dependent on the lead Commissioner. Private and Independent sector contracts are now agreed and NHS standard contract documentation will be signed by the 22 May 2015.

Activity levels for elective activity have been agreed in order to maintain the 18 week standard and we have put in place a joint review approach with our providers to respond to any fluctuations to planned position if demand increases above contracted levels. A further activity funding budget has been established which if required could cover the cost of non-elective activity at up to 3% above 2014/15 outturn levels and allows for a modest increase in elective activity. This has not been applied to any individual provider as commissioners are retaining the flexibility to spot source capacity as required. In the case of our main community provider, commissioners agreed an 8.4% uplift on investment in mental health services representing a value in excess of our Parity of Esteem requirements and service development requirements. In recognition of the need for joint work on service transformation and system sustainability the contract agreement has included a number of service reviews and redesign projects to be driven through a new bipartite transformation board.

**Quality Innovation Productivity & Prevention (QIPP)**

QIPP covers all aspects of the NHS (national, regional and local) and aims to support clinical teams and NHS organisation's to prevent ill health, improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year improvements. See Appendix 1 for details.

**CCG Assurance Framework**

In quarter 2 of 2014/15, the CCG has been assured with support with concerns highlighted in the following areas:

- **Domain 1** due to the quality risk around Frimley Health (HWPH) and the need for robust oversight mechanisms to be put in place. An oversight risk committee has been set up and which monitors the delivery of the plan
- **Domain 3** Constitutional Standards as Frimley North (HWPH) did not achieve the 18 week, A & E performance, 31 day and 62 cancer targets for Q2.
- **Domain 6** Leadership an interim Accountable officer is now in post till July 2015.

The CCGs are reviewing their current arrangements for collaborative working and plans are underway to appoint into a permanent position.

Plans to reach a fully assured status in 2015/16 are outlined as follows:

- Recovery plans as outlined to achieve and sustain constitutional standards
- Transaction agreement in place with Frimley Health
- Use of contract levers to ensure that these are delivered
- Realignment of commissioning and performance teams to focus attention on key areas of delivery.
- Work with TV & Wessex leadership team
- Progress to appoint a substantive Accountable Officer

**Recovery Plans for providers not meeting the NHS Constitutional standards**

Plans to ensure sustained delivery of the NHS Constitutional standards in the following areas which are currently not being achieved are:-

| Constitutional Standards | Performance Threshold | Current Delivery | Date Target will be achieved | Actions to achieve (or sustain target where this is already met) |
|---|---|---|---|---|

| Constitutional Standards | Performance Threshold | Current Delivery | Date Target will be achieved | Actions to achieve (or sustain target where this is already met) |
|---|---|---|---|---|
| RTT Achievement in all specialities | 90% Admitted | B & A: 92.91% | April 2015 | ➢ The provider is engaged with IMAS and implementing their recommendations<br>➢ Demand and capacity modelling<br>➢ Referral Management process and each CCG as referral target<br>➢ Clinical Advise & guidance is being agreed<br>➢ Awaiting action plan from RBFT |
| RTT Achievement in all specialities | 95% Non-Admitted | B & A: 96.82% | April 2015 | |
| RTT Achievement in all specialities | 92% Incomplete | B & A: 94.48% | April 2015 | |
| Diagnostics | >=1% | B & A: 5.92%<br>Slough : 2.47%<br>WAM : 3.29% | April 2015 | Improvement plan in place at Frimley North site<br>➢ has increased capacity by agreeing new job plans, recruiting staff(clinical and administrative staff)<br>➢ New CT scanner<br>➢ New administrative process<br>➢ CCG have developed guidelines for diagnostics referrals and the referral pattern is monitored by the performance group |
| Dementia diagnosis | 66.7% | B & A: 58.59% | March 2015 | Peer review, Care homes quality project. (Jan 2015) NB there is a data error due to one practice's data not being recorded on the system – actual shows us on track to deliver. |

**Risks to delivery**

The CCG has a risk management strategy and framework which is followed to identify and manage risks. All high and extreme risks are reported on a quarterly basis in public to the CCG Governing Body is using the Assurance Framework ; each CCG has its own assurance framework aligned to its strategic objectives articulated in the 2 and 5 year plans. The top risks are:

Transaction: There is a risk in the delivery due to the newly formed Frimley Health Foundation NHS Trust.

Quality & Operational standards related to 18 week, A &E ,Cancer. In addition RBHFT continues to have significant problems with reporting their 18 week data which has resulted in NHS England granting the Trust a reporting holiday until this is resolved. This represents a risk to the CCG in respect of a number or constitutional standards .

**Governance & Local Assurance Process**

| Milestone | Committee | Dates |
|---|---|---|
| Review of 2014/16 Two Year Plan | Clinical Leads and Planned Care Group<br>Unplanned Care Group<br>Link to latest version ..\..\BACCG Planning\2 yr plan narrative\BACCG Commissioning Plan 2014-2016 201516 refresh.pptx | February 2015 |
| CCG Senior Management Team Review 2 year plan | CCG Senior Management Team:<br>• Finance<br>• Quality<br>• Contracts and Performance | February 2015 |
| Review of changes/updates to 2 year plan | Operational Leadership Team and Governing Body | 25th February 2015 |

| | | |
|---|---|---|
| Sharing with all providers | Joint Transformation board | 18 March 2015 |
| Sharing with system leaders | System leadership group | 20 March 2015 |
| Partnership review | Health and Wellbeing Board (chair to chair) | HWBB June 2015 |
| Final assurance of 2 year operational plan | Governing Body | April 2015 |
| Ongoing monitoring arrangements | Planned Care Board (reporting to OLT on planned care QIPP projects)<br>Unplanned Care Board (reporting to OLT on unplanned care projects)<br>Performance review group (reporting to GP Council on member practice performance on referrals, A&E activity and NELs)<br>Better Care fund Board and Steering group OLT | All meet monthly |

**Appendix 1 – QIPP Scheme description**
Bracknell and Ascot CCG, have three facets which underpin their approach to QIPP programme and these focus on:

I. Reducing variation: This entails ensuring that utilisation of services are managed to best clinical practice and upper decile norm, encompassing referrals, direct access, prescribing and admissions.
II. Transforming services: Schemes outlined in this document show where CCGs will work with clinicians and stakeholders in primary, secondary, community and mental health providers to transform services in line with best clinical practice.
III. Provider Relationships: CCG QIPP schemes will be profiled into contracts through the 2015/16 negotiation round together with appropriate quality and efficiency measures and Activity Planning Assumptions

| **QIPP Scheme name** | **Description** | **Impact** |
|---|---|---|
| Total Knee replacements ( B & A) | To fully establish a Total Knee Replacement (TKR) Avoidance Service following on from a successful pilot programme that has been in operation for 11 months.<br>• Reduce the number of knee replacement surgical procedures undertaken through effective screening and conservative management intervention programmes.<br>• Ensure that the conservative management programmes are delivered through cost effective, evidence based pathways which enable patients to achieve good functional outcomes and encourage patients to take responsibility for their own health and well-being.<br>• Extend the concept to hips | • Their quality of life is improved as a result of avoiding unnecessary surgery and the potential for post-operative complications<br>• They are able to achieve good functional outcomes and improvements in pain levels through a process that actively involves then and empowers them to take responsibility for their own health and well-being. |
| Leg ulcer (B & A CCG) | To commission a standard wound care service across primary and community care to ensure that patients in Bracknell and Ascot have access to a consistent, quality assured leg ulcer service. | • Improve healing time<br>• Reduction in planned and NEL admission |
| Urgent Care | To build on the first year's successful operation of the Bracknell UCC to drive out the full year effect of benefits such as the virtual fracture pathway | • Improve patient experience<br>• Reduce outpatients attendances |
| Diabetes | To proactively manage diabetic patients to reduce individual risk of and admission.<br>This will involve a the following approach:<br>• Increased early detection of diabetics<br>• Improved secondary prevention of known diabetics<br>• Change to service model and specification of community diabetes service:<br>• Recommend best value prescribing of medications in Type 2 Diabetes | • Improving the health of patients under Lifestyle, Self Help and Virtual ward services, tailoring services to the cohort of patients.<br>• Improve the quality of care for those with a diagnosis of diabetes.<br>• Reduction in NEL admissions towards end of 2015 specifically within the HRGs identified<br>• Prescribing savings<br>• |
| **QIPP Scheme** | **Description** | **Impact** |

| name | | |
|---|---|---|
| Cardiology | Use of Cardiology pathway to ensure that the population at risk has equitable access to cardiology clinical and diagnostic services in primary and community care.<br><br>Using NHS Right care data and deep dives information we have identified areas of improvement as follows:<br>• Heart failure<br>• Arrhythmias pathways<br>• Chest Pain<br>• Cardiac rehabilitation | • Improve its cardiovascular profile through better lifestyle interventions, healthier eating and more physical activity.<br><br>• Reduction in Non-elective admissions<br>• Prevention and Risk Management<br>• Improve and enhance case management<br>• Reduction in A&E attendances |
| Ambulatory Care Sensitive | To manage identified Ambulatory care pathways in the community as evidenced provided suggests that it provides better patient care.<br>The pathways with most potential for redesign are:<br>Influenza, COPD and cellulitis. | • Reduction in non-elective admissions<br>• Better quality and experience for patient and carer<br>• Reduction in A&E attendances |
| Integrated EOL | Explore improved patient choice for both receiving palliative care and choosing the place to die.<br>Work with primary care to drive up quality of experience and outcomes | • Increasing the proportion of people able to die in their preferred place<br>• Admission avoidance and reduced A&E, Out-patient attendances |
| Referral Management | To reduce clinical variation in the numbers of people referred to secondary care, through peer review, adopting best practice and achieving a rate of 119 per 1000 weighted population | • To ensure that patients receive the right care in the appropriate setting.<br>• To reduce the spend on outpatient first and follow up appointments, and eliminate unwarranted variation<br>• To maintain the GP referral target of 119 referrals /1000 weighted population (equivalent to 115 on previous weighted population), whilst reducing clinical variation across all practices in 15/16. |
| Medicine Sick day rule (All) | Production of Credit Card sized patient information with 5 common drugs causing acute dehydration in patients with a view to aim to reduce unplanned admissions due to acute dehydration. | Improve patient safety<br>Empower patients to optimise the use of patients own medicines<br>Reduction in A & E attendances and NEL activity |
| Prescribing | PrescQIPP is best known for the bulletins, toolkits, and comprehensive evidence based implementation resources that we deliver but we also provide a wide array of intelligence (data), learning webinars and events, governance around rebates and joint working, and hosting discussions within our prescribing community for prescribers to share innovation, ideas and experiences. | Improved learning opportunity from community boards and educational material.<br>Improved quality resources with respect to Medicines available to medicines optimisation team, CCG and patients. |
| **QIPP Scheme name** | **Description** | **Impact** |

| | | |
|---|---|---|
| Reducing Wasted Medicines | A public campaign to reduce the waste of prescription medicines. Through posters, leaflets, media and social media, the message of reducing waste medicines by only ordering what you need and telling a professional if you have stopped taking something will be widely disseminated. | Reduction in spend on unused prescription items<br>Safer use of medicines locally |
| Continuing Health Care | To ensure that best value from the overall use of nursing home placements. | To improve quality of patient care<br>To improve access |

**TO: HEALTH AND WELLBEING BOARD**
**4 JUNE 2015**

---

**REPORT OF THE BRACKNELL FOREST HEALTH AND WELLBEING BOARD**
**HEALTH INFRASTRUCTURE TASK AND FINISH GROUP**

## 1 PURPOSE OF REPORT

1.1 Bracknell Forest Health and Wellbeing Board, at its meeting in March 2015 determined that a task and finish group be established to look at the housing growth and demographic changes in the Borough and assess the impact on these on the need for health infrastructure in future years. This report is to inform the Board of the work of the sub-group and ask for **approval of a number of recommendations for further action**

## 2 RECOMMENDATIONS

**2.1** The task and finish group make the following recommendations to the Health and Wellbeing Board:

i. That support (including support for S106 contributions where appropriate) is given to the development of thriving and sustainable community hubs in the areas of greatest housing growth (Warfield and Crowthorne). These centres can then be used as a focus for activities to promote health and wellbeing in the communities and play a vital role, particularly in the preventative aspects of health and wellbeing

ii. That the concept of focussing on the identified 'hotspots' is agreed as a principle by which the Health and Wellbeing Board should focus its combined energy on addressing the changing needs of the population

iii. That the changing needs of the Crowthorne population are the first area for the task and finish group to focus on in some detail, to address the impact of the housing growth and the complexity arising from the close proximity of the Wokingham border. This will be achieved through close working with key stakeholders including Wokingham CCG, Wokingham Borough Council (initially via the public health consultant), local affected GP practices and Crowthorne Parish Council, as well as the developer.

iv. That further work is done, taking into account the JSNA and JHWS, and national exemplars, to investigate the opportunities the redeveloped town centre presents in terms of promoting health and wellbeing, and delivering health interventions. This will include understanding and influencing the possible redevelopment of Skimped Hill Health Centre

v. That the Health and Wellbeing Board assumes a role in influencing the future development of services at the RBH Bracknell Healthspace such that these are complementary to other health infrastructure solutions in the Borough, and reflect the changing needs of the population

## 3 REASONS FOR RECOMMENDATIONS

3.1 The group has considered the potential impact of housing growth and other demographic change on health infrastructure within and adjacent to the Borough and has identified a number of areas, 'hotspots' which if not the subject of further work may result in some compromise to equity and equality of access to health and wellbeing services to some residents. The recommendations are intended to address these issues

## 4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None applicable

## 5 SUPPORTING INFORMATION

5.1 The Health Infrastructure 'task and finish' group has been established and first met on 14th April 2015. The terms of reference for the group were agreed and are attached (appendix 1). The group has shared perspectives on the potential impact of housing and demographic growth on the needs for health infrastructure and expressed these in the form of a number of key questions which need to be addressed.

### KEY QUESTIONS

1. **What specific demographic, social and economic changes can we identify which will have the greatest impact on future demand over the next 5 years?** Taking into account factors which result in different demand as well as simply more demand

   Factors to consider:
   - We have an ageing population, with commensurate reductions in mobility, which places a greater emphasis on local access to services
   - The town centre will offer an estimated additional 3300 jobs, which will enhance wellbeing, but will compete with the care sector for workers, which is a market already under pressure
   - The location of new schools will determine to some extent the local concentrations of families.

2. **Where are the hot spots in terms of future pressure on services, which indicate where additional capacity should be provided?** The definition of a 'hotspot' in this context is a localised area of demographic change (as in Q1 above) which will in likelihood generate more demand for health services than the current capacity could absorb. This does not mean that there are not other local pressures on services, but the 'hot spots' described are those which will have the greatest impact if solutions are not put in place

   Factors to consider:
   - The overall population increase is approximately 11500 as a result of current planned housing (see Appendix 2)
   - Where there are additional housing developments outside the Bracknell Forest borders, notably in Wokingham, which will compound the impact of local housing growth.

- The location of the greatest concentration of housing development, and the mix

**3. What should the offer from the new town centre be in terms of opportunities for health services, opportunities and interventions?**

Factors to consider:

- Potential for more 'drop-in' opportunities for health screening, vaccinations and reviews for targeted health interventions
- Accessibility will be a key issue, and the health infrastructure needs of the town centre need to be considered in the light of its location as a public transport hub, which means it can serve a wider population particularly older and younger people, and others who do not drive.
- Possible redevelopment of Skimped Hill has the potential to be a hub for health in the town centre

**4. How else can health needs be met?**

Factors to consider:

- Community pharmacies are a great neighbourhood resource, and have been the subject of detailed mapping by public health
- Digital inclusion as a vehicle to access health advice and support
- Community hubs are planned for the neighbourhoods with most development, and these have potential to support the delivery of health and wellbeing services.
- Mobile 'point of care' solutions such as those delivering health checks in Self-care week have the potential to add capacity and reach out to communities in a targeted way
- Children's centres are local, well established facilities through which health and well-being services for families can be delivered.

**HOTSPOTS DEFINED**

- Crowthorne is a particular hot-spot. The housing growth at TRL and Broadmoor is significant, and is compounded by growth on the Wokingham side of the border. The existing GP practices closest to the developments in both Bracknell and Wokingham have little potential for expansion on their current sites. Therefore a new solution is required if the demands placed by planned housing growth are to be met in the locality
- Warfield has the potential to become a hot-spot as there is significant new housing planned, and the local surgeries at Tesco, North Bracknell (Waterfield and Gainsborough) and the next nearest Boundary House are constrained sites. The pressure is less intense than Crowthorne and the proximity of the Warfield expansion to the town centre makes Skimped Hill (if re-developed) a potential solution as it could provide accessible services at a scale that would be deliverable.

## 6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not applicable

Borough Treasurer

6.2 Not applicable

Equalities Impact Assessment

6.3 Any specific scheme going forward would be the subject of an individual EIA

Strategic Risk Management Issues

6.4 The task and finish group was established by the Board with the intention of mitigating the risk presented by a fragmented approach to assessing and responding to the health infrastructure needs represented by housing growth and demographic change

Other Officers

6.5 Membership of the task and finish group is as follows:

Core Membership:
Nominated members of the HWBB (or their representatives)

- Victor Nicholls, BFC (Assistant Chief Executive)
- Mary Purnell, Bracknell and Ascot CCG (Head of Operations)
- Lisa McNally (consultant in public health)
- Mark Sanders (Healthwatch Bracknell Forest )
- Nicky Wadely NHS England (Head of Primary Care)

## 7 CONSULTATION

Principal Groups Consulted

7.1 Not applicable

Method of Consultation

7.2 Not applicable

Representations Received

7.3 Not applicable

Background Papers

Appendix 1 - Terms of reference
Appendix 2 - Map showing housing growth and current primary care premises

Contact for further information
Mary Purnell
Mary.Purnell@nhs.net

APPENDIX 1

**Terms of Reference**

| | |
|---|---|
| Meeting/Group name: | Bracknell Forest Health and Wellbeing Board, Health Infrastructure Task and Finish Group |
| Chair: | Mary Purnell, Head of Operations, Bracknell and Ascot CCG |
| Frequency: | ad hoc to meet objectives |
| Accountable to: | Bracknell Forest Health and Wellbeing Board |

Bracknell Forest Health and Wellbeing Board have determined, at their meeting in March 2015, that a 'task and finish' group be established to consider the impact of housing development and demographic and economic change on the health needs of the local population. The group is asked to make recommendations on how health infrastructure should be developed in order to meet these needs, taking a forward look over the next 5 years

**Aims and Objectives**

- To bring together and engage key partners and stakeholders in the Borough to reach a common understanding of the likely impact of housing development and demographic change on the local health infrastructure needs
- To describe what initiatives and processes are already in place via the partner organisations to meet these needs and explore potential synergy in these
- To consider what actions should be taken to address the health infrastructure needs identified and develop options for delivery
- To ensure that actions and options developed have an evidence base in the JSNA and JHWS
- Make recommendations to the Health and Wellbeing Board for a programme of work to be adopted and monitored by the HWBB to deliver health infrastructure for the future population needs

**Key Relationships:**

- Member organisations of the HWBB
- GP Council
- NHS Foundation Trusts delivering services to Bracknell Forest residents
- Housing developers
- Wokingham HWBB (Borough Council and CCG)

**Membership**

Core Membership:

Nominated members of the HWBB (or their representatives)

- Tim Wheadon (Head of Planning and Deputy Chief Executive)
- Bracknell and Ascot CCG (Head of Operations)
- Director of Public Health (Lisa McNally)
- Healthwatch Bracknell Forest (Mark Sanders)

- NHS England (Head of Primary Care)

Plus co-opted members or attendees in line with the agenda for example (but not exclusively):

- Berkshire Healthcare NHS FT
- Royal Berkshire Hospital NHS FT
- Wokingham CCG
- Town and Parish Council representatives

Plus additional members in line with the agenda.

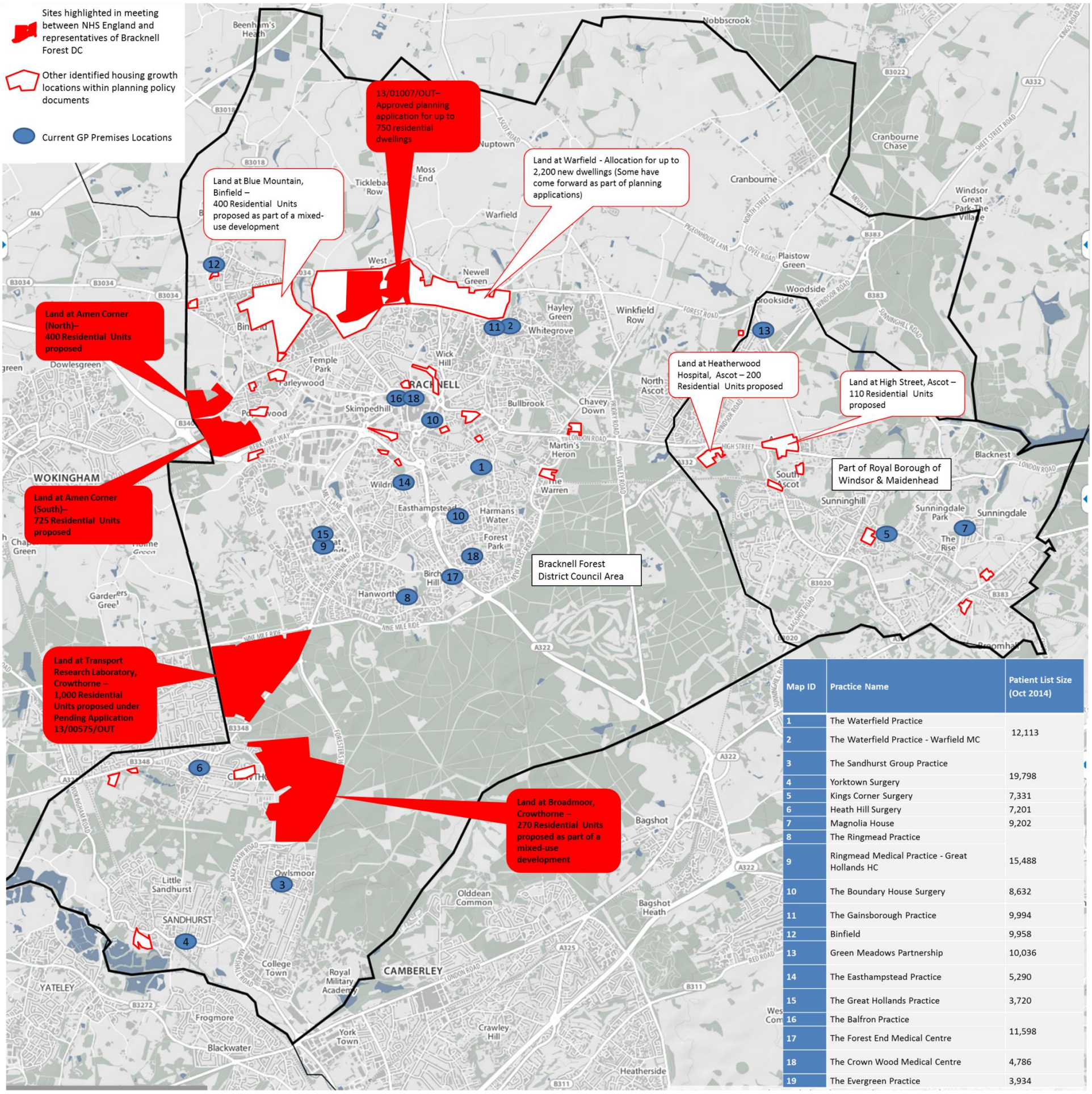
**Chair of the group**
The chair of the group will be the Head of Operations Bracknell and Ascot CCG (Mary Purnell). In the absence of the chair an interim chair will be appointed by the meeting.

**Frequency of Meetings**
Ad hoc as required to deliver the objectives

Quoracy
The group is not a decision making body so shall have no minimum quoracy

**DATE AGREED: 14TH APRIL 2015**

## Bracknell & Ascot CCG Area— Summary of Housing Growth Locations and GP Premises




Notes:

⇒ The above map highlights the specific sites that were identified during the meeting between NHS England (Thames Valley Area Team) and representatives of the Bracknell Forest Unitary Authority (shown in solid red).

⇒ Other wider housing growth locations contained within current and emerging Development Plan Documents are shown edged in red.

⇒ The CCG Boundary includes the whole of Bracknell Forest District Council area. The Ascot area falls within the southern edge of the Royal Borough of Windsor & Maidenhead.

⇒ The Allocations for Bracknell Forest are adopted, following adoption of the Core Strategy (2008) and the Site Allocations Local Plan (2013)

⇒ The Allocations within the Ascot area are currently included within the emerging Draft Local Plan (2013) for the Windsor and Maidenhead area.

⇒ The GP Premises information is drawn from the Thames Valley GP Contact List, and the HSCIC October 2014 update.

Bracknell Forest Population Forecast

## Housing Trajectory (April 2014 Update)

| Site Name | Actual Net Completions | | | | | | | | Projected Net Completions | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Sites | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Total Net |
| Broadmoor, Crowthorne (SA4) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 10 | 50 | 55 | 55 | 50 | 270 |
| Amen Corner North, Binfield (SA6) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 100 | 100 | 100 | 50 | 0 | 0 | 0 | 0 | 0 | 0 | 400 |
| Blue Mountain, Binfield (SA7) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 100 | 100 | 100 | 50 | 0 | 0 | 0 | 400 |
| Land at Amen Corner South, Binfield (SA8) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 100 | 100 | 100 | 100 | 100 | 50 | 100 | 25 | 0 | 0 | 725 |
| Land at Warfield (SA9) Area 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 150 | 150 | 150 | 150 | 164 | 0 | 0 | 0 | 0 | 814 |
| Land at Warfield (SA9) Area 2 (residual area) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 50 | 0 | 0 | 0 | 0 | 0 | 100 |
| Land at Warfield (SA9) Area 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50 | 100 | 100 | 100 | 104 | 0 | 454 |
| Total Strategic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 100 | 250 | 350 | 400 | 450 | 500 | 424 | 300 | 180 | 159 | 50 | 3163 |
| **GRAND TOTAL—Completions (Large, Medium, Small Sites) Projections, Small Sites, Allowances & SALP Sites** | **131** | **501** | **467** | **235** | **410** | **264** | **390** | **314** | **417** | **697** | **808** | **1147** | **1239** | **1117** | **1042** | **896** | **615** | **300** | **309** | **231** | **11620** |

## Projected Population Increase 2013/14-2025/26

| | Actual Net Completions | Projected Net Completions | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Total Net |
| Expected Housing Trajectory —Completions (Large, Medium, Small Sites) Projections, Small Sites, Allowances & SALP Sites | 314 | 417 | 697 | 808 | 1147 | 1239 | 1117 | 1042 | 896 | 615 | 300 | 309 | 231 | 11620 |
| **Expected Population Increase Based on 2.23 People Per Dwelling** | **722** | **959** | **1603** | **1858** | **2638** | **2850** | **2569** | **2397** | **2061** | **1415** | **690** | **711** | **531** | **21004** |

(Drawn From Housing Trajectory Document Updated April 2014)

The council does not appear to include any accurate population forecasts within the evidence base of its Development Plan Documents.

Utilising a standard occupancy rate of 2.3 people per new dwelling would indicate a potential population increase from **2013/14 to 2025/26 of 21,004 people** (The council should be contacted to confirm if they hold any more accurate population forecasts, or an updated occupancy rate figure where actual occupancy rates may vary).

Ascot Area of Royal Borough of Windsor & Maidenhead Population Forecast

No accurate housing trajectory is available for the Ascot area of the Royal Borough of Windsor & Maidenhead. For indication purposes only, the emerging Local Plan for the RBWM currently includes housing allocations in this area totalling 538 dwellings. Standard 2.3 occupancy rate would indicate a potential population increase of **1,237 people** from these site allocations. It is however important to note that these allocations are currently only at draft stage.

## HEALTH & WELLBEING BOARD: FORWARD PLAN 2015/16

(Scheduling of agenda items are subject to change)

**4 June 2015 (Annual Meeting)**

| Item | Decision | Responsibility | Submitted to Board: |
|---|---|---|---|
| CCG Operational Plan | For comment | Mary Purnell/ William Tong | Complete |
| Co-commissioning of Primary care and the implications for the HWBB | For comment | Mary Purnell/ William Tong | Complete |
| CAHMS Update | Decision | Janette Kaklins | Complete |
| Infrastructure Group Update | For comment | Mary Purnell | Complete |

**Next meeting of the Board: 3 September 2015 – LSCB Annual Report**

| Item | Decision | Responsibility | Submitted to Board: |
|---|---|---|---|
| Local Safeguarding Children Board Annual Report | For comment | Janette Karklins | |

This page is intentionally left blank