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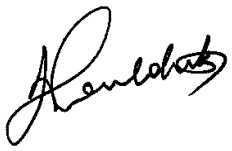
WOKINGHAM BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held at the Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 9 APRIL 2015** AT **5.00 PM**



Andy Couldrick
Chief Executive
Published on 31 March 2015

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Our Vision

A great place to live, an even better place to do business

Our Priorities

Improve educational attainment and focus on every child achieving their potential

Invest in regenerating towns and villages, support social and economic prosperity, whilst encouraging business growth

Ensure strong sustainable communities that are vibrant and supported by well designed development

Tackle traffic congestion in specific areas of the Borough

Improve the customer experience when accessing Council services

The Underpinning Principles

Offer excellent value for your Council Tax

Provide affordable homes

Look after the vulnerable

Improve health, wellbeing and quality of life

Maintain and improve the waste collection, recycling and fuel efficiency

Deliver quality in all that we do

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Keith Baker	WBC
Prue Bray	WBC
Charlotte Haitham Taylor	WBC
Nick Campbell-White	Healthwatch Wokingham Borough
Chief Inspector Rob France	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Dr Lise Llewellyn	Director of Public Health
Nikki Luffingham	NHS England
Judith Ramsden	Director of Children's Services
Clare Rebbeck	Place and Community Partnership
Stuart Rowbotham	Director of Health and Wellbeing
Katie Summers	NHS Wokingham CCG
Dr Cathy Winfield	NHS Wokingham CCG

ITEM NO.	WARD	SUBJECT	PAGE NO.
83.		**APOLOGIES** To receive any apologies for absence	
84.		**MINUTES OF PREVIOUS MEETING** To confirm the Minutes of the Meeting of the Board held on 12 February 2015. *(5 mins)*	**7 - 12**
85.		**DECLARATION OF INTEREST** To receive any declarations of interest	
86.		**PUBLIC QUESTION TIME** To answer any public questions A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice. The Council welcomes questions from members of the public about the work of this Board. Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Board or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions	

86.1 None Specific

Jim Stockley asked the Chairman the following question:

Question

Healthwatch Wokingham Borough have collated serious concerns from professionals, young people and parents about the Child and Adolescent Mental Health Services (CAMHS) in Wokingham Borough. A comprehensive independent review of CAMHS was undertaken a year ago. We understand that this service will not be recommissioned but that a local action plan for Wokingham is currently being finalised. Can you tell us who and which organisation is taking lead responsibility for turning this failing service around? Healthwatch Wokingham Borough believes that young people in Wokingham Borough are at risk of increased distress due to the lack of timely and effective emotional support being provided.

87. **MEMBER QUESTION TIME**

To answer any member questions

88. None Specific **HEALTH AND WELLBEING BOARD SUB-COMMITTEE** **13 - 20**

To receive a report regarding a Health and Wellbeing Board Sub-Committee.
(15 mins)

89. None Specific **PROTOCOL BETWEEN THE LOCAL SAFEGUARDING CHILDREN'S BOARD AND THE HEALTH AND WELLBEING BOARD** **21 - 26**

To receive a Protocol between the Local Safeguarding Children's Board and the Health and Wellbeing Board.
(15 mins)

90. None Specific **PERFORMANCE METRICS** **27 - 30**

To receive updates on performance against the following:

- Better Care Fund;
- Public Health Outcomes Framework, NHS and Adult Social Care,
- Health & Wellbeing Strategy 2014-17.

Please note that this will be by exception only.
(30 mins)

91. None Specific **BETTER CARE FUND SECTION 75 AGREEMENT** **31 - 92**

To consider a report regarding Better Care Fund Section 75 agreement. *(15 mins)*

92.	None Specific	**PRESENTATION ON DEPARTMENT OF HEALTH ASSURANCE PROGRAMME - BETTER CARE FUND** To receive a presentation on Department of Health Assurance Programme - Better Care Fund. *(10 mins)*	**-**
93.	None Specific	**PRESENTATION ON NEIGHBOURHOOD CLUSTERS** To receive a presentation on Neighbourhood Clusters. *(20 mins)*	**-**
94.	None Specific	**PRESENTION ON NHS WOKINGHAM CCG'S REFRESHED OPERATING PLAN** To receive a presentation on NHS Wokingham CCG's refreshed Operational Plan. *(15 mins)*	**-**
95.	None Specific	**BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST DRAFT QUALITY ACCOUNT** To consider the Berkshire Healthcare NHS Foundation Trust draft Quality Account. *(15 mins)*	**93 - 142**
96.	None Specific	**VOLUNTARY SECTOR REPRESENTATION** To discuss Voluntary Sector representation on the Health and Wellbeing Board. *(10 mins)*	**-**
97.		**ANY OTHER ITEMS WHICH THE CHAIRMAN DECIDES ARE URGENT** A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading	

CONTACT OFFICER

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MINUTES OF A MEETING OF THE
HEALTH AND WELLBEING BOARD
HELD ON THURSDAY 12 FEBRUARY 2015 FROM 5PM TO 6.45PM

Present:-

Keith Baker	Leader of the Council
Charlotte Haitham Taylor	Executive Member for Children's Services
Julian McGhee Sumner	Executive Member for Health and Wellbeing
Prue Bray	Opposition Member
Dr Lise Llewellyn	Director of Public Health
Judith Ramsden	Director Children's Services
Stuart Rowbotham	Director Health and Wellbeing
Dr Johan Zylstra	Wokingham Clinical Commissioning Group
Katie Summers	Wokingham Clinical Commissioning Group
Nick Campbell-White	Healthwatch Wokingham Borough
Chief Inspector Rob France	Community Safety Partnership
Clare Rebbeck	Place and Community Partnership

Also present:-
Helene Dyson, Public Health Service Manager
Darrell Gale, Consultant in Public Health
Madeleine Shopland, Principal Democratic Services Officer
Davina Williams, Policy & Strategy Manager (Community Safety, Partnership and Children's Service)

PART I

57. ELECTION OF A VICE CHAIRMAN FOR THE REMAINDER OF THE 2014/15 MUNICIPAL YEAR

RESOLVED: That Dr Zylstra be appointed Vice Chairman of the Health and Wellbeing Board for the remainder of the 2014/15 municipal year.

58. CONFIRMATION OF CLINICAL COMMISSIONING GROUP VOTING REPRESENTATIVE FOR THE HEALTH AND WELLBEING BOARD FOR THE REMAINDER OF 2014/15

RESOLVED: That:
1) it be noted that Dr Johan Zylstra would be the NHS Wokingham Clinical Commissioning Group voting representative on the Health and Wellbeing Board for the remainder of the 2014/2015 municipal year; and
2) if Dr Zylstra was unable to attend a Board meeting and a vote was required, his substitute would act as the voting representative.

59. MINUTES
The Minutes of the meeting of the Board held on 11 December 2014 were confirmed as a correct record and signed by the Chairman, subject to the addition of Judith Ramsden to the list of apologies.

60. APOLOGIES

Apologies for absence were submitted from Beverley Graves, Nikki Luffingham and Dr Cathy Winfield.

61. DECLARATIONS OF INTEREST

There were no declarations of interest made.

62. PUBLIC QUESTION TIME

There were no public questions received.

63. MEMBER QUESTION TIME

There were no Member questions received.

64. HEALTH AND WELLBEING SUB COMMITTEES

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Health and Wellbeing Board may establish formal sub-committees to discharge those of its functions it considers appropriate. It was proposed that the Health and Wellbeing Board's terms of reference set out in the Council's Constitution be updated to reflect this.

RESOLVED That the following amendment to the Health and Wellbeing Board's terms of reference as set out in the Council's Constitution be recommended to Council, via the Constitution Review Working Group;

> **"4.4.47 Health and Wellbeing Board Sub-Committees**
> The Health and Wellbeing Board has the ability to establish sub-committees and delegate functions to them. The Health and Wellbeing Board will agree the terms of reference and membership of any such sub-committee."

65. PERFORMANCE UPDATE

The Board received an update regarding performance.

Better Care Fund:

- The Board was presented with Better Care Fund metrics, which were also considered by the Wokingham Integration Strategic Partnership. The metrics indicated how the various Better Care Fund projects were performing.
- Board members were reminded that that the sole performance payment metric in the Better Care Fund Plan was reducing total emergency admissions to hospitals in 2015/6. The 2% reduction target would be challenging.
- Board members felt that the information could be presented in a different, simpler format to make it easier to understand. Some Board members suggested that the inclusion of comparative data would be helpful.
- It was agreed that a revised framework would be produced for the Board's next meeting.

Public Health Outcomes Framework:

- Darrell Gale provided an update on the Public Health Outcomes Framework, drawing Board members' attention to those indicators where performance was either poor or high. Some data was from 2012/13 and other sections were from more up-to-date data.
- Performance against the indicators relating to school readiness had been poor, in common with other areas of high affluence. However, progress had been made in

narrowing the gap and as part of the Families First project. Judith Ramsden explained that supporting school readiness was a key priority in Children's Services and that Early Years Resources had been refocused. Improvements were being made and an above average level of improvement was predicted.

- Performance against the Health Check indicators had been poor. Darrell Gale commented that it had been difficult to get lists of eligible patients from the GPs. Some GPs had been not been willing to offer the Health Check service. Four practices had expressed an interest and two had indicated that they did not wish to participate. Dr Zylstra commented that resources were an issue and that as capacity increased this was likely to improve. Whilst the number of those offered Health Checks had been low, the percentage of those offered a Health Check who then took up the offer was reasonably high. Clare Rebbeck stated that the voluntary sector was undertaking a pilot with three organisations willing to be involved in the Health Checks process.
- The Board discussed the indicators relating to sexual health related screening and vaccination. It was noted that a new contract for aspects of sexual health services was beginning in April 2015, and that this was likely to lead improvement in these areas through a focus on networked services and prevention. With regards to chlamydia screening, Dr Zylstra questioned whether there would be input from the schools. Helene Dyson stated that chlamydia screening would be targeted more and from April more work in the community would be taking place. In response to a comment from Judith Ramsden, Dr Llewellyn commented that outreach workers were trained to recognise the signs of child sexual exploitation.
- Nick Campbell-White queried the good performance of the indicator Statutory homelessness - households in temporary accommodation.

Implementation of the Care Act:

- Stuart Rowbotham updated the Board on the implementation of the Care Act.
- The Council was on track to meet the required changes for April 2015 and had completed a stocktake on its preparedness.
- There would be a new eligibility criteria and assessments as the Council moved from 'critical' to 'substantial.' Discussions with the Department of Health continued.
- Board members were informed that the Wokingham Better Care Fund Plan had been given full assurance.
- The Council was also on track regarding processes and new staff were being recruited to undertake the additional assessments. Extensive staff training was ongoing.
- Changes were being made to the IT systems to facilitate self-assessments.
- There would be a new entitlement to services for self-funders and carers.
- With regards to the Council's duties relating to the provision of information and advice, the Wokingham Information Network webpage was being enhanced.
- The Council had invested well in prevention services when it had moved to 'critical' eligibility criteria for adult social care services so Council was prepared for the duties regarding prevention.
- The Safeguarding Adults Partnership Board would become statutory.
- New requirements relating to managing provider failure would come into effect. In response to a query from Councillor Bray, Stuart Rowbotham clarified that more proactive checking to ensure providers were not failing would be required. The provider failure framework was being revised.
- Councillor Haitham-Taylor questioned whether the Council would develop contingency plans to follow if a major local provider was to go out of business by April and was informed that it would.

- There had been good communication with a wide range of stakeholders on the changes coming out of the Care Act.
- Stuart Rowbotham highlighted a number of risks;
  - The total implementation costs could be higher than predicted due to uncertainty regarding additional demand from carers and self-funders;
  - There was uncertainty about the 2016/2017 changes, including the care cap;
  - Confirmation of funding for the April 2016 reforms had not yet been received.
- The Board was assured that the Council was as ready as it could be and was in the upper quartile for preparedness.
- Clare Rebbeck commented that the voluntary sector was helping to spread the Care Act message and had produced toolkits. It would work with Healthwatch to further communication.
- With regards to the number of self-funders estimated in the area for 2015/16 and 2016/17, Katie Summers asked what percentage were likely to become depleters. Stuart Rowbotham indicated that it was difficult to predict but it was expected that it would be in the region of 8%.
- Stuart Rowbotham clarified that self-funders placed in care homes within the Borough were classed as Wokingham residents.

RESOLVED That the performance update be noted.

66. APPOINTMENT OF H&WB REPRESENTATIVE TO ATTEND CCG JOINT AND DELEGATED COMMISSIONING COMMITTEES

The Board was advised of the CCG's increased role in the commissioning of primary care services. In both joint and delegated commissioning arrangements, CCGs must issue a standing invitation to the local Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public are excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

RESOVLED That Stuart Rowbotham be appointed the Health and Wellbeing Board's representative to attend the CCG's joint and delegated commissioning committees.

67. PHARMACEUTICAL NEEDS ASSESSMENT

The Health and Wellbeing Board had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area. Dr Llewellyn presented the Pharmaceutical Needs Assessment (PNA).

During the discussion of this item the following points were made:

- The local consultation in Wokingham consisted of three tiers; dedicated pharmacy events, online promotion and utilising existing channels and events. Public Health, in conjunction with Healthwatch had held several events to engage with residents. The need for a detailed assessment of pharmacy opening hours had been identified and this had since been included in the PNA.
- When the draft PNA had been previously presented to the Board the impact of the SDL's on access to pharmacies had been raised. During the consultation the Consultant in Public Health and the Local Pharmaceutical Committee Chairman had visited pharmacies in areas affected by the development to assess more fully the capacity of the services to cope with increasing demand during 2015 – 2018. All pharmacies had reported that their premises could cope with the additional demand and could accommodate the additional staffing.

- Judith Ramsden commented that she had hoped to see reference made to child sexual exploitation and that all commissioning agencies had a safeguarding duty.
- Dr Zylstra questioned why internet pharmacies had not been included and was informed that this was not covered under the PNA's remit as internet pharmacy was considered a national rather than local resource.
- Katie Summers commented that the pharmacy opening hours was one of the major barriers for getting patients released from the Royal Berkshire Hospital in a timely fashion as 'to take outs' could only be completed by the hospital pharmacy.

RESOLVED That the final Pharmaceutical Needs Assessment document, following the consultation and revisions, be approved.

68. MENTAL HEALTH CRISIS CARE CONCORDAT

This item was deferred.

69. COMMUNITY SAFETY PARTNERSHIP RESTRUCTURE

Davina Williams updated the Board on the restructure of the Community Safety Partnership.

During the discussion of this item the following points were made:

- Due to various system test and reviews the Community Safety Partnership was re-configured in 2014 to enable a more planned approach and where necessary provide a responsive service to need.
- The delivery of community safety required a shared and committed approach.
- Various delivery Groups had been established and re-invigorated to meet local need and to work towards prevention.
- The Multi Agency Risk Assessment Conference (MARAC) membership had been reviewed. Recommendations had now been adopted as part of a pan Berkshire approach of good practice. A 'What is MARAC' local leaflet had been shared.
- All the delivery groups were led by a senior officer with experience in the relevant area.
- Davina Williams provided further information regarding the Domestic Abuse Strategy Group.
- Clare Rebbeck asked whether the Community Safety Partnership engaged with the voluntary sector providers and the faith community and was informed that it was.
- Dr Llewellyn commented that alcohol was a high driver of domestic abuse. Chief Inspector France stated that it was often difficult to access A&E data regarding admissions and alcohol. Katie Summers agreed to follow this up.

RESOLVED That the update on the Community Safety Partnership be noted.

70. FORWARD PROGRAMME 2014/15

The Board considered the Forward Programme for the remainder of the 2014/15 municipal year.

During the discussion of this item the following points were made:

- Clare Rebbeck informed the Board that she was due to stand down as the Chairman of the Place and Community Partnership which would mean that the Board would no longer have representation from the voluntary sector. The Board was asked to give consideration as to whether it would wish to have voluntary sector representation.
- The Board would receive an update on various aspects of performance, using an amended format, at its April meeting.

- Katie Summers informed the Board that the CCG's Operational Plan would be presented at the April meeting.
- Councillor Bray indicated that the Community Safety Partnership had considered the Broadmoor sirens issue and that an update would be presented to the Board in April.
- Judith Ramsden proposed that the Board receive an update regarding the work being undertaken in relation to child sexual exploitation, at its April meeting.

RESOLVED That the Forward Programme 2014/15 be noted.

These are the Minutes of a Meeting of the Health and Wellbeing Board.

If you need help in understanding this document or if you would like a copy of it in large print please contact one of our Administrators.

TITLE	**Health and Wellbeing Board Sub-Committee**
FOR CONSIDERATION BY	Health and Wellbeing Board on 9 April 2015
WARD	None Specific
DIRECTOR	Andrew Moulton, Head of Governance and Improvement Services

OUTCOME / BENEFITS TO THE COMMUNITY

The establishment of a Health and Wellbeing Sub-Committee to act as a Programme Board to manage the local healthcare delivery programme up to 2026.

RECOMMENDATION

That the Health and Wellbeing Board:

1) agree to establish the Health and Wellbeing Board Sub Committee;

2) agree the terms of reference and recommends their inclusion in the Council's Constitution, to Council, via the Constitution Review Working Group.

SUMMARY OF REPORT

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Health and Wellbeing Board may establish formal sub committees to discharge those of its functions it considers appropriate.

The purpose of the report is to establish a Health and Wellbeing Board Sub Committee to act as a Programme Board to manage the local healthcare delivery programme up to 2026, to and recommend the inclusion of its terms of reference (Appendix A) in the Council's Constitution to Council.

Background

The Health and Wellbeing Board received an update on Strategic Development Locations and Primary Care Facilities at its meeting in October 2014.

Planned population growth requires planned capacity growth within primary healthcare to ensure that no resident receives poorer services, and that services are readily and equally accessible throughout the Borough.

The Public Health Team commissioned Grimes Ltd. in January 2014 to carry out a needs assessment for primary healthcare requirements in the Borough's Strategic Development Locations at Arborfield Garrison, South of M4, Wokingham North and Wokingham South.

One of the main recommendations of the final report produced by Grimes Ltd. was that "*The Wokingham Health and Wellbeing Board forms a sub-committee, which includes co-opted external members as necessary, to act as a Programme Board to manage the healthcare delivery programme up to 2026."*

At its 9 October 2014 meeting the Health and Wellbeing Board agreed that an approach to meet this recommendation be agreed, making the necessary steps to recommend this approach to Full Council in due course.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION
The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

Contact Madeleine Shopland	**Service** Governance and Improvement Services
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Date 25.03.15	**Version No.** 1

APPENDIX A

HEALTH AND WELLBEING BOARD SUB-COMMITTEE

4.4.48 Introduction
The Core Strategy sets out the location and vision for community developments across the Borough to 2026. In taking forward the Core Strategy the Council recognises its responsibility with other stakeholders to meet the health needs of a growing and changing population.

The Health and Wellbeing Board Sub Committee will act as a Programme Board to manage the local healthcare delivery programme up to 2026.

4.4.49 Membership
The membership of the Health and Wellbeing Board Sub-Committee will be as follows:

a) Two Elected Members who sit on the Health and Wellbeing Board;

b) Two representatives from the Wokingham Clinical Commissioning Group;

c) One representative from NHS England;

d) One representative from local Healthwatch;

e) Wokingham Borough Council Consultant in Public Health;

f) One Wokingham Borough Council Director;

f) One senior Wokingham Borough Council Planning Officer working on the Strategic Development Location's delivery;

g) One representative representing the Health and Wellbeing Board Partnership Groups;

h) One representative from South Central Ambulance Service

The Health and Wellbeing Board Sub Committee may appoint such additional persons to be members of the Sub Committee as it thinks appropriate. The appointment of any additional members to the Health and Wellbeing Board Sub Committee will take place at Sub Committee meetings.

4.4.50 Co-optees
With the agreement of the Health and Wellbeing Board Sub Committee individuals may be co-opted to the Health and Wellbeing Board Sub Committee for an agreed period.

Representatives from other key partners may be invited to attend the Health and Wellbeing Board Sub Committee meeting where there is a specific agenda item which would benefit from their engagement. Representatives attending in this capacity will be non-voting attendees.

4.4.51 Appointment of Health and Wellbeing Board Sub Committee
Health and Wellbeing Board Sub Committee members will be appointed at the first meeting of the Health and Wellbeing Board of the municipal year.

4.4.52 Voting
The Health and Wellbeing Board Sub Committee will generally reach decisions by consensus. However, in the event that a vote is required the Chairman will have the casting vote.

4.4.53 Substitutes
Named substitutes are permitted to cover for representatives other than elected Members if they are unable to attend a meeting.

Organisations other than the Council represented on the Health and Wellbeing Board Sub Committee will appoint a substitute for their representative(s) at the beginning of the municipal year. Appointment as a substitute to the Health and Wellbeing Board Sub Committee may be renewable.

If representatives from organisations other than the Council are unable to attend a Board Sub Committee meeting they may ask the nominated substitute to act in their place (including vote on their behalf if applicable) at the meeting.

Substitute Members will have all the powers and duties of any Ordinary Member of the Board Sub Committee but will not be able to exercise any special powers or duties exercisable by the person they are substituting.

4.4.53.1 Changing Substitutes
Organisations other than the Council represented on the Health and Wellbeing Board Sub Committee will inform Democratic Services should they change the substitute for their representative(s) on the Board Sub Committee during the municipal year.

4.4.54 Chairman and Vice Chairman
The Chairman of the Health and Wellbeing Board Sub Committee will be appointed at the first meeting of the Health and Wellbeing Board Sub Committee of the municipal year.

The Vice Chairman of the Board Sub Committee will be appointed at the first meeting of the Health and Wellbeing Board Sub Committee of the municipal year and can be any other member of the Board Sub Committee.

4.4.55 Functions
The Health and Wellbeing Board Sub Committee will:

a) bring together relevant stakeholders and partners to ensure effective discussion of the commissioning of local health services as the Borough's population grows and changes;

b) effect decision making regarding the commissioning of local health services by providing recommendations to the Health and Wellbeing Board and other commissioning partners, how and where investment, resources and improvements could be made within the Borough.

4.4.56 Meetings
The Health and Wellbeing Board Sub Committee shall meet on a basis agreed by the Health and Wellbeing Board Sub Committee.

Additional (extraordinary) meetings may take place with the agreement of the Chairman. Dates, times and locations of meetings will be agreed by the Health and Wellbeing Board Sub Committee and published.

4.4.57 Reporting Lines
The Health and Wellbeing Board Sub Committee will report and make formal recommendations to the Health and Wellbeing Board as appropriate, in accordance with functions described in 4.4.55.

4.4.58 Attendance of Public and Press
The Health and Wellbeing Board Sub Committee will meet in public, unless confidential or exempt information is to be discussed, and the Access to Information Rules contained in Chapter 3.2 of this Constitution set out the requirements covering public meetings. The principles of decision making set out in Chapter 1.4 will apply to meetings of the Board Sub Committee.

4.4.59 Public and Member Questions
Public and Member questions can be asked in relation to items under their remit in accordance with the requirements set out in Chapter 4.2 of this Constitution.

The total time allotted questions from the public will be limited to 30 minutes and Member questions will be limited to 20 minutes. The total time allotted to public and Member Questions may be extended at the discretion of the Chairman.

At meetings after each main presentation, members of the public present will be allowed to ask questions (through the Chairman). Any questions from the floor must be relevant to the item or presentation just received, and not relate to personal cases. Question time would be limited to 5 minutes per item at the discretion of the Chairman.

4.4.60 Speaking Rights
A Member of the Council who is not a member of the Board Sub Committee shall be entitled to attend and speak (but not vote) at any full public meeting of the Health and Wellbeing Board Sub Committee at the discretion of the Chairman.

4.4.61 Quorum
The quorum of a meeting of the Health and Wellbeing Board Sub Committee shall be three.

If there is no quorum at the published start time for the meeting, a period of no more than 10 minutes will be allowed, and if there remains no quorum at the expiry of this period, the meeting will be declared null and void.

Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board Sub Committee.

4.4.62 Code of Conduct

All voting members of the Health and Wellbeing Board Sub Committee will be subject to the Local Code of Conduct for Members set out in Chapter 9.2 of this Constitution.

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TITLE	**Protocol Agreement between the Wokingham Safeguarding Children Board and the Health and Wellbeing Board**
FOR CONSIDERATION BY	**Health and Wellbeing Board on 9 April 2015**
WARD	**None Specific**
DIRECTOR	**Judith Ramsden, Director of Children's Services**

OUTCOME / BENEFITS TO THE COMMUNITY

The Protocol Agreement between the Wokingham Safeguarding Children Board and Health and Wellbeing Board (HWBB) specifies the interface between the Boards. It sets out the roles and responsibilities and expectations on the Boards, their Chairs and members to ensure safeguarding effectiveness and demonstrate its effectiveness in meeting its statutory responsibilities for safeguarding under section 13(3) Children Act 2004.

RECOMMENDATION

That the Health & Wellbeing Board agrees the revised Wokingham Safeguarding Children Board and Health & Wellbeing Board Protocol.

SUMMARY OF REPORT

The Wokingham Safeguarding Children Board & HWBB Protocol sets out the relationship between WSCB and the HWBB specifying the roles and interfaces between the boards, their membership, governance and the respective roles of their Chairs.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

Protocol Agreement between Wokingham Safeguarding Children Board and Health and Well-Being Board

1. INTRODUCTION

1.1. The Local Safeguarding Children Board's role is to promote the safeguarding of children in the local area including providing critical challenge to both individual organisations and other partnerships. The Health and Well Being Board brings together key leaders from the health and care system to improve the health and wellbeing of the local population and reduce health inequalities.

1.2. This document sets out the expectations of the relationship and working arrangements between Wokingham Safeguarding Children Board (WSCB) and the Health and Well-being Board (HWBB). It covers their respective roles and functions, membership of the two boards and arrangements to secure effective co-ordination and coherence between the two Boards.

1.3. The Chairs of the HWBB and the WSCB have formally agreed to the arrangements set out in this document, which will be reviewed annually.

2. RELATIONSHIP

2.1. The Local Safeguarding Children Board (LSCB) and the Health &Well Being Board have important but distinct roles in keeping children safe. The WSCB is responsible for scrutinising and challenging partner organisations in their work to keep children safe and includes the duty to promote co-operation to improve the wellbeing of children in the local area and to ensure the effectiveness of the arrangements made by wider partnership and individual agencies to safeguard and promote the welfare of children.

2.2. Both the HWBB and the WSCB will work together through the Chairs to ensure that action taken by one body does not duplicate the work of the other, and to ensure that policies, procedures, protocols and practice are co-ordinated.

3. RESPONSIBILITIES

3.1. Health & Well-Being Board

3.1.1. Health and Well-Being Boards were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Its focus is on securing the best possible health outcomes for all local people including children and young people.

3.1.2. Board members are expected to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services.

3.1.3. The Board has a duty to produce a Joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA) and taking into account the Public Health Outcomes Framework. Together, these will provide the overall framework for identifying local needs and the actions to improve local health and wellbeing and reduce inequalities throughout the life course. The Board will drive performance forward in each of its chosen priority areas.

3.2. Local Safeguarding Children Board

3.2.1. The WSCB is a statutory partnership - Section 13 of the Children Act (2004) requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs.

3.2.2. The statutory guidance Working Together To Safeguard Children (2013) sets out the role and functions of LSCBs in accordance with statutory legislation. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB - Developing multi agency policies and procedures for child protection, safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

- The action to be taken where there are concerns about a child's safety and welfare, including thresholds for intervention;
- Training of persons who work with children or in services affecting the safety and welfare of children.
- Recruitment and supervision of persons working with children;
- The safety and welfare of children who are privately fostered
- Investigation of allegations concerning persons working with children;
- Cooperation with neighbouring children's services and their board partners;

3.3. Governance and Accountability

3.3.1. In order to provide effective scrutiny, the WSCB is independent and should not be subordinate to, nor subsumed within, other local structures. Legislation requires the WSCB to have an Independent Chair so that it can exercise its local challenge function effectively. The local authority Chief Executive and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the WSCB.

3.3.2. The individual members of the WSCB have a duty as members to contribute to the effective work of the WSCB; including making the WSCB's assessment of performance as objective as possible, and in recommending or deciding on the necessary steps to resolve any problems. This should take precedence, if necessary, over their role as a representative of their organisation.

3.3.3. LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

4. CHAIRS' RELATIONSHIP

4.1. The WSCB is required by legislation to have an Independent Chair whereas the Chair of the Health & Well Being Board is an elected local authority Member. In practice, the two Chairs will work co-operatively to ensure the delivery of improved health and well-being outcomes for children and their safeguarding.

4.2. The Chief Executive and the Leader of the Council should be satisfied that local partnership arrangements are improving outcomes for children and supporting safeguarding.

5. COMMUNICATION AND ENGAGEMENT

5.1. Safeguarding is everyone's business. As such, all key strategic plans whether they are formulated by individuals, or by partnership forums, should include safeguarding as a cross-cutting theme. The H&WBB has a role in informing the strategic connections of safeguarding across the partnership and agreed priorities, just as the WSCB has a contribution to make to wellbeing. The H&WBB also has a role in coordinating commissioning opportunities and evaluating outcomes, of which safeguarding, prevention and protection will be part.

5.2. Specifically, the Joint Strategic Needs Assessment should informs the formulation of the Health and Well-Being Strategy and the WSCB's Business Plan. The development of both should inform each other in a reciprocal nature and the Boards should regularly update each other on progress made, in a context of mutual scrutiny and challenge.

5.3. In order to secure the opportunities set out above, each year the Independent Chair of the WSCB will present an annual report outlining performance against the Business Plan objectives in the previous financial year. In return, the HWBB will present to the WSCB the review of the Health and Well-Being Strategy, the refreshed JSNA and the proposed priorities and objectives for the refreshed Health & Well- Being Strategy.

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PHOF – Public Health Outcomes Framework				
PHOF Indicators set out a vision for Public Health and enable understanding on how public health is being improved and protected. Comparing Wokingham to the comparative deprivation decile majority of the indicators are green. The Board is focusing on those few red indicators that need improvement and thus is not reflective of performance across the whole of the PHOF.				
	Rag Rating	Bench Marker	Direction of Travel	Narrative
School Readiness				
The percentage of children achieving a good level of development at the end of reception.	60.7 AMBER 13/14	60.4 ENG	↑	Direction of travel based on 2 data points. Increased 13.3% since 12/13
The percentage of children with free school meals status achieving a good level of development at the end of reception	34.5 RED 13/14	42.1 ENG	↑	Direction of travel based on 2 data points. Increased 9% since 12/13
The percentage of year 1 pupils achieving the expected level in the phonics screening check	70.4 RED 13/14	75.2 ENG	↑	Increasing trend over the last three years
The percentage of year 1 pupils with free school meals achieving the expected level in the phonics screening check	49.2 RED 13/14	55.3	↑	Increasing trend over the last three years
Public health has identified £100,000 for a community chest to support parents to access interventions that will hit a range of PHOF's including School Readiness.				
Chlamydia Screening				
Chlamydia detection rate (15-24yrs)	966 RED 2013	2015 ENG	↓	The direction of travel is only based on two data points.
Chlamydia is a sexually transmitted disease with no symptoms that if left untreated can lead to infertility. This is a measure of the positivity rate found through the Chlamydia screening programme and not a measure of how many young people are taking the test. In a population such as that of Wokingham the rate of positivity would be expected to be lower that average. This means the programme within Wokingham needs to be very well targeting to those populations where we would expect a higher rate of positivity.				
Health Checks				
Cumulative % of the eligible population aged 40-74yrs offered an NHS Health Check	8.2 RED (13/14)	18.4 (ENG)	No Data	
Cumulative % of the eligible population aged 40	4.0 RED	9.0 (ENG)	No Data	

– 74 yrs receiving an NHS Health Check	(13/14			
Health Checks programme is aimed at identifying asymptomatic cardio vascular disease.				
Flu Coverage				
Population vaccination coverage (>65yrs)	74.3 RED (13/14)	73.2 (ENG)	↓	In line with England
Population vaccination coverage (at risk individuals)	52.3 RED (13/14)	54.4 (ENG)	↓	Against the England trend
The 14/15 data on vaccination coverage is a drop from this current PHOF figure, this is a reflection of the uptake nationally.				
Excess Winter Deaths				
Excess Winter Deaths Index (Single year, All ages)	32.6 AMBER Aug12 – Jul13	30.1	↑	Large spike 12/13 but has been amber since 06/07
Excess Winter Deaths Index (single year, >85yrs)	62.9 RED Aug12 – Jul13	28.2	↑	Large spike 12/13 to make red, amber since 07/08, green 06/07
The indicator needs to be given context such as how mild the winter in any given year was. Comparing a three year average can remove spikes owing to colder winters.				

Health and Well-Being Board Performance Report

Reporting Period: October to December 2015 (Quarter 3)

Key:	⇧	Performance Improving compared to previous period
	⇩	Performance Deteriorating compared to previous period

HWB Priority	HWB Strategy Objective	Performance Indicator (Better Care Fund Indicator are in BOLD)	Year End Target 2014-15	Benchmark 2013-14 Average	Provenance of Benchmark	Reporting Frequency	Period	Expected Performance this Period	Actual Performance this Period	RAG this Period	Direction of Performance (see key)	Expected Performance to Date	Actual Performance to Date	RAG to Date	Projected Year End Performance	Commentary
BCF	5a	**Total non-elective admissions in to hospital (general & acute), all-age**	2,469	TBC	TBC	Quarterly	Quarter 3 (October to December)	2,466	2,789	Red	⇩	7,249	7,906	Red	Not set	BCF Scheme yet to commence, Hospital to Home delay start to until July 2015. Higher than expected admission over winter, high acuity patients.
BCF	5a	**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes**	163	TBC	TBC	Monthly	January	13	5	Green	⇧	135	123	Green	148	Social care team working in RBFT to support improved decision making on resident and nursing care homes placement.
BCF	5a	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**	70%	TBC	TBC	Annual	January to March	70%	Survey currently being undertaken	NA	NA	70%	Survey currently being undertaken	NA	70%	Indicator is monitored over three months. The first month of data has been received and performance is 77%. The survey will be completed at the end of March 2015.
BCF	5a	**Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).**	4,999	TBC	TBC	Monthly	Dec-14	416	182	Green	⇧	3,749	3,373	Green	4,497	Royal Berkshire Fit to go lists remains low.
BCF	5b	**Number of patients going through reablement**	70	TBC	TBC	Monthly	February	69	94	Green	⇧	692	762	Green	914	
BCF	5b	**Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life?**	87.7%	TBC	TBC	Annual	2014-15	87.7%	Survey currently being undertaken	NA	NA	87.7%	Survey currently being undertaken	NA	87.7%	
		National GP survey is Section 8 Question 32: In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services.	Not set	64%	England	Annual	2014-15	64%	Survey currently being undertaken	NA	NA	64%	Survey currently being undertaken	NA	Not set	Data is based on collection during July-September 2014 and January-March 2015. Current performance is 66% which consists of fieldwork from January-March 2014 and July-September 2014.
		Adult Social Care User Experience Survey: 2. Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?	88%	TBC	TBC	Annual	2014-15	88%	Survey currently being undertaken	NA	NA	88%	Survey currently being undertaken	NA	88%	This indicator is a percentage of all respondants to the survey who said their quality of life was 'So good, it could not be better', 'very good', 'good' or 'alright'
		Number of Adult Safeguarding Referrals	441	591	Berskhire West	Monthly	February	42	46	NA	*Decreased*	504	466	NA	508	This is an area of significant concern and impact nationally and is something we need to monitor closely as a Board.
CCG - Local quality prioirity		Increase the number of referrals to the BHFT memory clinic	505	TBC	TBC	Qtrly	Quarter 2	126	160	Green	⇧	252	301	Green	602	Local target, to support increase in diagnsosis of Dementia
CCG - Local quality prioirity		Percentage of report dementia dignaosis	56.90%	TBC	TBC	Annual	Feb-15	55%	55.90%	Green	⇧			Green	56.90%	Expectation to acheive 67% for March 2016
CCG national quality prioirty		IAPT Acess: The proporation of paoteople woth depression /anxitiety thatnt have entered psychological therapies	15.90%	TBC	TBC	Qtrly	Quarter 2	3.80%	3.90%	Green	⇧	7.50%	7.70%	Green	15.90%	Increased investment from the CCG to the IAPT service in 2014-15
CCG national quality prioirty		IAPT recovery rate	50%	TBC	TBC	Qtrly	Quarter 2	50%	65%	Green	⇧	Not set	62.10%	Green	65%	Increased investment from the CCG to the IAPT service in 2014-15

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TITLE	**Better Care Fund Section 75 agreement**
FOR CONSIDERATION BY	Health and Wellbeing Board
WARD	None Specific
DIRECTOR	Stuart Rowbotham- Health and Well-Being

OUTCOME / BENEFITS TO THE COMMUNITY

The Better Care Fund (BCF) has been created to promote the integration of health and social care services, to provide a better service and develop efficiency across the system.

The BCF pooled budget under section 75 of NHS Act 2006 agreement will allow joint commissioning and provision of integrated health and social care services that avoid unnecessary hospital admissions, delayed transfers of care and residential care home admissions

RECOMMENDATION

That the Health and Wellbeing Board agree the section 75 pooled budget and proposed arrangements.

SUMMARY OF REPORT

NHS England requires Councils and Clinical Commissioning Groups (CCG) to hold the BCF pooled budgets in a section 75 agreement. Wokingham's section 75 agreement schedule 3 (attached as appendix 1) separates the budget into two pools, one to be hosted and commissioned by the Council, the other by the CCG.

Wokingham's BCF is close to the minimum amount prescribed by NHS England with only £900k additional funding being added to reflect the staffing cost of the Health Liaison team who are a key part of an integrated short term service.

The pooled fund can only be spent in accordance with the BCF.

This section 75 agreement is for next financial year only; this gives the Council and the CCG flexibility to decide their contribution to the agreement after 2015/16.

The agreement has been developed collectively by each authority's BCF finance lead and then has been reviewed by Wokingham Borough Council's legal team.

Each Pooled Fund is required to have a named Pooled Fund Manager, an officer of the hosting authority. The Pooled Fund Managers have yet to be decided, but will be a relevant senior officer of each host authority. Guidance from the Department of Health requires that Pooled Funds should be governed by a 'Partnership Board'. For the two Wokingham Pooled Funds it is proposed that the Wokingham Integration Strategic Partnership (WISP, a sub-group of the Health and Wellbeing Board) or a sub-group of WISP will provide the Partnership Board function.

The Pooled Fund Manager will monitor spending in line with the financial regulations

and protocols of the host authority but will also report monthly to WISP, the Health and Wellbeing Board and the Berkshire West Partnership Board. The Pooled Funds are to be deployed specifically for the purposes set out within the schedules to the s75 agreement, i.e. for the BCF services. In that regard and as the services are being developed from scratch there should be no risk of overspends within the Pooled Budget arrangement. In the unlikely event that an overspend does arise, it will be highlighted to WISP and remedial action will be decided.

Background

The 2015/16 Better Care Fund is subject to a number of conditions set by NHS England:

1. A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
2. A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
3. The fund is to be used in accordance with the agreed plan
4. The element of the fund linked to non-elective admissions reduction target will be released into the pooled budget proportional to performance, as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

Governance

Appendices - Schedule 3 – Risk Share and Overspends sets out how underspends and overspends will be managed through WISP.

Other schedules cover each of the 9 BCF schemes and areas such as conflicts of interest, performance reporting, etc.

Appendices

1- **Main agreement of section 75**
2- **Schedule 2 - Governance**
3- **Schedule 3- Risk Sharing and Overspends**

Version 9 - 23rd March - SR/SC

Dated **2015**

WOKINGHAM BOROUGH COUNCIL

and

NHS WOKINGHAM CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES BETTER CARE FUND

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THIS AGREEMENT is made on day of 2015

PARTIES

(1) **Wokingham Borough Council** of Civic Offices Shute End Wokingham Berkshire RG40 1BN (the **"Council"**)

(2) **NHS WOKINGHAM CLINICAL COMMISSIONING GROUP of Chalfont Surgery, Chalfont Close, Lower Earley, Berkshire RG6** (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Wokingham.].

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Wokingham.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

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

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also a means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;[and]

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.[and]

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION[1]

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

[Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.]

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price [means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any default liability or Performance Payment].[2]

[2]

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Chief Finance Officer (Section 113 Officer) or their nominated deputy for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Performance Payment Arrangement *means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.*

Performance Payments *means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.*

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

*[**Third Party Costs** means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the WISP Board*

Wokingham Integrated Strategic Partnership (WISP) means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 [Lead Commissioning Arrangements];

4.1.2 [Integrated Commissioning];

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

4.5 The relevant Functions are as set out in Schedule 9

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by and the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in Schedule 3, Risk Share and Overspends, and the scheme specification.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price*;*

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement;

7.6.5 ensuring that the Pooled Fund Manager complies with the Host Partners constitution and financial regulations.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Local Integration Board as required by the Partnership Board and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Partnership Board monthly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause [8.2] the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

8.4 The Partnership Board may agree to the viring of funds between Pooled Funds.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in Schedule 3, Risk Share and Overspends and the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification and Schedule 3, Risk Share and Overspends.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in Schedule 3, Risk Share and Overspends.

10.2 The financial contributions of each partner and budget for a financial year must be agreed by the Health & Wellbeing Board based on recommendations from the Partnership Board by 1st January preceding the financial year that the budget refers to. The Health & Wellbeing Board can choose to extend this deadline but in any event the budget must be agreed by 1st March preceding the financial year that the budget refers to.

10.3 Financial Contributions as set out in Schedule 3 will be paid in 4 quarterly instalments. The Host authority will raise quarterly invoices in advance and the contributing authority will ensure payment no later than mid quarter.

10.4 With the exception of Clause [13], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Partnership Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

12 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause [12.1], the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with schedule 3.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Locality Integration Group and the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the [Partnership Board] in accordance with schedule 3.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner [and the Partnership Board].

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners as set out in Schedule 3. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

Neither Pooled Funds or Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. Any capital expenditure other than that already identified in the budget and approved by the Health & Wellbeing Board must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Oversight of the Better Care Fund plans is the responsibility of the individual Health and Wellbeing Board.

19.2 The Partners have established a Partnership Board to:

19.2.1 Provide strategic oversight of the Berkshire West 10 Integration Programme, and the projects associated with it. The Partnership board is accountable to the local Health and Wellbeing Boards and will report progress and make recommendations which have a material impact on the BCF Schemes

19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Partnership Board shall be as set out in Schedule 2

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The [Partnership Board] [Health and Wellbeing Board] shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Partnership Board and Health and Wellbeing Board.

19.8 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any [Pooled Fund, Non Pooled Fund and Aligned Fund] and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board and Health and Wellbeing Board.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

21.1 During the [term of the Agreement], the Partners will develop and operate a joint complaints system. The application of a joint complaints system will be without prejudice to a complainant's right to use either of the Partners' statutory complaints procedures where applicable.

21.2 Prior to the development of a joint complaints system or after the failure or suspension of any such joint complaints system the following will apply:

21.2.1 where a complaint wholly relates to one or more of the Council's Health Related Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

21.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG;

21.2.3 where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the CCG, in line with local joint protocol;

21.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Partnership Board will set up a complaints subgroup to examine the complaint and recommend remedies. All complaints shall be reported to the Partnership Board.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 16, 22 , 23 and 25

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract

allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute, a copy of which should be received by the Chair of the Locality Integration Group, Partnership Board and Health and Wellbeing Board.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective Chief Executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 If the dispute cannot be resolved following mediation the matter shall be referred within seven days by the Partners for independent arbitration to the Institute of Arbitrators. The Partners will co-operate with any person appointed as Arbitrator whose decision shall be final and binding on the Partners and any costs will be paid as determined or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including

evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Head of Governance and Improvement;

Wokingham Borough Council,
Civic Offices,
Shute End,
Wokingham,
RG40 1BN
Phone 0118 974 6000
Fax: 0118 974 6542

29.3.2 if to the CCG, addressed to Chief Finance Officer
];

Berkshire West CCGs
57-59 Bath Road
Reading
RG30 2BA

29.3.3

Tel: 0118 982 2730
Fax: 0118 982 2914

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE COMMON SEAL of **THE COUNCIL OF Wokingham Borough Council** was hereunto affixed in the presence of:	))))

Signed for and on behalf of **NHS WOKINGHAM CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

40 SCHEDULE 1 – SCHEME SPECIFICATION

40.1 SUPPORT TO CARE HOMES 2014/15 QUIPP SCHEME

40.2 BERKSHIRE WEST 10 INTEGRATED HEALTH AND SOCIAL CARE HUB

40.3 HOSPITAL AT HOME

40.4 CONNECTED CARE

40.5 7 DAY WORKING

40.6 CCG REABLEMENT

41 SCHEDULE 2 – GOVERNANCE

The Partners agree to comply with the Policies of each organisation as amended from time to time

In the event of a conflict those of the designated Host Authority shall prevail

42 SCHEDULE 3 – RISK SHARE AND OVERSPEND

43 SCHEDULE 4 – JOINT WORKING OBLIGATIONS

43.1 PART 1 – LEAD COMMISIONER OBLIGATIONS

43.2 PART 2 – OBLIGATIONS OF THE OTHER PARTNER

44 SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

45 SCHEDULE 6 – BETTER CARE FUND PLAN

46 SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

The Partners agree to comply with the Policies of each organisation (as amended from time to time)

In the event of a conflict those of the designated Host Authority shall prevail.

47 SCHEDULE 8 – INFORMATION GOVERNANCE

The Partners agree to comply with the Policies of each organisation (as amended from time to time)

In the event of a conflict those of the designated Host Authority shall prevail.

48 SCHEDULE 9 - FUNCTIONS

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Schedule 2 – GOVERNANCE

1 Partnership Board

1.1 The membership of the Partnership Board known as Wokingham Integrated Strategic Partnership Board (WISP) will be as follows:

1.1.1 CCG: Wokingham Clinical Commissioning Group

or a deputy to be notified to the other members in advance of any meeting;

1.1.2 the Council: Wokingham Borough Council

or a deputy to be notified in writing to Chair in advance of any meeting;

1.1.3 other partners as determined by the Terms of Reference for WISP

2 Role of Partnership Board

2.1 The Partnership Board shall:

2.1.1 Provide strategic direction on the Individual Schemes

2.1.2 receive the financial and activity information;

2.1.3 review the operation of this Agreement and performance manage the Individual Services;

2.1.4 agree such variations to this Agreement from time to time as it thinks fit;

2.1.5 review and agree annually a risk assessment and a Performance Payment protocol;

2.1.6 review and agree annually revised Schedules as necessary;

2.1.7 request such protocols and guidance as it may consider necessary in order to enable teach Pooled Fund Manager to approve expenditure from a Pooled Fund;

3 BW10 Partnership Board

3.1 The Partnership Board shall as part of a wider partnership voluntarily contribute to working towards an integrated system. As such it is expected that the Partnership Board will report to and seek recommendations from BW10 Partnership Board from time to time.

3.2 For those schemes which are being managed by a third party on behalf of the Partnership Board and where the oversight is properly at the BW10 Partnership Board then a Memo of Understanding (MoU) will be agreed between the parties.

3.3 The MoU will as a minimum include:

3.3.1 name of all parties,

3.3.2 lead organisation,

3.3.3 roles and responsibilities

3.3.4 governance structure and reporting

3.3.5 scheme objectives to be delivered,

3.3.6 timetable of delivery,

3.3.7 cost of scheme,

3.3.8 funding source(s),

3.3.9 review and evaluation

4 Partnership Board Support

4.1 The Partnership Board will be supported by officers from the Partners from time to time.

5 Meetings

5.1 The Partnership Board will meet Quarterly at a time to be agreed within following receipt of each Quarterly report of the Pooled Fund Manager.

5.2 The quorum for meetings of the Partnership Board shall be a minimum of [one representative from each of the Partner organisations].

5.3 Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

5.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

5.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within [seven (7)] days of every meeting.

6 Delegated Authority

6.1 The Partnership Board is authorised within the limited of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

6.1.1 to authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

6.1.2 to authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

7 Information and Reports

7.1 Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

8.1 The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

Schedule 3 – RISK SHARE AND OVERSPENDS

1. To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund the partners have agreed:

   1.1. That the Health & Wellbeing Board shall be sole arbiter of allocation of the Performance Fund based on recommendations from the Wokingham Integrated Strategic Partnership (WISP) Board.

   1.2. That any allocation cannot exceed the amount achieved as a result of meeting the performance target as defined by the Department of Health.

2. The Partners agree that Overspends and Underspends shall be apportioned in accordance with this Schedule 3.

3. The agreed spending plan of the Better Care Fund and its sources of funding are shown in tables 1 and 2 at the end of this schedule.

4. The Risk Management Strategy document as agreed by the BW10 Partnership Board should also be referred to.

5. The partners have jointly agreed that each host will cover local management costs and overheads and make a contribution to any Integration programme wide costs from the pooled budgets. Any variation to this will be stated in clause 7 (Finance) in the relevant schedule 1.

<u>Identification and management of overspends</u>

6. A Monthly performance and financial report shall be submitted to the WISP and BW10 Partnership Board by the responsible Pooled Fund Manager.

7. The monthly report will set out for each scheme the budget allocation for the financial current year, spend to the end of the previous month, forecast to the 31st March, and therefore an over or underspend against each scheme. The report will also include the key metrics relating to each scheme as determined by the Wokingham Integrated Strategic Partnership Board (WISP).

8. The BW10 Partnership Board will recommend and WISP will determine as necessary the value of ‘minor’ and ‘major’ variances to be associated with each scheme as recommended by the Finance Sub Group.

9. Where in the course of a financial year it appears that there will be a variance (either an underspend or overspend) of any individual scheme by the end of the said financial year, the Pooled Fund Manager will:

   9.1. For minor variations, the monthly report will indicate the reason and action necessary to recover an overspend.

   9.2. For a major overspend a separate report will be submitted to WISP and BW10 Partnership Board within two weeks of the overspend being known detailing the extent of and reasons for the projected overspend and include an action plan to address. The report is to be submitted to the Chairman and Vice Chairman of the Board in advance of the next scheduled meeting, a copy of the report must also be sent to the Chief Finance Officer Berkshire West Clinical Commissioning Groups, and designated Finance

Business Partnering Manager at Wokingham Borough Council. The action plan to include:

i) Actions taken to date to mitigate the overspend and how successful these have been to date

ii) co-ordinated scheme management options undertaken that make every effort to manage back into line the projected overspend

iii) a review of the available options to reduce demand placed on the scheme to reduce spend back to within budget

iv) additional monies available that could be utilised to offset the projected over-spend

10. The WISP Board will consider and approve what action to take in respect of any actual or potential overspends based on recommendations from the Pooled Fund Manager.

11. The WISP Board shall acting reasonably having taken into consideration all relevant factors including, where appropriate the affected schemes action plan submitted by the responsible Pooled Fund Manager, the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

    11.1. action that can be taken in order to contain expenditure;

    11.2. whether there are any underspends that can be vired from any other fund maintained under this Agreement;

    11.3. if no more money is available agreeing a plan of action, which may include decommissioning all or any part of the Individual Service to which the Fund relates

12. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

13. Overspends which occur in relation to any Performance Payments shall, subject to alternative provisions in the relevant Performance payment Arrangement, be apportioned between the Partners pro rata to the value of their respective Financial Contributions [excluding Non-Recurrent Payments] for the Financial Year in respect of which the Overspend occurs.

14. Overspends that occur in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates save to the extent that such overspend is not the fault of the other Partner.

15. Where an overspend cannot be avoided the financial impact shall be shared between partners based on their original percentage contribution to the affected schemes total fund as set out in table 1 of this schedule.

16. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service of Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

<u>Underspends</u>

17. Reporting requirements are as set out in paragraphs 7 and 8 above.

18. Financial underspends on individual elements of the BCF scheme will be retained by the Pooled budget for use within the pool in year or rolled forward into the following year subject to agreement by WISP Board based on recommendations from the Pooled Fund Manager.

19. In the absence of WISP Board failing to agree on how any underspend shall be utilised, the underspend will be transferred to the contingency fund for subsequent utilisation as and when agreed by the WISP Board.

Capital

20. It is a requirement of the Department of Health that the Social Care Capital Grant and the Disabled Facilities Grant are included in the Better Care Fund.

21. The conditions relating to how these sums can be spent is as set out by the Department of Health (Social Care Capital) and Department for Communities and Local Government (Disabled Facilities). Due regard must be made to these terms when approving expenditure relating to these grants.

Financial Reserves

22. For 2015/16 the s75 pooled budget include provision for a contingency fund of £187k.

23. As part of the development of enhanced risk sharing arrangements in subsequent years, if applicable, and beyond consideration will be given to the creation of a contingency budget within the overarching pooled budget.

24. The creation of reserves will require the agreement of both partners and will be for a specific purpose (business case required) in addition to a general / contingency reserve.

25. The release / use of general reserves will require a business case and the agreement of the WISP Board in the case of any reserve.

26. Reserves created for specific purposes will not require additional WISP Board approval for draw down provided the reserve is released within 12 months of creation. Specific reserves to be retained for more than 12 months will require review and re-validation by the WISP Board as part of year end sign off procedures.

Pool 1 – Minimum Fund and Local Schemes – Hosted and Commissioned by Local Authority					
Pool Ref		**Scheme**	**WBC £000**	**CCG £000**	**Total £000**
1.1		Local Better Care Fund schemes/initiatives			
	1.1.1	BCF02 Integrated Short Term Health and Social Care Team	900	300	1,200
		Integrated crisis and rapid response services	155		155
		Reablement Services	390	641	1,031
		Bed based intermediate care services	130		130
		Sub Total	**1,575**	**941**	**2,516**

Pool 1 – Minimum Fund and Local Schemes – Hosted and Commissioned by Local Authority					
Pool Ref		**Scheme**	**WBC £000**	**CCG £000**	**Total £000**
	1.1.2	BCF03 Step Up/Step Down Beds		247	247
		Early supported hospital discharge Schemes	155		155
		Sub Total	**155**	**247**	**402**
	1.1.3	BCF04 Domiciliary Plus		528	528
		Community Equipment and Adaptations	236		236
		Telecare	30		30
		Sub Total	**266**	**528**	**794**
	1.1.4	Preventative Services			
		Mental health services	200		200
		Other preventative services	210		210
		Carers Grant	216	278	494
		Sub Total	**626**	**278**	**904**
1.2		Implementation of Care Act (No Scheme document required)			
		Protecting Social Care services	1,244		1,244
		Preparing for the Better Care Fund & Care Act	335		335
		Sub Total	1,579		1,579
		Total Revenue	**4,201**	**1,994**	**6,195**
1.3		Capital (No separate scheme documents)			
		Disabled Facilities Grant	425		425
		Social Care Capital	220		220
		Total Capital	**645**		**645**
		Pool 1 Total	**4,846**	**1,994**	**6,840**

Table 1

Pool 2 – Minimum Fund and Local Schemes – Hosted and Commissioned by CCG					
Pool Ref		**Scheme**	**WBC £000**	**CCG £000**	**Total £000**
2	2.1	Minimum Fund			
		Contingency		187	187
		Performance Fund		448	448
		Sub total		**635**	**635**
	2.2	Local BCF schemes/initiatives			
		BCF08 Neighbourhood Clusters, Primary Prevention and Self-Care		300	300
		BCF09 Access to General Practice		734	734
		Sub total		**1,034**	**1,034**

Pool 2 – Minimum Fund and Local Schemes – Hosted and Commissioned by CCG					
Pool Ref		**Scheme**	**WBC £000**	**CCG £000**	**Total £000**
	2.3	BW10 BCF schemes/initiatives			
		BCF01 Health and Social Care Hub		59	59
		BCF05 Hospital at Home Service		639	639
		BCF06 Enhanced Care and Nursing Home Support		145	145
		BCF07 Connected Care (NHS number/Interoperability of IT)		209	209
		Sub total		**1,052**	**1,052**
		Pool 2 Total		**2,721**	**2,721**
		BCF Total	**5,921**	**3,640**	**9,561**

Table 2

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Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2015

Draft

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.

About the Trust

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.

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Quality Account Highlights 2015

To be finalised at Q4

96% of community mental health and physical health patients would recommend the service for a friend of family member who needed it.
This is improved from 86% last year

85% of mental health inpatients rate their care as good or very good. This has improved from 75% last year

71% of staff would agree or strongly agree that they would be happy with the standard of care for a friend or family member. This compares with 60% for similar trusts nationally.

62% of staff agree or strongly agree they would recommend the organisation as a place to work (54% nationally)

By the end of March 2015, 66 extra health visitors will have been recruited over the last 2 years, exceeding the Trusts target.

5 of 7 community wards achieved the target of over 120 days without a developed grade 3 or 4 pressure ulcer.

The Trust is implementing its plan to be smoke free by the end of 2015/16

1. Statement on Quality

The Trust continues to deliver high quality care for the vast majority of patients and their families. Standards are continuing to rise despite significant financial pressures across the health and social care system.

Where lapses in best care occur there is an increasingly robust governance and incident reporting system to highlight areas for improvement and foster learning across the organisation. We continue to strive to improve these processes further.

Evidence continues to build of high levels of staff engagement. We recognize that our staff are working extremely hard, often over and above the requirements of their job plans, to deliver high quality care for patients with ever increasing demands. We do not take this dedication for granted and are very grateful to all our employees who strive every day to provide the best possible care.

This year we have particularly focussed on patient engagement and involvement in improving services. The Listening into Action methodology, which has been helping us to involve staff in removing obstacles to high quality care has been applied successfully to patients and carers. This has included involvement of people with learning disabilities. One of the key messages concerns the value of friendly and courteous interactions and thoughtfulness when working with patients in addition to good clinical skills. This has led to our SHINE campaign – Stop, Hear, Interested, Notice, Engage – to help all employees remember that the most important person at any time is the person in front of them.

There has been an emphasis in children's mental health services during the year, working with health commissioners and local authorities across the health and social care system to provide better joined up care from the community, home and school to specialist inpatient care. There is much work still to be done in this area, but a great deal of progress has been made in identifying what needs to change and securing additional investment to address this.

We have taken an opportunity to expand our involvement in primary care by taking over the running of a GP practice in Circuit Lane, Reading. This builds on our existing expertise in out of hours GP services and walk in centre provision. We are interested in taking on more GP services where we are best placed to improve services for patients and provide sound financial and quality governance management. This model is very much in line with the type of organisational structure being developed through the NHS Forward View.

The Trust is implementing its plan to go smoke free across all sites in 2015. This will have a major impact in promoting a positive message on illness prevention and, in particular, will help to tackle the major discrepancy in physical health outcomes for people with long term mental health problems.

The Trust's values - *caring, committed and working together* - remain key underlying principles which drive the pursuit of high quality care. These are embedded within the Trust appraisal system for all staff. The principle of *working together* extends beyond the organisation with respect to work with others to find innovative solutions to the wider health and social care challenges in Berkshire and beyond.

There has been very promising collaboration in Berkshire across providers and local authorities to improve care pathways for older people and with respect to urgent care. We very much welcome the involvement of Frimley Health Foundation Trust in driving improvements in the acute hospital services in East Berkshire. We are active participants in the Oxford Academic Health Science Network and the Thames Valley Strategic Clinical Networks with a view to learning from each other, contributing to research and service development and resolving unwarranted variation in care quality.

There is much more that can be done to ensure that the people of Berkshire receive amongst the best care in the country for physical and mental health problems. At Berkshire Healthcare NHS Foundation Trust we are determined to play our part in making sure that this is the case.

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 2014/15

This section of the Quality Account details Trust achievements against the 2014/15 priorities and information on the quality of services provided during 2014/15. The priorities support the trust quality strategy to provide accessible, safe, and clinically effective community and mental health services that improve patient experience and outcomes of care through the following six elements:

1. Clinical Effectiveness – providing services based on best practice
2. Safety – To avoid harm from care that is intended to help
3. Efficient – To provide care at the right time, way and place
4. Organisation culture –Patients to be satisfied and staff to be motivated
5. Patient experience and involvement – For patients to have a positive experience of our service and receive respectful, responsive personal care
6. Equitable – To provide equal care regardless of personal characteristics, gender, ethnicity, location and socio-economic status.

2.1.1 Patient Experience

The Trust aim was to continue to ensure patients and carers have a positive experience of care and are treated with dignity and respect. This has been measured in a number of ways, through the 'Friends and Family Test' where patients and staff are asked whether they would recommend the service they have received to a friend or family member if required and through learning from compliments and complaints

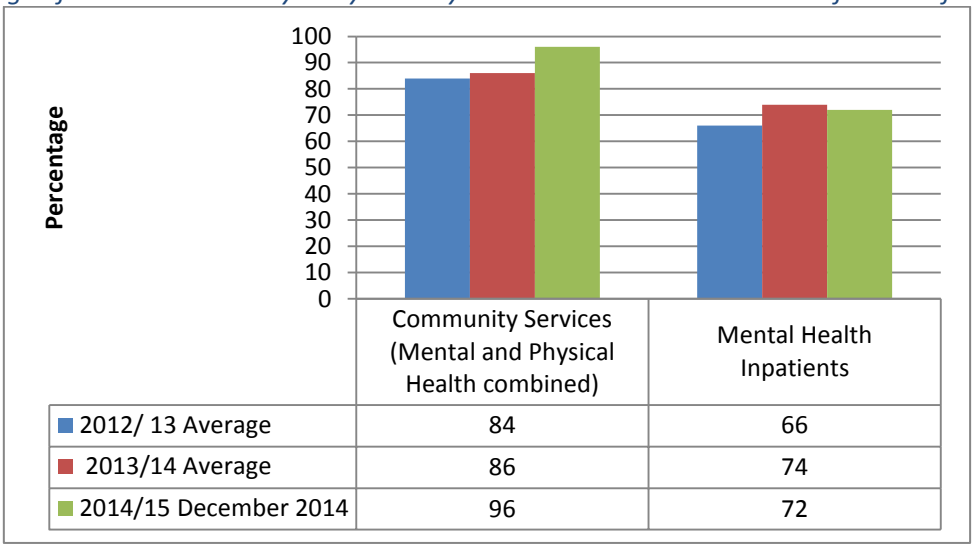
Improving patient participation and involvement has been a key theme for the Trust during 2014/15 and there have been a number of initiatives in this area.

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.

There has been a particular focus on enhancing patient, family and referrer experience in key areas and services. For example, in child and adolescent mental health services an independent review has been undertaken to understand better how to improve care pathways and reduce waiting lists.

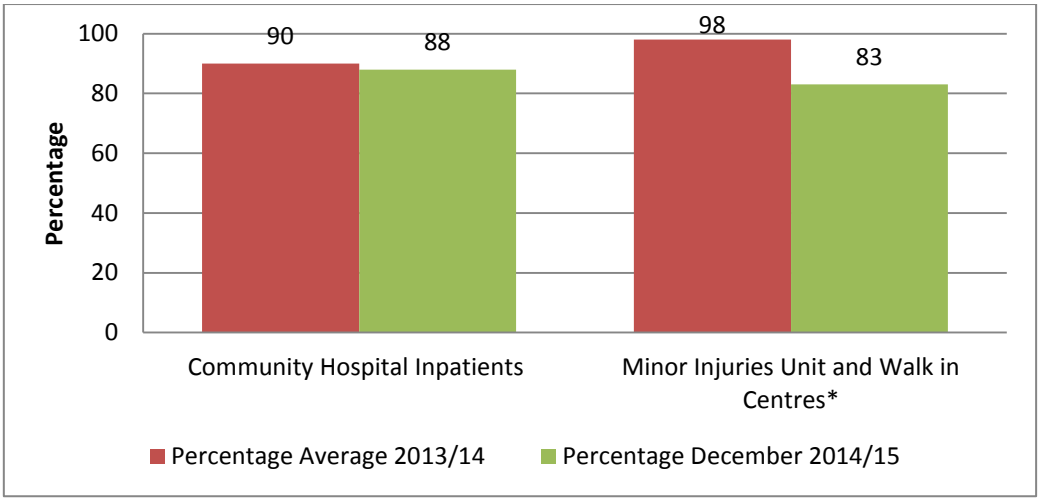
Figure 1. Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member (Q3)



	Community Services (Mental and Physical Health combined)	Mental Health Inpatients
2012/ 13 Average	84	66
2013/14 Average	86	74
2014/15 December 2014	96	72

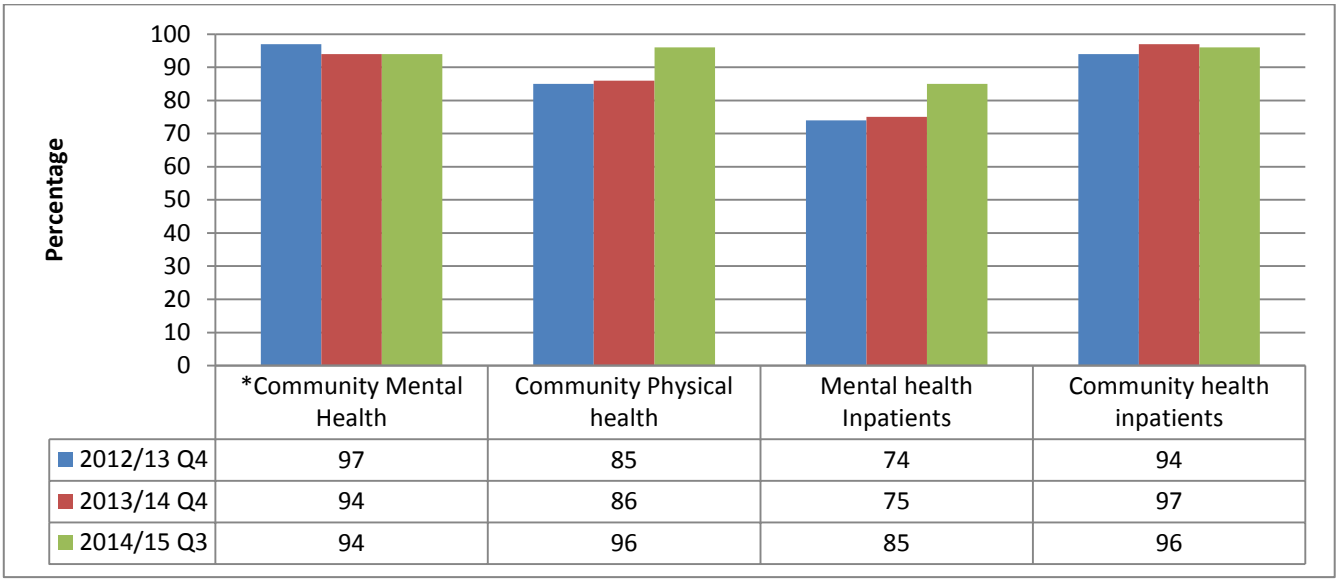
Figure 1 shows that our community services in both physical and mental health are highly valued with 96% of people surveyed likely to recommend the services. For our mental health inpatients the percentage who would recommend the services remains high considering the circumstances and challenges this patient group faces.

Figure 2 Percentage who would recommend to a friend or family member (no figures are available for 2012/13)(Q3).



** 2013/14 figures are for Minor Injuries Centre only 2014/15 figures include Slough Walk in Health Clinic. There has also been some change in the methodology to ensure visitors report in higher numbers and anonymously.*

Figure 3 Percentage of patients who rated the service they received as very good or good (Q3).



	*Community Mental Health	Community Physical health	Mental health Inpatients	Community health inpatients
2012/13 Q4	97	85	74	94
2013/14 Q4	94	86	75	97
2014/15 Q3	94	96	85	96

(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 children services are unavailable. Community Mental Health Teams and Electroconvulsive therapy included for 2013/14).*Source: Figure 1-3 Trust Patient Experience Reports.*

3,818 service users and carers have provided feedback through the internal patient survey programme, with 95% saying their experience was good or better. In addition 99% of patients with a Learning Disability who gave feedback said that they found their meeting with the service helpful. The vast majority of services have increased their satisfaction ratings in quarter three; all of the community hospital wards have increased their satisfaction ratings or maintained a 100% good or better satisfaction rating. This is also

reflected in all but one of the Mental Health inpatient wards (Rowan ward has decreased from 98.3% rating good or better to 90%). The low number of good or better ratings continues to be an issue in the Slough Walk in Health Centre. The impact of the implementation of the Friends and Family Test in this service is going to be monitored specifically.

In terms of volume the level of positive feedback received by services far outweighs the negative feedback found in complaints and on NHS Choices.

Patient 'big conversations' including an event for people with learning disabilities have been very successful. Increased patient and public representation on key groups and projects has occurred. Examples include the medical revalidation group and a collaborative project group developing Physician Associate courses at Reading University. The Trust is prominently involved with the Thames Valley Patient and Public Involvement, Experience and Engagement (PPIEE) Strategy Group.

Learning from Complaints

In Quarter three, the Trust received 58 formal complaints in comparison with 67 in quarter two and 61 in quarter one. In addition, eight complaints were received which were being led by a different organisation (in comparison with nine in quarter two and five in quarter one).

The Services that received the highest number of formal complaints during quarter three were Adult Acute Mental Health Inpatients (five), Community Mental Health Teams (eleven), Crisis Resolution/Home Treatment Team (six) and Child and Adolescent Mental Health Services (CAMHS) (nine).

The main themes from the complaints were care and treatment (23), attitude of staff (11) and waiting times for treatment (9).

The formal complaint response rate, including those within a timescale re-negotiated with complainants is 88% for quarter three. It took an average of 29 days to investigate and respond to a formal complaint during the quarter.

Waiting times for Child and Adolescent Mental Health services (CAMHS) continue to increase accounting for 55% of complaints about waiting lists. This is partly due to a very large increase in demand for these services. The trust recognises that some families wait too long for assessment and has asked commissioners for investment into the service to address these waits using the 'parity of esteem' funding stream. All these complaints are rightly upheld because children and young people are waiting too long to access an appropriate service.

Timely access is very important for these children in terms of their wellbeing and longer term development, including in many cases educational achievement levels.

75% of complaints received about care and treatment provided were attributed to mental health services. These complaints are often complex with patients unhappy about diagnosis, medication and the level of provision available i.e. related to patient expectation not being fully met. The deep dive survey into Community Mental Health Team patients will help the Trust to understand the service changes needed to improve patient experience.

Attitude of staff continues to be a theme with many complaints and the Listening into Action campaign 'Smile' and 'SHINE' were launched on 2nd February encouraging staff to think about the person in front of them and how they might come across. The 'Listening into Action' public sessions also showed that the public wanted staff to smile and be more welcoming in their approach, as well as providing effective care.

National Community Mental Health Survey

The Trust uses national surveys to find out about the experiences of people who receive care and treatment. The annual Community Mental Health Patient survey was published in September 2014. This year's survey asks different questions to previous years and therefore the results are not directly comparable overall.

The survey this year had 33 questions (compared with 38 last year), categorized within nine Sections. A score for each question is calculated out of 10.

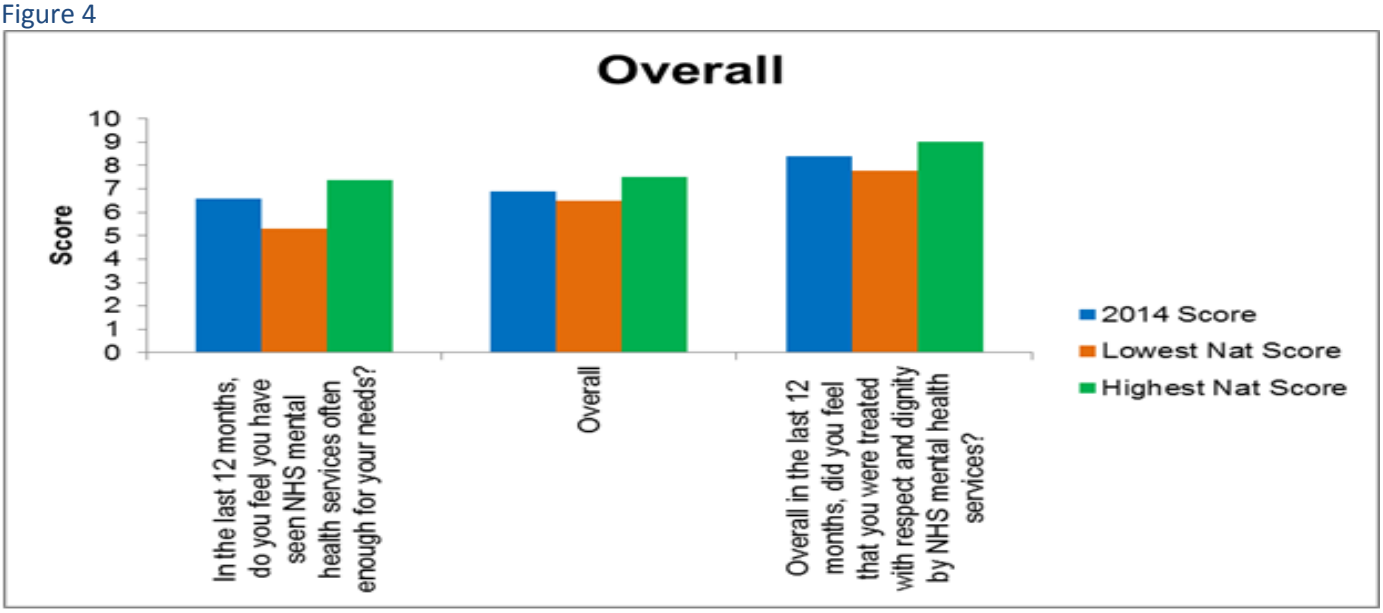
A questionnaire was sent to 850 people who received community mental health services. Responses were received from 238 people (28%).

This year the Trust has not received any ratings where performance has been judged to be lower than the majority of other Trusts, last year there were 12 questions rated in this category

There is one question which is identical to previous years where patients were asked whether services involved a member of your family or someone else close to you, as much as you would like. Previously the Trust was rated as performing lower than the majority of other Trusts in this area and this year is rated as performing at the same level as the majority of other Trusts. It is not unusual for families to report that they do not feel sufficiently involved or listened to, so this is an area where further improvement is sought.

The Trust would like to see improvement next year in how patients rate performance in supporting them to manage in a crisis in their illness. An initiative, in conjunction with the Centre for Mental Health, to get service users back into employment is a key patient outcome which should be reflected in the national survey results for future years.

Figure 4



(Source: DoN CMHS overview report)

2014 National Staff Survey

Figure 5 details the key results of the 2014 National staff survey, which was conducted between October and December 2014. As a result of the Trust decision to complete the survey electronically the response rate increased with over 1,800 staff participating.

The results are very positive and the Trust is again in the top 20% of similar Trusts for staff engagement. The Staff engagement measure is an overall rating that includes staff motivation at work, staff recommending the trust as a place to work and receive treatment and the ability to contribute towards improvements at work. This result is particularly important as research conclusively demonstrates the most powerful indicator from the survey in predicting the quality of care and performance of Trusts is the level of staff engagement.

The most significant improvement was in how appraisals are carried out. This year the Trust scored highest in comparison with similar trusts – 96% of staff responding said they had had an appraisal in the last 12 months and a higher percentage than last year (48% compared with 40%) said it was a well-structured appraisal. This is because of the improvements the Trust made to the appraisal process, guidance and paperwork. Also, the Excellent Manager Programme which was run for Trust managers has contributed to better quality appraisals. These scores are reinforced by the responses to questions which asked staff if they noticed a positive difference in their managers. The aim for the year ahead is to further increase the scores for 'well structured' appraisals.

Of the 1700 who replied to the question:

- 49% agreed or strongly agreed "Over the last 12 months I have noticed a positive difference in how my line manager listens to me and involves me in decisions that affect work."
- 50% agreed or strongly agreed "Over the last 12 months I have noticed a positive difference in the way my line manager role models the behaviours required by the Trust."

Also at a time when the media is reporting that only two thirds of staff feel secure in whistleblowing on poor care; the Trust had the best score (78%) amongst similar trusts for staff agreeing that they would feel secure raising concerns about unsafe clinical practice. This was 9 percentage points better than last year.

There has been significant work in this area over the year with increased awareness of the policy and practice on raising concerns, together with the improved response rate this demonstrates that progress has been made.

However, the Trust recognises that there is still more to do in creating a culture where everyone feels safe to speak up and this will continue to be an area of focus over the next few years.

One concerning result was staff perceptions about equal opportunities in respect of career progression and promotion. Although the score was in line with the national average it was less positive than last year. It is vital staff have the confidence in the integrity of the recruitment and selection processes. The Trust has clear policies and processes in this area. In line with the Trust values, poor practices that inadvertently or otherwise damage some colleagues' confidence in their managers' judgments will be identified and addressed.

The results overall for 2014 were the most positive to date for the Trust. Next year's staff survey will provide evidence as to whether planned further improvements make a difference for staff.

Figure 5

Question reference	Question	Trust 2012 %	**Trust 2013 %**	Trust 2014 %	National average for all mental health trusts 2014 %
Q12a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	62	71	**73**	65
Q12b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	69	75	**78**	71
Q12c	*I would recommend my organisation as a place to work (agree or strongly agree)*	58	62	**62**	54
Q12d	*If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (agree or strongly agree)*	64	69	**71**	60
Q5a	*I look forward to going to work (often or always)*	62	58	**59**	54
Q5b	*I am enthusiastic about my job (often or always)*	74	71	**74**	68
Q8g	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	47	44	**47**	42
Q11c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	35	41	**41**	32
Q11d	*Senior managers act on staff feedback (agree or strongly agree)*	26	38	**41**	29
Q18a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	54	54	**51**	44
Q18b	*My organisation encourages us to report errors, near misses or incidents*	88	90	**88**	86
Q18d	*My organisation blames or punishes people who are involved in errors, near misses or incidents (agree or strongly agree)the*	10	9	**10**	15
Q18e	*When errors, near misses or incidents are reported my organisation takes action to ensure that they do not happen again (agree or strongly agree)*	63	67	**67**	62
Q18f	*We are informed about errors, near misses or incidents that happen in the organisation (agree or strongly agree)*	51	48	**51**	46
Q18g	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree or strongly agree)*	49	48	**51**	48
Q19b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	74	71	**78**	69
Q19c	*I am confident that my organisation would address my concern (agree or strongly agree)*	58	55	**65**	57

(Source: 2014 National Staff Survey Table A3.2: Survey questions benchmarked against other mental health/learning disability trusts).

2.1.2 Patient Safety

Patient safety is fundamental to care and the Trust wants to continue to protect patients from avoidable harms. This can be achieved by encouraging a positive patient safety culture within the trust and ensuring a safe and reliable delivery of health care. This has been measured through an increased positive staff survey response to questions regarding incidents and learning. The staff survey (Fig.5) indicates that the Trust has maintained a positive culture with respect to incident reporting in comparison with similar Trusts. In particular, staff feel increasingly secure in raising concerns (Q19b) and confident that the organisation will address these (Q19c).

Figure 6 Overview of Pressure Ulcer Events during the last 12 months.

2014 - 2015										
Developed Pressure Ulcers	**Q1**			**Q2**			**Q3**			**Total**
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	
Category 2 PU	2	1	4	4	3	3	5	4	2	28
Cat 3 & 4 PU Avoidable	1	1						1	2	5
Cat 3 & 4 PU Unavoidable					1	2	2			5
Grand Total	**3**	**2**	**4**	**4**	**4**	**5**	**7**	**5**	**4**	**38**

The Trust also aimed to achieve no developed pressure ulcers on community and mental health wards and reports on the number of days without a developed grade 3 or 4 pressure ulcer on each of the wards. The aim during 2014/15 was to exceed 120 days on all wards

Figure 6 gives an overview of Pressure Ulcer Events during the past 9 months showing the number of pressure sores which patients have developed whilst an inpatient on one on our inpatient units. Five community wards have exceeded 120 days without a developed category 3 & 4 pressure ulcer during the year. Two wards have not achieved this yet. It was disappointing that in November and December three pressures ulcers were identified which could have been prevented. Full investigations are under taken to ensure we learn why they were not prevented and to ensure that these lessons are shared with staff

Patient Safety Thermometer

The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care.

The Trust has completed a pilot of a similar mental health tool which will be reported separately.

The NHS Safety Thermometer records the presence or absence of four harms:

- Pressure ulcers
- Falls
- Urinary tract infections (UTIs) in patients with a catheter
- New venous thromboembolisms (VTEs)

These four harms were selected as the focus by the Department of Health's 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. Patients are assessed in their care settings. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

All eligible patients are surveyed on one day of the month. This is typically around 4000 patients for the Trust

The national average for harm free care is 93.7% for the past 12 months to December 2014. The average monthly percentage for the Trust over the 12 months to December 2014 is 91.5%. The Trust has a lower number of harm free patients due to the significant number of 'acquired' pressure ulcers. This means that patients have acquired the pressure ulcers in another setting before coming in to the care of the Trust.

When compared nationally the data shows that compared to all organisations BHFT has a higher % of pressure ulcers reported. The number of community pressure ulcers has reduced in quarter 3, however (Fig 7). The percentage of falls with harm has usually been lower than the national percentage (Fig 8). The Trust has a lower percentage of harms due to catheters and UTI but a higher percentage due to Venous Thrombo Embolism (VTE). (Further details available in Appendix C)

Figure 7 Community Pressure Ulcers

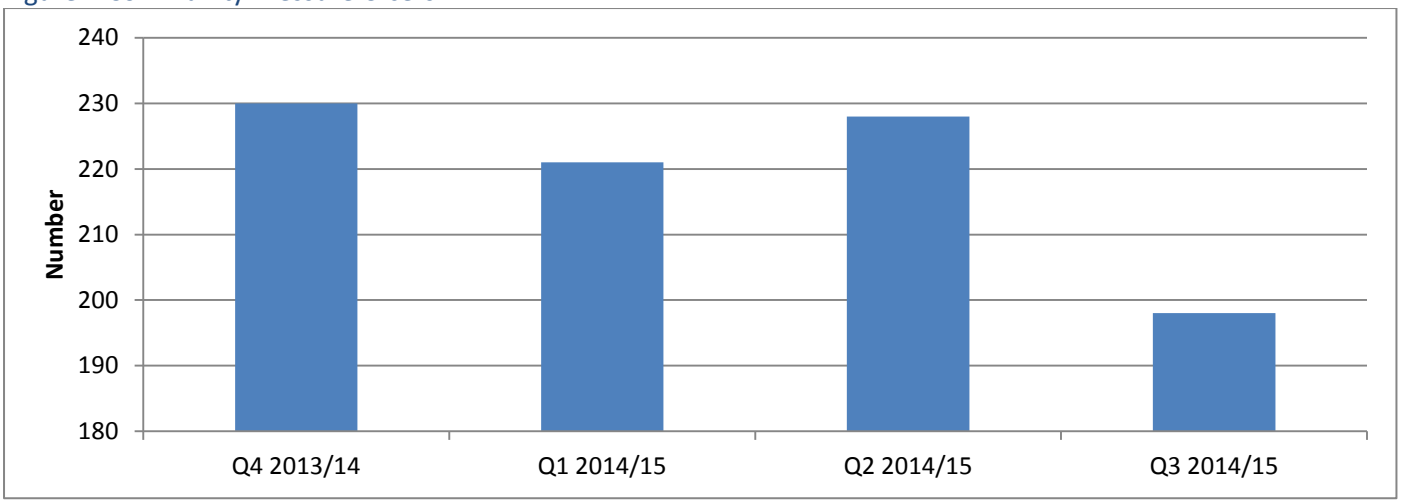
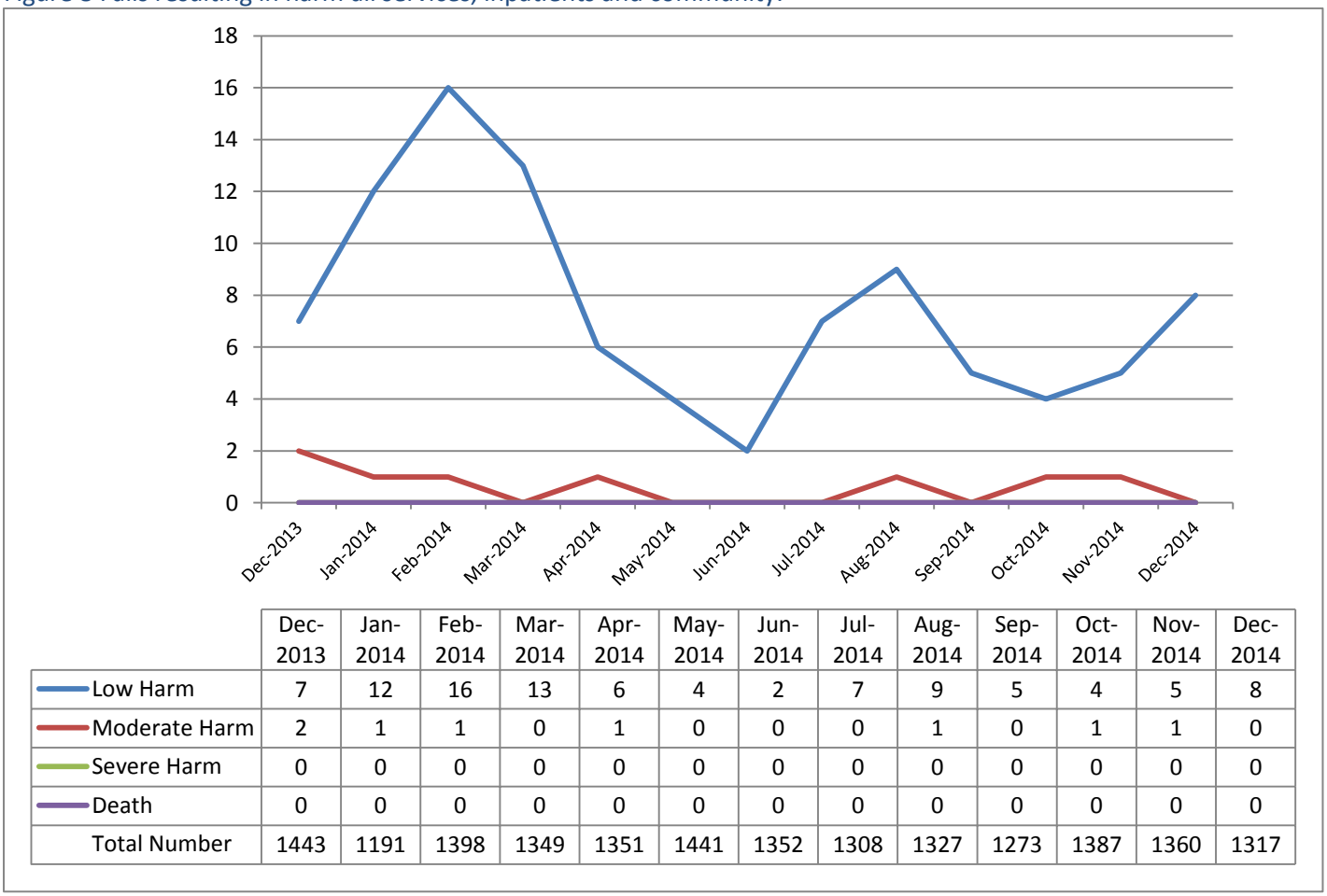


Figure 8 Falls resulting in harm all services, inpatients and community.



	Dec-2013	Jan-2014	Feb-2014	Mar-2014	Apr-2014	May-2014	Jun-2014	Jul-2014	Aug-2014	Sep-2014	Oct-2014	Nov-2014	Dec-2014
Low Harm	7	12	16	13	6	4	2	7	9	5	4	5	8
Moderate Harm	2	1	1	0	1	0	0	0	1	0	1	1	0
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number	1443	1191	1398	1349	1351	1441	1352	1308	1327	1273	1387	1360	1317

Quality Concerns

The Quality Committee of the Trust Board identify and review the top quality concerns of the organisation at each meeting to ensure that appropriate actions are in place to mitigate them. They are identified through some of the information sources provided within this account together with intelligence received from performance reports, our staff and stakeholders.

The current Trust quality concerns relate to four broad theme areas and the Board monitor the actions being taken to mitigate these.

- Staffing shortages in key areas
- Increasing demand against block contract funding
- Internal cultures
- Sharing of learning.

Additional information on the progress in tackling key quality concern priorities is also contained within Part two of this report both within the priorities for 2014/15 and the priorities for 2015/16. Some specific examples are included below.

Nursing Vacancies

Nursing and increasingly therapy staff vacancies mean that more agency staff are covering shifts. Research shows that often agency staff do not offer the same level of care as a permanent member of staff and therefore the quality of care has potential to be impacted. Equally, if there is insufficient nursing staff to offer a service the quality of care may be impacted. The level of vacancies across the trust means that there is increased risk of poor staff morale, serious incidents, complaints and poor patient satisfaction scores. The services particularly affected are Mental Health, Learning Disabilities and Community Inpatient Units, Crisis resolution and home treatment teams (CRHTT), Community Nursing Services particularly Bracknell and Slough, Musculoskeletal physiotherapy and Community Mental Health Teams. Inpatient safe staffing levels are monitored on a monthly basis and correlated across to incidents. Managers are monitoring staff morale and caseload levels.

There is an increasing national shortage of registered nursing staff and additional student placements have been commissioned, however these will not qualify for 3 years. Human Resources (HR) is working with services to develop recruitment campaigns to attract nursing staff. The trust is developing a workforce plan as there is a need to redesign the workforce to meet the increasing demand and staffing shortages. Where appropriate, changes in skill mix are being considered.

Child and Adolescent Mental Health (CAMHS)

The Trust Board is aware of the concerns associated with increased demand on CAMHS services within tier 3 and 4 having received regular reports. Waiting lists are of concern in several areas within the service.

Minors continue to be admitted to the Prospect Park Place of Safety (POS) and acute adult wards because insufficient specialist tier 4 CAMHS beds are available. Children and young people are safe in the POS or ward but the environment is not optimal for them and therefore quality of care is compromised.

Additional investment has been provided to reduce waiting lists and prior to Christmas the lists were reducing however since the New Year they have been slowly rising again. A triage process is in place to monitor children on the waiting and high risk patients are seen immediately.

The CAMHS service is using the funding received from winter pressures to manage risk by seeing those clients identified as high risk and seeing children more quickly when they present at A&E. This short term funding is also being used to extend the common point of entry opening hours until 8pm with sessions are being offered at weekends. In addition, an extended hours' pilot is taking place in the Windsor and Maidenhead specialist CAMHS service.

A tier 3 business case has been presented to commissioners for additional resourcing. A tier 4 business case has been presented to NHS England for the creation of a 24/7 unit at Berkshire Adolescent Unit - this is agreed in principle.

The University of Reading has been approached to assess those waiting on the Autistic Spectrum Disorder pathway to reduce waits in that service. Meetings have also been set up with colleagues in the Unitary Authorities to understand their current provision regarding the emotional health and well-being of children (including tier 1 and 2 services)

Ward environments

Some mental health wards, inherently, present a greater risk for the organisation in terms of the nature or vulnerability of the patients accommodated. The

Board has particularly focussed on the learning disability, Psychiatric intensive care unit and older peoples wards to seek reassurance that the environments and culture on these are conducive with optimal patient care.

Intervention has been put in place where necessary to improve leadership, staff supervision, performance management and culture on these wards.

Safe staffing levels are monitored on a monthly basis and have been maintained. Steps have been taken to avoid agency use or, where this is absolutely necessary, to use regular agency staff who know the ward well. Staff have worked hard with commissioners and local authorities to return patients to appropriate community placements in a timely fashion when inpatient care is no longer required.

Common Point of Entry, Crisis Resolution Home Treatment Team (CRHTT) and Community Mental Health (CMHT)

The interface between these three teams has been of some concern. It is important that it is clear which team is taking ownership of vulnerable and at risk patients at any time and that there is effective communication between services and with referrers, partners, patients and families at all stages of the care pathway. Patients often present with complex problems which could fall between agencies and services so excellent collaboration is required. One common example would be the combination of mental health, substance misuse and social problems. CRHTT caseloads are often much higher than the service was originally designed to cover.

A review of CPE has been commissioned and a business case for additional investment into CRHTT has been presented to commissioners under mental health 'parity of esteem' proposals because their caseloads continue to be over and above the level originally commissioned.

Waiting Times for Services

Where a patient is waiting for over 18 weeks or above the target commissioned their experience will be affected. Services currently under performing in December 2014 include:

1. Musculoskeletal physiotherapy (MSK) - waiting 7 weeks against a target of 4-6 weeks
2. Hearing and balance paediatrics (East Berkshire) - waiting 7 weeks against a target of 4 weeks
3. Speech and Language Therapy Ear Nose and Throat (West) - waiting times up to 26 weeks
4. Children's Occupational therapy (West) - waiting 26 weeks against a target of 18 weeks. There is high demand for this service in this area. ,
5. Children's physiotherapy (East) - waiting 26 weeks against an 18 week target.
6. Children's Integrated Assessment (East) - waiting 26 weeks against a target of 18 weeks

Actions have been taken in each service to resolve these waiting times. In MSK physiotherapy additional locum staff have been brought in to help address demand. A demand and capacity action plan has been created to address children's waiting list pressures on service delivery in the immediate future. This action plan is intended to mitigate the risk of increased waiting times and to ensure time is protected to complete a scoping exercise into practise across the service. Where relevant services are trying to recruit additional staff; in the mean time staff are being moved to provide cover. Agencies are being contacted should recruitment be unsuccessful. Caseloads are being reviewed to improve throughput. Waiting times are monitored on a monthly basis.

Falls

Some wards have been noted to have a higher number of falls than expected in comparison with others. This is partly related to the nature of the patients on the wards. However, staffing levels, ward leadership, learning culture and other factors play a part. Falls action plans have been developed and low rise beds procured which are particularly good for managing older adults at a high risk of falls. Falls are monitored on a monthly basis by the Executive. Additional investment into staffing for wards where required has been agreed.

Record Keeping

The quality of record keeping across the trust remains inconsistent and can be improved further. A record keeping strategy is in place for implementation across the Trust. For mental health inpatients there is a peer review process in place to improve the quality of risk assessment recording and patient and carers' views.

Demand Pressure on Services and Staff Morale

For some staff groups there is a perception that management do not recognise the pressure additional

demand is placing on their service in particular community nursing services. This means that when questioned some staff might say their morale is low and that the Trust does not listen to their concerns.

Managers are monitoring staff morale. The results of the national staff survey and staff pulse checks indicate that BHFT is in the top 25% of trusts. The CEO is building a culture of patient safety based on Trust vision and values and members of the Board regularly visit services. Listening into Action is a key staff engagement process. A workforce review is underway for community nursing led by the Deputy Director of Nursing.

Safe Staffing

During 2014/15 the trust has publicly declared that ward staffing levels have been safe.

The Trust monitors on a daily basis the levels of registered nurse and healthcare assistant staff on a shift. The staffing numbers for each shift on each ward have been agreed with the Trust Board. The number of staff required on each ward have been agreed using nationally recognised workforce tools that take in to account the number of beds on a ward and the amount of care that the patients on the ward need. The workforce analysis showed that three wards required additional investment for more staff. This additional investment was provided to the wards from April 2014.

The Trust agreed that staffing is safe on a ward when it has at least 90% of shifts filled because wards can cope with one fewer member on a shift providing this does not happen too often.

In assessing whether the wards were staffed safely the Director of Nursing considered the following information and whether there was any correlation to reduced staffing levels:

Mental Health and Learning Disability Inpatient Wards

- Actual versus planned staffing levels
- Numbers and types of incidents on each ward every 24 hours
- Number of times prone restraint used on each ward every 24 hours
- Number of patients who abscond or fail to return from leave at the agreed time
- Number of patients found on the floor on each ward every 24 hours
- Number of patient on patient assaults on each ward every 24 hours

Community Health Inpatient Rehabilitation Wards

- Actual versus planned staffing levels
- Pressure ulcers developed whilst in the care of trust staff declared
- Number of patients found on floor on each ward every 24 hours
- Numbers and types of incidents on each ward every 24 hours

All wards have other professionals working with patients during the day including doctors and allied health professionals such as occupational therapists and physiotherapists. All of these staff, along with the nurses, provide care to patients on Trust wards.

2.1.3 Clinical Effectiveness

The Trust aimed to provide services based on best practice through the implementation of the National Institute for Health and Care Excellence (NICE) Quality Standards and increasing access to psychological therapies in secondary care this will include mapping of skills within the workforce, training and supervision of staff.

Implementation of the National Institute for Health and Care Excellence (NICE)

In November 2013 NICE published guidance PH48 - Smoking cessation in secondary care; acute, maternity and mental health was issued. This builds on previous NICE guidance issued around smoking cessation and is based on the duty of health care providers to protect the health of, and promote healthy behaviour among, people who use, or work in, their services; including providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

Within the trust the aim is to support tobacco reduction amongst our staff and patients. We will do this by becoming a smoke free organisation during 2015/16 through encouraging temporary abstinence of tobacco during contact with us or by quitting.

Recommendations within NICE guidance relevant to the Trust:

- Provision of information to patients for planned or anticipated use of secondary care
- Identification of people who smoke and offer help to stop
- Provision of intensive support for people using mental health services
- Provision of information and advice for carers, family, other household members and hospital visitors
- Advise on and provide stop smoking pharmacotherapies
- Adjustment of drug dosages for people who have stopped smoking
- Making stop smoking pharmacotherapies available in hospital
- Putting referral systems in place for people who smoke
- Provision of leadership on stop smoking support
- Development and communication of smoke free policies
- Supporting staff to stop smoking
- Provision of stop smoking training for frontline staff

The approach is to implement becoming smoke-free organisation using a staged approach to maximise the chance of long term success with implementation of the full range of recommendations within the guidance, we will stagger the implementation of key milestones to ensure that we are not implementing all of the recommendations simultaneously with the goal being totally smoke free by October 2015.

The proposed Key Milestones around the staged implementation are:

- Implementation of recommendations to support staff reduction of tobacco reduction during March 2015 to include not smelling of smoke, professional image, not being seen smoking in or out of uniform during working hours
- Implementation of recommendations/ abstinence of patients in own homes during treatment and care delivery, OPD, hospital grounds during July 2015.
- Implementation of full recommendations / abstinence for patients within inpatient wards commencing October 2015.

Child & Adolescent Mental Health (CAMHS)

There has been a continued increase in the demand for specialist CAMHS and the Trust has been working closely with both the local commissioners, NHS England and local authorities to agree plans to ensure that effective care is provided for children and young people with mental health problems. Additional resource this year has enabled plans to be put in place to keep children safe, but waiting times still remain unacceptably high for those requiring the service.

Over the winter months the hours for specialist CAMHS support through the common point of entry (CPE) service has been extended from 8am-8pm (previously 9am-5pm). The trial has been successful and has given the ability to respond to young people in crisis later in the afternoon when they are home from school. A report showed that CPE had an additional 150 contacts in January calling during the extended period and prevented 20 young people presenting in A&E.

Staff in the service are working hard to ensure good communication with people who are waiting, and

providing information on what to do if something changes. This was as a specific action following a complaint.

Work with health commissioners for support in delivering more timely services. An exciting development is the agreement to create a 24 hour 7 day a week inpatient unit for children in Berkshire which will allow care to be provided close to family and home.

The service have been working to increase service user participation and as part of this a series of summer building inspections was carried out by service users who walked round buildings and identified the changes they thought would benefit the environment for others. As a result of their feedback, art workshops for service users have been held, the outputs of which will be put on display. The literature and information in the public waiting areas has been reviewed. In particular more positive information has been provided where possible and locations have been adjusted so that service users feel more comfortable to pick it up. Work is being carried out with the estates teams to develop separate areas in waiting rooms for younger children and teenagers and ensure that all waiting rooms have a staff photo board in them.

Increasing access to psychological therapies in secondary care.

We aimed to achieve the following:

1. Minimum of 70% of trust Care Pathways staff with clinical contact and not employed as a qualified psychologist or psychotherapist to have completed training in three psychological techniques.

2. Minimum of 40% of Care Pathways clients, who have been open to the teams for more than 4 months at the end of the year, to have been offered a psychological package.

3. Minimum of 75% of those clients who accept and complete a psychological intervention, to have completed outcome and satisfaction measures

This priority has been delivered through a number of steps. At the beginning of the Trust produced a training package established the required training and supervision for staff. Workshops were held and locality leads and champions were identified.

Three techniques were chosen based on their suitability as brief, stand-alone intervention to address specific difficulties commonly presenting as part of the complex problems experienced by clients in the Pathways teams (Problem Solving; Behavioural Activation; and Graded Desensitisation). Psychologists from within each Pathway team volunteered to develop and teach the training packages.

The content of the three training programmes (including e-learning, podcasts and manuals) were developed to enable staff to understand and utilise the psychological techniques with suitable clients. These will provide the essential learning but the teaching methods in each locality will be according to local requirements.

The trainers are working with Learning & Education and Informatics to create three e-learning/podcast teaching packages and accompanying manuals.

Supervisors have been identified to facilitate group supervision in teams to support and consolidate learning and ensure/monitor quality standards for delivery of the interventions.

The Trust committed funding to engaging a production company to create three training modules when it was identified that no training packages currently on the market were suitable for the audience. In addition, psychologists from all localities and L&D have been released to develop the content of the training packages and facilitate their production.

The training packages consist of the following modules for each of the three interventions:

- Internet based teaching, including slides and video that provide the rationale and aims for each intervention, as well as clear guidance on how to work through the techniques with clients and examples via role plays.
- Manuals for clinicians to guide them through the intervention; how to engage clients, working safely, the required steps, how to overcome obstacles, and endings.
- Manuals for clients that outline the purpose and steps of the interventions, as well as providing work sheets and self-help hints.

These modules have been developed for all three interventions and are available to staff.

The three training modules (including e-learning and manuals) provide the essential information to enable staff to understand and utilise the psychological techniques with suitable clients. In order to ensure that staff understand the materials and to support skilled application, the teaching will be supported by additional psychology input in each locality.

The delivery of this is according to local requirements. Three teams have had between 1 and 3 teaching or workshop days based around the internet training packages and facilitated by locality psychologists, one locality have an external psychologist contracted to provide teaching and supervision, 2 localities have dates for teaching days scheduled. For the 4 localities where training has been completed, approximately 79% of staff have been trained.

Psychologists in the localities are providing group supervision for community mental health staff to facilitate appropriate selection of clients to work through the interventions, discuss application of the materials and any obstacles so as to support safe and effective care.

Informatics arrangements (Rio care plans) for the recording, collation and reporting of psychological interventions offered have been established. The collation of outcome data will be by manual trawl at Q4.

The offer and delivery of Psychological interventions, evidenced via the relevant CQUIN care plan on Rio, is the focus for Q4.

2.1.4 Health Inequalities

The Trusted aimed to ensure that services responded better to population need. In 2013 the Trust recognised that it needed to increase the number of employed health visitors.

The Trust had a growth target of 52 new health visitor posts to achieve between April 2013 and April 2015. This was in addition to filling all vacant existing health visitor posts which totalled approximately 9 staff in April 2013. Therefore, a total of at least 62 more health visitors was required to be recruited by 2015, to meet our target of having 185 health visitors across Berkshire. Supporting the training of health visitors was part of the implementation plan.

There are currently 165 health visitors across BHFT. Another 23 completing their training in January 2015 have been appointed which brings the total to 189. This exceeds the Trust target. This represents an important success at a time when other Trusts are also trying to increase health visitor numbers.

Health visitors have been allocated across Berkshire as they have been recruited based on a model agreed with public health and the 6 local authority directors across Berkshire. This ensures that the areas of greatest need have the greatest part of the resource.

To improve accessibility of the age 2 reviews especially for working parents and hence improve uptake, the evening clinic trialled at Bracknell has proved very successful and will become a permanent feature. In Slough the team have used the new community room in the large Tesco store in the centre of town which has also had excellent attendance and will be now be used on a regular basis as well as the Saturday review slots in a Slough children's centre .

The next steps for the 2 year reviews are to link up with those children in childcare settings to ensure the results of their health reviews contribute to the early years development assessment undertaken. This work is being carried out with local authority colleagues.

Within Windsor, Ascot and Maidenhead the health visiting teams are in the process of reviewing how they run the drop in clinics and they have undertaken additional surveys of families to contribute to this work. They will be sharing what works best with all teams at the end of the project and this will be used together with the client survey results to help improve the clinic experience for all. In the meantime they have produced a health visitor newsletter for parents in response to feedback which is already proving popular.

In response to feedback from parents, the visit will be a combination of family focused conversations which include an holistic assessment to identify those families needing additional support.

The antenatal, new birth and post natal assessments have now been combined into one document to help ensure that clients are not asked the same questions

repeatedly as the information from the first assessment follows through into the others.

Diabetes Education Project

An agreement was reached in July 2014 that the Equality & Inclusion Strategic objective to "reduce inequalities in service usage by people with protected characteristics which correspond with inequity in life expectancy and health outcomes" would be met by developing and delivering a Diabetes Education programme across the Trust for staff. The Trust will progress work on improving access to people with long term conditions such as diabetes, who live in socio-economically deprived areas'.

Key objectives

1. To raise awareness amongst staff of Type 2 diabetes
2. To develop education materials relating to Diabetes Type 2
3. To increase recognition and identifying people who may have undiagnosed diabetes (as set out below).
4. To ensure that staff with protected characteristics access education materials
5. To ensure the diabetes education is rolled out to target staff working in in areas of greater prevalence. To develop this to enable a focus on (population) wards where there is deprivation and/or people with protected characteristics who make them more vulnerable to the disease, namely Reading and Slough.
6. To run the proposed education programme across all Trust services in Berkshire
7. To develop a tool to measure results.

A group was established in August 2014 with the aim to take early action with the large numbers of people expected to be diagnosed with Diabetes over the next 5 years and for the large number who remain undiagnosed. The trust is developing an education programme to raise diabetes awareness both internally with staff and externally with patients.

The aim is to reduce health inequality with respect to diabetes in the Berkshire area.

Key outcomes to date

1. The information for staff was updated with respect to diabetes and the associated risk factors
2. The Trust devised and launched a Diabetes Type 2 quiz as a survey monkey to be completed by staff to establish a baseline on knowledge and numbers of staff motivated to complete this. It was sent out in November and 129 staff completed the survey.
3. The Trust launched the Diabetes Education project with three roadshows –one at Upton Hospital, Bracknell and at Prospect Park Hospital for staff to make them aware of the risk factors for diabetes and how this may affect them or their families personally. This was to launch the project 'Together we can defeat Diabetes' which started on World Diabetes Day-November 14th 2014.
4. Trust communications were used to publicise information, quizzes on team brief and on Newsline in December 2014. This encouraged staff in all disciplines to be alert to the risk factors and to signpost themselves and their patients who may exhibit these risk factors to undertake a recognised diabetes risk assessment.

Future activity in progress

- To continue the project until World Diabetes day November 2015
- To re-advertise the Diabetes survey monkey and measure changes in uptake and knowledge
- To develop a factsheet to be attached to all payslips in April/May 2015
- To design information posters with Diabetes recognition information for display in Slough and Reading to all waiting areas and staff areas
- To request staff demographics from HR and work closely with Healthy Hearts and other Trust programmes to create a Trust health and well-being page for our staff.
- To work with Diabetes UK from April 2015 onwards to create a risk assessment tool that can be anonymised for BHFT staff so that data on success of the project can be collected specifically for BHFT and outcomes measured.

2.2 Priorities for Improvement 2015/16

2.2.1 Patient Safety

The Trust aim is to foster an environment where staff are confident to raise concerns about patient safety. Learning occurs with respect to errors, incidents, near misses and complaints across the organisation.

Further initiatives to achieve this will be implemented during 2015/16 and described in the Quality Account. The Trust will continue to engage with and contribute to cross organisational initiatives such as the patient safety collaborative. We will report specifically on the following:

Staff survey results will demonstrate continued improvement (Questions 18 and 19) with the aim of being amongst the best 20% of similar Trusts for these measures.

Staff Staffing, having the right capacity of registered nurse and care staff on each ward allows for staff to have the best chance of achieving safe care, however to ensure that patients receive a safe and quality service capability of the workforce is also important. To monitor safety of care delivered on the wards the Director of Nursing and Governance reviews a range of quality indicators on a monthly basis alongside the daily staffing levels. These indicators are and will be reported on:

1. Community wards
2. Falls where the patient is found on the floor (an unobserved fall)
3. Developed pressure sores
4. Medication related incidents
5. Mental health wards
6. AWOL (Absent without leave) and absconsion
7. Falls where the patient is found on the floor (an unobserved fall)
8. Patient on patient physical assaults
9. Seclusion of patients
10. Use of prone restraint on patients

2.2.2 Clinical Effectiveness

NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services. The Trust has continued demonstrate 100% compliance with technology appraisals but levels of assurance around other

NICE guidelines compliance assurance has reduced to below 75%. NICE guidance will be prioritised and assurance will be sought through expert opinion and clinical audit that all high priority guidance is adhered to. Assurance on all NICE guidance above 80% will be achieved.

2.2.3 Patient Experience

We will continue to report on the friends and family recommendations with an aim of further increasing this. A Friends and Family Test for Carers has been created which will be distributed to services from February 2015. This will give our carers the opportunity to share their experience with us in a dedicated way. Whilst this is not mandated within the Friends and Family national guidance, the Trust recognises the crucial role that carers have and the value that their feedback has. The Trust aims to demonstrate continuing improvement during the year and recommendation levels which are among the best of similar Trusts where this comparison is possible. Learning from complaints will remain a priority together alongside improving our results in national surveys.

2.2.4 Health Promotion

The Trust will deliver its priority to become smoke free across all sites in 2015/16. Delivery of the implementation plan will be reported on quarterly throughout the year and fully documented in the 2016 Quality Account. This will have a major positive impact on the physical and mental health of patients across all services and will also promote healthy lives among staff. The plans include a programme of activities for staff and patients to support them in stopping smoking.

Work to tackle diabetes and increase awareness among staff and patients will continue. This will focus on targeting high risk groups. Initiatives to support weight loss and exercise will be promoted.

Several clinical audits have indicated less than optimal monitoring of physical health risk factors, including weight monitoring, blood pressure and smoking among young people and adults with mental health problems. Associated action plans will be implemented to improve the physical health of these patients and further clinical audits carried out in this area.

Monitoring of Priorities for Improvement.
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 2016.

2.3 Statements of Assurance from the Board

During 2014/15 the Trust provided 72 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 2014/15 represents 100%* of clinical services and 89%* of the total income generated from the provision of NHS services by the Trust. **Figures to be confirmed*

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Further improvements in the metrics used and processes in place to gather good quality data in these areas were implemented early in 2014/15. 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

During 2014/15, 10 national clinical audits and 1 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare Trust provided.

During 2014/15 Berkshire Healthcare NHS Foundation Trust participated (or is due to participate) in 100% (n=10) 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.

National Clinical Audit and Patient Outcome Programme (NCAPOP)

1. NCAPOP - Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)
2. NCAPOP - National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
3. NCAPOP - Sentinel Stroke National Audit Programme (SSNAP)
4. NCAPOP - Falls and Fragility Fractures Audit Programme (FFFAP) - Incl. Hip fracture database, and National audit of falls and bone health *(TBC – query may only be relevant to acute services this time)*
5. NCAPOP - Chronic kidney disease in primary care
6. NCAPOP – Ophthalmology (*TBC – still not confirmed details*)
7. NCAPOP - Epilepsy 12 audit (Childhood Epilepsy)
    a. No relevant patients
8. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification
9. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder
10. Non-NCAPOP - National Audit of Intermediate Care

1. Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

Four National audits were removed from the quality account list in-year.

1. Non-NCAPOP - National Audit of Seizures in Hospitals (NASH)
    - Removed 9/7/14
2. Non-NCAPOP - Parkinson's disease (National Parkinson's Audit)
    - Removed 2/6/14
3. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 6: Assessment of side effects of depot antipsychotic medication
    - Postponed in light of national CQUIN – September 2014
4. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 15: Use of Sodium Valproate (provisional)
    - Postponed to September 2015

The reports of 4 (100%) national clinical audits were reviewed in 2014/15. This included 3 national audits that collected data in 2013/14 that the report was issued for in 2014/15.

- Prescribing Observatory for Mental health (POMH) - Topic 4: Prescribing antidementia drugs
- POMH - Topic 10: use of antipsychotic medication in CAMHS
- National audit of Schizophrenia 2013
- POMH - Topic 14: Prescribing for substance misuse: alcohol detoxification

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in figure 10 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.

Figure 10

NCAPOP Audits	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Registered to participate.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Registered to participate.
Sentinel Stroke National Audit Programme (SSNAP)	Registered to participate.
Chronic kidney disease in primary care	*Project noted as relevant to primary care – to be confirmed for SWIC.*
Ophthalmology	*(TBC – still not confirmed details)*
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients
Non-NCAPOP audits	
Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification	Data collected March – April 2014 54 patients submitted, across 6 teams. Report received September 2014
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 31 patients submitted, across 4 teams Report received January 2015
National Audit of Intermediate Care	Data collected June-July 2014 14 service elements included. Initial Report received.
Other audits reported on in-year (data collected in previous year(s)	
POMH - Topic 4: Prescribing antidementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS services
POMH - Topic 10: use of antipsychotic medication in CAMHS	Data collected March 2014. 48 patients submitted, across CAMHS services.
National audit of Schizophrenia 2013	Report received October 2014 111 patients submitted, across adult and CAMHS services.

The reports of all the national clinical audits were reviewed in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix A.

Local Audits

- Registered – (157 last year) 80
- Completed- (56 last year) 66 (may have started in previous year)
- Active – (159 last year) 184(may have started in previous year)
- Awaiting action plan – (19 last year) 18

The reports of 25 local clinical audits were reviewed by the Trust in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B. (NB: Projects are only noted as 'completed' after completion of the action plan implementation, which is why there may be more local projects 'reviewed' than total 'completed').

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in Figure 9 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.

Figure 9

NCAPOP Audits	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Registered to participate.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Registered to participate.
Sentinel Stroke National Audit Programme (SSNAP)	Registered to participate.
Falls and Fragility Fractures Audit Programme (FFFAP) - Incl. Hip fracture database, and National audit of falls and bone health	*(TBC – query may only be relevant to acute services this time)*
Specialist rehabilitation for patients with complex needs	*(TBC – query may only be relevant to acute services this time)*
Chronic kidney disease in primary care	*Project noted as relevant to primary care – to be confirmed for SWIC.*
Ophthalmology	*(TBC – still not confirmed details)*
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients
Non-NCAPOP audits	
Severe trauma (Trauma Audit & Research Network, TARN)	*Project noted as relevant to primary care – to be confirmed for SWIC.*
National Comparative Audit of Blood Transfusion programme	Registered to participate.
Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification	Data collected March – April 2014 54 patients submitted, across 6 teams.
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 Report yet to be received.
National Audit of Intermediate Care	Data collected June-July 2014 14 service elements included. Report yet to be received.
Other audits reported on in-year (data collected in previous year(s)	
POMH - Topic 4: Prescribing antidementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS services
POMH - Topic 10: use of antipsychotic medication in CAMHS	Data collected March 2014. 48 patients submitted, across CAMHS services.

The reports of all the national clinical audits were reviewed in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix A.

Local Audits

- Registered – (157 last year) 60
- Completed- (56 last year) 48 (may have started in previous year)
- Active – (159 last year) 183(may have started in previous year)
- Awaiting action plan – (19 last year) 22

The reports of 21 local clinical audits were reviewed by the Trust in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B. (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'

2.5 Research

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited to end of January 2015 to participate in research approved by a research ethics committee was as follows:

665 patients were recruited from 90 active studies, of which 218 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 447 were from non-Portfolio studies.

Figure 10 R&D recruitment figures 2014/15

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	218	55
Student	355	24
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	92	11

Source: R&D department.

2.6 CQUIN

A proportion of the Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and the Clinical Commissioning Groups (CCGs) through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period can be found in Appendix D.

The income in 2014/15 conditional upon achieving quality improvement and innovation goals is £1,440,148.18. The associated payment received for 2013/14 was £ (to be confirmed).

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 2014/15. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In 2013/14 the CQC inspected Sorrel ward where they raised two concerns and an improvement notice was given 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.

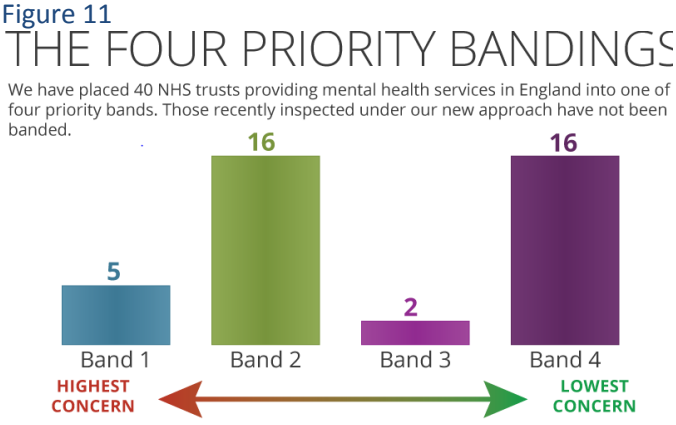
In August 2014 the CQC re visited Sorrel ward and lifted the two concerns which had previously been raised.

The Trust received a CQC Mental Health Act (1983) thematic review during the reporting period. The Trust was asked by the CQC to coordinate the inspection on behalf of the local authority, Thames valley police, South Central Ambulance Service and other stakeholders. The inspection focused on patients within the Windsor and Maidenhead area and included people who had experienced a mental health crisis and who are detained under Section 136 of the Mental Health Act (MHA). The CQC are yet to publish their findings on this review.

The current quality intelligence draft report which has replaced the CQC Quality & Risk Profile can be found at:
http://www.cqc.org.uk/Provider/RWX

Figure 11 details the priority bandings on a scale of 1 to 4 with 4 being the slowest concern. The Trust is currently banded as a priorit level 3 and this is due to a higher than expetced number of parlimentary health service ombudsman (PSHO) inquires into our complaints, it has been established that this number is in fact increased due to a backlog of complaints being cleared by the PHSO in the time frame reported on arther than an increase in the number reported to the PHSO.

Figure 11



2.8 Data Quality and Information Governance

The Trust submitted records during 2014/15 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:
98.6% for admitted patient care
100% for outpatient care.

The percentage of records which included the patient's valid General Practitioner Registration Code was:
100% for admitted patient care
100% for outpatient care.
100% for emergency care (Minor Injuries Unit)

Information Governance

The Trust Information Governance Assessment Report overall score for 2013/14 was (68%) and was graded satisfactory (Green).
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 was agreed to achieve this. This has led to an improved score from 2012/13 66% (Amber).to be confirmed at Q4 when submission for 2015 is due.

Data Quality

The 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
- Admissions to inpatient services had access to Crisis resolution home treatment teams (gatekeeping).

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 2014/15

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. The data source for all information within this section is the Trust assurance performance framework unless otherwise stated

Patient Safety

The Trust 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

Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The trust has not reported any never events in 2014/15.

Incidents and Serious incidents requiring investigation (SIRI)

Reporting levels remain consistent over recent quarters, with over 2,400 incidents reported in Q3.

The severity model is as expected, with near miss / no harm incidents accounting for the largest proportion of reports, followed by minor, then moderate incidents. Major and severe incidents are relatively rare, and are reported as SIRIs when they involve our services

The top 5 incident categories for Q3 Trust-Wide:

1. Pressure ulcers
2. Assaults
3. Behavioural
4. Nonphysical assaults
5. Falls

Key Learning points from SIRIs in 2014/15:

1. **Standards of clinical record-keeping** including triangulation of information from all sources into effective clinical assessments and care planning.
2. **Historical information** including summaries of in current records.
3. **Multi-Disciplinary / Multi-Agency Planning and Co-ordination** for patients presenting with complex mental, physical and social needs.
4. **Interface with substance misuse agencies** and access to dual diagnosis specialists in each locality.
5. **Changes in Risk Post-Discharge from Mental Health Inpatient Units.** Careful consideration needs to be given to changes in levels of assessed risk when mental health inpatients are discharged. Patients whose risk is contained on inpatient units may suddenly be re-exposed to outside stressors and risks in the community.
6. **Carer / Family Involvement** in care planning and treatment.

Trust-Wide Initiatives Informed by SIRI Learning

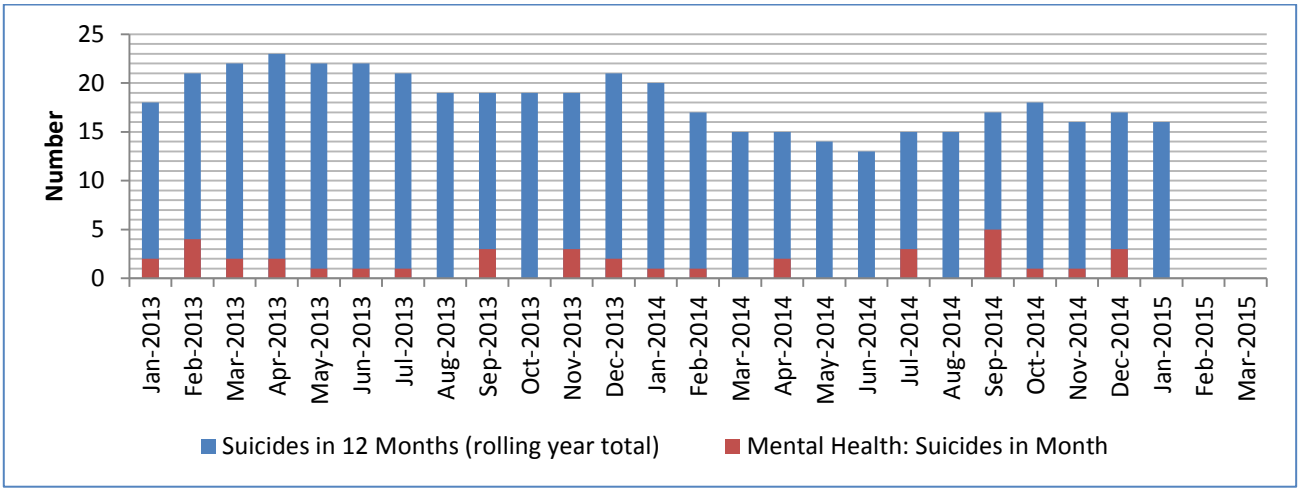
1. One of the key recurrent findings in mental health SIRIs is around the quality of risk assessments and clinical record-keeping. The Trust is launched a new record-keeping strategy in 2014/15, and has revised the Risk Assessment Policy and training. Auditing and one-to-one peer supervision have been extended from mental health inpatient units out into the community teams to support improvement.

2. Work is in progress to provide further support for mental health professionals in assessing and treating suicide risk; lead professionals are involved in promoting best practice with reference to the Interpersonal Theory of Suicidality (Joiner, 2005); this is also being piloted as an evaluation framework in SIRI investigations.

3. The Trust is reviewing its operational model in relation to Crisis Resolution and Home Treatment. SIRI cases have exemplified the systemic challenges faced in delivering this service, and have informed the decision to undertake an operational review.

There have been no inpatient suicides during 2014/15. 17 suicides occurred in the community (Figure 13) in the last 12 months. Clinicians have worked hard to improve processes for assessing and managing risks for patients in relation to suicide and self-harm.

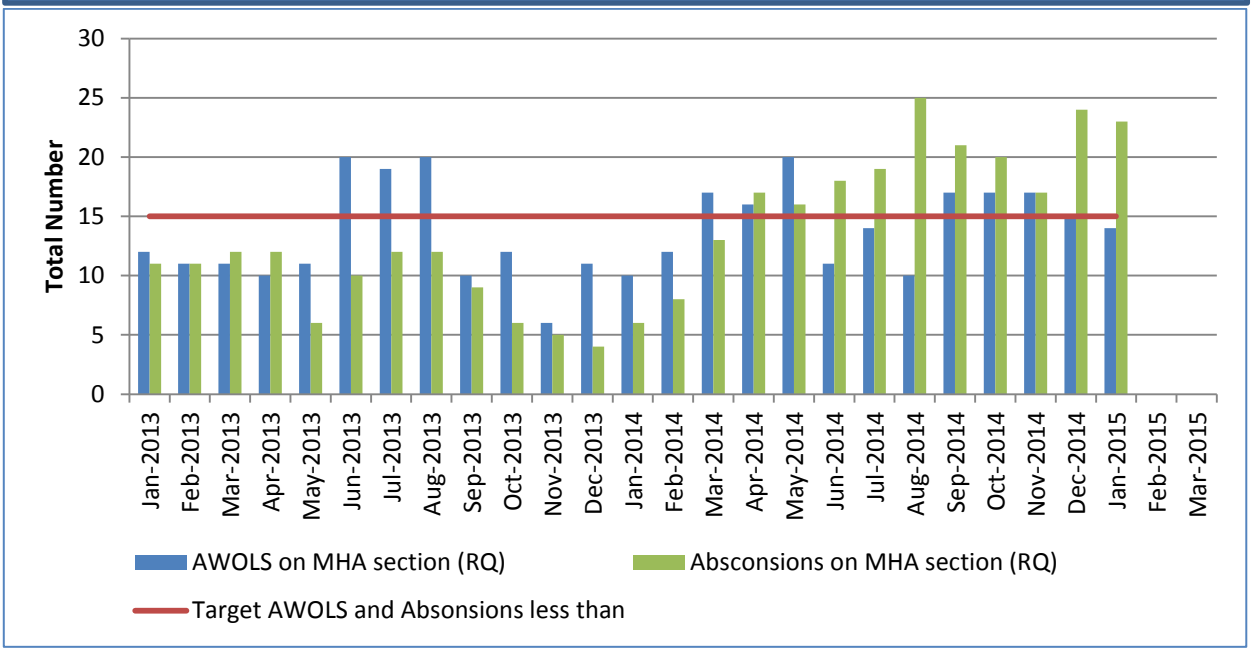
Figure 12 Suicides



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. There has been an increase in the number of absconsions on a MHA section.

Figure 13 Absent Without Leave (AWOL) and Absconsions on a Mental Health Act (MHA) Section



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Slips Trips and Falls

The number of slips, trips and falls is now being recorded since April 2014 per 1000 bed days, and therefore comparative data is not presented.

Figure 14

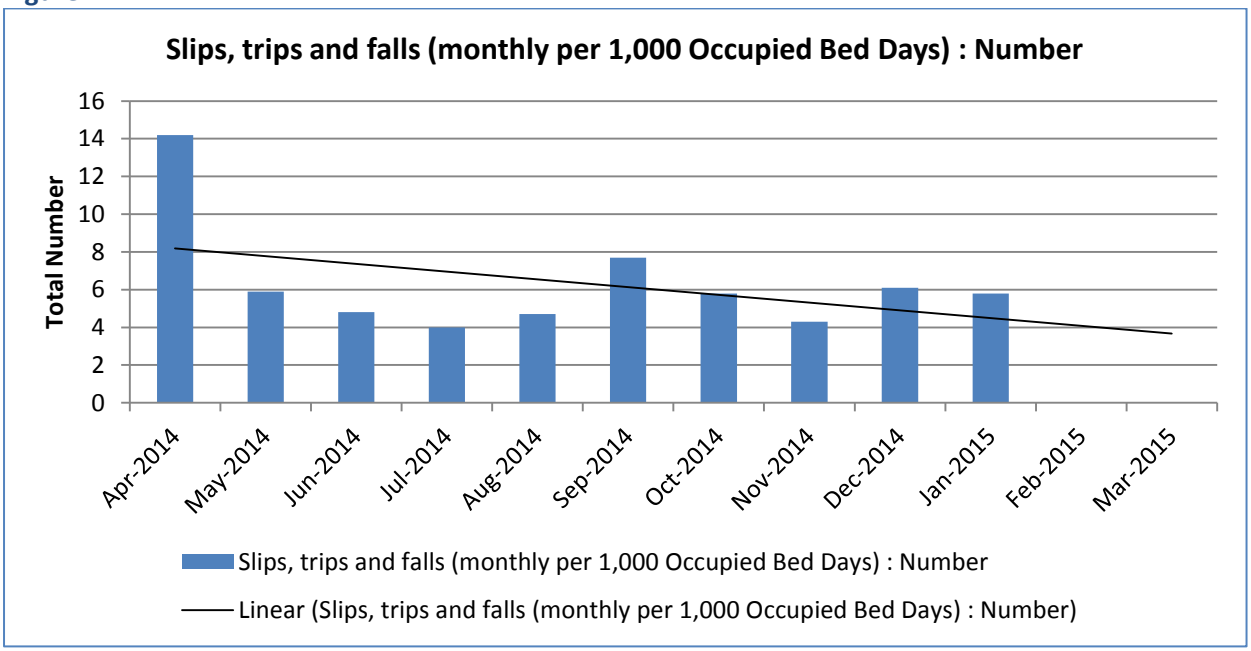
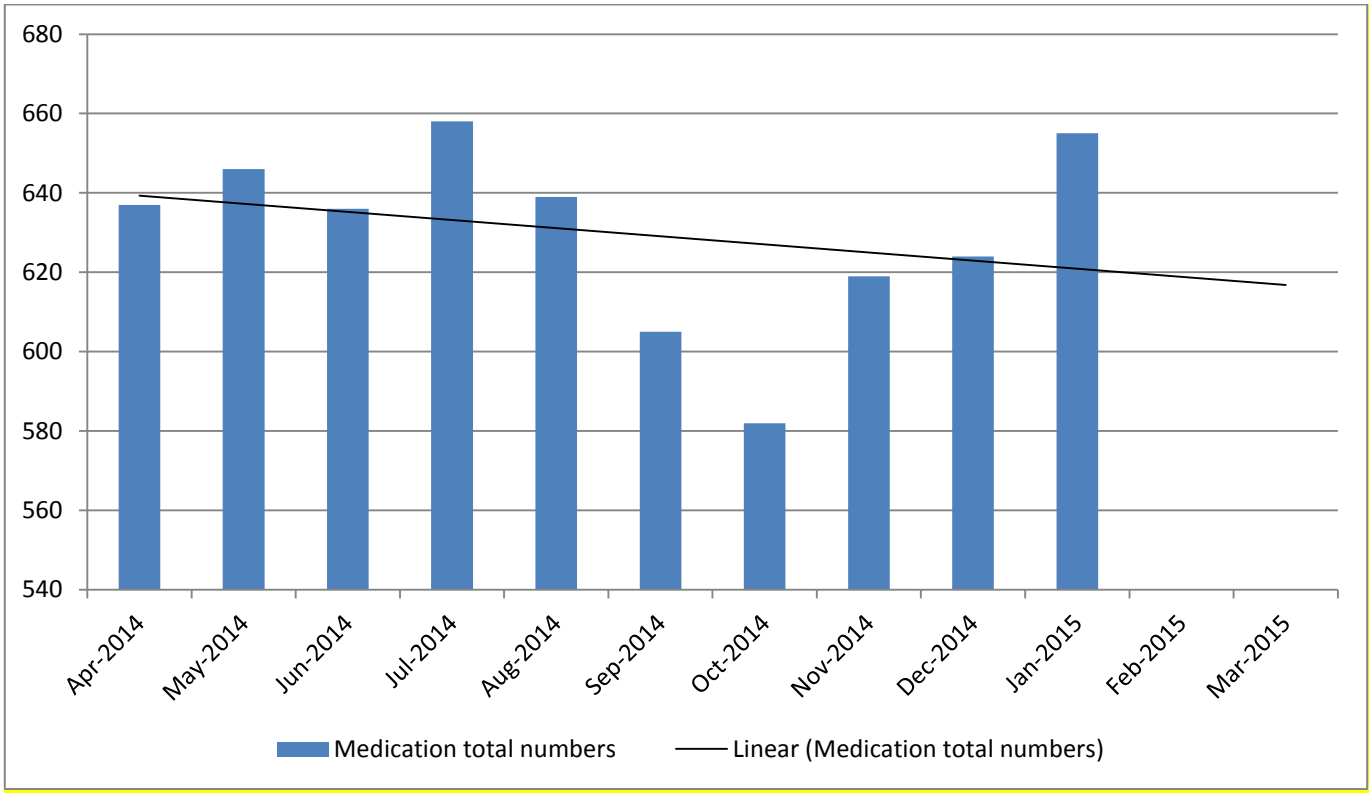


Figure 15 Medications Errors



Medication errors

Reporting levels with respect to medication errors have been maintained in the region of 600 each month. There has been 1 error rated as severe and 2 rated as moderate during the year with respect to patient harm. All others were of low severity. Audits have been carried out and action plans implemented with respect to 'blank boxes' on medication charts where it is not clear whether prescribed medication has been given or not. The Trust is looking at the options for electronic prescribing which will reduce medication errors and recording errors.

Physical Assaults

There have been fluctuations in the level of physical assaults on staff by patients with an increase in trend over time. Often these changes reflect the presentation of a small number of individual inpatients. Fluctuations in the level of patient on patient assaults appear to show a slight decrease in the last 8 months.

Figure 16 Patients to Patient and Patient to Staff Physical Assaults

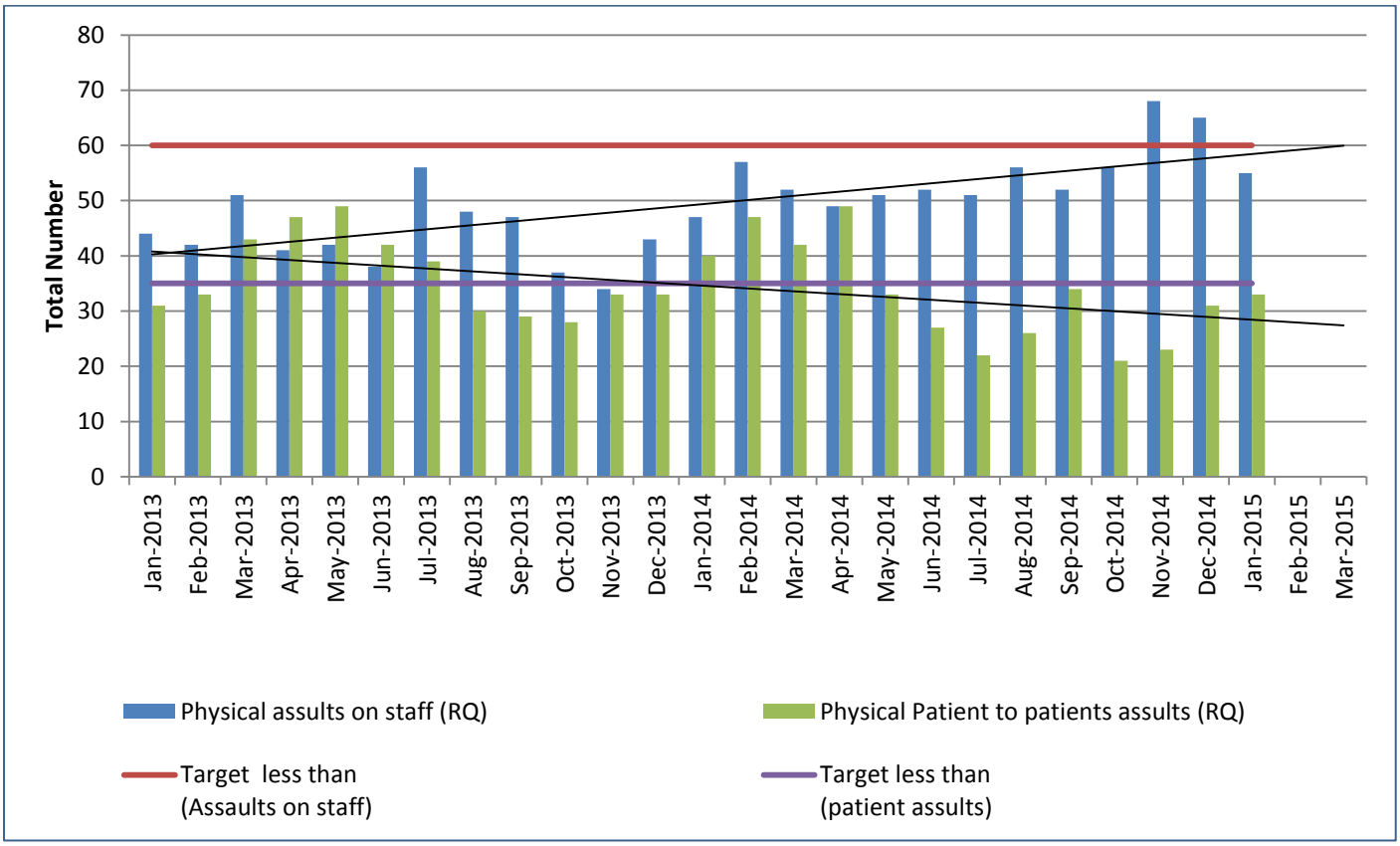


Figure 17 Compliments

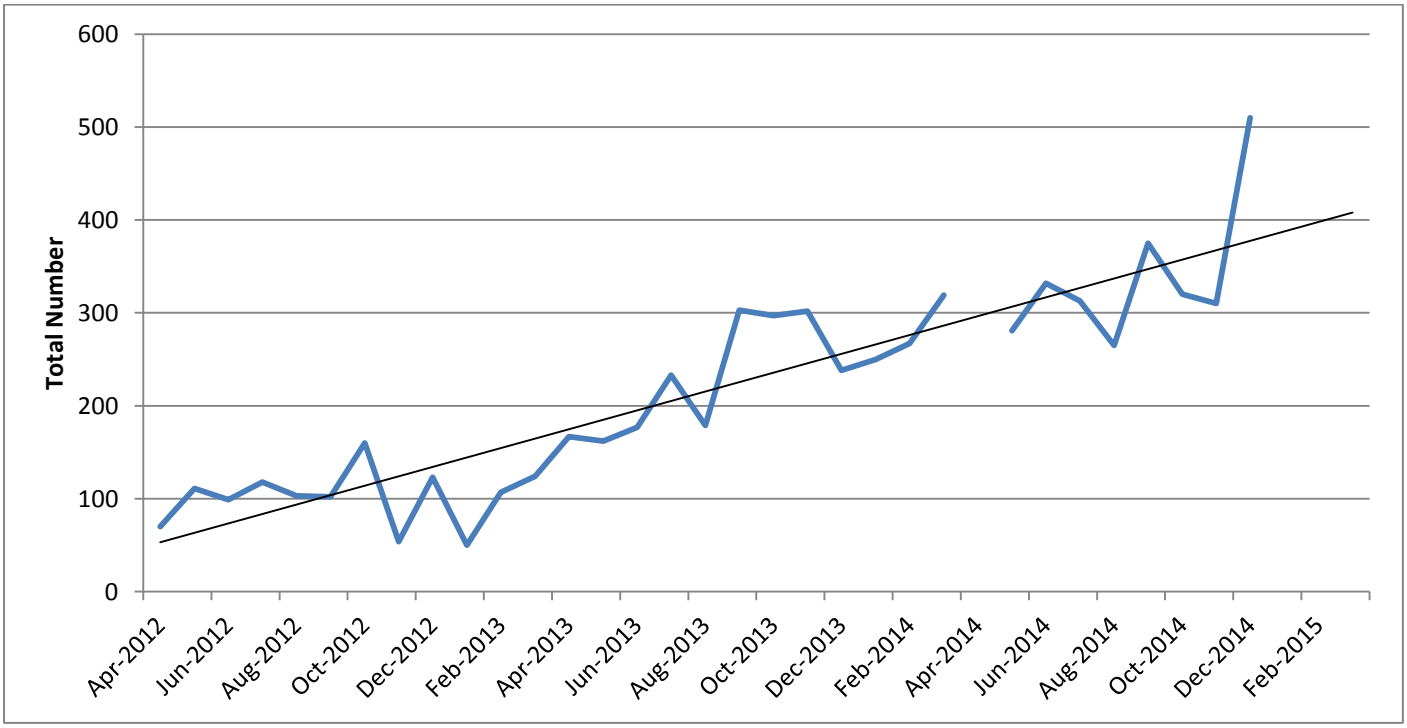
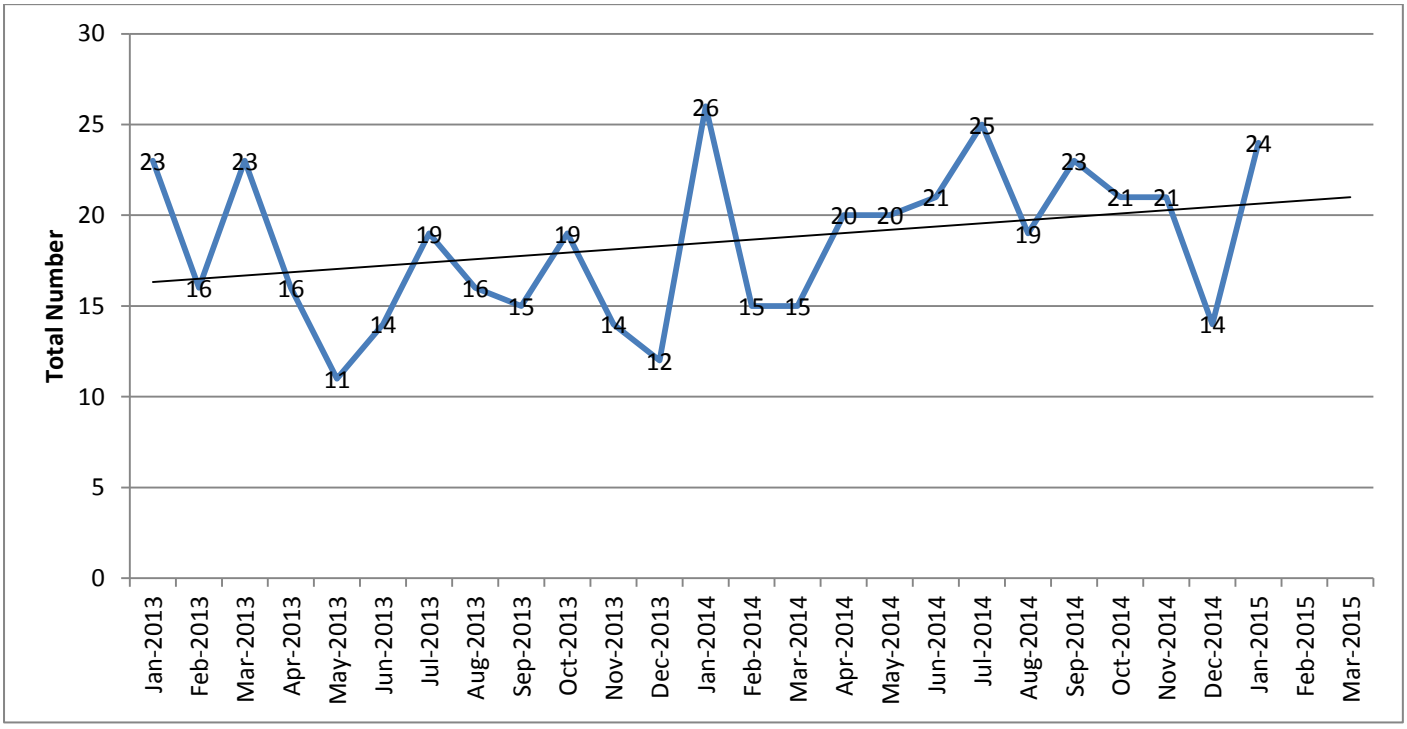


Figure 18 Complaints



Source complaints annual report 2013/14

Monitor Authorisation to be completed at Q4

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 (96.02%), delayed transfer of care (1.8%), community referral to treatment compliance (98.1%), Care Programme Approach review within 12 months (96.4%) and new early intervention in psychosis cases 136 (154 12/13).

Figure 19 Q3 figures based on PAF	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%**	**97.8%**	**(TBC)**	-
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 20	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%	**98.2%**	**(TBC)**	-
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 21	2011/12	2012/13	2013/14	2014/15	National Average	Highest and Lowest
The percentage of patients aged— (i) 0 to 15; and (ii) 15 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	9%	12%	**13.3%**	**12.7%**	**(TBC)**	

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:
The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be a deterioration in the patient's presentation at home due to unexpected events.
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 22	2011/12	2012/13	2013/14	2014/15	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%	**3.79**	**3.57**	**4.15**

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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.
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.

Figure 23(New section score for 2012/13)	2011/12	2012/13	2013/14	2014/15	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	7.8	About the same as similar Trusts	*7.3-8.4*

Berkshire Healthcare trust considers that this data is as described for the following reasons:
The Trusts score is in line with other similar Trusts
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 through a number of initiatives to improve both an individual's experience and if required to change the service provision.

Figure 24	2011/12	2012/13	2013/14	2014/15 (to end Q3)	National Average	Highest and Lowest
The number of patient safety incidents reported	3995	3661	3754	2759	n/a	
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days	19.7	30.2	32.7**	30.5**	26.71*	
The number and percentage of such patient safety incidents that resulted in severe harm or death	29 (0.7%)	42 (1%)	33 (0.9%)**	37 (1.3%)**	1.1%*	
*NRLS report 1st October 2013 – 31st March 2014 **Trust figure						

Berkshire Healthcare Trust considers that this data is as described for the following reasons:
The above data shows the reported incidents per 1,000 bed days with the targets set based on average reporting for the year. In the NRLS most recent report published in September 2014, the median reporting rate for the cluster nationally was 26.71 incidents per 1,000 bed days. High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.
Overall Incident reporting volume is in line with previous years.
The percentage of such incidents resulting in severe harm or death is slightly higher than in previous years, but is proximal to the national rate for the cluster of 1.1% shown in the most recent NRLS report, published in September 2014.
Berkshire Healthcare Trust has taken the following actions to improve this percentage, and so the quality of services, by the following:
Hosting Serious Incident learning events and online resources for clinical staff.
Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans.
Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.

Figure 25 Annual Comparators Q3	Target	2011/12	2012/13	2013/14	2014/15	Commentary
Patient Safety						
CPA review within 12 months	95%	97.6%	97.9%	96.4%	**96.5%**	For patients discharged on CPA in year last 12 month average
Never Events	0	1	0	0	**0**	Full year
Infection Control (MRSA bacteraemia)	< 2 per annum	1	0	0	**0**	Full year
Infection Control (C.*difficile*)	<10 per annum (reduced from <19)	15	5	5	**0**	Year to date C. Diff due to lapses in care
Medication errors	Increased reporting	574*	562	614	**655**	Cumulative total year end
Clinical Effectiveness						
Minimising delayed transfers of care	<7.5%**	3%	1.1%	2.6%	**1.8%**	average % in year Range 0-5.6%
Mental Health: New Early Intervention cases	99	155	154	136	**98**	Year to date
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge***	95%	99.6%	99.9%	99.9%	**99.4%**	Year average
Completeness of Mental Health Minimum Data Set	1) 97% 2) 50%	1) 99.6% 2) 97.9%	1)99.8 2)98.62	1)99.8 2)97.8	**99.8%** **99.3%**	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%.
Completeness of Community service data Referral to treatment information Referral information Treatment activity information	 50% 50% 50%	-	-	 70% 67% 99%	 **72%** **62.5%** **98.3%**	Year end average (new 2013/14)
Patient Experience						
Referral to treatment waiting times – non admitted -community***May 2013 - Updated figure to include Slough WIC	95% <18 weeks***	99.9%	99.9%	**98.1%**	**99.3%**	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 last 12 month average
RTT (Referral to treatment) waiting times - Community: Incomplete pathways	92% <18 weeks	-	-	**99%**	**100%**	Year end average (new 2013/14)

Figure 25 Annual Comparators	Target	2011/12	2012/13	2013/14	2014/15	Commentary
Access to healthcare for people with a learning disability	Score out of 24	22	22	**Green 22**	**Green 21**	
Complaints received	<25 per month	232	250	**193**	**208**	Cumulative in year (note PAF figure discrepancy of 2 (184) Q3 Patient Ex Board report with Nancy and Catherine Magee to resolve)
Complaints	100% Acknowledged within 3 working days	100%	91.3%	**93.3%**	**86%**	Final quarter
	90% Complaints resolved within agreed timescale of complainant			**64% (82%)**	**96%**	2014/15 note change to indicator previously 80% Responded within 25 working days (% within an agreed time)

*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

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.

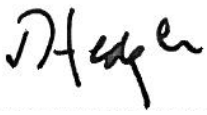
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14; The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2014 to May 2015
2. Papers relating to Quality reported to the Board over the period April 2014 to May 2015
3. Feedback from the commissioners dated XX 2015
4. Feedback from governors dated XX/XX/2015
5. Feedback from Local Health watch organisations dated XX/XX/2015
6. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/2015
7. The national patient survey 18th September 2014
8. The national staff survey 24/02/2015
9. The Head of Internal Audit's annual opinion over the trust's control environment dated XX/2015
10. CQC Intelligent Monitoring Report XX/04/2015

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



XX/XX/XXXX Date **John Hedger Chairman**

XX/XX/XXXX Date **Julian Emms Chief Executive**

Appendix A National Clinical Audits Reported in 2014/15 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Clinical Audits Reported in 2014/15 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust		
National Audits Reported in 2014/15	**Recommendation (taken from national report)**	**Actions to be Taken**
Non-NCAPOP audits		
POMH - Topic 4: Prescribing antidementia drugs 131	Data were submitted on over 9,000 patients with dementia, nearly 70% of who were prescribed an anti-dementia drug. Donepezil was by far the most commonly prescribed AChE inhibitor. There was marked variation in the prevalence of anti-dementia drug prescribing across the 54 participating mental health Trusts, from 35% to 98% in the samples submitted. The proportion of patients prescribed an antipsychotic drug also varied markedly across Trusts, from 0% to almost 70%. Multivariable analysis revealed that the variables significantly associated with being prescribed an anti-dementia drug included living at home (with or without a carer), being in the 66-75 age group, female gender and White ethnicity. Both severity and sub-type of dementia were also significantly associated with prescription of anti-dementia medication: these drugs were most commonly prescribed for patients with Alzheimer's, followed by mixed dementia and Parkinson's disease/Lewy body dementia, and for patients with dementia of moderate severity rather than mild or severe illness	Produce Trust Guidelines for prescribing of anti-dementia drugs (to include the standards set by the POMHUK audit.) Improve monitoring as part of memory clinic processes. Intermediate –time re-audit.
POMH - Topic 10: use of antipsychotic medication in CAMHS	The audit shows an improvement in the number of young people having undertaken appropriate investigations prior to initiating antipsychotic medication and an improvement in the monitoring of side effects since the baseline audit. However in comparison to other trusts BHFT performed worse than average with clear room for improvement. BHFT fared well in regards to recording the reasons for medication to be started and in following up young people in appropriate time scales however fared very poorly in recording of baseline measures and follow up measures.	Creation and adoption of antipsychotic initiation monitoring pack. Training for staff on above. Exploration of adoption of RiO based e-system to record above information.

POMH - Topic 14: Prescribing for substance misuse: alcohol detoxification	The National level results highlight that 16% of admissions were planned for those patients admitted under the care of a general adult psychiatrist for alcohol detoxification. The respective figure for those under the care of a specialist in alcohol detoxification was 93%. The Trust's performance for the NICE guideline on the proportion of patients prescribed medication for alcohol withdrawal is in line with the national standard of 95%. BHFT was successful in completing 85% cases as planned of alcohol detoxification.	The largest effect size could be achieved through addition of the AUDIT-C questionnaire to the 'admission pack' (a group of documents and checklists circulated at admission). This would allow swift and immediate assessment of newly admitted patients' alcohol histories, while not adding substantively to workload of clerking doctors and admitting nurses. A full action plan is being circulated for review and comment to clinical staff
Other audits reported on in-year (data collected in previous year(s)		
National audit of Schizophrenia (2013)	Availability and uptake of Psychological Therapies was average for our Trust though was still below what should ideally be provided Performance in monitoring of Physical Health risk factors was average for our Trust. Even then, it is below the ideal target and was poor for provision of intervention for service users with elevated blood pressure Many aspects of Prescribing Practice were approx. average for our Trust. However, a higher than average proportion of service users whose illness was not in remission did not appear to have an acceptable reason for not having had a trial of clozapine	Results have been disseminated to the clinical staff involved in the project. An action plan to improve compliance will be developed by the Clinical Audit Department in collaboration with the audit team and clinicians via the medicines audit action plan group initially.

Appendix B Local Clinical Audits Reported in 2013/14:

	Audit Title	Conclusion/Actions
1	Audit of anti-infective prescribing on BHFT impatient wards (Antibiotics) (2014)	There have been routine audits in this area as part of the infection control team's programme of work. The aim of the audit was to ensure that local policy (ICC014) on antibiotic prescribing was followed. There is an increased risk of patients developing Clostridium difficile infections (which are linked to poor antibiotic prescribing). The audit identified several areas for improvement. Action: An agreed Action Plan has been implemented.
2	Re-Audit: Consent to Treatment (2013)	This is a CQC related re-audit. The first cycle of the audit was carried out by a CQC inspection. It was identified that documentation of consent fell below the standard. As a result much work has been done following the last audit. The purpose of the re-audit was to further review documentation of patients consent to treatment. Action: An action plan has yet to be developed.
3	Re-Audit: Clinical Supervision (2014)	The aim of the reaudit was to establish the level of compliance with Clinical and Management Supervision for all BHFT staff, including clinical and non-clinical staff. Some criteria have shown an improvement since the previous audit last year, however, some have also declined. Action plans are currently in development to ascertain how improvements (where relevant) can be made. Action: Local action plans have been developed. The following areas of actions have been noted and will be followed up as part of the normal process. Inform staff re: content, frequency, and training availability Records of supervision and work/reflective diaries to be maintained accurately Staff to attend supervision and training.
4	Child protection clinical supervision - quantitative study	The aim of the audit was to ascertain if practitioners are receiving Child Protection Supervision in line with recommended time frames following new policy in 2012. The findings identified that 76% of practitioners working with the 0-19 children's community health teams across Berkshire were compliant with receiving individual child protection supervision between September 2012 and April 2013. Supervision is part of the Trust's quality schedule and there is a risk that the Trust will fail in this if it does not report and manage supervision effectively. Action: On-going monitoring of compliance. Maintain database tool on shared drive (health visiting & school nursing) To identify why compliance is currently 76% for the health visiting and school nursing teams. To identify the reasons for non-compliance by either practitioner to be documented more accurately.

	Audit Title	Conclusion/Actions
5	Dental Decontamination (2014)	The aim of the audit was to assess the salaried dental services' ability to comply with the essential quality requirements as set out in National guidance, and also their environment and their use of personal protective equipment. There were 17 standards that were non-compliant within all clinics, seven of these related to the issues requiring support from the Estates Department. Action: The audit report will be disseminated to the Joint Heads of Service for Dental in accordance with the requirements of the BHFT IPC annual audit programme. Managers will be responsible for ensuring identified deficiencies are addressed. Action: The action plan will be presented and reported within the Infection Prevention & Control Woking Groups and Infection Prevention and Control Strategic Group.
6	Quality and timing of GP letters (2014)	The audit was carried out in March 2013 covering all new patient referrals to Reading South Community Mental Health Team for Older People from June 2012 to November 2012. The audit was chosen due to anecdotal concerns about the length of time taken to complete documentation following the change in 2010 from paper patient records to an electronic recording system (RIO) of patient records. The audit identified that a high percentage of risk assessments were not completed in a timely basis. Action: The action plan is to be developed.
7	Management of Depression in Older Adults (2013)	The audit looked at how staff from the Reading Older People's Mental Health Services assessed people with depression and whether information was provided to patients on their condition and treatment Action: Present findings at the Reading OPMHS team meeting and the West Berkshire Clinical Effectiveness Meeting for the OPMHS.
8	Audit of Pathway of Inpatient Services (2013)	The aim of the audit is to confirm whether appropriate processes are in place around admission, treatment and discharge to and from BHFT's inpatient services for people with learning disabilities. The audit concluded that appropriate processes are in place for admission, treatment and discharge to and from inpatient services. The action plan relates to completion of fields on RiO. Action: Agreed actions are to complete the Formulation field on RIO for every patient admitted to inpatient services and the use of one standard CPA form across both units documenting whether patients have been invited to their CPAs. In addition, progress notes are to be documented in RiO or in agreed templates including the questions staff/professionals ask patients about their care and their responses. The 'MCA & Information Sharing & Consent' field in RIO is to be used to document & share with other professionals whether a patient has given consent for specific treatment or if consent's been reached.
9	Audit Of Urinary Catheter Care Bundle	The aim of the audit was to assess compliance with the requirements set out in the urinary catheter care bundle through review of completion/documentation on the care bundle. The audit found that community nursing demonstrated a high level of compliance with the requirements set out in the urinary catheter care bundle in comparison to inpatient wards. Action: An agreed action plan is to be developed.

	Audit Title	Conclusion/Actions
10	Client, Patient or Service User? The views of healthcare workers and the people they care for (2014)	The aim of the audit was to review consistency across documentation in the Trust, in light of awareness that different terms maybe preferred by different professionals. The term 'patient' was also termed as a 'client or 'service user' Action: The report is to be shared with Patient Experience, for information.
11	Re-Audit to ensure quality of accompanying documentation for patients admitted to community inpatient wards	The community hospitals have criteria and principles that support appropriate use of the community beds, providing clear guidance for the referrer around documentation and processes required to support a safe transfer. These criteria were shared with PCT, GP's, secondary care and unitary authorities' partners prior to approval within BHFT. Anecdotal evidence from ward staff across all wards is that referrers are not adhering to the criteria and principles for admission and this has potential to impact on patient safety. The aim of the audit was to gain objective evidence around the adherence to the admission criteria and principles that can support communication for improvement with relevant referrers. Action: The action plan is to be shared with the Hospital development group as sub-group of Adult SIG.`
12	Reaudit: Consent to ECT	The audit objective was to monitor current standard of obtaining consent to ECT and whether BHFT ECT department were compliant with national guidelines, if patients had a capacity assessment and relevant documentation was in place prior to ECT. Action: The audit findings resulted in the flowing action points: Monitor Capacity Assessments completion at each ECT Maintain updates of current & training of new ECT ward based leads ECT treating staff to check pathway at each treatment and ECT Pathway documentation sent to ECT on Completion
13	Audit of assessment letters sent to GP's by Clinical, Counselling Psychologists and Psychological Therapists	The aim of the audit was to establish if good practice is being followed in communicating through letters written by clinical and counselling psychologists to GPs. 100% compliance was met in all four service standards. Action: The observations within the report will be disseminated via locality patient safety and effectiveness groups for discussion It was advised that clinical/counselling psychologists and psychological therapists in older people services should complete a similar audit within three months and to share and discuss the findings of the report with locality teams and organise a retrospective audit for the period September 2014 – December 2014.

	Audit Title	Conclusion/Actions
14	Audit of antipsychotic medication monitoring for older adults with dementia	The decision to start anti-psychotics drugs for older adults is made in the context of a careful risk-benefit assessment. Although anti-psychotic medication has an important role in treatment of serious mental illness, it needs to be used with careful monitoring of physical health. Early detection is important to allow medication to be altered and adverse effects on physical health to be treated. The aim of the audit was to ensure that older adult services in Berkshire comply with Trust guidelines on anti-psychotic monitoring, to raise awareness of current guidelines and provide further education and reaudit following interventions to assess whether improvements have taken place, or whether further intervention is necessary. The audit identified low levels of compliance with monitoring. Action: An action plan is in development.
15	Prolactin monitoring in general adult inpatients receiving antipsychotics	The aim of the audit was to improve current clinical practice by establishing clear guidance on the use of antipsychotic drug treatment. A raised level of prolactin is a common consequence of the treatment, with clinically short and long term effects. Compliance was tested against three audit standards. Action: An action plan is in development.
16	GP Referrals to Memory Clinic	The aim of the audit was to ensure that the GP referral forms had vital information about the patients which helps in their assessment of memory issues including documented information on the required tests Action: The agreed action is to educate GPs to emphasise the importance of a standard referral.
17	Clinical audit of the copying of Windsor, Ascot & Maidenhead Memory Clinic letters to patients, their families and carers	In Berkshire Healthcare NHS Foundation Trust, a policy (Copying Letter to Patients; CCR107) was drawn up advising that letters should be copied to patients. Given the wealth of guidance, it seemed appropriate to seek to audit this element of practice within the Windsor, Ascot & Memory Clinic service. The audit identified that 58.8% patients had received a copy of their initial assessment letter but only 12% of cases where the letter was sent to the patient's carers. Action: An action plan is in development.
18	Survey of provision of Psychological services to Bluebell Ward	The project was to review the psychological therapies available to the ward and stakeholder opinions of these, plus what stakeholders would like to see offered. 33 responses were received in total. Action: An agreed action plan is in place.

	Audit Title	Conclusion/Actions
19	School Nursing Assessment Audit	This audit has been undertaken as part of the Berkshire Healthcare Foundation Trusts (BHFT) Universal Children's Services Improvement School Nursing Sub Group requirements, to assist with the quality assurance and development of the School Nursing assessment process and recording. The audit did identify areas of high compliance, but there were 33% of cases where all sections with demographic information had not been completed. Action: Record keeping task group to update assessment paperwork Written guidance for practitioners Training on the use/content of progress notes Audit tool to be amended to reflect change from Notable events to Event Timeline.
20	Early Detection of Deterioration in Health Score on In Patients Units	Older adult psychiatric inpatients often have multiple physical health co-morbidities and their physical health is as much a priority as their mental health. This quality improvement project was conceived after noticing multiple incidents of patients having abnormal physical observations recorded which should have warranted urgent review by a doctor, but were not raised as a concern. The audit identified that physical observations are poorly understood and under-utilised by mental health nursing staff. The project received raised some significant concerns over (lack of) use of NEWS, and also the lack of knowledge of observations and the interpretation/escalation procedure. As such it was taken to CEG as a special paper, and directly reported to the medical and nursing directors Action: Redoing the training in NEWS for staff on Daisy Ward and Bluebell Ward to ensure staff understand importance of scoring and escalating concerns. Relaunch of NEWS on Daisy & Bluebell Wards Audit of NEWS on Daisy & Bluebell to ensure compliance with standards Start NEWS on Snowdrop, Rose, Campion & Sorrel Wards.
21	CMHT Risk Assessment Triangulation Audit Initial Results from Audit Pilot	The aim of the audit is to help review how effective the work by the Risk Management and Crisis Contingency Sub Group implemented across the Trust is, and to ensure on going high quality of record keeping. Action: To set up a workshop for the auditors to ensure consistency in undertaking of the audit across the trust To undertake Peer review audit across the localities To undertake the next round of audits once the workshop has been undertaken. Provisionally October's Audit

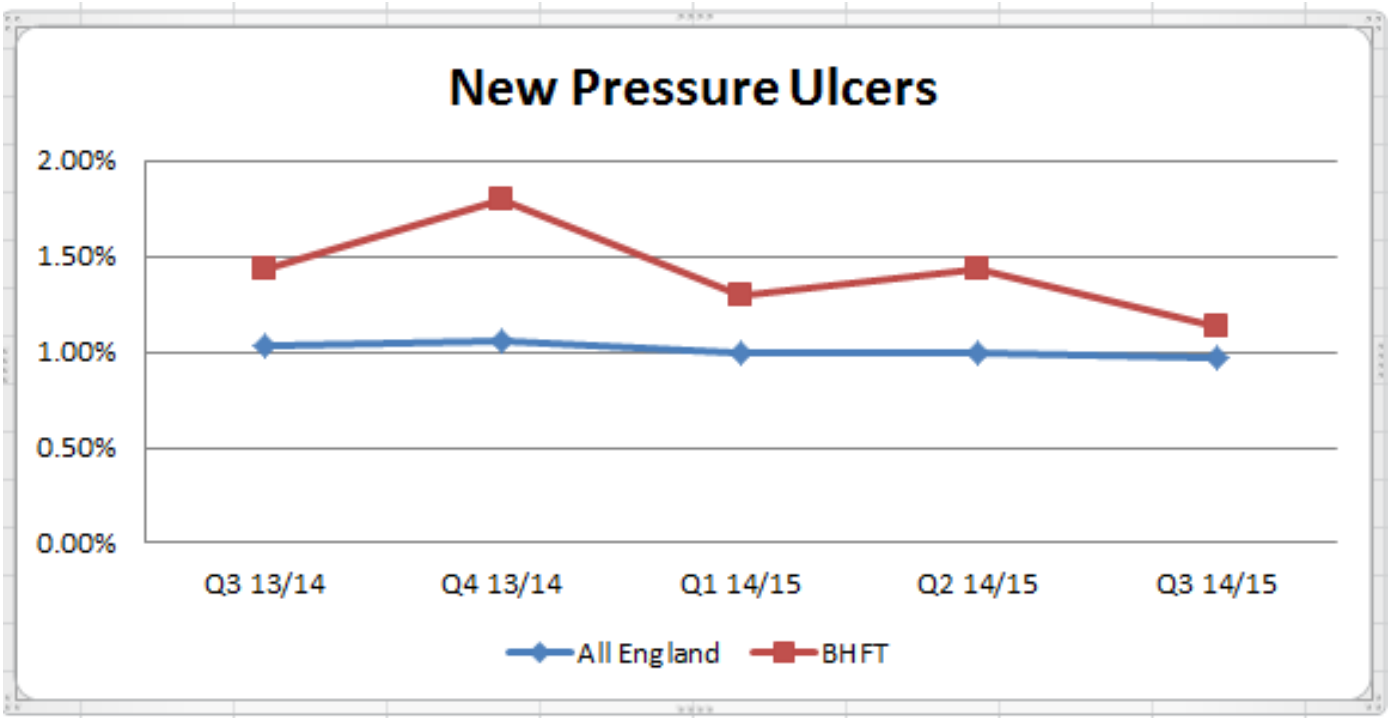
	Audit Title	Conclusion/Actions
22	Annual Audit of PGD's for Diptheria Tetanus Polio PGD	The aim of the audit was to ensure documentation required during administration of the DTP immunisation under Patient Group Direction (PGD) is of the highest standard. The audit set out to demonstrate that the PGD system of staff training, signing of the PGD and the correct documentation on each child's PGD consent form was correct. Action: The consent forms for DTP and Meningitis C need to have "Site of immunisation" and "Route of immunisations – intramuscular (IM) or sub-cutaneous (SC) added to them to improve the recording of these areas. The parent information sheet given to the child after the session stating what vaccine they received that day should be changed to include which arm each vaccine was given in. Staff training record sheet needs to be fully completed for each PGD that is being used. These are currently under review by the Patient Group Direction (PGD) working group.
23	Child Sexual Exploitation: An Audit of Staff Knowledge and Training Needs	The audit commissioned by Health Education Thames Valley was conducted to explore the child sexual exploitation (CSE) knowledge and training needs for staff required to undertake Level 2 and above safeguarding training across Thames Valley. This included staff from across the nine health care Trusts (including South Central Ambulance Service), and health care staff working in the community, including GPs, dentists and pharmacists. Action: The audit report will be shared with lead for safeguarding children, and deputy director of nursing.
24	Clostridium Difficile Infection (CDI) (East Berkshire CCG's) - Commissioning	The Clinical Audit Department at Berkshire Healthcare NHS Foundation Trust was commissioned by the three Clinical Commissioning Groups in the East of Berkshire (Slough, Bracknell & Ascot and Windsor & Maidenhead) to undertake an audit on Clostridium Difficile Infection and how it is managed and reported within the respective surgeries. The audit was designed to identify appropriate monitoring and reporting of patients who have been selected in the specific surgeries as having a Clostridium Difficile Infection episode recorded within their patient notes." Action: The completed audit report has been sent to the Commissioning CCG Lead.
25	Clostridium Difficile Infection (CDI) (West Berkshire CCG's) - Commissioning	The Clinical Audit Department at Berkshire Healthcare NHS Foundation Trust was commissioned by the four Clinical Commissioning Groups in the West of Berkshire (Newbury & District, North & West Reading, South Reading and Wokingham) to undertake an audit on Clostridium Difficile Infection and how it is managed and reported within the respective surgeries. The audit was designed to identify appropriate monitoring and reporting of patients who have been selected in the specific surgeries as having a Clostridium Difficile Infection episode recorded within their patient notes. Action: The completed audit report has been sent to the Commissioning CCG Lead.

Appendix C Safety Thermometer Charts

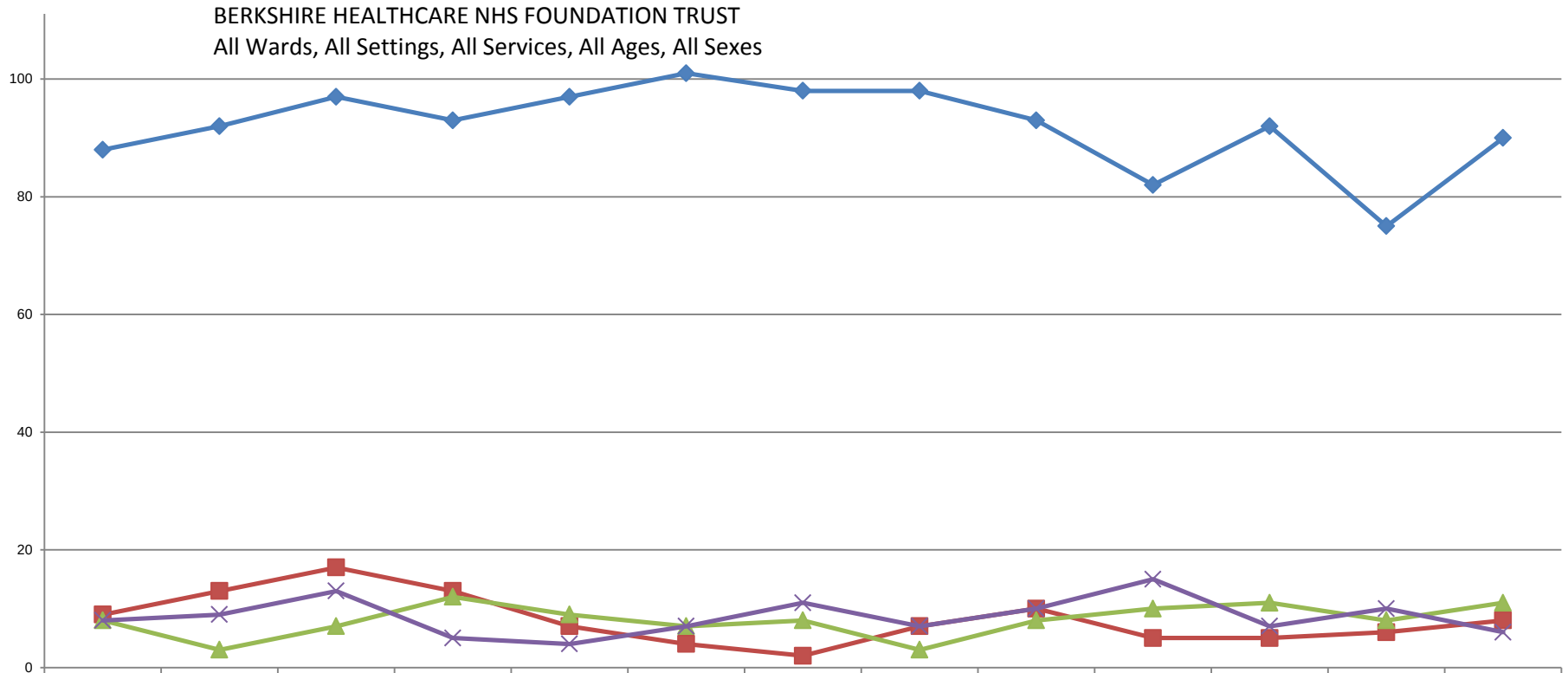
Below are the figures for the Quarter on the number of patients surveyed

Data capture period	Number of patients surveyed	Percentage of Harm free care
Q3 2014/15	4064	92.2%
Q2 2014/15	3908	91.3%
Q1 2014/15	4144	91.7%
Q4 2013/14	3938	90.9%
Q3 2013/14	4241	92.0%

When compared nationally the data shows that BHFT has a higher % of *all* pressure ulcers, but the gap is closing as can be seen below.



Types of Harm: patients with each type of Harm



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	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14
Pressure Ulcers	88	92	97	93	97	101	98	98	93	82	92	75	90
Falls	9	13	17	13	7	4	2	7	10	5	5	6	8
Catheter & UTI	8	3	7	12	9	7	8	3	8	10	11	8	11
New VTE	8	9	13	5	4	7	11	7	10	15	7	10	6
Patients	1443	1191	1398	1349	1351	1441	1352	1308	1327	1273	1387	1360	1317

Appendix D CQUIN 2014/15 and 2015/16 (to be confirmed)

Goal Number	Description of Goal	Expected Financial Value of Goal (subject to agreement of weighting)
1a	Friends and Family Test – Implementation of staff FFT	£43,204.45
1b	Friends and Family Test - Early Implementation – Outpatient and Day Case Departments	£14,401.48
1c	Friends and Family Test - Phased Expansion	£43,204.45
2	Safety Thermometer - Reduction in pressure ulcers	£100,810.37
4a	Cardio Metabolic Assessment for Patients with Schizophrenia	£57,605.93
4b	Patients on CPA: Communication with GPs	£28,802.96
Local 5a	Frail Elderly – HWPFT	£180,018.52
Local 5b	Frail Elderly – FPFT	£144,014.82
Local 5c	Participation in integrated working with the Frimley System	£108,011.11
Local 6	Care Planning – EAST	£144,014.82
Local 7	7 day working	£100,810.37
Local 8	Psychological Interventions in Secondary Care	£86,408.89
Local 9	Employment Support	£86,408.89
Local 10	Smoking	£100,810.37
Local 11	CRHTT/Urgent Care	£100,810.37
Local 12	CAMHS	£100,810.37
		£1,440,148.18