READING HEALTH & WELLBEING BOARD MINUTES – 17 JULY 2015

Present:

Councillor Eden	Lead Councillor for Adult Social Care, Reading Borough Council (RBC)
Councillor Hoskin (Chair)	Lead Councillor for Health, RBC
Sylvia Chew	Director of Children, Education & Early Help Services, RBC
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Ishak Nadeem	Chair, South Reading Clinical Commissioning Group (CCG)
David Shepherd	Chair, Healthwatch Reading
Ian Wardle	Managing Director, RBC

Also in attendance:

George Boulos	Clinical Lead, North & West Reading CCG
Andrew Burnett	Interim Consultant in Public Health, RBC
David Dobraszczyk	Youth Participation Officer, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Manasi Panshikar	Youth Cabinet Member, Reading Youth Cabinet
Sally Poole	Committee Services, RBC
Mandeep Kaur Sira	Chief Executive, Healthwatch Reading
Councillor Stanford-Beale	RBC
David Totterdale	Youth Cabinet Member, Reading Youth Cabinet

Apologies:

Gabrielle Alford	Director of Joint Commissioning, Berkshire West CCGs
Andy Ciecerski	Chair, North & West Reading CCG
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Frances Gosling-Thomas	Independent Chair, West Berkshire, Reading and Wokingham Local Safeguarding Children Boards
Councillor Lovelock	Leader of the Council, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs
Sarah Wise	CCG Manager, North & West Reading CCG

1. MINUTES

The Minutes of the meeting held on 17 April 2015 were confirmed as a correct record and signed by the Chair, subject to the following amendments:

Minute 4, Primary Care Update Report:

The surgery in South Reading CCG that had been inspected by the Care Quality Commission was Melrose Surgery and not Melrose Avenue Surgery and the money that had been set aside by the Council to work with Berkshire Healthcare NHS Foundation Trust and the local community had been for Circuit Lane Surgery.

In an update to Minute 10, on the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2013-14, Wendy Fabbro reported that the Chair of the West of Berkshire Safeguarding Adults Partnership Board had resigned and that Brian

Walsh had been appointed as Interim Chair from September 2015. In the meanwhile, Wendy Fabbro would be the point of contact for any issues that arose.

2. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

The following questions were asked by Tom Lake in accordance with Standing Order 36:

(a) AAA Screening

Given the low take-up of Abdominal Aortic Aneurysm (AAA) screening in South Reading are any measures in place to increase take-up?

REPLY by the Chair of the Health & Wellbeing Board (Councillor Hoskin):

Background

Arterial aneurysms are caused by a weakening in the walls of blood vessels leading to a ballooning of the vessel in the region of the weakness. These can leak or burst with disastrous consequences. The aorta, the largest artery in the body, can develop an aneurysm where it passes through the chest (a thoracic aneurysm) or in the abdomen. Here, because a number of smaller arteries branch off from the abdominal aorta, an aneurysm can compromise the blood flow to other organs, most significantly the kidneys, as well as leak or burst. About 80% of people who have a burst aortic aneurysm will die before emergency surgery or in spite of it.

The most common cause of abdominal aortic aneurysm is smoking.

It is possible to screen for abdominal aortic aneurysm and, if one of sufficient size is detected, offer elective surgery (which has a much lower mortality rate than emergency surgery for a leaking or burst aneurysm) or keyhole surgery repair by passing a graft up from one or other femoral artery in the groin into the aorta and inflating it within the lumen to seal off the aneurysm (this is known as EVAR – endo-vascular aortic aneurysm repair).

Abdominal aortic aneurysm is more common over the age of 65 years and is some six times more common in men than women (but this is likely to be related to past smoking differences between the sexes so we can expect proportionately more women to be affected in the future).

Currently in England, abdominal aortic aneurysm screening is offered to men aged 65 years and over. The programme, commissioned by NHS England, screened more than 260,000 men in 2013/14 and detected some 3,700 aneurysms[1] (although not all of these will have required an intervention). The national uptake rate was 78.2%.

[1] Public Health England. *NHS Screening Programmes for England 2013/14.* Public Health England. London. 2015

AAA screening uptake in Reading

Current data show that some 66% of eligible men in South Reading underwent AAA screening in 2013/14. However, these data are incomplete as they are based partly on PCT-level data and partly on CCG-level data. Full year data should be available in August.

Other than in Slough, uptake is lower in South Reading than in other Berkshire CCG areas (average 75-80%) which is consistent with the national experience of lower uptake in more deprived areas. We understand that NHS England is working with screening providers to try to increase uptake.

A health equity audit, with a particular focus on accessibility, has recently been undertaken and we expect to hear the outcomes of this in the coming weeks with a view to developing an improvement plan.

Reducing the risk of developing abdominal aortic aneurysm

The main risk for aortic aneurysm is smoking. It is noteworthy that in Sweden, where concerted work over several years has reduced the prevalence of smoking to 11% in men and 14% in women (one of the lowest in the industrialised world,[2] has led to a statistically significant reduction in the prevalence of abdominal aortic aneurysm sufficient to suggest that the thresholds for screening could be raised and in future confined to smokers.[3]

(b) Primary Care Strategy

The NHS Primary Care Strategy for Berkshire West has recently been made public and envisages merging or integration of smaller practices to a 10,000 minimum list size. Will the process of integration take into consideration transport and access issues or influence local transport policy, especially given that these matters are more important for vulnerable or deprived patients?

REPLY by the Chair of the Health & Wellbeing Board (Councillor Hoskin):

There will be full patient and public engagement around any significant changes to service provision resulting from implementation of the Primary Care Strategy. This will include any changes in the location of GP surgeries. Accessibility for patients, including public transport links, will be one of the factors taken into account by commissioners when considering any merger, relocation or premises development proposals as well as when commissioning new contracts. The involvement of local authority Health and Wellbeing Board representatives in the Joint Primary Care Co-Commissioning Committee will support joint working around transport and planning considerations. However, at this stage the draft Strategy only sets out high level principles for the future of primary care rather than specific plans for any changes to practices or surgery locations.

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[2] See www.ncbi.nlm.nih.gov/pmc/articles/PMC2598496/ (accessed 10 July 2015)

[3] Svensjo S, Bjorck M, Gurtelschmid M, Gidlund KD, Hellberg A, Wanhainen A. Low prevalence of abdominal aortic aneurysm among 65 year-old Sewdish men indicates a change in the epidemiology of the disease. *Circulation* 2011; 124:1118-23

Some of the Reading practices that may work together in future are already located in close geographical proximity. It is also important to note that the upscaling of practices described may be achieved by practices working together in networks or federations as much as through formal mergers and does not necessarily imply any change in the location of services.

Irrespective of the discussion around practices working at greater scale, an initial priority will be to address issues with GP premises identified by CQC visits. The CCGs are working with NHS England to consider how this can best be delivered.

(c) Child Obesity

What are the current local trends in child obesity? What measures are in place to help children start a life of healthy activity and good nutrition?

REPLY by the Chair of the Health & Wellbeing Board (Councillor Hoskin):

Background

Overweight and obesity[4] are an increasing problem in the population. This is principally because obesity substantially increases the risk of developing various long-term conditions (most notably diabetes) and the consequential impact of these conditions on health inequalities as well as on health and social care costs.[5] Overall, taking the risks of diabetes and the other life-shortening conditions associated with obesity into account, it has been estimated that obesity reduces life expectancy by some nine years and accounts for 30,000 deaths in the UK each year.[6]

What is happening in Reading?

The National Child Measurement Programme (NCMP) is a mandatory public health service for councils. It enables trends in childhood obesity to be monitored as well as

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[4] The body mass index (BMI), which is the most commonly used way of measuring someone's relative weight and height, is calculated by dividing weight (in kilograms) by the square of the height (in metres). Someone with a healthy weight has a BMI in the range 18.5-24.9. A BMI of 25-29.9 is defined as being overweight. 'Class I obesity' is defined as a BMI of 30-34.9, 'Class II obesity as a BMI of 35-39.9, and 'Class III' or 'morbid' obesity a BMI of 40 or greater.

By way of example, someone who is 5'9" tall (1.75m) and who weighs 12st 7lb (79.63kg) has a BMI of 26 and is clinically overweight. If this same person weighed 14st 13lb they would have a BMI of 31 and be clinically obese

[5] Obesity in childhood is associated with increasing the risk of developing diabetes, asthma, other respiratory conditions, musculoskeletal conditions, psychosocial and mental health problems, being bullied and having a lower educational attainment.

Obesity in adulthood is also associated with a substantially increased risk of heart attack and stroke, high blood pressure, osteoarthritis, obstructive sleep apnoea (a condition that interrupts breathing during sleep causing a drop in blood oxygen levels causing daytime fatigue and difficulties in cognition, but, more importantly, increases the risk of heart failure and death), some types of cancer, heart failure, pulmonary embolism, gallbladder disease, chronic back pain

[6] Holt RIG. Obesity – an epidemic of the twenty-first century: an update for psychiatrists. *J Psychopharm* 2005; 19(6) Suppl: 6-15

increases awareness of the issue and is a useful vehicle for engaging with children and families about healthy lifestyles and weight issues. NCMP data show that the levels of childhood overweight and obesity in Reading in reception class children have largely remained largely in line with the England average and are slightly higher than the South East England average, except between 2009-2011, where prevalence reached a peak of 26.2%. Since this peak, there has been a levelling out to 22-23.5% between 2011-2014 (see Table 1).

The levels of childhood overweight and obesity in Reading in year-6 have generally remained in line with the England average, with the exception of a peak in 2009/10. They do however tend to be slightly higher than the South East average. Since peaking at 36.2% in 2009/10, prevalence has now levelled out to 34.5/6% between 2012/14 (see Table 2).

Table 1: Proportion (%) of overweight and obese children in Reading schools – reception class.

Period		Reading Value	South East	England
2006/07	🟡	25.3	21.2	22.9
2007/08	🟡	21.3	20.8	22.6
2008/09	🟡	22.1	21.7	22.8
2009/10	🔴	26.4	21.6	23.1
2010/11	🔴	26.2	20.9	22.6
2011/12	🟡	23.5	20.8	22.6
2012/13	🟡	22.0	20.3	22.2
2013/14	🟡	23.5	20.5	22.5

Source: Health and Social Care Information Centre, National Child Measurement Programme

Table 2: Proportion (%) of overweight and obese children in Reading schools – Year 6

Period		Value	South East	England
2006/07	🟡	32.9	29.7	31.7
2007/08	🟡	34.1	29.8	32.6
2008/09	🟡	34.6	30.1	32.6
2009/10	🔴	36.2	31.0	33.4
2010/11	🟡	34.6	30.6	33.4
2011/12	🟡	35.4	30.8	33.9
2012/13	🟡	34.5	29.7	33.3
2013/14	🟡	34.6	30.3	33.5

Source: Health and Social Care Information Centre, National Child Measurement Programme

- 🟡 - Similar to England Average.
- 🔴 - Worse than the England Average.

A significant point to note is that there is a substantial increase in the proportion of overweight and obese children by the time they reach year 6.

What is being done in Reading to help to address this?

There are a number of initiatives and work being done by specialists, including:

Health Visitors
The health visiting service (shortly to become a council responsibility) consists of specialist community public health nurses and teams who provide expert information, assessments and interventions for babies, children and families and for families with complex needs. This includes advice on breastfeeding, healthy weight, healthy nutrition and physical activity.

School Nurses
The school nursing service (already a council responsibility) provides public health interventions and health care support to school age children and their families to enable children to make the most of their education and wider social opportunities, to improve health and health outcomes for children and families. It provides services set out in the Healthy Child Programme 5 – 19 years, including working with others to deliver universal services. Priorities include the NCMP programme and targeted support and advice to families with overweight/obese children on diet/healthy lifestyles and onward referral.

Breast-feeding peer support
Breastfeeding contributes to the health of mother and child in both the short and long terms and provides all the nutrients a baby needs.

Let's Get Going
The public health team commissions a weight management and healthy lifestyle service for children aged 7-12 years which offers family based advice on healthy eating, behaviour change and a practical physical activity element in local schools.

Beat the Street
RBC and Reading CCGs have jointly funded 'Beat the Street', an initiative designed to inspire people to walk more. People scan a card or key fob onto 'Beat Box' scanners located around the community to indicate that they have walked between the boxes, earning points that add up to win prizes for their team or school. The 2015 Beat the Street competition ended on Wednesday 24 June and 23,992 players (11% of the population) travelled a total of 306,600 miles. This is a 63% increase in participants from 2014.

Health Walks
A health walks co-ordinator is co-funded by RBC's public health team and leisure and transport teams to encourage and increase opportunities for walking in the community and to reduce barriers to physical activity across the population. There is a particular focus on the least active segments of the. The programme's co-ordinator has organised walking events for local schools and walks are open to children accompanied by an adult.

Across Reading Borough Council

Across other council directorates, we commission a range of healthy lifestyle programmes and offers aimed at children and families to provide them with opportunities to be physically active including Reading Play (see http://www.readingplay.co.uk/), Reading Sport and Leisure (see http://www.readingleisure.co.uk/activities-children/) and parent and child cycle training in partnership with CTC (see http://www.ctc.org.uk/article/cycling-guide/parent-and-child-cycle-training-in-reading).

3. PETITION – NHS COMMUNITY CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) / STAFF

A petition with regard to CAMHS was presented to the Board by the Lead Petitioner, Paul Farmer. The wording of the petition, which had 33 signatures, was as follows:

"1. Without any local NHS community Child & Adolescent Mental Health (CAMH) services/staff being commissioned at weekends (even emergency services/staff) Berkshire's young folk with mental health issues (and their families) are still being left to face all crises alone.
2. Without any local specialist NHS CAMH services/staff being commissioned, Berkshire's under 16 year old victims of sexual abuse/rape (despite a confirmed increase of 40% in reported UK cases in 2014 – The professional body for policing) and their families are still being left to face the many (and long-term) mental health traumas associated with child/adolescent sexual abuse/rape alone (it has recently been officially acknowledged that over 75% of all adult mental health problems first surface during childhood or adolescence and 25% as a direct result of childhood or adolescent sexual abuse or rape – the Independent Mental Health Task Force Study 2014/15).
3. Also only 78 full time equivalent community NHS CAMH staff are still being commissioned for Berkshire (the same level as year end March 2000!!!) – despite acknowledged increases in demand each year since 2000!

So, please sign our petition for:

a) Expert NHS Support at weekends for Berkshire's young folk with mental health problems, and for the ever rising numbers of victims of childhood/adolescent sexual abuse/rape in Berkshire; and for
b) More NHS community staff/services for Berkshire's young folk with mental health problems in general and help try to take away their fear and isolation and help try to increase the commissioning of NHS services/staff which support them across Berkshire.

Further notes/points:

The National Institute for Health and Care Excellence (in Jan 15) estimated that:

a) £44m a year could be saved by supporting young folk with mental health problems as soon as they surface – thereby preventing adult mental health problems and/or psychiatric hospitalisation!
b) That 1 in 20 A&E cases were caused by mental health cases - the majority of which surfaced during the individual's childhood or adolescence!
c) The Princes Trust (in 2015) has revealed that 1 in 9 of the UK's young folk are emotionally or sexually abused at home and as a result twice as likely as their peers to suffer mental health problems."

RESPONSE by Councillor Hoskin (Chair of the Health & Wellbeing Board):

Thank you for presenting your petition. Child and Adolescent Mental Health Services (CAMHS) are an extremely important area of local healthcare provision about which this Health and Wellbeing Board takes a very close interest.

The Board commissioned and received at its last meeting a joint report from Reading's NHS Clinical Commissioning Groups and Reading Borough Council on the strategic direction and service improvement plans of CAMHS. The Board made a partnership commitment to its Action Plan which aims to build a transformed comprehensive and integrated full CAMHS service to Reading families.

With regard to the specific issues you have raised in your petition I hope the following response if helpful.

CAMHS commissioning at weekends

- The psychological medicines service at the RBH has been commissioned from NHS Berkshire Healthcare Foundation trust (BHFT) since 2013. The service operates 24 hours a day, 7 days a week. This service is commissioned to see young people under the age of 18 years and provides high quality outcome focussed interventions to those presenting at the Emergency Department with mental health problems and also those admitted to medical wards with physical health complications but have co-morbid mental health problems.
- CAMHs services follow NICE guidance. There is an on call CAMHS psychiatrist available 7 days a week 24 hours a day in addition to the psychological medicines service staff.
- The Berkshire Adolescent Unit is now open 24/7.
- There has been an expansion of on line support services available 7 days a week. There is growing evidence to suggest that online help is a preferred support option for some children and young people. Berkshire West CCGs have invested in Young SHaRON- an on line support platform for young people which is moderated by CAMHS workers. This extends the hours that CAMHS support is available. The CCGs have no plans to reduce face to face and telephone support.
- Berkshire West CCGs are working with BHFT to develop services over weekends when clinically appropriate.

Specialist mental health services for young people who have been sexually abused

The Ministry of Justice has commissioned Trust House Reading http://www.trusthousereading.org/

Trust House Reading is a subsidiary of The Survivors Trust (www.thesurvivorstrust.org). They are a rape and sexual abuse support centre providing specialist support to women, men and children living in Berkshire who have been affected by rape or sexual abuse. They can support people who have historic or recent experiences of sexual violence and also supporters of survivors such as friends and family.

All services are free and confidential.

They include:
◦One-to-one counselling
◦Telephone and email helpline

◦Emotional and practical ISVA (Independent Sexual Violence Advisor) support
◦Play therapy

Being a victim of sexual abuse is not a mental illness. Some victims will require a medical response and CAMHS continues to provide a service for these individuals.

Number of CAMHS practitioners

The total number of staff providing specialist Tier 3 CAMH services through Berkshire Healthcare Foundation Trust is 96.36. That figure is inclusive of managers and administrators. The number for purely clinical staff is 69.63 staff in the Tier 3 specialist service.

This is data for the year ending March 2015. I am afraid that we couldn't obtain data from 2000 but can confirm that the CCG's have invested significantly in the specialist service for 2015-16 onwards and that that will enable an increase in clinical staff of approximately 28 across Berkshire.

4. PRESENTATION ON READING YOUTH CABINET'S CAMPAIGNS ON MENTAL HEALTH AND PSHE

Manasi Panshikar and David Totterdale, members of the Reading Youth Cabinet, gave a presentation on the current campaigns for the Youth Cabinet, which were on Mental Health and Personal, Social and Health Education (PSHE).

They explained that increased social and education pressures had led to higher levels of children and young people with mental health issues and so the Youth Cabinet campaign aimed to raise awareness of mental health and wellbeing through education and to increase the level of support available.

They also explained that the other part of their campaign was on PSHE. They were concerned as PSHE was intended to provide a rounded education that equipped young people to cope with everyday life and to develop emotional resilience, but many of the staff that were teaching PSHE had no formal training in the subject and so lessons were often based on the personal experience of the teacher, which was inconsistent and not always relevant to the pressures facing young people today.

The meeting expressed support for the campaigns and thanked the Youth Cabinet members for their presentation.

Resolved -

(1) That the Reading Youth Cabinet members be thanked for their presentation on the Youth Cabinet's campaigns on Mental Health and PSHE;

(2) That representatives from the Youth Cabinet be invited to contribute to the Council's PSHE Support Group;

(3) That the Adult Social Care, Children's Services and Education Committee be informed that the Council's Education Strategy (Reading First Raising Attainment Strategy 2015-18 & Improvement Plan) should encompass the

resources required for young people, teachers and parents to support positive mental health and wellbeing;

(4) That the Youth Cabinet be invited to a future meeting to provide an update on the progress made on these campaigns.

5. BERKSHIRE WEST PRIMARY CARE STRATEGY 2015-19

Eleanor Mitchell and Maureen McCartney presented the Berkshire West Clinical Commissioning Groups' (CCGs) Primary Care Strategy 2015-19. The CCGs 5 Year Strategic Plan described how, by 2019, enhanced primary, community and social care services in Berkshire West would work to prevent ill-health within the local populations and support patients with complex needs to receive the care they needed in the community, only being admitted to hospital where this was absolutely necessary. This Primary Care Strategy built on the overarching strategy by describing a more detailed vision for primary care services in Berkshire West anticipating that primary care would play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social economy in the light of increased demand and financial pressures. In order to deliver this vision the following five strategic objectives had been developed for primary care:

- Addressing current pressures and creating a sustainable primary care sector;
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting;
- Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home;
- Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need;
- Making effective referrals to other services when patients will most benefit.

Each of these objectives will be supported by specific workstreams.

Maureen McCartney explained that the strategy set out a high level direction of travel for developing primary care and was the basis for ongoing dialogue with partners and the public. The high level principles reflected what patients told the CCGs at the "Call to Action" and patient engagement events that were held over the preceding 18 months. The CCGs would be engaging with all three HWBs in Berkshire West on the strategy. She emphasised that this was one point in an ongoing dialogue and as specific proposals emerged the CCGs expected to consult on these.

She also confirmed that the four Berkshire West CCGs had recently been approved to jointly commission GP services with NHS England under co-commissioning arrangements and that there was a national governance process in relation to how these responsibilities were discharged. The Joint Primary Care Co-Commissioning Committee had met for the first time on 24 June 2015 with Wendy Fabbro representing Reading Borough Council and Healthwatch also represented on the

Committee. The work of this Committee would be guided by the Primary Care Strategy.

Dr George Boulos gave an overview of some of the work that had already been carried out to deliver elements of the strategy in the North & West CCG.

Eleanor Mitchell added that the South Reading CCG were working with GP practices but that some would struggle to increase their hours or capacity due to issues with staffing and being sited in buildings that could not be extended. However, they embraced the need to provide a sustainable health care service that reflected the needs of the local population and so would endeavour to find creative solutions by working together.

Wendy Fabbro stated that the Council was keen to be involved in the delivery of the Primary Care Strategy, but felt that the role of the Council should be one of co-production rather than consultation, especially as this linked with the Council's delivery of adult social care and the Better Care Fund.

It was also noted that the Adult Social Care, Children's Services and Education (ACE) Committee could provide a critical role in providing scrutiny of the emerging strategy and by ensuring the patients and Healthwatch were actively involved.

Mandeep Kaur Sira explained that Primary Care was a priority for Healthwatch as this was the theme of over 30% of their contacts.

The Chair concluded that this was an important and critical strategy for the health and wellbeing of people in Reading and so it was essential that the Council had comprehensive involvement through co-production with the CCGs and Healthwatch and that all residents, not just current service users, should be encouraged to be involved.

Resolved - That the Primary Care Strategy and position be noted.

6. SOUTH READING & NORTH & WEST READING CCG QUALITY PREMIUM TARGETS 2015/16

Eleanor Mitchell and Maureen McCartney submitted a report to outline the Quality Premium targets that had been prioritised by the South Reading and the North & West Reading CCGs. The report explained that, under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England had the power to make payments (Quality Premiums) to CCGs to reflect the quality of services that they commissioned, the associated health outcomes and reductions in inequalities.

The Quality Premium measures agreed in 2015/16 would be paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – and would be based on six measures that covered a combination of national and local priorities, some of which required the approval of the Health and Wellbeing Board.

The six measures were within the following categories:

- Mental Health (30%);
- Urgent Care (30%);
- Potential Years of Life Lost (10%);

- Antibiotic Prescribing (10%);
- Local Measure 1 (10%);
- Local Measure 2 (10%).

The report outlined the measures in more details and the review of local data that had led to the choice of the targets that had been set by the individual CCGs.

The report stated that within the Mental Health Quality Premium Indicator there were four measures and within the Urgent Care Quality Premium Indicator there were three measures and that the selection of one or more of these measures had to be chosen, based on local need, in conjunction with the local NHS England team and the relevant Health and Wellbeing Board.

In addition the local targets had to be chosen from an area of local concern that reflected local priorities and these had been linked to the Health and Wellbeing Strategy for Reading.

Resolved -

That the following quality premium measure targets set for North & West Reading CCG (NWRCCG) and South Reading CCG (SRCCG) for 2015/16 be noted and agreed:

(a) That the weekend discharge indicator be picked for the whole 30% of the urgent and emergency care measure (NWRCCG & SRCCG);

(b) That the paid employment indicator be picked for the whole 30% of the mental health measure (NWRCCG & SRCCG);

(c) That the local Quality Premium Indicators for SRCCG be:

(i) Increase referrals to Eat 4 Health;

(ii) Increase referrals to alcohol service IRIS;

(d) That the local Quality Premium Indicators for NWRCCG be:

(i) Increase the number of carers identified by GP practices;

(ii) Increase the uptake of bowel cancer screening.

7. IMPROVING SUPPORT TO THE EX-GURKHA COMMUNITY: ACCESS TO AND EXPERIENCE OF HEALTH AND SOCIAL CARE SERVICES IN READING

Mandeep Kaur Sira and Melanie O'Rourke submitted a joint report to update the Board on a Healthwatch Reading survey that had been commissioned by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England, to explore how the ex-Gurkha community accessed health and social care services. The report set out Healthwatch Reading's recommendations to care providers and the providers' responses. A full copy of the Healthwatch Reading report 'How the ex-Gurkha community access and experience health and social care services in Reading' was attached to the report at Appendix 1.

The report stated that Healthwatch Reading had gathered feedback from more than 100 members of the ex-Gurkha Community on how they accessed health and social care services and then their experience of those services.

The report explained that most people who had taken part in this survey had reported difficulties in accessing and using services, principally because of speaking/reading little English and not receiving clear guidance on how to obtain interpreter support. The problems were compounded in that the ex-Gurkha community in Reading needed to understand a very different healthcare system from the one that they knew in Nepal – with no universal access but many more medicines available over the counter and more direct access to secondary care.

The report also stated that the ex-Gurkha community in Reading had a high incidence of a number of long term conditions, that many were living on low incomes and that most of the community were aged 60-75 years with significant numbers living in the UK without the support of adult children and providing unpaid care to others.

The report set out the recommendations made following the survey and the responses received by health and social care providers, many of which had started to address the issues raised and had committed to work in partnership to make further improvements.

Resolved -

(1) That the findings of Healthwatch Reading and the responses from health and social care providers as set out in the report '*How the ex-Gurkha community access and experience health and social care services in Reading'* be noted;

(2) That the Reading Integration Programme Manager be directed to develop and monitor a whole system Action Plan based on the report and responses received, and that this Action Plan be monitored through the Reading Integration Board;

(3) That a progress report be submitted to the Health & Wellbeing Board in January 2016.

8. HEALTHWATCH READING ANNUAL REPORT 2014/15

Mandeep Kaur Sira submitted the 2014/15 Annual Report for Healthwatch Reading.

She explained that this was their second annual report and that during 2014-15 they had received over 400 contacts from members of the public. The top three issues that people had reported were GP services (31%), hospital services (21%) and mental health services (11%).

The report outlined the role of Healthwatch as making health and social care better for ordinary people by designing local services around their needs and experiences. Their mission was to campaign for better care for the community by advising people of their rights, giving them information and signposting to other services, by advocating on behalf of local people to raise concerns, make a complaint or support them to have their voice heard, and by taking action by listening to people to understand their experiences and influencing those with the power to change things.

(a) Engaging with people who used health and social care services

The report explained that Healthwatch Reading had organised or taken part in nearly 100 different engagement events and activities that had included more than 3,000 individuals and groups, including some of the most vulnerable and disadvantaged, and given them the opportunity to talk in-depth about their experiences of health and social care services. This information had then been used to inform and influence local providers.

(b) Providing information and signposting for people who used health and social care services

The report stated that approximately 50% of Healthwatch's work was providing information, advice and advocacy. In 2014 they had been awarded the contract to provide advocacy services for those who wished to raise a concern or make a complaint about an NHS service and they would also be providing advocacy under the Care Act in 2015-16.

(c) Influencing decision makers with evidence from local people

The report also stated that Healthwatch had been involved in a number of projects that had resulted in being able to influence how services were developed and commissioned.

Resolved - That the report be noted.

9. INTEGRATION UPDATE

Further to Minute 3 of the meeting held on 17 April 2015, Melanie O'Rourke submitted a report outlining the local non-elective performance target (NEL) for admissions to hospital, national and local performance indicators under the Better Care Fund (BCF), an indication of the impact of the local BCF scheme - Discharge to Assess, and a proposal that the submission of quarterly returns be delegated outside the Health & Wellbeing Board meeting structure. There was a table with details of performance and reporting arrangements under the BCF and the wider Integration Programme attached to the report at Appendix A.

The report illustrated the disparity between the submission dates to NHS England and the dates of the Health & Wellbeing Board and so suggested that the authority for reporting on BCF performance be delegated to the Director of Adult Care and Health Services in consultation with the Chair of the Health & Wellbeing Board.

In addition, further to Minute 3 (3) of the last meeting when the authority to review the local non-elective target had been delegated, it was reported that the final figure submitted had been an increase of non-elective activity of 3.3%. The report also stated that any increase in activity into hospital could have an adverse impact on demand for adult social care, but the meeting agreed that it was important to consider people rather than just targets and to also monitor outcomes in terms of improvements to people's lives.

The report also described the benefits of the Discharge to Assess service, which had started on 1 April 2015 and which aimed to facilitate timely discharge from hospital to either a community setting or a bed-based setting at The Willows to prevent long

term admissions into care homes and to increase the number of people that were able to return to their home or into extra care housing schemes.

Resolved -

(1) That the responsibility of the Board for monitoring and reporting on BCF performance, including the technicalities of reporting to NHS England, be noted;

(2) That authority be delegated for the Director of Adult Care and Health Services, in consultation with the Chair of the Health & Wellbeing Board, to approve BCF performance submissions outside of the Health and Wellbeing Board timetable;

(3) That the revised non-elective target submitted to NHS England on 15 May 2015 be approved;

(4) That the early indicators of the impact of the Discharge to Assess Scheme be noted.

10. UPDATE REPORT ON INFORMATION SHARING WORK BEING TAKEN FORWARD BY THE LSCB

Further to Minute 5 of the last meeting, Sylvia Chew submitted a report that set out the progress of the Local Safeguarding Children Board (LSCB) Information Sharing Task and Finish Group.

The report explained that, in March 2015, following the publication of the Government response to the child sexual exploitation (CSE) cases in Rotherham, all Chief Executives, Directors of Children's Services, LSCBs and Health and Wellbeing Boards had received a joint letter from Government Ministers stating that the effective sharing of information was a key factor in keeping children safe.

The LSCB had set up an Information Sharing Task and Finish Sub Group to produce a clear information sharing protocol on this topic as there was unanimous agreement that CSE was a current high risk area and that the protocol was vital to support front line staff in making appropriate decisions.

The report stated that a draft document had already been produced in West Berkshire, and that the group would review this as it had been agreed that moving towards a West of Berkshire or Pan Berkshire approach would be beneficial for many agencies that spanned more than one local authority/LSCB area. However, the different organisations within Health did not all use the same database, so sharing information between Health colleagues, such as details of presentations at Accident and Emergency and Health Visitors needed clarity.

The group would consider the current Reading Information Sharing Protocol against the LSCB Procedures and recent Government guidance and make any recommended changes. All partners would be asked to sign up to the protocol.

Resolved -

(1) That the report be noted;

(2) That a further report be produced for the Board once the protocol had been agreed.

11. READING CHILDREN'S TRUST CHILDREN AND YOUNG PEOPLE'S PLAN 2015-2018

Sylvia Chew submitted a report providing a summary of the Reading Children's Trust (CTB) Children and Young People's Plan (CYPP) 2015-18, a copy of which was attached to the report at Appendix 1, and which had been endorsed by the Adult Social Care, Children's Services and Education Committee on 29 June 2015.

The report explained that purpose of the Children's Trust was to hold all partners to account for their contribution to improving the life of children who lived in Reading. It provided a strategic framework within which partners could commission services together, consult with each other and agree a common strategy on how they would co-operate to improve children's wellbeing and to help embed partnership working in the partners' routine delivery of their own functions.

The Children's Trust Board had reviewed data from the Joint Strategic Needs Assessment, data from the last CYPP and the priorities from key strategies and plans from partner organisations and had produced a range of areas of concern which were collated and grouped into the following three overarching priorities which formed the basis of the new CYPP:

- Priority 1 - Having the best start in life and throughout;
- Priority 2 - Learning and employment
- Priority 3 - Keeping children safe

Resolved - That the Children & Young People's Plan 2015-18 be noted.

12. DATES AND TIMES OF FUTURE MEETINGS

Resolved –

That the meetings of the Health & Wellbeing Board for 2015/16 be held at 2.00pm on the following dates:

- Friday 9 October 2015
- Friday 22 January 2016 (moved from 29 January 2016)
- Friday 18 March 2016

(The meeting started at 2.00pm and closed at 4.05pm)