Bracknell Forest Council

NOTICE OF MEETING

Health and Wellbeing Board
Thursday 10 April 2014, 2.00 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health and Wellbeing Board

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr William Tong, Bracknell Forest & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Glyn Jones, Director of Adult Social Care, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group
Dr Lise Llewellyn, Director of Public Health
Andrea McCombie-Parker, Local Healthwatch
Helen Clanchy, Thames Valley Area Team

ALISON SANDERS
Director of Corporate Services

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If you require further information, please contact: Priya Patel
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Published: 2 April 2014

Health and Wellbeing Board
Thursday 10 April 2014, 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 subject to the provisions of the Council's protocol for recording. Those wishing to record proceedings at a meeting are 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 arrangements can be discussed and the agreement of the Chairman can be sought.

AGENDA

Page No

1. **Apologies**

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

2. **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.

3. **Urgent Items of Business**

   Any other items which the chairman decides are urgent.

4. **Minutes from Previous Meeting**

   To approve as a correct record the minutes of the meeting of the Board held on 13 February 2014. 1 - 8

5. **Matters Arising**

6. **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 Priya Patel: priya.patel@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.

7. **Berkshire Healthcare Foundation Trust's Quality Account Quarter 3**

The Board is asked to comment on the Quality Account for Quarter 3 of the Berkshire Healthcare NHS Foundation Trust. Comments made by the Board will be used to inform the final quality account which will be published on the NHS Choices website and also on the Trust's website. 9 - 56

8. **Update on Child and Adolescent Mental Health (CAMHS) Services Tiers 1-4**

The purpose of this report is to describe what a good modern Child and Adolescent Mental Health Service (CAMHS) would be like; to set out the current tiers of support and who is responsible for commissioning that provision; and identify the plans and re-commissioning arrangements for CAMHS across each tier of support. 57 - 78

9. **Better Care Fund**

The Director of Adult Social Care Health & Housing to deliver a presentation to update the Board on the Better Care Fund.

10. **Update on the Progress of the Frimley Park Foundation Trust (FT) Acquisition of Heatherwood & Wexham Park Hospitals NHS Foundation Trust**

To update the Health and Wellbeing Board of progress in the Frimley Park Hospital NHS FT acquisition of Heatherwood and Wexham Park Hospitals NHS FT. 79 - 82

11. **Two Year and Five Year Clinical Commissioning Group Plans**

A presentation from the Clinical Commissioning Group.

12. **The Health & Wellbeing Board - First Year Review**

The purpose of this report is to set out a process to:- 83 - 84

- review the membership of the Health and Well Being Board; and
- establish the Board's priorities for 2014/15

13. **Protocol Between the Health & Wellbeing Board, Healthwatch and the Health O&S Panel**

The purpose of this report is to set out a draft protocol between the Health and Wellbeing Board, Bracknell Forest Healthwatch and the Health Overview and Scrutiny Panel. 85 - 94

14. **Actions taken between meetings**

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

15. **Forward Plan**

Board members are asked to make any additions or amendments to the Board's Forward Plan as necessary. 95 - 98

16. **Dates of Future Meeting**

5 June 2014
4 September 2014
11 December 2014
5 March 2015

HEALTH AND WELLBEING BOARD
13 FEBRUARY 2014
2.00 - 4.15 PM

Bracknell Forest Council

Present:
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children, Young People & Learning
Glyn Jones, Director of Adult Social Care, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Lisa McNally, Consultant in Public Health
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group
Mark Sanders, Local Healthwatch
Helen Clanchy, NHS England, Local Area Team

Apologies for Absence were received from:
Andrea McCombie-Parker, Local Healthwatch
Lise Llewellyn, Director of Public Health
Dr William Tong, Bracknell & Ascot Clinical Commissioning Group (Vice-Chairman)

In Attendance:
Eve Baker, Bracknell & Ascot Clinical Commissioning Group
Zoe Johnstone, Chief Officer: Adults and Joint Commissioning
Lynne Lidster, Head of Joint Commissioning
Dr Jenkins and Mr Elwood, One Medicare

69. **Declarations of Interest**

There were no declarations of interest.

70. **Urgent Items of Business**

There were no urgent items of business.

71. **Minutes from Previous Meeting**

RESOLVED that the minutes of the Health & Wellbeing Board held on 12 December 2013 be signed by the Chairman and approved as a correct record.

72. **Matters Arising**

Minute 65: Services around Children's Mental Health
The Director of Children, Young People & Learning reported that she had met with Berkshire Healthcare Foundation Trust to discuss commissioning arrangements and a further meeting had been arranged to consider future arrangements for tiers 1 to 3. A steering group had now also been formed to address the issue of future commissioning arrangements in this area.

The Local Area Team agreed to provide the Board with timescales for Tier 4 commissioning.

The Chairman expressed concern that little progress had been made since the last meeting despite the Board requesting that progress on joint commissioning arrangements be brought to them before this meeting.

The Chief Executive reported that a number of partners needed to come together to deliver this work and that whilst the Council would take the lead in bringing the partners together, this work couldn't be delivered by any one partner alone and the Council could not ultimately determine how the waiting lists worked for CAMHS.

It was agreed that the CCG and NHS England would liaise with the Director of Children, Young People & Learning to set out timescales for the development of a joint commissioning strategy for CAMHS, with a view to a strategy being in place by September 2014 and submit a report to the April 2014 Board meeting to report progress.

The Chairman asked that he and the Vice Chairman be kept informed of developments on this as actions develop.

73. **Public Participation**

The Chairman reported that a series of questions had been submitted by the Peoples Healthwatch, however similar questions had been submitted and answered at the Board's previous meeting and as a result the Board would not be answering them a second time. If the Peoples Healthwatch wanted further statistical information this could be gleaned from the NHS England website or the World Health Organisation.

74. **Royal Berkshire Bracknell Healthspace: Urgent Care Centre**

Representatives of One Medicare, Dr Jenkins and Mr Elwood gave a presentation to the Board as the providers of the Urgent Care Centre at the Royal Berkshire Bracknell Healthspace and made the following points:

- In terms of their background, One Medicare was now entering their tenth year in practice. They were based in Leeds and had centres across Yorkshire, Lincolnshire as well as an office in London and now the Urgent Care Centre (UCC) in Bracknell Forest. Their role included build, design and managing GP's in good quality community premises. They were an experienced team clinically and operationally. One of their core values as an organisation was to put patients first, this was absolutely critical.
- The Bracknell Forest UCC would be a place for people with acute need for medical help but who did not need emergency care. The UCC would cover illness and injury; this would include fractures and dislocations. X-rays could also be undertaken at the UCC. The UCC would be able to deal with most sports and playground injuries. The UCC would not be able to treat critically ill patients, major trauma, and fractures to long bones or compounds.
- The UCC would be run in accordance with the requirements of local commissioners. One Medicare was keen to fulfil the needs of the local community. It would be open 8-8pm every day of the year. There would be a paediatric clinic which would run after school and bookable appointments would be available for this. One of the GPs at the UCC had a strong paediatric background and would be available to see children under five.

- GPs would be on site throughout the opening times of the UCC as well as an emergency nurse practitioner. GPs would be able to refer to the UCC and so too would the NHS 111 line.
- The UCC would keep people in the community and would look and feel like primary care, this was deliberate. Local GPs would have knowledge of their patient's attendance within four hours, electronically. There was recognition that it was important that the UCC did not interfere with the relationship between the GP and patient.
- There would be a Patient Education Centre, advocating 'talk before you walk'. Given that people were living longer, self care was critical. One Medicare had already had discussions with the Public Health team around smoking cessation and healthy eating and joint work in these areas.
- One Medicare would work closely with A&E, Clinical Commissioning Groups, the South Central Ambulance Service and the 111 NHS line.
- One Medicare would encourage patient and community feedback and would present feedback in a transparent way on notice boards and on their website for all to see. Further an action plan would be created based on feedback.

In response to Board members' queries, representatives from One Medicare made the following points:

- The target for waiting times at the UCC would be 30 minutes.
- One Medicare had also presented to the Bracknell and Ascot Clinical Commissioning Group as well as Public and Participation Groups.
- The UCC would adopt local safeguarding policy and act in accordance with locally agreed protocols for adults and children.
- It would be key to communicate an integrated message to the public around when to go to A&E or the UCC. They would work with Public Health and other local partners to ensure a consistent message was achieved.
- If the UCC experienced frequent attenders, these people would be considered further and a care plan developed where appropriate.
- The UCC would be able to access patient information and would be subject to the Caldecott Guardian principles. They recognised that the more patient information that they were able to access, the safer the experience would be for the patient.
- It would not be necessary to register to attend the UCC, the UCC would support those patients that were not registered anywhere in the NHS. These patients often had chaotic lifestyles and were hard to reach and suffered inequalities in the health system.
- It was confirmed that if patients arrived at A&E and could be referred back to the UCC, this would happen. There would be a round robin to gauge capacity of all health providers locally. They would also work with the Ambulance teams to ensure patients were brought to the UCC and not A&E wherever possible.

The Board welcomed the strong emphasis of supporting families.

The Director of Adult Services, Health & Housing stated that it would be key to work closely with One Medicare on a jointly commissioned service for older people and for the UCC to be able to refer patients in and out of the Council's social care services.

The Chairman thanked Dr Jenkins and Mr Elwood for their presentation and stated that he looked forward to seeing the UCC up and running.

75. **Better Care Fund**

The Director of Adult Services, Health and Housing (ASCHH), reported that the report before the Board set out the initial joint plan for the use of the Better Care Fund in accordance with the guidance received to date. The Government had announced £3.8bn of funding to encourage integration amongst healthcare providers. The funding aimed to encourage seven day working and a move away from reliance on A&E services.

The Integration Task Force established by the Board had been instrumental in driving progress. There had been some discussion with providers, but a strong recognition that more detailed involvement was needed as well as with other stakeholders in the identified activity areas.

The aim of the Better Care Fund programme ultimately would be a population that was happy, healthy and active for longer, through having better information, access to health and care services when required and support to make the right choices. In practical terms this would mean that people:

- would only have to tell their story once, as there would be integrated, shared records based on the NHS number as the unique identifier.
- need would be met with the minimum time spent in hospital or travelling to access the services needed
- care planned with people who work together to understand people and their carers and put the person in control, co-ordinate and deliver services to achieve best outcomes.

There were already strong foundations in place for joint working locally and these would be built upon. Three strategic themes had been identified which would be worked up into work streams:

i) Prevention and self-care
ii) Integrated delivery of care
iii) On-going Care and Support

The CCG intended to put a sum of £0.302m in addition to the increase in S256 funding for 2014/15. Plans would be developed in order to ensure that both the CCG and Council use the resource to support the transformation required. In addition, it was reported that the CCG had proposed to make an additional contribution equivalent to 1% of total budget during 2014/15. This sum would be used to secure a strong position in preparation for 2015/16. Funding would need to be pump primed in order to see a reduction in hospital admissions.

Work would be necessary to ensure ICT systems could work together.

In terms of the five national targets that needed to be measured, Bracknell Forest performed well in all of these areas. The whole programme would be overseen by the Board. Whilst the Health & Wellbeing Board would play a fundamental role it was not the right vehicle to manage the detail of the operational changes required. It was therefore proposed to reframe the ITF into the Better Care Programme Board (BCPB). The Chairman and Vice Chairman of the Health & Wellbeing Board would be invited to attend the Board.

The joint plan had been to the Council's Executive and the CCG's Governing Body. Following the Board's endorsement, the joint plan would be submitted to the Local Area Team the following day.

In response to Members' queries, the following points were made:

- It was reported that in order to ensure that existing service providers were not destabilised in would be critical for there to be strong partnership arrangements in place and people would have to remain at the centre of all decisions with an emphasis on providing care in the best possible settings.
- Risks would need to be pooled rather than to be pushed on any particular organisation. Expectations would need to be managed as demand rose year on year across the board in terms of acute services and social care services.

The Chairman stated that it would be key that partners did not 'huddle around their own handbags' and only consider their own services. Conversations around an integrated approach would need to start early. The Director of ASCHH stated that partners would need to start from the premise of a shared vision with the CCG, with people at the centre and how they were to be supported in a safe and sustainable way.

It was **RESOLVED** that the Health & Wellbeing Board;

i) approved the submission of the template attached as Annex A of the report,

ii) approved the establishment of a Better Care Board as set out in 5.3.5 and

iii) agreed that additional resources for staff to programme manage the approach be delegated to the Director of Adult Social Care, Health and Housing in conjunction with the Executive Member within the funding envelope.

76. **Local Healthwatch Forward Plan**

Mark Sanders, representative from Healthwatch presented the Forward Plan to the Board and made the following points:

- Healthwatch had now been operational for three months and was part of a consortium of local community and voluntary organisations, powered by The Ark Trust Ltd. Healthwatch had a bank of volunteers that they could draw from, they would be holding a public meeting in April to elect a public chair and public members onto the board.
- Healthwatch had raised their profile by using social media sites. It was reported that public engagement had been difficult, specific areas had been targeted and 5,000 leaflets had been delivered to houses across the borough.
- Healthwatch would be attending the Priestwood AGM and be working with the press to create a news release to raise their profile. They would also be targeting major employers in the area and establishing 'Healthwatch Voices'.
- Healthwatch were unclear how their role linked in with the Board and the Health O&S Panel but hoped to explore this further and to achieve some clarity. They would be continuing their work with the Council's Adult Social Care teams and Children's Services and would be meeting with the CCG to discuss further their role with the CCG.
- It was reported that as the bank of volunteers expanded, the work of Healthwatch could be expanded. At present, Healthwatch were receiving numerous invites to various community functions but did not have the capacity to attend all of these.
- Healthwatch would be meeting with One Medicare as well as undertaking some work with the South Central Ambulance Service around response times. Their work would be driven by feedback. It was noted that the Health O&S

Panel had already completed some work around ambulance response times and that Healthwatch should liaise with them.

Board Members recommended that Healthwatch attend and present at town and council annual meetings where possible, Sandhurst would be having their meeting in the upcoming weeks. It was also recommended that Healthwatch attend and present at the Town and Parish Liaison Group meeting.

It was reported that Healthwatch had invited the People's Healthwatch – a group that had been formed by local residents, to discuss common issues with them. Healthwatch had also released a statement into the press with their branding and there were signs that their branding was starting to be recognised.

CCG representatives stated that there had been a certain amount of pressure from the CCG requesting that Healthwatch participate with them, it was crucial to the CGG that Healthwatch was a strong body as it was the CCG's route into the community. There needed to be a symbiotic relationship. It was also noted that work around patient reference groups needed professional development which Healthwatch would be well placed to provide.

77. **Pharmaceutical Needs Assessment**

The Public Health Consultant presented a report that set out what was required within a PNA, the approach to be used and the timeline for delivery of the project. The Public Health Consultant made the following points:

- The Director of Public Health and her team would be co-ordinating the PNA as part of Berkshire Shared Services. She would ensure that Bracknell Forest's needs were met and their voice heard.
- It was now widely recognised that pharmacists did much more than simply dispense medicine, they had become a trusted adviser to the local community and were well placed to deliver numerous local services.
- The PNA would be used by the NHS to commission pharmaceutical services in Berkshire. It would also be used by the public health team in Bracknell Forest to commission locally enhanced services.
- Existing pharmaceutical services in Berkshire would be mapped against population density and against the rate of long term diseases. The Joint Strategic Needs Assessment and other relevant existing documents would be used to identify health needs of the population and a gap analysis undertaken.
- The Public Health team already commissioned some services through pharmacies such as the Stop Smoking services. A good working relationship therefore already had been established with pharmacies in Bracknell Forest.
- A steering group would be set up to ensure stakeholder involvement and compliance with statutory requirements as set out in the report. The PNA would need to be in place by 1 April 2015 and progress report would be submitted to the Board in December 2014.

NHS England reported that it was critical that this work was undertaken comprehensively and properly, she was confident that this would be the case in Berkshire given the ground work that had been undertaken to date. The PNA presented an opportunity to influence the provision of pharmacies and there would be an expectation that social development and anticipated developments would be carefully considered within any PNA.

In terms of consultation, pharmacists would be consulted as well as residents and other health professionals. Local authority Planning departments were also required to be consulted, this ensured current and future needs were mapped.

It was **RESOLVED** that the Health & Wellbeing Board agreed to undertake a Pharmaceutical Needs Assessment and agreed the process outlined in the report.

78. **Roles of the Health & Wellbeing Board, Healthwatch and Overview & Scrutiny Committees**

The report set out the roles of the Board, Healthwatch and Overview & Scrutiny (O&S) Committees. The report would also be submitted to the relevant O&S Committees and was based on national guidance and advice provided by the Centre for Public Scrutiny.

The Chief Executive reported that this was the manifestation of a national problem and that there needed to be clarity of roles to ensure that duplication of effort was avoided.

It was clear to the Board that it was key that Healthwatch acted as an effective conduit for the Board, the CCG and NHS England with the local community. Whilst Healthwatch were not a decision making body, they did have an important role in terms of intelligence gathering and feeding in views and opinions of the local community into the system appropriately. The Healthwatch representative reported that national guidance on this was expected to be issued soon and that he understood that Healthwatch would play a large role in terms of signposting.

The Chairman reported that if any partner or councillor was contacted it was important that a consistent message was presented as to which body issues should be referred and when.

It was **RESOLVED** that:

i) initial discussions be arranged between Healthwatch, O&S and officers to agree a protocol which set out how providers and commissioners etc should engage with each the Health & Wellbeing Board, Healthwatch and O&S Committees to avoid duplication and to ensure issues were dealt with by the most appropriate body.

ii) results of these discussions be brought back to the Board to consider.

79. **Actions taken between meetings**

No actions were reported.

80. **Forward Plan**

The following items be added to the Forward Plan:

- Progress report on the development of a joint commissioning strategy for CAMHS, setting out timescales with a view to a strategy being in place by September 2014. Report to the April 2014 Board meeting, CCG to lead.

- Two Year and Five Year CCG plans to be submitted to the April 2014 Board meeting.

81. **Dates of Future Meeting**

10 April 2014
5 June 2014
4 September 2014
11 December 2014
5 March 2015

CHAIRMAN

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Quality Account for Health and Wellbeing Board

Meeting Date	6th March 2014
Title	2014 Quality Account Q3
Purpose	The 2014 Quality Account is due to be published in June 2014. This paper provides an update on progress with regard to Quality Account priorities and mandated information at the end of Quarter 3. The paper sets out the format for the final Quality Account. It should be considered by the Board as an early draft rather than a final document for publication. Areas which have not been completed are highlighted and are dependent upon receipt of year end detail. The Trust welcomes any comments from the Board and will also consider any suggestions for improvement of clarification which may be incorporated into the final document, including with respect to the quality priorities for 2014/15
Business Area	All localities
Executive Director	Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improves patient experience and outcomes of care.
CQC Registration/Patient Care Impacts	The CQC requires registered healthcare providers to regularly assess and monitor the quality of the services provided. They must use Quality governance and improvement activities to ensure that action is taken to protect people who use services from risks associated with unsafe care, treatment and support.
Resource Impacts	N/A
Legal Implications	NHS foundation trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the *NHS (Quality Accounts) Regulations 2010* as amended by the *NHS (Quality Accounts) Amendments Regulations 2011* and the *NHS (Quality Accounts) Amendments Regulations 2012* (collectively "the Quality Accounts Regulations").
SUMMARY	The Quality Account sets out progress on quality priorities for the year and plans for quality priorities for next year with respect to clinical effectiveness, patient experience and patient safety. Other mandated areas for quality reporting such as research, clinical audit and board assurance statements, as well as additional quality performance data are included in section 3. The draft quality account with Q3 data will be presented to various stakeholders for consultation prior to the publication of the full year quality account and comments will be included in the final published document.
ACTION REQUIRED	The Health and Wellbeing Board is asked to note the draft Quality Account for Berkshire Healthcare NHS Foundation Trust, to make any recommendations for improvement or clarification and to provide any comments for inclusion in the final published document.

Document Control

Version	Date	Author	Comments
1.0	14.02.2014	Amanda Mollett Head of Clinical Effectiveness & Audit	
2.0	17.02.2014	Justin Wilson, Medical Director	
2.1	26.02.2014	Justin Wilson, Medical Director Following Trust Quality and Assurance Committee	

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Quality Account 2014

Quarter 3 Report

What is a Quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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Quality Account Summary 2014

To be added to and updated in Q4

97% of patients in community health wards rated the care as good or better 76% for mental health wards. This is an improvement

98% of community health inpatients and minor injuries unit patients would recommend the service to friends and family. 72% of mental health inpatients. This is an improvement.

Compliments recorded each month have doubled during the year.

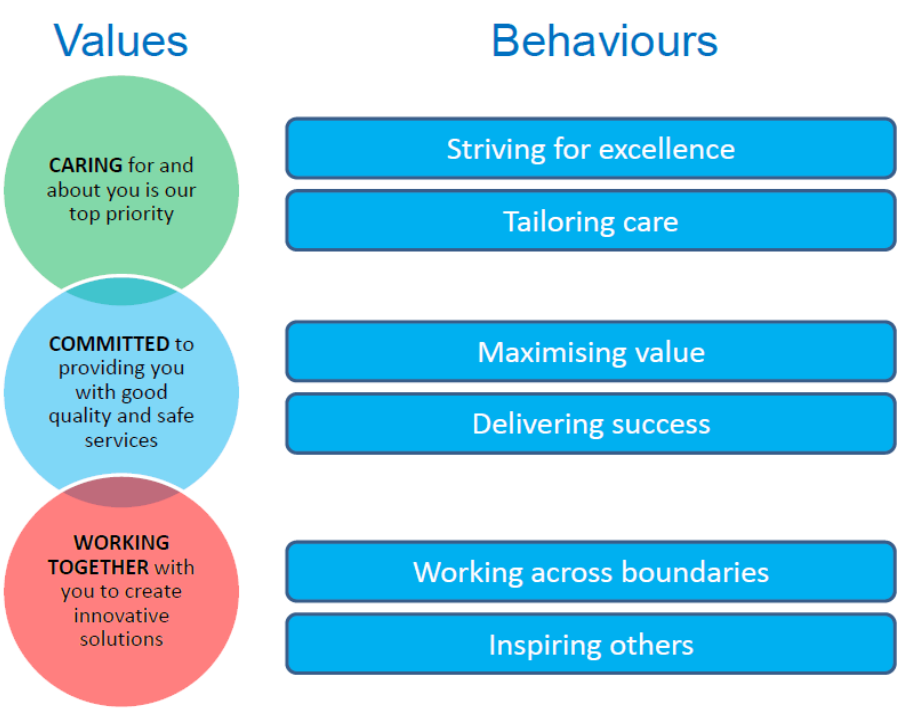
Number of complaints per month have not altered significantly overall

69% of staff would agree or strongly agree that if a friend or relative needed treatment, they would be happy with the standard of care provided by the organisation (National average 59%). This is an improvement.

71% of staff agree or strongly agree that care of patients / service users is my organisation's top priority (National average 63%). This is an improvement.

Use of Recovery tools for patients on the Care Programme Approach have not improved in Q3. An action plan is being implemented to resolve this.

Berkshire Healthcare NHS
NHS Foundation Trust



1. Statement on Quality from the Chief Executive (early draft)

Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services to a population of around 900,000 within Berkshire. We operate from more than 100 sites across the county including our community hospitals, Prospect Park Hospital, clinics and GP Practices. We also provide health care and therapy to people in their own homes.

The vast majority of the people we care for are supported in their own homes. We have 252 mental health inpatient beds and almost 200 community hospital beds in five locations and we employ more than 4,000 staff.

The health and social services in Berkshire face real challenges to maintain high quality care with increasing demands and limited resources. We are committed to working with others to develop innovative transformational solutions.

I want Berkshire Healthcare to deliver quality health services that work together to make a difference to individuals, their families and their communities. We can only do this by getting to know our communities and the people in them so we can deliver the best services to meet their health needs.

As Chief Executive I rely on patients, carers and their families to tell me when we are getting it right and when we get it wrong. I think that listening to the people we support and learning from them is the only way I can be sure that we are providing the best care. We will focus during the next year on further improving involvement of patients and carers to make the care we provide as good as possible.

Our staff are dedicated to ensuring the best outcomes for our patients their families, so I also rely on them to help me understand what the issues are and how we can improve our care. We have worked very hard to develop and listen to staff during the past year. They have come up with excellent solutions through our 'Listening into Action' programme to remove obstacles to providing the best care. I am very pleased that staff engagement levels are among the top 20% of similar Trusts in the country and we aim to build upon this success to further improve care for the people we serve.

Our vision

The best care in the right place: developing and delivering excellent services in local communities with people and their families to improve their health, well-being and independence.

The way we go about our work is defined by our values – which were developed after talking with our patients and their carers, our staff, our commissioners and our partners. These shared values are the foundation on which quality performance is built.

A theme running through our quality account and quality strategy is the achievement of improvements across both mental and physical health services. This means our community health services adopting a model of care similar to our mental health model, focused on early intervention, case management and admission avoidance.

Equally, our mental health services will align and integrate, where appropriate, with community health services, for example in providing better care for older people and for children. We are strengthening primary care partnerships in the provision of core services and integrating our services with social care and acute services, organised around patient need.

We are also working to use technology to drive quality and productivity improvements. We are building on our telehealth and mobile working initiatives to support clinicians and drive innovation.

This quality account is a vital tool in helping to support the delivery of high quality care. The information provided in this report is, to the best of my knowledge, accurate and gives a fair representation of the current services provided.

Julian Emms CEO

2.1 Priorities for Improvement 2013/14

This section of the Quality Account details our achievements to date against the 2013/14 priorities and information on the quality of services provided by the Trust during 2013/14.

2.1.1 Patient Experience

In 2013/14 we aimed to ensure patients and carers had a positive experience of care and were treated with dignity and respect

We asked patients:

1 "How likely are you to recommend our service /ward to friends and family if they needed care or treatment."

2 How do you rate the service you received? Very Good, Good, Adequate, poor, very poor

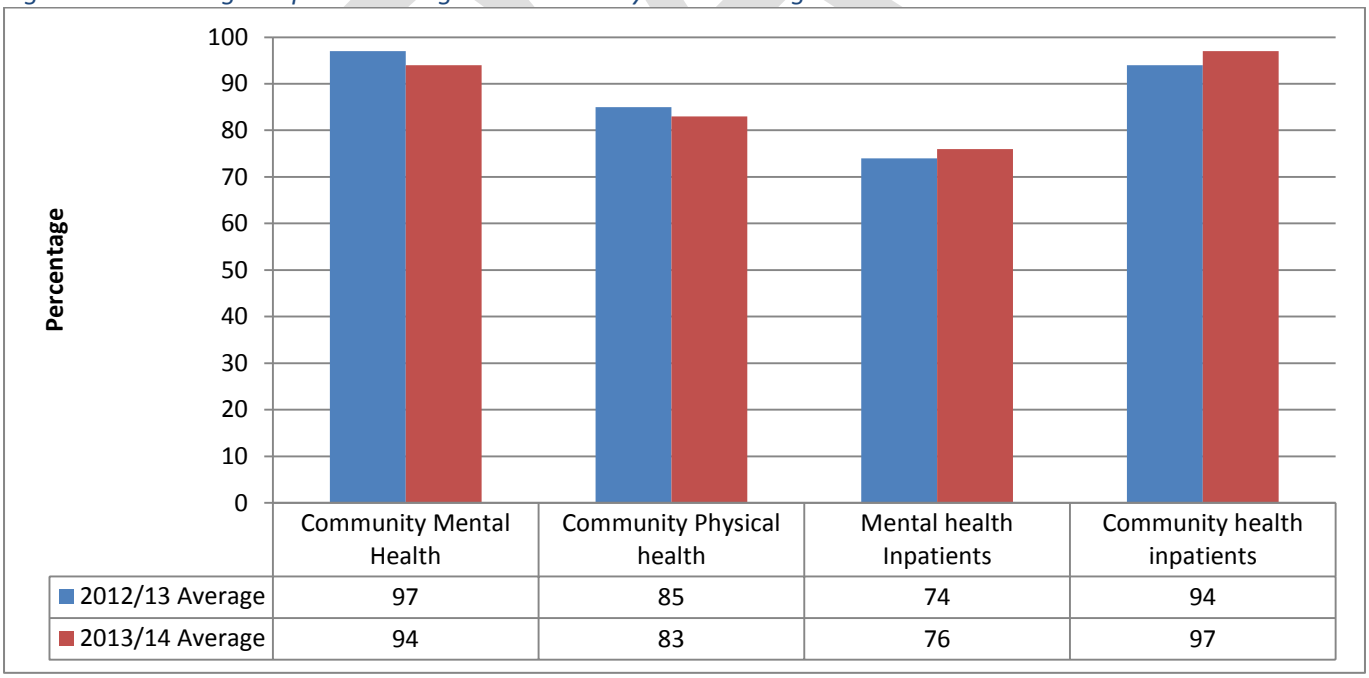
Our goal was to show an increased rate of positive experience over time. Figure 1 below shows the percentage of patients who rated the service they received as very good or good. To date at Q3 a slight decrease in community services and a slight increase in hospital (inpatient) services rated as good or better.

Figures 2 show over 90% of patients who had stayed in a community hospital or visited the minor injuries unit (MIU) at West Berkshire Community Hospital would recommend the services they received to their friends or family.

Figure 3 shows that over 80% of people who had received either physical or mental health care in the community would recommend the service to their friends or family members. Over 70% of people who had been an inpatient and received care for their mental health would recommend the services they received.

Further details on the number or compliments and complaints we received together with actions we have taken can be found in part 3 (p33).

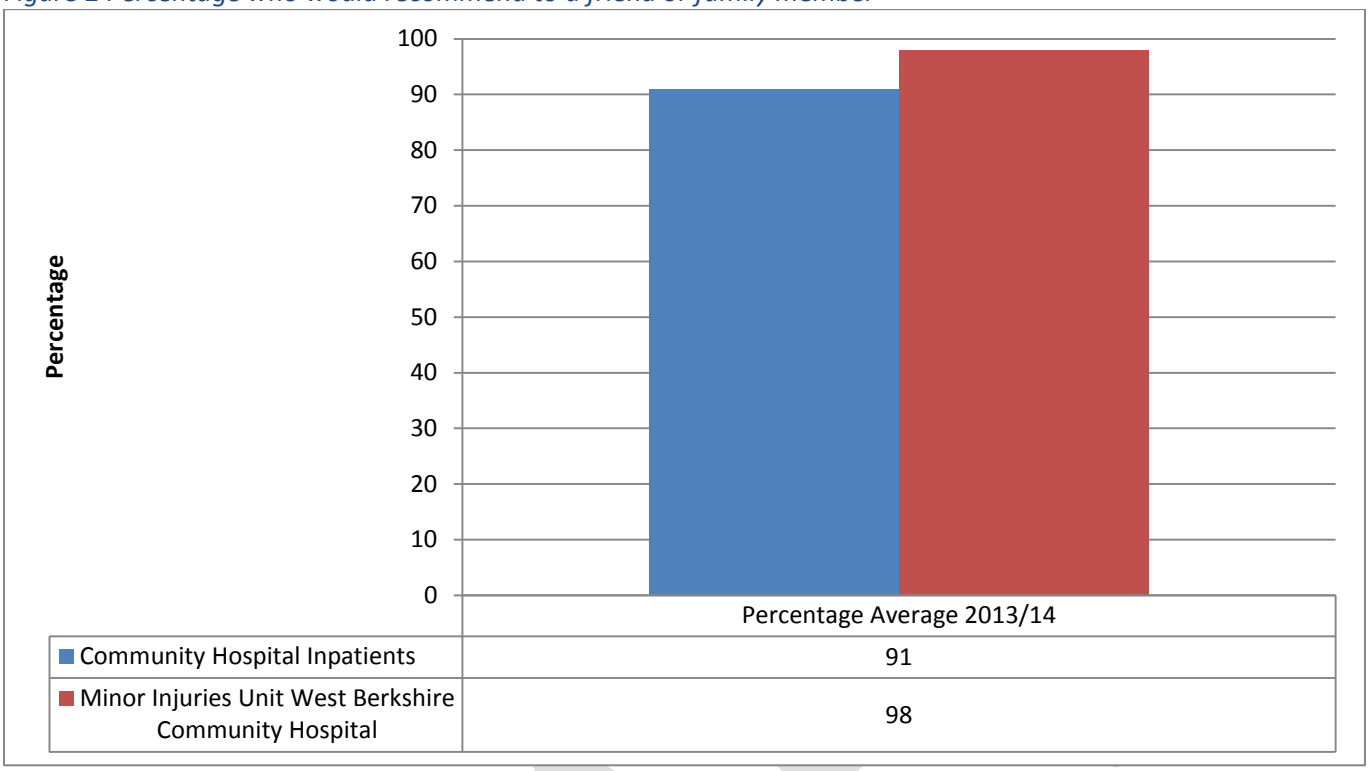
Figure 1. Percentage responses rating the service they received as good or better



	Community Mental Health	Community Physical health	Mental health Inpatients	Community health inpatients
2012/13 Average	97	85	74	94
2013/14 Average	94	83	76	97

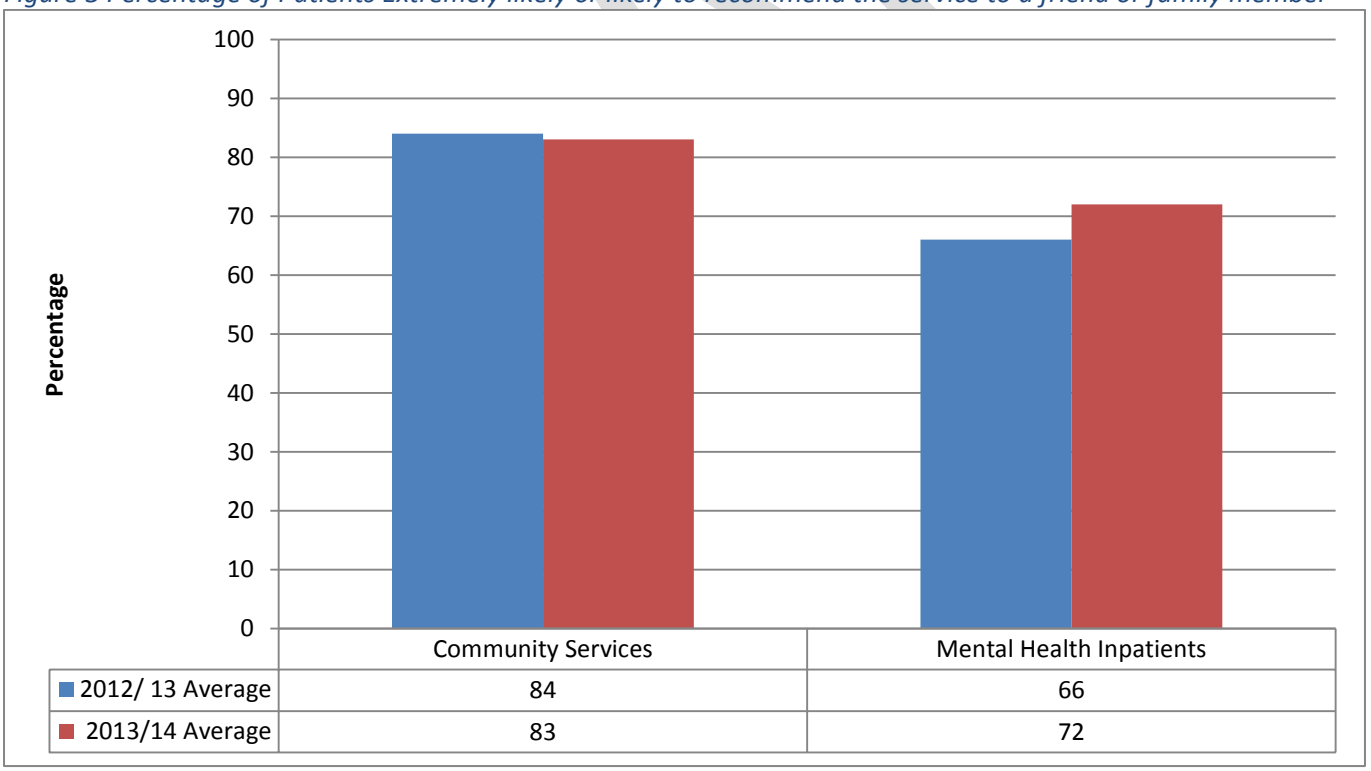
(Year end average rounded to nearest whole number. 2012/13 Community mental health results only include learning disability and older people's services as data for adult and child services are unavailable. CMHT and ECT included for 2013/14)

*Figure 2 Percentage who would recommend to a friend or family member **



** Acute methodology used for Inpatients and MIU although not mandated for non-acute trusts.*

*Figure 3 Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member ***



(Q1, 2 and 3 average (red) compared with full year average for 2012/13(blue)

***Increased number of both physical and mental health community services participated in 2014 compared to 2013*

National Community Mental Health Survey

The national report was published in September 2013 Service users aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 July 2012 and 30 September 2012. Responses were received from more than 13,000 service users nationally (29%).The Trust response rate was 31%.

The results of the survey show once again an improvement in performance, with the Trust demonstrating improvement in 13 areas, remaining the same in 32 areas and worsening in 2.

http://www.nhssurveys.org/Filestore/MH13/MH13_BM/MH13_Berkshire_Healthcare_NHS_Foundation_Trust_RWX.pdf

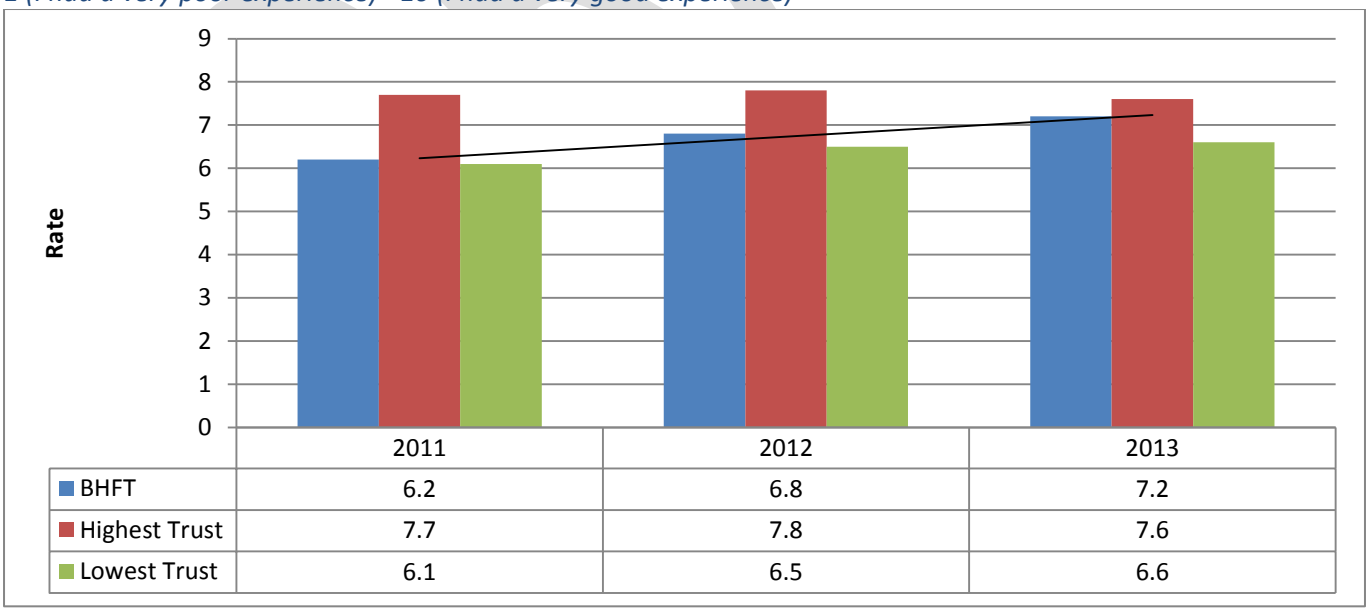
On review of our performance against trusts within NHS South of England we have moved our position significantly. For the overall experience section the Trust was 5th out of 16 regional trusts.

The Care Quality Commission (CQC) rate the Trust 'about the same' as most other trusts (Neither worse nor better).

Actions taken to improve quality:

- Results published across the trust
- Results to be shared with and disseminated into teams for information and discussion.
- Patients written to informing them who their Care Co-ordinator or Lead Professional is, enclosing a copy of the most current care plan
- Psychological skills training programme rolled out between September 13 and March 2014 to the Community Mental health workforce based on the Cognitive Behavioural Skills (CBT) training.
- Improved the advertisement of medicine information sources to staff, patients and their carers.

Figure 4 Overall, how would you rate the care you have received from the Trust in the last 12 months 1 (I had a very poor experience) - 10 (I had a very good experience)



	2011	2012	2013
BHFT	6.2	6.8	7.2
Highest Trust	7.7	7.8	7.6
Lowest Trust	6.1	6.5	6.6

Figure 5 Areas highlighted by the CQC as a significant increase in satisfaction

	2011 Score	2012 Score	2013 Score	2013 Lowest National Score	2013 Highest National Score
In the last 12 months, has a mental health or social care worker checked with you how you are getting on with your medication?	6.6	6.3	7.7 ↑	6.8	8.6
Do you know who your Care Co-ordinator (or lead professional) is?	7	5.4	6.8 ↑	5.5	8.2
Were you given a chance to express your views at the (care review) meeting?	8.5	7.7	8.6 ↑	7.5	9.1
In the last 12 months, did anyone in NHS mental health services ask you about any physical health needs you might have?	6	4.6	5.6 ↑	4.8	6.9
Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?	5.8	5.5	6.7 ↑	5.5	7.5

Whilst the CQC analysis did not identify any areas where there has been a significant decrease in satisfaction, upon reviewing the results in comparison with 2012 there are areas where satisfaction has decreased. These are shown in Figure 6.

Figure 6 Areas with a decrease in satisfaction in comparison with the 2012 survey

	2011 Score*	2012 Score	2013 Score	2013 Lowest National Score	2013 Highest National Score
Were the purposes of the medication explained to you?	8.3	8.2	7.7 ↓	6.1	9.1
Were you given information about the medication in a way that was easy to understand?	7.4	6.7	6.4 ↓	4.7	6.7
Section Score (Talking Therapies) *1	-	7	6.3 ↓	6.2	8.2
Did you find the NHS talking therapy you received in the last 12 months helpful?	6.6	7	6.3 ↓	6.2	8.2
Section Score (Day to Day living)*2	-	5.2	4.9 ↓	4	6.2

**calculations changed from percentage to scores *2 – the scoring methodology for a number of questions within this section has changed for the 2013 survey. The individual question scores for 2012 have been amended and updated however the 2012 section score results have not been revised*

These results suggest that the Trust has made significant improvements in care coordination, involving patients in care planning and in supporting mental health patients with physical health needs, although further improvement is required to be among the best Trusts in these areas. The organisation needs to work hard to maintain high standards with respect to providing accessible information about medicines for patients. There is a need to improve access to talking therapies for people with more severe mental health problems – those on a 'care programme approach'. The Trust is well positioned to respond positively to this as it provides very well regarded talking therapy services (improving access to psychological therapy) across Berkshire.

2013 National Staff Survey

The figure below shows how the Trust compares with other mental health/learning disability trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.

Figure 7 shows the trust's score of 3.83 for overall staff engagement was in the highest (best) 20% when compared with trusts of a similar type.

These Key Findings relate to the following aspects of staff engagement:

- staff members' perceived ability to contribute to improvements at work
- their willingness to recommend the trust as a place to work or receive treatment
- the extent to which they feel motivated and engaged with their work

The trusts score for recommendation as a place to work or receive treatment (figure 9) was significantly higher than 2012 and in the highest (best) 20% when compared to other similar trusts.

Figure 7

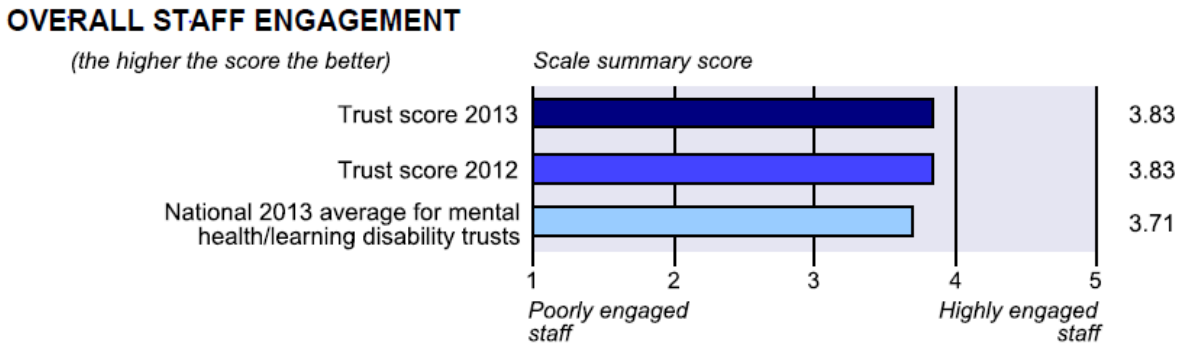


Figure 8

		Your Trust in 2013	Average (median) for mental health trusts	Your Trust in 2012
Q12a	"Care of patients / service users is my organisation's top priority"	71	63	62
Q12b	"My organisation acts on concerns raised by patients / service users"	75	71	69
Q12c	"I would recommend my organisation as a place to work"	62	53	58
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69	59	64
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.75	3.54	3.61

Figure 9

Listening into Action LiA

Our Listening into action (LiA) programme is of central importance as a key means of engaging our staff. It aims to achieve a fundamental shift in the way the Trust works and leads, putting clinicians and staff at the centre of change for the benefit of our patients, staff and the Trust as a whole. It is all about:

- Changing the way we work for the benefit of our staff, patients and the organisation
- Connecting and bringing people together across the boundaries
- Empowering staff to get on and make the changes we all want to see
- Collaborating to come up with good ideas and then quickly turning them into action
- Celebrating our successes and using our stories to inspire others
- Sharing ownership and responsibility for improving care for our patients and working lives for ourselves

The LiA process is now becoming an accepted way of working together to solve issues in the organisation. The 'Big Conversations' between staff and the Chief Executive which identify issues requiring change, the action taken as a result and provision of prompt feedback to staff, all build confidence that concerns raised will be acted upon, and enable staff to get involved in making changes themselves.

We are able to measure the impact of our work to increase staff engagement through the in – house 'pulse' surveys, as well as the national staff survey. Our pulse surveys have shown us to be performing well – improving our scores on all questions asked since last year, with above average scores in comparison to the 24 other Trusts taking part in LiA. Our biggest improvements have been that more staff feel valued for the contribution they make and the work they do (up 21% on last year), and more staff believe we provide high quality services (up 22 %)

'Quick wins' and 'enabling our people schemes' have delivered improvements in key areas identified by staff such as communication, recruitment, care pathways, mobile working and protected reflective time for staff. The three waves of pioneer teams have introduced many high impact changes at team level which have made a real difference to patient care.

Excellent Manager Programme

Our organisational Development Strategy identified the requirement to support our managers in their development and performance – recognising the crucial importance of effective management at all levels.

In response to this, our own 'Excellent Manager' programme has been developed and is being implemented. It is important to emphasise that this programme was developed by talking to people about what they wanted and needed, and also by listening to what people said in the LiA Big Conversations. Through this programme we are aiming to align good management skills and practice with our new values based framework for appraisal. We firmly believe that designing the programme around the needs of our staff is the most significant factor in the success of the programme – which has received exceptional feedback from participants so far.

Talent Management

As part of our Organisation Development strategy the Trust identified Talent Management as a key priority, and we have subsequently become one of the organisations participating in a national talent management pilot, overseen by the NHS leadership academy.

This provides a way of identifying early potential, a mechanism for individuals to signal their intent, insight into where there are gaps in talent development and a way of ensuring business continuity and being prepared for unanticipated departures / absences. The process is aligned with and driven by the new values based appraisal system.

2.1.2 Patient Safety

Aim: To protect patients from avoidable harm.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from;

1. Pressure ulcers
2. Falls
3. Urinary infection in patients with catheters
4. VTE (venous thromboembolism)

The trust wanted to reduce the amount of harm by identifying and learning from our incidents and to demonstrate continued improvement in relation to these important patient safety measures.

These four harms were selected as the focus by the Department of Health's Quality Innovation productivity prevention (QIPP) Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care.

The concept of Harm Free Care was designed to bring focus to the patient's overall experience. Data has been collected for all the eligible patients seen on one day of the month. Data is collected on a monthly basis from the inpatient community hospital wards, older people's mental health wards, learning disabilities units and community teams, and all community nursing and older people's mental health nursing. There has been significant improvement in the data accuracy with teams being challenged when the data submission sheet is not correctly completed

Figure 11 shows the percentage of harm free care per month compared to the national harm free figure.

On average during quarter 3, 91.96 % of patients received harm free care compared with 89.29% in Quarter 2.

There has been a gradual increase in the percentage of patients who receive harm free care. The national average is 93.5%. The Trust may have a lower number of harm free patients due to the significant number of old pressure ulcers. This means that patients have acquired the pressure ulcers in another setting before coming in to the care of the Trust.

The numbers of harm free care have increased since the training of staff on the correct definitions of the harms and the increase in the number of patients surveyed. The majority of patients only have one harm.

Appendix C details the individual charts depicting the level of harm from Pressure ulcers, Falls, Urinary infection in patients with catheters, and VTE (venous thromboembolism. The charts demonstrate the number of harms that each patient acquired.

The majority of patients who suffer a harm recorded for the month only have one harm

Pressure ulcers remain the highest harm. However since May there has been a reduction in the number of pressure ulcers reported.

There has been a reduction on the MEAN number of pressure ulcers which have developed on our wards over the last 6 months from the previous 6 months.

The Pressure Ulcer strategy is focused on zero tolerance of new pressure ulcers and the impact of this will be monitored at the pressure ulcer strategy group. There is new training for all clinical staff; all new pressure ulcers are reviewed by the ward and Deputy Director of Nursing at a monthly meeting. There is also to be a patient awareness raising campaign.

There have been 3 wards that have not had a developed pressure ulcer for 90.

The next 6 months will be monitored to assess whether the pressure damage prevention campaign had made a difference to the number of pressure ulcers across the trust. The trust compares favourably with other community trusts on their new harms.

Source: Berkshire HealthCare Foundation Trust Patient Safety Thermometer feedback Quarter 23 report 2013/14

Figure 11 –Percentage of Harm free care

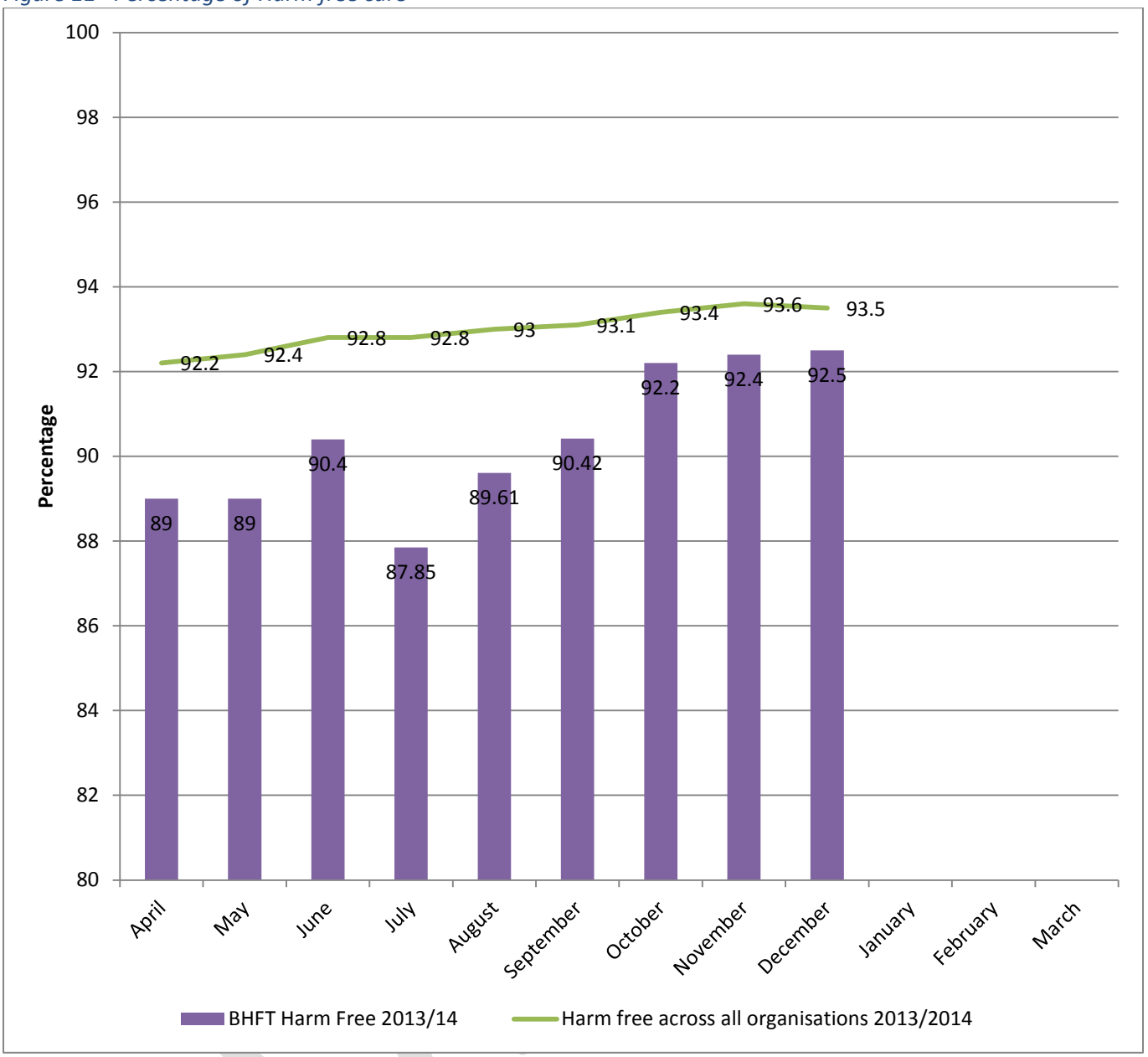
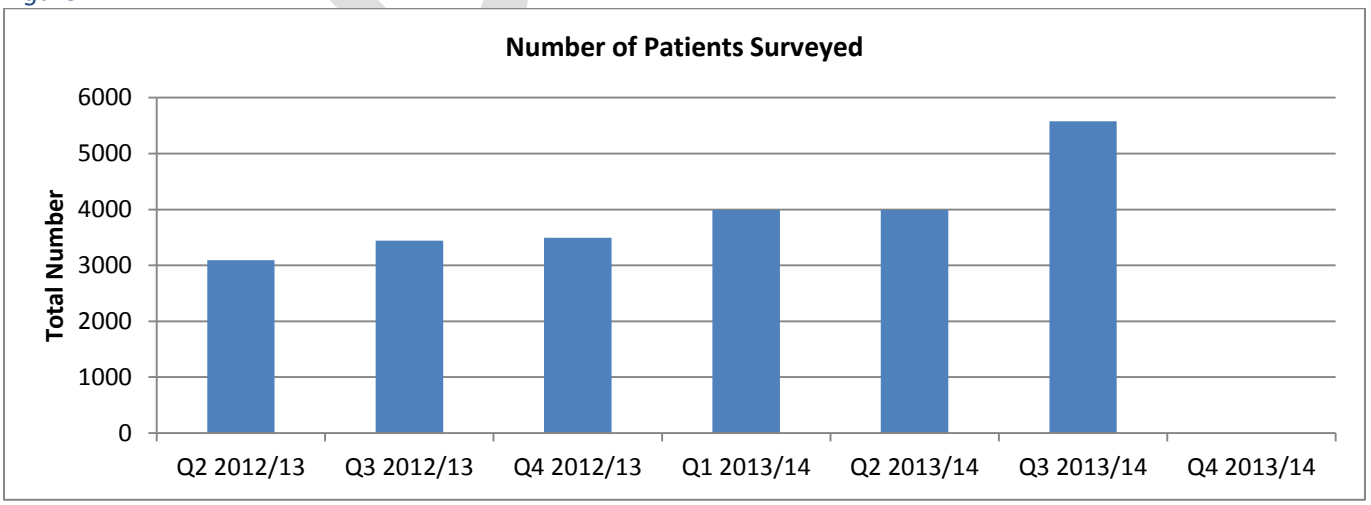


Figure 12



2.1.3 Recovery

Mental Health

Aim: To enable people to recover from episodes of ill health and enhance their quality of life.

Primary Measures:

1. To continue to offer the mental health recovery star and Wellness Recovery Action Plans (WRAP) with improved uptake for people with enduring mental health problems.

During 2012/13 the Trust focussed on the training of staff in the use of the mental health Recovery Star and

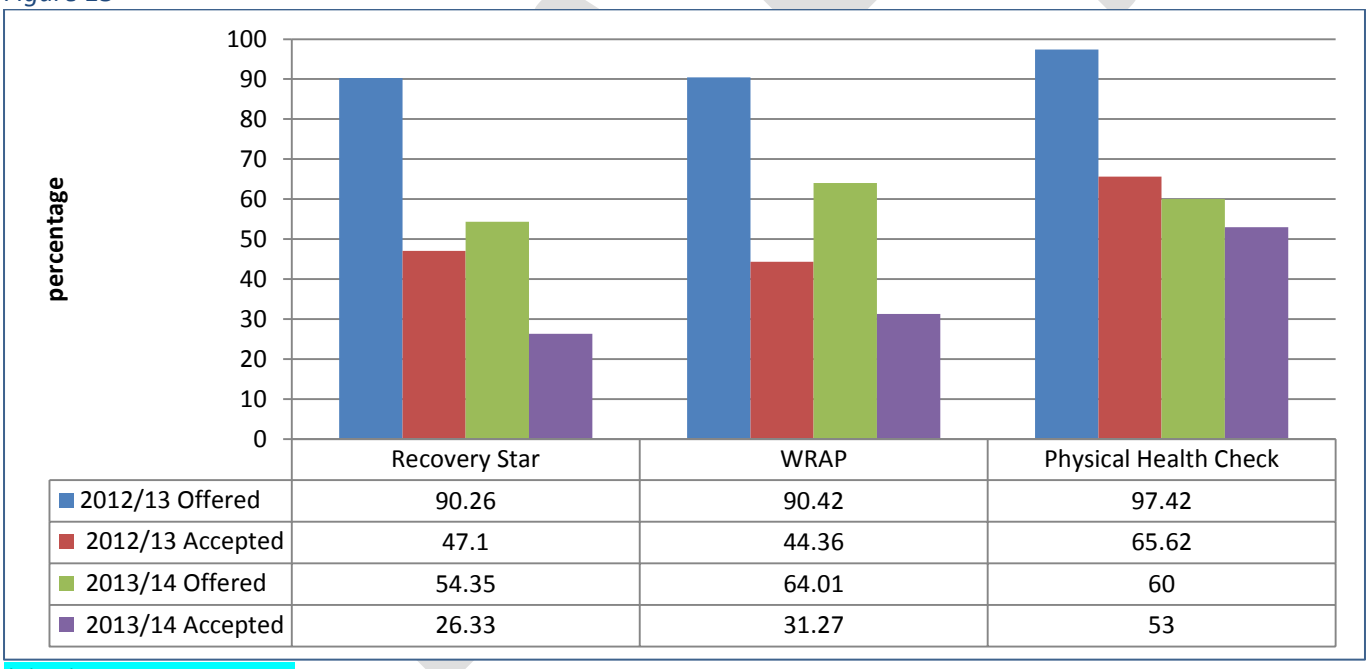
(CPA) are being offered the use of these tools in their care plans. The aim is to build on these metrics and seek ways to demonstrate improvements in the recovery outcomes for patients during the next year. Wellness Recovery Action Plans (WRAPs) and ensuring that patients on an enhanced Care Plan Approach

Figure 13 shows that there has been a decline in Q3 of the number who were offered and who accepted both Recovery star 54% and WRAP 64% of clients were offered the use of a Recovery Star and WRAP, of these26% (38% Q2) and 31% (42% Q2) retrospectively accepted the offer and proceeded to engage with the method of recovery. An action plan is being put in place led by the West Berkshire Locality Director to resolve this before the end of the year.

To be updated Q4

60% of clients have been offered a physical health check to date and of those 53% have accepted.

Figure 13



	Recovery Star	WRAP	Physical Health Check
2012/13 Offered	90.26	90.42	97.42
2012/13 Accepted	47.1	44.36	65.62
2013/14 Offered	54.35	64.01	60
2013/14 Accepted	26.33	31.27	53

* (Q3) to be updated Q4

Physical Health

The process of engaging people in their care, supporting them to take control and get the most out of life with a long term condition (LTC) is the central thread of the LTC strategy. Planning care in this way is more proactive and meets individuals' full range of needs. Patients who are better able to self-manage also have fewer contacts with health services.

Aim: To enable people to recover from episodes of ill health and enhance their quality of life.

Primary Measures:

1. To demonstrate for people with long term conditions that wellbeing outcomes are measured and associated plans implemented to help people make the most of their lives.

Three LTC which are reported on within this account are:

1. Heart Failure
2. Cardiac Rehabilitation
3. Neuro rehabilitation

Heart Failure

Heart failure affects over 1% of the population causing symptoms of breathlessness, oedema and fatigue and has a negative effect on quality of life worse than many long term conditions (Hobbs et al. 2002).

Treatments are led by physical symptoms and yet the National Institute for Health and Clinical Excellence and others state treatment plans need to be individualised and should consider all aspects of physical and psychological health (NICE, 2010).

The Heart Failure Service began to use an assessment tool to measure and monitor quality of life in heart failure patients from January 2012.

An internal audit of patients under the care of the Berkshire Healthcare NHS Foundation Trust Heart Failure Service showed that although asked if they have a history of depression, there was no evidence to illustrate quality of life had been assessed. Therefore a measurement tool was needed to assess and monitor quality of life in heart failure patients to meet key service outcomes of improving quality of life and developing patient centred plans of care.

Over the last year the tool has become established within the assessment process and is routinely used by all specialist nurses in the team. Analysis of scores revealed 41% of patients have a poor quality of life (Figure 14) and a breakdown of domains into physical and emotional components showed that those who had high sub scores also scored highly in their overall assessment.

420 patients have been assessed and these results and graphs remain fairly static. Although number are small, the team is are now beginning to record scores on discharge and it can be seen that there is a reduction in poor quality of life scores from 41% to 17% and 'good' quality of life has increased from 31% to 50% (Figure 15)

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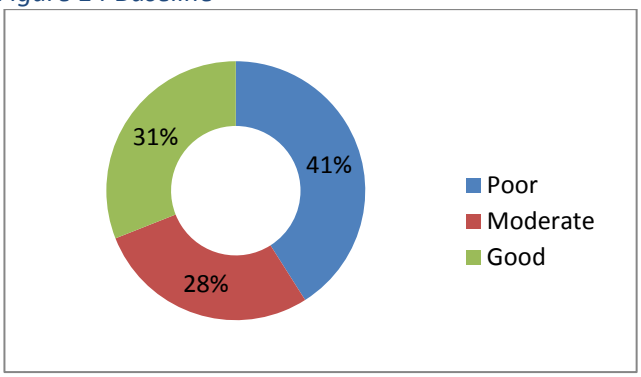
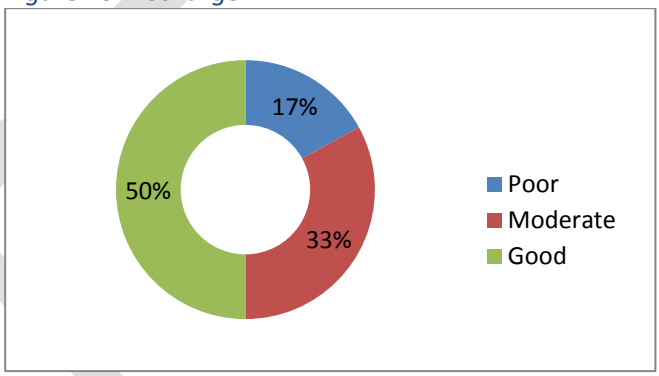
Figure 14 Baseline



Minnesota Living with heat Failure tool

Figure 15 Discharge



The results show that poor quality of life is an on-going issue for patients living with heart failure. In the next month our first Living Life with Heart Failure Course is starting, this is a new initiative with the IAPT Talking Health Team and as is open to all of our heart failure patients. The course is 6 weeks long and is intended to help them cope with their diagnosis. It will start in the Reading locality. Over the next year the service aims to address this with the following:

1. Enhancing the service to provide appropriate psychological support allowing the heart failure team to adhere to NICE guidelines of individualised care planning considering physical and psychological health, and meet local service outcomes of improving quality of life.
2. Heart failure nurses to complete appropriate IAPT training.
3. Work with local colleagues to develop pathways for onward referral where needed.
4. Ensure all patients have their quality of life assessment repeated on discharge from the service.
5. Long term patients to have their quality of life assessed every six months to monitor the effectiveness of interventions whether physical or psychological.

Cardiac Rehabilitation

There is evidence that exercise-based cardiac rehabilitation: is effective in reducing total and cardiovascular mortality and hospital admissions in people with coronary heart disease and reduces all-cause and cardiovascular mortality rates in patients after myocardial infarction (MI heart attack) when compared with usual care, provided it includes an exercise component significantly reduces hospitalisation for chronic heart failure and significantly improves quality of life and exercise tolerance for people with heart failure.

The aim of the programme is to reduce the risk of subsequent cardiac problems and to promote a return to a full and normal life. The Figure 16 (April 2013/Oct 2013) shows that 281 (69%) of patients achieved an increase in their level of fitness by at least 10% with a further 65 (16%) achieving a partial improvement (0-10%).Pre and post scores 'achieved' represents a 10% or more improvement in patients level of fitness after the intervention of cardiac rehab, Partially achieved means a 0-10% improvement in patients level of fitness after the intervention of cardiac rehab

Neuro rehabilitation

The National Service Framework (NSF) for Long-term Neurological Conditions requires rehabilitation resources to be available at all stages in a neurological condition, in both community and hospital Settings. The Neuro-Rehabilitation team works with people aged 18 and above with acquired and long-term neurological conditions, helping them to achieve maximum independence in all aspects of daily life

The Neuro-Rehabilitation team works with people aged 18 and above with acquired and long-term neurological conditions, helping them to achieve maximum independence in all aspects of daily life

The Canadian Occupational Performance Measure (COPM) is an individualized, client-centred measure designed for use by occupational therapists to detect changes in a client's outcomes in areas of self-care productivity and leisure. The Figure 17 shows that 78% of patients achieved their outcome goals.

Fig 16

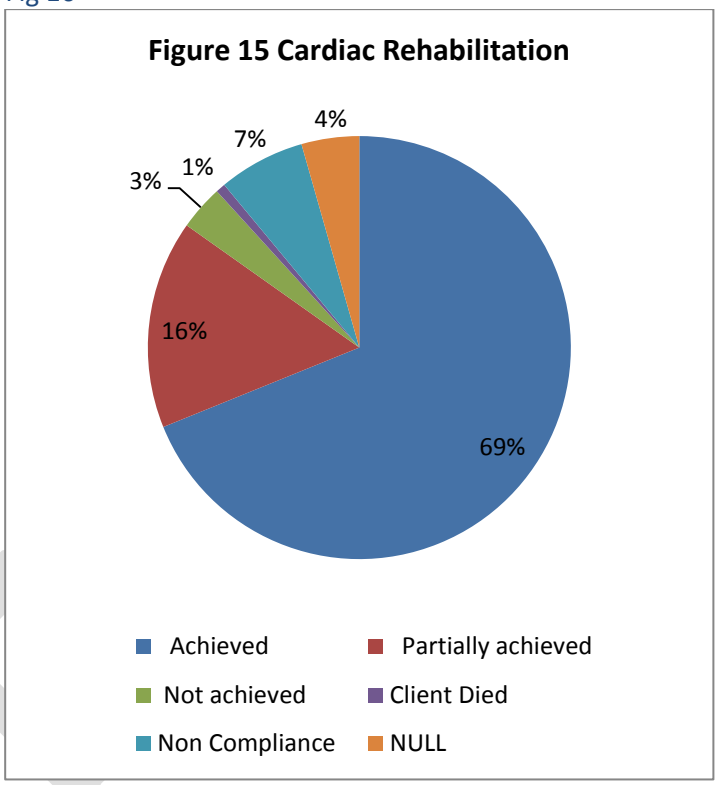
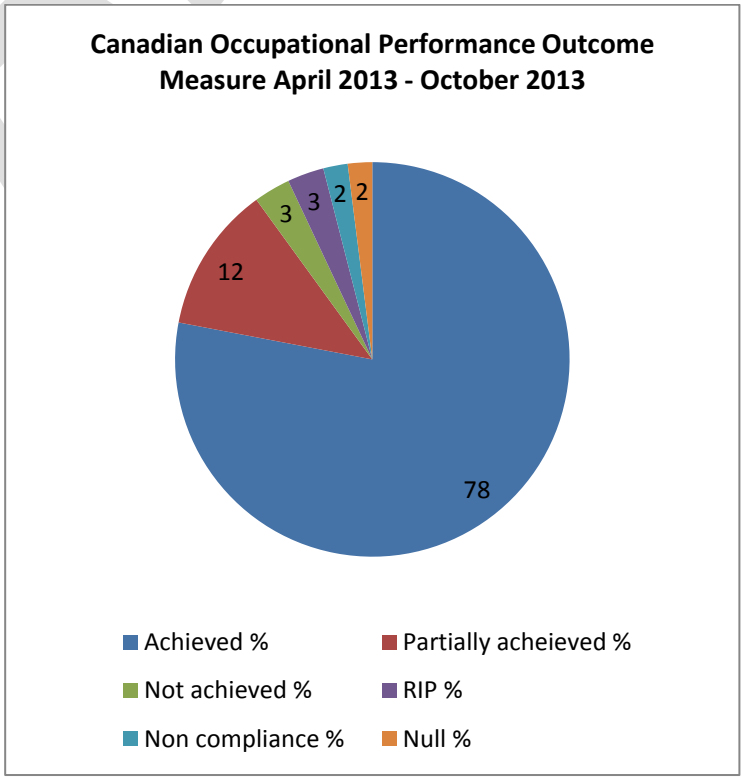


Figure 17



2.1.4 Dementia and Mental Health in acute hospitals

Aim: To improve dementia care and mental health liaison for people in acute hospitals in Berkshire.

Primary Measures:

1. Training of acute hospital staff across Berkshire to improve dementia awareness. To train 3000 staff (cumulative) to support admission avoidance and reduce length of stay as well as improving quality of care.

There has been progress on development of the older people's mental health liaison team in East Berkshire. There are regular ward rounds on care of the elderly wards in Wexham Park Hospital; which includes supporting those patients with:

- Self-harm and attempted suicide.
- Behavioural problems associated with dementia: aggression; agitation; wandering.
- Functional mental health disorders: mania; psychosis; psychotic depression and severe depression with poor food and fluid intake.
- Delirium
- Discharge planning for complicated delayed discharges.
- Complex capacity assessments requiring specialist second opinion

In addition to the improved management of dementia patients in the hospital. The referral rate has increased, with more referrals for functional psychiatric problems. Heatherwood and Wexham Park Foundation Trust have introduced dementia awareness training for their staff. Further outcomes will be available by year end (Q4)

In the West of the county Berkshire West Clinical Commissioning Groups (CCGs) have agreed to fund an expanded Hospital and Community based liaison services for 2014/15. The hospital based service will be located within the Royal Berkshire Foundation Trust Hospital and brings together the current older peoples health liaison team, A&E liaison and the children's and adolescents mental health self-harm post, which with additional investment will form an integrated Hospital liaison service.

The Community Liaison service will incorporate the Medically unexplained symptoms (MUS) service, and will focus on supporting timely discharge of patients from the Royal Berkshire Foundation Trust, and improving outcomes for people with long term conditions who are reviewed through integrated cluster teams. The East and West clinical commissioning groups have confirmed funding for 2014/15 to consolidate and further develop the liaison psychiatry initiatives in the community that began in 2012. The funding will enable the consultant liaison psychiatrist to continue collaborative working with primary care and acute trusts in Berkshire.

In brief, the community initiatives include:

- Providing specialist intervention for medically unexplained symptoms in collaboration with clinical health psychology, IAPT and general practitioners to reduce inappropriate healthcare utilisation. The project received 70 referrals in year 1 and 65 referrals (ongoing) in year 2.

- Outpatient assessment and management of patients with medically unexplained neurological symptoms (MUS). This weekly clinic at the Royal Berkshire Bracknell Clinic has received 70 referrals since it was set up in August 2012.

- Outpatient assessment and management of patients with respiratory long term conditions (LTC) and comorbid psychological distress. This weekly clinic at King Edward VII chest department has received 55 referrals since it was set up in February 2013.

- Primary care liaison in the form of assessment and management of complex patients with medically unexplained symptoms and physical/psychological comorbidity as part of the Common Point of Entry service. This initiative includes assessments in all 6 localities across Berkshire and has received 103 referrals since it was set up in June 2012.

- Education and training of general practitioners, acute care clinicians and mental health professionals in the management of complex conditions with physical and psychological overlay.

2.1.5 Health Inequalities

The Trust is increasingly focussed on developing its contribution and commitment to tackling health inequalities. Ensuring fair access to services, enabling children and young people to maximise their capabilities and have control over their lives, contributing to fair employment and good work for all and strengthening ill health prevention.

Aim: To ensure that service provision is targeted to population need.

Primary Measure:

1. A baseline assessment to identify where action is required for adult services. It is anticipated that the focus will be within the Reading and Slough localities and the needs of diabetic patients
2. Allocation of further additional health visitor resources to reflect the population need and levels of deprivation.

Following a workshop in May, all localities within BHFT have set objectives. The following list highlights developments:

•**Slough** mapping of diabetes clinic attendance and other diabetes patients usage of services is on track. Data due in Quarter 4.

•**Reading** locality working jointly with Berkshire Diabetic Eye Screening service to improve awareness and ethnicity recording so that mapping of diabetes patients in Reading can be undertaken accurately in the future; the relationship between diabetes prevalence and disadvantage/ diabetes and ethnicity has been analysed. The locality is also developing a project to educate Reading based CMHT patients who are also diabetic about the management of their condition. Data due in Quarter 4.

•**Bracknell** seeking additional funding to provide young SHaRON (web-based peer support to young parents); recording of perinatal patient data on track, analysis against baseline delayed; scheduled IAPT support provided on monthly basis to children's centres; outstanding data reports requested for quarter 4.

•**Wokingham** specialist health visitor (HV) is making good progress engaging the local Gypsy, Roma and Traveller (GRT) community across a number of settlements; significant success reported by HV in tackling Measles, mumps and rubella (MMR) immunisation rates, and raising awareness of major health conditions and providing other support/equipment; outstanding data reports requested for quarter 4.

The 'Family First' initiative in Wokingham involves health visitors, school nurses, child, adolescent and adult mental health, social services and other partners working with troubled families. The group has worked with about 80 families so far with impressive outcomes:

Health: members of all but one of the families have underlying health needs, either physical or emotional, which were previously untreated.

Criminality and antisocial behaviour: All but two of the families identified for criminality and antisocial behaviour have stopped offending completely.

Education: School attendance for the young people of statutory school age has increased from an average of 20% to over 85%

Employment: 41% of families now have an adult who has entered employment (many for the first time)

•**Windsor and Maidenhead** are focussing on the physical health needs of mental health patients and are developing a web-based database to facilitate the monitoring of physical health care for this group.

Quote – 'Since being involved in the MH Forum I have learned more about the things I can get involved in. I enjoy working on Community Mapping. When I get out and about I feel I am doing something worthwhile. Sometimes you think life is a lump of coal, but if you chip away slowly you will find a glimmer of the nugget of gold'

•**West Berkshire** face-to-face Learning Disability training for clinicians on-going, Trust-wide training needs identified and roll out planned for November 2013; improvement in recording LD data evidenced; Easy read Podiatry information being piloted. Reports on LD patient satisfaction requested for quarter 4.

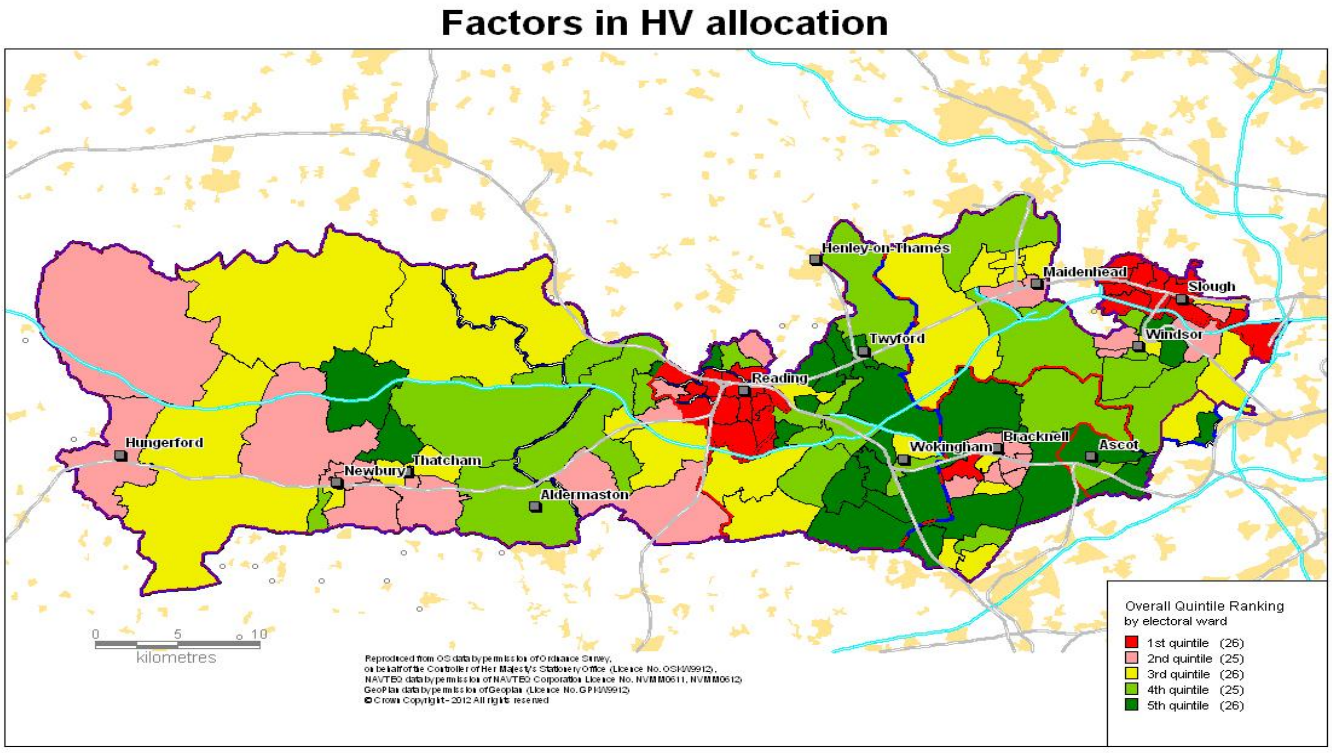
•**Mental Health Inpatients and Urgent Care** - Urgent care questionnaire on cultural competence being undertaken; tools being sourced for inpatient teams based on patient satisfaction data. Awareness raising conferences taking place in November 2013 (South Asian culture/mental health) and Spiritual care/mental health conference being planned for February 2014. Reports on patient data and patient satisfaction requested for quarter 4.

Health Visiting

The planned allocation of the 24 new health visitor posts for 2013/14 this year was based on the commissioner's decisions and the deprivation in each locality. However it became apparent in the year that the Trust was in danger of not meeting the target of recruitment so the decision was made to take on new staff to whichever area they wanted to work to ensure we did not lose them. This has been successful and we have retained the vast majority of staff trained and expect to meet the March 2014 target (some staff still in recruitment process so cannot finalise this yet.)

In 2014/15 we will be using this year's allocation of new staff to rectify any mismatch of staff to need arisen due to this change in recruitment using the overall deprivation and incorporating the version of the model below (Figure 18).This will be done following confirmation of posts for this year . The end result will be that by March 2015 the new HV posts will be allocated to ensure that all caseload sizes reflect the appropriate needs of the locality

Figure 18



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2.2 Priorities for Improvement 2014/15

The Trust's first goal is to provide accessible, safe and clinically effective services that improve patient experience and outcomes of care. In March 2014 (subject to ratification) the Trust is formally launching its Quality Strategy (Appendix A note) both the strategy and quality priorities linked to it will enable us to deliver this goal. Below are the 2013/14 priorities alongside the proposed development of the priority for 2014/15.

2.2.1 Patient Safety

In 2013/14 we aimed: To protect patients from avoidable harm

Primary Measure: The NHS Safety Thermometer.

1. Pressure ulcers
2. Falls
3. Urinary infection in patients with catheters
4. Treatment for VTE (Venous Thromo-Embolism)

Outcome: To reduce the amount of harm by identifying and learning from our incidents. To demonstrate continued improvement in relation to these important patient safety measures

Proposed for 2014/15

In 2013 we participated in the South of England Improving Safety in Mental Health Collaborative. This programme has been set up to improve safety in mental health. The aim of the programme is to develop and build a culture of patient safety and quality improvement with the support of a Patient Safety Faculty with expertise in Improvement Science. The programme focuses on four key areas to reduce harm to users of mental health services.

Aim: to continue to protect patients from avoidable harms

Primary Measure:

1. To have a positive patient safety culture within the trust.
2. Safe and reliable delivery of mental health care

Outcome:

1. Increased positive staff survey response to questions regarding incidents and learning.
2. Deaths as a result of self-harm in patients in receipt of care from community teams reduced to zero or greater than 300 days between such events by March 2015;
3. Severe harm in patients on inpatient wards reduced to zero or greater than 300 days between such events by March 2015;
4. Severe harm in patients in receipt of care from community teams reduced to zero or greater than 300 days between such events by March 2015;

Additional Option

For 2013/14 we reported on pressure ulcers within the patient safety thermometer. For 2014/15 we will focus particularly on Pressure ulcers, building on our pressure ulcer prevention campaign 'Under Pressure – our journey from inevitable to zero'. Pressure ulcer prevention champions have been appointed as part of this campaign. We will prioritise a clear outcome with respect to this.

Primary measure:

Our aim is to achieve no developed pressure ulcers on community and mental health wards. We will report on the number of days without a developed pressure ulcer on each of our wards and aim to exceed 120 days on all wards during 2014/15.

2.2.2 Clinical Effectiveness

In 2014 we aimed: To enable people to recover from episodes of ill health, enhance their quality of life and improve dementia care for people in acute hospitals in Berkshire.

Primary Measures:

1. To demonstrate for people with long term conditions that wellbeing outcomes are measured and associated plans implemented to help people make the most of their lives.
2. To continue to offer the mental health recovery star and Wellness Recovery Action Plans (WRAP) with improved uptake for people with enduring mental health problems.

Outcome: Increased rate of uptake over time for recovery star and WRAP

Primary Measures:

1. Training of acute hospital staff across Berkshire to improve dementia awareness.

Outcome: To train 3000 staff (cumulative) to support admission avoidance and reduce length of stay as well as improving quality of care.

Proposed 2015

Aim: to provide services based on best practice

Primary Measures:

1. Implementation of the National Institute for Health and Care Excellence (NICE) Quality Standards to include but not exclusive to:

a. Self-Harm
b. ADHD
c. Dementia

2. Implementation of PH48: Smoking cessation in secondary care: acute, maternity and mental health services.
3. Increasing access to psychological therapies in secondary care this will include mapping of skills within the workforce training and supervision of staff.

Outcomes: In line with NICE recommendations we will strive for 100% against quality measures within the quality standards and aim to fully implement smoke free services for 2015. Details of a CQUIN in relation to increasing access to psychological therapies are being negotiated with commissioners. The outcome will be included as a quality account priority in line with a request from Trust Governors.

2.2.3 Health Inequalities

In 2014 we aimed: To ensure that service provision is targeted to population need.

Primary Measure:

1. A baseline assessment to identify where action is required for adult services. It is anticipated that the focus will be within the Reading and Slough localities and the needs of diabetic patients
2. Allocation of additional health visitor resources to reflect the population need and of deprivation.

Proposed 2015

Aim: to ensure that services are based on need.

Primary Measure:

1. Following the identification of the baseline assessments by services in 2014 to ensure that the actions identified are implemented.
2. Local health inequalities initiatives will be reported on
3. Achievement against the target of 185 whole time equivalent health visitors by April 2015 allocated to best meet population need.

2.2.4 Patient Experience

In 2014 we aimed: To ensure patients and carers have a positive experience of care and are treated with dignity and respect

Primary Measure: Friends and Family test

1 "How likely are you to recommend our service /ward to friends and family if they needed care or treatment."

Outcome: to show an increased rate of positive experience over time

Proposed 2015

Aim: To continue to ensure patients and carers have a positive experience of care and are treated with dignity and respect.

Primary Measures.

1. Friends and Family Test
2. Learning from compliments and complaints

Outcome: to show an increased rate of positive experience over time

As part of this we will also report on measures to demonstrate that people with learning disabilities, cognitive and memory problems are having a positive experience of care and treated with respect and dignity.

Improving patient Involvement will be a key theme for the Trust during 2014/15. Initiatives to further enhance this will be developed and implemented following a presentation to the Board at the start of the year. Examples being considered include:

1. 'Listening into action' events with staff to identify the best ways to remove barriers to better patient and carer involvement in their clinical areas.
2. 'Listening into action' events with patient and carer groups to improve care.
3. Closer association with key local and national patient representative groups and charities to help improve the development of services.
4. The employment of a patient involvement lead and champion reporting directly to the Chief Executive and sharing best practice across the Trust and beyond.
5. Increased involvement of experts through experience on key quality groups and committees.
6. Enhanced patient quality feedback systems to encourage and respond to suggestions for improvement.

Monitoring of Priorities for Improvement.
By the end of June 2014 we will have agreed the detailed action plans and improvement targets that will deliver the priorities. They will be monitored on a quarterly basis by the Quality Assurance Committee as part of the Quality report and the Board of Directors will be informed of performance against agreed targets. We will report on our progress against these priorities in our Quality Account for 2015.

2.3 Statements of Assurance from the Board

During 2013/14 the Trust provided 72tbc NHS services. The Trust Board has reviewed all the data available to it on the quality of care in all 72 of these NHS services. The income generated by the NHS services reviewed in 2012/13 represents 100% of clinical services and 89% of the total income generated from the provision of NHS services by the Trust.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Improvements in the metrics used and processes in place to gather good quality data in these areas were implemented early in 2013/14. The key quality performance indicators presented to the Board have been further reviewed. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.4 Clinical Audit (Q3 to be revised Q4)

During 2013/14, 10 national clinical audits and 1 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare Trust provided.

During 2013/14 Berkshire Healthcare NHS Foundation Trust participated in 100% (n=8) national clinical audits and 100% (n=1) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in (figure 20)

The reports of 3 (100%) national clinical audits were reviewed in 2013/14. This included 2 national audits that collected data in 2011/12 or 2012/13 that the report was issued for in 2013/14. (figure 20)

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed in table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number registered cases required by the terms of the audit or enquiry.
Local Audits

- Registered – 157
- Completed- 56 (may have started in previous year)
- Active – 159 (may have started in previous year)
- Awaiting action plan - 19

The reports of 51 local clinical audits were reviewed by the Trust in 2013/14 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare. (NB: Projects are only noted as 'completed' after completion of the action plan implementation, which is why there are more local projects 'reviewed' than total 'completed').

The reports of all the national clinical audits were reviewed in 2013/14 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare.

Full details Actions planned by the Trust, as a result of these national and local audits, will be included in the final Trust Quality Account for 2013/14.

2.5 Research (Q3 to be revised Q4)

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited to end of December 2013/14 to participate in research approved by a research ethics committee was as follows:

241 patients were recruited from 61 active studies, of which 115 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 126 were from non-Portfolio studies.

Figure 19 R&D recruitment figures 2013/14 Q3

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	115	28
Student	111	26
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	15	7

The Trust has been active in the development of the Oxford Academic Health Science Network (AHSN) and has been particularly focussed on ensuring that community and mental health services are prominent in the priorities of the network.

The Oxford AHSN incorporates a 'Best Care' programme which involves a series of clinical networks. Mental health networks have been developed within the AHSN with respect to dementia; improving access to psychological therapies for depression and anxiety; early intervention in mental health and physical/mental health comorbidities.

Linked to these developments there has been further close collaboration with the University of Reading including the opening of the Berkshire Memory and Cognition Research Centre.

Figure 20

National Clinical Audit and Patient Outcomes Programme (NCAPOP) Audits	
National re-audit of schizophrenia (NAS) (2013)	Data collected October 2013 111 patients submitted, across adult and CAMHS
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Data collected November 2013 – January 2014 Data submitted for 1 GP surgery, out of 1 relevant GP surgery (170 patients 100%)
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients –Nil return
Non-NCAPOP audits	
Prescribing for ADHD (March 2013)	Data collected March-April 2013 126 patients submitted, across adult and CAMHS
Prescribing anti dementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS
Monitoring of patients prescribed lithium	Data collected June 2013 104 patients submitted.
Use of antipsychotic medication in CAMHS	January 2014 Data collection currently in progress. Minimum of 10 patients per locality to be submitted.
National Memory Clinics Audit	Data collected July-September 2013 6 clinics submitted, out of a relevant 6 (100%)
National Confidential Inquiries	
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness (NCISH)	8 (100%)
Other audits reported on in-year (data collected in previous year(s)	
National Audit of Schizophrenia (2011)	Involved 80 patients in a case note review, with 30 service user responses and 22 carer responses to survey. Initial Trust level report received April 2012 and final national report December 2012. Reviewed April 2013
Prescribing antipsychotic medication for people with dementia	Data collected Sept 2012 1,016 patients submitted, across older adult teams east and west.

2.6 CQUIN

A proportion of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and the Primary Care Trusts, NHS Berkshire through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period can be found in Appendix F and G

The income in 2013/14 conditional upon achieving quality improvement and innovation goals is £4,074,898. The associated payment received for 2012/13 was £4,100,918.

2.7 Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against Berkshire Healthcare Foundation Trust during 2013/14. Berkshire Healthcare Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The CQC inspected three of our services during 2013/14;

1. Sorrell Unit (Psychiatric Intensive Care Unit) at Prospect Park Hospital,
2. Ryeish Green Children's Respite Unit
3. Berkshire Adolescent Mental Health Unit (BAU) at Wokingham Community Hospital.

Sorrell Unit was assessed as being compliant with three of the five 'Outcomes' assessed, but received an improvement notice in respect of Outcome 1 (Respecting and involving people who use services), and Outcome 2 (Consent to care and treatment). For Outcome 1, the CQC said, "It was not clear if people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care". For Outcome 2, the CQC said, "It was not clear that care and treatment was planned and delivered in a way that ensured people's safety and welfare". On this latter point, the CQC wanted to see improvement in the quality and triangulation of risk assessments, care planning and progress notes recorded on the Trust's clinical record keeping system. BHFT has put actions in place to address these issues.

Ryeish Green and BAU were assessed as meeting all of the Essential Standards inspected.

The Trust received a CQC Mental Health Act (1983) Monitoring Visit during the reporting period. This visit, the first of its kind involving BHFT, involved the CQC engaging multiple agencies and service users to evaluate standards of assessment and detention of mental health patients in accordance with the Act. The assessment identified areas of good practice and positive feedback, alongside developmental issues to be addressed by BHFT, its commissioners and partner agencies.

The Trust had an internal CQC inspection programme for 2013/14 which was delivered to provide assurance to the Executive and Board that CQC compliance with the essential standards is maintained across all services, and to highlight any risks to compliance.

The current CQC Quality & Risk Profile (Appendix D) published on 31st January 2014. Shows one change since the last profile published in November 2013. Outcome 11: (R16) Safety, availability, and suitability of equipment has improved from a high green to a low green rating.

2.8 Data Quality

Berkshire Healthcare Foundation Trust submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:
99.9% for admitted patient care
99.9% for outpatient care.

The percentage of records which included the patient's valid General Practitioner Registration Code was:
99.8% for admitted patient care
95.1% for outpatient care.
87.8% for emergency care (Minor Injuries Unit)

Information Governance

Berkshire Healthcare Trust Information Governance Assessment Report overall score for 2013/14 was (66%) and was graded (Amber).

The Information Governance Group is responsible for maintaining and improving the information governance

Toolkit scores, with the aim of being satisfactory across all aspects of the IG toolkit for Version 11. An action plan is being agreed to achieve this for the Version 11 final response which is due March 2014. Progress against the actions is monitored by the Information Governance Group.

One aspect of information governance includes clinical coding. A clinical coding audit in December 2013 revealed correct primary diagnosis and secondary diagnosis coding of 86% and 72% respectively for mental health. This is a marked improvement on previous clinical coding audits.

Data Quality

Berkshire Healthcare Foundation Trust has taken the following actions to improve data quality.

The Trust has invested considerable effort in improving data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information line and action plans.

Data quality audits were carried out on all lines that were rated as low ('red') quality in the IAF. The findings of these data quality audits were shared with the Data Quality Group and the Trust Senior Management Team

The key measures for data quality scrutiny mandated by the Foundation Trust regulator Monitor and agreed by the Trust Governors are (Full descriptions Appendix X to be added):

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge from hospital
- Admission to inpatients services having access to crisis resolution home treatment teams
- Medication Errors STC

BHFT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

3.1 Review of Quality Performance 2013/14 (Q3)

In addition to the key priorities detailed, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. These metrics are closely monitored through the Trust Quality Governance systems including the Quality Executive Group and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework.

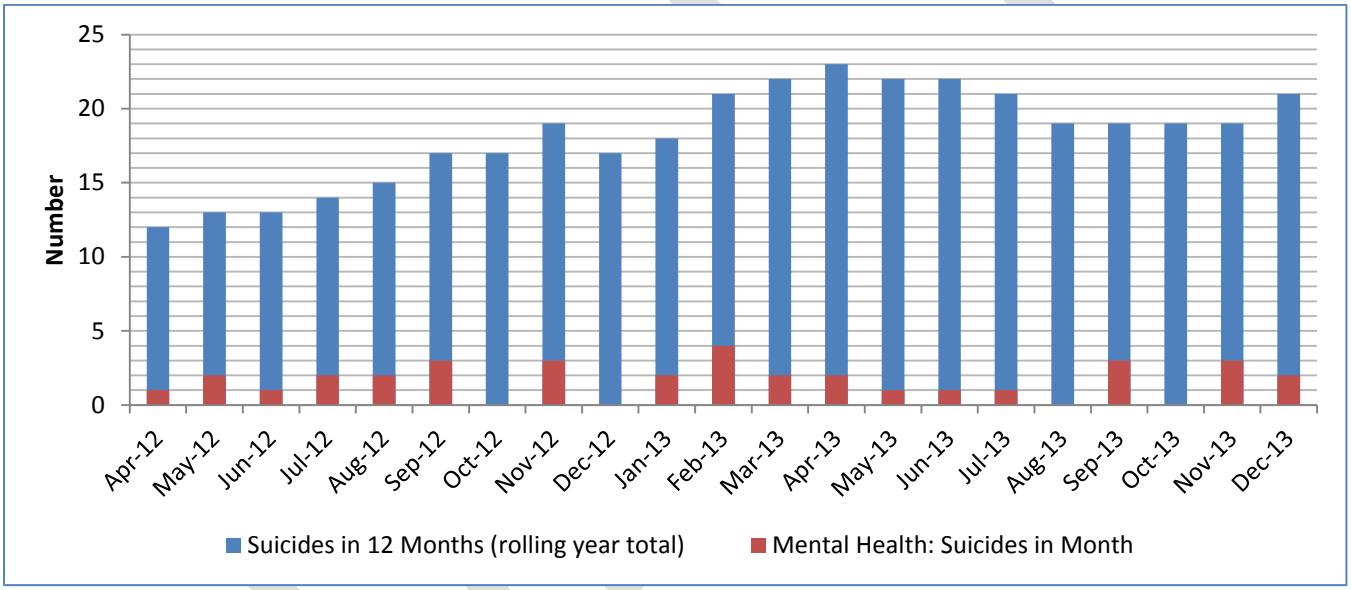
Patient Safety

Berkshire Healthcare aims to maximise reporting of incidents whilst reducing the severity levels of incidents through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture.

Never Events

None reported at Q3

Figure 21 Suicides



Suicide rates for those in contact with the Trust appear to have plateaued at around 19 per year. Clinicians have worked hard to improve processes for assessing and managing risks for patients in relation to suicide and self-harm. There have been no inpatient suicides during 2013/14. All suicides occurred in the community.

Absence Without Leave (AWOL)

There have been fluctuations in patients AWOL from the ward and in episodes of absconding. There has not, however been any clear trend in these areas. Three AWOL incidents relate to an older adult client on new Orchid Ward. One client was responsible for two awol incidents from Bluebell ward - On Bluebell ward there is a pilot project to see the impact of having the ward door unlocked for periods during each day, however in both these instance the client ran away from staff whilst on an escorted walks. This same client was also responsible for one of the absconsion from Bluebell ward in December 2013, by kicking open the fire door

AWOLS - information to add in here from the patient safety project Q4 Patient Safety Manager JG

Slips Trips and Falls

The number of slips, trips and falls across the Trust has remained stable at around 225 per quarter. 3 falls resulting in fracture have occurred during the first half of the year.

Figure 22 Absent Without Leave (AWOL) and Absconsions on a Mental Health Act (MHA) Section

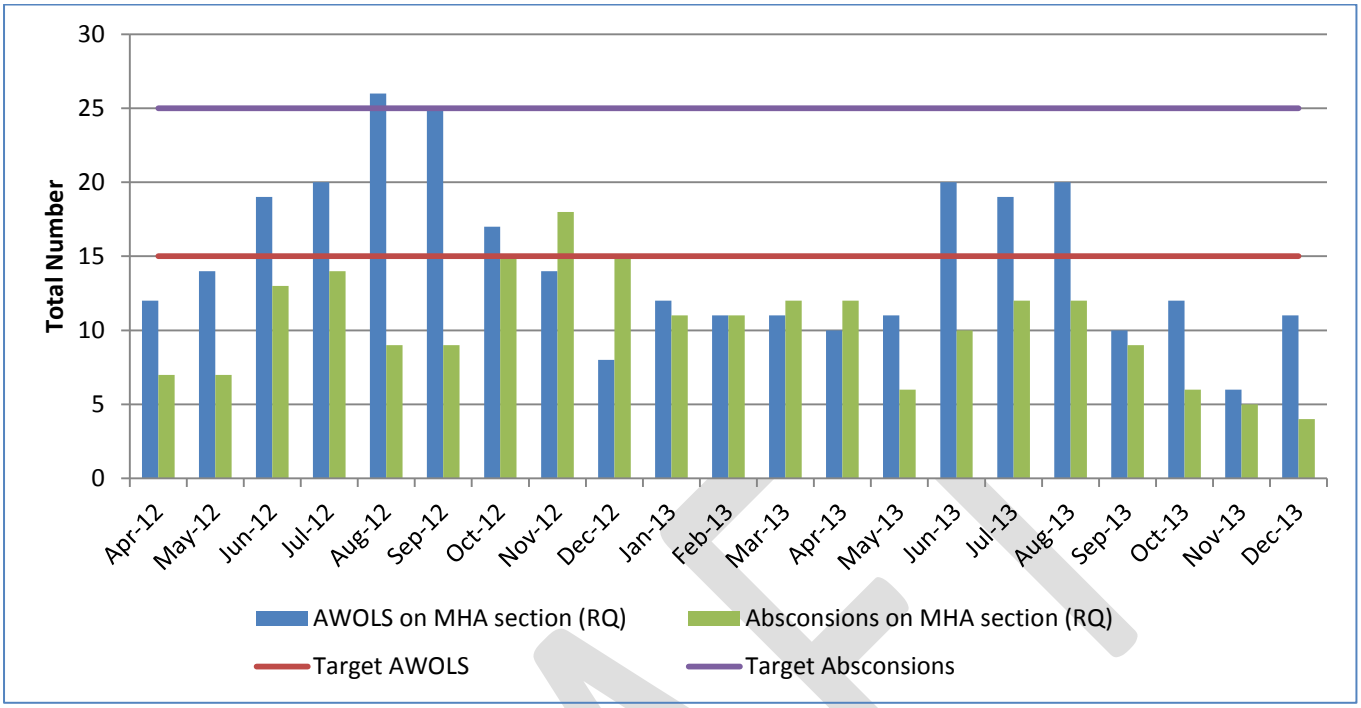


Figure 23 Total number of Slips Trips & Falls Incidents against those resulting in fracture

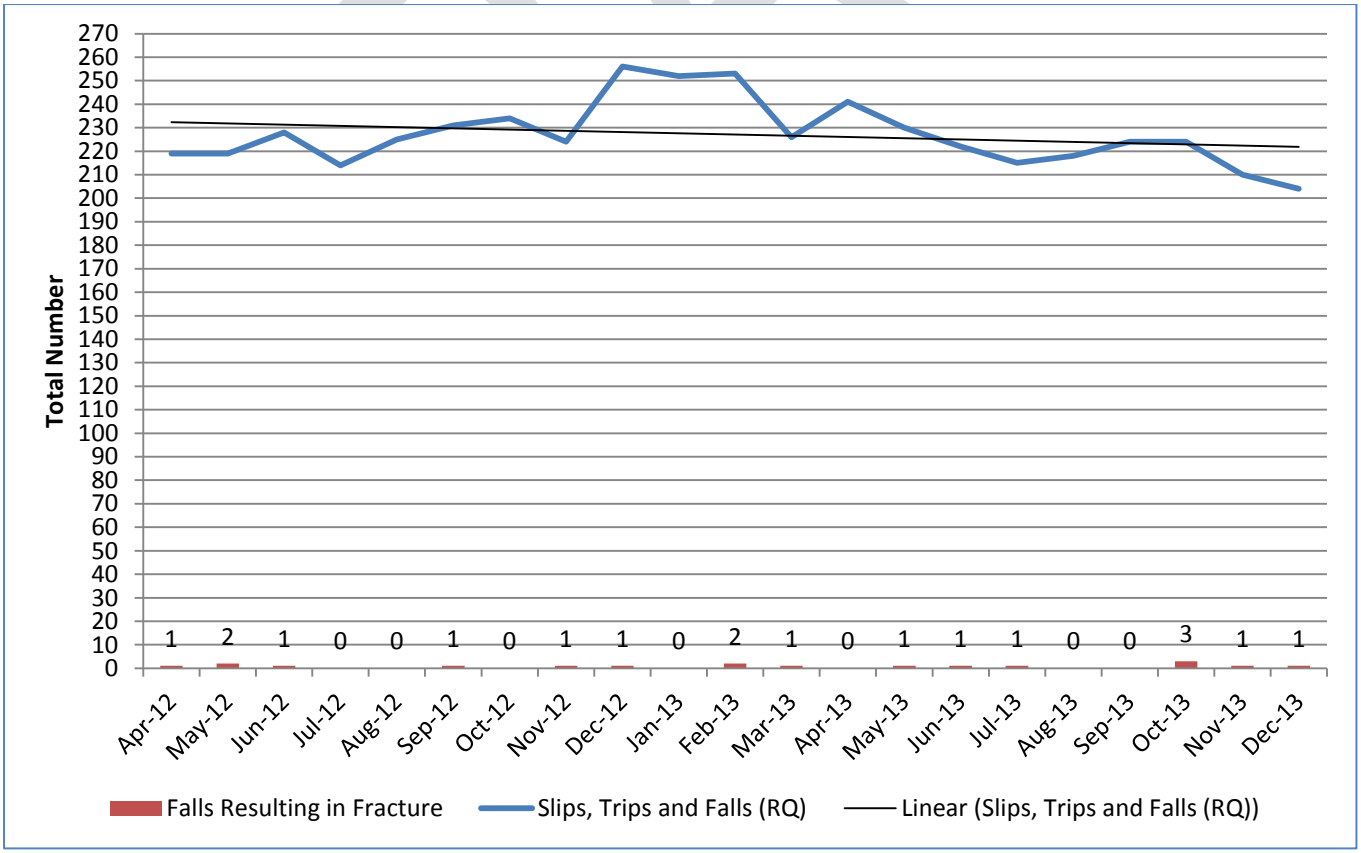
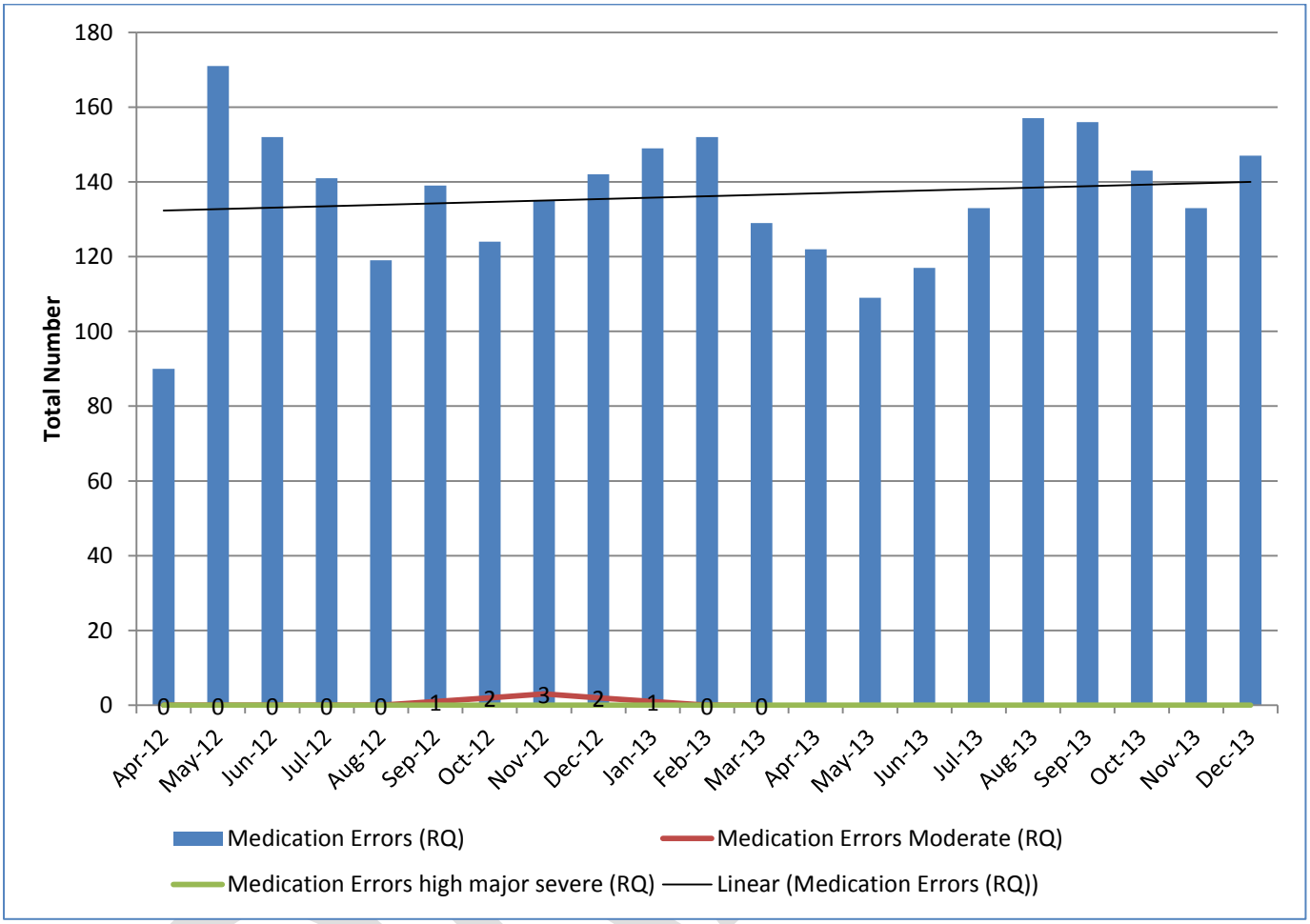


Figure 24 Medications Errors
(No errors resulted in moderate or severe harm)



Medication errors

The number of medication errors reported has fluctuated on average around 140 (117 – 156) per quarter with no clear trend. The Trust aims to maximise the reporting of errors but reduce the occurrence of serious errors which cause harm to patients. To date 420 medication errors have been reported none of which have resulted in moderate or severe harm to patients.

Pressure Ulcers

The number of grade 3 and 4 Pressure Ulcers reported has increased in the first half of the year due to a change in reporting thresholds (including inherited pressure ulcers). – No new grade 3 pressure ulcers were reported in December 2013, Q1 55 in total, Q2 81 in total Q3 41in total [This will be revised to incorporate latest analysis of pressure ulcer data Q4].

Physical Assaults

There has been some reduction in physical assaults on staff by patients during the first half of the year with a slight increase in patient on patient assaults.

Figure 25 Newly Acquired Pressure Ulcers

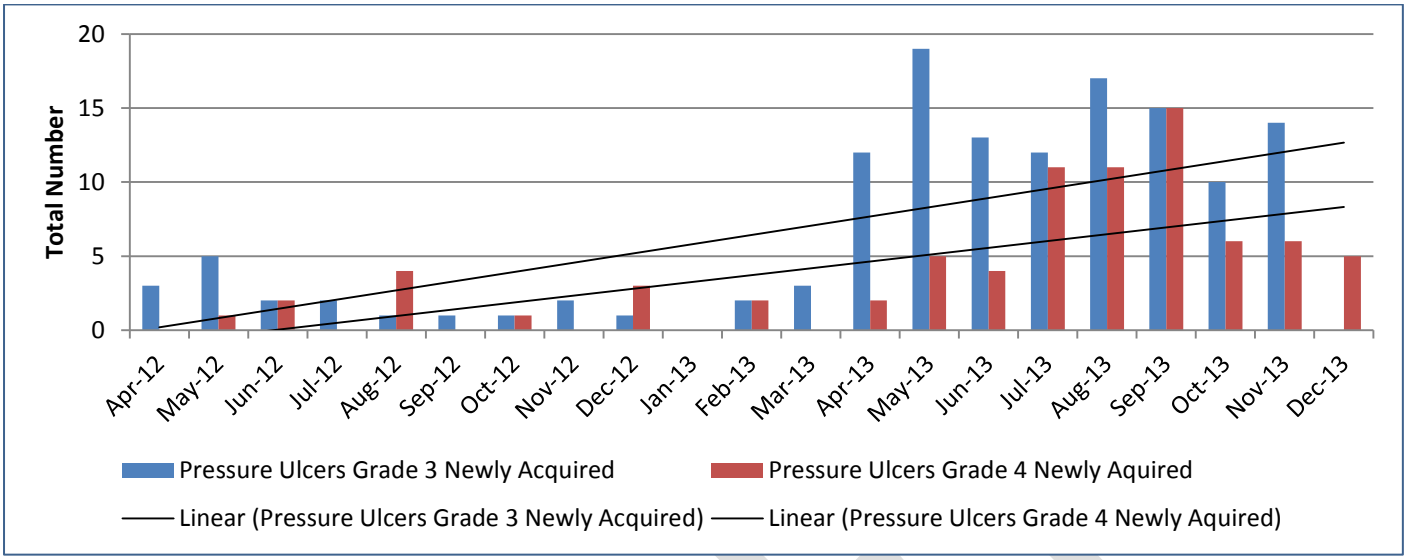


Figure 26 Patients to Patient and Patient to Staff Physical Assaults

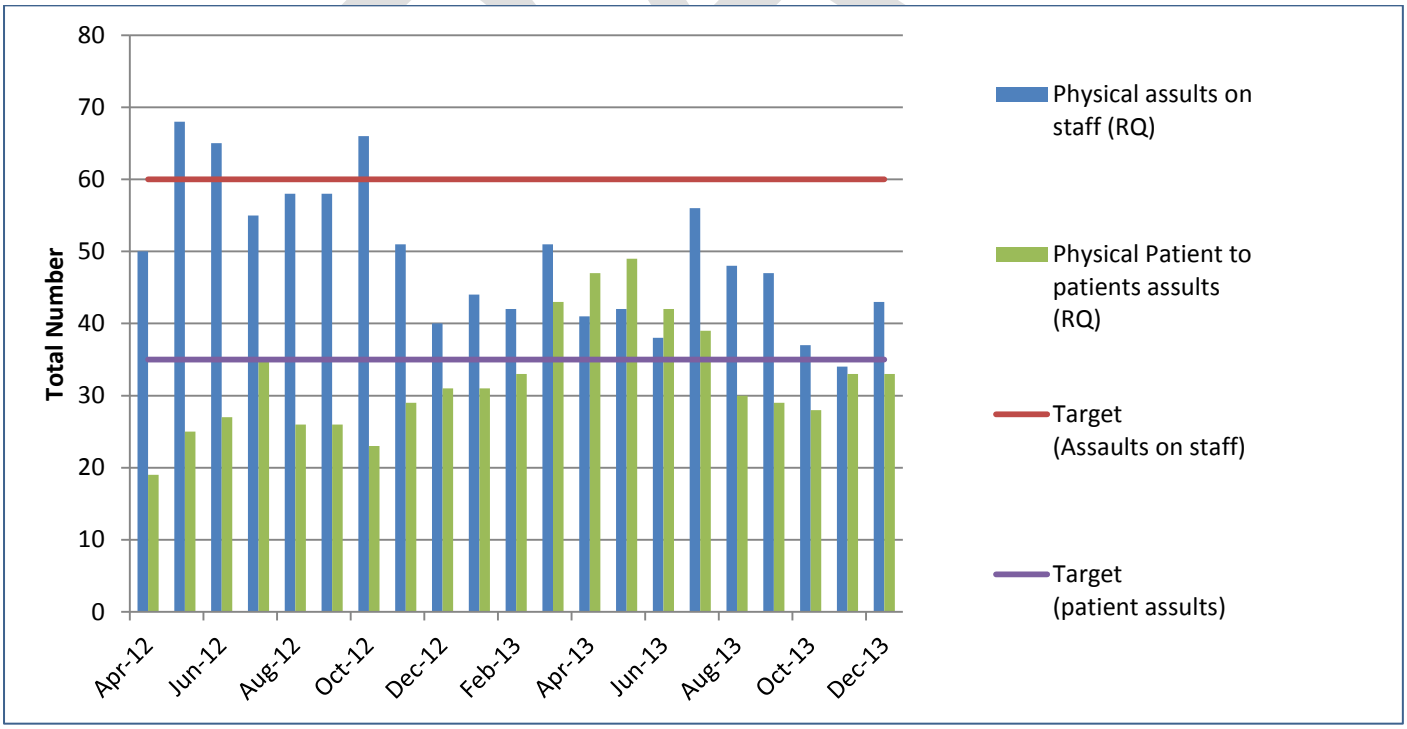


Figure 27 Compliments

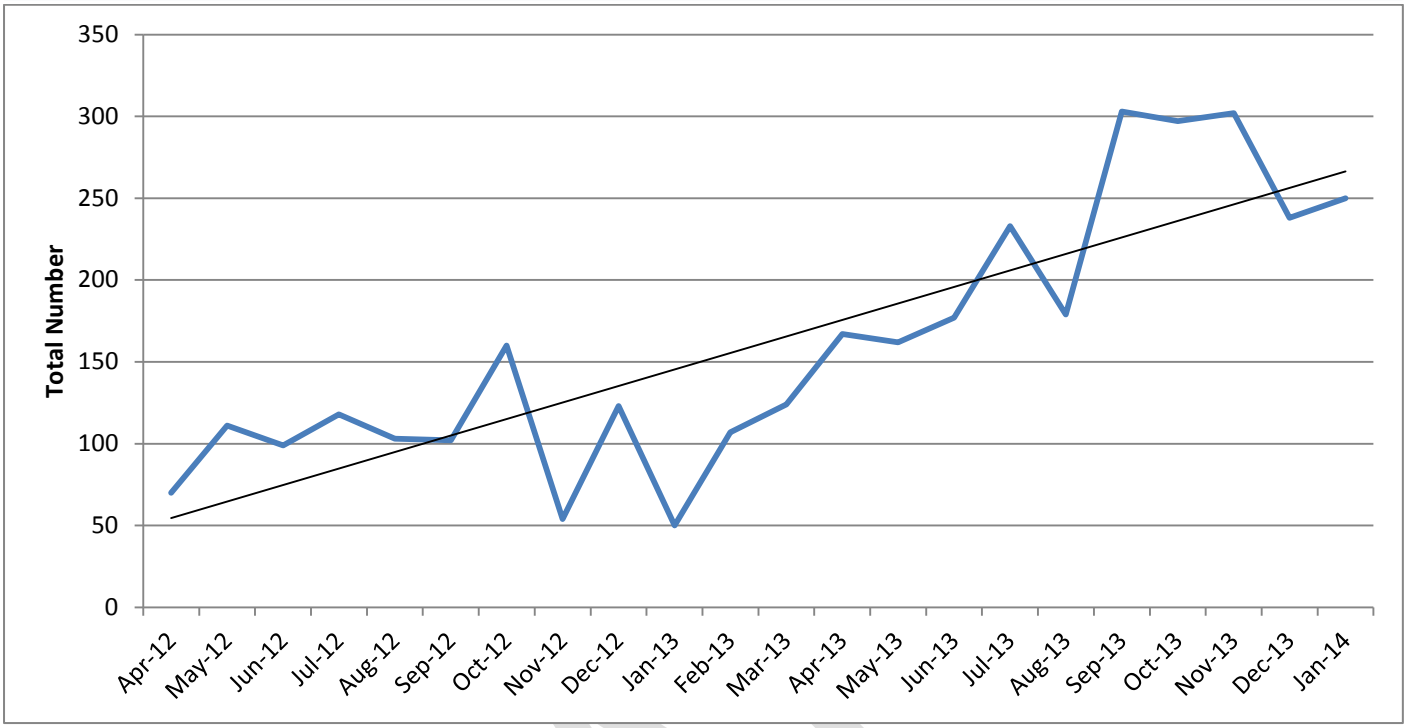
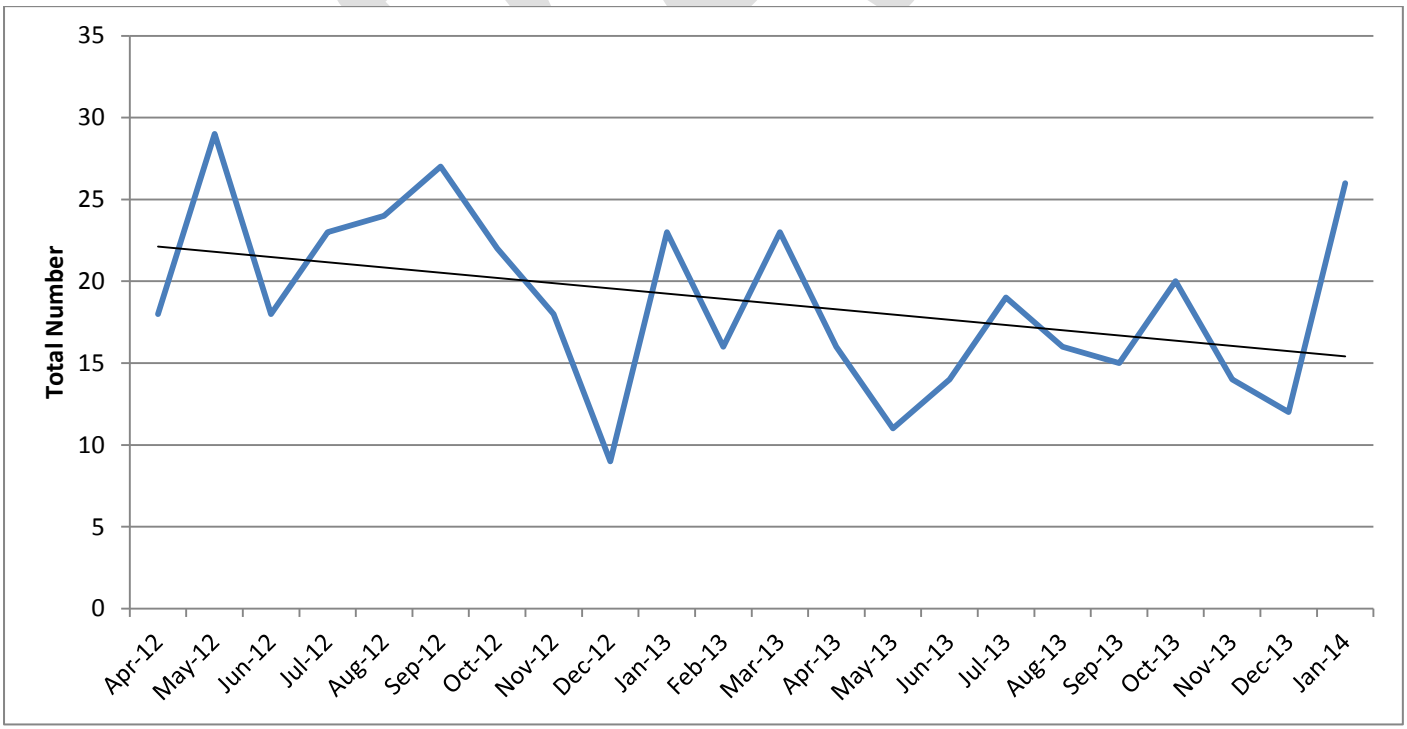


Figure 28 Complaints



Compliments and Complaints

The Trust is committed to improving patient experience, using complaints and other forms of feedback to better understand the areas where we perform well and those areas where we need to do better

The response rate within 25 working days for formal complaints is 51%. The response rate including those re-negotiated with complainants has increased to 75% for quarter three, and was 89% during December 2013. The average number of days to respond to a complaint was 29 days in November and 32 days in December2013.

The main themes from the complaints are care and treatment, communication and access to services.

Actions identified to improve the service we provide to our service users and their carers arising from complaints continue to be discussed at the Locality Patient Safety and Quality Groups. Whilst learning from individual complaints is led by the Service, it is recognised that themes need to be recognised and addressed by Localities.

You Said	We Did
Poor feedback around the general perspective of the service provided by the **Slough Walk-in Health Centre**.	This has been discussed in staff meetings and also on informal individual basis to encourage changes in approach to patients. The appointment booking system has been changed to allow a more structured approach. The times of Practice Nurse clinics have changed to include out of normal working hours. There has also been a change in the way people are surveyed in order to get more balanced feedback.
Many patients are not aware that the **Palliative Care Team** are available at the weekend.	This feedback was shared at the team meeting and agreed that there would be a concentrated effort to inform patients. This will also be monitored in future questionnaires.
On **Ward 12 (MH Inpatients)** there are constant issues with the remote control and it would be helpful to have some things to do.	Extra resources such as arts and crafts materials, games and TV remote controls have now been provided for the ward.
Quicker appointments needed on referral to **Community Dental**.	Service now contacting patients to explain long waits and offering appointments at different clinics if would like to be seen quicker.

Monitor Authorisation

Performance in relation to metrics required by Monitor, the Foundation Trust regulator, has achieved the required targets. This relates to mental health 7 day follow up (97.07%), delayed transfer of care (2.2%), community referral to treatment compliance (98.3%), Care Programme Approach review within 12 months (96.4%) and new early intervention in psychosis cases 102 (154 12/13).

Figure 29	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98%	96%	**95.8%**	**97.07% (Q3)**	**97.4% (12/13) to be updated March 14**	-

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:

In line with national policy to reduce risk and social exclusion and improve care pathways (CQC 2008) we aim to ensure that all patients discharged from mental health in patient care are followed up (either face to face contact or by telephone) within 7 days of discharge, this is agreed and arranged with patients prior to discharge to facilitate our high level of compliance.

Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services:

Berkshire Healthcare trust meets the minimum requirement set by Monitor of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and learning Disability In-patient Care Policy. In addition the data is audited as part of the independent assurance process for the Quality Account and any actions identified through this are fully implemented to ensure that we maintain our percentage of compliance.

Figure 30	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	100%	94%	97.6%	**97.7%(Q3)**	**98.2% (12/13) to be updated March 2014**	-

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:

Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services, by:

The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service and has increased our percentage compliance.

Figure 31	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period *The data presented here includes only emergency readmissions within 28 days (67) in the last 6 months as a percentage of discharges (527) in the same period and excludes any readmissions coded as planned.*	9%	12%	**11.4% (Q3)**	***To be published March 2014-***	***To be published March 2014-***

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:
We have a lower bed base than average and this can cause the readmission rate to be higher than in other Trusts.

Berkshire Healthcare trust intends to take the following actions to improve this percentage, and so the quality of services:
Further work will be done by the relevant Service Improvement Group to work on the high level of readmissions, to identify why the trust has seen an increase and to identify actions to reduce it.

Figure 32	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The indicator score of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	3.55 65%	3.61 64%	**3.76** **69%**	**3.54** **59%**	

Berkshire Healthcare trust considers that this data is as described for the following reasons:
The Trust's score is better than average and improving year on year. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. Advocacy of recommendation along with staff involvement, and staff motivation are strong indicators of the level of staff engagement with in the trust. ***To be updated following publication of national figures***
Berkshire Healthcare trust has taken the following actions to improve this data, and so the quality of services, by:
Implementing a five year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care. ***To be updated following publication of national figures***

Figure 33(New section score for 2012/13)	2011/12	2012/13	2013/14	National Average	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	-	8.5	8.7	*Not published*	*8.0 Lowest* *9.0 Highest*

Berkshire Healthcare trust considers that this data is as described for the following reasons:
The Trusts score is in line with other similar Trusts and shows a continued commitment to improving service user experience
Berkshire Healthcare trust has taken the following actions to improve this data, and so the quality of services, by:
Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place to improve both an individual's experience and if required to change the service provision.

Figure 34	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The number of patient safety incidents reported	3995	3661	2789	-	-
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days	19.7	30.2	TBC	26.8	TBC
The number and percentage of such patient safety incidents that resulted in severe harm or death	29 (0.7%)	42 (1%)	28 (1%)	1.3%	-
*NRLS report 1st October 2012 – 31st March 2013**Trust figure					

Berkshire Healthcare Trust considers that this data is as described for the following reasons:
The percentage of incidents reported relating to severe harm or death is in line with national averages for similar Trusts, as set out in benchmarking reports published by the NHS Commissioning Board. Among these 28 cases were 13 suicides of people in the community who were either using mental health services or had been in contact within the previous six months. There were no inpatient suicides. The remaining 15 cases were unexpected deaths of community mental or physical health patients (including community wards) where suicide not suspected, an attempted suicide in the community, and two patient falls.
Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services, by the following:
Promotes the reporting of all incidents, with an emphasis on learning from near misses and minor incidents in order to prevent more serious issues arising. Ensures that all serious incidents are thoroughly investigated and the findings used to create improvement plans to enhance the quality of its services. Serious incidents requiring investigation are also reported to commissioners and the Care Quality Commission to ensure transparency and external scrutiny of safety and quality. We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts. There is also clinical judgement in the classification of an incident as "severe harm" as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

Figure 35 Annual Comparators (Q3)	Target	2010/11	2011/12	2012/13	2013/14	Commentary
Patient Safety						
CPA review within 12 months	95%	-	97.6%	97.9%	**96.4%**	For patients discharged on CPA in year
Never Events	0	0	0	1	**0**	Full year
Infection Control (MRSA bacteraemia)	< 2 per annum	0	1	0	**0**	Full year
Infection Control (C.*difficile*)	<10 per annum (reduced from <19)	0	15	5	**3**	Full year
Medication errors	Increased reporting	179	574*	562	**420**	Cumulative total
Clinical Effectiveness						
Minimising delayed transfers of care	7.5%**	1.86%	3%	1.1%	**2.22%**	All delays in year
Mental Health: New Early Intervention cases	99	-	155	154	**102**	Year to date
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	N/A	99.6%	99.9%	**99.9%**	Year average
Completeness of MHMDS (Mental Health Minimum Data Set)	1) 97% 2) 50%	1) 99% 2) 86%	1) 99.6% 2) 97.9%	1)99.8 2)98.62	**1)99.8** **2)97.27**	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%. Year Average
Patient Experience						
Referral to treatment waiting times – non admitted -community	95%***	N/A	99.9%	99.9%	**98.33%**	Consultant led services in East CHS, Diabetes, and Consultant Led Paediatric services Year average
Access to healthcare for people with a learning disability	Score out of 24	22	22	22	**Green**	CM to confirm still 22 at Q4
Complaints received	<25 per month	134	232	250	**137**	Cumulative in year
Complaints	100% Acknowledged within 3 working days 80% Responded within 25 working days	100%	100%	91.3%		Final quarter

*Community Health services joined the Trust**Delayed transfers of care (Monitor target) is Mental Health delays only (Health & Social Care), calculation = number of days delayed in month divided by OBDs (Inc HL) in month. New calculation used from Apr-12***.Waits here are for consultant led services in what was East CHS, Diabetes, and Consultant Led Paediatric services from referral to treatment (stop clock). Notification has been received from NHS England to exclude Sexual Health services from RTT returns and so they have been excluded here (Included 2012/13).

3.2 Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14; The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2013 to June 2014
2. Papers relating to Quality reported to the Board over the period April 2013 to June 2014
3. Feedback from the commissioners dated May 2014
4. Feedback from governors dated 02/02/13, 21/03/13, 16/05/2013
5. Feedback from Local Healthwatch organisations dated May 14
6. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014
7. The national patient survey 13/09/2013
8. The national staff survey 25/02/2014
9. The Head of Internal Audit's annual opinion over the trust's control environment dated xx/03/2014
10. CQC quality and risk profiles dated 31/01/2014

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered; the performance information reported in the Quality Report is reliable and accurate; there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

May 2014 Date **John Hedger Chairman**

May 2014 Date **Julian Emms Chief Executive**

Appendix A National Clinical Audits Reported in 2013/14 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust: Actions to Improve Quality

National Audits Reported in 2013/14	Recommendation	Actions to be Taken
Prescribing for ADHD	Under review to be added Q4	Action plan in development
National Audit of Schizophrenia (2011)	While there are many examples of good practice in this area, results from this audit suggest that more work needs to be done to improve communication between clinical teams if these basic requirements for keeping people well are to be delivered. The audit also shows that some patients are receiving more than one antipsychotic drug at a time, something for which there is no clear evidence of benefit except in the minority of situations. Others, whose health does not improve when they are offered standard treatment, do not appear to have been offered psychological and pharmacological treatments that could help them. Further attention needs to be paid to the needs of people who do not respond to the treatment they are initially offered, if the health and quality of life of all people with schizophrenia is to be improved.	Carry out spot check on Rio of documentation of initial assessment data for patients with schizophrenia /schizoaffective disorder being seen via community mental health teams (CMHTs) Emphasise the importance of clinical staff printing and handing out medicines related patient leaflets and discussing options with patient during appointment. Promote availability of medicines management training for doctors Remind clinical staff that they should have access to physical health test data. Circulate summary results and action plan to relevant clinicians Trust wide, in preparation for 2013 re-audit. Review the use of a medicines management algorithm.
Prescribing of antipsychotics for people with dementia	The audit demonstrates that the Trust has markedly reduced prescribing of antipsychotics for people with dementia during the past year and such prescribing occurs at a significantly lower level than in the national sample. The larger sample in 2012 reveals that, with respect to some audit standards, there is a lower level of achievement than indicated in the 2011 audit. Results for these standards, however, are still favourable when compared with national outcomes	Review within specialist old age teams of findings. Checklist implemented to ensure that compliance with best practice is assured with regards to risk benefit for antipsychotic prescriptions and medication review

Appendix B Local Clinical Audits Reported in 2013/14: Actions to Improve Quality Q4 Addition

Local Audits Reported in 2013/14	Recommendation	Actions to be Taken

Appendix C Figure 1 Percentage of all Pressure Ulcers

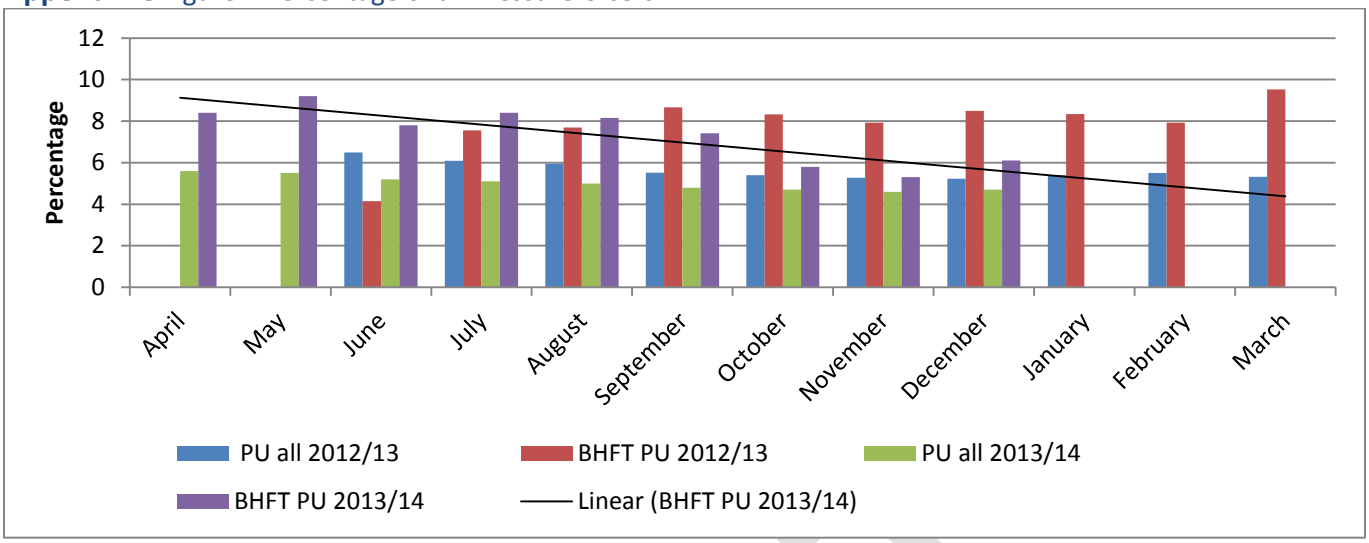
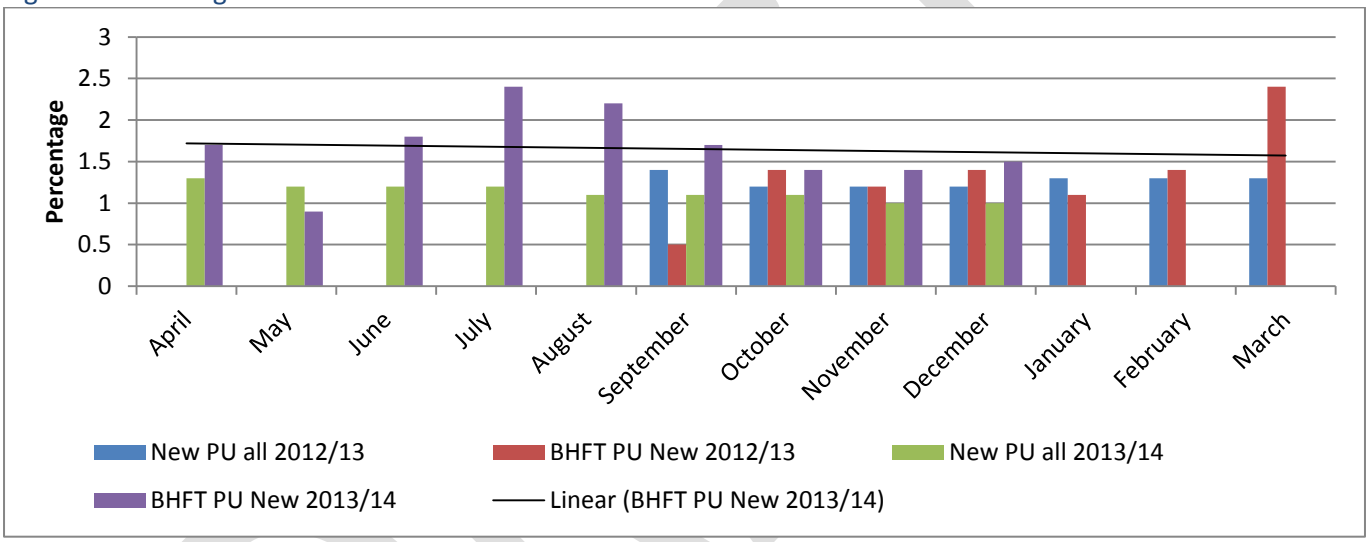


Figure 2 Percentages of New Pressure Ulcers



Note: reporting of new PU started September 2012/13

Figure 3 Percentage of Venous Thromboembolism (VTE)

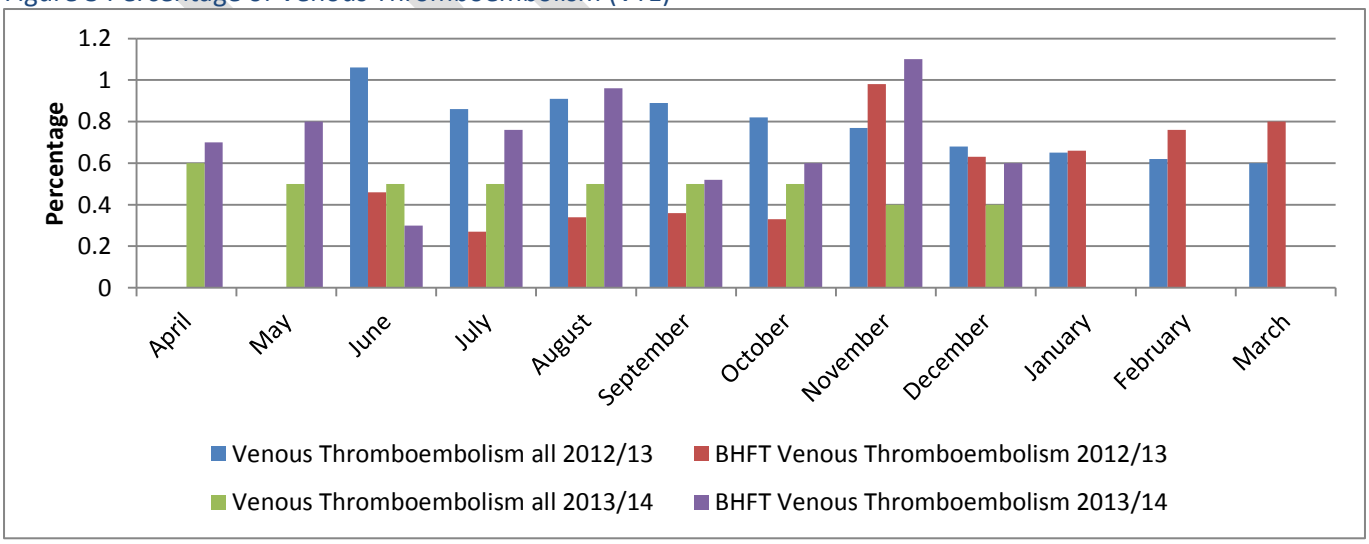


Figure 4 Percentage of Falls with harm

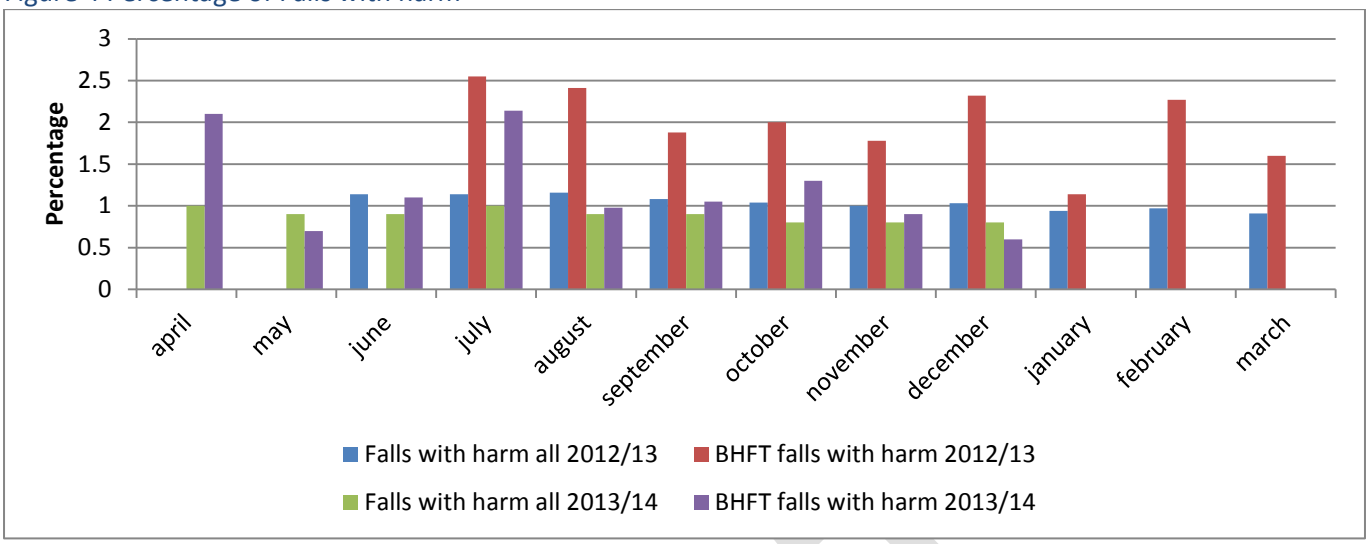
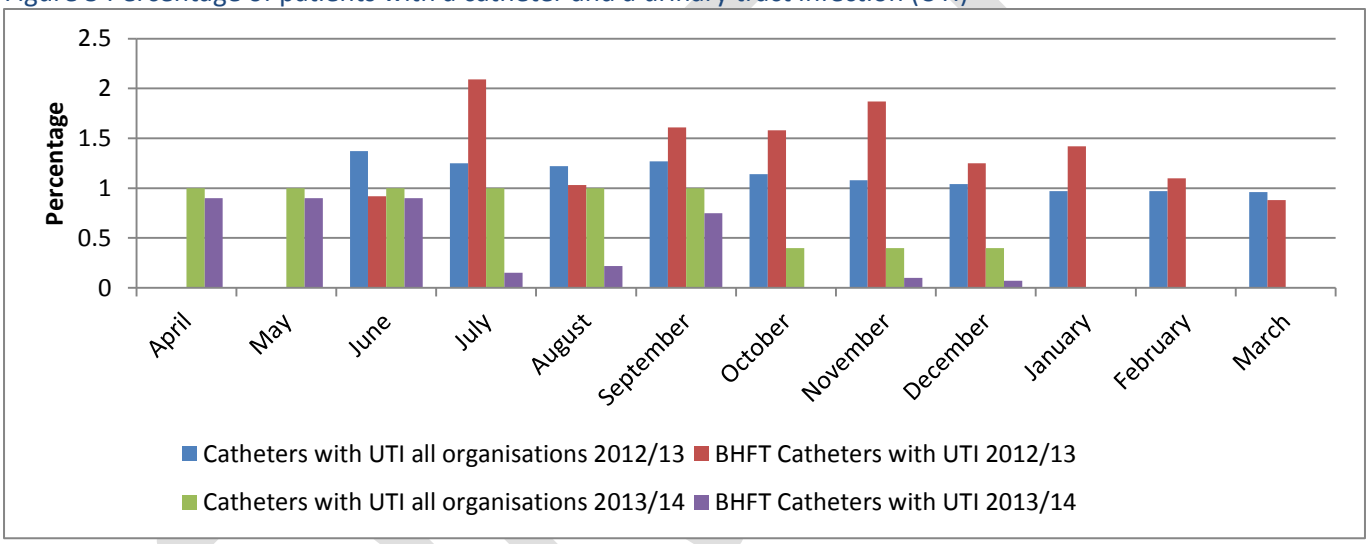


Figure 5 Percentage of patients with a catheter and a urinary tract infection (UTI)



Appendix D

Trust Quality & Risk Profile v5.06 31.01.2014

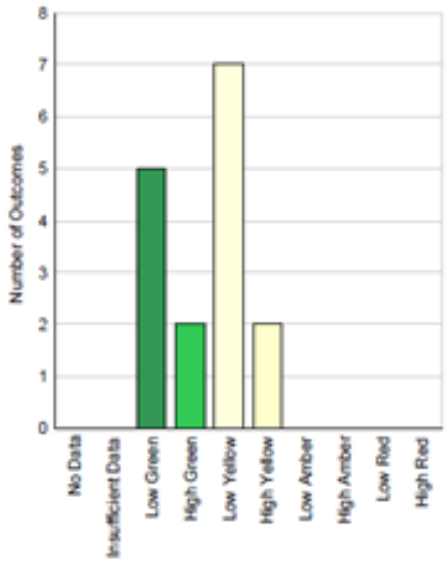
Quality and Risk Profiles (QRP) enable CQC to assess where risks lie and prompt front line regulatory activity, such as site visits. They do not direct front line regulatory activity. They support teams to make robust judgments about the quality of services. They are used alongside CQC's guidance about compliance, including the judgment framework, and additional information known to inspectors

Summary information

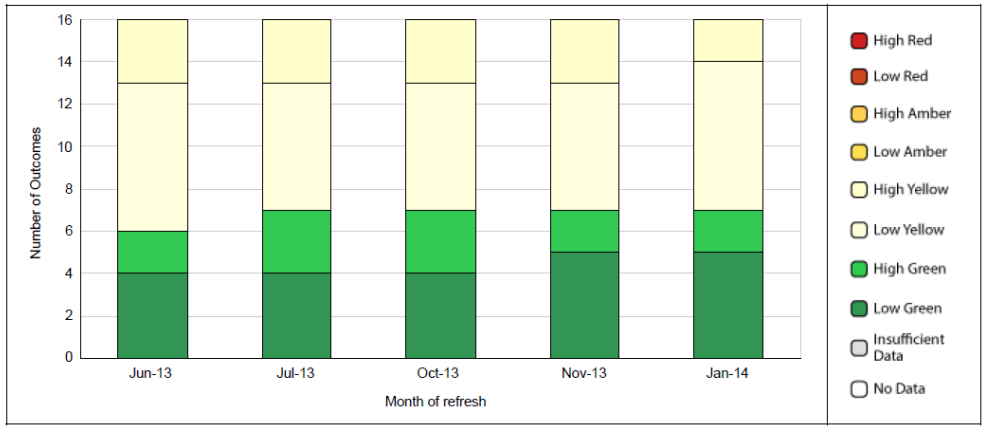
Provider type: NHS Healthcare Organisation	
Date registered with CQC	01/04/2010
Number of regulated activities	5
Number of locations	18
Total no. of data items in QRP	992
No. of qualitative data items	168
No. of quantitative data Items	824

52

Latest risk estimates



Risk Estimates over time



The QRP has been relatively stable during the year and that there are no areas where the CQC considers there to be a high level of risk with regard to the quality of services delivered by the Trust.

Appendix E CQUINs 2013/14 –Quarter 4 final achievements to be added at the beginning of May 2014 following agreement with commissioners.

CQUIN	Title	Indicator description	Value K	Achievement 2013/14
1				
2				
3				
4				
5				
6				
7a				
7b				

Appendix F CQUIN 2014/15 to be added (Subject to final agreement

CQUIN	Title	Indicator description	Value K	Achievement 2013/14
1				
2				
3				
4				
5				
6				
7a				
7b				

Appendix G Glossary to be added Q4

Appendix H Statements from Stakeholders to be added April 2014

Unrestricted

TO: HEALTH AND WELLBEING BOARD
DATE: 10 APRIL 2014

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
Public Health for Bracknell Forest
Bracknell & Ascot Clinical Commissioning Group
Berkshire Healthcare Foundation Trust and
NHS England

1 PURPOSE OF REPORT

1.1 The purpose of this report is to describe what a good modern Child and Adolescent Mental Health Service (CAMHS) would be like; to set out the current tiers of support and who is responsible for commissioning that provision; and identify the plans and re-commissioning arrangements for CAMHS across each tier of support.

1.2 The successful delivery of CAMHS requires a partnership approach between providers at each service tier, and between commissioners and providers. This report highlights work in progress.

2 RECOMMENDATIONS

That the Health and Wellbeing Board (HWBB):

2.1 Endorse what good looks like and support the ambition to improve Bracknell Forest's emotional health and well being support for children and young people and CAMHS services to achieve at this level

2.2 Note the arrangements in place for commissioning and the plans for re-commissioning services for children with emotional and mental health issues.

2.3 Endorse the determination for early intervention and prevention of escalation where possible to higher tiers of service.

2.4 Request that a lead is identified for each of the Tiers 1-4.

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.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Why are child and adolescent mental health services important?

5.1 The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) brings together leading organisations with an interest in commissioning for mental health and learning disabilities. They published a guide in October 2013 on child and adolescent mental health services and are considered an important source of information on current and best practice.

They have identified four main reasons why CAMHS is important:

1. Prevalence

5.2 One in ten children aged five to sixteen has a clinically significant mental health problem. Problems most relevant to children and young people are: emotional disorders (eg phobias, anxiety, depression), conduct disorders (eg severe defiance, and physical and verbal aggression, and persistent vandalism), obsessive compulsive disorder, attention deficit hyperactivity disorder, other behavioural problems, tics disorders and Tourettes syndrome, autism spectrum disorders (ASD), substance misuse problems, eating disorders (eg pre-school eating problems, anorexia nervosa and bulimia nervosa), post traumatic stress disorder, the psychological effects of abuse and neglect, attachment disorders (eg children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major carer givers), the psychological effects of living with a chronic illness, somatisation disorders, psychosis, emerging borderline personality disorder.

5.3 Some children experience more than one mental health problem (comorbidity). This can make assessment, diagnosis and treatment more complex.

5.4 Mental health problems and disorders in childhood can have high levels of persistence 25% of children with a diagnosable emotional disorder, and 43% with a diagnosable conduct disorder, still had the problem three years later according to a national study. Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively). Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood. A number of disorders are persistent and will continue into adult life unless properly treated – it is known 50% of life time mental illness (except dementia) begins by age 14.

2. Risk Factors

5.5 Mental health problems in children and young people are the result of complex interactions between constitutional factors (including genetic factors) and environmental factors with the relative contributions varying to disorder and by individual. Although any child or young person can develop a mental health problem there are individual and family/social factors and experiences which can increase vulnerability to developing mental health problems.

5.6 Risk factors include: living with a long-term physical illness or disability, children and young people with intellectual disabilities are at increased risk of developing additional mental health problems, children and young people who are looked after by a local authority (often because of family breakdown) have much higher rates of mental health problems, children and young people who have experienced abuse and neglect, children and young people in contact with the criminal justice system, having a parent with a mental health problem, having a parent with a substance misuse or alcohol problem, having a parent in prison, being from low income households, families where parents are unemployed or where parents have low educational attainment, young people who are lesbian, gay, bisexual or transsexual (LGBT). A range of protective factors in the individual, in the family, and in the community influence whether a child or young person will experience problems. In particular, receiving consistent support from a trusted adult is a strong protective factor.

3. Evidence of Effectiveness

5.7 As noted above, mental health problems which begin in childhood and adolescence are not only common but can have wide ranging effects causing distress, affecting

educational attainment and employment prospects, social relationships and longer term physical and mental health. The National Institute for Health and Clinical Excellence (NICE) has produced a number of detailed clinical guidelines to guide intervention in mental health problems occurring in children and young people.

4. The Economic Case

5.8 There is compelling evidence of the cost benefits of using evidence based interventions. Using conduct disorder as an example, by the time a person is 28 years old, individuals with persistent antisocial behaviour (evident at age ten) will have cost society ten times as much as those without the condition. Parent education and training programmes can have good medium to long term effects at a relatively low cost, by a cost factor of £8 saved to every £1 spent if the costs of crime are included.

What does a good child and adolescent mental health service good look like?

5.9 There is no prescribed 'best practice' model but most would agree that a good service would provide timely support without the need for long waits for interventions. It would be effective and meet the needs of children and young people and be efficient in terms of delivery. Access should be via clear care pathways which are well signposted and understood. The JCP-MH guidance is very comprehensive and proposes a clear model of good service delivery which has been reproduced for information in appendix 1.

5.10 It is recommended that this framework in appendix 1 of what is good practice is endorsed by the HWBB as helping to set out the ambition for Bracknell Forest services.

National perspective and concerns

5.11 The Government's mandate sets the ambition to give children the best start in life. It also sets an objective for NHS England to put mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole.

5.12 In January 2014 the Department for Health published its priorities for transforming support for people with mental health problems over the next two to three years. This is called 'Closing the Gaps'. It sets out 25 priorities for action for children and young people and adults. An LGIU briefing summarises the full report and is attached for further information as appendix 2.

5.13 Nationally there are concerns about the provision of services to support emotional health and well being. In February 2014, in the light of concerns expressed by the Chief Medical Officer and others about both the extent to which children and adolescents are affected by mental health problems and difficulties with gaining access to appropriate treatment, the Health Committee has decided to undertake an inquiry into children and adolescent mental health and Children and Adolescent Mental Health Services (CAMHS). The inquiry will consider the current state of CAMHS, including service provision across all four tiers:

i) Access and availability; funding and commissioning; and quality.
ii) Data and information on children and adolescent mental health and CAMHS.
iii) Preventative action and public mental health, including multi agency working.

iv) Concerns relating to specific areas of CAMHS provision, including perinatal and infant mental health, urgent and out of hours care, the use of S136 detention for under 18s, suicide prevention strategies and the transition to adult mental health services.
The inquiry will report in March 2014.

Local provision

5.14 Current provision for young people with anxiety and depression, psychosis, attention deficit hyperactivity disorder, conduct disorders, autistic spectrum disorder, deliberate self harm, eating disorder or other mental health needs is currently delivered through a network of services in four tiers, depending on the severity or complexity of needs.

5.15 **Tier 1** is provided by universal services such as schools and GPs, along with youth services and support provided by charities and voluntary groups. Tier 1 services provide initial support and are delivered by non-specialist mental health workers.

5.16 For example, Schools provide pastoral care and can sign post to additional information. The Council commission Youthline which provides young people with telephone counselling support. The Public Health team is commissioning new, innovative programmes at a preventative level, often in collaboration with other council teams. This includes projects aimed at promoting well-being via physical activity among children. For example, the Family Health & Learning Project for 4 – 5 year olds, currently being piloted in two primary schools, seeks to increase children's and family's physical activity levels along with providing the child with an opportunity to develop self-esteem, confidence and improve their ability to co-operate and work well with others.

5.17 **Tier 2**: These are targeted services usually provided once a referral is made by schools - some targeted services are commissioned by the Council on behalf of schools such as behaviour support, family and parenting support, educational psychological services, anti bullying work, and Family Focus. Other examples include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Youth counselling services provided by the voluntary sector and some more specialist health practitioners such as Looked After Children's nurses, Family Nurse Partnership practitioners and Youth Offending teams also provide Tier 2 support.

5.18 **Tier 3 – CAMHS**: These are specialist community CAMHS which are commissioned pan Berkshire. Tier 3 services are commissioned locally by the Bracknell & Ascot Clinical Commissioning Group (CCG) from Berkshire Healthcare Foundation Trust (BHFT), and is accessed through a GP referral through the common point of entry (CPE), which also sign posts to other services if required. The service accepts referrals from professionals including schools, but predominantly referrals are from GPs and other medical professionals. The report to the HWBB (12/12/2013) by Clare Bright explained the services and quality improvement targets.

5.19 Tier 3 services are usually multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Team members are likely to include:

- child and adolescent psychiatrists
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
- occupational therapists, and
- art, music and drama therapists.

5.20 Local Tier 3 services are organised into a number of evidence based “pathways”, which include urgent care and Monday – Friday inpatient resources, along with longer term specialist interventions. The Berkshire Adolescent Unit provides some in patient beds 4 nights a week at Tier 3. Children and young people return home at weekends. This model of care is an outlier to other areas of the UK where an enhanced community based provision which is available out of hours and over weekends, particularly for those in crisis or with more acute difficulties is often commissioned. The evidence base for the various models of care at Tier 3 is being reviewed.

5.21 Both numbers of referrals to Tier 3 services, and numbers of children who require support at tier 3 have increased significantly in the last two years, with year to date referral numbers already reaching or exceeding year end totals for 2011/12 in many areas.

5.22 From 1 April 2013 Child and Adolescent Mental Health Services (CAMHS) Tier 4 (inpatients) became the responsibility of NHS England, having previously been commissioned by primary care trusts. Nationally, to date, there have been some significant challenges, the key ones being:-

- Available capacity to meet demand
- Children and young people having to travel long distances to access a bed
- Inequity in provision
- Quality concerns about services resulting in temporary closures to admissions
- Closure to admissions impacting upon capacity.

5.23 NHS England has undertaken the following actions to address and mitigate these issues:-

5.23.1 Commissioned a 3 month national review of CAMHS Tier 4 which is due to report in early April. The terms of reference are:

a. Undertake a factual assessment of current provision and commissioning issues
b. Identify commissioning proposals for CAMHS Tier 4 that include
    i. quality standards
    ii. access standards
    iii. environmental standards
    iv. contract levers
c. Recommend a preferred procurement route with rationale to support the recommendation along with how new market entrants or developments should be managed.
d. Identify any further work required that may include education provision, workforce development or mapping other Tiers of provision.

The proposed review work includes:

- Map current Tier 4 provision split by service type (e.g. secure, Eating Disorders etc.), number of beds, age range, and geographic location
- Collate and compare for each service (type) admission criteria
- Conduct a census and identify by age, Mental Health Act classification, gender, length of stay, out of area placements (defined by out of the originating area specialised service geographic patch)
- Identify number of beds temporarily closed to admissions from 1 September 2012, type, length of time beds closed and reason for closure – source providers triangulating response with commissioners

- Identify any 'best practice' where local services, agencies and commissioning organisations are working together to improve the pathway.
- Requesting Area Teams (Specialised) to provide information about the level and type of tier 3 services commissioned and in place locally along with any evidence of decommissioning or intended decommissioning since 1 September 2012.
- Working with the Clinical Reference Group:
    - Determine access assessment standards (generic and by service)
    - Identify 'best practice' for trial or home leave
    - Identify 'best practice' for discharge thresholds and discharge planning Produce guidance on managing suicidal ideation
    - Identify environmental standards for inpatient units
    - Consider and comment on the potential impact on demand and capacity by introducing these standards.

5.23.2 Dedicated Case Management - The Area Team has appointed a CAMHS case manager to ensure robust pathway management. This includes supporting the effective management of local capacity; timely admission to safe, quality services, which is often very challenging given the current capacity restraints; timely discharge and supporting transition arrangements; close liaison with other agencies eg. LA regarding residential placements and ensuring regular contact is maintained with young people placed off patch, via the CPA and care coordination process.

5.23.3 The Wessex Area Team is undertaking quality visits to provide assurance regarding the quality and safety of CAMHS Tier 4 units on the patch is satisfactory.

5.23.4 There is a weekly national UNIFY process that is undertaken by all Tier 4 CAMHS providers and commissioners each Friday whereby Providers are required to input vacant capacity to a national database. This is followed by a national telecon involving all 10 commissioning teams to review identified capacity, inappropriate admissions to adult or paediatric wards and any concerns in the system preventing access such as delayed discharges, quality and safety concerns, closure of units etc. This information is used to support teams, particularly on a Friday when there is often the greatest pressure on beds. It is also informing the National Tier 4 CAMHS Review.

5.23.5 The Area Team is undertaking a review of the Berkshire Adolescent Unit and commissioning arrangements. There is ongoing work to scope and define the clinical work of the service and to what extent this meets the specification of Tier 4 and to understand any gaps. The unit is engaged in the QNIC peer review process and was included in the provider survey element of the National Tier 4 CAMHS Review.

Current Waiting Times for Treatment

5.24 In 2012/13 Berkshire CAMHS waiting times were slightly below the national average (reference NHS Benchmarking December 2013). However Berkshire CAMHS has seen a 25% increase in referrals over the past year. Comparing Quarter 3 in 2012-13 with 2013-14 the numbers have increased by 1,221 (3462 to 4,683), more than a third. Waiting times in Berkshire have risen as a result. This picture has been mirrored in other parts of the country. In Berkshire all referrals are triaged prior to children and young people being seen face to face, with the exception of urgent care referrals. The waiting targets are as follows: urgent (to be seen within 24 hours) – no breaches year to date; soon (to be seen within 4 weeks) – currently this target is not always being met. Children and young people with attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD) should be seen within seven weeks of return of forms by parents and school. There has been a very significant

increase in referrals from these groups and the majority of children are waiting longer than 7 weeks for treatment.

5.25 All children and young people, including non- urgent cases are to be offered a face to face appointment within 12 weeks. Over Q1 and Q2 87% of children and young people from Bracknell were seen within 12 weeks.

Re-commissioning Services

5.26 Commissioners of all tiers of service are reviewing provision. However, the timetable for any potential re-commissioning process has not yet been confirmed. BHFT is working closely with commissioners to further understand the nature of local challenges (which includes engagement with children and their families) and to agree required action in partnership.

5.27 NHS England is currently reviewing Tier 4 provision nationally. A report is expected in April. Nationally demand for Tier 4 beds outstrips supply and there are no dedicated beds in Berkshire at Tier 4.

5.28 Public Health are in the process of preparing for the council's new responsibility to commission health visiting services for 0 to 5 years and the Family Nurse Partnership for first time young mums from pregnancy until the baby is 2 years old. This responsibility will commence in 2015. A programme for a whole-system review of children's universal public health services has been set out (as reported to the Health and Well-Being Board on December 12th 2013). A joint Public Health/Children & Young People 'Task & Finish Group' is reviewing services for 0 – 5 years, whilst being mindful of the links to public health provision for 5 – 19 year olds, including the school nursing service. The review will have at its core a specific focus on promoting the emotional health and wellbeing of children and young people and ensure that there is effective link up with more specialist tiers of service such as CAMHS.

5.29 CCGs in Berkshire are reviewing CAMHS services with support from Thames Valley Strategic Clinical Network. The review will consider "does CAMHS provide timely, effective and efficient services to the population of Berkshire?" and include findings from the national Tier 4 review as well as results from stakeholder and service user engagement. The review will report to CCGs in mid May 2014. Commissioning intentions for the future will then become clearer.

5.30 The review of the Berkshire CAMHS service is going to involve an engagement exercise with those that use the service, have used the service and those who are involved in providing the services. The comprehensive plan includes:

- a survey for children and young people (designed by young people)
- a survey for parents and guardians
- a survey for clinicians and others involved in providing services.
- a survey for GPs
- interviews and focus groups

5.31 There will be a consistency across the surveys so that some areas can be directly compared and other sections specific to the group being surveyed.

5.32 In addition, interviews and focus groups will be organised with families who either identify themselves as willing via the surveys and others identified by CAMHS clinicians.

5.33 We are also seeking other opportunities to engage with groups and individuals eg Community Partnership Forum meetings.

5.34 There will also be awareness raising of this work through the local media.

What do we want to achieve?

5.35 Each service wants to deliver a timely service which meets the needs of young people. At the same time, as far as possible, we all want to prevent young people's needs escalating leading to referral to higher tiers. However, it is recognised that some young people will need to receive higher levels of support and will need to be able to access that provision in some cases immediately and for others within a reasonable timescale.

Examples of re-commissioning emotional health and wellbeing services

Early Intervention – Tier 1

5.36 The Public Health team has already started a process for enhancing the system of support aimed at improving mental well-being among young people. The overarching aim is two-fold. First, the intention is to increase the range of options for young people when they need to seek confidential advice or counselling. Second, the aim is to facilitate the development of positive mental well-being and self esteem via programmes aimed at promoting physical health and social participation. In both cases, new initiatives will build on and enhance any programmes that are already in place.

5.37 For example, a service specification is currently being prepared for the delivery of on-line, confidential counselling that will provide a readily accessible alternative or supplement to existing, face to face counselling provision. Research suggests that young people readily use the internet when seeking help with mental health issues (Burns et al 2010) and review-level evidence indicates that web-based counselling is effective in improving outcomes (Hanley & Reynolds, 2009). A service for Bracknell Forest will utilise fully accredited counsellors and be linked up with local systems for education, support and safeguarding. The programme will be evaluated using standardised measures of well-being as well as feedback from those using the service.

5.38 In addition, new initiatives are being put in place to prevent the uptake of smoking among children, which evidence suggests has an adverse effect on mental as well as physical well-being (via its effects on neurotransmitters such as serotonin). The smoking prevention programmes will have poor self esteem as a key consideration and focus on harnessing social influences in a way that addresses the place of smoking (and other health related behaviour) within youth culture.

Family and Parenting Support – Tier 2

5.39 This has been reviewed and is being re-commissioned providing greater clarity of outcomes and better targeting of parenting programmes to need. This will be fully implemented by September 2014.

Early Intervention Proposal and possible external funding bid for a Social Impact Bond Bid

5.40 We are at a very early stage of exploring the possibility of preparing a bid for external funding for early intervention around preventing cases escalating to Tier 3 CAMHS. It is too early to state if this will be successful and there would be costs associated with payment for achieving the agreed outcomes should the SIB go forward.

Greater Understanding of Transition

5.41 The current system at Tiers 2+-4 requires certain trigger points to be met before a service can be accessed. Seeing service provision as part of a continuum could help resources to be better deployed. A Council/CAMHS Partnership working group is in place, meeting on a quarterly basis. This group brings together agencies in Bracknell Forest to work in partnership to deliver a range of mental health services and link to

Borough wide initiatives as appropriate. Based on a needs analyses the group monitors the priorities and actions within its strategy. The work of this group will be revisited and a paper will be presented at the Children and Young people Partnership meeting in May looking at the way forward. It is envisaged that this group will focus more on the Tier 1 and 2 provision. There is also a Pan Berkshire Strategic commissioning and development group chaired by the CCG commissioner with LA representatives. The focus of this group is moving towards a more strategic view of how the system works across the tiers in Berkshire.

Future Outcomes

The challenge and ambition is:

5.42 To ensure that a "pathway" model of service commissioning enables each tier to deliver the required response times, avoiding unnecessary escalation to higher tiers. However to achieve this ambition the implication for service delivery needs to be considered- if all children and young people were treated within 4-6 weeks there would need to be a massive growth in capacity .

5.43 To confirm an evidence-based trajectory at each tier, which informs levels of investment in services. For example, young people's needs being met in a timely manner at the least restrictive level, and them making a sustained recovery and/or reducing days missed from school due to ill health. This would also require further investment.

5.44 CAMHS will continue to see urgent cases e.g. those who are suicidal or in crisis within 24 hours.

5.45 At a national level the outcomes from the Health Select Committee Inquiry into children and adolescent mental health and CAMHS will further inform and direct service provision.

Conclusion

5.46 There is clearly a great deal of work that is currently taking place both on a national level and local, but it is too early yet to understand the full implications of that work. In preparing this report a number of those strands of work have been brought together and further meetings of commissioners held to confirm the stages reached in developing those arrangements. The new Children and Young People's Plan will continue to co-ordinate the emotional health and wellbeing strands at Tiers 1 and 2.

5.47 It is recommended that once the national reports are concluded, the outcome of the local consultation by the CCG is known in May that a follow-up paper is presented to the HWBB later this year which focuses on next steps and timescales. This needs to include a specific strand of work and investment plans to prevent cases escalating to Tiers 3 and 4 which are high cost for the CCG and NHS England.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal provisions are contained within the main body of the report.

Borough Treasurer

6.2 The financial impact of any recommissioned services will need to be established and implications agreed with the responsible funding body prior to effecting any changes.

Contact for further information
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APPENDIX 1

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

Extract from Guidance for Commissioners of Child and Adolescent Mental Health Services (JCP-MH) October 2013

What would a good child and adolescent mental health service look like?

Model of Service Delivery
While there is no prescribed 'best practice' model, and services need to relate to local need and circumstances, a good CAMHS should be able to provide care that is:

- Timely – delivered without long (internal or external) waits for interventions appropriate to the age and needs of the child or young person.
- Effective – have sufficient numbers of staff with the right skills to be able to offer evidence based interventions that meet the needs and goals/wishes of children, young people and families.
- Efficient – with a delivery model that best focuses the capacity of the service to the demands of the population.

Access

- There should be clear care pathways with agreed referral processes and signposting.
- Staff within universal and targeted services should be able to discuss potential referrals and receive advice and support through supervision/consultation.
- There should be close working links between targeted and specialist services (including education and local authority children's services, as well as voluntary sector services) to facilitate easy, smooth transfer between the different service tiers, as well as joint working.
- There should be strategies to reach out to groups historically less likely to access CAMHS which are tailored to the particular needs of local populations
- There should be 24 hour services/on-call provision.
- There should be agreement on emergency provision including assessment facilities in Accident and Emergency, place of safety during assessment and access to emergency inpatient beds.

Strategic direction

- Good clinical and managerial leadership should be in place to provide the operational and strategic direction for the team.
- At a multi-agency level there must be commitment to delivering integrated services both in terms of strategic direction and appropriate resourcing (this will require not only effort on the part of CAMHS, but also by multi-agency partners, and commissioners should play a central role in ensuring this occurs).
- Involving young people in planning services is key.

Provision

- There should be an appropriate range of services. These include 'sub-specialist' services for children with learning disabilities, acute hospital liaison services for children with serious and chronic physical illness, services for children and young people with Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) (which may be provided jointly with community child health/community paediatrics), infant mental health services (which may be provided as part of multi-agency early years provision), eating disorder services,

substance misuse services, and community adolescent forensic services (this is not an exhaustive list and there may be additional needs).

- There should be services which are able to offer more intensive interventions than standard care to children and young people who may otherwise require admission to hospital – these include acute crisis care, but could include services for young people requiring more intensive treatment over a longer period of time (eg young people who are housebound, young people with severe eating disorders, or young people who repeatedly self-harm).
- The commissioning footprint for the sub-specialist services may be larger than the population the CCG is responsible for – in such situations individual CCGs will need to jointly collaborate and doing this can reduce the need for more expensive packages of care by preventing escalation up the care pathway.
- A critical mass of staffing is essential – standard 9 of the National Service Framework recommended that a generic specialist multi-disciplinary CAMHS at Tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of twenty whole time equivalent clinical staff (WTEs) per 100,000 total population, while a non-teaching service required a minimum of 15 WTE clinical staff.
- It is unlikely that a fully comprehensive, flexible service (in terms of both offering routine appointments outside traditional hours and at a location other than the clinic) which can offer timely access can be achieved with fewer resources.
- Local geography should be taken into account – where teams cover dispersed populations over a large geographical area, travelling time needs to be factored in when calculating staffing profiles.
- Teams should include a range of skills in both assessment and treatment, including child and adolescent psychiatrists, clinical psychologists, CAMHS nurses, CBT therapists, child psychotherapists, family therapists, creative therapists (depending upon the local team remit/need for access to occupational therapists and speech and language therapists who may be embedded in the team).
- A variety of therapeutic skills are needed, including behavioural, cognitive, interpersonal, psychodynamic, pharmacological and systemic approaches – there is a growing evidence base of interventions that have a positive effect on mental health outcomes for children and young people.
- Services should be provided in appropriate, safe, child/young person centred surroundings.
- There should be good support and development for all staff through supervision, appraisal, continuing professional development (CPD) and mentoring.
- Services should be part of a peer network such as the Quality Network for Community CAMHS (QNCC) and the CAMHS Outcomes Research Consortium (CORC).
- The services need to be sustainable in terms of recruitment and retention.
- Many services have a role in relation to training and workforce development, and this is vital in meeting the needs of future generations.
- Adequate administrative support should be available to the team to maximise the clinical time available for children, young people and their families.

Discharge/transition

- Discharge planning should receive equal attention to referral processes, including where appropriate services/agencies can offer on-going support.
- Clear processes should be in place for young people who will require intervention and support in adult life, and the young person should be involved in the decision making.

Outcomes, evaluation and feedback

- All services should have a system of routinely collected patient outcomes as recommended by the Children and Young People's Health Outcomes Forum further supported by the Government response 'Improving Children and Young People's Health Outcomes; a system-wide response to the Report of the Children and Young People's Health Outcomes Forum'.
- Such outcomes are one aspect of quality which should also include measures of patient, user and carer experience.
- The information from these outcome measures should be used by clinicians to guide on-going interventions, and used by service managers to improve service provision.
- Many services are already implementing some system of outcomes monitoring.
- The Children and Young People's Improving Access to Psychological Therapies (IAPT) project is:
    - Mandating the collection of a national agreed outcome framework for participating services (these are used on a high frequency, or a session-by-session basis).
    - Using outcome data in the direct supervision of the therapist, to determine the overall effectiveness of the service (and produce service 'benchmark' data).
    - Making these outcome tools, data-sets and guidance available at www.iapt.nhs.uk.
- The CAMHS Outcome Research Consortium (CORC) is a collaboration between CAMHS which use an agreed common set of measures to routinely evaluate outcomes from at least three key perspectives (the child, the parent/carer and the practitioner).
- Effective outcomes monitoring requires administrative and clinical time, commitments, as well as IT resource which must be accounted for in commissioning.

Outcome measurement is one aspect of service evaluation. Others include patient/carer experience, audit, monitoring of adverse events and serious incidents.

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POLICY BRIEFING

Closing the gap: priorities for essential change in mental health

17 February 2014

Christine Heron LGiU associate

Summary

The Department of Health has published its priorities for transforming support for people with mental health problems over the next two to three years. The priorities are to be carried out at national and local level and include:

- a crisis care concordat setting out expectations for patients in crisis
- an 'information revolution' to improve data, including work by PHE to gather information on promoting wellbeing and preventing mental ill-health
- choice of consultant/mental health professional at first outpatient appointment.

Briefing in full

Background

Closing the Gap supports the measures in the national mental health strategy No Health Without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through 25 priorities for action – issues that current programmes are starting to address and where 'strategy is coming to life'. The government will report on progress on these priorities next year.

Increasing access

1 High quality mental health services with an emphasis on recovery and meeting local need

Commissioners need better information on what works in mental health. Action to provide this includes.

- NICE has produced a range of quality standards and is producing more.

- NHS England has launched a mental health leadership programme for clinical commissioning groups (CCGs), is producing best practice specifications for specialist mental health services such as schizophrenia, and is developing a range of commissioning tools including those to support integration of physical and mental healthcare.
- The Joint Commissioning Panel for Mental health has produced value-based commissioning guidance.
- A national summit on best practice in psychosis in March 2014.
- PHE to build evidence on promoting wellbeing and preventing mental illness
- PHE, NHS England and the LGA are working together on joined up resources e.g. drug and alcohol and mental health.

2 An information revolution around mental health

There is a need for better understanding about mental health to be used as a basis for improvement.

- A mental health intelligence network (MHIN) – similar to the national cancer intelligence network – will be established to identify trends such as age, and geography, and information about what local services are provided and how effective these are. This information will be made publicly available but will primarily be for health and wellbeing boards, CCGs and other partners to implement change.
- PHE will run a new programme to gather information about mental health, wellbeing and prevention and will produce a framework for action early in 2014. The DH has produced the mental health dashboard to track key measures from the outcome frameworks; work will take place to assess whether these are the best outcome measures – currently there is work to investigate an outcome around recovery.
- Better local information sharing is important for ensuring personalised, joined up support.

3 Waiting time limits for mental health services

The Government's Mandate to the NHS sets out a commitment to developing access or waiting time standards to establish parity with physical health. NHS England is collecting data on this, and new standards will be introduced in 2015 for adults and children and young people's mental health.

4 Tackling inequalities in access

Work is taking place to address inequalities in service use and outcomes, e.g. low take up of psychological therapies by black and minority ethnic communities, older people and ex offenders and veterans; the DH is working with groups such as Age Concern and the Race Equality Foundation to increase take-up.

5 & 6 Increasing access to psychological therapies for adults and children

600,000 adults receive psychological therapies every year, and in the last three years 45,000 have been helped to come off benefits and return to work. The government intends to increase uptake to 900,000 a year. It is incentivising CCGs to increase access through the Quality Premium additional funding scheme. NHS England is planning a country-wide extension of the transformation programme for talking therapies for young people by 2018.

7 The most effective services will get the most funding

A new payment system for mental health was introduced in 2012 – assessing people in clusters of conditions (e.g. cognitive impairment or dementia) with a scale of seriousness (e.g. low-level need) that are linked to payments for care packages rather than block contracts. The government is working with NHS England and Monitor to develop the new payment and pricing system for mental health (payment by results although this term is becoming less common) to base it more on quality and outcomes rather than volumes of activity. From April 2014, the Health and Social Care Information Centre will provide monthly reports to commissioners on provider performance. The report indicates 'In the future this could mean that the best services i.e. those that deliver the most successful outcomes, such as highest recovery rates, get more funding'.

8 More choice

The government is establishing new legal rights for choice in mental healthcare similar to what is available in physical healthcare – choice of provider/consultant/ mental health professional when people attend their first outpatient appointment (with some exemptions around emergencies or compulsory detentions). NHS England is working with local areas on applying personal health budgets in mental health.

9 Reduce all restrictive practices and end the use of high risk restraint

The government has asked the Royal College of Nursing to work with others to develop new guidance which will then be consulted on.

10 Friends and family test

The use of the test to allow patients with mental health problems to comment on their experience of services has been piloted and will be used routinely from December 2014. The report encourages providers to start in advance of this date.

11 Poor quality services identified sooner and action taken

The report points to measures being taken to make Care Quality Commission (CQC) inspection and regulation more robust. Specific measure relating to mental health include a thematic review of emergency mental health, and mental health inspections to be more focused on the views of people who use services and their carers, including those detained under the Mental Health Act.

12 Better support and involvement for carers

The Standing Commission on Carers is focusing its fact-finding visits on how carers of people with mental health problems are being supported. The Carers Trust has produced best practice guidance and an assessment tool for involving carers in the planning and delivery of mental health services.

Integrating physical and mental healthcare

13 Better integration of mental and physical health

As much as 80 percent of all mental health care takes place in GP surgeries and hospitals. Work to ensure staff in these settings understand mental health include.

- Health Education England (HEE) to develop training programmes to equip all healthcare workers to understand the links between physical and mental health
- A new NHS England programme to ensure equal priority with physical health across the entire health system
- Public Health England (PHE) has started work to improve understanding of mental health in the public health workforce
- The Royal College of GPs is working to improve GPs' understanding of severe mental illness including physical health needs and crisis care; it will appoint a mental health clinical lead and will enhance GP training to better cover mental healthcare.
- The government has allocated the Better Care Fund, and most of the 14 integrated care pioneers include a focus on joined-up mental health.

14 Front-line services respond more effectively to self-harm

The report indicates that emergency departments often ignore NICE guidelines to offer a comprehensive physical, psychological and social assessment of people who self-harm. GPs should also refer people to talking therapies where appropriate. A new measure in the NHS Outcomes Framework will identify the percentages of those who attend emergency departments that receive a psychosocial assessment. The government will also identify how other frontline services can improve their response to self-harm.

15 No one in mental health crisis should be refused a service

The report indicates that people in crisis are turned away from service at weekends or if they are full and that this must not continue. Crisis support should focus on avoiding hospital admission.

- A national Crisis Care Concordat developed with a range of stakeholders will be published shortly; this will set out what people in crisis should receive, focusing on better coordination between emergency and mental health services including a single point of access.

- The government is also piloting 'street triage' in which people with mental health problems work with police officers to provide rapid assessment and referral for people who have not committed crimes.

Promoting mental wellbeing and preventing mental health problems

16 Better support for postnatal depression

Around ten percent of women suffer mental health issues around pregnancy or birth. Health Education England is involved in mental health training for health visitors and midwives, with a specialist in every birthing unit by 2017.

17 Schools supported to identify mental health problems sooner

New developments include.

- The new special educational needs code of practice due to be introduced in September 2014 will provide statutory guidance on identifying children and young people with mental health problems who have a special educational needs.
- An interactive e-Portal providing access to the latest evidence, guidance and tools will be operational early in 2014.

The government also encourages all schools that have not implemented measures in the Mental Health Strategy Implementation Framework to do so as soon as possible.

18 End the cliff-edge of lost support at age-18

The report indicates that too many young people with ongoing mental health problems no longer receive the right levels of support when they turn 18, with the most affected often the most vulnerable and disadvantaged.

- NHS England is developing a service specification for transition from child and adolescent mental health services (CAMHS) which can be used by CCGs and councils to apply best practice and monitor performance.
- A high level scoping study is being carried out to examine the evidence for both physical and mental health services for people aged 15 to 24 years and the implications for care pathways.

Improving the quality of life of people with mental health problems

19 People with mental health problems will live healthier and longer lives

The report describes the health inequalities and lifestyle and social issues faced by people with mental health problems. It is encouraging GPs, mental health workers and people with mental health problems to take more action to improve their physical health.

20 More people will live in homes that support recovery

Although settled, safe accommodation is vital for people with mental health problems there are no clearly defined models for what this should look like. The government 'wishes' to allocate up to £43 million to support a small number of housing projects designed with and for people with mental health problems and learning disabilities and to learn from this to showcase good practice. A national forum on housing will be hosted in 2014.

21 A national liaison and diversion service

The government is introducing a Liaison and Diversion service at police interview and custody suites and courts to provide early assessment, support. Information about individuals' assessments will be shared with the court and will be taken into account in decisions about charging and sentencing. The service will be trialled in twenty areas over the next two years, evaluated, and rolled out swiftly thereafter. The government is also looking to change how people are treated post-sentencing, e.g. improving access to mental health treatment requirements.

22 Enhanced support to victims of crime

People with mental health problems are far more likely to be victims of crimes than perpetrators. The new Victim's Code which came into effect in December 2013 gives enhanced support to people with mental health problems in the criminal justice system, such as the right to ask to give testimony by video link. From October 2014 the majority of support for victims will be commissioned by local police and crime commissioners who can work with health and care commissioners to ensure a shared approach.

23 Support employers to help more people with mental health problems stay in or enter employment

NHS England is working with the Department for Work and Partners to identify best practice for employers in recruitment, retention and support. PHE is carrying out a major programme of support for employers. From late 2014, the government is introducing a new health and work service to provide advice to employers, and assessment and support for employees who have been on sickness absence for four weeks to help them back to work.

24 New approaches to help people with mental health problems move into work and support them when unable to work

Psychological Wellbeing and Work: Improving Service Provision and Outcomes – research commissioned by DH and DWP – made a number of proposals which the Government is considering developing into pilots focusing on better integration between employment and health services. Initiatives may include developing the link between psychological therapies and employment support, resilience building in people out of work, and access to work and wellbeing assessments online, by phone and face to face. These will complement existing programmes such as Access to Work and Work Choice.

25 Stamping out discrimination

The report expresses the intention to 'continually challenge' and 'ultimately remove' stigma and discrimination. It points to the Time to Change campaign led by Mind and Rethink Mental Illness which aims to change public attitudes, and has already reached 29 million people. It describes research into the impact of the Equality Act 2010 which shows people with mental health problems are already experiencing less discrimination from friends, family and in society. The government wants all departments and NHS organisations to sign the Time to Change pledge.

Comment

This report is a useful update on significant developments such as the Crisis Care Concordat. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate. It was signed off by the Deputy Prime Minister and the Secretary of State for Care and Support, perhaps emphasising the particular support for this policy from the Liberal Democrat part of the coalition.

As the document was published, a row was taking place about the decision by NHS England and Monitor to reduce the tariff for mental health and community trust services by 20 percent more than that for acute providers in 2014-15, in effect requiring a fifth higher savings; this was on the basis that implementing the Francis report did not apply to these providers. Health Service Journal (HSJ) reports that a coalition of organisations – the Mental Health Network, NHS Confederation and Foundation Trust Network – appealed to Jeremy Hunt, but no change has been made. HSJ understands that some may be considering whether to apply for a judicial review on the grounds that this breeches the Government's parity of esteem policy.

Care and Support Minister Norman Lamb has said he is 'appalled' by NHS England and Monitor's decision, and that trusts' draft budgets will be scrutinised by Government, with action taken if there was evidence that mental health finances were suffering unduly. NHS England has pointed to the need for better financial, activity and performance data in mental health which is being addressed by the 'information revolution' – one of the 25 priority areas. The clinical director for mental health warned providers against disinvestment in intensive clinical teams and pointed to major investment by NHS England in training CCG mental health leads to roll out parity of esteem.

The dispute rumbled on through February with NHS Board member Lord Adebowale expressing the view that the decision was 'astonishing' and 'unacceptable'. NHS England and Monitor issued a joint statement saying that commissioners and providers are able to negotiate and agree local prices under the national payment system guidance published in December. The Mental Health Network has countered by claiming that 'the starting point for local negotiations will be a differential'.

A further dispute took place in the House of Lords about the government's decision to stop the annual survey of mental health spending. Opposition representatives said the survey showed the proportion of NHS spending on mental health had fallen for two years, and that it was being scrapped because it revealed cuts. The government said that the survey had been stopped in 2012 to 'reduce bureaucracy' and that NHS England will publish data on mental health spending in 2012-13.

Establishing national *mandatory* tariff-based pricing has been a long and difficult process in mental health. This was due to be introduced in April 2014, but has been paused by Monitor due to problems with data quality and different stages of readiness in applying the cluster model across the country. The current system of national tariff and local negotiation will continue as data quality and work to link the tariff to outcomes improves; only then will a decision be made on whether setting national prices in mental health will be appropriate in the longer term.

Closing the Gap refers to basing future payment systems on outcomes and quality rather than activity, which are laudable aims. It would seem though that plans to target funding at providers delivering the most successful outcomes are unlikely to be achieved in the near future.

Related policy briefing

Preventing suicide in England: one year on

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

Unrestricted

TO: Health and Wellbeing Board
DATE OF MEETING
10 APRIL 2014

UPDATE ON THE PROGRESS OF THE FRIMLEY PARK HOSPITAL NHS FT ACQUISITION OF HEATHERWOOD & WEXHAM PARK HOSPITALS NHS FT

1 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board of progress in the Frimley Park Hospital NHS FT acquisition of Heatherwood and Wexham Park Hospitals NHS FT

2 RECOMMENDATION

2.1 The Board is asked to note the report.

3 REASONS FOR RECOMMENDATION

3.1 The report is for information

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None applicable

5 SUPPORTING INFORMATION

5.1 Frimley Park Hospital NHS FT is continuing with its plans to merge with Heatherwood and Wexham Park Hospitals NHS FT through acquisition. The Trust has shared its rationale for entering into this process as aiming to:-

- Future proof services for patients currently provided at both trusts and leave the enlarged trust in a strong position for growth
- Continue to develop services for patients in the enlarged Trust catchment and ensure they are financially sustainable
- Create a new vision for patient services across the new catchment.

The financial challenge faced by the NHS means that there is a continued impetus for increased efficiency, greater specialisation and 24 hour working, meaning that medium sized Trusts such as Frimley Park and Heatherwood and Wexham Park will potentially need much bigger catchment populations.

The developing model is for full hospital services to remain at Frimley and at Wexham with a new elective site at Heatherwood Hospital in Ascot. If there are any changes in services in the future at any site in the enlarged trust, they will be implemented gradually and all stakeholders will be informed well in advance, and consulted as appropriate.

The acquisition is being thoroughly scrutinised and will need to be approved by each Trust's Board and Council of Governors, the Office of Fair Trading and Monitor, the foundation trust regulator. It will only go ahead if parties across the health system believe it is right for patients and financially sustainable.

The future vision of the enlarged trust is that

- It will allow the trust to provide excellent quality patient service across all three sites, meeting the national standards that patients should expect
- The new organisation will provide a consultant–led service, recognised by Sir Bruce Keogh as essential to providing the very best care to the most seriously ill and injured patients
- It will put the enlarged organisation in a strong position to gain super A&E status for local patients – one of the 40 to 70 proposed in the Department of Health's national vision
- An extended trust would have the option to develop Heatherwood as a centre for planned surgery to serve patients from both trusts' existing catchments. This would take some pressure away from both the Frimley and Wexham Park sites.
- Care of elderly people will be developed, with less reliance on patients spending time in hospital and more support provided in local communities. This fits well with Bracknell Forest Health and Wellbeing Board strategy for integrated services under the Better Care Fund arrangements.
- The Trusts will take the opportunity to make savings in corporate support functions that will help meet the 4% year on year efficiency savings required under NHS funding.

If the acquisition goes ahead there will be sufficient funding available from other sources to remove the current Heatherwood and Wexham Park debt and turn the finances around into a positive year-on-year position. If not, Frimley Park Hospital will not proceed with the acquisition.

Capital investment from the Department of Health into the Heatherwood and Wexham Park sites is expected to continue throughout and after the acquisition. No current Frimley Park capital will be needed immediately for HWPH, so capital plans relating to the Frimley Park Hospital site will continue.

The six main CCGs who commission from the two Trusts are Chiltern CCG, Bracknell & Ascot CCG, Slough CCG, Windsor Ascot and Maidenhead CCG, North East Hampshire and Farnham CCG, and Surrey Heath CCG. The CCGs understand the rationale for the acquisition and are working with the Trusts to develop the Full Business Case. This provides an opportunity to model the transformational changes signalled by the clear Health and Social Care strategy to strengthen investment in social care, community care and primary care in order to reduce the amount of time people spend unnecessarily in hospital.
CCGs will also be monitoring closely throughout the merger process to ensure that standards of quality and patient experience stay at the highest possible levels throughout.

Timescales for the transaction are short. The Full Business Case is due for completion by the end of April, with Frimley Park Board making their decision in May. If this is positive the new combined trust will commence in July 2014.

Contact for further information
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Unrestricted

TO: HEALTH AND WELL BEING BOARD
10 APRIL 2014

HEALTH AND WELL BEING BOARD – FIRST YEAR REVIEW
Director of Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 The purpose of this report is to set out a process to:-

- review the membership of the Health and Well Being Board; and
- establish the Board's priorities for 2014/15

2 RECOMMENDATIONS

That the Health and Well Being Board:-

2.1 Agree the action in 5.1 to provide additional support to the Board from the Joint Commissioning Team.

2.2 Agree to hold a workshop with the aim of:-

- **reviewing role and function of Board, including membership (see 5.2)**
- **establishing the Board's priorities for 2014/15 (see 5.3)**

3 REASONS FOR RECOMMENDATIONS

3.1 The Health and Well Being Board has been operational for a year in its current format. In this context, reviewing the membership and functioning of the Board is timely, given the changing priorities that have occurred during the course of the year.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 Do nothing and risk being unresponsive to local and national developments.

5 SUPPORTING INFORMATION

5.1 Supporting the Health and Well Being Board

5.1.1 The Board has been supported during the year by officers as part of their 'day to day' activity. On reflection, this has meant that this has resulted in a more reactive rather than proactive approach. This will become more relevant if the Health and Well Being Board establishes its priorities and develops an action plan from the reviewed Joint Health and Well Being Strategy.

5.1.2 With this in mind, the Joint Commissioning Team has been restructured in order to free up the Head of Joint Commissioning for 2 days a week to undertake the role of 'Business Manager'. This has been created using 'one off' resources and will need to be reviewed at the end of 2014/15.

5.2 Reviewing the Board

5.2.1 The Board has been in existence for a year now under the new regulations. This seems an opportune time to reflect on the demands made on the Board and the best way of discharging these responsibilities in an effective manner.

5.2.2 Clearly, various government departments are requiring that various reports are presented to the Health and Well Being Board, regardless of other governance arrangements. This could mean on one level that the Health and Well Being Board simply endorses plans, policies and reports formally agreed elsewhere.

5.2.3 Additionally, if the Board is to establish its priorities (see 5.3), then this needs to be factored in.

5.2.4 There are many examples of how this is achieved around the country which could be considered and reflected on in our local context.

5.3 Developing the Board's Priorities

5.3.1 At the current time, the Health and Well Being Board's priorities could be said to have been established by the Joint Health and Well Being Strategy. However, the Board has not formally endorsed the key areas where it expects to see action and a refocusing of commissioning effort.

5.3.2 In establishing a small number of agreed priorities, the Health and Well Being Board can add its weight to supporting the changes required. From this will also develop a set of relevant performance indicators by which progress can be developed.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

6.1 Borough Solicitor

The proposals within this report are all within the Council's powers.

6.2 Borough Treasurer

There are no direct financial implications within this report, for the Council.

6.3 Equalities Impact Assessment

N/A

6.4 Strategic Management Issues

N/A

Contact for further information

Glyn Jones, Adult Social Care, Health and Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

TO: HEALTH AND WELLBEING BOARD
10 APRIL 2014

PROTOCOL BETWEEN THE HEALTH AND WELLBEING BOARD, HEALTHWATCH AND HEALTH OVERVIEW AND SCRUTINY PANEL
Director of Adult Social Care, Health and Housing

1. PURPOSE OF REPORT

1.1 The purpose of this report is to set out a draft protocol between the Health and Wellbeing Board, Bracknell Forest Healthwatch and the Health Overview and Scrutiny Panel.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:-

2.1 Agree the protocol between the Health and Wellbeing Board, Healthwatch and Scrutiny.

2.2 Recommend that the protocol be presented for agreement to the Health Overview and Scrutiny Panel.

3. REASONS FOR RECOMMENDATIONS

3.1 The reasons for setting out and agreeing a protocol between the Health and Wellbeing Board, Healthwatch and Scrutiny Committees are to ensure:

- Appropriate governance arrangements
- Defined and agreed accountabilities defined
- Duplication is avoided and issues are not missed

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 There is no alternative.

5. SUPPORTING INFORMATION

5.1 The Health and Wellbeing Board received a report in February detailing the roles and responsibilities of the Board, the Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest.

5.2 The Board requested that a meeting be held between Healthwatch Bracknell Forest, an officer representing the Council's Overview and Scrutiny Function and an officer representing the Health and Wellbeing Board to develop a protocol regarding the roles, responsibilities and working arrangements between the three bodies. The draft protocol is attached as Annex A to this report.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal implications are contained within the main body of the report.

Borough Treasurer

6.2 The Borough Treasurer is satisfied that there are no direct financial implications arising from this report.

Equalities Impact Assessment

6.3 Any proposals for service redesign will consider the impact on people in the community.

Strategic Risk Management Issues

6.4 If roles and responsibilities of the partners are not clear there is a risk of duplication of effort and insufficient capacity to deliver on the priority areas.

7. CONSULTATION

Principal Groups Consulted

7.1 Members of the Health and Wellbeing Board, NHS providers and members of scrutiny panels.

Method of Consultation

7.2 Workshop held in October 2013.

Representations Received

7.3 Representations have been incorporated into this report.

Contact for further information

Glyn Jones, Adult Social Care, Health and Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Protocol between the Bracknell Forest Health and Wellbeing Board, the Bracknell Forest Council Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest.

This protocol concerns the relationship between the Bracknell Forest Health and Wellbeing Board, Bracknell Forest Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest. Its purpose is to ensure that:

- Mechanisms are put in place for exchanging information and work programmes so that issues of mutual concern/interest are recognised at an early stage and are dealt with in a spirit of co-operation and in a way that ensures the individual responsibilities of the Health and Wellbeing Board, the Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest are managed

- There is a shared understanding of the process of referrals and exchange of information and that arrangements are in place for dealing with these.

……
Chairman of the Health and Wellbeing Board

……..
Chairman of the Health Overview and Scrutiny Panel

…….
Chair of the Healthwatch Bracknell Forest Board

THE BRACKNELL FOREST HEALTH AND WELLBEING BOARD

The Health and Wellbeing Board is a committee of the Council. The membership of the Board includes local Councillors, officers of the Council, representatives from the NHS and local Healthwatch. The board takes the lead on improving health and wellbeing outcomes and reducing health inequalities for the local community. Although there is a prescribed minimum membership, boards operate differently responding to local circumstances. Health and Wellbeing Boards are an executive function of the Council and are responsible for identifying current and future health and social care needs and assets through the Joint Strategic Needs Assessment and developing Joint Health and Wellbeing Strategies to set health and social care priorities.

The role of the Health and Wellbeing Board is to:

- Set priorities and to drive the development of health and social care within the Borough
- Bring together individual and organisational knowledge, expertise and experience and to act as a system leader
- Develop a strategic, area-wide view of health and social care needs and resources through the Joint Strategic Needs Assessment
- Agree an area-wide alignment of services to deliver improved health and wellbeing through the Joint Health and Wellbeing Strategy
- Facilitate shared understanding of information to improve outcomes from decision making
- Develop arrangements to involve key providers in improved health and social care.

To do this the Board will:

- Communicate and engage with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their health and wellbeing by working with other stakeholders
- Have oversight of the relevant health and social care resources across all sectors so that it can drive the further integration of health, social care and public health
- Monitor performance against agreed targets and service standards across the local health and social care economy to inform future commissioning by the Council and the National Health Service.

HEALTH OVERVIEW AND SCRUTINY PANEL

Councils with social care functions can hold NHS bodies to account for the quality of their services through powers to obtain information, ask questions in public, and make recommendations for improvements that have to be considered. Proposals for major changes to health services can be referred to the Secretary of State for determination if they are not considered to be in the interests of local health services. Within Bracknell Forest this is done in conjunction with the Executive Member and Council. The way Councils use the powers is commonly known as "health scrutiny" and forms part of Councils' overview and scrutiny arrangements. From April 2013, all commissioners and providers of publicly funded health and social care services may be subject to overview and scrutiny, as may the health and social care priorities arising from the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. Scrutiny also has a pro-active role in helping to understand communities and tackle health inequalities.

The Health Overview & Scrutiny Panel has decided that the overall aim of Health scrutiny is:

> *'Through constructive challenge and accountability, to work with the Executive, the Health and Wellbeing Board and Health Service Providers to help ensure good health services are provided to residents of Bracknell Forest, reducing health inequalities, and helping everyone to stay fit and lead healthy lives.'*

In relation to the Health and Wellbeing Board and Healthwatch, the role of the Health Overview and Scrutiny Panel is to:

- Evaluate policies arising from processes and decisions and outcomes from services
- Consider whether service changes are in the best interests of the local health service
- Carry out pro-active qualitative reviews that can inform and enhance policy and services
- Work with Healthwatch to capture the views of people using services to inform their work.

To do this the Health Overview and Scrutiny Panel will:

- Take the lead for Overview and Scrutiny function on the relationship between O&S with Healthwatch Bracknell Forest, referring matters to other panels as appropriate
- Refer issues to Healthwatch Bracknell Forest for investigation or may commission HWBF to research evidence.

HEALTHWATCH BRACKNELL FOREST

Local Healthwatch is the consumer champion for health and social care, representing the collective voice of people who use services and the public in general. Healthwatch will build up a local picture of community needs, aspirations and assets, and the experience of people. It will report any concerns about services to commissioners, providers and Scrutiny committees. It does so by engaging with local communities including networks of local voluntary organisations, people who have used or are using services, and the public. Through its seat on the Health and Wellbeing Board, local Healthwatch will present information for the Joint Strategic Needs Assessment and discuss and agree with other members of the Board a Joint Health and Wellbeing Strategy. It will also present information to Healthwatch England to help form a national picture of health and social care. Local Authorities have the responsibility to ensure that the local Healthwatch operates effective and is value for money; managing this through local contractual arrangements.

The role of Healthwatch Bracknell Forest is to:

- Act as a “watchdog” and advocate for consumers
- Be a source of information for people in the community; to share information from networks of voluntary and community groups
- Gather and present evidence and information for Joint Strategic Needs Assessments and support scrutiny reviews
- Use good public engagement to demonstrate the “real-time” experiences of people who have experience of using health and social care services
- Highlight concerns about services to health scrutiny. In line with national guidance, Healthwatch has a duty to report concerns to Health Scrutiny. Within Bracknell Forest, it has been agreed that Health Overview and Scrutiny Panel will act as the recipient of the concerns.
- Cascade information to people in the community and the public about services and support that is available.

To do this Healthwatch Bracknell Forest will:

- Collect and share relevant public opinion and experiences using an evidence based approach
- Have an oversight of trends and local issues
- Access the Healthwatch England repository of information
- Exercise its powers to “Enter and View”
- Hold regular discussions with people in the community, commissioners and providers
- Provide evidence based feedback, attend Health Overview and Scrutiny Panel meetings as an observer, relevant workshops and working groups.
- Pefer matters to the Health Overview and Scrutiny Panel for the purposes of securing information and expertise
- In accordance with The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health And Local Healthwatch) Regulations 2012 (SI 2012:3094), escalate issues as necessary to the Health

Overview and Scrunity Panel. The respective Overview and Scrunity Panel has an obligation to acknowledge referrals within 20 working days of receipt.

For more information about Healthwatch Bracknell Forest please visit: www.healthwatchbracknellforest.co.uk

WORKING PRINCIPLES

Given that the common aims of the Health and Wellbeing Board, the Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest are to improve outcomes for people and ensure the commissioning and delivery of high quality, appropriate and efficient services, it is vital that they:

- Work in a climate of mutual respect, courtesy and transparency
- Have a shared understanding of their respective roles, responsibilities, priorities and different perspectives
- Promote and foster open relationships where issues of common interest are shared and challenged in a constructive and mutually supportive manner
- Share work programmes and information or data that have obtained to avoid duplication of effort

PRACTICE EXAMPLES

Scenario 1: The refreshed JSNA has indicated a need for integrated health and social care teams aligned with GP practices

Health and Wellbeing Board	The board has a duty to support integrated services and, reflecting on the JSNA, **decides** to include integrated teams as a priority in the Joint Health and Wellbeing Strategy. Following the implementation of the strategy, it **assesses what impact** the changes have had and **makes recommendations** for improvement.
Local Healthwatch	**Undertakes local research** about what people who use services are looking for, **identifies gaps** on service provision and **feeds the outcomes** onto the Health and Wellbeing Board to i**nfluence** the Joint Health and Wellbeing Strategy.
Health Scrutiny	**Examines** the process in light of members' knowledge of the local area and **makes recommendations** about how people in the community, particularly vulnerable groups, can be informed about changes to services. Depending on the outcomes or any issues raised, scrutiny could consider whether it would merit the establishment of a working group, recognising that there may be competing priorities.

Scenario 2: An issue related to health inequalities: A low uptake of child vaccination in particular wards

Health and Wellbeing Board	The refreshed JSNA indicates a low uptake that has implications for health and social care in some Council wards. Because the reasons are unclear, the Health and Wellbeing Board **asks Health Scrutiny to review** the issue.
Local Healthwatch	Through their seat one the Health and Wellbeing Board, local Healthwatch were **involved in reviewing** the JSNA, and now it uses its local networks to **gather views** about why some children are not being immunised and **reports** this to the Health and Wellbeing Board and Scrutiny.
Health Scrutiny	**Scrutiny asks Local Healthwatch** to gather local views. As a result of the discussions with Clinical Commissioning Groups, schools, health visitors and social workers, **makes recommendations** about ways to improve immunisations.

Scenario 3: A reconfiguration of maternity services across Council areas

Health and Wellbeing Board	Providers have proposed this as a solution to improving outcomes and make better use of available resources. The health and wellbeing board **assesses** whether the plans fit their Joint Health and Wellbeing Strategy and **takes a strategic view** on the outcomes and engagement with the clinical commissioning groups.
Local Healthwatch	**Undertakes a comprehensive exercise to gather views** from people who use services and the public, **checks** whether consultations reflect what is known about best practice and **presents views** as a health and wellbeing board member and to Council scrutiny during the formal consultation process.
Health Scrutiny	Agrees that proposals are a substantial/significant variation and, either individually or through joint arrangements with other Councils, **engages in early discussions** with the commissioners/providers regarding policy, plans and consultations. During the formal consultation stage it would **analyse the proposals** in a public forum, taking evidence and **coming to a conclusion** about whether the proposals are in the best interest of the local health service. This would be in conjunction with key officers and the Executive Member to seek to secure a "Council" response to proposals.

Unrestricted

HEALTH & WELLBEING BOARD: FORWARD PLAN 2014/15

Scheduling of agenda items are subject to change.

Last meeting of the Board: 13 February 2014

Item	Decision	Responsibility	Submitted to Board:
Local Healthwatch Forward Plan	For comment	Andrea McCombie-Parker	**SUBMITTED**
Pharmaceutical Needs Assessment	For comment	Lise Llewellyn	**SUBMITTED**
Better Care Fund	For comment	Glyn Jones	**SUBMITTED**
Roles of the Health & Wellbeing Board and Health O&S	For comment	Glyn Jones	**SUBMITTED**
Presentation on the Urgent Care Centre	Presentation	Onemedicare	**SUBMITTED**

10 April 2014

Item	Decision	Responsibility	Submitted to Board:
Report on the development of a Joint Commissioning Strategy for CAMHS	For comment	Janette Karklins, Mary Purnell and William Tong	
Protocol for Roles of HWB, HW and HOSP	For comment	Lynne Lidster	
2 Year and 5 Year CCG Plans	For comment	Mary Purnell/ William Tong	
Better Care Fund	For comment	Glyn Jones	
Frimley Acquisition	For comment	Mary Purnell/ William Tong	
Berkshire Healthcare Foundation Trust QSR 3	For comment	BHFT	
HWB – First Year Review	For comment	Glyn Jones	

5 June 2014

Item	Decision	Responsibility	Submitted to Board:

4 September 2014

Item	Decision	Responsibility	Submitted to Board:
Pharmaceutical Needs Assessment	For comment	Lisa McNally	

Other Areas the Board may need to consider:

Health and Social Care Act - Issues subject to commencement

Item	Decision	Responsibility
Charges for specific health services	To **receive information** on section 50 regulations relating to the application of application of Charges to Health Improvement and Health Protection Measures and to **decide** future action	CCG / LA
Personal health budgets	To **receive information** on section 55 regulations relating to personal health budgets and to **decide** future action	CCG

Item	Decision	Responsibility
Mental Health Advocacy	To **receive information** on section 55 regulations relating to mental health advocacy and to **decide** future action	LA
Establishment of Care Trusts	To **agree** the protocols for establishing Care Trusts between the LA and the CCG	

New or draft legislation

From April 2013

Item	Decision	Responsibility
Draft Care and Support Bill	To **agree** arrangements for the joint working of the NHS CB, CCG, LA and carers' organisations and agreeing plans and budgets to support carers	William Tong/ Glyn Jones/Janette Karklins/NHS CB Representative

BF Local Safeguarding Children Board Annual Report 2011/2012 – Subject to approval of document

Item	Decision	Responsibility
General Practice, Health Visiting and Midwifery Case Review Recommendations	To **agree** protocols for ensuring the Board and Clinical Commissioning Group and other health providers commissioned through the Health and Wellbeing Board are sighted on Case Reviews and lessons learned for General Practice, Health Visiting and Midwifery Case Review Recommendations are integrated into CCG and General Practice quality assurance systems	
Co-sleeping and bed-sharing for infants and small children	For the Board **to give a view** on community health professionals' advice on co-sleeping and bed-sharing for infants and small children	
Child protections practice of health economy providers	For the Board **to give a view** on the potential application of the Exemplar Safeguarding	

Item	Decision	Responsibility
	Audit Tool to audit the child protections practice of health economy providers	
Single and Inter-agency Training	*There is covered in section 4 – does the Board need to take a view on extending this throughout the new health economy?*	