Ian Wardle
MANAGING DIRECTOR

Civic Offices, Bridge Street,
Reading RG1 2LU
☎ 0118 937 3787

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

Direct: ☎ 0118 937 2112
e-mail: nicky.simpson@reading.gov.uk

22 January 2015

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 30 JANUARY 2015

A meeting of the Health & Wellbeing Board will be held on **Friday 30 January 2015 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

CIVIC CENTRE EMERGENCY EVACUATION: *If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble on the corner of Bridge Street and Fobney Street. You will be advised when it is safe to re-enter the building.*

../Cont

6. NHS FIVE YEAR FORWARD VIEW 89

A document presenting the NHS's Five Year Forward View, setting out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that the NHS can promote wellbeing and prevent ill-health.

7. BERKSHIRE CAMHS (CHILDREN & ADOLESCENT MENTAL HEALTH SERVICES) verbal report

A verbal report from the Director of Joint Commissioning, Berkshire West CCGs, on the current position with regard to CAMHS in Berkshire, following a review of CAMHS carried out in 2014.

8. BEAT THE STREET READING 2014 130

A report providing feedback on and presenting the evaluation report of the Beat the Street Reading 2014 walking challenge and setting out proposals to deliver Beat the Street in 2015 across Reading.

9. UPDATE ON JOINT WORKING TO SUPPORT CHILDREN & FAMILIES 178

Further to Minute 52 of the meeting held on 21 March 2014, a report giving an update on the work of the sub-group set up to progress opportunities identified across the Council's Children's Services and Public Health teams, the two Clinical Commissioning Groups and local health services to strengthen joint working to improve health outcomes for children and families. The report outlines the revised action plan focus, achievements and progress made and barriers being experienced.

10. UPDATE ON CHILD SEXUAL EXPLOITATION STRATEGY 2014-17 185

A report presenting a strategy agreed by the Reading Local Safeguarding Children Board which sets out the partnership intent to improve the delivery of services to prevent children becoming at risk of Child Sexual Exploitation, protect children who are at risk or are victims, pursue and disrupt the activity of individuals and or groups of perpetrators and help victims and their families to recover from the abuse.

11. TACKLING POVERTY IN READING STRATEGY AND NEEDS ANALYSIS 199

A report presenting the draft Tackling Poverty in Reading strategy, action plan and needs analysis, developed with partners through the Tackling Poverty Delivery Partnership.

../Cont

12. UPDATE ON FEMALE GENITAL MUTILATION 283

A report giving an update on the current position in Reading in relation to Female Genital Mutilation (FGM), as a result of a request from the Thames Valley Police and Crime Panel to have a regular overview item on the Board's agenda for FGM.

13. PROTOCOL AGREEMENT BETWEEN READING HEALTH AND WELLBEING BOARD AND WEST OF BERKSHIRE ADULTS SAFEGUARDING PARTNERSHIP BOARD (SAPB) 300

A report seeking endorsement of a protocol setting out the expectation of the relationship and working arrangements between Reading Health and Wellbeing Board and the West of Berkshire Safeguarding Adults Partnership Board (SAPB).

14. FINAL PHARMACEUTICAL NEEDS ASSESSMENT 305

Further to Minute 9 of the meeting on 10 October 2014, a report presenting the final draft Pharmaceutical Needs Assessment (PNA) for approval and publication. The consultation period for the PNA in Reading ended on 16 December 2014 and the report includes the key issues identified from the consultation.

15. DATE OF NEXT MEETING – Friday 17 April 2015 at 2pm -

READING HEALTH & WELLBEING BOARD MINUTES – 10 OCTOBER 2014

Present:

Councillor Eden	Lead Councillor for Adult Social Care, Reading Borough Council (RBC)
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Hoskin (Chair)	Lead Councillor for Health, RBC
Lise Llewellyn	Director of Public Health for Berkshire
Councillor Lovelock	Leader of the Council, RBC
Eleanor Mitchell	Operations Director, South Reading Clinical Commissioning Group (CCG)
David Shepherd	Chair, Healthwatch Reading
Ian Wardle	Managing Director, RBC
Avril Wilson	Director of Education, Adult and Children's Services, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

Also in attendance:

Susan Bicknell	Member of the Public
George Boulos	Clinical Lead, North West Reading CCG
Vicki Lawson	Head of Children's Services, RBC
Pete Loomes	Senior Strategic Planning Redesign Manager, Central Southern Commissioning Support Unit
Nikki Luffingham	Interim Director of Operations Delivery, Thames Valley Area Team, NHS England
Maureen McCartney	Operations Director, North & West Reading CCG
Rebecca Norris	Development Officer, Healthwatch Reading
Melanie O'Rourke	Integration Programme Manager, RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Suzanne Westhead	Head of Adult Social Care, RBC

Apologies:

Frances Gosling-Thomas	Independent Chair, West Berkshire, Reading and Wokingham Local Safeguarding Children Boards
Alistair Flowerdew	Medical Director, Royal Berkshire NHS Foundation Trust
Ishak Nadeem	Chair, South Reading CCG
Asmat Nisa	Consultant in Public Health, RBC
Councillor O'Connell	RBC
Rod Smith	Chair, North & West Reading CCG
Councillor Vickers	RBC

1. MINUTES & MATTERS ARISING

The Minutes of the meeting held on 18 July 2014 were confirmed as a correct record and signed by the Chair.

2. QUESTION IN ACCORDANCE WITH STANDING ORDER 36

The following question was asked by Susan Bicknell in accordance with Standing Order 36:

(a) Lymphoedema Diagnosis & Treatment

"In 2003 Professor Christine Moffatt et al wrote an article - Lymphoedema: An Underestimated Health Problem, following research. I would like to know, why, is it still so difficult, eleven years after this piece of work, for people like myself, with non-cancer related Lymphoedema, to actually get diagnosed and then get any treatment in Reading and indeed, Berkshire?

With Lymphoedema, any delay in treatment can affect the successful outcome significantly. If Royal Berkshire Hospital is treating people for Lymphoedema who have this painful problem through cancer treatment i.e. surgical removal of compromised lymph glands or radiotherapy, then why can't they also treat people with Lymphoedema from other causes i.e. Trauma, side effect of prescribed drugs or other triggers?

Why should people like myself, be left in limbo with a severely painful condition that is ongoing and degenerative and if untreated leads to other complications? According to the NHS UK website the recommended treatment is the therapy that I am having to pay for privately but is available in most other areas of England.

How many other patients in the Reading and wider area are suffering in this way, does the board and CCG have any idea of actual numbers? I find it difficult to believe I am the only one, in fact in the last week I have discovered two other sufferers.

(I have given further background and personal information in separate documents to enable the preparation of a reply.)"

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

"This response has been provided by Dr Cathy Winfield, Chief Officer of Berkshire West Clinical Commissioning Groups (CCGs) on behalf of Reading's two CCGs.

I plan to use any supplementary to arrange for myself and the CCGs to more fully investigate Ms Bicknell s concerns.

On non cancer related lymphoedema services, the Clinical Commissioning Groups' 2014/15 strategic objectives make clear the CCGs' aim to commission appropriate healthcare based on identified health needs - and within the resources available, thus ensuring value for money.

The CCGs' commissioning decisions reflect the needs articulated by Berkshire West's Health and Wellbeing Boards in the Strategic Needs Assessments, in the Joint Health and Wellbeing Strategies, and the views expressed by patients through a series of consultation events run as part of the national 'Call to Action' programme, and those from patient representative groups e.g. the recent CAMHS (child and adolescent mental health services) engagement exercise; and any significant themes identified through patient feedback in enquiries and complaints.

The article in the link provided (Lymphoedema: An Underestimated Health Problem at http://qjmed.oxfordjournals.org/content/96/10/731.full) indicates a prevalence of 1.33/1000 people with lymphoedema which means that in Berkshire West there are potentially some 700 patients with the condition - from a total population of c500,000 - and it could well be that of these 700 the majority also have or have had cancer. That same article also includes the following: "The quality of evidence on effectiveness of the various physical management strategies – skin care, external pressure (bandaging & hosiery) and massage – is poor"."

Resolved -

That Councillor Hoskin investigate further with the CCGs why treatment for non-cancer-related lymphoedema was not being provided and the scale of the issue in Reading.

3. FINDINGS OF HEALTHWATCH READING ON THE EXPERIENCE OF DELAYED DISCHARGE FROM HOSPITAL

Suzanne Westhead submitted a report presenting a report by Healthwatch Reading on the findings of a project collecting the experiences of people affected by delayed discharge from Royal Berkshire Hospital. The report had appended a 'whole system' response to Healthwatch's findings, prepared by Reading's Health & Social Care Board (HSCB), and an action plan to deliver on the commitments in the response.

David Shepherd presented the Healthwatch report and Rebecca Norris gave a presentation which focussed on the experiences of one of the patients and looked at how proposed actions in the new action plan could affect a similar patient's future 'journey'.

The report explained that Healthwatch Reading had carried out a series of in-depth interviews between September 2013 and March 2014 with people affected by discharge from the Royal Berkshire Hospital being delayed beyond the point when the patient had been fit to leave. 70 pieces of feedback had been collected from seven Reading residents and/or their relatives/carers and a report had been prepared in April 2014 - "The experiences of people whose discharge from hospital was delayed".

The Healthwatch report gave details of the findings of the project and made a number of recommendations. It stated that the project had uncovered strong evidence directly from people who used services that the hospital discharge process needed urgent reform. Extra evidence had also been volunteered that pointed to serious failings in settings such as sheltered housing and care homes to protect the health and safety of vulnerable older people and the report urged health and social care commissioners and providers to act swiftly to transform the patient experience.

The Healthwatch report had been taken to the Reading HSCB in June 2014, a body which brought together senior officers overseeing the delivery of care across local agencies and directed the Reading Integration Programme to develop better co-ordination of health and social care services around individual needs. The HSCB had welcomed the insights in the report into the patient/customer experience and had directed Reading's Integration Programme Manager to develop an action plan to address the issues highlighted. The action plan would be monitored through the Reading Integration Programme Board, of which Healthwatch was a member.

The report noted that, whilst many people were discharged from hospital in Reading without delay every day, Healthwatch's report describing the impact on those who experience delayed discharge made a powerful case for the need to integrate care provision. It stated that there was a strong local commitment to developing more integrated services, now largely articulated through Reading's proposals for use of the Better Care Fund, and stated that the reduction of delayed discharges from hospital was a key metric within Reading's Integration Programme.

The report stated that the Adult Social Care, Children's Services and Education Committee was responsible for the overview and scrutiny of all functions for which the Committee was responsible, as well as for undertaking the health scrutiny functions of the local authority, and would therefore be an appropriate body to undertake a scrutiny review of the 'whole system' response to the Healthwatch report findings.

It was reported that Healthwatch planned to carry out a further set of in-depth interviews of people awaiting hospital discharge in the future, to review progress, and it was noted that it would be useful if that report could be based on a larger sample of patients.

Resolved -

(1) & That the following be noted and all those involved be thanked for their work:

(a) & The findings of Healthwatch Reading as set out in the April 2014 report: *The experiences of people whose discharge from hospital was delayed;*

(b) & The joint response to Healthwatch submitted by members of the Health and Social Care Board; and

(c) & The Action Plan developed to deliver on the commitments made in response to Healthwatch's findings, which would be monitored through Reading's Integration Programme Board.

(2) & That the Adult Social Care, Children's Services and Education Committee be recommended to review the response of local care providers to Healthwatch's findings as a scrutiny enquiry;

4. INTEGRATION UPDATE INCLUDING BETTER CARE FUND SUBMISSION

Further to Minute 3 of the last meeting, Melanie O'Rourke and Maureen McCartney submitted a report giving an update on the progress made:

a) in developing plans for health and social care integration in Reading;
b) on Reading's Better Care Fund (BCF) plans; and
c) in developing a Frail Elderly Care Pathway and an Operational Resilience and Capacity Plan for the local health and social care system.

The report also presented Reading's revised (August 2014) BCF proposals for the Board's formal approval, with Appendix 1 providing a detailed description of the

schemes included in the submission. The full submission had been made available on the Council's website, comprising the following documents:

- Better Care Fund Planning Template – Part 1
- Better Care Fund Planning Template – Part 1 – Annex 1 (Appendix 1 to the report)
- Better Care Fund Planning Template – Part 1 – Annex 2
- Better Care Fund Planning Template – Part 2
- Better Care Fund Library of Supporting Documents

The report explained the history to Reading's submission to the BCF which provided for local funding for health and care services in ways which would take forward the integration agenda. It stated that, following receipt of the initial bids, around 30 local areas, including Reading, had been judged to have particularly strong 'examplar' proposals for use of the BCF and had been invited to 'fast track' their bids. By the end of August 2014, there had only been five local areas remaining on the fast track process, including Reading. The Reading local team had received consultancy support arranged by NHS England and the BCF Plan had been revised, ready for submission by the deadline of 29 August 2014. The schemes within the revised BCF Plan, as set out at a seminar hosted by Health and Wellbeing Board members on 27 August 2014 and detailed in Appendix 1, were:

- Hospital @ Home
- Enhanced Support to Care Homes
- Berkshire West Connecting Care (Intra-operability)
- Discharge to Assess/Time To Decide beds
- Whole System/Whole Week (7 day working, Health and Social Care Hub and Neighbourhood Cluster Teams)

The revised BCF bid would be subject to a rigorous quality assurance process. Initial feedback, whilst very positive, had indicated five areas for further development in Reading. Additional information related to those key lines of enquiry would need to be supplied in October 2014 with a view to obtaining final ministerial sign off of the bid by the end of October 2014.

The report also gave details of progress in developing a Frail Elderly Care Pathway, which had informed the schemes in the BCF proposals, and a Berkshire West Operational Resilience and Capacity Plan (ORCP) for 2014/15, which had been submitted to NHS England for approval. Formal feedback on the ORCP was expected shortly and initial feedback had been that it was a good plan with evidence of good cross organisational engagement within the Urgent Care Programme Board.

It was reported at the meeting that the Berkshire West ORCP had been signed off by NHS England and assessed as medium risk.

Resolved -

(1)& That the following be noted:

(a) & The progress made in developing plans for health and social care integration in Reading;

(b) & The recognition Reading's Better Care Fund plans had received as 'exemplar' proposals;

(c) & The work that had been done in developing an Operational Resilience and Capacity Plan for the local health and social care system;

(2) & That Reading's revised (August 2014) Better Care Fund submission, as set out in the following documents, be formally approved:

- Better Care Fund Planning Template – Part 1
- Better Care Fund Planning Template – Part 1 – Annex 1
- Better Care Fund Planning Template – Part 1 – Annex 2
- Better Care Fund Planning Template – Part 2
- Better Care Fund Library of Supporting Documents

5. DEMENTIA SERVICES IN BERKSHIRE WEST – UPDATE

Pete Loomes and Maureen McCartney submitted a report by the Berkshire West GP Mental Health Lead and the South Reading CCG Chair, which gave an update on the work in progress in dementia service development locally in support of the National Dementia Strategy and implemented as part of the Long Term Conditions Programme. The report stated that this work had been steered by a Berkshire West Dementia Stakeholders Group, with representation from health commissioners and providers, unitary authorities and voluntary sector partners.

The report gave details of national expectations for improvements to dementia care as a result of the National Dementia Strategy (2009) and the 2012 'Dementia Challenge'. The Challenge required that, from April 2013, there needed to be a quantified ambition for diagnosis rates across the country. According to a provided Dementia Prevalence Calculator Tool, the adjusted diagnosis figures for August 2014 were:

- North & West Reading CCG – 49.5% of expected prevalence
- South Reading CCG – 49.0% of expected prevalence

The diagnosis ambition across Reading was to achieve a rate of 67% by the end of 2015/16.

The report explained that a number of key improvements for dementia services had been proposed at a Dementia and Elderly Care Conference hosted by NHS South Reading CCG on 14 May 2013. The Berkshire West Dementia Stakeholder Group had reviewed the list of priorities identified by delegates, and the report listed the six key areas which had been identified.

The report stated that there was already a significant amount of joint working in this area between health agencies, local authorities and the voluntary sector. In addition, seven proposals had been submitted to the Dementia Challenge Fund, of which five had been successful and one the Berkshire West CCGs had decided to fund themselves.

The report gave detailed updates on the work in progress in dementia services, set out the latest list of priorities for local development identified by the Berkshire West

Dementia Stakeholders Group, and had appended a work plan for dementia in Berkshire West, showing the priority areas, the intended projects and an indicative timeline for the work.

Resolved -

(1) & That the report be noted;

(2) & That the members of the Health & Wellbeing Board commit to supporting the continued work on dementia as a priority within Reading.

6. READING LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2013/14

Vicki Lawson submitted a report presenting the annual report of the Reading Local Safeguarding Children Board (LSCB) 2013/14, which was appended to the report.

The report explained that the Reading LSCB was the key statutory mechanism for agreeing how the relevant organisations would co-operate to safeguard and promote the welfare of children in Reading and for ensuring the effectiveness of what they did, as outlined in statutory guidance Working Together to Safeguard Children 2013.

The LSCB Chair was required to publish an Annual Report on the effectiveness of child safeguarding and promoting welfare of children in Reading; this report had a wide distribution and was sent to key stakeholders and partners so that they could be informed about the work and use the information in planning within their own organisations to keep children and young people safe. It was being presented to the Health and Wellbeing Board in line with the protocol agreement agreed at the Health and Wellbeing Board meeting on 18 July 2014, and would also be presented to the Children's Trust Board and the Adult Social Care, Children's Services and Education Committee (ACE).

The report listed the LSCB achievements and challenges set out in the Annual Report.

Resolved - That the annual report of the Reading Local Safeguarding Children Board 2013/14 be noted.

7. DRAFT SHARED STRATEGIC VISION – READING LOCAL SAFEGUARDING CHILDREN'S BOARD, HEALTH AND WELLBEING BOARD AND CHILDREN'S TRUST BOARD

Vicki Lawson submitted a report presenting a draft strategic vision document (Appendix 2) which built on the protocol setting out the expectation of the relationship and working arrangements between Reading Local Safeguarding Board (LSCB), Reading Health and Wellbeing Board and Reading Children's Trust that had been agreed at the last meeting (Appendix 1 - Minute 8 refers), giving details of governance arrangements and proposing a way forward to clarify performance reporting across the boards.

The draft strategic document clarified the Performance Monitoring arrangements of each board and detailed which board held primary responsibility for monitoring and challenging performance, outcomes and impact for the children and young people of Reading. It was aimed at all stakeholders, offering one document articulating the collective governance and ambition for all children and young people.

The draft document had appended a compendium of performance, which was currently being completed, to offer an overarching reference document detailing all performance collected across partners in respect of children and young people. Most of this performance information, or a very similar data set, was already collected. From the completed compendium each board would have a determined set of performance information that they were primarily responsible for overseeing and, once the system was in place, reporting could be by exception.

It was proposed that the three Board chairs, as well as the chairs of the Community Safety Partnership, Youth Offending Management Board, Corporate Parenting Board, the Director of Education, Adult Children's Services, Lead Councillor for Children's Services and Families, Managing Director, Chair of the Berkshire West Clinical Commissioning Groups and Director of Public Health would meet six monthly in June and December to collectively reflect on progress and set strategic direction and associated priorities for services.

The proposals had already been agreed by the LSCB and would be taken to the Children's Trust for agreement. The final document would be presented to the Health and Wellbeing Board on 30 January 2015.

The meeting discussed the possible timing of performance reporting arrangements, noting that this could be aligned with the review of the Health and Wellbeing Strategy Action Plan. It was suggested that the timing of performance monitoring reports to the Board, eg six monthly or annually, be considered further at the next meeting when the final vision document was received.

Resolved –

(1) & That the draft strategic vision document be endorsed;

(2) & That completion of the performance reporting arrangements and attendance at the bi-annual strategic challenge meetings be supported;

(3) & That the final strategic vision document be submitted to the next Board meeting and the timing of performance monitoring reports be considered at that meeting.

8. HEALTH & WELLBEING STRATEGY ACTION PLAN

Further to Minute 5 of the last meeting, Lise Llewellyn submitted a report giving an update on Health and Wellbeing Strategy activity delivered and progressed through 2013/14 and 2014/15 to date. The report had appended:

Appendix 1 – A summary of the Health and Wellbeing Strategy Goals and Objectives
Appendix 2 – The updated Health and Wellbeing Action Plan for 2014/15

The updated action plan set out, for each goal and objective in the Health and Wellbeing Strategy, the following information:

- What do we want to achieve?
- What we will do
- Key delivery partners
- RAG status (red/amber/green)

- Progress update
- Next steps

The report explained that, following feedback from the last Board and subsequent discussions with health partners and other contributors to the delivery of the strategy, the action plan for 2014/15 had been reviewed and progress updates collated on all activity in 2013/14 and 2014/15 to date.

Paragraphs 4.2 to 4.5 of the report proposed a process for Public Health to review lessons learnt to date and develop a framework for the development of an improved baseline action plan for 2015/16. It proposed that the Public Health team hold a workshop with partners contributing to the health and wellbeing agenda, to ensure that the action plan for 2015/16 focused on and captured key deliverables from all partners that contributed to the delivery of the Health and Wellbeing Strategy 2013-2016. Key outcome measures would also be included in the action plan for 2015/16, following feedback from partners, to ensure the impact was clearly demonstrated.

The action plan for 2015/16 would be expanded to include contributions from other partners, including Healthwatch, voluntary sector providers and provider organisations, and a baseline action plan for 2015/16 would be presented to the Board in April 2015.

The report also proposed a reviewed process for keeping the action plan updated, at paragraphs 4.6 and 4.7. Public Health would monitor and track progress to the strategy and the delivery of activity. Partners would be asked to regularly review activity that they had put themselves forward as being accountable for, and provide progress updates that would be collated and reported to the Health and Wellbeing Board every six months.

Resolved -

(1) & That the progress of activity contributing to the delivery of the Health Wellbeing Strategy to date, as set out in the updated Health and Wellbeing Action Plan for 2014/15 in Appendix 2, be noted;

(2) & That the proposed process for developing a baseline Action Plan for 2015/16, to be presented to the Board in April 2015, as set out in paragraphs 4.2 to 4.5 of the report, be agreed;

(3) & That the reviewed process for keeping the Action Plan updated, as set out in paragraphs 4.6 and 4.7 of the report, be agreed.

9. DRAFT PHARMACEUTICAL NEEDS ASSESSMENT

Lise Llewellyn submitted a draft Pharmaceutical Needs Assessment (PNA) for the Reading Borough Council area for 2014, for the Board to approve for consultation.

She explained that the PNA was the statement for the needs of pharmaceutical services of the population in a specific area. It set out a statement of the pharmaceutical services which were currently provided, together with when and where these were available to a given population. From 1 April 2013 every Health and Wellbeing Board (HWB) in England had a statutory responsibility to keep an up-to-

date statement of the PNA and the PNA had to be published by April 2015. The HWB had to consult a number of people and organisations on the draft PNA, including neighbouring HWBs, and Reading's consultation would be held until mid-December 2014. The final PNA would then be brought to the 30 January 2015 HWB meeting for sign-off.

The draft PNA described the needs of the population of Reading Borough, which was different from the previous PNA which had been West Berkshire-focussed. It described: the statutory PNA requirements; national pharmacy commissioning; geography of Reading PNA; Reading Borough demographics; Reading Borough needs assessment; local commissioning strategies; current pharmacy provision; pharmacy access and analysis of a user survey, concluding with a number of recommendations. These included suggesting that there were a number of opportunities for community pharmacies to play an increasing role in the Health and Wellbeing Strategy's focus on self-care, health promotion and early intervention, for example in:

- Promotion of healthy lifestyles
- Prescription-linked interventions
- Public Health campaigns
- Signposting
- Support for self-care
- Early identification of patients at risk of complications through Medicine Use Reviews

The PNA also listed a number of health needs that the Joint Strategic Needs Assessment had identified, which could potentially be addressed through locally-commissioned pharmaceutical services.

Lise proposed that, as Director of Public Health, she should work in consultation with with the Chair of the Board to respond to neighbouring authorities' consultations on their draft PNAs and then bring back a summary to the next meeting.

The meeting considered the draft PNA and the points made included:

- The statement on page 26 of the PNA that there were four times the number of children on child protection plans than the South East average needed checking for accuracy.

- The proposals to make more use of community pharmacies were welcomed and it was suggested that they could also be involved in identifying carers in the community so that their needs could be supported.

Resolved –

(1) & That the draft Pharmaceutical Needs Assessment be approved for consultation and the final draft be brought back to the next meeting;

(2) & That the Director of Public Health be authorised to respond to other Local Authorities' consultations on their draft PNAs, in consultation with the Chair, and a summary be submitted to the next meeting.

10. READING JOINT STRATEGIC NEEDS ASSESSMENT

Lise Llewellyn submitted a report giving an update on progress on Phases 1 and 2 of the development of the Reading Joint Strategic Needs Assessment (JSNA), as well as giving information on Phases 3 and 4 and the suggested timeframes for completion.

The report explained that, following the changes to the health and social care systems, introduced in April 2013 as a result of the Health and Social Care Act 2012, a new phased approach to the JSNA had been introduced in 2013/14:

- Phase 1 – Develop a web-based JSNA which told the local story with refreshed data and newly-created ward profiles
- Phase 2 – Further develop the web-based JSNA to link to key strategies across the Council
- Phase 3 – Build on other local information/data to provide details of health and wellbeing inequalities
- Phase 4 – Review and update

The project plan had included a review of the process at the end of Phase 2 and the report gave details of this review. This included an explanation of the reasons for and details of the phased approach, a summary of the completed phases (1 and 2), including lessons learned, and a look forward to Phases 3 and 4, with Phase 3 completion programmed for the end of March 2015 and Phase 4 for the end of March 2016.

Resolved -

(1)& That the report be noted;

(2)& That Phase 3 of the development of the JSNA and the suggested timeline for completion be endorsed.

11. DATE AND TIME OF NEXT MEETING

Resolved –

That it be noted that the next meeting of the Health & Wellbeing Board would be held at 2.00pm on Friday 30 January 2015.

(The meeting started at 2.05pm and closed at 3.39pm)

Royal Berkshire NHS Foundation Trust

Reading Health & Wellbeing Board

Title: **CQC Improvement Plan Update**

Date: **30th January 2015**

Lead: **Caroline Ainslie, Nurse Director**

Purpose: This paper informs the Board of progress against the Trust's CQC Improvement Plan in response to the findings following the inspection of March 2014.

Key Points:

- Following the CQC formal inspection 24th – 26th March, the Trust was awarded an overall rating of 'Requires Improvement'.
- The report findings included 7 'Compliance Actions' (regulatory legal actions that confirm the essential standards the Trust must meet through delivery of the action plan).
- Following the inspection, the Trust implemented a CQC Improvement Plan in response to the findings. Progress has been made against each of the key actions; some are progressing quicker than others due to the nature and scale of improvement required.
- The Trust has implemented an internal review process to test that actions taken have been embedded throughout the organisation and that there is evidence of improvement to provide assurance.
- The Trust is also working in collaboration with Bournemouth NHS Foundation Trust and is setting up an external Peer Review arrangement.

1 Background

1.1. Following the inspection on 24th-26th March, an overall rating of 'Requires Improvement' was given to the Trust, with separate ratings for each CQC domain (safe, effective, caring, responsive, and well-led) and ratings for each core service.

	Safe	Effective	Caring	Responsive	Well-led
Overall domain for the trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

1.2. Two individual specialties were awarded an 'outstanding' rating, and these were Critical Care, and End of Life Care.

1.3. The report findings included a total of 13 actions the Trust must take and a further 14 actions that the CQC suggested the Trust should take. These actions were amalgamated into 7 'Compliance Actions' (regulatory legal actions that confirm the essential standards the Trust must meet through delivery of the action plan).

1.4. The Trust developed a detailed action plan addressing all of the issues raised in the final CQC report. This was cascaded to all staff across the Trust who were engaged in developing the actions required.

1.5. Progress is monitored by the CCG at their bi-monthly Quality Review Group.

2. Compliance Actions and progress to date

2.1 Progress made by the Trust against the key areas within the 7 Compliance Actions has been as follows:

1. Risks of receiving care and treatment / assessment of need

- Cancelled / re-scheduled appointments – priority specialties identified and actions taken to improve booking process (Trust currently at 11% against target of 9% by May 2015).
- Mental Capacity Act and Deprivation of Liberty awareness –training programme implemented - 89% of staff have now received level 1 training, and 84% received specialist training.
- Dementia Training – training programme in place – 64% staff have received training to date.

2. Maintenance and availability of diagnostics and screening equipment

- Radiology - new Radiology information system being upgraded. Additional equipment agreed – due April 2015.
- Trust wide equipment – 5 year programme and maintenance programme in place.

3. Privacy and Dignity

- Mixed sex ward at Newbury Hospital – plan underway to address this, due to be completed by April 2015.
- A&E – new observation bay opened November 2014.
- Use of Do Not Resuscitate / CPR – processes improved. Education programme underway.

4. Maternity and Midwifery premises and maintenance

- New ventilation unit being installed – on track for completion by end March 2015.

5. Consent Practice

- Work underway to develop standardised documentation Trust wide, supported by updated Patient Information leaflets outlining risks.

6. Staffing

- Nursing skill mix programme implemented to ensure sufficient levels of staffing across the Trust.
- Recruitment and Retention strategy developed and being implemented.
- Hospital at Night team expanded and review of doctors rotas underway.
- Additional staffing being recruited into Maternity (obstetricians and midwives),

7. Medical Records

- Trust wide programme implemented in June 2014 made up of 6 work streams to improve security, availability and content of patient records.
- Availability within outpatients already improved – now focusing on inpatients.

2.2 To ensure that all of the actions being taken are embedded and demonstrating improvement, the Trust has implemented an internal review process whereby staff visit ward areas each month via various means, such as Matrons Roundings to 'test' the issue is now addressed. This enables the plan to remain as a 'live' document, with supporting evidence to provide the Board with assurance.

2.3 The Trust has also collaborated with Bournemouth NHS Foundation Trust to implement a Peer Review arrangement. The first such review is due to take place at the end of January to provide further assurance against actions taken and to identify the need for any further work.

Contact: Caroline Ainslie, Nurse Director, Tel: 0118 322 7591

NHS England
Thames Valley

Reading Health and Wellbeing Board

Briefing Paper

General Practice Care Quality Commission Reports

Primary care plays a vital role in our health and social care system. Good primary care can play a significant role in improving the quality of people's lives, including those of the older people; people with long-term conditions; new mothers; children and young people and people with mental health issues. GPs work with others in the health and social care system to keep people well and are a trusted source of information and advice, often being the first port of call for those in need of care. Crucially, they are the central coordination point for the care of people who move between hospitals, care homes, care in the home and community health services.

All GP practices must be registered with the Care Quality Commission (CQC) and in the latter part of 2014 the CQC inspections have now been linked to ratings.
The new vision and direction for the Care Quality Commission is set out in the document *Strategy for 2013- 2016, Raising standards and putting people first* and in they also consulted via *A new start,* on changes to the way they regulate health and social care services.

New inspection ratings

☆ **Outstanding –** the service is performing exceptionally well.

● **Good** - the service is performing well and meeting our expectations.

● **Requires improvement** – the service isn't performing as well as it should and we have told the service how it must improve.

● **Inadequate** – the service is performing badly and we've taken enforcement action against the provider of the service.

● **No rating/under appeal/rating suspended** – there are some services which we can't rate, while some might be under appeal from the provider. Suspended ratings are being reviewed by us and will be published soon.

The changes included a focus on highlighting good practice; and a commitment to listen better to the views and experiences of people who use services. The inspections cover five key questions about services:
:
zz Are they safe?

- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

Practices in North and West Reading were visited during November 2014 and the reports on these inspections and the ratings of practices are now being published. The first of these are now available on the CQC website.

Western Elms Surgery, North and West Reading: **Rating Good**
http://www.cqc.org.uk/location/1-542961738

Peppard Road Surgery, North and West Reading: Rating: **Requires Improvement**
http://www.cqc.org.uk/location/1-570778343

Priory Avenue Surgery, North and West Reading: **Rating Inadequate**
http://www.cqc.org.uk/location/1-715881521

Where the CQC identifies areas requiring improvement the practice must produce and implement an action plan.

The CQC GP Inspection report on Priory Avenue Surgery will conclude that it should be placed in 'special measures' for six months as of 22 January 2015.

Priory Avenue

The CQC GP Inspection report on Priory Avenue Surgery concludes that it should be placed in 'special measures' for six months as of 22 January 2015.

This means the practice will have a short period of time in which to improve on all of the recommendations made in the report in order to bring the working of the practice up to standard. Additional support for the practice will come from the Royal College of GPs in the form of a package part funded by the practice and part funded by NHS England. The support is specifically designed to help practices that have been placed in special measures following CQC inspections. It is tailored to the individual practice and its development needs. They will assist with the development of the action plan required by the CQC as part of the work. This plan is currently being finalised.

Nicky Wadely
Contract Manager
NHS England
Jan 23rd 2015

Western Elms Surgery

Quality Report

317 Oxford Road, Reading, RG30 1AT
Tel: 0118 959 0257
Website: www.westernelms.com

Date of inspection visit: 11 November 2014
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Western Elms Surgery is located in a converted building in West Reading. There are approximately 16,000 patients registered at the practice. We carried out an announced comprehensive inspection of the practice on 11 November 2014. We visited Western Elms Surgery during this inspection. This was the first inspection of the practice since registration with the CQC.

The practice has had significant changes to staffing over the last two years, specifically changes in the GP partners. The patient population is very transient and this means the patient list changes a great deal over time. The practice monitors its appointment system and is aware of some concerns among patients about the ability to book non-urgent appointments. The practice responds to changes in demands by auditing its appointment system when there is concern about the demand for appointments. Patients were able to make appointments when they needed them. The premises were accessible to patients with limited mobility and all clinical areas were located on the ground floor. Patients told us staff were caring, friendly and considerate. The practice patient participation group is involved in the running of the practice and has been involved in making changes to the practice. For example, they lobbied the local authority for on street disabled parking due to the shortage of spaces at the practice and achieved their goal.

We spoke with nine patients during the inspection. We met two of the patient participation group, three GPs, the practice manager, assistant manager, three members of the nursing team and administration staff.

Western Elms Surgery practice was rated good overall.

Our key findings were as follows:

Patients were mostly positive about the care they received from GPs and nurses. All the patients we spoke with or who provided feedback told us staff were caring. Some patients were concerned about the booking appointments with their GP, saying they may have to wait up to three weeks to see them, but that they could see other GPs when they needed. All patients we spoke with said they could book an urgent appointment. The practice had systems to keep patients safe including safeguarding procedures and means of sharing information about patients who were vulnerable. Western Elms Surgery was hygienic and infection control was monitored. The practice was well maintained and equipment was serviced. There was strong strategic leadership and a positive culture which encouraged learning and openness.

Summary of findings

We saw one area of outstanding practice including:

- The practice had implemented an IT tool which assisted the practice in identifying patients at risk of unplanned admissions and 45 vulnerable patients per GP had been identified as requiring a care plan.

However, there were also areas of practice where the provider should make improvements.
The provider should:

- ensure nursing staff have an appropriate understanding of the Mental Capacity Act 2005.

.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Staff were trained in responding to medical emergencies and fire safety. There were arrangements to ensure staff could identify and respond to any concerns regarding vulnerable adults and children. Risks to patients were assessed and well managed. There were enough staff to keep patients safe and checks were in place to ensure staff were of good character. Medicines were stored safely. Controlled drugs were not stored in line with the practice's policy. The practice was clean and infection control processes were in place to ensure patients and others were protected from infection.

Are services effective?

Good

The practice is rated as good for effective. Data showed most clinical outcomes related to patient care were within the same range as the regional average. National guidelines was used in planning and delivering care and treatment. Patients' needs were assessed and delivered in collaboration with other services to ensure continuity of care. Staff received training appropriate to their roles and they had access to guidelines and protocols to support them in delivering care. The practice provided various opportunities for patients to access health checks and was pro-active in promoting patient health and well-being.

Are services caring?

Good

The practice is rated as good for caring. Patient feedback from the national survey and practice survey showed patients were positive about staff, reporting that they were caring, considerate and treated them with dignity and respect. Patients understood the care options available to them and were involved in decisions about their treatment decisions. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Staff understood the needs of their local population and considered patients' needs. Patients reported good access to the practice. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was

Summary of findings

an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy which incorporated long term planning to maintain and improve patient outcomes. Staff were clear about their responsibilities in the day to day running of the practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to support and assist staff in their activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this feedback was considered in the running of the practice. The practice had an active patient participation group (PPG) which was supported by the leadership team. Staff had received inductions, regular performance reviews and attended staff meetings and events. Training was managed using a monitoring log.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

Staff had systems to quickly identify vulnerable adults. Patients over 75 had a named GP to promote continuity of care. The premises were accessible to those with limited mobility. GPs provided care to patients in two local care homes and there were processes to ensure these patients had continuity in their care. Flu vaccinations were promoted for over 65s and the uptake was slightly below national average. The practice had participated in a dementia friends event organised by the patient participation group. There were strong working relationships with external services such as district nurses.

People with long term conditions

Good

Patients with health conditions were well managed by the practice. Where there were concerns from national data regarding diabetic check-ups the practice had introduced a new means of delivering diabetic care and this new system was being monitored. Patients were provided with access to regular health reviews in line with national standards. Off-site health checks were organised if patients could not attend the practice. There were walk-in cardiovascular clinics to improve patient attendance and flexibility. There were clinical leads for different long term conditions. Patients could be discussed at virtual reviews with external specialists from local hospitals without referring patients to local hospitals. Flu vaccinations for patients at risk of serious health concerns associated with flu (due to long term health conditions), were above national average.

Families, children and young people

Good

Staff had systems to quickly identify children at risk of abuse. There were regular meetings with the local child safeguarding team and other relevant services. There were walk-in family planning and sexual health clinics available which had been increased by the practice due to their success. The premises were accessible for prams and buggies. Thirty minute antenatal appointments and postnatal clinics were available. The practice worked with health visitors to share information and provide a continuity of care for new babies and families.

Working age people (including those recently retired and students)

Good

Extended hours appointments were available on Monday and Tuesday evenings until 8pm and on Saturday mornings from 8.30am to 12pm. The evening extended hours were walk in surgeries for

patients who could not attend during normal working hours. Some patients who worked were concerned about the waiting time for appointments when attending the practice. This was reflected in practice survey. Staff told us they were opportunistic in undertaking health checks, such as smears, when patients who did not attend regularly were at the practice.

People whose circumstances may make them vulnerable

Good

Staff had systems to quickly identify patients who may be vulnerable so they could take appropriate action when planning or delivering care. Disabled patients were considered in the design and layout of the building; including accessibility to reception, waiting areas and treatment rooms, plus there was a hearing aid induction loop. The practice had implemented an IT tool which assisted the practice in identifying patients at risk of unplanned admissions and 45 vulnerable patients per GP had been identified as requiring a care plan. The practice worked with local drug and alcohol support services to care for this vulnerable group of patients. Patients at a local probation hostel received care from the GP practice. A translation service was available for patients who did not speak English.

People experiencing poor mental health (including people with dementia)

Good

External support services were advertised on the practice website and in the waiting area for patients experiencing poor mental health. The practice provided Improving Access to Psychological Therapies (IAPT) access to patients experiencing poor mental health. Staff had regular meetings with the community mental health team (CMHT) and local psychiatrists to discuss and plan patient care. Annual health checks were offered and the practice achieved the national average in the uptake among patients experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of over 400 patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received above national average on positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 84% of nurses were good at listening to them. The survey also showed 89% aid the last GP they saw and 85% said the last nurse they saw was good at giving them enough time. This was above the local average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. There were some comments relating to the waiting time in reception and that it was sometimes difficult to book an appointment with a preferred GP. The national survey found that 86% of respondents found it easy to get through to this surgery by phone and 92% said the last appointment they got was convenient. Seventy eight per cent of patients described their experience of making an appointment as good, which is above the local average.

Patients told us waiting times in the surgery when they had a booked appointment could be long. The practice survey identified this as an issue with 33% of patients stating they waited a long time and 13% saying they waited more than 15 minutes. Some patients who worked full time told us that this caused a problem for them. However, the majority of feedback we received from speaking with patients and from comment cards was very positive in all aspects of the practice. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Data from the national patient survey showed 77% (below the local average) of practice respondents said GPs involved them in care decisions and 84% (above the local average) felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 89% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. This included any decisions about referrals which they said were explained clearly. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Areas for improvement

Action the service SHOULD take to improve

- ensure nursing staff have an appropriate understanding of the Mental Capacity Act 2005.

Summary of findings

Outstanding practice

- The practice had implemented an IT tool which assisted the practice in identifying patients at risk of unplanned admissions and 45 vulnerable patients per GP had been identified as requiring a care plan.

Western Elms Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice manager and practice nurse. The inspection was supported by a member of staff from the Surveys and Qualitative Intelligence team at CQC.

Background to Western Elms Surgery

Western Elms Surgery has a patient population of approximately 16,000. The premises are located on two floors with all treatment and consultation rooms on the ground floor. There is wheelchair access to the waiting area and to most consultation rooms. There are eight GP partners and a total of 12 GPs working at the practice, as well as locums. There is a mix of male and female GPs working at the practice. The nursing team consists of four practice nurses and two phlebotomists. Administrative and reception staff also work at the practice. Western Elms Surgery is a training practice.

The practice has a General Medical Services (PMS) contract. PMS contracts are subject to local negotiations between commissioners and the practice.

This was a comprehensive inspection.

We visited Western Elms Surgery 317 Oxford Road, Reading RG30 1AT.

The practice has opted out of providing Out Of Hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice and on the website.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Reading Healthwatch, NHS England and Public Health England. We visited Western Elms Surgery on 11 November 2014. During the inspection we spoke with GPs, nurses, the practice manager, deputy manager, reception staff, patients and representatives of the patient participation group (PPG). We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check

Detailed findings

the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients living in vulnerable circumstances
- Patients experiencing poor mental health (including patients with dementia)

The practice was located in an ethnically diverse area. Some sections of the local community were deprived according to national data. There were a higher proportion of young patients registered at the practice. The turnover of patients was high.

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed significant events and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred in recent years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting took place regularly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. We saw a significant event related to a needle stick injury. The incident had been investigated robustly and staff we spoke with were aware of investigation.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were available for staff. The practice had a dedicated GP appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. This may be children subject to child protection plans. This also enabled reception staff to identify vulnerable patients and take appropriate action to ensure they could make an appointment and see the right GP or nurse.

A chaperone policy was in place and visible on the waiting room TV screen and in consulting rooms. Chaperone training had been undertaken by all staff who performed the role. If nursing staff were not available to act as a chaperone some receptionists had also undertaken training and understood their responsibilities when acting as chaperones.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called Vision which collated all communications about the patient including scanned copies of communications from hospitals. We saw comprehensive records were stored for the patient record we reviewed.

We looked at meeting minutes from a child protection meeting. The practice identified when there were concerns about children on the at-risk register (a register of children whose circumstances make them vulnerable to abuse) and what considerations staff should take when caring for these children.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. There was a policy for expired and unwanted medicines which stated they should be disposed of in line with waste regulations.

We saw a record of a prescribing meeting from February 2014 with a representative from the local medicines management team. There were actions noted for the practice in response to changes in the use of certain medicines and where the practice needed to review their use of medicines. For example, the use of inhalers and insulin use were noted as needing a review.

Are services safe?

Vaccines were administered in line with legal requirements. There was a practice protocol for receiving and storing vaccines. The vaccines were stored within appropriate temperatures and there was a log of temperatures which indicated the practice checked the fridges regularly. The fridges were alarmed to ensure that staff were alerted if the temperature range required for the vaccines was not maintained.

Prescriptions and repeat prescribing were managed by a designated member of staff. The prescribing clerk was able to explain how they ensured all prescriptions were allocated to GPs to be signed and processed.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. Controlled drugs were stored in a secure cupboard and access to them was restricted and the keys kept securely. Two members of staff were allocated to receiving controlled drugs and undertaking stock checks. The practice policy for controlled drugs stated stock should be checked every month to ensure the stock list matched the actual store of medicines.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. All staff received training in infection control specific to their role at regional training days. We saw evidence the practice carried out audits every two months and improvements were identified and actions listed. We saw from sequential audits that actions were completed. For example, one audit identified that some clinical worktops were not just being used for clinical purposes as other materials were being stored on them in one treatment room. We noted that all clinical work tops were clutter free and ready for use by the staff for clinical purposes.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

There was also a policy for needle stick injury. This was available on the intranet, although this was not displayed on clinical treatment room walls. One member of staff did not know that they should ideally attend occupational health within one hour, if possible, when we asked them what action they should take in the event of a needle stick injury. All other staff we asked were aware of the appropriate action to take. We saw from significant events there had been one needle stick injury within the last year and the appropriate action was taken.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had tested the water tanks on the premises for legionella (a germ found in the environment which can contaminate water systems in buildings). The practice did not have a full risk assessment for the building but the checks ensured that the tanks, water supply and air conditioning units were legionella free.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was in good working order and we saw equipment maintenance logs and other records that confirmed it was well maintained. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales. There were arrangements for the ordering and stock checking of medical supplies such as swabs and single use medical equipment for clinical procedures.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting staff. The practice did not check all the GP partners' registration with the General Medical Council

Are services safe?

(GDC) as a part of their staff checks and some partner's staff files did not contain proof of registration. However, we were shown evidence that all the GPs were registered to practice by the end of the inspection.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff informed us there was a rota system in place for all the different roles in the practice to ensure there were enough staff on duty. The practice had not used any locum GPs for a number of months. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place monitor and manage risks to patients, staff and visitors to the practice. These included regular checks of the building, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which was reviewed yearly.

We saw that any identified risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Risks were assessed and managed. For example, there was a control of substances hazardous to health (COSHH) risk assessment for the storage of chemicals. Fire protocols were followed, such as testing the alarm system and regular fire drills. A fire risk assessment was undertaken with an action plan to mitigate risks in the event of a fire and to prevent the risk of fire. We saw the action log showed the action was being completed. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice. These included medicines for the treatment of a number of conditions. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff had access to templates for managing and accessing certain conditions. We found they reflected up to date national guidance. Staff told us that changes to national guidance were disseminated to them through meetings, emails and through information discussions. The patient records we reviewed showed GPs and nurses managed patients' care, in line with NICE guidelines.

Patients had a named GP which helped the practice to provide continuity in patients' care. The GPs told us they led in specialist clinical areas such as diabetes and respiratory diseases and that practice nurses supported this work which allowed the practice to focus and manage specific conditions more efficiently. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this had happened.

The practice used computerised tools to identify patients with complex needs and worked with external services to implement multidisciplinary care plans. These were documented in patients' notes. The practice had implemented a tool called 'QAdmission' which assisted the practice in identifying patients at risk of unplanned admissions based on a number of risk parameters. Around 45 vulnerable patients per GP had been identified and had care plans written to reduce the risk of hospital admissions.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The Quality Outcomes Framework (QOF) showed patients with long term conditions were assessed at regular intervals and their care planning ensured that they were seen by a GP or nurse when they needed a health check. Patients with concerns regarding their health conditions could be discussed at virtual reviews with external specialists from local hospitals, enabling GPs to access specialist advice without referring patients in every circumstance of managing complicated health problems.

Staff told us reviews referrals were undertaken via peer review between GPs to ensure that referrals were appropriate. A GP partner told us GPs were aware of each other's lead roles and would refer patients to another GP where this was possible to speed up assessments of patients' needs and reduce the need for referrals to secondary care in many cases.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for patients

Staff from across the practice had roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts, prescriptions management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in recent years. We saw some were examples of completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We saw audits undertaken on the treatment of gout, atrial fibrillation and urinary tract infections using a specific anti-biotic. Of the two audits we saw were completed (repeated) there were clear lessons learnt and action for the individual GPs or practice to consider. We saw audits were stored in a location accessible for all staff and the outcomes were discussed at clinical team meetings.

The practice used the QOF (a national performance measurement tool) to identify whether patient assessment and care met national standards. In the 2012/13 QOF there were concerns about the lack of certain assessments for diabetics. Following the results, and as a result of a change of staffing, the practice implemented a new system of managing diabetic care led by a GP. The GP worked closely with the nursing team to ensure that the practice's performance in managing diabetes was improved and the GP told us that the monitoring of these changes was indicating a significant improvement in QOF results. Staff spoke positively about the culture in the practice around audit and quality improvement.

Are services effective?

(for example, treatment is effective)

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicine alerts when the GP went to prescribe medicines.

Effective staffing

Practice staffing included GPs, nurses, managerial and administrative staff. We reviewed a staff training log and saw that nearly all staff were up to date with attending courses such as annual basic life support, safeguarding adults and children, information governance, equality and diversity and fire safety. The deputy manager used the log to monitor training.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. A diabetes nurse had recently undertaken specific training in diabetic care. As this was a training practice, GPs who were in training to be qualified as GPs were supervised and supported by their GP mentors.

Working with colleagues and other services

The practice had close links with staff from other services including district nurses, health visitors and midwives who they worked with in delivering patients' care. The practice had a procedure for passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received.

The practice held multidisciplinary team meetings and other means of communication with external services. This included liaison with the community mental health team via bi-monthly meetings and contact with psychiatrists. Gold standards meetings were held to manage the care for patients who were on the end of life register, including local support organisations and district nurses. The practice participated in child protection meetings where specific cases of concern were discussed. The staff we spoke with told us information sharing with district nurses, health visitors and the local social care team worked well and they spoke positively of the relationship with these external professionals.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, GPs told us patient information was frequently shared via special notes from the local out of hours providers. The system used by the practice meant the information could be shared instantly. Electronic systems were also in place for making referrals. Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record called Vision was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Nurses were aware of the Act but did not fully understand when or how it should be applied. There was no formal training provided to nurses on the Act.

There was a consent policy which included how to gain consent, where this should be recorded and issues related to gaining consent from children. There was a section on patients who lack capacity to consent. There was a MCA 2005 policy to support staff on how to assess patients who may lack capacity to determine whether they could or could not consent to their care. There was guidance on how to reach a best interest decision in the policy. Some nurses told us they would refer any concerns where a patient may lack capacity to a GP in order to reach a decision. The consent policy referred to the Gillick competencies for the ability of children to consent to treatment.

Health Promotion & Prevention

New patients had their medical records assessed and those who were on a repeat prescription were given an appointment with registered GP to discuss their needs. Staff told us they were proactive about providing health checks for patients, such as offering smears to patients during routine appointments. Walk in clinics for family planning and sexual health were available to encourage patients to attend for check-ups. Annual physical health

Are services effective?

(for example, treatment is effective)

checks were provided to patients with mental health problems and QOF data showed the practice was achieving similarly to other practices nationally in meeting annual health checks for these patients.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities these patients were offered an annual physical health check. The practice had identified the smoking status of 81% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients.

The practice offered a full range of immunisations for children, patients at risk of specific conditions and travel advice and vaccines. Last year's performance for child immunisations was similar to national average. Flu vaccinations were offered to patients at risk of serious health concerns associated with flu (due to long term health conditions) and the uptake was above national average and also offered to those over 65 where the uptake was slightly below national average.

External support services were advertised on the practice website and in the waiting area. This included mental health and drug addiction support services.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of over 400 patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received above national average on positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 84% of nurses were good at listening to them. The survey also showed 89% aid the last GP they saw and 85% said the last nurse they saw was good at giving them enough time. This was above the local average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. There were some comments relating to the waiting time in reception and that it was sometimes difficult to book an appointment with a preferred GP. However, the majority of feedback we received from speaking with patients and from comment cards was very positive in all aspects of the practice. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy. Reception staff were careful to prevent patients overhearing potentially private conversations.

The practice's patient charter indicated patients should be treated without discrimination and consideration to their religious beliefs and cultural and personal preferences. The charter did not refer to ensuring patients' sexual orientation was respected in the delivery of care. We saw no evidence that patients experienced any kind of discrimination.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 77% (below the local average) of practice respondents said GPs involved them in care decisions and 84% (above the local average) felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 89% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. This included decisions about referrals which they said were explained clearly. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. Notices in the patient waiting room, on the TV screen and patient website signposted patients to a number of support groups and organisations, such as dementia and carer support. The practice's computer system alerted GPs if a patient was also a carer. A carers audit was undertaken to identify what improvements could be made to support carers in

Are services caring?

accessing the practice and other local support services. Reception staff were given training in how to communicate effectively with patients who may be challenging due to emotional or mental health problems.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood by the leadership team and staff who delivered care to patients. For example, nurses told us they were aware of the local problems with drug addiction and worked with local drug and alcohol support services to care for this vulnerable group of patients.

There had been a significant change the GP partners over the last two years but staff told us this had been managed to ensure there was consistency in patients' care. The practice did not use locums. Patients reported that on the whole there was good continuity of care and reasonable accessibility to appointments with a GP of choice. Longer appointments were available for patients who required them such as long term condition reviews, postnatal check-ups and health checks for patients with learning disabilities This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP. Patients who could not attend the practice were offered home visits when needed. The practice worked with health visitors in providing postnatal care.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, disabled parking was sought from the council to help access for disabled patients and the PPG was successful in achieving this goal.

The gold standards framework for end of life care was used by the practice. There was a palliative care register and regular internal as well as multidisciplinary meetings to discuss patients and their families and support needs. The practice provided Improving Access to Psychological Therapies (IAPT) access to patients experiencing poor mental health.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. GP partners told us the practice registered patients who had no fixed abode. A telephone translation service was used to assist in providing care to patients who could not speak English.

The practice provided equality and diversity training to staff. The premises and services had been adapted to meet the needs of patients with limited mobility. Automatic double doors and level access had been installed. There was a verbal and visual call system for patients with either hearing or visual impairments. An induction loop was available for patients who had hearing impairments. The practice provided care to patients in a local probation hostel.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. Extended hours appointments were available on Monday and Tuesday evenings until 8pm and on Saturday mornings from 8.30am to 12pm. The evening extended hours were walk in surgeries for patients who could not attend during normal working hours. Comprehensive information was available to patients about appointments on the practice website and in the reception and waiting areas. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There was also information for patients on how to access out of hours care and treatment on the website for when the practice was closed.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients told us if they wanted to see the GP of their choice it could take up to three weeks. The national survey found that 86% of respondents found it easy to get through to this surgery by phone and 92% said the last appointment they got was convenient. Seventy eight per cent of patients described their experience of making an appointment as good, which is above the local average. To meet the capacity demands on the practice, there has been an increase in four consultation rooms in recent years to enable more patients to be seen. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Patients told us waiting times in the surgery when they had a booked appointment could be long. The practice survey identified this as an issue with 33% of patients stating they

Are services responsive to people's needs?

(for example, to feedback?)

waited a long time and 13% saying they waited more than 15 minutes. Some patients who worked full time told us that this caused a problem for them. The practice offered phone consultations when requested by patients. This enabled patients who worked to access advice from GPs. A cardiovascular disease clinic was run in the evenings. Drop in clinics for family planning and sexual health were available.

The practice was situated on the first and second floors of the building with services for patients on the ground floor. The practice had provided space for the use of patients with mobility scooters and wheelchairs in reception and wide door ways to a corridor where the majority of consultation and treatment rooms were located. This made movement around the practice easier and helped to maintain patients' independence.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We saw that information was available to help patients understand the complaints system in the reception area in the form of a notice and leaflets. We looked at several complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely manner.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review from March 2014 and no themes had been identified, however lessons learnt from individual complaints had been discussed at meetings and acted upon. We saw complaints were discussed regularly at meetings.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

There were significant changes to the GP partners in recent years which required strong strategic leadership to enable to practice to continue to deliver a continuity of care to patients. For example, roles such as clinical specialisms had to be re-attributed to new staff and where necessary new processes for managing patient care. The practice was in the process of changing the way diabetes care was delivered and all the relevant staff were involved in this change. Clear strategic goals were set to ensure patient care was at the centre of how the practice operated. A decision was made by the leadership team to set a cap for the patient population due to the high numbers of patients joining and leaving the practice. This enabled the practice to ensure capacity met demand. There was also a decision to stop using locum GPs in 2013 partly to improve the continuity of care and the practice had achieved this goal by ensuring there were adequate staff available to cover when GPs were not able to work or on leave.

We found details of the patient charter displayed for staff and patients although it did not include patients' sexual orientation when referring to the considerations of staff in delivering patient care. The practice operated a policy of non-discrimination in the delivery of its services.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the intranet on any computer within the practice. We looked at several of these policies and procedures. All the policies and procedures we looked at had reviews noted and a date of review for future reference.

The practice held regular governance meetings. We looked at minutes from a governance meeting and found that performance, quality and risks had been discussed. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. Staff told us that QOF data was regularly discussed at monthly team meetings and there were leads in different areas of the QOF. The practice had completed a number of clinical audits, where action was taken to improve the service. This included a diabetes audit undertaken following underperformance on the QOF due to specific health checks not being achieved for some diabetics

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been carried out on clinical treatment rooms. A fire risk assessment and resulting actions were in place.

Leadership, openness and transparency

Staff told us there was a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, involved in the running of the practice, well supported and knew who to go to in the practice with any concerns.

Staff were involved in meetings, where they could receive important communication and provide feedback. Staff told us that there was an open culture within the practice. There were away days held twice a year but these did not involve the whole staff team, only GP partners and the management team.

We were shown the electronic staff handbook that was available to all staff, this included sections on equality and harassment, whistleblowing, confidentiality and bullying and harassment.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys and comments and complaints. We looked at the results of the annual patient survey and saw that the findings were considered and any action to improve the service provided was included in the survey report. Some of this was information for patients such as where to gain access to the complaints policy.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups, but the members we spoke with described their difficulty in recruiting younger patients and broadening the representation from different ethnic backgrounds. The PPG had been pro-active in trying to recruit new members. For example, PPG members engaged with mothers during postnatal clinics during the summer in

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

2014. The PPG members told us they were fully involved in designing and analysing of the last patient survey. They told us all eight partners had attended a recent PPG meeting. They had been supported in organising health talks for patients and these had been well attended. The PPG was valued and supported by the practice leadership.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues or the leadership team. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had regional training away days where guest speakers and trainers attended. Western Elms Surgery was a GP training practice and supported GP trainees through supervision and mentoring.

The practice had completed reviews of significant events and other incidents and shared learning outcomes with staff via meetings to ensure the practice maintained a safe environment and, where necessary, improved outcomes for patients.

Peppard Road Surgery

Quality Report

45 Peppard Road
Caversham
Reading
Berkshire
RG4 8NR
Tel: 0118 9462224
Website: www.peppardroadsurgery.co.uk

Date of inspection visit: 06/11/2014
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Peppard Road Surgery is located in an urban area of Berkshire. It provides primary medical services to approximately 2200 registered patients.

We carried out an announced, comprehensive inspection on 6 November 2014.

We visited the practice location at 45 Peppard Road, Caversham, Reading, Berkshire,RG4 8NR

Peppard Road Surgery is rated as requires improvement overall.

Our key findings were as follows:

- The practice is rated as requires improvement for safe. We identified areas of concern regarding aspects of staff training, for example, safeguarding children and vulnerable adults and an inadequate recruitment process, including lack of Disclosure and Barring service checks for staff.
- The practice is rated as requires improvement for effective. We identified one area of concern regarding lack appraisals for all staff. The GPs had a thorough understanding of patients' healthcare needs and provided care in line with local and national guidance. However, Quality and Outcomes Framework data showed patient outcomes were variable with the practice performing better in some areas than others.
- The practice is rated as good for caring. Feedback from patients and survey data showed the practice performed above the clinical commissioning group (CCG) and national averages on most aspects of patient satisfaction. We heard many examples of compassionate care from patients.
- The practice is rated as good for responsive. The practice performed significantly better than the CCG average for access to appointments. The practice did not have an accessible complaints policy in place.

Summary of findings

- The practice is rated as requires improvement for well-led. We identified areas of concern regarding the lack of regular performance reviews for staff. The practice did not proactively seek feedback from patients through a patient participation group.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must

- Ensure that criminal records checks through the Disclosure and Barring Service or risk assessments are carried out.
- Ensure staff are supported through appraisals to identify training and development needs
- Ensure staff receive appropriate regular training, for example in basic life support, safeguarding children and vulnerable adults and health and safety

We have issued two compliance actions for the regulations relating to Requirements relating to workers and Supporting workers.

In addition the provider should:

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure systems are in place for the management of legionella
- Ensure complaints information is accessible to patients
- Ensure feedback is sought from patients, for example, through a patient participation group.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. We identified a number of areas of concern: there was a lack of safeguarding children training for reception and administration staff and lack of safeguarding vulnerable adult training for all staff. Recruitment checks were not documented in accordance with current regulations including lack of Disclosure and Barring check or risk assessment. There was no system in place for the management of legionella. Cleaning materials were not stored securely. Administration and reception staff had not received training in basic life support. A business continuity plan was in place but had not been fully completed. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Medicines were handled safely and fridge temperatures were checked daily.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. We identified one area of concern regarding support for staff through lack of training for administration and reception staff and lack of appraisals for all staff. Patients' needs were assessed and care was planned and delivered in line with local and national guidance. This included assessment of capacity and the promotion of good health. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with respect and compassion.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good satisfaction with access to the practice for urgent/ same day appointments and routine appointments. Complaints information was not easily accessible although there was evidence demonstrating that the practice responded quickly to issues when they were raised. There was evidence of shared learning from complaints with staff to improve services.

Summary of findings

Are services well-led?

The practice is rated as requires improvement for well-led. We identified a number of areas of concern: The practice did not proactively seek feedback from patients through a patient participation group (PPG). Staff did not receive regular performance reviews and were not supported to develop in their roles. There were systems in place to monitor and improve quality and identify risk. For example, through fire risk assessment and infection control audit.

Requires improvement

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Requires improvement

The practice is rated as requires improvement for care provided to older people. We identified concerns relating to staff recruitment, training and development. The practice had a lower proportion of patients over 55 years compared to the clinical commissioning group (CCG) and national averages. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, allocating older patients early appointments to avoid them travelling home in the dark. The practice was responsive to the needs of older people, including offering home visits and prioritised care for patients with complex needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. We identified concerns relating to staff recruitment, training and development. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had regular contact with their GP to check their health and medicines needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. We identified concerns relating to staff recruitment, training and development. The practice has a higher proportion of patients up to the age of nine years compared to the local clinical commissioning group (CCG) average. Immunisation rates were in line with all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours. The practice worked in partnership with midwives, health visitors and school nurses to deliver care.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group of the working-age people (including those recently retired and students). We identified concerns relating to staff recruitment, training and development. The practice had a higher proportion of patients between 30 to 44 years compared to the clinical commissioning group (CCG) and national averages. The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, for example one late evening surgery was provided each week. The practice performed significantly above average, compared to the local CCG, for patient satisfaction with the access to appointments. The practice was proactive in offering opportunistic health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. We identified concerns relating to staff recruitment, training and development. The practice serves a population which is more affluent than the national average. The practice did not have a register for patients with learning disabilities, although had some younger patients with learning disabilities and met their needs appropriately. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. GPs were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out-of-hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). We identified concerns relating to staff recruitment, training and development. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Six out of nine patients with severe mental health conditions had care plans in place. The GP referred patients to the memory assessment clinic when needed. The practice had a system in place to follow up on patients who had been discharged from hospital to support them in the community.

Summary of findings

What people who use the service say

The 2014 national GP survey results for Peppard Road Surgery based on 103 (39%) responses showed the practice was better in all areas relating to making an appointment compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of interacting with the nurse during consultations. However, we found the low nurse scores were due to a large proportion of respondents stating the question did not apply to them.

During the inspection on 6 November 2014 we spoke with six patients. All the patients we spoke with were very satisfied with all aspects of the care they received including access to appointments. We received 50 comment cards from patients who had visited the practice over the previous two weeks. All the comment cards expressed gratitude and praise for the care provided by the staff.

Areas for improvement

Action the service MUST take to improve

- Ensure that criminal records checks through the Disclosure and Barring Service or risk assessments are carried out as part of the staff recruitment process.
- Ensure staff are supported through appraisals to identify training and development needs
- Ensure staff receive appropriate regular training, for example in basic life support, safeguarding children and vulnerable adults and health and safety

Action the service SHOULD take to improve

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure systems are in place for the management of legionella
- Ensure complaints information is accessible to patients
- Ensure feedback is sought from patients, for example, through a patient participation group.

Outstanding practice

The practice provided outstanding access to appointments. The national GP survey indicated 97% of patients described their experience of making an appointment as good compared to the CCG average of 76% and similarly 97% found it easy to get through by phone compared to CCG average of 76%. This was confirmed by the 50 comment cards and patients we spoke with.

Continuity of care was provided by the practice through the availability and longevity of GPs and staff. This enabled the GPs to have acquired extensive knowledge about patients changing health care needs and social circumstances. Feedback from patients indicated this information was used during regular consultations to provide meaningful emotional support and personalised care.

Peppard Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and an Expert by Experience.

Background to Peppard Road Surgery

Peppard Road Surgery is located in a detached house in an urban area. It provides primary medical services to approximately 2200 registered patients. The practice has nine staff, including two GP partners: one male GP and one female GP, one practice nurse, administration and reception staff. The senior partner also manages the practice.

The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local clinical commissioning group (CCG) average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

We visited the practice location at 45 Peppard Road, Caversham, Reading, Berkshire, RG4 8NR

The practice has opted out of providing out-of-hours services to its own patients and uses the services of a local out-of-hours service. The practice holds a General Medical Services contract.

The announced, comprehensive inspection at Peppard Road Surgery took place on 6 November 2014. This was the first inspection since registration. We spoke with six patients and six staff during this inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Prior to the inspection we contacted the North and West Reading Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Peppard Road Surgery. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 6 November 2014. We spoke with six patients and six staff. We also reviewed 50 comment cards from patients who shared their views and experiences.

Detailed findings

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including two GPs, practice nurse, administration and reception staff.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local CCG average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed an incident related to incomplete labelling of urine samples. The delays in obtaining results which potentially impacted on patient care and treatment.

We reviewed ten safety records and incident reports and discussed these with the GP. This showed the practice had managed these consistently over time and so could evidence a safe track record over a period of time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence that learning had taken place across GPs and nurses. All staff including receptionists, administrators and nursing staff were aware of the system for raising issues in the practice. We reviewed reports of ten incidents recorded in the previous 18 months. They all showed evidence of analysis, reflection and learning.

National patient safety alerts were received and acted upon by the senior GP. For example, we saw an information notice at the entrance to the practice regarding the outbreak of the viral disease, Ebola, in Africa.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that GPs and nursing staff had received relevant role specific training on safeguarding children. Although, reception and administration staff had not received formal regular training on safeguarding children and vulnerable adults, they had an awareness of potential signs of abuse and said they would refer any concerns to the GP. We noted safeguarding vulnerable adult training for staff was scheduled to take place in the next few months. GPs demonstrated a good understanding of how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. Contact details for the local authority safeguarding team were easily accessible.

One of the GPs was the safeguarding lead for children and vulnerable adults. All staff we spoke with were aware who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and notices available in consulting rooms, although not in the waiting area. Reception and administration staff had been trained as chaperones by the senior GP and were frequently used in that capacity. However, they had not had Disclosure and Barring Service checks performed. Two patients told us they recalled being offered a chaperone prior to an examination.

Patient's individual records were written and managed in a way to help ensure safety. The senior GP preferred handwritten notes. An electronic system (SystmOne) was also used, this collated all communications about the patient including scanned copies of communications from hospitals. The practice had a system for identifying vulnerable patients including children and older patients. Patients on long term medication were regularly reviewed to ensure the appropriateness of continued use.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Fridge temperatures were checked and recorded daily.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance, for example for the administration of flu vaccine.

Prescriptions were stored securely when not in use. The GPs handled all prescriptions personally including requests for repeat medicines. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Requires improvement

Are services safe?

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the practice to be clean and tidy. A regular, long standing cleaner carried out cleaning according to the practice's cleaning schedule three times a week. Staff and patients we spoke with told us they had no concerns about the standard of cleanliness or hygiene.

The practice's lead for infection control was the senior partner. An infection control audit had been carried out in the previous month and an action plan in place to make improvements. Staff had not had infection control training.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Regular checks had not been carried out to reduce the risk of infection to staff and patients.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw a sample of equipment maintenance checks and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Cleaning materials were stored in a cupboard, however it was not secure and located in an area accessible to patients.

Staffing and recruitment

The practice had nine staff, the majority of whom had been in post for many years. We reviewed the record of one member of administration staff who had been recruited in the last two years. We found there was no record of appropriate recruitment checks. For example, proof of identity, references, health check. There was no record of Disclosure and Barring Service (DBS) checks or a DBS risk assessment for administration or reception staff and the senior GP confirmed DBS was not sought for reception or administration staff, although they were expected to act as chaperones when needed.

All staff except for the senior partner worked part-time, most staff worked six to 12 hours per week. Administration and reception staff worked flexibly and covered periods of absence due to sickness or holiday. The practice had not used GP locums for approximately 15 years; the two GPs provided cover for each other. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice was located in small premises and if issues were identified by staff they were immediately raised with the senior GP. For example, security of the practice had recently been improved to safeguard patients and staff.

The practice had a health and safety policy statement, however regular environmental risk assessments were not carried out. Staff had not received training in health and safety.

Systems were in place to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients with complex conditions were seen regularly to monitor their condition and review their medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing the GPs and nurses had received training in basic life support and it was scheduled to be updated. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with were aware of the location of this equipment and records we saw confirmed these were checked regularly. Administration and reception staff had not received training in basic life support.

Requires improvement

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, key particulars such as location of the fuse box, water stop valve and contacts of suppliers had not been completed.

Fire equipment was in place; a fire risk assessment had recently been undertaken and the report that included actions required to maintain fire safety was pending. Staff had not received fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The evidence we reviewed confirmed the practice aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The GPs worked very closely and over time had built up extensive knowledge about patients and their family support networks, including social circumstances. This enabled the GPs to tailor treatment to meet patients' healthcare needs. The female GP had an interest in gynaecology, family planning and child health.

All referrals, except for suspected cancers which needed to meet the national two week referral target, were made through Choose and Book. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Referral rates were below the CCG average and were regularly discussed with the CCG by the GPs.

Management, monitoring and improving outcomes for people

The senior partner had overall responsibility for all aspects of patients' care. Designated administration staff had specific responsibilities to ensure records were up to date with, for example child immunisation or whether a patient had attended for cervical smear.

The practice made available one clinical audit which we reviewed. The clinical audit that had been undertaken in the last year. It involved patients treated with vitamin B12 injections and highlighted those who had not attended. A re-audit was planned to review progress.

The practice also used the information they collected for the quality and outcomes framework (QOF- a national voluntary performance measurement tool) and their performance against national screening programmes to monitor outcomes for patients. The practice achievement for the QOF clinical domain was 88%, which was lower than the CCG average. The practice was aware of the areas it had not achieved on, for example it had not referred diabetic patients to a structured education programme, although the majority of other indicators had all been achieved for diabetes. The CQC GP specialist advisor saw a number of examples where the GPs had sought advice from clinical specialists, for example, via the regular virtual diabetic clinics. Another example related to advice from a consultant haematologist. The GPs then applied the learning from this in subsequent cases. For example, to seek genetic advice when there was an unusual blood result.

We saw data from the local clinical commissioning group (CCG) to show the practice participated in the prescribing quality scheme including meeting diabetes targets. The GPs monitored their patients with long term conditions closely through regular appointments rather than issue repeat prescriptions without seeing the patient. The GPs discussed patients to agree strategies to monitor and review those patients' needs. Repeat prescription requests were taken by email and in writing and handled by the GP personally. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, the practice monitored accident and emergency attendance and was below the CCG average.

Effective staffing

We identified one area of concern regarding the lack of training, for example: fire training, safeguarding, infection control, basic life support, for reception and administration staff. There was also a lack of appraisals and personal development plans for nursing staff, reception and administration staff. Staff were clear of their own responsibilities and duties, however non-urgent tasks were not always covered if a member of staff was absent. For example, summarising new patient registrations.

Both GPs were up to date with their yearly continuing professional development requirements and the senior GP had been revalidated in 2013. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has

been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All aspects of the revalidation had been completed.

The practice nurse kept up to date with the required skills necessary to perform her duties. For example, we saw certificates of attendance at wound management courses, diabetes and health and safety.

Working with colleagues and other services
The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received electronically and by post. GPs were responsible for reading and actioning any issues arising from communications with other care providers on the day they were received.

The practice held quarterly meetings with the multidisciplinary team including the district nurse, palliative care nurse and occasionally the community matron. These meetings were a forum to discuss the needs of patents with complex needs and vulnerable patients, for example, those with end of life care needs. The practice worked with the community diabetic specialist via virtual clinics. A regular virtual diabetes clinic was held every two to three months with a community diabetic specialist to discuss and advise on the management of particular patients.

The practice worked with the mental health care team to manage patients with severe mental health problems; six out of nine patients with severe mental health conditions had care plans in place.

Information sharing
The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Referrals were made electronically through Choose and Book.

The practice used paper based records in conjunction with the IT system (SystmOne).The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff were able to coordinate, document and manage patients' care using both systems, although there was some duplication of paper and electronic records.

Consent to care and treatment
We found GPs and nurses were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the GP and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The GP described a number of patients where their capacity had been determined to uphold their rights. For example, one patient who refused a particular medicine due to the potential side effects. The patient's capacity was assessed and the decision recorded in the patient's notes. Another patient who wished to live at home had been referred to the memory assessment clinic to ensure their best interest was upheld. They were enabled to remain at home with support from social services and the community matron.

All GPs and Nursing staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Written patient consent was not documented, although the risks of the procedure was explained and documented in the notes, for example, when fitting an intra-uterine contraceptive device.

Health promotion and prevention
It was practice policy to offer all new patients registering with the practice a health check. The senior GP told us the practice promoted a holistic approach to care and GPs maximised contact with patients to maintain or improve mental, physical health and wellbeing. For example, opportunistic health checks were carried out for patients over the age of 45 years. The practice had also identified the smoking status of 78.8% of patients over the age of 16. The practice consistently achieved the CCG target of 70% for flu immunisations, one of the GPs visited housebound older patients to administer the flu vaccine.

The practice's performance for cervical smear uptake was in line with the CCG average (81%). The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

There was wide range of leaflets in the patient waiting room related to health conditions and support groups/ organisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2014 national GP survey results for Peppard Road Surgery based on 103 (39%) responses showed the practice was better in all areas relating to making an appointment compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of interacting with the nurse during consultations. However, the low nurse scores were due to a large proportion of respondents stating the question did not apply to them. In most other areas the practice performed better or close to the CCG average. Ninety four per cent of patients described their overall experience of the practice as good compared with the CCG average of 89%. The number of patients who said they would recommend the practice was lower than the CCG average, however, the number of patients who responded negatively to this question was small.

During the inspection on 6 November 2014 we spoke with six patients. Five out of six patients had partners and children attending the practice and five patients were working age. Two of the patients told us they felt the GP knew their condition very well. For example, if the patient had been seen in hospital a few days after discharge. Four out of six patients noted the attention GPs paid to the pace of information they imparted, particularly when speaking to children and made every effort to involve them in decision making. An example of compassionate care by the practice was in the allocation of earlier appointments for older patients. This was to avoid unaccompanied older patients travelling home in the dark.

All the patients we spoke with were very satisfied with all aspects of the care they received including access to appointments. Everyone was able to obtain urgent and non-urgent appointments when needed. We received 50 comment cards from patients who had visited the practice over the previous two weeks. There was one minor negative comment included on one otherwise positive card; the remainder all described friendly, empathetic care and highlighted the ease of obtaining appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was one area of the practice where there was a potential breach of confidentiality; patients' names on the appointment diary were visible by patients waiting at the reception desk.

We observed reception staff greeted patients by name and were polite in their interactions. The GP called each patient into the consulting room personally. Waiting times in the practice were short; five minutes or less. This was confirmed by the national GP survey results.

All administration, reception and practice management staff wore identity badges. During the inspection we witnessed a number of caring and discreet interactions between staff and patients to preserve their dignity and privacy. The practice scored above the CCG average for the level of privacy when speaking to receptionists at the practice.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed the practice was rated above or similar to national average for doctors and nurses involving patients in decisions about their care. For example, the GP specialist advisor saw a record of a patient who had refused a particular course of treatment due to the potential side effects and this had been documented in their notes.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who needed language support. However, the GPs

Good

Are services caring?

we spoke with did not routinely consider the use of independent translation services when the patient was accompanied by a relative or friend who could act as a translator.

The practice did not maintain a formal register for patients with learning disabilities. However, the GPs and staff knew their younger patients with learning disabilities and reviewed them regularly. The GP specialist advisor saw how patients with learning disabilities and those with mental health conditions were supported to make decisions through the use of care plans which they were involved in agreeing. For example, one vulnerable patient had been referred to hospital for treatment in accordance with their wishes to reduce their stress and anxiety.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received indicated patients were very positive about the emotional support they were offered. Especially, for example, following bereavement.

All the patients we spoke with mentioned how much they valued the emotional support provided by the GPs during consultations and particularly at times of acute illness and bereavement. The GPs encouraged older patients to attend appointments with their younger relatives. This provided opportunities for the GP to involve the family in the care of the older patient and provide information and support.

Carers were identified in the notes and recorded in the patient registration form. Information for carers such as support groups was available in the waiting area.

The practice told us they had a high proportion of working age professionals in stressful occupations. Some of whom had private health insurance. The GP referred patients for anxiety or stress related conditions to private clinics or NHS talking therapies.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local clinical commissioning group (CCG) average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

The practice had two GPs and patients were able to see the male or female GP. Home visits and longer appointments were available for older people, people with long term conditions and those in vulnerable circumstances to meet their needs. The practice had a palliative care register and had regular multidisciplinary meetings to discuss patients and their families' care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example, with the out-of-hours service provider.

Tackling inequity and promoting equality

The practice was located on two floors with patient areas on the ground floor. There was ramp access to the entrance for wheel chairs and push chairs. Accessible toilet facilities were available for all patients attending the practice but there was no baby changing facilities. The practice told us they had no patients in wheelchairs, although sometimes patients with mobility scooters did attend. The reception desk was at a height suitable for most patients.

Parking in the area had become difficult due to commuters using the road for all day parking. The practice had recently campaigned with local residents to introduce parking restrictions outside the practice. This was to ensure parking spaces would be available for patients, particularly older patients or those with mobility difficulties. This was due to come into effect shortly.

The GP specialist advisor saw notes to show the GP regularly communicated with some patients who either had a hearing impairment or had difficulty communicating verbally. This enabled patients to have questions answered without time constraints, in between appointments.

Access to the service

Patients were very satisfied with the appointments system urgent and routine appointments. The national GP survey indicated 97% of patients described their experience of making an appointment as good compared to the CCG average of 76% and similarly 97% found it easy to get through by phone compared to CCG average of 76%. This was confirmed by the 50 comment cards and patients we spoke with.

The practice was open 8am to 6.30pm weekdays, except Thursdays. GP appointments were available between 9.15am to 11.15am weekdays and 4.30pm to 6.00pm every week day expect Thursday, when a late evening surgery; 5.30pm to 7pm (and later) was available. Nurse appointments were available on Tuesday mornings only.

Basic information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Online booking and online repeat prescription requests were not available.

Patients told us the registration process was quick and efficient. All new patients were seen by the GP as part of the registration process.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns although, complaints information for patients was not displayed in the waiting area or on the practice website.

Staff said complaints were very rare and if they did receive any complaints they would refer them to the GP. The senior GP handled all complaints. The practice had received four complaints since January 2013, which had all been

Good

Are services responsive to people's needs?

(for example, to feedback?)

resolved. We found the senior GP handled complaints as incidents and these were investigated and analysed for lessons to be shared amongst GPs or other staff to improve practice.

The practice told us feedback was in many forms including letters, cards, NHS email and notes handed in at reception.

The practice leaflet indicated the practice welcomed comments about the practice. None of the patients spoken with had ever needed to make a complaint.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice's statement of purpose included the aim to provide a 'friendly, convenient and efficient service.' They provided continuity of care for their patients through long standing staff and one of the two GPs was always available. The practice did not have a documented business plan in place.

Staff told us the senior GP provided leadership and management of the practice. The senior partner had identified a need to obtain support to reduce their management responsibility, however, this had not yet been implemented.

One of the GPs engaged with the clinical commissioning group by attending the monthly clinical commissioning group meetings.

Governance arrangements

All staff were managed by the senior GP. All staff told us the GPs were very approachable and they were able to raise issues as and when they arose. The practice had nine staff, eight of whom worked part-time, most six to 12 hours per week. Staff were updated, for example, in relation to changes to practice policies and procedures, individually in writing or verbally. Staff meetings were only scheduled if there were sufficient items of importance to convene a meeting for all staff to attend. We reviewed the notes of the last three staff meetings which had taken place between September 2013 and May 2014. There was evidence of discussions regarding practice procedures and development.

The practice used a combination of paper based records and an IT system to manage information. We reviewed a number of policies which had been updated in the previous month and were accessible to staff in hard copy. All staff had signed a confidentiality agreement and we saw records of these. GPs were very diligent in maintaining records and audit trails of all communication and referral letters.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing below the CCG average in some areas. The practice chose to focus its efforts on particular areas of QOF.

The female GP had an interest in gynaecology, family planning and child health and led the practice in these areas.

The practice made available one clinical audit which we reviewed. The clinical audit that had been undertaken in the last year. It involved patients treated with vitamin B12 injections and highlighted those who had not attended. A re-audit was planned to review progress.

Arrangements were in place for identifying, recording and managing risks. The practice was small and issues were identified by staff to the GP as and when they arose. A fire risk assessment had recently taken place and infection control audit which highlighted a number of recommendations. However there was not a comprehensive risk assessment process in place.

Leadership, openness and transparency

The senior GP was responsible for the management of the practice. We spoke with six members of staff and they were all clear about their own roles. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from notes of team meetings which were held infrequently, however we were told this was due to the large number of part-time staff and availability of all staff for team meetings was difficult to manage. Communication was mainly verbal and memorandums to individual staff.

Practice seeks and acts on feedback from its patients, the public and staff

A patient participation group was not in place to gather and facilitate constructive feedback to the practice. The practice welcomed individual patient feedback and information on how to do this was available on the practice leaflet. The practice website contained limited information for patients and some sections stated 'under construction'.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the GPs.

The practice had a whistle blowing policy which was available to all staff in the staff handbook.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Management lead through learning and improvement

The senior GP had considered the feedback following his last appraisal and had taken steps to improve management support at the practice in the future.

Reception and administration staff had not received regular training or appraisals to develop them in their roles.

Nursing staff had not received regular appraisals to develop them in their role.

The practice had completed reviews of significant events and other incidents and shared with staff to ensure the practice improved outcomes for patients. For example, we reviewed an incident related to incomplete labelling of urine samples. The GP had raised the issue with the CCG and suggested how the system could be improved.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered provider did not ensure that the all the information specified in Schedule 3 was available. Regulation 21 (b).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered provider did not have suitable arrangements to ensure persons employed were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely. Regulation 23 (1) (a)(b).**

Priory Avenue Surgery

Quality Report

2 Priory Avenue
Caversham
Reading
Berkshire
RG4 7SF
Tel: 01189 472431
Website: www.prioryavesurgery.co.uk

Date of inspection visit: 27 November 2014
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Inadequate**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Priory Avenue Surgery on 27 November 2014. The practice was rated inadequate in the safe, effective and well led domains. The practice was rated requires improvement in the caring and responsive domains.

Our overall rating for the practice was inadequate.

On the basis of the ratings given to this practice at this inspection I am placing the provider into special measures.

Our key findings were as follows:

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw staff treated patients with kindness and respect, and maintained confidentiality.

Some patients reported considerable difficulty in accessing a named GP and they experienced a poor continuity of care. However, all patients told us urgent appointments were usually available the same day.

Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. The practice was going through a significant staffing crisis and there had been severe staff disruption in recent months. The practice was working closely with the NHS England area team to ensure they took immediate corrective action, which would enable them to fulfil their basic functions safely. The North and West Reading Clinical Commissioning Group were also monitoring the concerns and issues within the practice.

We saw no evidence that audit was driving improvement in performance to improve patient outcomes. We found, the recent staff shortages had an adverse impact on patient records. This posed a significant risk to patient

Summary of findings

safety as their patient records were not up to date with recent test results and discharge information from hospital. Therefore, patients may not have received appropriate follow up treatment or care.

There was no formalised induction programme for new administration and reception staff. However, training had taken place and staff felt supported by their immediate team and manager.

The practice did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by the directors.

There were also other areas of practice where the provider needs to make improvements.

Importantly, the provider must :

- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
- Ensure all staff identified as requiring a criminal records check through the Disclosure and Barring Service (DBS) have one undertaken as soon as possible.
- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
- Take immediate corrective action to address current staffing issues to ensure safe minimum levels are reached.
- Implement a system to ensure all staff members receive regular supervision and appraisal.
- Provide clinical leadership and management to all practice staff.
- Develop a clinical audit process and implement findings from audits.
- Develop and maintain a system to identify risks and improve quality in relation to patient safety.
- Implement a process to disseminate learning from significant events, clinical audits, complaints and referral, to practice staff members.
- Take immediate action to ensure all patients' records are updated with appropriate information and documents in relation to the care and treatment they have received.
- Undertake and record all relevant risk assessments.
- Undertake regular infection control audits that are documented and introduce a cleaning schedule for practice equipment.

Action the provider SHOULD take to improve:

In addition the provider should:

- Introduce a legionella risk assessment and related management schedule.
- Organise an induction programme for all new starters.

On the basis of this inspection and the ratings given to this practice the provider has been placed into special measures. This will be for a period of six months when we will inspect the provider again.

Special measures is designed to ensure a timely and coordinated response to practices found to be providing inadequate care.

We are currently piloting our approach to special measures, working closely with NHS England. The proposals we are piloting are that GP practices rated as inadequate for one or more of the five key questions or six population groups will be inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, they have failed to make sufficient improvement, and are still rated as inadequate for a key question or population group, we will place them into special measures. In a small number of cases, a GP practice will have such significant problems that people who use services are at risk or there may be sufficiently little confidence in the practice's capacity to improve on its own. In these instances the practice will be placed straight into special measures.

Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services. Although the practice reviewed when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice was going through a staffing crisis and there had been severe staff disruption in recent months. This posed a significant risk to patient safety. We found no evidence of any completed infection control audits. The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients. We found all recruitment and employment information required by the regulations was not documented in all staff members' personnel files.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. There were limited completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Some multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. We found the recent staff shortages had an adverse impact on patient records. We saw a sizeable backlog had built up in the recent months. For example, new patients records were awaiting to be processed by a GP, repeat prescriptions were delayed and medical reports were not up to date. There was no formalised induction programme for new administration and reception staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was available. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. However patient survey results showed that patients rated the practice much lower than others for some aspects of care. For example, 57% of patients described their experience of making an appointment as good. Forty

Summary of findings

five per cent of patients said they do not normally have to wait too long to be seen. These percentages were much lower when compared to national and clinical commissioning group (CCG) averages.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Services were not always planned to meet the needs of the local population. Some patients we spoke with reported considerable difficulty in accessing a named GP and poor continuity of care. All patients told us urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Patients could access information about how to complain in a format they understood. However, there was no evidence that learning from complaints had been shared with staff.Patients we spoke with on the day gave us mixed responses about the booking of appointments and their continuity of care.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no leadership structure and staff did not feel supported. Administration staff and nurses worked well in their roles but told us they did not always feel supported by the management team, directors and the GPs. Governance meetings were not held regularly and had not been held at all for a number of months. The GPs and nursing staff told us they had not received regular supervision.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Requires improvement

Patients over 75 years of age had a named GP. However, due to staff shortages this was not being maintained. Patients reported that they were unable to see the same GP and this had impacted upon the continuity of their care. Home visits were arranged for housebound patients. The practice provided medical services to two local nursing homes. The practice ran various clinics to support elderly patients. These included specialist wound care, minor operations and Doppler clinics.Flu immunisations were offered to patients over 75 years. The practice data showed 79% of older patients had been vaccinated. The practice also ran vaccination clinics for shingles and pneumonia for older people. The practice provided community enhanced services to all over 75 years of age patients.

People with long term conditions

Requires improvement

Flu immunisations were offered to 'at risk' patients. This group of patients, were invited for regular reviews. Patients with long term conditions had a care plan in place to prevent unplanned admissions. Diabetic eye screening appointments were offered at the practice. The practice held dedicated clinics for patients diagnosed with conditions such as diabetes, respiratory and cardiovascular disease. The practice had robust recall systems in place to ensure patients with long term conditions received appropriate monitoring and support.Patients had an annual review of their condition and their medication needs were checked at this time. However, patient records and test results were not always being processed and reviewed in a timely way. Therefore this increased the risk of patients receiving delayed treatment and care.

Families, children and young people

Requires improvement

Childhood immunisations were carried out at the practice. Antenatal, baby checks and family planning clinics with a GP were available. Cervical screening was offered at the practice. We saw that the waiting area and treatment rooms were able to accommodate patients with prams and buggies. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Chlamydia testing was offered to 15 to 24 year old patients. The salaried GPs of the practice told us that they were unable to attend to their full range of duties due to the staff shortages. This included the review of safeguarding action plans and risks to individual patients.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice provided a range of appointments between 8am to 8pm. The practice was also open two Saturdays each month. At the time of the inspection the extended hours appointments had been reduced due to the staff shortages. This reduced the availability of access to patients who worked and we unable to visit the practice during working hours. Telephone calls to patients who were at work were made at times convenient to them. There was an online appointment booking system and repeat prescription service. The practice also offered NHS Health Checks to all its patients aged 40-75, in line with national guidelines.

People whose circumstances may make them vulnerable

Requires improvement

The practice held a register of patients with learning disabilities. We saw 36 patients were recorded on the register, of which eight patients had received a health review. A GP carried out ward rounds for all patients with learning disability in a local care home. All vulnerable patients were prioritised, and given same day appointments. The practice provided medical services to homeless patients and temporary residents. Interpreters were used for patients whose first language was not English. Patients in vulnerable circumstances were at risk of delayed care and treatment, due to the shortage of GPs in the practice. The practice systems to review the care and support of those in vulnerable circumstances were not effective. The lack of leadership in the practice meant there was limited oversight and review of the patient population. This included changes to tailor the practice services to the needs of their population.

People experiencing poor mental health (including people with dementia)

Requires improvement

Longer appointments were available for people who needed them, such as those suffering from poor mental health. A drug counsellor held a monthly session at the practice and appointments were offered to patients for this. The practice referred patients to appropriate mental health services. The referrals to other NHS services had not always been monitored or reviewed by the practice within their clinical governance processes. Practice data identified that the overall referral rates had increased recently. We were unable to evidence how the practice ensured their appropriateness and whether they were in line within current local and national referral guidance.

Summary of findings

What people who use the service say

We spoke with nine patients which also included the patient participation group (PPG) chairperson. A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements could be made. We received further feedback from two patients via comment cards. The feedback from the patients we spoke with was mixed. Some patients told us it was very difficult to get a routine appointment. They told us that they often had to wait for over four weeks to get a routine appointment. Some patients were concerned about the lack of continuity of care they received. This was due to seeing different nurses or GPs at subsequent appointments for on going treatment or care. All the patients we spoke with told us if needed to be seen urgently, then they were offered same-day appointments. Patients were mostly positive about the care they received from GPs and nurses. Patients told us staff were usually very caring and supportive.

Patients told us the GP and nurses involved them with decisions about their treatment and care. Some patients told us they were provided with printed information when this was appropriate. Patients commented the practice was safe and clean.

We reviewed patient feedback from the national GP survey from 2014 which had 51 responses. The results from the national GP survey showed, 76% of patients said they found it easy to get through to the surgery by phone. Fifty seven per cent of patients said they were able to see their preferred GP and 57% of patients described their experience of making an appointment as good. Forty five per cent of patients said they do not normally have to wait too long to be seen. These percentages are very low when compared to national and clinical commissioning group (CCG) averages.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must :

- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
- Ensure all staff identified as requiring a criminal recordscheck through the Disclosure and Barring Service (DBS) have one undertaken as soon as possible.
- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
- Take immediate corrective action to address current staffing issues to ensure safe minimum levels are reached.
- Implement a system to ensure all staff members receive regular supervision and appraisal.
- Provide clinical leadership and management to all practice staff.
- Develop a clinical audit process and implement findings from audits.
- Develop and maintain a system to identify risks and improve quality in relation to patient safety.
- Implement a process to disseminate learning from significant events, clinical audits, complaints and referral, to practice staff members.
- Take immediate action to ensure all patients' records are updated with appropriate information and documents in relation to the care and treatment they have received.
- Undertake and record all relevant risk assessments.
- Undertake regular infection control audits that are documented and introduce a cleaning schedule for practice equipment.

Action the service SHOULD take to improve

In addition the provider should:

- Introduce a legionella risk assessment and related management schedule.
- Organise a formalised induction programme for all new starters.

Priory Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, and two GP specialist advisors. The team also included a practice nurse and practice manager advisor.

Background to Priory Avenue Surgery

The practice provides personal medical services to over 8,050 patients in Caversham, Berkshire. There was an older than average practice population, with a high proportion of patients aged over 65, and low deprivation scores.

The practice occupies a victorian building in a prominent location on the main road through Caversham. The building was converted for general practice usage and had been extended several times in the last 10 years to meet patient needs. Consultation and treatment rooms are spread over the ground and first floors. The practice does not have onsite parking facility for patients. Limited disabled parking was available for patients with restricted mobility.

Care and treatment is delivered by a number of GPs, practice nurses and health care assistants. Outside normal surgery hours patients were able to access emergency care from an Out of Hours (OOH) provider. Information on how to access medical care outside surgery hours was available on the practice leaflet, website and in the waiting area.

The practice had undergone significant management changes in the last two years and included partnership changes in 2012. The former partnership dissolved and the practice was handed over to NHS Berkshire West Primary Care Trust (PCT) in September 2012. The current management, Specialist Health Service Ltd (SHS) tendered for and took over the practice. They have been running the practice since August 2013 and have an eight year contract with NHS England. The practice is now part of the North and West Reading Clinical Commissioning Group.

The current management team comprises of four directors. Two of the directors are GPs, but do not practise at the Priory Avenue Surgery. The third director is a retired GP and the fourth director is a business/practice manager at Priory Avenue Surgery. GP consultations are solely delivered by salaried and locum GPs and have been since the new practice was formed in August 2013.

A team of salaried doctors were recruited in 2013 and after some initial issues and changes, the medical service provision appeared to be stabilising. However, due to the increasing management and leadership concerns there have been a series of resignations in July and August 2014 from many of the salaried GPs. As a result management at the practice has become a major challenge and the practice experienced significant difficulties in recruiting new salaried GPs.

NHS England has received an action plan from the practice outlining the action they are planning to take to resolve the staffing and management issues identified in the previous eight weeks. This was agreed in November 2014 and the actions required are currently in progress. The action plan will be reviewed by NHS England. The clinical commissioning group are also involved in the recovery plan and supporting the practice.

The practice has a Alternative Personal Medical Services (APMS) contract. APMS agreements are locally agreed contracts between NHS England and a GP practice. This was a comprehensive inspection.

Detailed findings

The practice provides services from

Priory Avenue Surgery, 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Prior to the inspection, we reviewed wide range of intelligence we hold about the practice. Organisations such as local Healthwatch, NHS England and the clinical commissioning group (CCG) provided us with any information they had. We carried out an announced visit on 27 November 2014. During our visit we spoke with the practice staff team, which included GPs, practice nurses, and the administration team. We spoke with nine patients including the Patient Participation Group (PPG) chairperson who used the service and reviewed two completed patient comment cards. We observed interactions between patients and staff in the waiting and reception area and in the office where staff received incoming calls. We reviewed policies and procedures the practice had in place.

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Inadequate

Are services safe?

Our findings

Safe track record

The practice had not raised any safeguarding alerts within the last year. We reviewed some recent Medicines and Health Regulatory Agency (MHRA) alerts and saw these had been appropriately dealt with. The practice had a 'Handling of Medical Safety Alert' policy in place and staff were familiar with these.

Individual GPs were responsible for safety alerts, in line with the national guidelines. GPs told us safety alerts were not being discussed routinely at meetings or being recorded. We were unable to review all safety records and minutes of meetings in the previous six months because they had not been held or recorded. This showed the practice was not routinely managing safety and risk consistently overtime and therefore were unable to demonstrate a safe track record.

Learning and improvement from safety incidents

We saw some evidence of some reporting, recording, and monitoring of significant events. The practice manager recorded significant events on a register. However, we found no evidence of action being taken. The events had not been discussed or reviewed for identification of trends and learning was not being shared. The salaried GPs told us, meetings to discuss significant events should be taking place every two months, however these had not taken place recently.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff had received safeguarding training, appropriate to their roles. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. The contact details of these agencies were easily accessible to staff.

A safeguarding lead had been appointed and had undertaken appropriate safeguarding training. The safeguarding lead was long term sick leave, and a deputy lead had been appointed.

All staff we spoke to were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had a chaperone policy in place. The administration and reception staff members had acted as a chaperone. The administrative staff we spoke with told us patients were informed they were part of the non-clinical team and sought their consent before supporting as chaperone. We saw evidence all chaperones had a Disclosure and Barring Service (DBS) check in place. We found no evidence which confirmed staff had received appropriate chaperone training. We saw notices in the waiting area and next to examination couches in the surgeries informing patients that they could request a chaperone. Some patients we spoke with told us they had been offered a chaperone if they required an intimate examination.

Medicines management

The practice had management of medicines policies and procedures and staff knew how to access these. The vaccines and medicines were monitored by the Health Care Assistant (HCA).

We found all medicines and vaccines stored were within expiry date and there were appropriate stock levels. Vaccines were stored appropriately in dedicated vaccine fridges and they were transported safely. These fridges were subject to daily temperature checks to ensure the vaccines were stored at the correct temperatures. This was supported by the fridge temperature logs made available to us. Medicines kept in one of the nurses rooms were being monitored by the HCA on a monthly basis. However, there were no written records of these checks.

The practice had procedures for repeat prescriptions, and protocols for how to handle repeat prescription requests. Staff we spoke with knew how to access this information. We found the prescription pads were stored safely and securely. All prescriptions were required to be signed by the GP before they were issued to the patient. The practice had systems in place for safe disposal of medicines.

Are services safe?

Patient Group Directions (PGDs) were available at the practice. PGDs are specific written instructions for the supply and administration of a licensed named medicine. There is a requirement that all PGDs should be signed at the time of issue. We reviewed a sample of PGDs issued in February and July 2014. We found these PGDs had been completed and signed by a GP. However, we noted that these had not been signed until November 2014.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and dust free. The patients we spoke with commented the practice was clean and appeared hygienic. We noted during our interview with one of the GPs, their room was cluttered. For example, we saw notes and letters scattered on the floor and on the desk. The GP told us they had been in the process of catching up on some administration work. Other rooms appeared to be tidy and clutter free.

The practice had a comprehensive infection control policy. This provided staff with guidance on hand hygiene, importance of personal protective equipment, handling of blood samples and how to deal with microbiological swabs. The staff we spoke with were familiar with these. The Health Care Assistant (HCA) was the lead for infection control, they were not available on the day of the inspection.

The practice had employed a cleaning company, who came in daily. Cleaning schedules were in place and these confirmed the areas the cleaners were required to clean and how frequently. This was monitored by the infection control lead. We found appropriate arrangements were in place to enable the safe removal and disposal of any waste from the practice.

We found no evidence of any completed infection control audits. This was supported by the staff we spoke with told us they were not aware such audits and this had not been shared with them. A blank 'Infection control audit' document was made available to us. There was no cleaning rota for the practice equipment, such as telephones, spirometry, keyboards and BP cliffs. The cleaning of these items was not being monitored.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients.

Equipment

Staff had access to a defibrillator and oxygen. Staff knew the location of the resuscitation equipment. We saw servicing records for medical equipment were up to date and within their expiry date. A schedule of testing was in place. Electrical appliances were tested to ensure they were safe. We saw a log of calibration testing for the practice and all equipment was calibrated in February 2014. Disposable medical instruments were stored in clinical treatment rooms in hygienic containers ready for use.

Staff told us they had received training in fire safety and health and safety. The GPs and nursing team had received training in basic life support (BLS) this year. The administration team had not received BLS training. The practice had health and safety protocols and staff knew how to access these should the need arise. Health, safety and welfare procedures were also available in the staff handbook.

Staffing and recruitment

Recruitment policies and procedures were in place. We reviewed the personnel files of six staff members who had been recruited in the last two years. These included two GPs, a nurse, an HCA and two members of the administration team. We found not of all the information required by the regulation was recorded in the individual staff files.

We saw one of the administration members file only included an employment contract. There was no evidence of application form or CV, references, identity checks, or recent photograph. In another file, there was evidence of application form, references had been requested but not received and employment contract was in place. There was no evidence of criminal records check through the Disclosure and Barring Service (DBS), for both staff members.

We noted in the health care assistant's file, references had been sought and received and a contract of employment was in place. However there was no application form,

identity checks, a recent photograph and criminal records check contained in the file. The nurse practitioner file did not include any of the information required under the regulation.

We reviewed two GP personnel files. In one GP file there was evidence of identity checks, and professional registration. However there was no evidence of an application form or CV, a recent photograph, no employment contract or evidence of relevant qualifications for the member of staff. In the other GP personnel file we saw evidence of a CV and employment contact. However there was no evidence of confirmation of professional registration or if they were part of the NHS England performers list. There was no evidence of a criminal records check through the Disclosure and Barring Service (DBS) for one of the GPs.

The practice had not obtained evidence for staff to ensure they were physically and mentally fit to carry out their roles. We found a documented risk assessment to determine which staff required a DBS check and the risks this posed to patients, was not in place. This meant, the practice did not have suitable recruitment systems in place, to ensure patients were treated by skilled and qualified staff.

The practice provided medical services to over 8,050 registered patients. The practice had identified that the ideal number of clinical sessions required to support and manage an 8,050 patient list should be approximately 43 sessions per week. At the time of the inspection, the practice had four salaried GPs who were providing 19 clinical sessions between them and the nursing team provided 10 sessions. Patient safety may be at risk because the practice would not be able to fulfil its basic functions safely.

We found the practice did not have sufficient regular clinical staff on duty to support the needs of the patient population safely. A full time salaried GP had left the practice in October 2014. A long term locum had been appointed to cover these GPs clinical sessions. One salaried GP was on long term sick leave, and had recently resigned.

A number of current working salaried GPs had resigned and were serving their notice period. The loss of these GPs would then leave a total of just nine regular clinical GP sessions per week between the two remaining salaried GPs, who delivered four and five sessions per week respectively. If the practice did not make immediate improvements to staffing levels, the practice may be at more significant risk of not being able to ensure patient safety.

One of the directors, who was also the business manager had resigned from the company and was due to leave in December 2014. The management team told us a recruitment programme was in place to look for a new experienced practice manager. This person would provide management support and be a lead to the administration and reception team.

The staffing shortages had an adverse impact on practice staff, the running of the practice and the clinical and non-clinical workload. A salaried GP told us at present they were only seeing patients and were unable to complete necessary paperwork. They said there had been occasions when only one GP turned up for work and the practice was unable to get cover for urgent matters. Salaried GPs told us previously a 'Buddy system' was in place to cross cover when GPs were on annual leave. However this system had completely collapsed, due to the recent staffing disruptions.

The administrative team we spoke with told us there was not enough clinical staff to support the practice population. In particular difficulties arose, when a salaried GP was sick. They told us on occasions many appointments had to be rescheduled or cancelled. This had left the patients unhappy and the staff in a difficult position. Another staff member told us, they were concerned about the on going clinical staffing issues. They said on one occasion, there was only one salaried GP working (who left midday) and there was no duty GP. There was no nurse working on the day and the two locum GPs worked until 5pm. The staff member said the practice manager was unable to sort out these issues. They were worried this could impact patient safety, because of increased workload and pressure on the existing staff.

The administration team told us there were also staff shortages in their team. For example, when the medical secretary, clinical data manager and the person responsible for scanning documents were on leave, there were no cover arrangements in place. They told us this work was not actioned and left for the staff members return.

Inadequate

Are services safe?

The senior management told us about the serious staffing challenges they faced due to the delays in recruitment, staff sickness and the recent resignations. As a result, a recruitment programme had been commenced and the management team had been working closely with several medical recruitment consultants to appoint new salaried GPs and a medical partner. This had proven to be challenging due to the present national shortages of GPs. The practice manager told us the practice was trying to recruit full time GPs but this was proving difficult due to a lack of qualified staff applying for the vacant roles. The practice was using locums regularly.

The management team were aware the usage of locum GPs was not sustainable long term. The use of locums had adverse effect on the practice. Some issues identified included a patient dissatisfaction with the lack of continuity of care, increased referral rates, increased prescribing costs and difficulty in ensuring clinical governance was effective. However, the management team told us they had no choice but to use locums until full complement of full time staff were in place.

We saw some evidence that efforts had been made to ensure a continuity of staffing in the nursing team. Initially the practice had employed a nurse practitioner with specific responsibility to lead the nursing team. However, the nurse practitioner's employment was ceased as the salaried GPs and the nursing team did not feel the person was appropriate for the role. A new nurse practitioner had since been employed who had meetings with the nursing team and planned to carry out appraisals for them. A Health Care Assistant (HCA) had been appointed to reduce the routine tasks that were being completed by a nurse, which could be done by a HCA.

We found the general work availability was operated to cater for the needs of the GPs and not for the needs and requirements of the patient population.

Monitoring safety and responding to risk

The business continuity plan identified the range of risks the practice could face that would prevent the delivery of care and treatment. The plan identified how these risks would be mitigated and actions needed to restore services to patients. However, they had failed to identify the risks associated with the staffing problems when they began to arise earlier in 2014. We were unable to evidence how the practice management and leadership team had identified this risk and had taken immediate and corrective action to minimise the impact for patients and the practice.

We found no evidence of relevant risk assessments. For example, risk assessments in fire safety, a control of substances hazardous to health (COSHH) risk assessment and there was no overall health and safety risk assessment in place.

Arrangements to deal with emergencies and major incidents

The practice had a system and procedures in place to deal with most emergencies. The practice had a 'Disaster Handling and Business Continuity Plan' to deal with most emergencies that could interrupt the smooth running of the practice. This plan outlined protocols for staff to follow in the event of, losing computer system/essential data, loss of telephone system and loss of the main building. The practice manager told us the document was available to staff on the computer system. Some of the staff we spoke with were not familiar with the business continuity plan. The practice manager kept copies of the document and other insurance policies off site.

The practice had alarm buttons to alert staff in the event of emergencies. Staff had access to emergency medicines and medical equipment. We found the medicines were within their expiry date. The practice nurse was responsible for checking resuscitation equipment and medicines and recorded this information weekly.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing team we spoke with were able to describe and demonstrate how they access both guidelines from the National Institute for Health and Care Excellence and from local commissioners. All the GPs and nurses we interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The CQC specialist GP advisor sampled some patient records. They found all patients were well managed and patients were on appropriate treatments. We saw patient records were computerised. Medical notes included information such as laboratory, X-ray and scan results, correspondence with secondary providers and prescribing information was recorded accurately until September 2014.

The provider did not maintain an accurate record in respect of each patient which shall include appropriate information and documents in relation care and treatment provided to the patient. We found, the recent staff shortages had an adverse impact on patient records. We saw a sizeable backlog had been built up over the last two months. For example, new patients records were awaiting to be processed by a GP, repeat prescriptions were delayed, medical reports were not up to date and there was a backlog of hospital letters and reports that needed to be processed. The salaried GPs we spoke with told us in the last couple of months they were only seeing patients and did not have time to complete the necessary paperwork. Locum GPs did not complete administration tasks and other necessary paperwork. This increased the salaried GPs workload and further increased the backlog.

Referrals were made using the Choose and Book service. The process involved GPs completing a referral form, the administration team then processed the referral and documented this on patient record and patient was contacted. We found the referrals were dealt with appropriately and in timely manner. We saw evidence of appropriate use of Two Week Wait referrals. Salaried GPs told us due to lack of regular clinical meetings, recent referrals were no longer discussed and learning opportunities were not available. There had been an increase in the number of referrals from the practice as a consequence. Audits had not been undertaken to measure the referral rates per GP and the reasons to confirm the appropriateness.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The 2014 QOF data made available to CQC showed the practice had either met QOF targets or exceeded them. The practice had done well in all clinical and public health areas. A specialist diabetes nurse had been employed in June 2014, and practice anticipated improved QOF scores in diabetes.

We found no evidence of completed clinical audit cycles in the last two years. A clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. The audit documents made available to us did not reflect this definition.

During our visit we were provided with a loose leaf folder of practice audits, which included five documents. For example, one document had identified the number of home visits made in the local care home and it was acknowledged that this was not an audit. Another document was named 'Audit' for patients receiving, medicines to reduce cholesterol levels and to control blood pressure. This appeared to be results of a straightforward computer search and was not a complete audit. We found no evidence of a topic for clinical audit being selected and a detailed methodology and data collection process being tested for the audit. There was no evidence of the results then being shared with practice staff, an action plan devised to monitor changes and evidence of repeat audit planned, in the audit documents made available to us.

Inadequate

Are services effective?

(for example, treatment is effective)

The salaried GPs we spoke with told us clinical audits had lapsed. The nursing team had not been involved in any clinical audits, in the last two years. The meeting minutes made available to us, showed there was no discussion of any recently completed clinical audits.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The nursing team told us they had regular training and new members of staff were provided with structured induction programme. Some of the recent training included, information governance, children and adult safeguarding and resuscitation. One nurse we spoke with told us they had been offered a lot of support from the IT team to understand the practice IT systems. However, there was no formalised induction programme for new administration and reception staff. Staff we spoke with told us the nature of their roles was discussed. However, their competence was not checked before being allowed to work unsupervised.

Working with colleagues and other services

The practice had a strong working relationship with the district nurse team and the community matron, who were based within the premises. They were called into the practice when information needed to be shared. The practice also worked closely with midwife and health visitor who visited the practice regularly and ran clinics from practice.

The practice held multi-disciplinary meetings which were attended by district nurses, midwives, a community matron and palliative care nurses. We reviewed minutes of a recent palliative care meeting, dated August 2014 and we saw there was discussion on all patients receiving palliative care and how they could be best supported. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice maintained a register for children at risk. The practice worked closely with the multi-agency safeguarding hub (MASH). The MASH process was operating effectively to ensure early notification of referrals across agencies, information was shared and appropriate action secured by relevant parties to promote early help as well as preventative work. The salaried GPs were clear about the role of and referral processes to the MASH. We saw a recent example of referral to MASH and saw this had been appropriately deal with.

Information sharing

Blood results, X-ray results, letters from hospital accident and emergency and outpatients and discharge summaries, and the 111 service were received electronically and by post. The process of information sharing had been severely compromised. We found there was a backlog of letters from hospital, A&E reports, and reports from out of hours services which needed to be processed and actioned by a GP. This information had not been dealt with in timely manner.

We saw evidence of special notes that had been used to share information with the Out of Hours (OOH) service.

Consent to care and treatment

The GPs we spoke with had a sound knowledge of the Mental Capacity Act 2005 (MCA) and its relevance to general practice. The GPs and nurses we spoke with understood the principles of the legislation and described how they implemented it. Staff were able to describe the action they would take if they thought a patient did not understand any aspect of their consultation or diagnosis. They were aware of how to access advocacy services. The GPs we spoke with told us they maintained their own knowledge on these areas, and had no support from the practice. For example, there was no collaboration or communication between them and the practice (i.e. through team meetings) on these issues.

The GPs we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to consent. GPs and nurses demonstrated a clear understanding of Gillick competencies, used to identify children under the age of 16 who have the legal capacity to consent to medical examination or treatment.

Health promotion and prevention

GPs and nurses referred patients to appropriate organisation for further help and support with their

Inadequate

Are services effective?

(for example, treatment is effective)

treatment and care. The nurses we spoke with told us they had referred patients to smoking cessation groups, provided information on eating healthy and advised on appropriate healthy living pathways.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and the practice had a recall system in place to follow up non-attenders.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. These included information on, diabetes, asthma, cancer and carer's support.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff took steps to protect patients' privacy and dignity. Patients we spoke with told us they were treated with privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Receptionists closed a glass screen on the reception desk when speaking to patients on the phone. Staff told us all computers were password protected and only the practice staff had access to the systems. We saw a self-check in facility was available. This ensured long queues were avoided at reception, which reduced conversations being overheard.

The practice confidentiality policy highlighted the importance of patient confidentiality and staff responsibility to ensure patient medical records were not moved from the premises. The design and layout of the reception area meant patient records could not be viewed by those attending the practice, and records were maintained securely and confidentially. The practice complied with data protection and confidentiality legislation and guidance.

We reviewed the recent data available for the practice on patient satisfaction. This included information from the national patient survey and a practice survey completed by of 89 patients, in November 2013. The 2014 GP national survey showed that 85% of patients said the last GP they saw was good at treating them with care and concern. Fifty six per cent (61% CCG average) of patients were satisfied with the level of privacy when speaking to receptionist at the practice and 86% of patients found the receptionists at the practice helpful. Seventy six per cent of patients described their overall experience of the surgery as good and 68% (85% CCG average) of patients said they would recommend this practice. Some of these percentages were low when compared to national and CCG averages.

We saw the November 2013 practice survey showed 51% of patients rated their GPs as very good for treating them with care and concern and 39% of patients rated it as good. Thirty seven per cent (46% CCG average) of patients rated their experience as very good and 40% (43% CCG average) as good.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national GP survey showed, 89% of patients said the last GP they saw was good at listening to them and 90% of patients said their GP was good at giving them enough time. Seventy six patients said their GP was good at involving them in decisions about their care and 76% (83% CCG average) of patients said the GPs they saw were good at explaining tests and treatment.

Patients we spoke with told us they felt that they had been involved in decisions about their own treatment and that the GPs and nurses gave them plenty of time to ask questions and had not been rushed. Patients were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and practice website also signposted people to a number of support groups and organisations, such as carer support, counselling, dealing with loneliness for older people, memory loss and bereavement support. The practice website had information about family health, long term conditions and minor illness.

The practice website had online resources, which included information about health advice for young people and online talking therapies and support clinics. The online clinics covered a wide range of health conditions.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection told us GPs and nurses were supportive.

Requires improvement

Are services caring?

The practice maintained a register for patients with depression and provided these patients with appropriate care and support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The current staffing crisis had impacted the practice function of responding to meet patient's needs. For example, the change in GP staffing levels had meant the principle of 'personal list' had ceased. All the over 75 year old patients had a named GP. However this was no longer supported or possible due to the low numbers of GPs in the practice.

Longer appointments were available for people who needed them, such as those suffering from poor mental health and patients with long term conditions. This also included appointments with a specialist nurse, such as appointments for diabetes checks. The practice provided medical services to a local care home. One of the GPs visited one morning each week to carry out a ward round to see patients. Home visits were provided at the discretion of GPs and according to clinical need. The practice reserved these for older patients, disabled and terminally ill patients or for emergencies. One of the GPs undertook monthly visits to local residential care home and provided treatment and care to many of the autistic patients.

The practice had patient registers including learning disability, long term conditions and palliative care registers. For long term conditions, the practice held registers for diabetes, asthma, arthritis and chronic obstructive pulmonary disease (COPD). We found there was a recall and annual review system in place for patients with diabetes and respiratory disease, and this process was nurse led. The practice held an unplanned admissions register, however in recent months this was not being maintained or completed by the GPs. No meetings had been held to discuss unplanned admissions and to share learning with staff

There was an online repeat prescription service for patients. This enabled patients who worked full time to access and order their prescriptions easily. Patients could also drop in repeat prescription forms to the surgery to get their medications. Some patients we spoke with told us that the repeat prescription service worked well at the practice. However, we found a back log of repeat prescription requests on the day of inspection.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of people with mobility problems. The doorways were wide and there was space for wheelchairs and mobility scooters to turn. All elderly and frail patients and those with limited mobility were seen in the ground floor consultations rooms. If patients needed help with access, they were able to ring the doorbell at the patients' entrance and a receptionist staff member would assist them accordingly. The practice had limited reserved car spaces for patients with disabilities. Adapted toilet and washroom facilities were available for patients.

Staff told us that translation services were available for patients who did not have English as a first language. They said it was rare that this service was required. The practice also utilised language skills within the practice team, to support patients who did not understand English. We saw the self-check in service available in several other languages. The practice website could be translated into over 50 languages. These included Urdu, Spanish, Polish and Arabic.

Access to the service

Patients were able to book an appointment to see a GP or nurse by text, telephone, online and in person. The practice were contracted to offer a range of appointments available to patients every weekday between the hours of 8am and 8pm. The practice also offered Saturday and Sunday appointments. This improved access to patients who worked full time. However, at the time of inspection the directors had withdrawn the extended hours service, and had decided to concentrate on normal hours until the practice was fully staffed.

The patient feedback on access was mixed. Some patients we spoke with reported considerable difficulty in accessing a named GP and poor continuity of care. Patients told us there had been a significant change of locum GPs in the last two months and this affected their continuity of care. One patient told us they saw a different GP each time they had come in the last month. Patients said access to a preferred GP was poor and at times had to wait for a routine appointment with preferred GP for over four weeks. Other patients said they were happy to see any GP and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

were able to make an appointment fairly easily and did not have wait too long to be seen. Patients were generally happy with the opening hours. All patients told us urgent appointments were available on the day.

We reviewed the results of the 2014 national GP survey. We saw the practice had scored below the CCG average, on service access. For example, 57% of patients said they were able to see their preferred GP and 57% (76% CCG average) of patients described their experience of making an appointment good. Sixty per cent of patients said they usually had to wait 15 minutes or less after their appointment time to be seen. Forty five per cent of patients said they did not have to wait too long to be seen. Seventy six per cent of patients found it easy to get through to surgery by phone.

Listening and learning from concerns and complaints

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the practice website and leaflet. The complaints procedure provided further information on how to make complaint and who at the practice would deal with the complaint. The practice had a complaints and procedure and this was displayed in the waiting area. The practice manager was the complaints lead and would in the first instance speak to patients face to face to diffuse the situation and provide patients with immediate resolution. Patients were provided with a complaints form to raise a complaint and were advised of the timescales of when they would be responded to.

The practice manager kept a record of all written complaints received. The complaints we reviewed had been investigated by the practice manager and responded to, where possible, to the patient's satisfaction.

We found patients' comments made on the NHS Choices website were not always monitored. We noted some comments on the NHS website were positive and others were negative. We saw the practice had not responded to any of the comments.

Some patients we spoke with told us they would be comfortable making a complaint if required. Others said they would not raise a formal complaint, as they were worried there would be repercussions and this would affect the care and treatment they would receive. In particular they feared that they would be removed from the practice list.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

Priory Avenue Surgery was formerly a group general practice. In 2012 the partnership was dissolved and the practice was handed back to NHS Berkshire West Primary Care Trust (PCT). In April 2013, a new provider was found, Specialist Health Services Limited (SHS), who had put in a successful bid and were offered an eight year APMS contract.

The SHS management structure comprised of four directors. Two of the directors were GPs, but did not practise at Priory Avenue Surgery. The third director was a retired GP and the fourth director a business/practice manager at Priory Avenue Surgery. We spoke with all four directors during our inspection. The directors told us the aim and vision of the practice was to let the salaried GPs run and manage the practice and the directors would be responsible for the running of the premises. This had not been well received by the salaried GPs, who had expected and had asked for clinical management support from the management team and directors.

The staff we spoke with did not know what the practice vision or strategy was. Staff told us they did not know who was responsible for what area or who had lead roles in clinical matters. For example, during our inspection we were told a salaried GP was the lead in cancer, thyroid and epilepsy for the practice. However, the staff member was not aware they were the lead for these clinical areas.

We found the practice had not developed a business or strategic plan for the future. There was no evidence of succession planning for the salaried GPs who were due to leave soon. The practice had not identified or developed internal staff to fulfil leadership positions within the practice. Staff told us the practice did not have regular team meetings and there was no discussion on practice visions and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice computer system. These included policies in safeguarding children and vulnerable adults, complaints, whistle blowing, clinical waste management, recruitment and repeat prescribing. All of these policies were updated to reflect new legislation and guidance and future review dates were also in place.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The 2014 QOF data for this practice showed they were performing in line with national standards. We saw the practice had performed well in areas such as, coronary disease, stroke, and diabetes.

The practice did not hold governance meetings to discuss performance, quality and risks and this was confirmed by the GPs and nurses we spoke with. Salaried GPs told us that previously meetings took place regularly, where QOF, unplanned admissions, referrals and prescribing initiatives were discussed. However, in the last 18 months, these meetings had become less frequent and were inconsistent. The nurses told us they had never been invited to any previous clinical meetings and would welcome involvement in these.

Nursing team meetings had recently commenced, and these were chaired by the new nurse practitioner. The administration and reception team also had their own meetings and issues were discussed and learning was shared regarding incidents and topics in relation to their area of the practice.

The practice did not have systems in place to monitor all aspects of the service such as complaints, incidents, safeguarding, risk management, and clinical audit. The recent staffing crisis had an adverse impact on these processes and systems, and as a result this work had lapsed.

Clinical audits had not being undertaken in the previous two years to drive improvement and change. We found evidence which identified how recent clinical audits were not effective. For example, during our inspection we were presented with a copy of an audit which looked at patients receiving pain management medication and without proton pump inhibitor (PPI) cover. This audit was completed in April 2014. The audit included a data table section and the information and results had not been recorded. The results of the audit concluded there was no change in the treatment and care of patients or the usage of pain management medications. It was not clear from the records which GP undertook the audit. These results were

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

shared with the salaried GPs. Later on the inspection day we were provided with another audit document by the same GP, which had the same title, the same front page and the same date of data collection, as first audit reviewed. However, now the data collection showed that 1000 patients (out of 8000) were receiving specific pain management medication and no patients were receiving antiplatelet drugs without proton pump inhibitor (PPI) cover. The results of this audit concluded 'It was heartening that we found no patients in the warning group'. We were unable to confirm which audit accurately and correctly represented the practice or what changes and actions were taken following this.

Leadership, openness and transparency

At the time of the inspection, there was no clear leadership structure at the practice. Staff were not clear about their own roles and responsibilities, and this had been affected by the constant changes in staffing. The practice had gone through a period of change in the last two years. We found that no formal leadership team or processes were in place or in development to manage and implement the significant change. There had been constant failures in communication between the current directors and salaried GPs, which had led to a breakdown in relationships and the failing of any leadership in the practice. The environment had left the practice staff demotivated, demoralised and disillusioned with the lack of management support. The departure of salaried GPs and other staff in the recent months further de-stabilised the practice team.

All the salaried GPs, nurses and the administration team told us there was no leadership at the practice and that this was something they had asked for constantly from the directors since August 2013. All staff we spoke with told us the current directors were rarely seen at the practice. One salaried GP had never met all of the directors of the organisation until the day of inspection. Another member of staff told us, there was no leadership within the medical team. They said they did not have a lead or partner to go to discuss issues or concerns.

During our visit the directors told us the about the issues that had been escalated by the salaried GPs behaviour. They felt the salaried GPs had shown constant resentment to any possibility of leadership emerging from their team. There was no unity between the salaried GPs and directors.

The management team recognised and understood the issues at the practice. The directors accepted that they should have been more proactively involved and should have overseen the clinical management and leadership until full complement of staff were in place.

The directors told us, following initial difficulties the practice had begun to run in stable fashion and they did have a full complement of staff. However, the recent resignations and communications from salaried GPs had precipitated the staffing crisis and a number of other issues causing an adverse impact. This had only recently been identified. These included a lack of cohesion amongst salaried GPs, lack of team meetings, lack of leadership and management failures.

The directors had taken some action to address these issues. This included, a recruitment drive which had been launched to employ new GPs. A decision was made to recruit a medical partner, who would be the clinical management lead for all staff, and to increase pay and improve working conditions to retain and attract staff. The directors had decided they would be present in clinical and practice meetings, and we saw evidence a team building session had been organised. The practice was looking to recruit a new practice manager, with the relevant experience and skills. The practice was in discussions with the NHS England and an action plan had been produced confirming the actions that will be taken to address the ongoing issues.

The directors were aware of severity of the issues and the potential significant risks these posed to patients. They were working hard to address these concerns, but at the same time were realistic of what could be achieved. The November 2014 action plan submitted to NHS England, stated if they were unable to recruit the GPs to fulfil patient requirement, they would hand over the contract and cease the business, which could lead to immediate closure of the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a patient participation group (PPG), where six members attended. The PPG chairperson told us they met every month and the meetings were attended by the practice manager and one of the directors. The present PPG group comprised of predominately retired patients. The PPG had identified it was difficult to get teenagers and

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

working age people involved and had they tried different ways to attract these patients, but were unsuccessful. We saw evidence that the PPG had advertised information on how to join the group on the practice website and in the waiting area.

We spoke with the PPG chairperson who told us they felt valued and thought their views were listened to. We were given examples of where the PPG had highlighted areas and the feedback was acted on and changes were made. For example, the PPG had suggested arm chairs were required in the waiting area, for patients with arthritis to ensure they were comfortable. This was reviewed and new arm chairs were put in place. The PPG had suggested that a greeting message should be introduced to inform patients to call for test results after 11am. This would reduce the telephone traffic in the early morning and make it easier for patients calling for an appointment to get through to staff. The practice had actioned this and had also introduced online appointment system.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns within the practice. All staff we spoke with told us they were comfortable to whistle blow, should the need arise. Staff were also aware of the external organisations should they have any concerns that needed to be escalated outside the practice. This included, the local clinical commission group (CCG), NHS England and the Care Quality Commission (CQC).

Management lead through learning and improvement

The practice did not have systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Staff told us regular clinical meetings were not taking place. As a result, topics such as referrals, prescribing methods/errors and significant event analysis were not being discussed or shared. Staff said learning from complaints or audits were also not being shared or discussed. Limited team meetings took place for administration and reception team. The administration team told us the practice did not hold away days or meetings for all the staff and that they had not been invited to join the recent one held away day held.

The practice manager and administration and receptionist team had regular annual appraisals, to discuss individual support needed to develop their knowledge and skills. The administration team told us although they did not have regular supervision; they were supported by the practice manager and would go to them if they had any concerns.

GPs and nurses told us they maintained their own continual professional development (CPD). They said it was their responsibility and that they had not been supported by the management team with this.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Requirement relating to workers** **The registered person must ensure all information specified in Schedule 3 is available in respect of staff employed for the purpose of carrying on the regulated activity. Regulation 21 (a) & (b).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control** **The registered person must ensure an effective operation of systems designed to assess the risk of and prevent, detect and control the spread of a health care associated infection. Regulation 12 (2) (a).**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The registered person must regularly assess and monitor the quality of the services provided. And identify, assess and manage risks relating to health, welfare and safety of patients. Regulation 10 (1)(a) and (b), (2) (b)(i) and (c)(I)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Records The registered person must ensure an accurate record in respect of each patient which shall include appropriate information and documents in relation to the care and treatment provided to each patient. Regulation 20 (1) (a).

NHS

FIVE YEAR FORWARD VIEW

October 2014

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

NHS support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – enhanced health in care homes

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage

recruitment and retention in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.

READING BOROUGH COUNCIL

REPORT BY MANAGING DIRECTOR

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**30th January 2015**	**AGENDA ITEM:**	**8**
TITLE:	**Beat The Street: Reading**		
LEAD COUNCILLOR:	**CLLR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**Sarah Wise /Asmat Nisa**	**TEL:**	
JOB TITLE:	**CCG Manager /Consultant in Public Health**	**E-MAIL:**	**Sarah.wise2@nhs.net Asmat.nisa@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Purpose of this report

The purpose of this report is to provide headline feedback on the 2014 Beat the Street programme, commissioned by the North West and South CCGs, with independent evaluation funded by Public Health. The 2014 project was developed based on the positive reception of the 2013 Caversham Beat the Street project funded by RBC Transport service grant.

The report also sets out proposals to deliver Beat the Street in 2015 across Reading.

2. RECOMMENDED ACTION

2.1 That Health and Wellbeing Board note the background to the Beat the Street walking initiatives and the feedback and evaluation results for the 2014 Beat the Street Project as summarised

2.2 That the Health and Wellbeing Board support the delivery of Reading Beat the Street in 2015.

3. POLICY CONTEXT

3.1 The Reading Health and Wellbeing Strategy identifies promoting health-enabling behaviours and lifestyle tailored to the differing needs of communities as one of its four main goals within its Delivery Plan, making promotion of physical activity a key area of focus for prevention and behaviour change programmes.

3.2 & Clinical Commissioning Groups have a responsibility to make efficiency savings and improve care for patients through a plan for 'Quality, Innovation, Productivity and Prevention' (QIPP) that has a budget attached to it. Beat the

Street is a preventative project aiming to change habits and behaviours, particularly by targeting certain groups.

4. THE PROPOSAL

4.1 Background

Intelligent Health is a company founded and directed by Dr William Bird, a local GP. The company focuses on promoting physical activity to improve health outcomes.

Intelligent Heath's Beat the Street community initiative is designed to inspire people to walk more. People scan a card or key fob onto 'Beat Box' scanners located around the community in order to indicate that they have walked between the boxes, earning points that add up to win prizes for their team or school.

4.2: Beat the Street for Reading 2014 was commissioned by North and West and South NHS CCGS and supported by Reading Borough Council Public Health and Transport teams to increase physical activity levels and support sustainable travel. A focus was given to engaging people who had a long term conditions and who had low levels of physical activity.

15,074 people took part in Beat the Street 2014. Headline independent evaluation results after three months showed:

- 18% increase in people categorised as inactive to active (from 35-53% in Reading). This change is statistically significant.
- 12% of survey respondents had a long-term condition such as COPD, arthritis or diabetes.
- 82% said that Beat the Street helped them feel more active.
- 73% said they felt healthier.
- 78% of people said Beat the Street helped them to walk more than usual.
- 76% of people said they would try to continue the changes after the competition ended.
- The main reason given for taking part was 'having fun'.
- Many people reported that Beat the Street got them out of their cars for shorter journeys.

4.3 Beat the Street 2015. An 8 week Beat the Street competition for Reading CCGS and Reading Borough Council in 2015 would build on the project outcomes from last year. Lessons learned from previous Beat the Street projects will be applied including an enhanced user experience, updated website and more opportunities to play by providing beat boxes in more areas.

The project would retain a clear focus on narrowing the health gap - targeting people with long term conditions and those who are least active. Public Health would work in partnership with CCGs to ensure clear links between Beat the Street and other RBC programmes around workplace, sports and leisure and school travel initiatives, including the Reading schools expansion programme, and ensure strong linkages with RBC's Health Walks Programme Lead.

5 FINANCIAL IMPLICATIONS

5.1 The total cost to deliver the Beat the Street programme for 155,000 residents is £208k.

Following CCG Board meetings in January 2014 N W Reading and South Reading CCG's have both confirmed their interest in running Beat the Street again in 2015 and propose to invest £70K each in Beat the Street for 2015 via their QIPP procedure.

Based on their QIPP criteria and on the outcomes from Beat the Street 2014, CCGs will be recommending that the project continues to represent worthwhile use of the QIPP budget.

It is proposed that Public Health funding of up to £70K is also made available to enable joint and overall resourcing and delivery of the programme in 2015.

The burden of disease and conditions attributable to inactivity in Reading is estimated at over £1.6million per year. Evidence from the report Walking Works, endorsed by Public Health England, highlights that physical activity is becoming a public health problem comparable to smoking. An inactive person spends 37% more days in hospital and visits their doctor 5.5% more often. Promoting walking schemes is a "best buy" for both health and active travel. Schemes to promote local walking (and cycling) routes typically have benefit to cost ratios of 20:1; compared to road/rail schemes which typically have ratios of 3:1.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 This programme supports delivery of the Reading Health and Wellbeing Strategy strategic Goal 4: Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities; and Goal 4 sub Objective 3 – Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes

Beat the Street, Reading, 2014

Intelligent Health

Summary Report V2

Contents

Cover : 244, 537 miles travelled by Reading residents playing Beat the Street, England

Executive Summary

Beat the Street was commissioned by NHS North and West Reading and South Reading Clinical Commissioning Groups with the aim of increasing physical activity levels across the area.

15,074 people took part in Beat the Street in Reading between May 1st and 4th June and in the outlying villages between 26th June to 22nd July 2014. 8,416 of these were school children and 6,658 were adults.

From the responses to a survey at the end of Beat the Street, 12% reported that they had a long-term condition such as COPD, arthritis or diabetes.

Fifty teams competed for top prizes of between £2500 and £250 for their **chosen charity or cause**. Thirty of these teams were primary schools. The winning team was All Saint's Primary school

The community as a whole walked an estimated distance of **244, 537 miles,** securing the release of a further £3000 for the Mayor of Reading's charitable causes.

The majority of valid journeys were undertaken on the way to school or to work, although the beat boxes were also used at weekends and in the evenings by people cycling and walking with their families and friends.

The competition was universally positively received and succeeded in engaging 10% of the population of Reading. Beat the Street was given extensive media coverage, with over 40 articles in various publications.

At the beginning of the competition, 35% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). **By the end of the competition, this had increased to 45%. Two to three months later this was maintained at 53%.** This increase is statistically significant, meaning that it is not likely to have happened by chance. The changes remained when data from individuals was matched up rather than only looking at averages.

The changes remained when data from individuals was matched up rather than only looking at averages.

78% of people said Beat the Street helped them to walk more than usual and 70% said they continued to walk more after Beat the Street ended.

76% of people said they would try to continue the changes after the competition ended and two to three months later 75% said they continued to be more active.

The main reason given for taking part was 'having fun'. The majority of people cited gaining health benefits from participating. Many people reported that Beat the Street got them out of their cars for shorter journeys.

Representatives from the winning teams in Beat the Street, Reading 2014

What is Beat the Street?

Beat the Street uses the principles of 'nudge' theory to move people into a more active lifestyle. However activity is also a fundamental component to build a strong community through volunteering, socialisation, leisure, sport employment and family activities.

The whole town becomes a game with points and prizes creating the ultimate gameification model. Participants are then encouraged to walk or cycle in their own neighbourhood connecting them to place and people and giving them a purpose by raising money.

How does it work?

Intelligent Health's schemes are designed around a 'real world walking game' concept where people compete for points by walking or cycling around their local area: to work, to school or as part of a daily routine.

Walking and cycling is recorded by touching personalised smart cards onto electronic sensors called Walk Tracking Units (WTUs) or 'Beat Boxes' that are placed in and around the town. The WTUs send real-time data to a central database and participants can follow their progress on a website.

As part of the challenge, schools and businesses can be invited to compete against each other to see which one can accumulate the most points. As an incentive for anyone who doesn't fall into one of these schools or business categories, a target is set for the whole town and participants are entered into prize draws with prizes donated by local businesses.

The beat boxes are positioned at key destinations, including schools, the station, shops and aim to be within 0.5km of every resident.

RFID cards are provided to engage 50% of the total population of each area. The cards can be distributed in the following ways:

1. Cards can be distributed to children in all of the primary and secondary schools.
2. Cards can be distributed to key work places and to the public through local shops and businesses.
3. Cards can be made available from the local library, leisure centres and through local Parent Teachers' Associations.

4. Family doctors and local pharmacies are engaged to distribute cards.

The scheme is then promoted through the card outlets to encourage the whole community in each location to walk or cycle a cumulative distance such as walking to the moon 238,000 miles.

Every person is encouraged to take part through his or her school, doctor, work place or through a family member.

The Beat the Street website records individuals' progress and the progress of their team and the whole community.

> "I have been always active going to gym and walking and had weight problem with yo yo dieting. I had to stop two years ago with my knee problem. I started following NHS choices healthy eating plan but was not able to commit to any physical activity but with beat the street now I walk at least one hour every day, some days more. I have lost about half a stone of weight. Now I am motivated and hopefully will carry on after its finished." Shaheen Kausar, Beat the Street Participant

Key objectives of Beat the Street in Reading

The NHS North and West Reading and South Reading Clinical Commissioning Groups (CCGs) appointed Intelligent Health (IH) to create a challenge to increase physical activity levels in Reading in Summer 2014. The aim was to engage 20% of the population of Reading (30,000 people), with a focus on primary school children and the least active adults.

The initiative invited the entire community to get active with a specific focus on primary school children and the most inactive.

Beat the Street ran from 1 May - 4 June in Reading and in the three villages of Mortimer, Pangbourne and Theale from 26 June – 22 July.

A target was set for the whole community to travel 238,000 miles to the moon. On completion of the challenge, the top 5 teams won cash prizes and a donation of £3000 was made to the Mayor's Charity Fund, supporting good causes across Reading. The challenge was free to the end user and the focus was on getting involved and having fun in a community-wide project.

Recruitment

Intelligent Health worked with partners from Reading Borough Council Public Health, Education, Transport and Leisure services to promote the project to its stakeholders, schools and community groups.

Schools

IH wrote to all the head teachers in the schools in Reading, telling them about the opportunity to take part and potentially win cash prizes for their school to spend on equipment or donate to their chosen charity. In total 36 schools out of a total of 39 primary schools agreed to take part. A letter was sent, via the school, to the childrens' parents, informing them of the initiative and asking them to contact the school if they **did not** want their child to take part. No parent opted out of the competition.

IH then distributed RFID keyfobs to the schools, with each fob assigned to a particular pupil in the primary schools. In this way, all primary school children were 'pre-registered' in the competition, using just their first name, first initial of their second name and their class and school details.

We provided schools with maps and powerpoint presentations to give to pupils in assemblies, explaining the rules of the game and how they can win points and prizes and cash for their school. On request, the IH team presented these, but the majority of schools were happy to take on the responsibility of this and the keyfob distribution to pupils themselves.

Each school became a 'team' competing against other community group or workplace teams.

8,000 children were recruited through the primary schools. In turn, many children recruited their parents and grandparents to join their school team.

Health

Beat the Street was funded in Reading by the Clinical Commissioning Groups. There was therefore a focus on recruiting the least active – and therefore those who had the most potential health gain.

In the Reading area, only 1 person in 10 meets the guidelines of 150 minutes of moderate intensity physical activity (adults).

IH presented the initiative at conferences and events attended by health professionals, including 'Training in Practice' sessions, nursing conferences health promotion events. Along with an outline of how Beat the Street would work and its general aims and objectives, IH gave an overview of the benefits of short walks for patients with a range of long-term conditions. General Practitioners, clinical specialists, nurses and health promotion experts were encouraged to hand out the Beat the Street cards to their patients, explaining the benefits of walking for their specific condition.

Articles were produced for CCG newsletters and adverts for the challenge displayed on digital screens in GP surgeries.

Community

IH enlisted the help of local media partners, including the Reading Post Newspaper, to advertise the project and to invite groups and schools to form teams and join in the game.

The project was promoted at community and school events during April and May and advertised through posters in libraries and local shops. Libraries, shops, leisure centres, the Council offices, Reading Museum and community centres also displayed dispensers with the RFID cards and leaflets.

Digital posters about Beat the Street were displayed on buses across Reading, encouraging bus passengers to 'get off a stop early and walk to the moon'. In addition, for several days just after the launch date, Beat the Street team members handed out cards in the Town Centre and in local high streets.

Beat the Street partnered with Reading F.C. to jointly promote the project to its supporters, advertising in the match programme and handing out cards at home matches.

Reading Business Improvement District (BID) and the two shopping malls both promoted at town information points and via City banners.

Voluntary groups were encouraged to distribute cards and promoted via their networks. Community police were engaged.

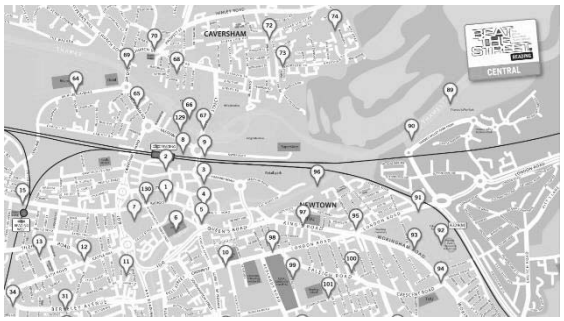
Walking groups were provided with maps and cards and Timebanks shared the information out with hard to reach groups.

In total 45,000 cards were distributed through these channels.

Teams

Fifty teams played the game including thirty primary schools, staff at the Royal Berkshire Hospital and Reading University and other community group teams. Scores were based **on team averages** rather than total points.

Positioning of the Beat Boxes

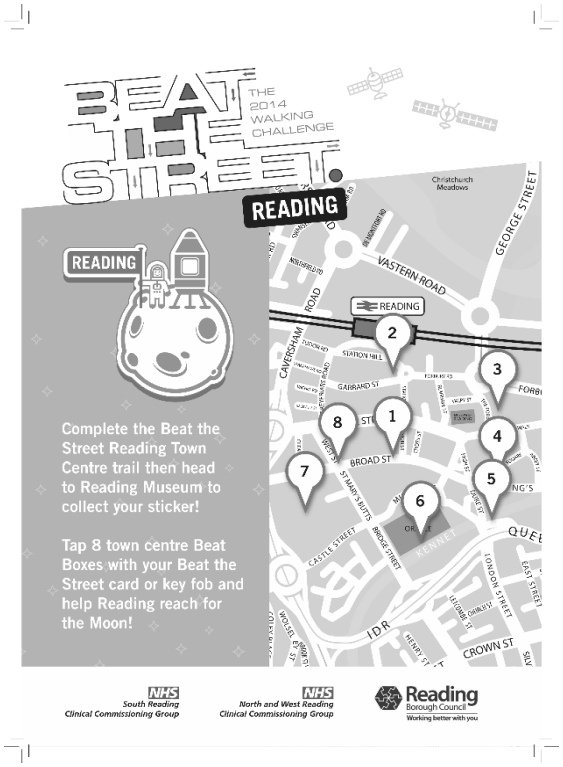


130 electronic beat boxes were placed throughout Reading, with an average distance between each one of 0.5 to 0.7 miles. Ten points were awarded for every valid journey. A valid journey consisted of a tap on two beat boxes within one hour. The majority of beat boxes were affixed to lampposts or street signs. Locations were chosen for their proximity to the schools that had signed up to participate and in their respective catchment areas.

Boxes were also placed along favoured walking routes across the town and on leisure walking routes, e.g. along the river. IH also installed beat boxes in the main parks in Reading to encourage families to go out walking at weekends and in the evenings. A full risk assessment was undertaken for each location and permission was obtained from Reading Highways department ahead of installation.

The boxes were installed between the 27th and 29th April, a few days ahead of launch date.

Maps showing the locations of the boxes were printed and distributed to all primary school children, doctors' surgeries, libraries and community centres. Maps were also made available on the Beat the Street website. A smaller separate map of a 'Town Trail' with just 8 boxes was produced to encourage visitors to the Town centre to take part in the competition.



Promotion and events

Reading Museum agreed to display moon fragments obtained from the National Space Centre, in keeping of the theme of Reading 'reaching for the moon'. The results of a poster competition, sponsored by local media were also displayed at the museum.

Beat the Street was integrated with Reading Borough Council events including a Children's Festival and half term activities.

'Bonus' beat boxes were set up at events such as the local 10K run and sports taster days at the local leisure centre.

Bonus boxes were also placed in temporary locations on longer walking routes, encouraging families to walk a 3 mile route to the neighbouring village of Sonning, along the Thames.

These events were promoted via a dedicated Facebook and Twitter site and through a notification panel on the Beat the Street website.

There were also weekly articles in the local media to promote the events and highlight progress in the competition.

Intelligent Health secured LEGO Friends, LEGO Movie and LEGO Super heroes aspartners for the schools to provide prizes. These included 3,000 mini prizes, 30 large box sets and a

private screening of the LEGO Movie to the winning team.

Mortimer Lunch Club members ready to play

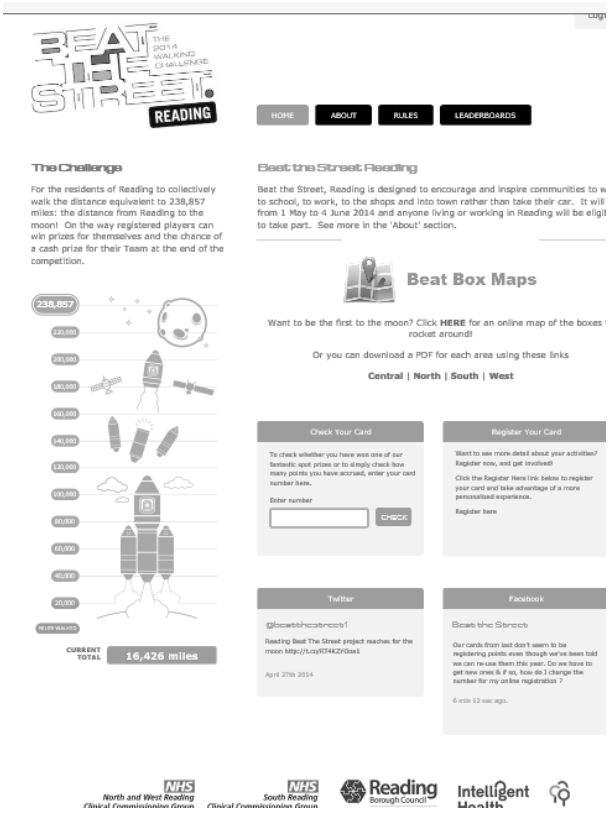
Reading CIC, Oracle and Broad St Mall all supported and allowed Beat the Street to promote on site and around the town.

Reading BTS Banner in town centre, Oracle Shopping Centre

Launch of village competition

Website

A dedicated user interface was created for the challenge: reading.beatthestreet.me. The website address was printed on the cards and leaflets and posters. Participants were encouraged to register their Beat the Street RFID cards, providing some basic demographic information including name, postcode, email and/or contact number. The rules of the game specified that in order to win a prize, cards needed to be registered.



Reading.beatthestreet.me webpage

The website registration also asked people to answer two simple questions about their current physical activity levels and their walking habits. These were based on the validated Single Item Physical Activity Questionnaire[1] and a modal choice question used by Reading Borough Council's transport department.

The website also displayed the rules of the game, the leader boards and a point checker where people could check their points and see which beat boxes they had tapped their card on. The home page graphic showed a scale of 0 – 238,000 miles as the target for the community to walk.

People were able to start using their card straight away, before registering and although this meant that a true baseline measure of physical activity wasn't always captured, it did ensure a greater degree of participation as it made it easy to join in. This was accounted for in the final analysis of the data and anyone who had waited more than 3 days to complete the registration was discounted from the matched pair analysis.

Participants were also able to register by using postcards at their library or GP surgery which were sent into the team at IH to enter onto the website. Only around 40 people registered in this way, however it was felt that offering a pen and paper alternative for registration was crucial to keeping the competition inclusive.

All primary schoolchildren were pre-registered using the lists obtained from the school and pre-allocated to their school team.

[1] Milton, K., Clemes, S., Bull, F. *Br J Sports Med* 2013;**47**:44-48

Extension to Pangbourne, Mortimer and Theale

Towards the end of the Reading competition the Beat the Street, Reading project board extended it into the Reading North and West CCG territory of Pangbourne, Mortimer and Theale.

IH visited GP surgeries and invited them to take part. The practices were very enthusiastic but needed more notice to be able to promote and

	Pangbourne Surgery	Theale Surgery	Mortimer Surgery
No of Cards	400	400	400
No of Cards Used	22	35	26
Hit Rate	6%	9%	7%

therefore uptake of patients was low.

IH invited the four primary schools to take part and promotional staff were placed in the three villages for the start of the new competition. Village shops and libraries took cards and promotional material and IH took a stall at the Mortimer village fete which drew lots of interest.

IH produced maps of the four villages and supported local events including school sports days. Theale Primary won the village's competition and teacher Sue Gallagher said: "The whole school has really gone for it over the past week. We encouraged them to start with but I've seen so many families out over the weekend walking and running around the boxes and the kids have just loved it. It's got me back out running too and I just wish it was on for longer!"

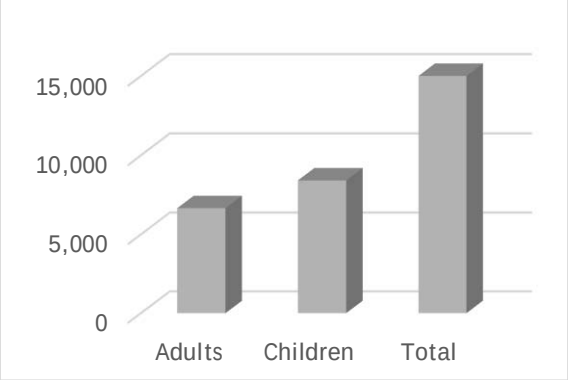
Theale Primary received a share of a cash prize of £600 with Mortimer St Johns and St Marys who also walked huge distances in their teams.

Four thousand cards were distributed and 1,000 people played.

Mrs S, Mortimer Village "I'm in my eighties and yesterday I went into Budgens and said 'I want a map to the moon!' They got me your map and it made us all laugh! I've been following the trail with my granddaughter."

Results

15,074 people took part in Beat the Street in Reading between May 1 and 4 June and in the outlying villages between 26 June to 22 July 2014. **8,416** of these were school children and **6,658** were adults.



Beat the Street key fobs given to primary school children.

A total of **514,198** valid swipes were recorded on the system which automatically discounts multiple swipes.

(Appendix 2, Table 2)

244, 537 miles were travelled by Reading residents playing Beat the Street, England

The majority of the journeys took place during the time when people would have been walking to school or to work. (Appendix 2, Figures 1,2). More activity was seen in parks and green spaces in the evenings and at weekends (Appendix 2, Figures 3,4,5).

Spikes in usage correspond to peaks in promotional activities. Schools found many innovative ways to increase their activity.(Appendix 2, Figures 6, 7). These include school walks, daily texts from the school to families and even a dad's pub crawl around the town centre beat boxes!

The winning team was All Saints' Infant and Junior school; the position was hotly contested by Redlands School and the staff team from Reading University.

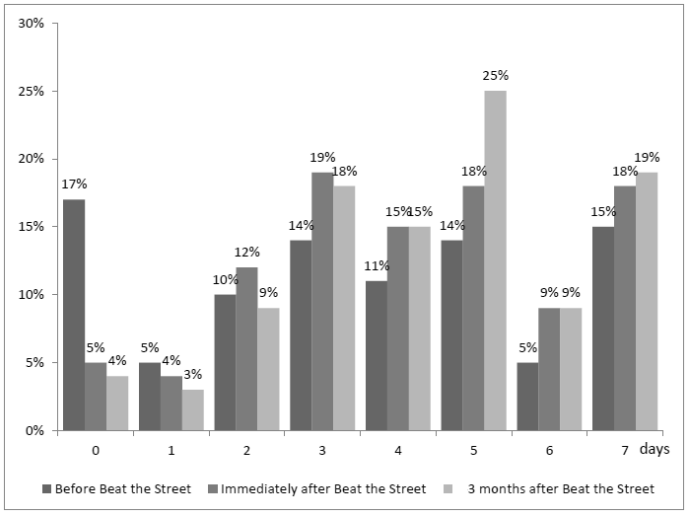
Linda Phillips Head of All Saints Infants said "It's a great initiative and has really got our children and adults walking and cycling around Reading. I am so pleased that one of the oldest and the youngest school in Reading have come together and won. It's really brought the schools and community together"

Of the 3,748 people who completed the online and postcard questionnaires, 3,708 of these scanned their card on at least one journey. 1,051 people completed the follow-up survey on the last few days of the competition and 319 completed the three month follow up survey. The results of the follow-up questions and the feedback from users in contained in the separate independent

evaluation carried out by The Evidence Centre (Appendix 1).

The exit survey shows that Beat the Street was effective in increasing physical activity levels immediately after Beat the Street.

A further follow-up survey was carried out in October 2014 to see how much of the change in behaviour has been sustained. 319 individuals completed the follow up survey. At the beginning of the competition, 35% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the competition, this had increased to 45%. Two to three months later this was maintained at 53%. This increase is statistically significant, meaning that it is not likely to have happened by chance. The changes remained when data from individuals was matched up rather than only looking at averages.



'*Days in the past week on which you have undertaken 30 minutes or more of physical activity*'. Data from 3,748 people at baseline, 1,051 follow up at the end of BTS and 319 people 3 months after BTS ended.

Some explanation of the sustained behaviour change can be found in the qualitative comments in the three month follow up survey (Appendix 1) including people starting to get into the habit of walking to school.

"*Children have changed their habits and are happy to walk longer distances, as they've done them before.*"

76% of people said they would try to continue the changes after the competition ended and two to three months later 75% said they continued to be more active.

Appendix 1 contains data regarding the number of patients with long-term conditions who took part in the competition.

The proportion of cards given out by GP surgeries was lower than expected. Each surgery was given 400 cards to distribute to patients. Three of the 26 surgeries significantly outperformed the others, managing to distribute around 50% of their cards. Millman Road surgery saw the greatest card usage with 167 (42%) of their card stock being used by participants. (Appendix 2, Table 1)

In addition to the feedback received via the survey, many people commented and provided feedback via facebook and twitter and to the team@beatthestreet.me email address.

Dr Rod Smith, Chair of North and West Reading CCG: "Beat the Street has added a competitive and exciting element to getting active. We've been hugely impressed that so many people in Reading, Pangbourne, Mortimer and Theale have walked, run and cycled their way to fitness and have enjoyed hearing stories of people that have literally gone the extra mile in pursuit of the goal of reaching the moon. Hopefully, the Beat the Street project has encouraged many people to make the daily activity a life-long habit."

Many schools teams became much larger than the number of pupils indicating families supporting the initiative.

Return on Investment

The BTS programme, when analysed with the NICE Return on Investment for Physical Activity Calculator (3) results in 191 QALYs gained after 2 years.

The total cost of the BTS programme in Reading was £110,000. For **every £1** spent on the programme, there is a **£3.53** return on investment in **transport** savings, **£14.58** in **healthcare** costs and savings of **£16.39** to the **economy** after 2 years[i].

(See Appendix 3)

Feedback event

The Reading community were invited to a feedback event held on one evening two weeks after the end of the competition in one of the local school halls. IH presented the results of the competition and presented prizes to the winning teams and to the individuals who had walked the furthest, including two VIP passes to Reading Festival. Much of the feedback received at this event was consistent with the feedback reported in Appendix 1 and provided IH with suggestions for improving the competition in future iterations.

In essence people wanted :

- More information about the competition in advance
- Better information about the beat box locations
- More beat boxes

Post Beat the Street: Lucky tap prizes were distributed and communicated to participants via twitter and Facebook and local media.

Media

Intelligent Health secured Reading Post as media partner for the challenge. They produced weekly print and online articles promoting the event. They also produced a pull out of all the maps at the start of the campaign and ran a competition to engage children.


TEAMWORK: top walkers are rewarded at prizegiving

Beat the Street is hailed a success

Over 40 articles were produced by local media during the competition, all positive.

BBC Radio Berks, Reading Chronicle, Families Magazine and XN Media were very vocal in their support of the initiative.

Organisers reported increased attendances where Beat the Street visited including Reading Borough

Beat the Street Facebook reach was over 5,000 with 739 likes. IH posted images and stories to keep the community engaged and received some very positive interactions.

40 press cuttings were collated. The total value of the media coverage has been estimated at £24,000 using industry standard calculations.

Over 7,000 certificates were distributed to primary schools.

Reading Museum reported a 51% increase in visitors from May 2013 at half term which they attribute to the bonus beat box installed for the week and the LEGO prizes provided.

Ann Brown, Town Hall Receptionist: "Everyone was really enthusiastic about the Beat the Street project and particularly keen to get their extra points from our box over half-term and collect their Lego goodies. I would say that on the days I was here there was a steady stream of people coming in throughout the day."

Stuart Singleton-White "This was brilliant, engaging and competitive. So many people associated with our school actively took part. Something like this works on so many levels. Not only in its main purpose, to get us walking more. But on other levels too, not least the sense of community, of tribalism and of the shared experience it creates. Thanks Beat the Street you've got a great thing here. " Facebook 5 June 11.23am

Appendix 1

Results of Independent Evaluation carried out by The Evidence Centre

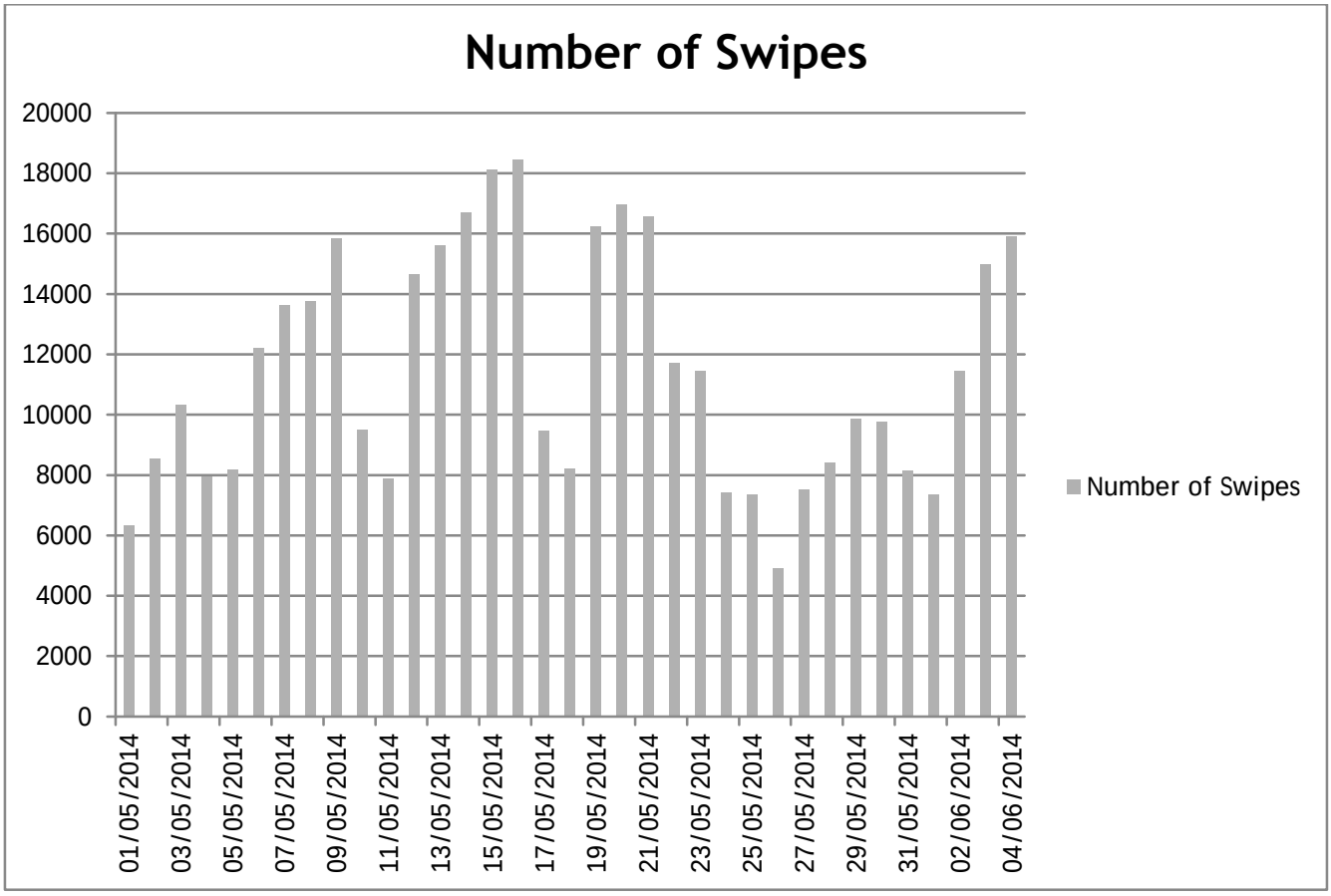
Appendix 2

Results : Tables and Figures

Table 1 – Card distribution from GP Surgeries

Surgery	No. of Cards	Cards Left (est)	% cards issued	Cards used	% cards issued that were used
Abbey Medical Centre	400	350	13%	12	24%
Balmore Park	400	300	25%	72	72%
Chatham Street Surgery	400	300	25%	24	24%
Circuit Lane Surgery	400	290	28%	33	30%
Eldon Road Surgery	400	350	13%	5	10%
Emmer Green Surgery	400	230	43%	55	32%
Grovelands Medical Centre	400	200	50%	66	33%
Kennet Surgery	400	200	50%	25	13%
London Street Surgery	400	397	1%	3	100%
Longbarn Lane Surgery	400	250	38%	24	16%
Melrose Surgery	400	400	0%	19	0%
Milman Road Health Centre	800	403	50%	167	42%
Pembroke Surgery	400	150	63%	29	12%
Peppard Rd Surgery	400	350	13%	18	36%
Priory Avenue Surgery	400	330	18%	66	94%
Reading Walk-In Health Centre	400	200	50%	18	9%
Russell Street Surgery	400	230	43%	13	8%
South Reading Medical Centre	400	300	25%	15	15%
The New Surgery /London Road	400	200	50%	6	3%
Tilehurst Medical Centre	400	300	25%	9	9%
Tilehurst Tylers Place	400	400	0%	54	0%
Tilehurst Village Surgery	400	300	25%	13	13%
University Medical Practice	400	350	13%	15	30%
Western Elms	400	50	88%	33	9%
Westwood Road Surgery	400	30	93%	21	6%
Whitley Villa Surgery	400	180	55%	6	3%
	10800	**7040**		821	

Table 2 - Number of swipes per day



1

Figure 1 - Heat map showing tap data for 10,000 swipes over the whole of Reading

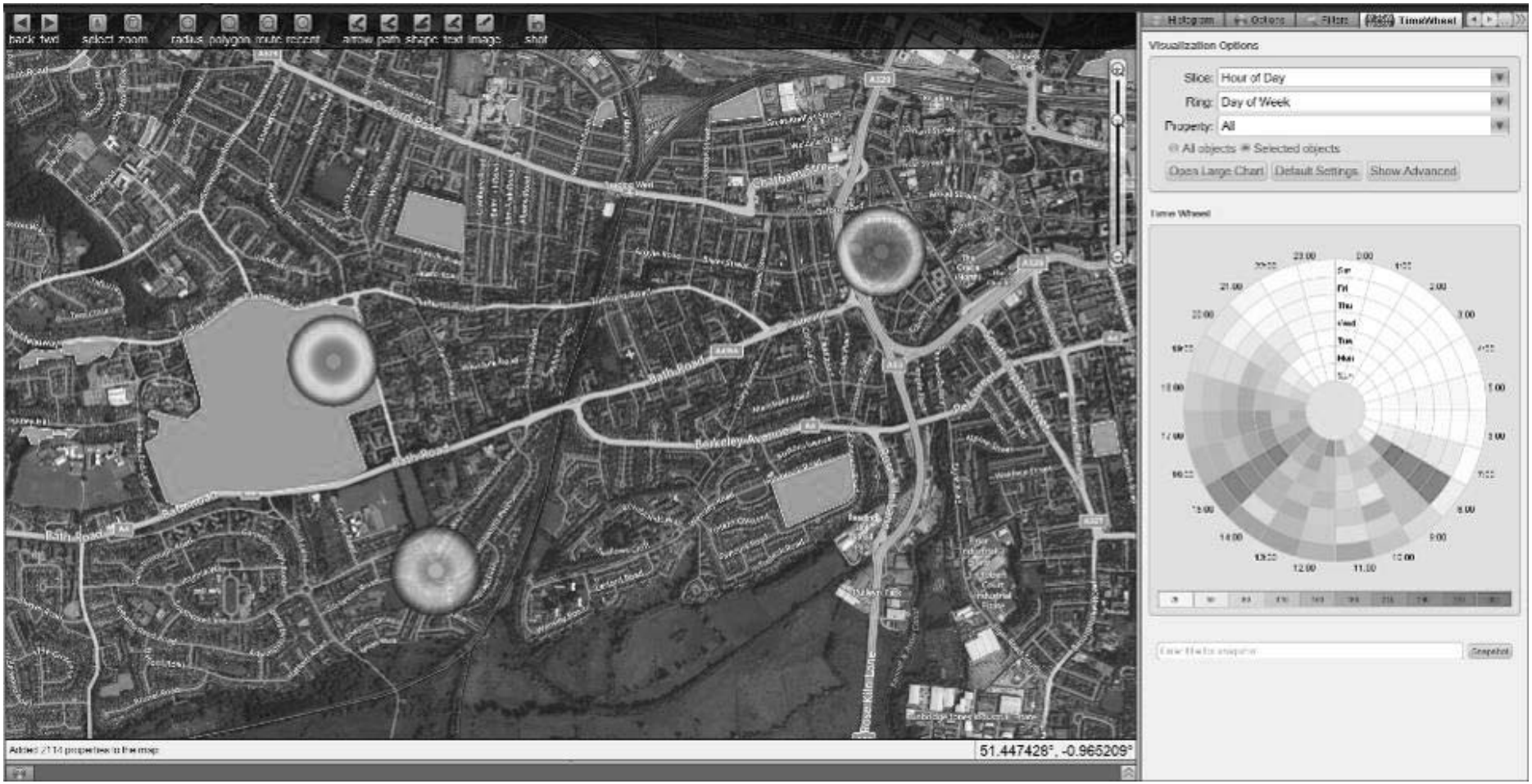


Figure 2 – Heat map and timewheel showing taps three different beat boxes; City Centre, Park, Sub-Urban

1

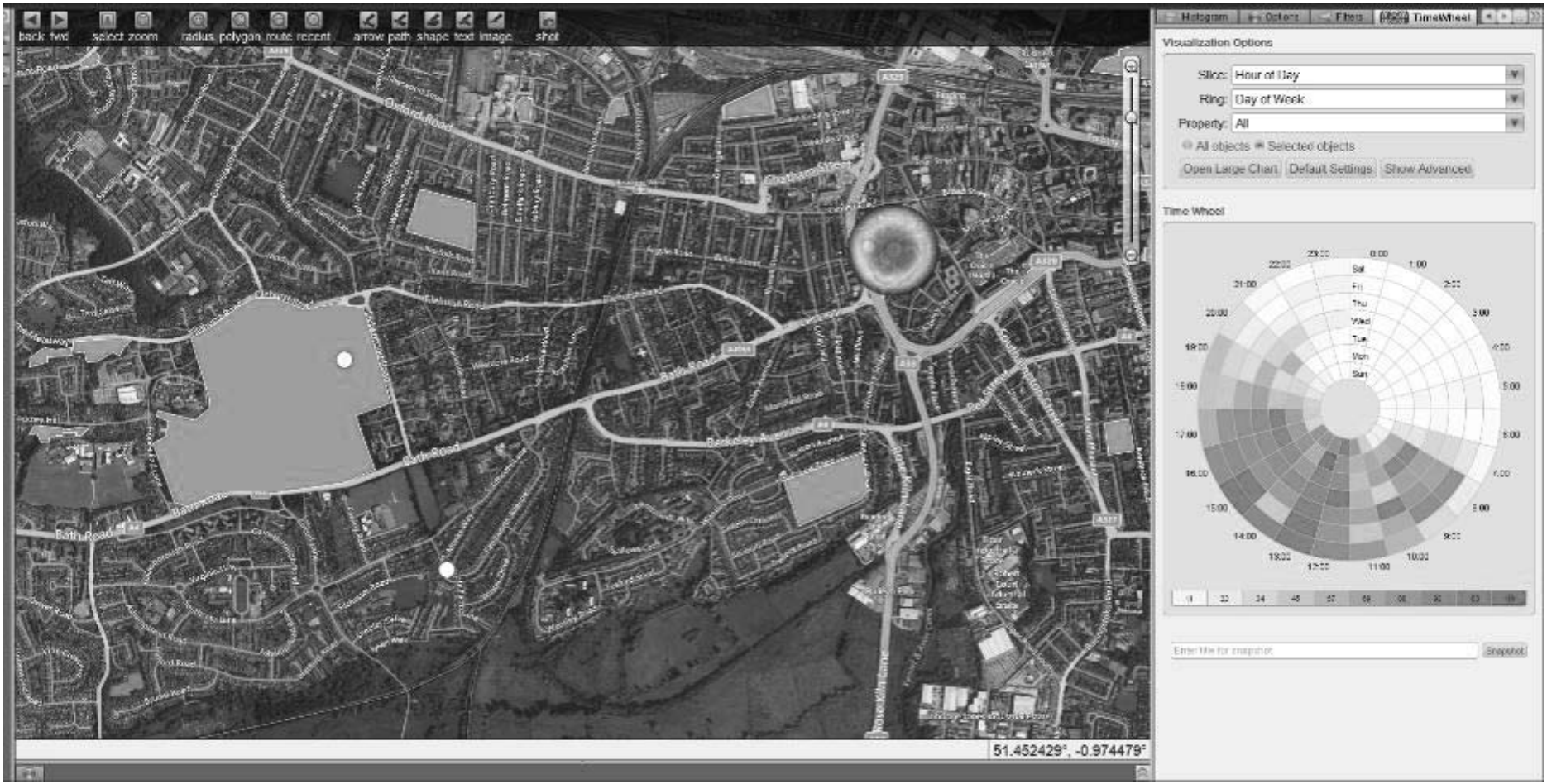


Figure 3 - Heat map and time wheel of City Centre Beat Box usage

2

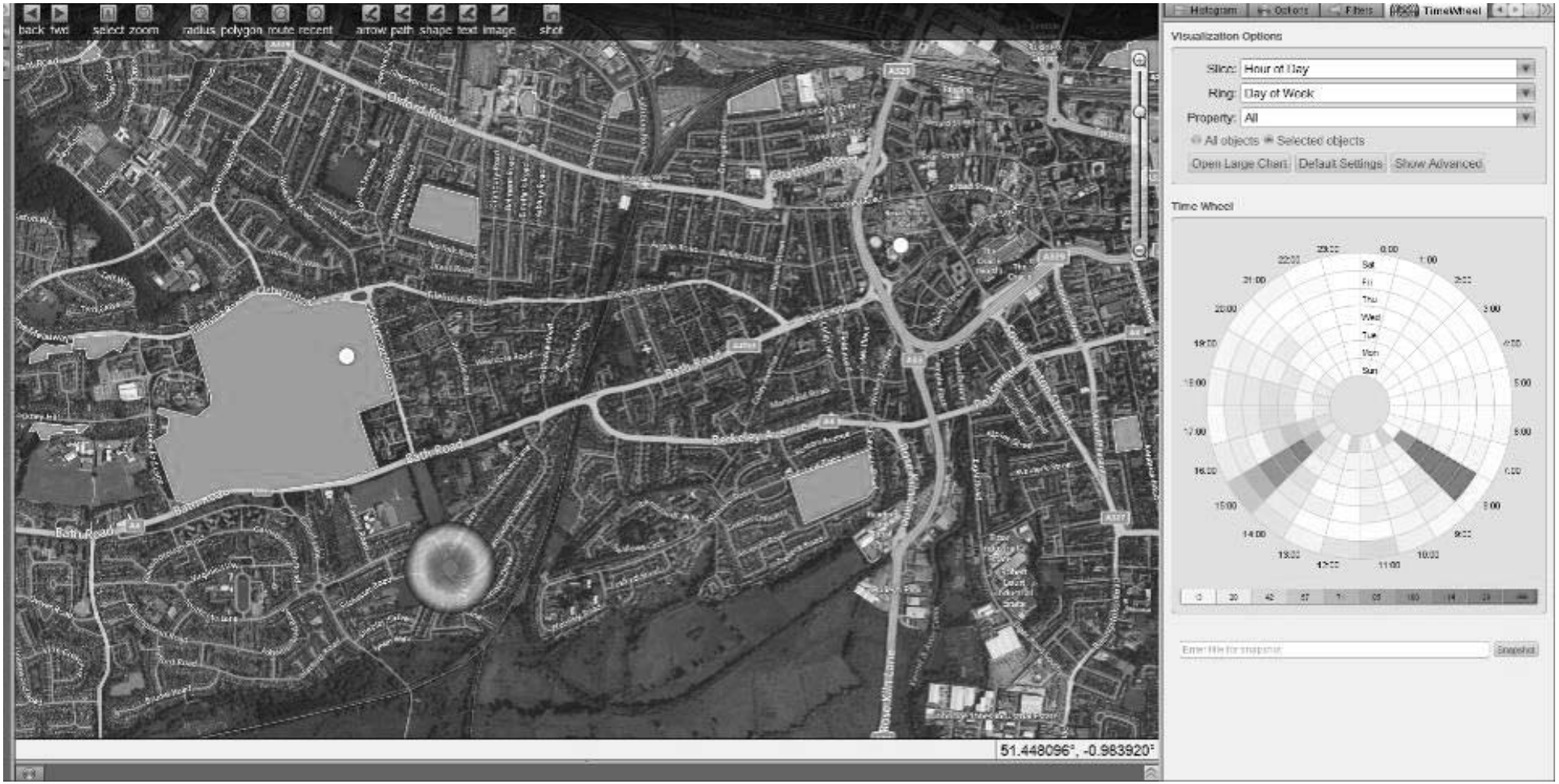


Figure 4 - Heat map and time wheel of Sub-urban Beat Box usage. (Predominantly school arrival and departure time)

3

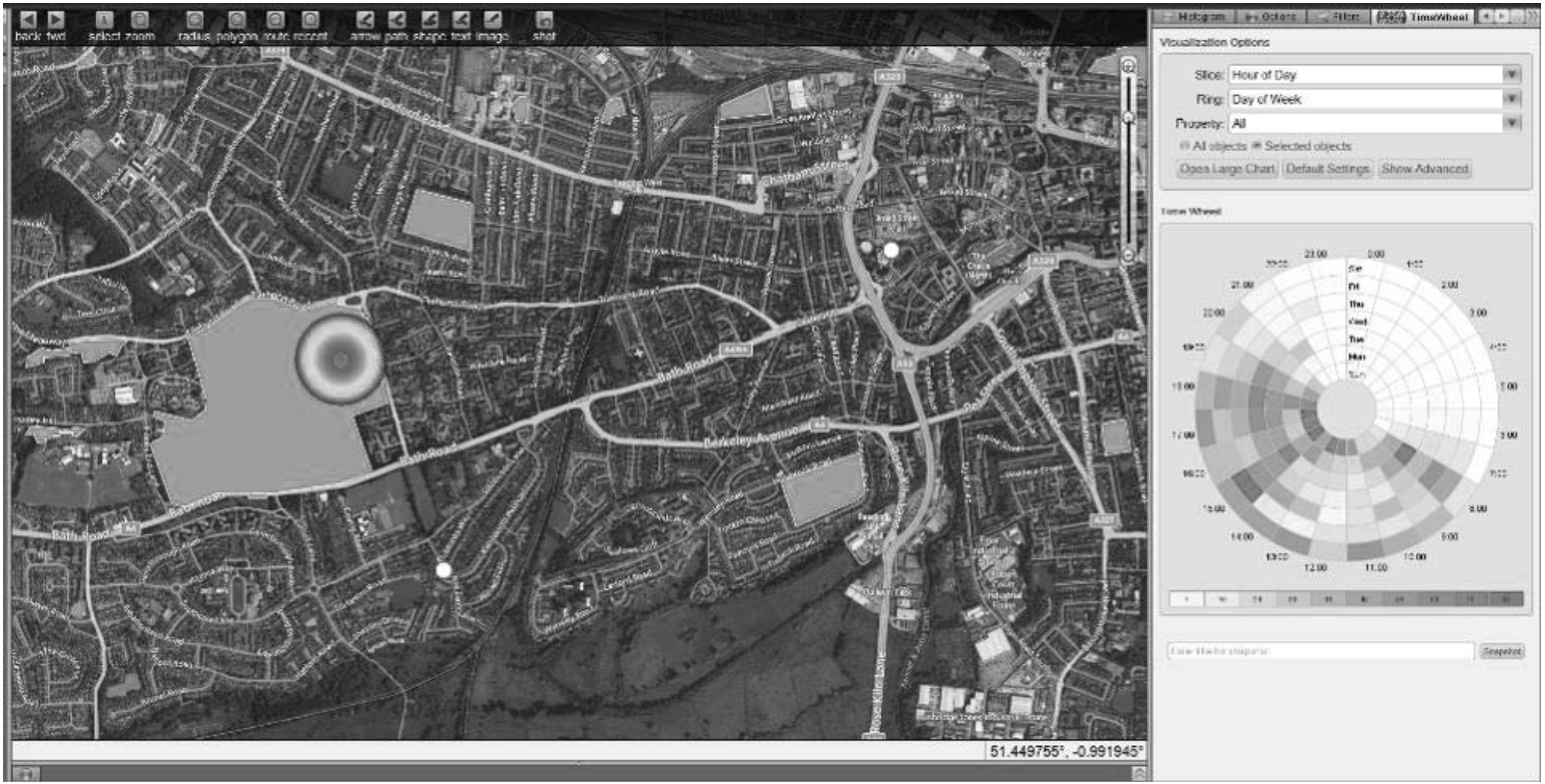


Figure 5 - Heat map and time wheel of Park Beat Box usage. (More weekend and evening use).

Appendix 3

Return on Investment Calculation for BTS

For every £1 spent on Beat the Street Reading (ROI based on adult participants and inactivity levels of 44%)		
	2 years	5 years
QALY'S gained	191	192
Transport	£3.53	£8.38
Healthcare	£14.58	£14.72
The economy (productivity)	£16.39	£38.87

i)https://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Physical-activity-return-on-investment-tool

What do people get out of Beat the Street?

Feedback from Reading

August 2014

Key messages

Beat the Street is a community initiative designed to inspire people to walk more. People scan a card or key fob onto 'Beat Box' scanners located around the community in order to indicate that they have walked between the boxes, thus earning points that add up to win prizes for their team or school.

In May 2014, 3,748 adults completed a survey when they registered online for Beat the Street in Reading and 3,708 of these scanned their card on at least one journey. Many more people took part but did not register, including school children. At the end of the competition, everyone who registered was invited to provide follow-up feedback and 1,051 did so (28% of registered adult participants).

The main findings from the survey were:

- People were very positive about Beat the Street and the benefits they had gained.
- 94% of people said they would recommend Beat the Street to friends and family.
- The most commonly reported benefits from Beat the Street were having fun, feeling more healthy, getting fit and spending time with family or friends.
- **78% of people said Beat the Street helped them to walk more than usual**.
- At the beginning of the competition, 35% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the competition, this had increased to 45%. This change is statistically significant, meaning that it is not likely to have happened by chance. The changes remained when data from individuals was matched up rather than only looking at averages.
- **76% of people said they would try to continue the changes** after the competition ended.
- People with high blood pressure, diabetes, arthritis, heart disease, emphysema / COPD or a long-term mental health condition were just as likely as everyone else to say that they benefited from Beat the Street and that it helped them walk more and be more active. 78% of these people said Beat the Street helped them walk more than usual, 77% said Beat the Street helped them feel healthier and 41% said Beat the Street helped them with their health problems.
- The most common suggestions for development were having more Beat Boxes in different locations and advertising more widely.

The survey suggests that Beat the Street is feasible and worthwhile. It reached a large number of people, motivating them to increase their physical activity.

Contents

Beat the Street in Reading

Beat the Street is an innovative community initiative designed to inspire people to walk more. 'Beat Box' scanners are located around the community and people can earn points by scanning their Beat the Street card or key fob on scanners to indicate that they have walked between the boxes. Individuals, schools and villages compete to see who can achieve the most points, achieve targets and win prizes. In Reading the competition ran mainly from 1 May to 4 June 2014, with three villages taking part between 26 June and 22 July.

3,748 adults registered online to take part in the competition. Many other people took part but did not register. For example, schools took part but children did not register online. 3,708 of those registered undertook at least one valid journey during the competition, meaning that 99% of those who registered to take part did so to some extent.

During registration and again at the end of the competition, adults were asked to provide brief feedback online. This report summarises people's feedback about the impacts of Beat the Street. Feedback was not collected in this way from school children as they were not asked to register in the same manner.

Collecting feedback

Surveying participants

An online survey with seven questions plus demographic questions was developed with the support of an independent evaluator. This ensured that the survey could be tailored to the needs of Reading Beat the Street, whilst building on good practice. The survey explored what people thought they got out of Beat the Street and any changes in their physical activity levels or walking behaviour.

All 3,748 people who had registered online (thus completing 'baseline' questions) were emailed a link to the online survey immediately after the competition ended. They were given one to three weeks to respond. A prize draw was offered as an incentive.

1,051 people shared their views, giving a response rate of 28%. Response rates for online surveys are typically in the region of 10-15%, so **the response rate for Reading Beat the Street was good**. Having feedback from more than 1,000 people is a good basis to draw conclusions about what people who took part thought of the initiative.

The analysis was undertaken by an independent team.

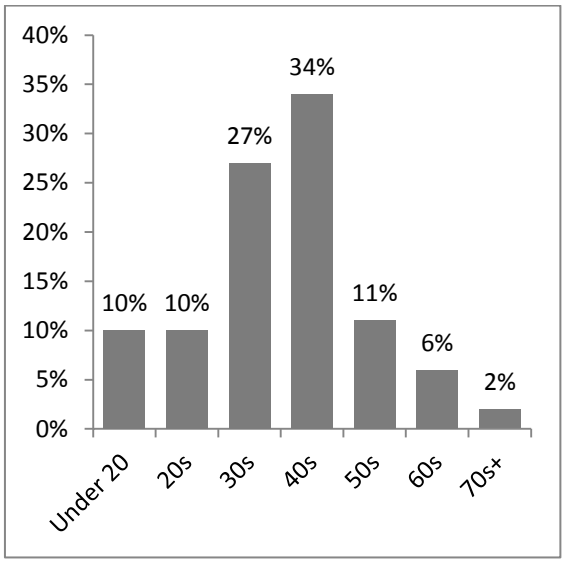
Characteristics of people surveyed

The people who responded to the survey were similar to those who registered to take part in Beat the Street as a whole in terms of their age, gender and the wards in which they lived. This information was collected by comparing the follow-up survey data to the baseline questions everyone completed when they registered. This is important because it demonstrates that feedback was collected from a wide range of people and that those who chose not to respond to the survey did not have markedly different demographic characteristics.

Seven out of ten of those who provided follow-up feedback were women (72%) and three out of ten were men (28%).

A good mix of people of different ages provided feedback (see Figure 1).

Figure 1: Age groups of people surveyed



Note: 1,051 people provided feedback.

12% of people reported that they had one of the following long-term conditions: high blood pressure, diabetes, arthritis, heart disease, emphysema / COPD or a long-term mental health condition (126 people). These are referred to as 'selected long-term conditions' throughout the report.

There were no major differences in people's feedback according to their demographic characteristics. Where there were some differences, these are noted in the text.

Benefits of Beat the Street

Joining Beat the Street

Most people said they received their Beat the Street card from either their local library or their child's school (see Figure 2). However, a quarter of people said that they had received their card from a wide range of other sources such as local charities, the Council, hospital, gym, swimming pool, shopping centre, university or workplace (28%). 11% of people said they received a card from the reception at their GP clinic. Only 1% of people said that their GP or another healthcare worker gave them a card.

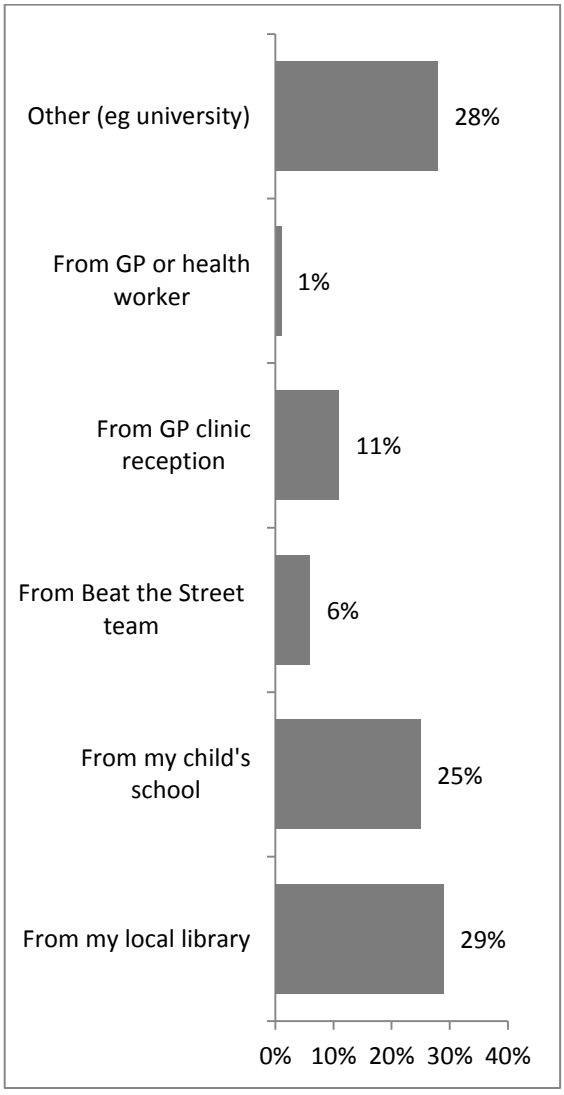
People aged 60 years and over were more likely to have received their card from a local library whereas younger people were more likely to have received their card from their child's school.

Women and men were equally likely to get their Beat the Street card from the same places.

People with selected long-term medical conditions were more likely than others to have received their card from the reception at their GP clinic (17% of people with selected long-term conditions versus 9% of people without long-term conditions).

95% of people said it was easy to get a Beat the Street card.

Figure 2: Where did you get your Beat the Street card?



Note: 999 respondents answered this question (95%).

What did people get out of Beat the Street?

Once the competition was over, people were asked to reflect about anything they got out of taking part. They were invited to provide open-ended comments as well as selecting as many options as they wished from a pre-specified list.

The open-ended feedback asked people to answer the question: 'If Beat the Street helped you or you did anything differently during the competition, please tell us what.' 75% of 1,051 people provided an answer (785 people). The most common feedback was:

- increased walking or cycling
- doing things as a family
- changing usual walking, running or cycling routes
- exploring new places in the local area
- interacting with other people taking part in the competition
- promoted team spirit as schools, families and communities worked together
- motivated to start other healthy activities such as training for fun runs or long distance walks

People said that they sometimes got up earlier to walk to school with their children, took different routes to find Beat Boxes or walked more on weekends as a family. Adults talked about the benefits for themselves as well as their children and other family members.

Box 1 provides examples of people's verbatim feedback.

Box 1: Quotes from people talking about what they did due to Beat the Street

"As a family we definitely walked further - eg by taking detours to find beat boxes and also by going on family Beat Box walks. It was a fantastic way of incentivising the kids to walk and scoot further."

"Beat the Street helped me massively as it got me outdoors with my kids and allowed me to lose an amazing amount of weight!"

"Encouraged my child to walk to school and into town (versus car), and also go on a few cycling trips."

"Got out walking and running with the children made us feel good contributing to our community and also helping the school."

"Got the whole family moving, we had a competition between family members about who could get the most points. Husband stopped driving to work so he could tap on the way to the train station and back."

"As a family, we went out together more. We cycled, practised cycling skills and talked about road safety."

"This scheme helped incentivise me to visit parts of Reading I haven't been to before just to find more Beat Boxes."

"I had to walk further than usual to get the boxes. My 9 year old nephew LOVED it and went out with his friends to do boxes (he's never been interested in going out playing with his friends before). Beat boxes changed his life!"

In the closed-ended feedback, the most commonly reported benefits of Beat the Street were having fun (mentioned by 62%), getting fit (46%) and feeling more healthy (46%), spending time with family and friends (44%) and doing something good for the environment (34%). Figure 3 illustrates the broad range of perceived benefits.

Men and women, people from different age groups and people with and without long-term conditions all selected the same four top benefits of Beat the Street.

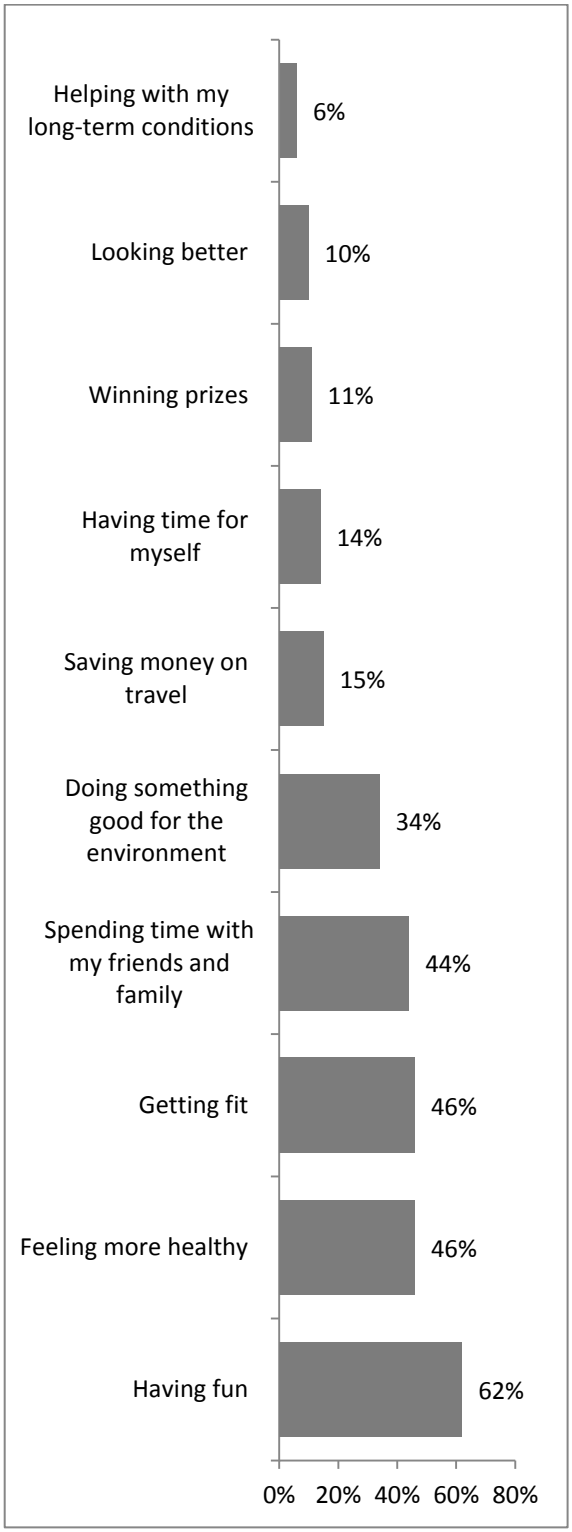
Overall, 82% said that Beat the Street helped them feel more active and 73% said they had already felt the knock-on effects of this, saying Beat the Street had helped them feel healthier (see Figure 4).

14% of people said that Beat the Street helped them with their health problems, but 64% said this question was not relevant to them (due to not having health problems). Of those who specified that they had one of the long-term conditions of particular interest, 41% said that Beat the Street had helped them with their health problems.

Three quarters of people said they would continue any changes they had made after Beat the Street ended. The Beat the Street team plans to follow up people in three to six months to see whether they did continue to walk more.

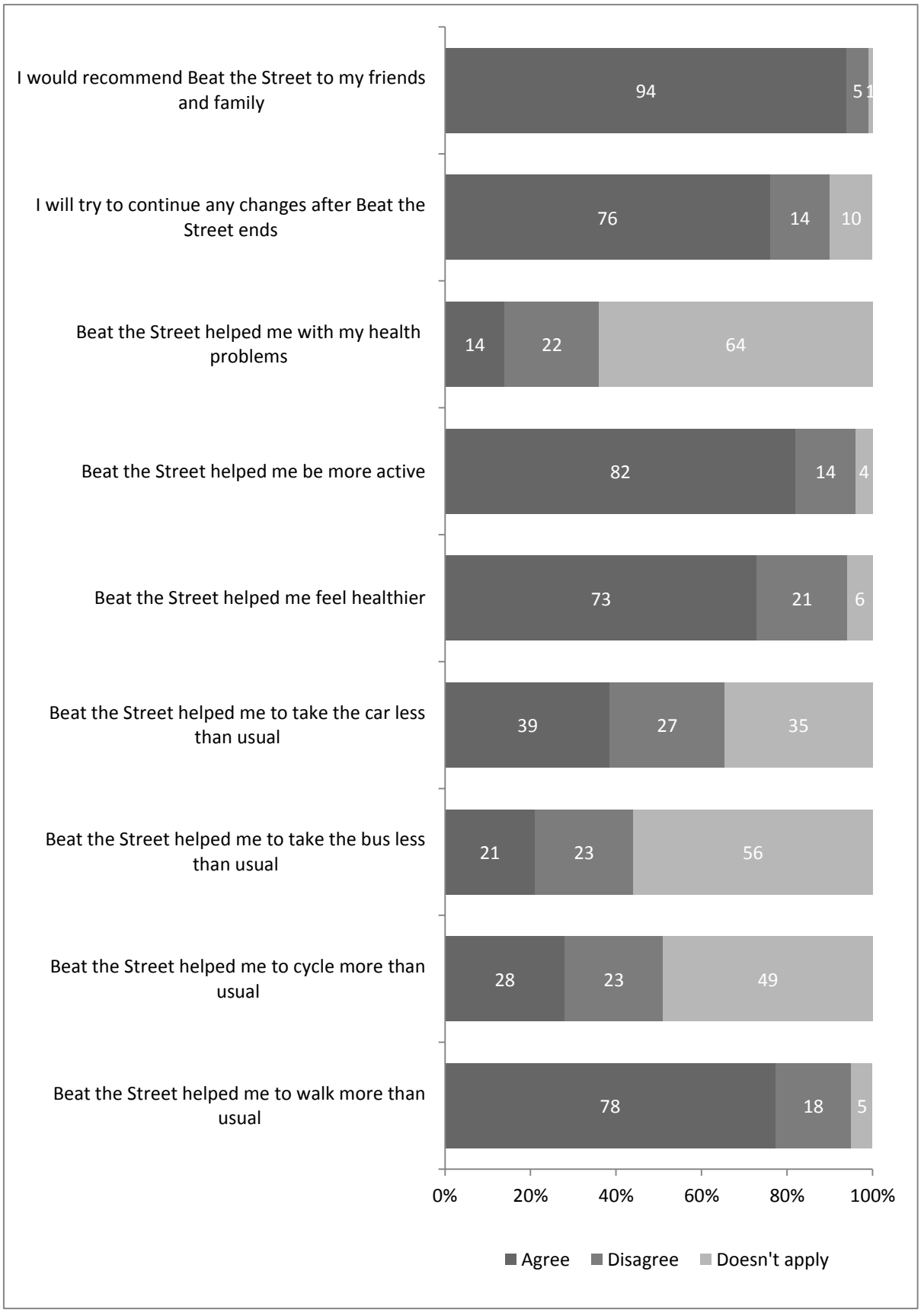
There were no major differences in these trends according to whether participants were women or men, their age groups and whether or not they had a long-term condition.

Figure 3: What are the main things you got out of Beat the Street?



Note: 1,051 respondents provided feedback about the things they got out of taking part (100%). Percentages add to more than 100% because people could select as many options as they wished.

Figure 4: Extent to which people agreed or disagreed with various statements



Did Beat the Street influence people's activity levels?

As well as feeling that Beat the Street had positive health, environmental, social and community benefits, the people surveyed reported tangible changes to their walking behaviours.

Three quarters of people said Beat the Street had helped them to walk more than usual (78%) and one quarter said Beat the Street had helped them to cycle more (28%).

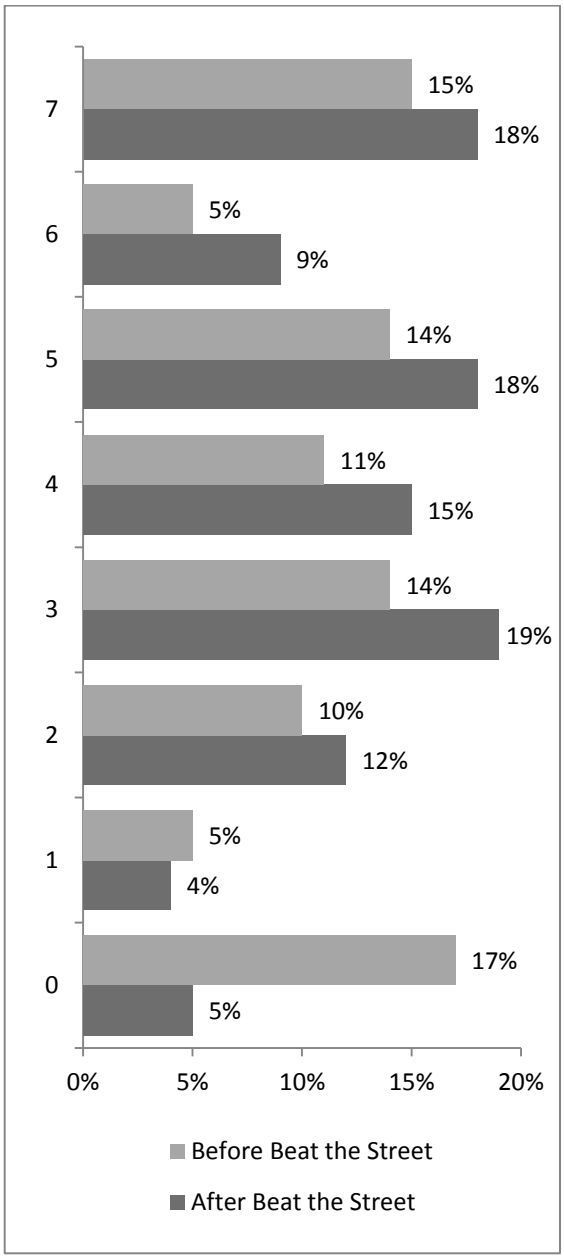
One fifth said that Beat the Street had helped them take the bus less than usual (21%) and two fifths said Beat the Street had helped them travel less by car (39%).

Importantly, **eight out of ten people said they would try to continue the changes they had made** after Beat the Street ended (76%).

There were no major differences in these trends according to whether participants were women or men and whether or not they had a selected long-term condition. However, people under the age of 20 were more likely than all other age groups to say Beat the Street had encouraged them to cycle more and travel by car less often.

This feedback was reinforced by reports about how frequently people walked or took part in other physical activity. Figure 5 illustrates how many days per week people reported undertaking 30 minutes or more of physical activity, comparing the beginning of the competition to after Beat the Street ended. On average, people were undertaking 30 minutes or more of physical activity three days per week at the beginning and four days per week at the end of Beat the Street.

Figure 5: Days in the past week week of 30 minutes or more of physical activity



Note: Participants were asked 'In the past week, how many days have you done 30 minutes or more of physical activity, which was enough to raise your heart rate? This may include sport, exercise and brisk walking or cycling, but not things that are part of your job.' 'Before' data were collected from 3,748 people at registration and 'after' data were collected from 1,048 people completing the follow-up survey.

The Department of Health recommends that adults should aim to be active daily and that over a week, activity should add up to at least 150 minutes (2.5 hours) of moderate intensity activity. This averages 30 minutes of physical activity at least five days per week. 35% of people said they were achieving this target when they registered for Beat the Street, and this had risen to 45% by the end of the competition. This is a statistically significant increase, which means it is unlikely that this change happened by chance (probability of seeing this result by chance: <5%).

At the end of Beat the Street, men were more likely than women to say that they were active five or more days (53% of men versus 43% of women).

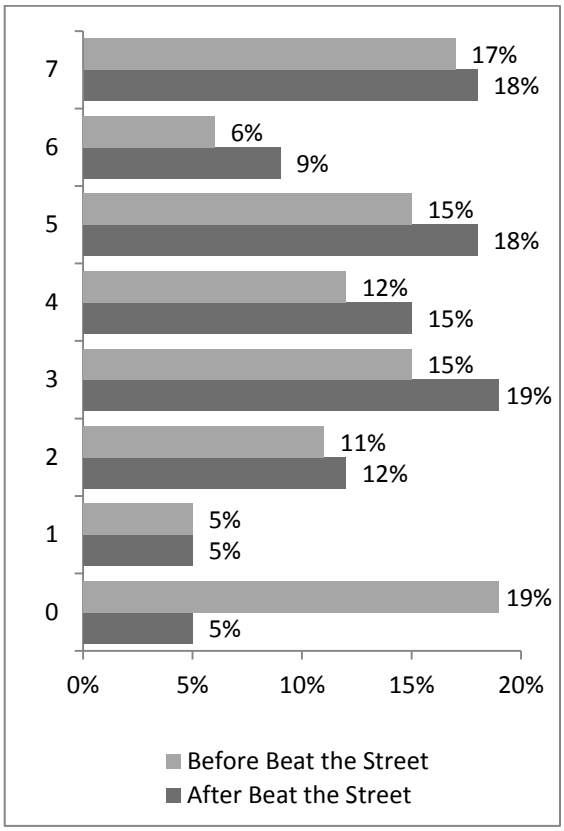
People under the age of 20 were more likely than all other age groups to say they were active five or more days (64% versus 46% of all others).

People who completed the follow-up survey may have been most active and engaged during Beat the Street. Comparing the data from all people who registered with the follow-up feedback from potentially the most engaged participants may therefore give a skewed result. To check this, the analysis team compared the data available from people who completed both the registration survey and the follow-up survey. People's individual data were matched by their Beat the Street card number. This allowed a comparison of activity levels of individual people before and after Beat the Street.

This 'matched pair' analysis revealed positive findings. Individual before and after data were able to be matched for 616 people based on their Beat the Street card number. Of these, **38% of people said they were achieving the Department of Health physical activity level target when they registered for Beat the Street, and this had risen to 45% by the end of the competition.** This is a statistically significant increase, which means it is unlikely that this change happened by chance (probability of seeing this result by chance: <5%).

Importantly, **the proportion of people who were doing no days per week of recommended physical activity significantly decreased** (from 19% to 5%).

Figure 6: Days in the past week of 30 minutes or more physical activity from 616 people with before and after data



Did people with long-term conditions experience the same benefits?

About one out of ten people who completed the follow-up survey said they had high blood pressure, diabetes, arthritis, heart disease, emphysema / COPD or a long-term mental health condition (12%). The analysis explored whether these people reported the same benefits from Beat the Street.

People with the selected long-term conditions reported the same key benefits as everyone else: having fun, improving health and fitness and spending time with friends and family (see Figure 7).

These people were just as likely as others to report that Beat the Street helped them walk more and feel more healthy. They were more likely than others to say that Beat the Street helped them with their health problems (41% versus 14% of the total sample, see Figure 8).

Matching up the data from individuals before and after the competition using Beat the Street card numbers found that people with long-term conditions were more likely to report being physically active for five or more days per week after Beat the Street than they were beforehand (53% vs 41% before, see Figure 9, probability of seeing this result by chance: <5%).

These results suggest that Beat the Street can be feasible and effective for people with selected long-term conditions.

Figure 7: Main things people with selected long-term conditions got out of Beat the Street

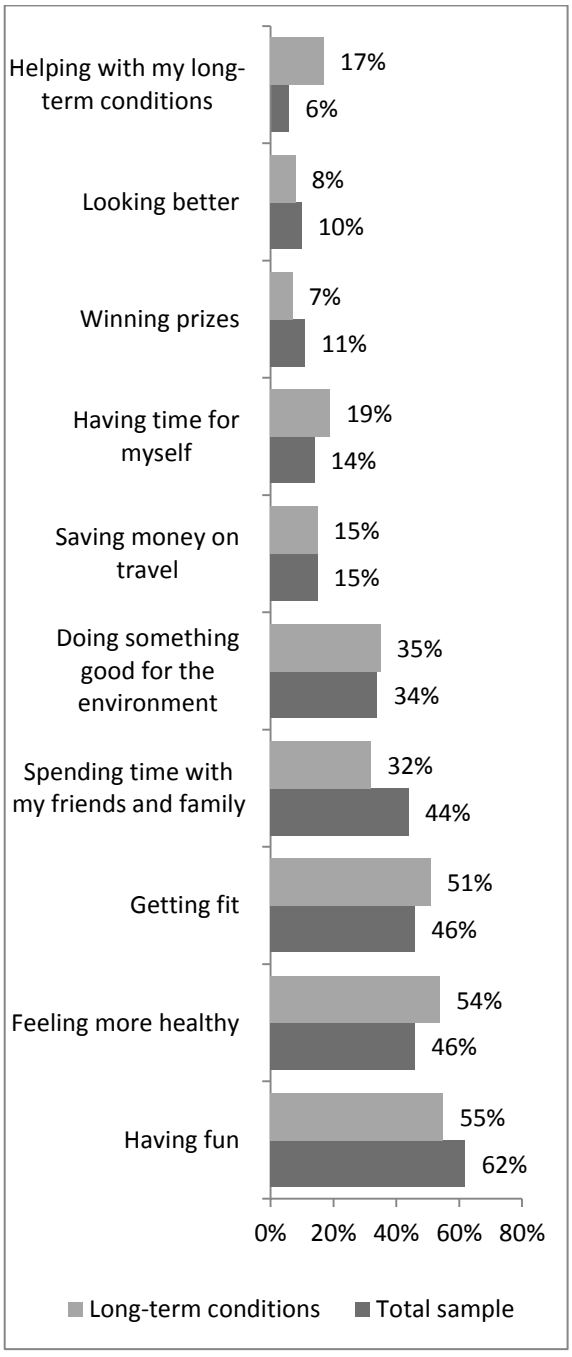


Figure 8: Extent to which people with selected long-term conditions agreed with various statements

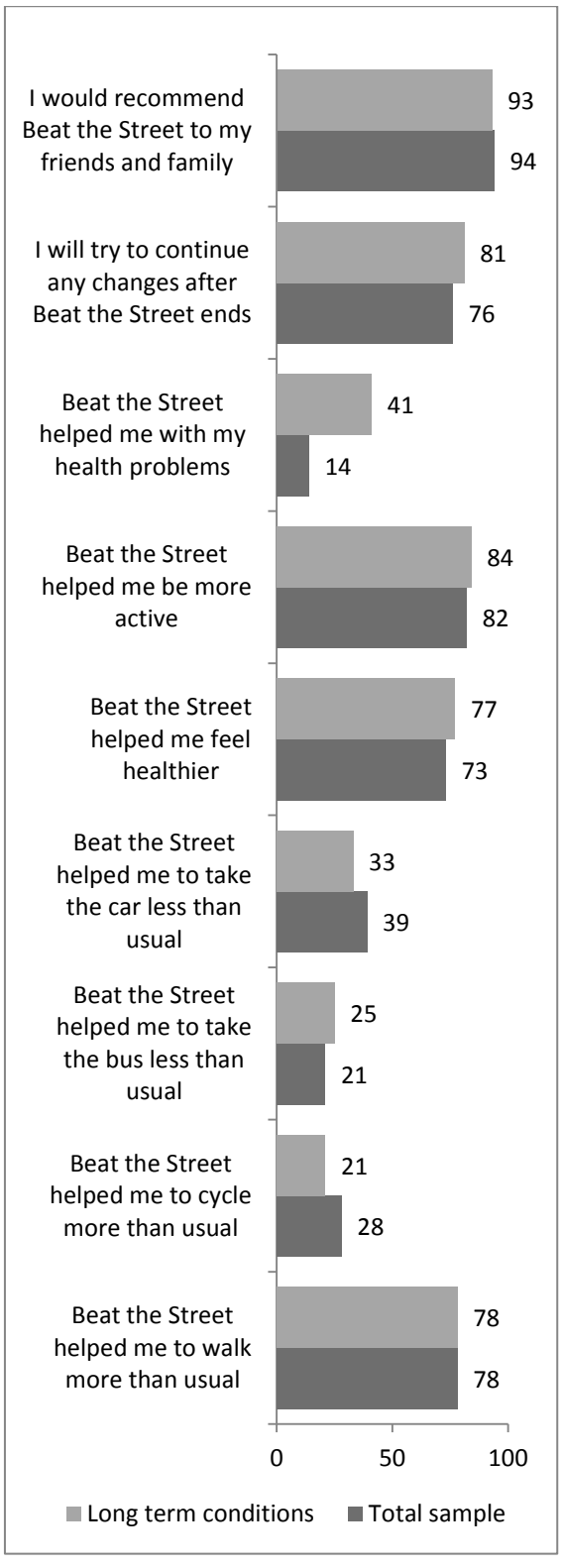
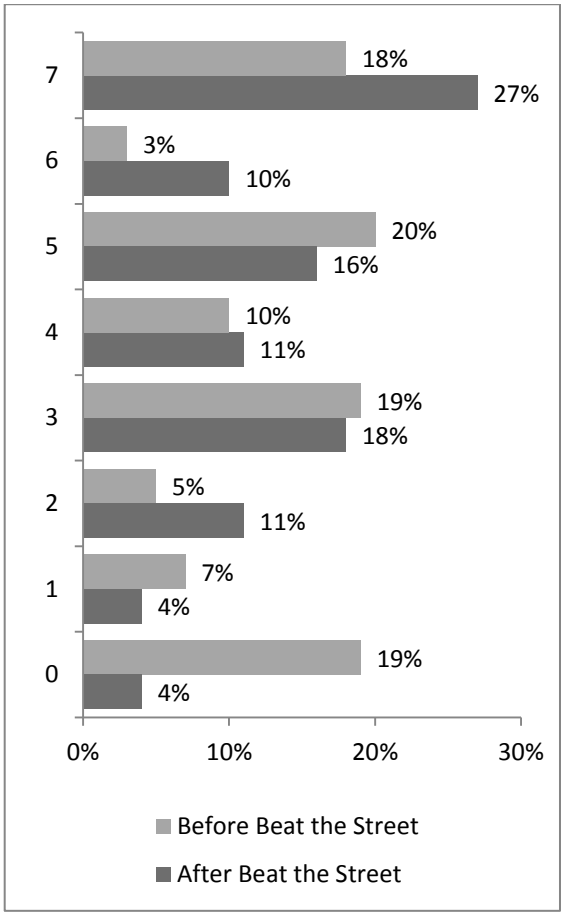


Figure 9: Number of days in the past week of 30 minutes or more physical activity before and after Beat the Street among people with selected long-term conditions



Note: This figure is based on matched before and after data from 74 people.

Suggestions

The overall impression from the follow-up survey was that people enjoyed Beat the Street and thought they got a lot out of it. Almost everyone said they would recommend Beat the Street to friends or family (94%).

The Beat the Street team are constantly seeking to develop further and are always eager to hear suggestions. People were asked how Beat the Street could be made even better, using an open-ended question. 784 people provided suggestions (75%). The most common suggestions related to:

1) expanding the competition
2) promotion and communication
3) practical and technological issues

Box 2 provides examples of verbatim feedback from participants.

Potential for expansion

People believed that there was much scope to make the competition even bigger and better. They suggested:

- adding more Beat Boxes and having them in different locations
- running the competition more regularly or for longer
- having more types of competitions, such as between age groups
- providing more ways to keep people interested such as receiving additional bonus points
- having prizes for individual schools, such as sports equipment for the school after a certain number of points are amassed

Promotion and communication

In terms of promotion and communication, people suggested:

- wider promotion of Beat the Street by the NHS and Council so that people who do not have links with schools hear about it and know they can also take part. This included the suggestion for more active promotion by GP clinics
- being more precise about the location of Beat Boxes
- communicating more regularly with participants using updates by email
- providing more information printed on the Beat Boxes themselves so people know what they are for and where to sign up
- clarifying the rules of the competition, including on the website
- providing more rapid responses to email and online queries

Practical issues

Suggestions about other practical issues included:

- making sure Beat Boxes were in place from the beginning of the competition, before maps are given out
- checking on the equipment to make sure it was working (and including a telephone number or email address on boxes so people could report if they weren't working)
- making it possible to see the total points that individuals had amassed to foster competition and encourage people to beat their friends – or giving schools access to this information so they could create their own leader boards

People provided these helpful suggestions because they were specifically asked for them, but overall respondents were very positive about the concept of Beat the Street and what it achieved.

Box 2: Quotes from people talking about suggestions for ongoing development

Examples related to expansion

"Beat the Street is a great incentive to get fit, get kids and families active and outside. Perhaps schools would drive it more internally if there was a reward for their actual school? For example new sports kits, balls, skipping ropes, playground equipment etc, publicity? Our generation of kids do need to be more active and Beat the Street encourages parents and children to do just that. The joining in then allows them to feel the benefit of being active physically, psychologically, financially and allows the new attitude and behaviour to continue beyond the end date of Beat the Street."

"It was fun, it engaged the children. Probably better over a longer term to let them build up points and encourage others to join."

"Maybe have a few more boxes, spread out a little more, as there seemed to be groups of boxes together, then big gaps between some of the groups."

Examples related to promotion

"As a family - and also as a school community - this has been a fabulous activity and we're sad that it's finished. We have really pulled together to walk further and get points for the team! It's been very sociable as we've bumped in to other families on our walks. The kids have loved being part of a collective activity and have been encouraged to walk further which means we as adults have been able to walk further too… One suggestion - as we went round I was asked what the Beat Boxes were for - they generated a lot of interest. So wider community involvement would be great eg perhaps community centres, pubs, streets, health centres etc could be encouraged to form teams and get involved. Perhaps Beat the Streets ambassadors could volunteer to drum up participation in their neighbourhood. It's a great way of building community spirit."

"Great idea, my children and other children at school really enjoyed it… The local GPs could have been a little bit more active at handing out cards, maybe actually giving cards to people at reception, rather than having a passive poster on wall. There could have been posters / banners outside GPs. There could have been a bit more advertising of the scheme on the Beat the Street boxes, as some people asked me what the beeping was! I would say more active giving out of the cards would have got more people involved."

Example related to practicalities

"Put QR codes on the boxes so people can find out about it using their mobiles, amazing the number of people who looked at a box after I tagged it… Could make the boxes a bit brighter to attract attention. Have a bonus box per day, a random box posted on Facebook as the "bonus box" extra 50 points. Send the user a daily/weekly email to promote interaction and maintain involvement. Individual score board, high score per day/week."

Summary

The follow-up survey of 1,051 people who participated in Beat the Street in Reading suggests that people got a lot out of taking part. **The three most frequently reported benefits were having fun, feeling fit and healthy and spending time with friends and family.**

People said that they had walked more and used their cars less during Beat the Street.

There was a statistically significant **increase in the number of people meeting the Department of Health's physical activity target for adults**.

Importantly, eight out of ten people said that they **planned to continue any changes** they had made after the competition ended.

People with one of the long-term conditions of particular interest (high blood pressure, diabetes, arthritis, heart disease, emphysema / COPD or a long-term mental health condition) were as likely as everyone else to say that Beat the Street was worthwhile and that it had helped them to increase their levels of walking and physical activity. Two fifths of these people also thought that Beat the Street had helped them with their health problems.

People who took the time to complete the survey might be more likely to be engaged with the initiative and view it positively, however there was feedback from people from a broad range of age groups and wards within Reading as well as many suggestions for future development.

The overall message is that Beat the Street is a feasible initiative that is able to generate community support, change people's immediate modes of transport and encourage people to want to keep walking more in future. People with long-term conditions can take part and are just as likely as others to find the competition useful and motivating for increasing their physical activity.

In a few months the Beat the Street team plans to follow up people to see whether the reported changes in walking and physical activity were maintained after the competition ended.

JOINT REPORT FROM READING BOROUGH COUNCIL, SOUTH READING CLINICAL COMMISSIONING GROUP, NORTH & WEST READING CLINICAL COMMISSIONING GROUP, BERKSHIRE HEALTHCARE FOUNDATION TRUST and ROYAL BERKSHIRE HOSPITAL

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**30 January 2015**	**AGENDA ITEM:**	**9**
TITLE:	**UPDATE ON JOINT WORKING TO SUPPORT CHILDREN & FAMILIES**		
LEAD:	**CLLR JAN GAVIN**	**TEL:**	
JOB TITLE:	**LEAD COUNCILLOR FOR CHILDREN'S SERVICES & FAMILIES**	**E-MAIL:**	**jan.gavin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 & In September 2013, a report to the Health & Wellbeing Board set out the opportunities identified across the Council's Children's Services and Public Health teams, the two Clinical Commissioning Groups and local health services to strengthen joint working to improve health outcomes for children and families.

1.2 & The Board agreed to set up a sub-group to progress the opportunities and to report regularly. The first report was given to the board in March 2014 providing an update on the work over the first six months. This report outlines the revised action plan focus, achievements and progress made and any barriers being experienced.

1.3& The revised Action Plan (Sept 2014) agreed by the sub-group is attached as Appendix A.

2. RECOMMENDED ACTION

2.1 To note the progress made to date and to support the further development of the work, as set out in the report.

2.2 To agree for the sub-group to continue to meet quarterly to maintain oversight of ongoing progress against the action plan.

3. POLICY CONTEXT

3.1 A number of national policy and guidance documents (such as the Department of Health's 'Healthy Child Programme', the government's 'Working Together to Safeguard Children' guidance, and the NHS Outcomes Framework) recommend local agencies working together in an integrated way to better support health outcomes for children.

3.2 Locally, the sub-group's work also aligns with Reading's Health & Wellbeing Strategy, particularly **Goal Two** - "Increase the focus on early years and the

whole family to help reduce health inequalities" - and **Goal One** - to "promote and protect the health of all communities particularly those disadvantaged".

3.3 Reading's Early Help Strategy was published in November 2013, broadly covering the range of services supporting children and families below the threshold of Children's Social Care or very specialist interventions. The sub-group's work supports the delivery of a number of key actions identified within the Strategy to support health priorities – for example, increasing breastfeeding support.

4. PROGRESS TO DATE

4.1 Following the Board's approval, regular meeting have been held. Membership includes Reading Borough Council (both Public Health and Children's Services), South and North & West Reading CCG's, Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital (Senior Children's Nurse)

4.2 The group has reviewed, revised and streamlined its Action Plan. The action plan now has 3 key themes;

a) **Improved Access and knowledge of family services (across both Health and RBC)**
b) **Education opportunities and Support for Families**
c) **Increasing our quality and impact in specific areas (supporting breastfeeding, uptake of immunisations/ reducing Post Natal Depression (PND)/ reducing obesity**

4.3 The key achievements to date against the Action Plan and work agreed to progress this further is set out below under the three themes below (point 4.5 onwards).

4.4 The subgroup is pleased to report the securing of funding from South Reading CCG and RBC Public Health for a joint project manager. This is for a year-long post to focus on accelerating progress in the education support to early year's parents, improving early identification and help in mental health support to women and staff during pregnancy and into the first 2 years after the child's birth.

4.5 It is anticipated that the post-holder will be in post by March/April 2015 reporting to both South Reading CCG and RBC Children's Services.

Theme One - Improved Access and knowledge of family services (across both Health and RBC)

4.6 A pilot scheme set up across South and East CCG, RBC and Berkshire Healthcare Foundation Trust (BHFT) has been set up to provide a single referral route for local GPs to contact their local Children's Centre. Using the already well-established single point of access, the Health Hub, a partnership has been formed to enable GPs to refer families needing early help directly to Children's Centres. Set up as a pilot in October there has been limited use in the first 6 weeks by GPs but it is recognised that embedding service change in primary care takes time. We are fully expecting to run the pilot past the initial 3 months planned, and if proved successful to widen the offer to all Reading GP's.

4.6 Over the summer, the CCGs worked in collaboration with Public Health to deliver a series of healthy winter messages during the week 6-12 October in the Broad Street Mall. The Roadshow was funded from NHS England winter resilience money and comprised an information leaflet and videos incorporating both NHS and Reading Borough Council messages describing how to stay healthy over winter. The messages were focussed on the elderly and families:

- Importance of the flu jab
- How to keep your home healthy
- Self Care / App
- NHS 111
- Where to go for advice: Reading Walk in Centre, pharmacists

The event was staffed by one member of staff over 7 days, however, patient representatives from both Reading CCGs attended the roadshow to help reach larger numbers of people. South Central Ambulance Service also attended to promote NHS 111 following public feedback that the service was not well known. From numbers of leaflets distributed, it is estimated that over 2,000 members of the public were engaged with.

4.7& Reading CCGs have produced a booklet on managing common childhood illnesses aimed at parents and carers of children aged birth to 5. These have been widely distributed across Reading to A&E, GP practices, Walk in Centre, Health Visitors, Family Nurse Partnerships, libraries and toddler groups. Online versions are available on the CCG websites and the Reading Resource Guide.

4.8& An early summer event as part of the Children's Festival has been identified as an opportunity to promote some key messages to families on topics such as oral health, exercise, weight management, immunisations. A task group has been set up to identify the detail and coordinate with the events team in RBC to deliver this event.

Theme Two - Education opportunities and Support for Families

4.9 It is recognised that parent education from health workers could have an impact in improving parent confidence in positively managing their child's health and development. The action plan aims to develop an education support package in all 5 clusters to deliver information and advice consistently on Immunization, Common Childhood illnesses and injury prevention, Mental and emotional well-being for mother and baby, feeding /breastfeeding, and language development (oral health?). This service offer needs to link to the ages and stages developmental check from health visitors. The initial programme has been identified and with the appointment, expected in early 2015, of the jointly funded project manager into public health this action will gain more momentum.

Theme Three - Increasing our quality and impact in specific areas (supporting breastfeeding, uptake of immunisations/ reducing PND/ reducing obesity. The action plan identifies the following aims:

4.10& Improve Breastfeeding rates in particular to families who are difficult to reach. Recently both the Acute and Community health Trusts have achieved the National UNICEF baby friendly accreditation which evidences the high standard of care, support and information that the mothers and families of Reading are

now receiving. However this is the first stage in developing a robust process for the whole of Reading to move to being Breast feeding friendly. Going forward Public Health, Children's Centres and the Health visiting service have committed to work closely on ensuring coordination funding and services.

4.11 Increase the profile and promotion of immunisations in to families who are difficult to reach. The task group have reviewed most recent data on immunisations and will be targeting catch up at school as its primary focus.

4.12 Reduce the impact of Post Natal Depression (PND) in families and on children's lives. What to progress has been agreed as joint training to support early detection between Children's Centre and Health staff, re-locate to increase access to face-to-face Talking Therapies provision into Children's Centres, recommend alternative PND services to be delivered in CCs. With the appointment, expected in the early 2015, of the jointly funded project manager into public health these actions will be owned by a dedicated resource to drive them forward.

4.13 Support the healthy weight strategy to reduce levels of obesity in families. Exact details need to be confirmed with Public Health colleagues.

5. FUTURE OPPORTUNITIES

5.1 While making progress on a number of actions in a short space of time, the sub-group has also identified a number of issues that require further work to be addressed over a longer time period. These include:

- GP use of non-health services to support families/ children
- To work with public health (locally and PH England) and out local schools to take a similar approach to the recent boost to MMR for other 'catch up' immunisations at transition points into schools
- Stronger link to the obesity strategy to align our contribution to this work-stream.
- To maintain the recent success of the Breastfeeding Initiative and explore widening its impact by applying this to the Council.

6. NEXT STEPS

6.1 The Health Wellbeing Board established this sub group to provide momentum to improve support for children and families around health outcomes in Reading, and to increase access to early help services for families in need of support.

6.2 It is recognised that a number of actions require ongoing work from the partners involved in the sub-group, and that a longer time period is required to demonstrate impact on health outcomes.

6.3 It is proposed that the sub-group continues to meet quarterly to maintain strategic oversight of progress against the action plan and monitor collective impact.

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 The group's work has been informed by a number of consultations with children, young people, parents and carers. This includes the consultations completed on

the Health and Wellbeing Strategy and the Early Help Strategy, as well as the 'Listening into Action' work by Berkshire Healthcare Foundation Trust to understand the views of parents about health visitors and other services.

8. BACKGROUND PAPERS

8.1& 'Joint Working Opportunities to Support Children & Families Across Health And Children's Centres' – reports to the Health & Wellbeing Board, 20th September 2013 & 21st March 2014

8.2 Reading's Early Help Strategy 2013-16

8.3 Reading's Health and Wellbeing Strategy 2013-16

8.4 Healthy Child Programme guidance

8.5 'Working Together to Safeguard Children' Guidance

Children & Families Joint Working Sub-Group - Action Plan Agreed Sept 2014

	Area of Development	Actions	Who is responsible?	Time frame	Outcomes/ Measures	RAG rating
Theme One - Improved Access and knowledge of family services (both Health and RBC)						
1	Improving understanding across health services of the range of Early Help services available	• Set up a single email/ telephone pathway for GPs to identify vulnerable families for CC support. Piloting in South CCG. • Review pilot and decide to use with North & West CCG	Reading Borough Council (Children's Action Teams/ CCs), BHFT, N W Reading CCG, South Reading CCG	January 2015	Number of families referred and those now using CC services Timescale measured between referral and successful outreach GP feedback	AMBER
		• Run winter messages roadshow at Broad street mall	South Reading CCG,	Dec 2014		GREEN
		• Run a health children and families event, alongside Reading Children's Festival	South Reading CCG, Reading Borough Council (Events Team)	June 2015	Number of families accessing event	AMBER
Theme Two - Education opportunities and Support for Families						
2	Making the most of the role of Health professionals to support and advise the large majority of families at key development milestones	• Develop a programme of health education sessions in our Children's Centres by a team including Health Visitor, a perinatal mental health nurse, an acute Children's Community Nurse, a speech and language therapist, and CC Family Development Worker. • Run and review the programme sessions in all 5 clusters in a consistent way in areas of Immunization, Common Childhood illnesses and injury prevention, Mental and emotional well-being for mother and baby, feeding /breastfeeding, and language development	BHFT, Reading Borough Council (Children's Centres), South CCG	Dec 2014 Sept 2015	Number of families accessing sessions Feedback from families on confidence in 5 key areas Families using sessions increase: • Immunisations • Breastfeeding rates HV reporting children using service are/ are not reaching key milestones…	AMBER
Theme Three – Increasing our quality and impact in specific areas (supporting breastfeeding, uptake of immunisations/ reducing PND/ reduction obesity						

Version 2 post Nov sub group meeting

3	Increasing profile and promotion of immunisations in areas where this is a priority, particularly to families who are difficult to reach	• Need to discuss what can happen here…. • CCGS to request regular data (from TVPCA I think)	BHFT, Reading Borough Council (Public Health)		Meeting target of 95% of children under 1 immunised	AMBER
4	Reducing the impact of Post Natal Depression (PND) in families and on children's lives	• Re-locating and consider commissioning some additional face-to-face perinatal Talking Therapies intensive face-to-face provision into Children's Centres • Delivery of a rolling programme of training for Children's Centre staff on the signs and early detection of mothers suffering from PND. • Research commissioning of a specific PND service to be delivered from CCs	BHFT, Reading Borough Council (Children's Centres + Public Health), South CCG	April 2015 Sept 2015 Sept 2015	Number of sessions and rate of positive use from families. Number of staff trained and confidence measure of staff	AMBER
5	Reducing Obesity levels, in areas where this is a priority, particularly to families who are difficult to reach	• See public health plan • Implementation of the healthy weight strategy. • Maximise the access and use of the health lifestyle activities at our children's centres….	RBC (public health)			TBC at next meeting
6	Improving Breastfeeding rates, in areas where this is a priority, particularly to families who are difficult to reach	• To maximise the work of the Breastfeeding network within our Children's Centres • Review current funding and initiatives supporting breast feeding to ensure best value services are being provided. • Regular review of uptake data	Reading Borough Council (Children's Centres + Public Health), South CCG BHFT & RBH hospital	April 2015 April 2015	Improving Breastfeeding rates in particular areas	AMBER

RAG rating definitions

GREEN – completed or confident that on track
AMBER – element of concern of not being completed on time but will be completed
RED – risk of not being completed at all

READING BOROUGH COUNCIL

DIRECTOR OF EDUCATION, ADULT AND CHILDREN'S SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**30 JANUARY 2015**	**AGENDA ITEM:**	**10**
TITLE:	**UPATE ON CHILD SEXUAL EXPLOITATION STRATEGY**		
LEAD COUNCILLOR:	**COUNCILLOR GAVIN**	**PORTFOLIO:**	**CHILDREN'S SERVICES AND FAMILIES**
SERVICE:	**CHILDREN'S SERVICES**	**WARDS:**	**ALL**
LEAD OFFICER:	**VICKI LAWSON**	**TEL:**	**0118 937 4163**
JOB TITLE:	**INTERIM HEAD OF CHILDREN'S SERVICES**	**E-MAIL:**	**Vicki.lawson@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To advise the Health and Wellbeing Board of the latest Child Sexual Exploitation (CSE) Strategy. The actions contained within the strategy will be developed into a detailed action plan/project plan to be monitored by the CSE Children Gone Missing Steering Group which reports to the Reading Safeguarding Childrens Board (RSCB). The strategy is intended to improve service delivery, reduce the risks associated with CSE and improve outcomes for children.

1.2 The CSE strategy sets out the partnership intent to improve the delivery of services to **Prevent** children becoming at risk of CSE, **Protect** children who are at risk or are victims, **Pursue and Disrupt** the activity of individuals and or groups of perpetrators and help victims and their families to **Recover** from the abuse.

1.3 &The actions against the priorities are intended to ensure that we address all of the dimensions of CSE and deliver improved outcomes for children. The priorities and actions reflect the recommendations from the published enquiry into Rotherham, Ofsted thematic inspections and the voice of children. Achieving the action plan will be stretching and will require all partners to align and commit time and resources to ensure the outcomes are achieved at pace. The actions build on the successful foundations that are in place but are none the less ambitious and not without resource implications. The size and scale of CSE in Reading is not fully understood and needs to be improved, once this is achieved we will only then fully understand the resource implications that are required to deliver the ambitions of the strategy in their entirety.

2. RECOMMENDED ACTION

2.1 To note the strategy and requirement for an action plan to deliver it.

3. POLICY CONTEXT

3.1 The profile of CSE has been raised at a national level with the experience of areas such as Rotherham and Rochdale. CSE will have an increased focus during an Ofsted inspection with a clear expectation that the Reading Safeguarding Childrens Board takes a leadership role in ensuring that children are safe from CSE and that there is adequate pace and resources attached to the improvements required.

4. PROGRESS TO DATE

4.1 &The governance of the strategy sits with the RSCB, who agreed this on 17 December 2014.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 & The strategy needs to address the diverse needs of the community and recognise that children at risk of CSE and in need of protection are a vulnerable group in their own right. CSE touches all parts of the community and we will need to ensure the delivery of the strategy takes into account the diversity of the Reading community.

6. BACKGROUND PAPERS

6.1 CSE Strategy

A Strategy to Safeguard Children and Young People at Risk of or Experiencing Sexual Exploitation in Reading 2014 – 2017

Reading Local Safeguarding Children Board

V2.4 8/01/15

1. Introduction

Child Sexual Exploitation (CSE) is a form of sexual abuse that requires effective multi-agency partnership working to safeguard those who are being abused and those at risk of being exploited. CSE cannot be dealt with solely by individual local authorities, police divisions or public health authorities each operating in their own silos. Offenders and victims cross administrative boundaries and so should the collective response of the LSCB to safeguard the children of Reading.

This strategy builds upon the Statement of Intent produced by Thames Valley Police in February 2013 and has been further developed as part of the work of the Reading LSCB Child Sexual Exploitation Steering Group.

This strategy is also informed by the following reports:

- Professor Alexis Jay OBE, *Independent inquiry into child sexual exploitation in Rotherham (1997–2013),* Rotherham Borough Council, 21 August 2014;
- *Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children,* Department for Children and Families, August 2009
- *I thought I was the only one. The only one in the world*, Office of the Children's Commissioner Inquiry into Child Sexual Exploitation in Gangs and Groups *(CSEGG)*, Interim Report, November 2012;
- The sexual exploitation of children: it couldn't happen here, could it? Ofsted, November 2014
- 'Real Voices', Child exploitation in Greater Manchester and independent report by Ann Coffey, MP October 2014

This 3-year strategy builds on the progress that has already been made in Reading to ensure that we are effective in **Preventing** CSE from happening, **Protecting** those who may be at risk, to **Pursue** and **Disrupt** those who may be posing a risk to children and to ensure victims of CSE are supported in their **Recovery**.

Throughout this document the term 'child' has been used to describe any child or young person aged 0-18 years. Whilst it is acknowledged that teenagers would wish to be referred to as 'young people' the term 'child' in this context helps professionals and the public stay focussed on the fact that they are children being abused and not young adults making positive choices.

2. Definition

The sexual exploitation of children and young people can take many forms and this strategy uses the definition set out in the Statutory Guidance on Safeguarding Children and Young People from Child Sexual Exploitation 2009:

> *'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them sexual activities.*
> *Child sexual exploitation can be via the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.*
> *In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability"*
>
> (DCSF,HMSO 2009)

3. National Context

In December 2011, the Department for Education informed all Local Safeguarding Children Boards (LSCBs) that the national 'Tackling Child Sexual Exploitation Action Plan', was a follow up to the 'Government Guidance on safeguarding children and young people from sexual exploitation' issued in 2009.

In July 2012, 'Tackling Child Sexual Exploitation Action Plan: progress report' was published and a 'Step by Step Guide' for practitioners was issued by the Department for Education

The Action Plan published by the Department for Education cited the expectation that LSCB's will implement a local action plan to:

- map the needs of their own area
- monitor ongoing prevalence and responses to child sexual exploitation within their area, making use of existing monitoring tools
- Develop an effective local strategy ensuring there is a co-ordinated multi-agency response to child sexual exploitation;

- increase understanding of child sexual exploitation, in the professional and wider community
- safeguard and promote the welfare of groups of children who are potentially more vulnerable;
- consider whether it is appropriate to set up a working group or sub-group on child sexual exploitation, either on a short term or standing basis, and appoint a lead officer who provides a co-ordinated response across statutory authorities and the voluntary sector
- Develop links with neighbouring authorities and meet them on a formal basis and as required where there are cross border concerns.

In July 2012 the Children's Commissioner published a briefing for the Secretary of State for Education on child exploitation in gangs and groups, with a focus on children in care. In November 2012, the Children's Commissioner published 'Seeing the signs of sexual exploitation' in which it identifies running away as an indicator that a child is at risk and extremely vulnerable. The report cites that, one in four of such children will end up in a harmful or dangerous situation and more needs to be done to keep children safe.

Professor Alexis Jays report into the sexual exploitation of children in Rotherham was a wake up call for every professional working in the filed of protecting children from sexual exploitation. The catalogue of failings across agencies has prompted the majority of authorities to review how is prevents and protects children from sexual exploitation.

The sexual exploitation of children: it couldn't happen here, could it? Ofsted, November 2014 goes further to recommend every area has a CSE action plan that robustly monitors the capabilities and progress of agencies to keep children safe from CSE. The Single Inspection Framework has been reviewed to ensure there is increased scrutiny of the local authority's performance.

'Real Voices' by Ann Coffey, MP demonstrates the need to ensure the voice of children is visible in everything we do across the levels of need. Whilst children are clearly vulnerable to CSE they also have a contribution to make in the design and delivery of local services recognising the issues of growing up in a modern world where the use of technology plays an increasing role

National guidance, key national reviews and briefings will continue to shape our local response to tackling CSE in Reading and will support our planning of operational work and training.

4. Our achievements so far

In Reading we are working towards developing a clearer picture of the extent to which CSE affects children locally. Implementation of this strategy will facilitate improved recording, monitoring and reviewing to provide a sense of prevalence in the Reading area. Nationally we know that the issue has not always been recognised and that the extent of the problem has been underestimated. Research undertaken by

Barnardos 'Puppet on A String', shows that nationally the reporting of abuse through child sexual exploitation is growing year on year with a 16% growth in reporting between 2008/09 and 2009/10

Whilst we recognise there is still more to do to ensure we are effective in tackling all aspects of CSE across the Reading LSCB partnership, progress has been made in a number of areas that gives a strong foundation for moving forward:

- The LSCB now has a CSE and Missing steering group reporting to the LSCB, chaired by the Director of Children and Education Services.
- The CSE and Missing Children Operational Mapping Group is fully established.
- CSE champions have been identified across Reading Borough Council.
- There has been significant investment in training of professionals through single and multi-agency training at universal, targeted and specialist levels.
- Bespoke training has been delivered on sharing intelligence with the police and guidance issued to frontline practitioners.
- An educational/preventative programme has been delivered in nine schools which included the use of 'Chelsea's choice' reaching approximately 2000 young people.
- Completed and ongoing investigations pursuing those who have harmed or present a CSE risk to children.
- We have a number of established services to support victims of CSE including: counselling services, CSE champions, Source Team, Health drop ins, Youth Outreach nurse and Targeted Youth Support.

5. Strategic priorities – Prevent, Protect, Pursue

All agencies providing services to children have a statutory duty under Section 11 of the Children's Act 2004 to understand the risks and ways in which children can be exploited sexually and the ways in which their agencies can safeguard them against this.

Our strategic priorities facilitate a multi-agency approach that emphasises the need to:

- Recognise the possible indicators of sexual exploitation;
- Safeguard and promote the welfare of children and young people;
- Work together to provide children with strategies to exit sexual exploitation;
- Investigate and prosecute those who coerce, exploit and abuse children and young people in this way;
- Ensure that voice of children informs service delivery and plans to keep them safe from CSE.

As a partnership we are committed to:

Prevent:

Child Sexual Exploitation takes place within our community. We must raise awareness and understanding of Child Sexual Exploitation in order to prevent children from becoming victims.

Protect:

We will work together to identify children at risk of, or subject to sexual exploitation, so that we can safeguard and support them and prevent further harm. It is important that professionals, public, families and children understand the many forms of CSE so that they are better able to protect children and not miss signs.

Pursue and Disrupt:

We will work together to assist in bringing offenders to justice and disrupt behaviour, whilst ensuring that children and young people are not subject to further risk and harm

Recovery:

We will ensure that victims of CSE are provided with the necessary support to aid their recovery. This support needs to be delivered in such a way that we do the right thing, in the right way and at the right time to aid their recovery. Recovery should also include the provision of services to enable them to reach their potential and reduce the likelihood of needing support services in the future.

Vision	For children and young people to be free from the risks and harm of sexual exploitation in Reading		
	Priorities		
Prevent	Ensure the governance framework for CSE delivers an effective partnership response to CSE	Provide awareness and targeted training to professionals across the partnership. Engage Parents, Schools, colleges, local communities and the voluntary sector in prevention and awareness training	Establish a targeted prevention and self-protection programme for use by schools, voluntary/community organisations and with targeted vulnerable groups including children going missing and looked after children.
Protect	Ensure that multi agency processes and procedures are in place and are effective in using collective intelligence to identify children at risk of CSE	Ensure there is a clear pathway in place that manages the risk of CSE at the appropriate level of need	Ensure that victims of CSE receive the appropriate support and are protected from further harm
Pursue and Disrupt	Use the collective intelligence gathered whilst preventing and protecting to produce Problem Profiles	Proactively identify and disrupt locations where there maybe CSE activity	Proactively use criminal and civil enforcement legislation to challenge and confront inappropriate and harmful behaviours
Recovery	Ensure there are clear recovery pathways for the victims of CSE	Ensure there are smooth transitions between Children and Adult services	Ensure that the needs of parents and families of victims of CSE are considered and appropriate support provided

Action Plan 2014 - 2017

PRIORITY AREA	HOW
PREVENT	
Ensure the governance framework for CSE delivers an effective partnership response to CSE	▪ CSE Missing Children Strategic group meeting scheduled to take place every 6 weeks. ▪ CSE Missing Children Operational group scheduled for monthly meetings (minimum). ▪ CSE Champions Group scheduled monthly and expanded to multiagency. ▪ Terms of Reference for the above groups reviewed on an annual basis ▪ Governance framework agreed by LSCB and Community Safety Partnership ▪ CSE Missing Children Strategy group will monitor progress of the action plan and report progress to the LSCB ▪ Reading LSCB will report to and inform the work of the Community Safety Partnership ▪ The CSE and Missing Children Strategy group will facilitate links to relevant strategies across the partnership to include; Domestic abuse strategy, Children Missing Out on Education, Children and Young People's Plan, Early Help Strategy. ▪ Ensure that the local plans and strategies are informed by the voices and experiences of children.
Provide awareness and targeted training to professionals across the partnership. Engage Parents, Schools, colleges, local communities and the voluntary sector in prevention and awareness training	▪ Universal CSE E-learning training for professionals across the partnership including schools and colleges. ▪ Tiered CSE training packages - Introductory level, targeted and specialist for services most likely to identify CSE victims through their work with high risk groups ▪ All front line staff working with children aged 10+ to receive CSE awareness training. ▪ All agencies report on the numbers of staff trained at the level appropriate to their role. ▪ Develop and deliver appropriate training for the licensing/hospitality sector including taxis, hotels ▪ CSE champions identified and trained in all LSCB partnership agencies. ▪ Respond to the training needs of those additional services in communities which, whilst not directly working with children, may have a contribution to make in tackling CSE, such as housing providers and community safety services. ▪ The LSCB has ensures there is effective quality assurance of all training on offer. ▪ Provide 'spotting the signs' information and guidance to parents on parenting programmes ▪ Introduce a Peer mentoring scheme to schools to involve learners in raising awareness and supporting pupils in efforts to keep themselves safe

Establish a targeted prevention and self-protection programme for use by schools, voluntary/community organisations and with targeted vulnerable groups including children going missing and looked after children.	▪ Establish a targeted preventative and self-protection programme on child sexual exploitation for looked after children and children who go missing. ▪ Engage with learning providers; provide CSE prevention resources and curriculum support to School PSHCE leads for children Year 5 and above. ▪ Provide CSE prevention resources to Juice Health drop in providers delivering in Schools and the community ▪ Provide curriculum support to schools through the PSHCE partnership on topics such drugs and alcohol, domestic abuse, CSE, Internet safety and Sex and relationship education ▪ Annual campaign in schools through Chelsea's Choice/Theatre production or through RBC PSHCE menu offer with the inclusion of sign posting options for parents ▪ All missing children will receive a return interview and the thematic findings will be reported to the CSE Missing Steering group as a standard agenda item
PROTECT	
Ensure that multi agency processes and procedures are in place and are effective in identifying children at risk of CSE	▪ Review the LSCB multiagency threshold criteria and ensure that CSE and missing is reflected across the levels of need ▪ Produce a CSE and Missing Toolkit for use by all agencies that includes an agreed screening tool and referral processes. ▪ Establish a risk management model ▪ Publish a Framework for Intelligence, Confidentiality and Information Sharing ▪ Gather intelligence through Mapping and CSE Champion subgroups will be used to inform local delivery of services with regular thematic reports provided to the CSE missing steering group
Ensure there is a clear pathway in place that manages the risk of CSE at the appropriate level of need	▪ Review existing policies and procedures to ensure that strategy meetings, child protection and conferences include children, parents and consider disruption as part of the action. ▪ Introduce a single data set giving information about children and young people screened and assessed as at risk of CSE

Ensure that victims of CSE receive the support and are protected from further harm	▪ All children being exploited and children believed to be being exploited have a risk assessment on file ▪ Auditing of CSE cases is included in the cycle of LSCB multi agency audits and reports received from single agency audits that relate to CSE ▪ Explore the potential for the collocation of professionals working with victims of CSE
PURSUE and DISRUPT	
Use the collective intelligence gathered whilst preventing and protecting to produce Problem Profiles	▪ The CSE and Missing Children Operational Mapping Group will produce Problem Profiles to be used for operational partnership disruption activity ▪ The CSE Strategy group will receive reports on Problem Profiles to inform strategic planning and allocation of resources.
Proactively identify and disrupt locations where they maybe CSE activity	▪ Ensure that any targeting of location engages other appropriate services in communities which can ▪ support enforcement agencies ▪ Where there is intelligence on locations, a disruption plan will be developed and deployed ▪ Gather intelligence to inform local problem profiles, identifying persons of interest, potential victims and hotspots. ▪ Use visible policing and street youth work in areas where child sexual exploitation is known or suspected to be taking place
Proactively use legislation to challenge and confront inappropriate behaviour	▪ Monitor the prosecution rate and disruption activity of CSE perpetrators and report to the LSCB ▪ Disruption guidance will be included in the CSE toolkit. ▪ Use legislation to enforce/prevent children accessing certain premises, businesses or individuals: ➢ Anti-Social Behaviour Orders ➢ Risk of Sexual Harm Orders ➢ Sexual Offences Prevention Order ➢ Issue Child Abduction Warning Notices

RECOVERY	
Ensure there are clear recovery pathways for the victims of CSE	▪ All young people who have been in local authority care and sexually exploited will receive leaving care or other appropriate services regardless of their care leaving status. ▪ All support services across statutory and voluntary sector orgaisations are mapped and included within the toolkit including how therapeutic needs will be prioritised and met. ▪ Review clinical pathways and ensure there is a fast track to therapeutic intervention for CSE victims if required.
Ensure there are smooth transitions between Children and Adult services	▪ Ensure there are clear transition pathways for victims of CSE and that every victim receives a seamless service. ▪ Include the pathways in the CSE toolkit.
Ensure that the needs of parents and families of victims of CSE are considered and appropriate support provided.	▪ Ensure that whole family assessments are considered for children who are victims of CSE ▪ Develop support programmes for parents and families of CSE victims ▪ Harness the potential of the voluntary and community sector to support families of CSE victims in the community ▪ Provide parenting groups and peer support for parents of CSE victims.

References

Berkshire LSCB Child Protection Procedures – July 2014 update **http://berks.proceduresonline.com/index.htm**

See Me, Hear Me: Framework for Action from the Final Report from the Inquiry into Child Sexual Exploitation in Gangs and Groups Policy Briefing January 2014-10-15
http://www.trixonline.co.uk/website/news/pdf/policy_briefing_No-104.pdf

Statutory guidance Safeguarding children and young people from sexual exploitation DCSF 2009

https://www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance

Cutting them free how is the UK progressing in protecting its children from sexual exploitation Barnardo's, 2012

http://www.barnardos.org.uk/cuttingthemfree.pdf

Childhood lost October 2013 – Nicola Blackwood

"I thought I was the only one. The only one in the world" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Interim report November 2012

Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013 Alexis Jay OBE

The sexual exploitation of children: it couldn't happen here, could it? Ofsted, November 2014

'Real Voices', Child exploitation in Greater Manchester and independent report by Ann Coffey, MP October 2014

READING BOROUGH COUNCIL

REPORT BY MANAGING DIRECTOR

TO:	**Health and Wellbeing Board**		
DATE:	**30th January 2015**	**AGENDA ITEM:**	**11**
TITLE:	**Tackling Poverty In Reading Strategy and Needs Analysis**		
LEAD COUNCILLOR:	**Cllr Lovelock**	**PORTFOLIO:**	**Leader**
SERVICE:	**Corporate Support Services - Policy**	**WARDS:**	**Borough-wide**
LEAD OFFICER:	**Clare Muir**	**TEL:**	**0118 9372119**
JOB TITLE:	**Policy and Voluntary Sector Manager**	**E-MAIL:**	**Clare.muir@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents the draft Tackling Poverty in Reading strategy, action plan and needs analysis.

1.2 The strategy and action plan were developed with partners through the Tackling Poverty Delivery Partnership.

1.3 The strategy has 4 aims:

1. Improving Life Chances – breaking the cycle.
2. Supporting those who can't work / on low incomes – income maximisation.
3. Increasing Employability / Addressing Low Income – up-skilling and employment support.
4. Creating Sustainable Communities – improving quality of life in our more deprived communities.

1.4 These aims are pursued through six themes identified at the Tackling Poverty in Reading event held in November 2013:

1. Advice on Tax credits and Entitlements '
2. Affordable Credit '
3. Support into Work '
4. Best start in life '
5. In work poverty '
6. Affording Basic Needs '

A further 4 cross-cutting themes run throughout the strategy these are: Disabled People, Older People, Tackling Poverty in a Multicultural Community, Health and Wellbeing.

1.5 The Tackling Poverty in Reading strategy and action plan are provided at Appendix 1.

1.6 The Tackling Poverty in Reading Needs Analysis is provided at Appendix 2.

1.7 Appendix 1 - Tackling Poverty in Reading strategy and action plan

2. RECOMMENDED ACTION

2.1 That the Board note the report.

2.2 That the health aspects of the Poverty Needs Analysis and action plan be included in the Health and Wellbeing Strategy Action Plan and the Joint Strategic Needs Assessment.

3. POLICY CONTEXT

3.1 In November 2013 the Council held a 'Tackling Poverty in Reading' community engagement event to initiate the development of a strategy to tackle poverty in Reading in a context where welfare reforms, reducing public sector expenditure and the slow economic recovery are creating increasing hardship for many residents, including some of the most vulnerable; and where there is an increasing negative public perception about people in poverty.

3.2 The Council's Policy Committee (January 2014) agreed that a strategy and action plan based on the priorities and pledges made at the event would be prepared.

3.3 Health and Wellbeing Board received a report on 21st March 2014 and agreed that the Board would be the lead on the Health and Well-being theme in the Tackling Poverty strategy.

3.4 The Board was also invited to recommend health service representatives to join the Tackling Poverty Delivery Partnership.

3.5 The Council's Policy Committee on 1st December agreed the Tackling Poverty Strategy and Action Plan which had been prepared through the Tackling Poverty Delivery Partnership.

4. THE STRATEGY AND ACTION PLAN

4.1 The strategy has 4 aims:

1. Improving Life Chances – breaking the cycle.
2. Supporting those who can't work / on low incomes – income maximisation.
3. Increasing Employability / Addressing Low Income – up-skilling and employment support.
4. Creating Sustainable Communities – improving quality of life in our more deprived communities.

4.2 These aims are pursued through six themes identified at the Tackling Poverty in Reading event held in November 2013:

1. Advice on Tax credits and Entitlements
2. Affordable Credit
3. Support into Work
4. Best start in life
5. In work poverty
6. Affording Basic Needs

4.3 A further 4 cross-cutting themes run throughout the strategy these are: Disabled People, Older People, Tackling Poverty in a Multicultural Community, Health and Wellbeing.

4.4 The strategy does not seek to catalogue and pull together all existing activity that contributes towards alleviating poverty and which is already carried out as part of the core business of the Council and its partners. Rather, it sets out the priorities for action that the Council and its partners have identified are things we can pool our resources on locally to make a difference.

5. POVERTY NEEDS ANALYSIS

5.1 A Poverty Needs Analysis was prepared to support the development of the strategy. It provides an analysis of the key data informing each key theme. The Needs Analysis is provided at Appendix 2. This and a set of themed Fact Sheets are provided on Reading Borough Council's website at www.reading.gov.uk/tacklingpoverty

The data shows that:

- Reading's economy is buoyant but there is a growing differential in wealth and across geographies
- Low unemployment levels mask high costs of living and low wages for many. National research shows that out-of-work benefits fall far short of what is needed for a minimum acceptable standard of living but also that families working full time on the minimum wage also fall significantly short of meeting their needs.
- JSA claimant rate for over 50 is higher than both the South East and UK
- Reading has a significant number of NEETs, at 6.3%
- Child poverty is above average in Reading.
- 30% of Reading Pupils eligible for pupil premium. That is the highest in Berkshire where the average is 20%. The gap in attainment at GCSE level for those pupils eligible for pupil premium is 28.5 % points.
- The cost of child poverty in Reading is calculated to be £85m pa in cost of services (e.g. NHS and schools), lost tax receipts, cost of benefits and loss of earnings (CPAG 2013)
- The highest numbers of children in relative poverty are in areas of South Reading and the Amersham Road area, with a number also around the Oxford Road area.
- Almost three quarters of children in poverty live in lone parent families, higher than both the national and regional figures.
- A higher proportion of Mixed race and Black children are eligible for free school meals
- Homelessness figures have risen sharply in the last year

- Reading has a higher degree of overcrowding than both the South East or England

- 9.8% of households in Reading are living in fuel poverty. While energy efficiency levels in Reading have improved since 2006, fuel poverty has increased, primarily related to increases in energy tariffs and the economic circumstances of households affected.

- Fuel poverty is linked with excess winter deaths in older people. The excess winter deaths ratio in Reading is currently one of the highest in the country.

- The proportion of deprived people aged 65 and over is well above the average for South East.

- The starkest statistic is that life expectancy is 9.2years lower for men and 6.3years lower for women in the most deprived areas of Reading than in the least deprived areas.

- The level of teenage pregnancy is significantly worse than the England average.

- In 2012/13, the debts of clients coming to Reading CAB and Reading Welfare Rights Unit totalled £2,245,231.

5.2 Page 36 of the Poverty Needs Analysis sets out the Health specific data on poverty. A presentation on the health related data on poverty will be provided at the meeting.

6. HEALTH SPECIFIC ASPECTS OF THE STRATEGY

6.1 & The LSP Breaking the Cycle of Poverty group has taken the lead on the Child Poverty strand of the strategy. Its focus has been to address the evidence that children living in income-deprived families are prone to significantly worse health outcomes, both during childhood and later in life.

There are a high number of children in Reading not attending 2 year old Health Reviews, resulting in more than half of Reading's children not having health and development issues beginning to be addressed at an early stage, especially around healthy eating.

The group is identifying specific action to support the health visiting service to increase attendance at 2 year Health Reviews in Reading to ensure that more families can access the support they need.

The target is to bring attendance at 2 year Health Reviews in Reading from 45-50% to 60%.

6.2&The Winter Watch scheme is funded through Public Health to provide draught proofing and home insulation to support those living in fuel poverty. Target groups included pensioners, families with young children, people with serious illness and disabilities and those on a wide range of welfare benefits. This is in partnership with a number of local community groups and voluntary organisations including Reading CAB, Berkshire Community Foundation, Aster Living, Age UK Berkshire, Reading Voluntary Action and Transition Town Reading.

7. TACKLING POVERTY DELIVERY PARTNERSHIP

7.1 & The Tackling Poverty Delivery Partnership, chaired by the Leader of the Council has overseen the development of the Tackling Poverty strategy and action plan. The Partnership includes the lead partners on the strategy:

- Reading Advice Network (Theme lead – Advice and Support) '
'
- Berkshire Community Savings and Loans (Theme lead – Affordable Credit) '
'
- Elevate Reading partnership '
'
- LSP Breaking the Cycle of Poverty group ((Theme lead – Best Start in Life)
- Reading UK CIC (Theme lead – Support in to Work and In Work Poverty)
- Acre (Alliance for Cohesion and Racial Equality)
- Health and Wellbeing Board (Berkshire Healthcare NHS Foundation Trust, Reading CCGs)

7.2 The Partnership meets on a quarterly basis to review economic and poverty data and monitors the progress of the action plan.

8. PROPOSAL

8.1 & It is proposed that the health aspects of the Poverty Needs Analysis and action plan be included in the Health and Wellbeing Strategy Action Plan and the Joint Strategic Needs Assessment.

9. CONTRIBUTION TO STRATEGIC AIMS

9.1 This decision contributes to the Council's strategic aims to develop a sustainable economy at the heart of the Thames Valley; and to promote equality, social inclusion and a safe and healthy environment for all because the strategy and plan will address support into work, low pay and in work poverty, health inequality and will specifically address poverty faced by disabled people, children, older people and ethnic minority communities.

10. COMMUNITY ENGAGEMENT AND INFORMATION

10.1 & The Tackling Poverty in Reading event in November 2013 was an open event. Invitations went out to public service providers, businesses, employers, schools, providers of employment, training, voluntary and community organisations, trades unions, faith organisations and residents involvement databases, through both the Council's and partners' routes. The event was promoted through the website, twitter and press release. Around 200 people attended on the night.

10.2 & Participants were invited, when registering, to say what their main concern was about poverty in Reading. This survey gave a good indication of the key Poverty issues for Reading. Their responses were used to theme the workshops and subsequently the themes of the strategy.

10.3 Experiences of poverty of local people were recorded on at the event through video, written word, case studies and participation in the workshops.

11. EQUALITY IMPACT ASSESSMENT

11.1 & Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11.2 & The Equality duty is relevant to the decision to develop a strategy and action plan on tackling poverty in Reading. An Equality Impact Assessment has been undertaken. The assessment is that poverty has a differential impact on different equality groups and a poverty strategy and action plan will positively impact on these groups. The assessment report was presented to Policy committee in January 2014.

12. LEGAL IMPLICATIONS

12.1 Under the Child Poverty Act 2010, local authorities and named partner authorities have a statutory duty to co-operate to reduce and mitigate the impacts of child poverty in their area (these named partner authorities to whom the duty applies include health, the police, youth offending teams, probation and Jobcentre Plus); to prepare and publish a local child poverty needs assessment and prepare a joint child poverty strategy for the local area.

13. FINANCIAL IMPLICATIONS

13.1 The development of a Tackling Poverty strategy and action plan will be met within existing budgets.

14. BACKGROUND PAPERS

14.1 Minutes of Tackling Poverty Delivery Partnership

TACKLING POVERTY IN READING

Tackling Poverty in Reading: Strategy Document 2014

Reading Borough Council
Working better with you

Tackling Poverty Strategy - 2014

Improving Life Chances

Child Poverty in Reading:

Outcome: Our young people have the best start in life

Actions: Broaden the skills and resources of a wide range of partners to better support families to encourage younger children to develop their communication skills.

Increase attendance at 2 year Health Reviews in Reading to ensure that more families can access the support they need.

Raise awareness of a range of services for families amongst all sectors, and understanding how they can work more effectively together.

Support schools to further improve their standards when they need help

Income Maximisation

Advice on Tax Credits & Benefits

Outcome: residents are supported and encouraged to claim the benefits they're entitled to

Actions: Develop capacity for support and training for people on claiming. (RAN)

Benefits Take up Campaign to encourage residents to claim benefits they may be missing out on. This will focus on Older People, In Work Poor and Disabled (RBC)

Establish a Digital Inclusion Action Plan to ensure that residents are not left behind in the move to digital service delivery (RBC)

Sustainable Communities – Improving Quality of Life

Affording Basic Needs

Outcome: Partners will work together to support the basic needs of residents.

Actions: Improve communication of what agencies are doing with a new signposting directory (Tackling Poverty Delivery Partnership)

Run training sessions for agencies to come together (RVA)

Supporting the Governments fuel poverty strategy by draught proofing and insulating homes and providing funding to do so. (RBC)

Continuation of Financial Crisis Support Scheme to March 2016 (RBC)

Affordable Credit

Outcome: Money management education to children & parents. Increased credit union visibility.

Actions: Work with our partner, Community Savings and Loans Berkshire to provide money management education for parents and school children

Increase visibility of credit unions. (RBC)

Continue to work with Stop the Loan Sharks to protect our residents from illegal lenders. (RBC)

Increasing Employability / Addressing low income

Support Into Work

Outcome: Our residents supported in developing a desirable skill set and helped into finding suitable employment .

Actions: Provide opportunities & support for volunteers (LSP Productive Pathways Group)

Provide holistic linked up support mechanisms to get young people into employment (Reading UK CIC, City Deal)

Training to build skills & help for applying for jobs

Build on successful schemes offered by partners such as New Directions and SITE which provide targeted interventions for specific groups with lone parents who face barriers to employment. (UK CIC, City Deal)

Empower volunteers from ethnic minorities (LSP)

Addressing in work poverty

Outcome: Reading Employers committed to the Living Wage Campaign.

Residents are empowered to choose alternatives to zero hours contracts.

Actions: Encourage & support employers to achieve Living wage accreditation (Reading UK CIC)

Work with the Living Wage Foundation to review all our contracts as part of the drive towards accreditation (RBC)

Educating residents on the alternatives and benefits of contract hour employment. (UK CIC)

1. Foreword

Never has there been a more important time for a strategy to tackle poverty. The economic recession, cost of living and welfare reform has changed the world we live in.

Never has there been a more important time to challenge the negative perception about poverty and people in receipt of benefits. The British Social Attitudes Survey, September 2013 documented that the last three decades has seen a dramatic decline in support for welfare benefits for disadvantaged groups and yet it could be any one of us, or our families.

Indeed when Reading Borough Council took over responsibility Financial Crisis Support, previously provided by the Government we were led to believe it was only used by young men who couldn't manage their budgets. Our statistics show that half the people who need the scheme are families, the main reason for their crisis is delay of benefits payments and they need help with basics such as food, fuel and white goods.

Welfare reforms, reducing public sector expenditure and the slow economic recovery are creating increasing hardship for many of our residents, including some of the most vulnerable. The Local Government Association estimates that as a result of welfare reforms, households claiming benefit in Reading will see their income drop by £1,665 a year. Many of those affected are people who are in work but have incomes that cannot meet the rising costs of living. 1 in 5 children are deemed to be living in poverty in Reading.

We are seeing the impact of this on local people. For example, calls to Reading Citizens Advice Bureau (CAB) have almost doubled since June 2012. Reading Community Welfare Rights Unit, reports that during the same period the number of people attending the open door drop in sessions has doubled and food parcel referrals by Readifood have increased by 400%. The vast majority of people seeking advice are families who are really struggling to survive.

Whilst we cannot change government policy or macro-economic conditions, it is important that we seek to provide the best possible, coherent, local response in order to support Reading's residents. This includes providing more opportunities for local people to benefit from what remains a strong local economy with good prospects for growth; using what resources we do have available to gain maximum impact; and working together in partnership.

In November 2013 we held a conference 'Tackling Poverty in Reading' to initiate the development of a new strategy to tackle poverty and to identify key practical actions we can take together with our partners and the community. This is the new strategy and action plan.

2. Context

It has long been recognised that poverty is a significant issue for Reading, impacting negatively on the quality of life of many of its residents. The impacts of poverty are pernicious with effects going far beyond material well-being. Over and above struggling to pay for essentials such as food, clothes and fuel, poverty has a hugely detrimental effect on longer term outcomes across generations. Higher levels of poverty are strongly correlated with poorer health, lower educational achievement, worklessness, higher crime rates, more children in the social care system and a host of other negative outcomes.

Under the Child Poverty Act 2010, local authorities and named partner authorities have a statutory duty to co-operate to reduce and mitigate the impacts of child poverty in their area (these named partner authorities include health, the police, youth offending teams, probation and Jobcentre Plus); to prepare and publish a local child poverty needs assessment and prepare a joint child poverty strategy for the local area.

The national Child Poverty Strategy focuses on 4 key areas:

1. Life Chances – breaking the cycle.
2. Those who can't work – income maximisation.
3. Employability / Low Income – up-skilling and support.
4. Sustainable Communities – improving quality of life in more deprived neighbourhoods.

Tackling poverty is not only an issue for Council and named statutory partners to address. The voluntary, community and faith sectors stand at the front line tackling poverty and businesses and employers have a huge part to play in the employment, skills and training routes out of poverty. Tackling poverty is truly everyone's business.

In 2011 the Reading Local Strategic Partnership (LSP) adopted a new Sustainable Community Strategy based around an agreed vision for Reading in 2030. This Strategy identified breaking the cycle of poverty, skills for all and building capable communities as key 'Levers for Change' to address inequality and create the conditions for the longer-term socio-economic success of the town.

Breaking the cycle of poverty concentrates on 'the best start in life', particularly focusing on families with young children in 4 key areas:

- Obesity/Healthy Lifestyle
- Parental Substance Misuse
- Home Learning Environment
- Early Language and Communication

With the responsibility for Public Health now transferred to local authorities, there is a valuable opportunity to address the relationship between health and poverty in partnership with the local NHS.
The Joint Strategic Needs Analysis (jsna.reading.gov.uk) as well as the Health and Wellbeing Strategy outline in detail Reading's response to health inequality.
Reading's Public Health responsibilities include:

- Health promotion and enabling people to make healthier lifestyle choices (such as improving personal fitness, reducing weight or stopping smoking).
- The prevention of ill-health and protecting people from disease and illness (for example through immunisation)
- Working to tackle health inequalities for people on high and low levels of income

Skills for all focuses, primarily, on helping young people (16 – 24 yrs) to progress into meaningful education, employment or training. The 'Productive Pathways' group brings together many of the key partners in the area who provide a range of services and support to this age group – Department for Work & Pensions , Reading College, Reading UK CIC, Reading Voluntary Action, Adviza, A4E, Connect Reading etc. Through this group, and the links to a far wider range of agencies, a concerted effort is being made to join up, increase and make visible all the information and support that is available, but not always easily accessible, to young people. A practical outcome of this is a new website – ElevateMe, launched in March 2014 - which has had extensive input from a range of user groups in its development, to put all this information directly in the hands of young people and their advisers for the first time. The website is fully functional and visible on all mobile devices (phones, tablets etc.). ElevateMe is funded largely through O2's Local Government Futures Fund and can be viewed on this link: www.elevateme.org.uk . We will be embedding ownership and further development of ElevateMe as part of the Berkshire .

Capable communities is a major effort to empower local communities and improve the sense of grassroots ownership of local projects by:

- strengthening local leadership and unlocking the hidden potential for leadership within Reading's communities;
- improved networking and collaboration between existing community organisations
- strengthening the quality of resources available to community groups.

A major resource in delivering this is the Reading Community Enterprise Programme. The scheme provides training, mentoring and grants for leaders (existing and potential) who can demonstrate they have the vision to plan and execute worthwhile projects. Additionally, as part of a centrally-funded programme, Reading has, from April 2014, four paid community organisers on 1-year placements, with a possible extension. These injections of funding and resources for community projects are expected to provide a real boost to the quality and volume of grassroots activity throughout the coming year and beyond.

What Poverty Looks Like in Reading

"Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the type of diet, participation in the activities and they have the living conditions and the amenities which are customary, or at least widely encouraged or approved in the societies to which they belong.
Their resources are so seriously below those commanded by the average family that they are in effect excluded from the ordinary living patterns, customs, and activities." Townsend

We have carried out an analysis of poverty in Reading (Appendix 1). The key facts are:

- Reading's economy is buoyant but there is a growing differential in wealth and across geographies
- Low unemployment levels mask high costs of living and low wages for many. National research shows that out-of-work benefits fall far short of what is needed for a minimum acceptable standard of living but also that families working full time on the minimum wage also fall significantly short of meeting their needs.
- In 2012/13, the debts of clients coming to Reading CAB and Reading Welfare Rights Unit totalled £2,245,231
- JSA claimants rate for over 50 is higher than both the South East and UK
- Reading has a significant number of NEETs at 6.3%
- Child poverty is above average in Reading.
- 30% of Reading Pupils eligible for pupil premium. That is the highest in Berkshire where the average is 20%. The gap in attainment at GCSE level for those pupils eligible for pupil premium is 28.5 % points.
- The cost of child poverty in Reading is calculated to be £85m pa in cost of services (e.g. NHS and schools), lost tax receipts, cost of benefits and loss of earnings (CPAG 2013)
- The highest numbers of children in relative poverty are in areas of South Reading and the Amersham Road area, with a number also around the Oxford Road area.
- Almost three quarters of children in poverty live in lone parent families, higher than both the national and regional figures. '
- The level of teenage pregnancy is significantly worse than the England average

DRAFT

- A higher proportion of Mixed race and Black children are eligible for free school meals

- Homelessness figures have risen sharply and are increasing

- Reading has a higher degree of overcrowding than both the South east or England

- 9.8% of households in Reading are living in fuel poverty. While energy efficiency levels in Reading have improved since 2006, fuel poverty has increased, primarily related to increases in energy tariffs and the economic circumstances of households affected.

- Fuel poverty is linked with excess winter deaths in older people. The excess winter deaths ratio in Reading is currently one of the highest in the country. .

- The proportion of deprived people aged 65 and over is well above the average for South East.

- The starkest statistic is that life expectancy is 9.2 years lower for men and 6.3years lower for women in the most deprived areas of Reading than in the least deprived areas.

DRAFT

3. Vision

> ' Narrowing the gap - creating opportunities so that more people have security, employment, improved health and the chance to thrive'

4. Strategic Aims

This Strategy sets out the challenge Reading faces in tackling poverty, and provides a framework for the action which the Council its partners and the wider community will take in seeking to address poverty and its consequences more effectively.

The strategy has 4 aims, taken from the national Child Poverty Strategy which provides a useful framework:-

1. Improving Life Chances – breaking the cycle.
2. Supporting those who can't work / on low incomes – income maximisation.
3. Increasing Employability / Addressing Low Income – up-skilling and employment support.
4. Creating Sustainable Communities – improving quality of life in our more deprived communities.

This strategy does not seek to catalogue and pull together all existing activity already carried out as part of the core business of the Council and its partners, which contributes towards alleviating poverty. Rather, it sets out the priorities for action that the Council and its partners have identified are things we can pool our resources on locally to make a difference.

5. Working Principles

Whilst we cannot change government policy or macro-economic conditions, it is important that we seek to provide the best possible, coherent, local response in order to support Reading's residents. We will work together in partnership to:

- Challenge the growing negative perception about poverty and people in receipt of benefits;
- Provide more opportunities for local people to benefit from what remains a strong local economy with good prospects for growth
- Identify and make the best use of the resources that are available
- Achieve maximum impact from the areas we can influence

6. Priorities for Action

Our priorities for action have been identified through our Tackling Poverty in Reading conference in November 2013 and develop the strategic aims through key themes:

1. Best start in life
2. Advice on Tax credits and Entitlements
3. Support into Work
4. In work poverty
5. Affordable Credit
6. Affording Basic Needs

1. Child Poverty in Reading: Best Start in Life

Across Reading's wards, the level of child poverty differs greatly – from 1.3% in Mapledurham through to 33.7% of all children in Church ward. In addition, 74.1% of children who belong to lone parent families in Reading live in poverty.

One of the clearest indicators for a child in poverty is a family not in employment or an underemployed family. By working to ensure that people are supported in to work, and that underemployment is effectively addressed, we can help to ensure that children are lifted out of the cycle.

Children living in income-deprived families are prone to significantly worse health outcomes, both during childhood and later in life. The impact of unemployment on physical and mental health for example, and the links to a higher risk of depression, and increased morbidity are well documented. Poor parental health combined with financial hardship has an inevitable flow-on effect on the wellbeing of children. Deprivation can influence behavioural choices that are known to impact on the health of adults and children such as breastfeeding, eating habits and participation in sports and exercise.

Reading is a multicultural community and one of the most diverse authorities in the South East. Children from ethnic minorities face a particularly high risk of growing up in poverty. Risks of poverty are highest for Bangladeshi, Pakistani and Black Africans, but are also above average for Caribbean, Indian and Chinese people.

We also know that there is a significant reduction in the life chances of children who cannot adequately speak and communicate with others by the age of 5. There is also a high number of children in Reading are not attending 2 year old Health Reviews, resulting in more than half of Reading's children not having health and development issues beginning to be addressed at an early stage, especially around healthy eating.

Alongside the work of partners, initiatives such as the Pupil Premium, Troubled Families and City Deal present opportunities to draw down money from central government to break the cycle of poverty.

Because of these particular initiatives being aimed at children of school age, and the cross-cutting work being carried out across many partners to support families,

'

this strategy focuses our efforts on some particular pieces of work with families of children under the age of 5, to enable them to have the best start in life.

Actions:
Early Language and Communication (LSP)
1. Broaden the skills and resources of a wide range of partners to better support families to encourage younger children to develop their communication skills.
2. Increase attendance at 2 year Health Reviews in Reading to ensure that more families can access the support they need.
3. Raise awareness of a range of services for families amongst all sectors, and understanding how they can work more effectively together.
4. Support schools to further improve their standards when they need help (RBC)

What will this look like in Reading?

1. Children and young people in Reading will be supported to achieve the best start in life.
2. More young people will attend health reviews, with health problems addressed early.
3. Schools will be supported to deliver the best results for Reading's young people and children.

How will we measure it? (Key Measure)

1. Attendance at 2 year Health Reviews in Reading from 45-50% to 60%.
2. Early Years Foundation Stage outcomes data
3. Schools rated 'good' or 'outstanding' by Ofsted

DRAFT

2. Advice and Support

We know that a number of Reading residents are missing out on benefits they are entitled to. Analysis shows that as many as 6,500 residents of pensionable age may not be claiming support they are eligible for as a result of living in poverty. This is of particular importance in Reading where the proportion of older people who are deprived is well above the average figure for the South East. Many old people are not aware of the benefits available to them while others may be aware but reluctant to claim.

Under recent welfare changes an estimated 18,665 people in Reading will lose £1,665 a year[1]. Those hit hardest are the disabled, in work poor and older people. In addition, many services used by our most vulnerable residents are now being moved online. Residents may be left even more confused by the implementation of Universal Credit in Reading which the Government intends to introduce by 2016 and which will have an online interface.

Nationally, a third of all disabled adults aged 25 to retirement are living in low income - around one and a half million people. This low-income rate is around double that for non-disabled adults and, unlike that for children and pensioners, is higher than a decade ago[2].The number of people living in Reading with a limiting long term illness is in line with the national average but the distribution of people living with a disability that limits them a lot is unevenly distributed among wards, with some wards having double the proportion of residents with a long term limiting illness.

Recent welfare reform and the introduction of Personal Independence Payments (PIP) are of concern for those who are disabled and impacted by benefits changes and 73% of those seeking advice from Reading Community Welfare Rights Unit are disabled.

Actions:

1. Develop capacity for support and training for people on claiming. (RAN)
2. Benefits Take Up Campaign to encourage residents to claim benefits they may be missing out on. This will focus on Older People, In Work Poor and Disabled (RBC)
3. Establish a Digital Inclusion Action Plan to ensure that residents are not left behind in the move to digital service delivery (RBC)
4. Shared advice surgeries in deprived areas (RAN)
5. Virtual information points in community areas (RAN)

What will this look like in Reading?

[1] Local Impacts of Welfare Reform: Impact model, LGA, Sept 2013 http://www.local.gov.uk/documents/10180/11531/Impact+modelling+tool/572bb1d3-2be3-43e5-8ca3-4075b25f192c

[2] The Poverty Institute

'

1. Residents will be supported in seeking comprehensive advice on the benefits they're entitled to.
2. Residents will be supported in using the internet to access the services and advice they need.

And how will we measure it?

1. An increase in the skills training delivered to staff handling claims advice
2. Impact figures from CAB & Reading Community Welfare Rights Unit
3. 100% of Reading Services account for the digitally excluded in their service delivery. '

'

DRAFT

3. Support into Work

The evidence is clear that the root causes of families being in poverty are worklessness or low earnings.

According to the Child Poverty Action Group, it costs a minimum of £148,000 in total - around £160 per week - to bring up a child to age 18 and meet the child's minimum needs.

The minimum necessary cost rose by 4% in 2013, while the minimum wage rose by 1.8%; average earnings by 1.5%; benefits for families and children by just 1%, and child benefit did not rise at all.

Although the numbers of children in relative poverty have fallen recently, those in absolute poverty increased by more than 275,000 in 2011/12[3]. Since 2010 there has been a dramatic 15 per cent decline in the number of children in workless households but a big rise in the proportion of poor children who are in families where someone is in work. Two-thirds of poor children are now in working households.

DRAFT

Actions:

1. Provide volunteering and support for volunteers (Elevate Reading Partnership)
2. Provide holistic linked up support mechanisms to get young people into employment (Reading UK CIC, Elevate Reading Partnership)
3. Training to build skills help for applying for jobs (UK CIC will report on activities delivered at The Elevate Reading hub, delivery partners include Adviza, Job Centre Plus, New Directions and RVA)
4. Build on successful schemes already being offered by partners such as New Directions and SITE which provide targeted interventions for specific groups with lone parents who face particular barriers to employment. (Reading UK CIC, Elevate Reading Partnership)
5. Empower volunteers from ethnic minorities (Reading UK CIC, Adviza)

What will this look like in Reading?

1. The active volunteer community in Reading will be supported to continue to deliver the valuable skills they contribute across the community.
2. Our young people will be supported into employment
3. Our residents will be supported in developing a desirable skill set and helped into finding suitable employment
4. We will have an active and empowered ethnic minority volunteer community

And how will we measure it?

1. JSA Claimant Count
2. RVA Registered volunteers
3. The Elevate Reading outcomes

[3] State of Nation Report, Social Mobility and Child Poverty in Great Britain, 2013

4. Tackling In Work Poverty

While employment figures show signs of promise and recovery, and there are positive indicators to suggest that the worst of the recession may be over, these figures mask an emerging increase in those facing in work poverty. We know that nationally two thirds of children living in poverty are part of in work households.

Increasingly, employment may be unstable or insufficient with the use of zero hours contracts or part time contracts ever more frequent – particularly in the hospitality and retail industries. While Reading wages are above the national average, Reading also has a high cost of living in line with the South East. While unemployment is down wage levels remain depressed.

Actions:

1. Encourage Employers to join the Living Wage Campaign (Reading UK CIC)
2. Continue to work towards "Living Wage Accreditation – investigate options available in relation to pursuing 'Living Wage Accreditation' (RBC)
3. Work with the Living Wage Foundation to review all our contracts as part of the drive towards accreditation (RBC)
4. Educating residents on the alternatives and benefits of contract hour employment.(Reading UK CIC)

What will this look like in Reading?

1. Employers are encouraged and supported to use an ethical approach to employment.
2. Residents understand the options available to them and the alternatives to zero hour employment.

How will we measure success?

1. Establishment of awards and number of employers signed up
2. RBC employees paid the living wage

DRAFT

5. Affordable Credit

A lack of affordable credit will continue to fuel the fire of payday loans as well as loan sharks which present significant challenges and dangers to those already in poverty. Recent analysis indicates that interest of £25 on every £100 borrowed by payday lenders is certainly not uncommon. Reading Borough Council has already banned payday loan companies from advertising on Council property and facilities but there is more to be done. Often those who are most vulnerable are unable to see an alternative solution. As well as alternatives to payday loans, there is a need to provide practical and accessible advice on budgeting and managing finances to both adults and children in order to effectively break the cycle of poverty. Increasingly, Residents coming to partners for advice present with a number of priority debts and complex cases.

Actions:

1. Work with our partner, Community Savings and Loans Berkshire to provide money management education for parents and school children
2. Increase advertising for alternatives offering affordable credit. (RBC)
3. Increase visibility of credit unions through a centrally located shop front. (CSLB)
4. Continue to work with Stop the Loan Sharks to protect our residents from illegal lenders. (RBC)

What will this look like in Reading?

1. Our young people will be equipped with the knowledge and skills to effectively manage money which will contribute towards breaking the cycle of poverty
2. Our parents will be supported with the skills they need to effectively manage the household budget and protected from illegal lenders.
3. Credit Unions will be a visible and viable alternative for those tempted in to borrowing from loan sharks and high interest pay day lenders.

How will we measure this?

1. Number of schools participating in training (out of possible 17) & percentage of pupils regularly saving with BCSL

DRAFT

'

6. Affording Basic Needs

National figures indicate a significant rise in homelessness over the last two years and we know that in Reading, homelessness has increased over the past year.

Those who don't find themselves homeless may be coping with substandard living conditions. Research by The Children's Society indicates that over half of all children in the UK who say they are in poverty are living in homes that are too cold and a quarter live in damp or mould-ridden conditions. In Reading, non-decency is particularly evident in the private rented sector as evidenced in the most recent homes survey.

The latest Central Government Fuel Poverty Strategy places a particular emphasis on addressing fuel poverty by improving the energy efficiency of homes which may lack basic insulation and energy saving measures, pushing up energy bills and increasing the amount of household expenditure spent on fuel. In Reading, the Winter Watch scheme works to support those living in fuel poverty.

Food poverty also continues to be a cause for concern in Reading with 486 food parcels issued by the Financial Crisis Support Scheme. Furthermore, recent evidence from Reading Community Welfare Rights shows more people presenting with debts arising from meeting their basic needs such as food, energy and housing costs.

Actions:

1. Improve the communication of what agencies are doing with a new signposting directory (Tackling Poverty Delivery Partnership)
2. Run training sessions for agencies to come together (RVA)
3. Supporting the Governments fuel poverty strategy by draught proofing and insulating homes and providing funding to do so as well as continuing to provide grants to bring homes to a decent standard.(RBC)
4. &Continuation of Financial Crisis Support Scheme to March 2016 (RBC)

What will this look like in Reading?

1. Our residents will have a clear understanding of where to turn to when in need of support
2. Partners in Reading will work together in order to support the basic needs of residents
3. Reading will offer support to those residents who are fuel poor through the winter watch scheme.

How will we measure it?

1. Output figures for Winter Watch.
2. Financial Crisis Support Scheme Output figures

&

DRAFT

Governance

The Tackling Poverty Delivery partnership oversees and monitors the development of the strategy and action plan.

The Partnership is chaired by the Leader of Reading Borough Council.

Membership of the Tackling Poverty Delivery Partnership includes the lead partners on the strategy:

- Reading Advice Network
- Berkshire Community Savings and Loans
- Elevate Reading partnership
- LSP Breaking the Cycle of Poverty group
- Reading UK CIC
- Acre (Alliance for Cohesion and Racial Equality)
- Health and Wellbeing Board (Berkshire Healthcare NHS Foundation Trust, Reading CCGs)

The Partnership meets on a quarterly basis to review economic and poverty data and monitor the progress of the action plan.

DRAFT

Tackling Poverty Strategy: Action Plan

Aim	Theme	Actions	Key Measures
Improving Life Chances – breaking the cycle			
	Child Poverty in Reading: Best Start in Life	Early Language and Communication (LSP) 1. Broaden the skills and resources of a wide range of partners to better support families to encourage younger children to develop their communication skills. 2. Increase attendance at 2 year Health Reviews in Reading to ensure that more families can access the support they need. Healthy Start in Life (LSP) 3. Raise awareness of a range of services for families amongst all sectors, and understanding how they can work more effectively together. Education (RBC) 4. Support schools to further improve their standards when they need help	1. Attendance at 2 year Health Reviews in Reading from 45-50% to 60%. 2. Early Years Foundation Stage outcomes data 3. Reading's FSM, Pupil Premium, looked after children and BME pupils exceed national average measures for Early Years, Key stage 2 and Key stage 4.
Supporting those who can't work or are on low incomes – income maximisation			
	Advice on Tax Credits & Benefits	1. Develop capacity for support and training for people on claiming. (RAN) 2. Benefits Take up Campaign to encourage residents to claim benefits they may be missing out on. This will focus on Older People, In Work Poor and Disabled (RBC) 3. Establish a Digital Inclusion Action Plan to ensure that residents are not left behind in the move to digital service delivery (RBC) 4. Recruitment of volunteer peer mentors 5. Common Referral Process 6. Establish a local advice forum 7. Shared advice surgeries in deprived areas 8. Virtual information points in community areas	1. An increase in the skills training delivered to staff handling claims advice 2. Impact figures from CAB 3. 100% of Reading Services account for the digitally excluded in their service delivery. 4. Number of peer mentors in deprived areas 5. Number of advice surgeries in deprived areas 6. Usage of virtual information points in selected community locations
Increasing Employability / Addressing low income – up-skilling and employment support			

DRAFT

'

<table>
<tr><th>Aim</th><th>Theme</th><th>Actions</th><th>Key Measures</th></tr>
<tr><td></td><td>Support Into Work</td><td>1. Provide opportunities support for volunteers (Elevate Reading Partnership)
2. Provide holistic linked up support mechanisms to get young people into employment (Reading UK CIC, Elevate Reading)
3. Training to build skills help for applying for jobs (UK CIC will report on activities delivered at The Elevate Reading hub, delivery partners include Adviza, Job Centre Plus, New Directions and RVA)
4. Build on successful schemes already being offered by partners such as New Directions and SITE which provide targeted interventions for specific groups with lone parents who face particular barriers to employment. (UK CIC, Elevate Reading)
5. Empower volunteers from ethnic minorities (UK CIC, Adviza)</td><td>1. RVA Registered volunteers
2. JSA Claimant Count
3. JSA 16-24 claimant count
4. Elevate Partnership to achieve the following:
+Targets 16-24 age
 
<table>
<tr><th></th><th>TVB</th><th>Reading</th></tr>
<tr><td>Engage young people</td><td>4500</td><td>750</td></tr>
<tr><td>Young people into jobs
> 6 months
don't reclaim within 9m</td><td>1300*
800
900</td><td>216*
133
150</td></tr>
<tr><td>Apprenticeships</td><td>300*</td><td>50*</td></tr>
<tr><td>Work experience
Traineeships</td><td>1500*</td><td>250*</td></tr>
<tr><td>Increased Earnings</td><td>450</td><td>75</td></tr>
<tr><td>Youth Contract wage incentives</td><td>800</td><td>133</td></tr>
<tr><td>Reducing Job churn</td><td>150</td><td>25</td></tr>
<tr><td>Loan Parents '</td><td>200</td><td>33</td></tr>
<tr><td>Employers Supported</td><td>3100*</td><td>516*</td></tr>
</table></td></tr>
<tr><td></td><td>Addressing in work poverty</td><td>1. Promote and encourage employers in Reading to sign up to the living wage campaign (Reading UK CIC)
2. Continue to work towards “Living Wage Accreditation – investigate options available in relation to pursuing ‘Living Wage Accreditation’ (RBC)
3. Work with the Living Wage Foundation to review all our contracts as part of the drive towards accreditation (RBC)
4. Educating residents on the alternatives and benefits of contract hour employment. (Reading UK CIC)</td><td>1. Number of employers signed up to the Living Wage Campaign
2. RBC employees paid the living wage</td></tr>
</table>

DRAFT

'

Aim	Theme	Actions	Key Measures
Creating Sustainable Communities - improving quality of life in our deprived communities			
	Affordable Credit	1. Work with our partner, Community Savings and Loans Berkshire to provide money management education for parents and school children 2. Increase advertising for alternatives offering affordable credit. (RBC) 3. Increase visibility of credit unions through a centrally located front office. (RBC) 4. Continue to work with Stop the Loan Sharks to protect our residents from illegal lenders. (RBC)	1. Number of schools receiving training (out of possible 17). Percentage of pupils regularly Saving with BCSL 2. Continuing STLS protocol
	Affording Basic Needs	1. Improve the communication of what agencies are doing with a new signposting directory (Tackling Poverty Delivery Partnership) 2. Run training sessions for agencies to come together (RVA) 3. Supporting the Governments fuel poverty strategy by draught proofing and insulating homes and providing funding to do so as well as continuing to provide grants to bring homes to a decent standard.(RBC) 4. Continuation of Financial Crisis Support Scheme to March 2016 (RBC)	1. Output figures for Winter Watch. 2. Financial Crisis Support Scheme Output figures

DRAFT

TACKLING POVERTY IN READING

NEEDS ANALYSIS

November 2014

TACKLING POVERTY IN READING

Reading Borough Council
Working better with you

CONTENTS

Poverty and Older people

- Census Overview
- Index of income deprivation affecting older people
- Excess winter deaths
- Benefit claimants

Poverty and Disability

- Census Overview
- Benefit claimants
- Index of health deprivation and disability

Debt

- Reading Citizens Advice Bureau
- Welfare Rights Unit

POVERTY – THE NATIONAL PICTURE

Poverty is a very real phenomenon in the UK. In a time of economic stagnation and following significant reform of our national welfare system, many households are increasingly struggling to make ends meet.

In 2012/13, 9.7 million individuals were in relative low income poverty[1], whilst 10.6 million were in absolute low income poverty[2][3].

While the proportion of pensioners in poverty is at its lowest for almost 30 years, the proportion of working-age adults without children in poverty is the highest on record.

Average incomes have fallen by 8 per cent since their peak in 2008. As a result, around 2 million people have a household income below the 2008 poverty line but are not considered to be in poverty today.

The number of people in low-paid jobs has risen. There are now around 5 million people paid below the living wage.

Following recent changes to the social security system, many people on means-tested benefits have reduced incomes. Around 500,000 families face a cut in housing benefit via the under-occupation penalty and a reduction in Council Tax Benefit.

Almost a quarter of adults have no academic, vocational or professional qualifications and almost a fifth of households are living in social housing[4].

POVERTY IN READING

Reading is the fourth largest urban area in the South East. It is a UK top-ten retail destination with a thriving night-time economy, serving a population that extends far beyond the Borough's boundaries. There has been a huge structural shift from the town's working class origins of beer, bulbs and biscuits to a compact service economy specialising in business services. Strategically located as a major transport hub and in close proximity to Heathrow, Reading is now home to the largest concentration of ICT corporations in the UK and is the service and financial centre of the Thames Valley and beyond.

However, the pace of change has been rapid and there is a clear mismatch between outstanding economic success and the level of benefits to local

[1] *below 60 per cent median household income; this is the measure generally used*
[2] *below 60 per cent of median household income held constant at 2010/11 level*
[3] *Households Below Average Income, DWP 2012/13*
[4] *Poverty in Numbers, Church Urban Fund 2013*

people, most dramatically illustrated by a comparison of the skills and earnings of the workforce with those of the resident population.
Equally graphic is the scale of the gap between Reading's most and least prosperous neighbourhoods. Reading has, within a small geographic area, some of the most affluent and the most deprived neighbourhoods in the whole of the Thames Valley.

Reading has a diverse population across all income groups and a very wide cultural mix. It has extremes of both wealth and poverty in very small areas that are masked by statistics at borough and even ward levels.

Index of Multiple Deprivation 2010

The most comprehensive and widely adopted overall measure of deprivation is the Index of Multiple Deprivation (IMD), last updated in 2010. The overall IMD combines indicators across 7 domains: income, employment, health, education / skills, barriers to housing / services, living environment, and crime.

According to the IMD, **Reading as a whole was ranked the 125th most deprived out of 326 local authorities in the country and has 12 Lower Super Output Areas (LSOAs)[5] in the worst 20% nationally** *(see map)*.

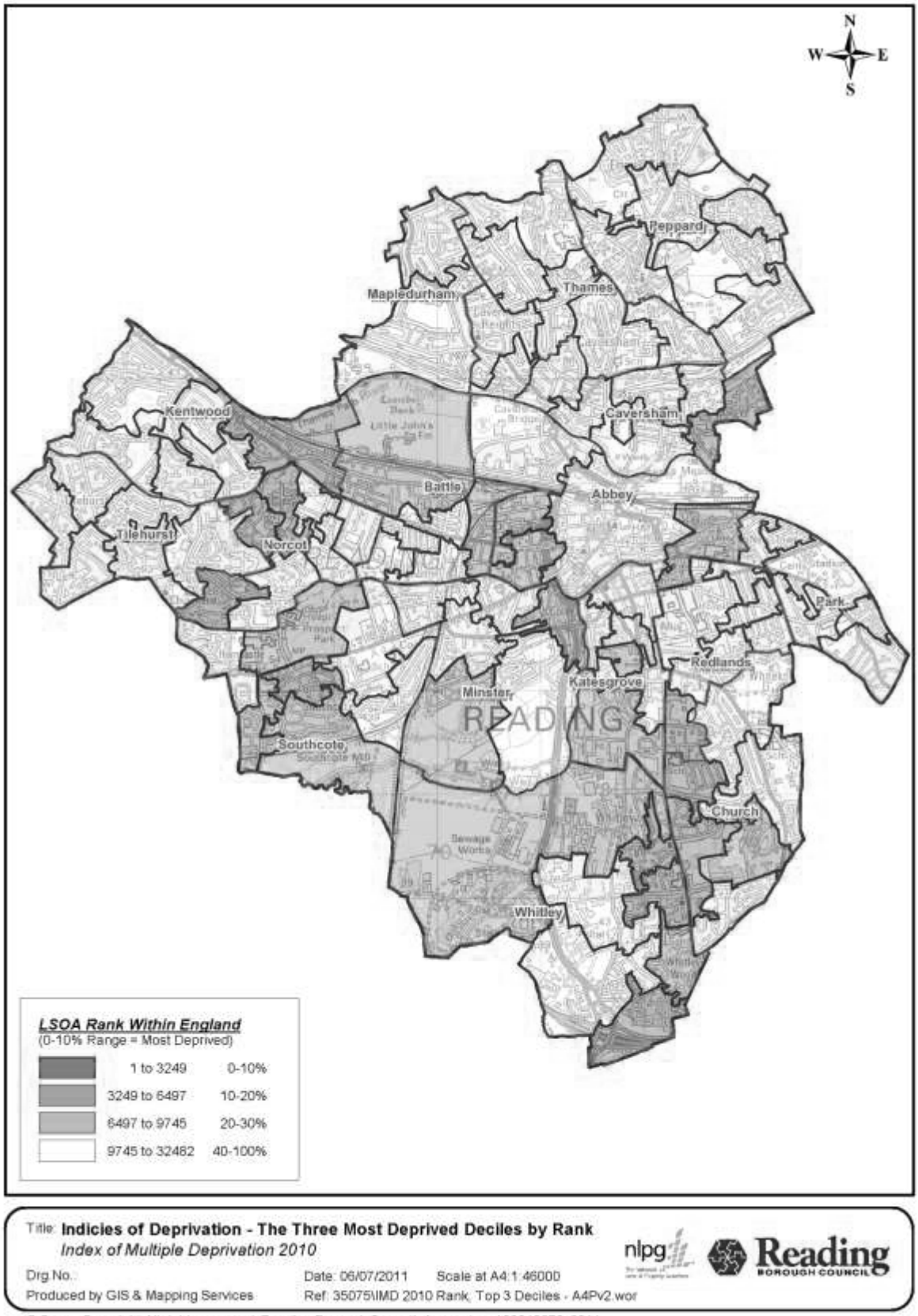
However, within this Reading exhibits marked extremes at a more refined locality level and, in this respect, is very different from any other local authority in the South East region.

The map shows the areas within Reading having the highest levels of deprivation according to the IMD, predominantly in the south, with four areas in the west and one in the north.

2011 census data shows that 11.3% of the overall population and 15.5% of children and young people aged 0-18 years, live in the 20% most deprived LSOAs nationally.

[5] *Super Output Areas (SOAs) are a set of geographical areas developed following the 2001 census. Lower Layer Super Output Areas (LSOAs) typically contain 4 to 6 OAs with a population of around 1500.*

Index of Multiple Deprivation 2010 (most deprived LSOAs)



Title: **Indicies of Deprivation - The Three Most Deprived Deciles by Rank**
Index of Multiple Deprivation 2010

Drg No.: Date: 06/07/2011 Scale at A4:1:46000

Produced by GIS & Mapping Services Ref: 35075\IMD 2010 Rank, Top 3 Deciles - A4Pv2.wor

© Crown Copyright. All rights reserved. Reading Borough Council. Account no. 100019672. 2011.
Department for Communities and Local Government, Indices of Deprivation 2010.

Source: Dept for Communities and Local Govt 2010

Census Deprivation Dimensions 2011

This dataset provides 2011 estimates that classify households in England and Wales by four dimensions of deprivation:

- Employment
- Education
- Health and disability
- Household overcrowding

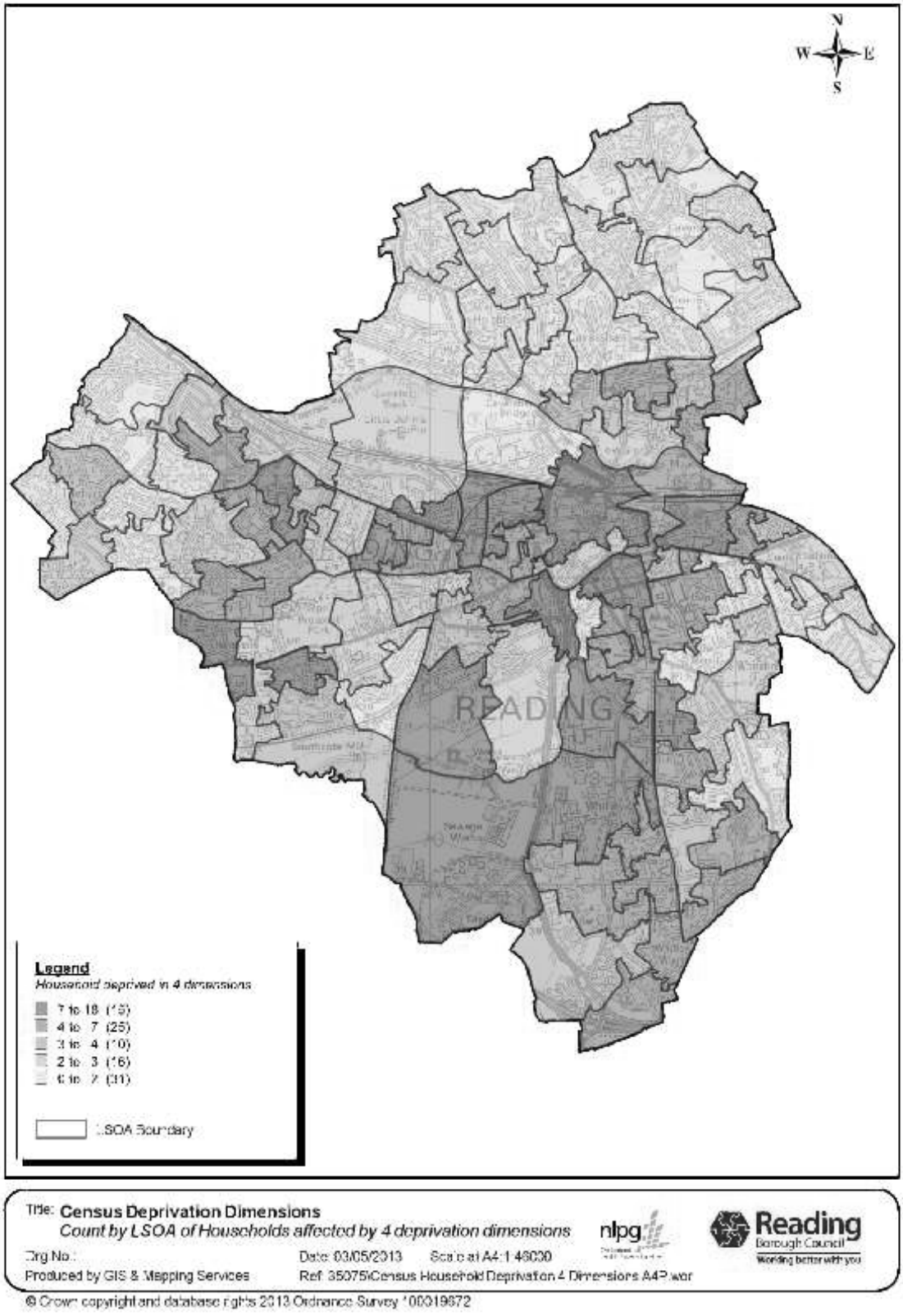
	All Households	*Household is Not Deprived in Any Dimension*	*Household is Deprived in 1 Dimension*	*Household is Deprived in 2 Dimensions*	*Household is Deprived in 3 Dimensions*	*Household is Deprived in 4 Dimensions*
Abbey	6,331	2,657	2,308	1,013	299	54
Battle	4,480	1,922	1,480	769	276	33
Caversham	4,225	2,274	1,161	612	162	16
Church	3,287	1,187	1,160	722	200	18
Katesgrove	4,230	1,924	1,431	622	217	36
Kentwood	3,746	1,829	1,196	580	132	9
Mapledurham	1,179	704	374	95	6	0
Minster	4,532	2,105	1,496	700	203	28
Norcot	4,260	1,589	1,462	901	279	29
Park	3,842	1,985	1,234	473	137	13
Peppard	3,843	2,110	1,181	495	54	3
Redlands	3,567	1,804	1,102	494	144	23
Southcote	3,582	1,323	1,201	798	236	24
Thames	3,647	2,335	958	309	43	2
Tilehurst	3,715	1,613	1,228	731	134	9
Whitley	4,403	1,515	1,471	1,012	361	44

Source: Office for National Statistics, Census 2011

In comparison with the IMD, **the Census deprivation dimensions data for Reading suggest that a number of additional areas are deprived**, particularly Abbey and (part of) Caversham wards, New Town area and parts of Tilehurst, Whitley and Southcote.

This is likely to be due to the fact that the IMD includes a higher weighting for social housing, which tends to hide those who are poor but not in social housing.

Census deprivation dimensions 2011
(households deprived on 4 dimensions)



Source: Census 2011

CHILD POVERTY

National picture

On average throughout the UK, just under one in five children are classified as below the poverty line (before housing costs)[6].

Over the last 15 years, the UK has gone from having one of the highest levels of child poverty in Europe to a rate near the average. However, the UK's rate of child poverty is still almost twice as high as that in the best performing countries of Scandinavia. Numbers of children in relative poverty have fallen recently but those in absolute poverty increased by more than 275,000 in 2011/12[7].

The Institute for Fiscal Studies predicts a growth in child poverty of 400,000 between 2011 and 2015, and a total of 800,000 by 2020[8].

Since 2010 there has been a dramatic 15 per cent decline in the number of children in workless households but a big rise in the proportion of poor children who are in families where someone is in work. Nationally, two-thirds of poor children are now in working households[9][10], though this should be viewed in the context that the large majority of children are from families with at least one adult in work.

In 2012/13, 2.3 million children (17%) were in relative income poverty[11], before housing costs, and 2.6 million children (20%) were in absolute poverty[12][13].

We know from research carried out by Save the Children in 2011[14] that:

- well over half of parents in poverty (61%) say they have cut back on food and over a quarter (26%) say they have skipped meals in the past year.
- around 1 in 5 parents in poverty (19%) say their children have to go without new shoes when they need them.
- a large number of children in poverty say they are missing out on things that many other children take for granted, such as going on school trips (19%) and having a warm coat in winter (14%).
- only 1 in 5 parents in poverty (20%) say they have not had to borrow money to pay for essentials, such as food and clothes, in the past year.

---

[6] *End Child Poverty, Child Poverty map of UK, Feb 2013*
[7] *State of Nation Report, Social Mobility and Child Poverty in Great Britain, 2013*
[8] *End Child Poverty, Child Poverty map of UK, Feb 2013*
[9] *State of Nation Report, Social Mobility and Child Poverty in Great Britain, 2013*
[10] *Households Below Average Income 2012/13, DWP*
[11] *below 60 per cent median household income; this is the measure generally used*
[12] *below 60 per cent of median household income held constant at 2010/11 level*
[13] *Households Below Average Income 2012/13, DWP*
[14] *End Child Poverty, Child Poverty map of UK, Feb 2013*

The Child Poverty Act requires the UK Government to publish and update a UK poverty strategy every three years. The final version of the Government's second Child Poverty Strategy 2014-17 was published in June 2014 and aims to show how the Government will build on its 2011 strategy.

UK Government's targets for child poverty are:

- To reduce the proportion of children who live in relative low income (family income below 60%of the median) to less than 10%
- To reduce the proportion of children who live below an income threshold fixed in real terms ('absolute' poverty) to less than 5%

Children in Low-Income Families Local Measure

The definitive national measure of relative child poverty, as set out in the Child Poverty Act 2010, is based on the Households Below Average Income data set which is based on the Family resources Survey.

However, at the local level, the 'children in low-income families' measure provides a broad proxy for relative low-income child poverty. This is the former N116 national indicator and measures children living in families in receipt of out of work benefits or in receipt of in-work tax credits where their reported income is less than 60 per cent of median income. However, this measure is not comparable with the national HBAI measure due to methodological differences.

Reading still broadly reflects the national picture with just under 1 in 5 children in poverty. However it is worth noting that the local measure includes all those households claiming out of work benefits, not just those with less that 60% median income, so the number of children in poverty may actually be lower than this.

On this measure, child poverty has generally decreased between 2011 and 2012, largely due to a decrease in the number of children in families receiving tax credits with an income less than 60 per cent of the median. However, this does not necessarily imply that the incomes of these families have improved; the change may be due to a decrease in the low income threshold[15].

Child poverty in Reading 2006-2012

year	*No children[16] in families in receipt of CTC (<60% median income) or IS/JSA*	*% of children in low-income families*	*SE*	*England*
2012	**6,470**	**18.8%**	**13.5%**	**18.6%**
2011	6945	20.8%	14.6%	20.1%
2010	7110	21.7%	15.0%	20.6%

[15] *Commentary on children in low-income families measure*
www.gov.uk/government/statistics/personal-tax-credits-children-in-low-income-families-local-measure-2012-snapshot-as-at-31-august-2012
[16] *All dependent children under 20*

2009	7020	22.1%	15.4%	21.3%
2008	6640	21.5%	14.5%	20.9%
2007	6760	22.3%	14.9%	21.6%
2006	6420	21.2%	14.4%	20.8%

Source: HMRC

Child poverty by ward 2012

	2011		*2012*	
Ward	*No children in families in receipt of CTC (<60% median income) or IS/JSA*	*% of Children in low-income families*	*No children in families in receipt of CTC (<60% median income) or IS/JSA*	*% of Children in low-income families*
Abbey	350	21.2%	320	18.8%
Battle	590	22.8%	565	21.0%
Caversham	470	21.0%	410	18.1%
Church	780	33.7%	675	29.1%
Katesgrove	375	23.2%	375	22.1%
Kentwood	480	19.8%	455	18.4%
Mapledurham	10	1.3%	10	1.7%
Minster	455	23.5%	420	20.6%
Norcot	680	27.2%	625	24.0%
Park	345	16.1%	360	16.1%
Peppard	165	8.2%	135	6.6%
Redlands	290	21.8%	265	19.2%
Southcote	440	22.7%	455	22.3%
Thames	115	4.4%	100	3.9%
Tilehurst	345	16.0%	350	15.9%
Whitley	1,060	31.4%	950	27.3%

Source: HMRC 2012

This shows the highest numbers of children in relative poverty in areas of Whitley and Amersham Road, with a number also around the Oxford Road area. It also shows that while the child poverty measure has reduced overall in Reading, it has increased slightly in a few areas *(see map of child poverty at LSOA level).*

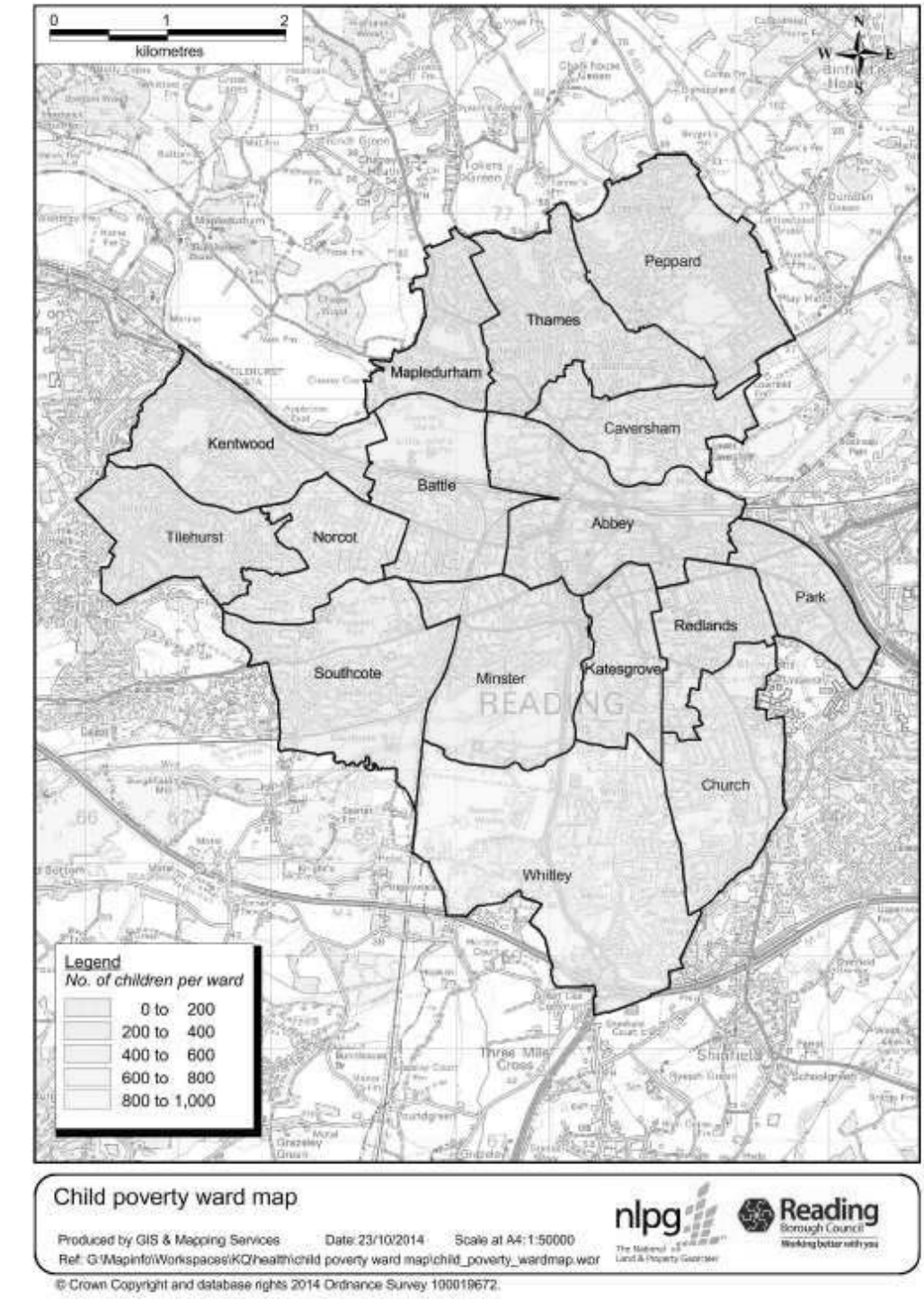
Index of Income Deprivation Affecting Children 2010

The Index of Income Deprivation Affecting Children (IDACI) is one of the domains forming the Index of Multiple Deprivation. **This suggests a slightly worse picture of child poverty in Reading than the children in low income families local measure**, probably reflecting the fact that in Reading low income rather than unemployment is a key determinant of relative poverty.

Just under a quarter of children and young people live in the 18 (of 93) Lower Super Output Areas (LSOAs) in the 20% most deprived nationally. The 5 LSOAs in Reading featured in the 20% most deprived on the IDACI, but not in the 20% most deprived on the overall IMD, mainly fall in central Reading and include parts of Katesgrove, Minster and the western area of Abbey *(see map).* They thus pick up areas with a number of different socio-economic profiles and in particular the large and growing BME population that is

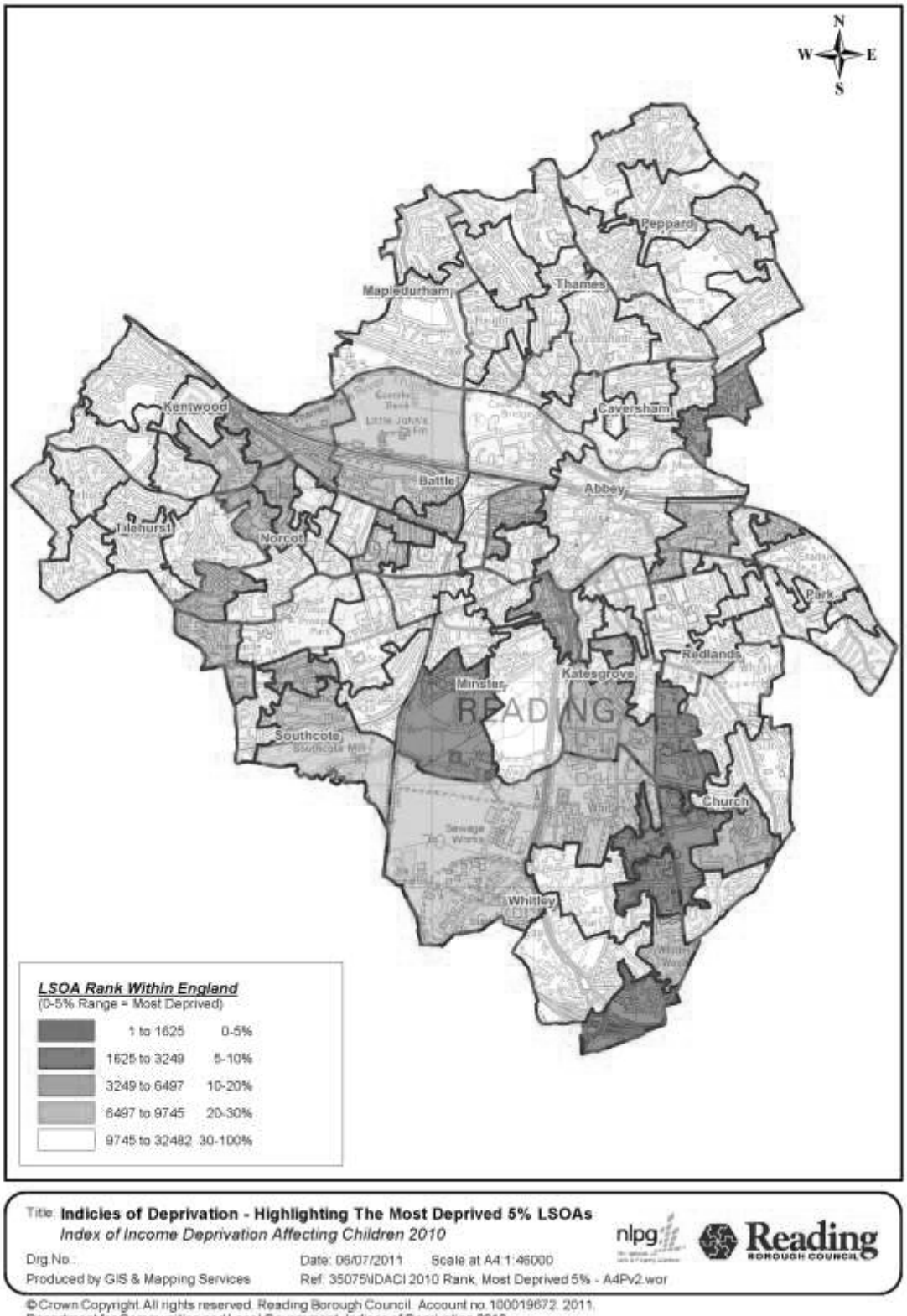
traditionally more concentrated in the older inner area private housing stock.

Child poverty by ward 2012
(children in low income families local measure)



Source: HMRC 2012

Index of Income Deprivation Affecting children 2010
(most deprived LSOAs)



Source: Index of Multiple Deprivation 2010

Lone parent families

Almost three quarters of children in poverty live in lone parent families, higher than both the national and regional figures. Not surprisingly, the map shows that lone parents claiming key benefits across Reading match areas with high levels of child poverty.

Children in lone parent families

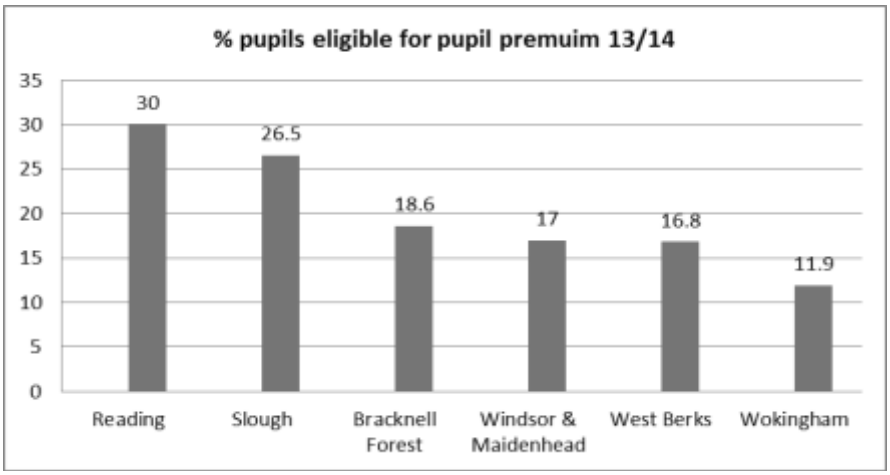
	No children in families in receipt of CTC (<60% median income) or IS/JSA			*% children in families in receipt of CTC (<60% median income) or IS/JSA*		*% of Children[17] in "Poverty"*
	Couple	*Lone parent*	*All*	*Couple*	*Lone parent*	*All Families*
England	654,760	1,499,225	2,153,985	30.4%	69.6%	18.6%
South East	71,605	180,910	252,515	28.4%	71.6%	13.5%
Reading	**1,660**	**4,815**	**6,475**	**25.6%**	**74.4%**	**18.8%**

Source: HMRC 2012

Pupil Premium

The Pupil Premium is additional funding given to schools so that they can support their disadvantaged pupils and close the attainment gap between them and their peers. It is allocated to schools to work with pupils who have been registered for free school meals at any point in the last six years.

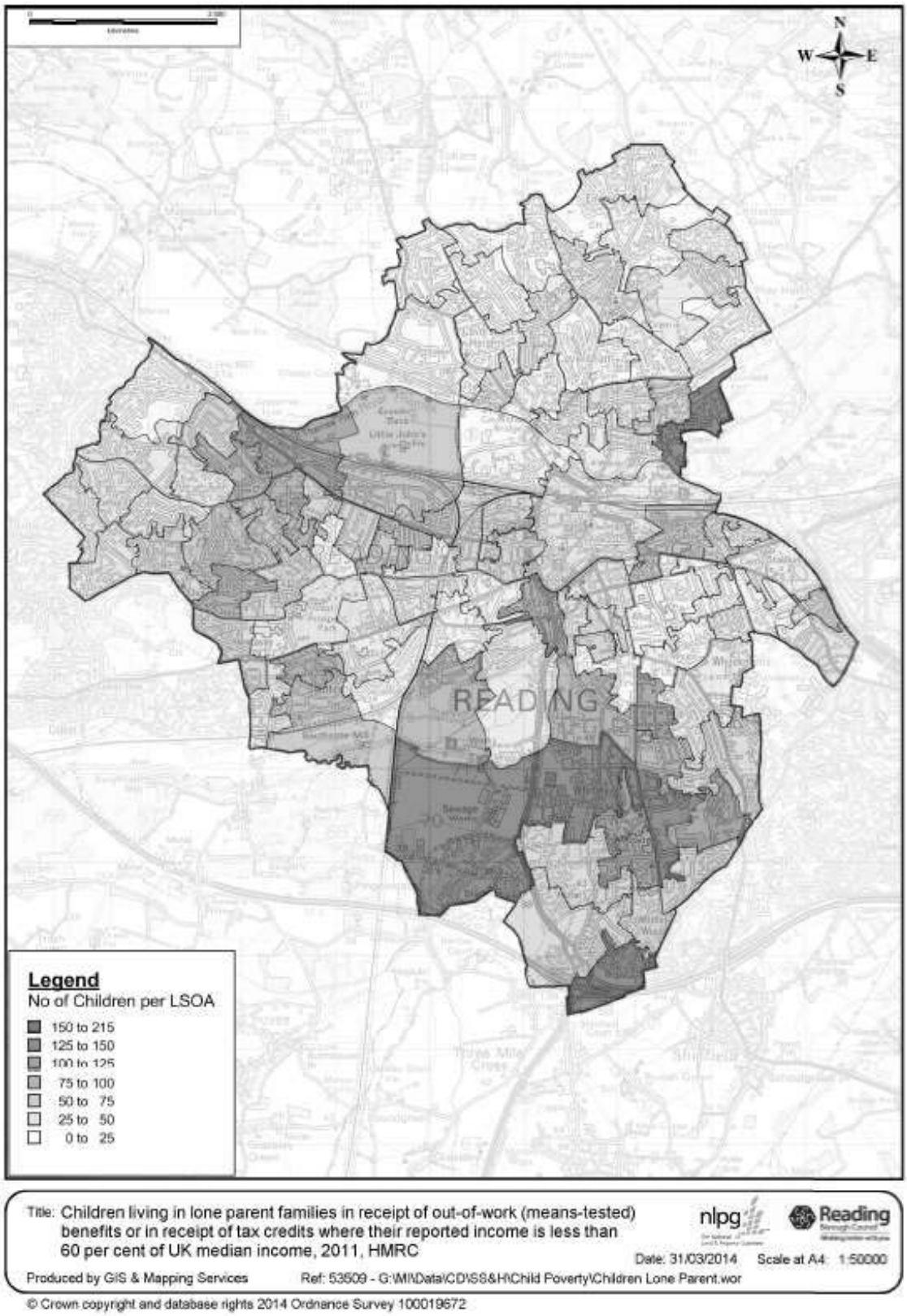
30% of Reading pupils are eligible for pupil premium (5,000 pupils), the highest percentage in Berkshire, compared with 22.2% for SE and 29.2% for UK.



Source: DFE Pupil premium 2013 to 2014 final allocation tables, Dec 13

[17] *All dependent children under 20*

Children in poverty in lone parent families



Source: HMRC 2011

Educational attainment

The link between poverty and poor educational outcomes is well documented. Children who grow up in poverty face serious disadvantage and consequently struggle to thrive and achieve often resulting in their own children also living in poverty and facing similar barriers – a cycle of intergenerational poverty. Low educational achievement, amongst other factors, can increase the risk that families will not have the resources for a decent standard of living, negatively impacting on their children's life chances.

Reading has a higher proportion of pupils eligible for free school meals than the South East and the other Berkshire authorities. Those in receipt of free school meals tend to do less well in terms of educational attainment.

Percentage of pupils eligible for free school meals

	Percentage of pupils eligible for free school meals in state-funded primary schools in 2012	*Percentage of pupils eligible for free school meals in state-funded secondary schools in 2012*
South East	**13.1**	**10.5**
Slough	18.3	14.3
Reading	**20.6**	**18.7**
Windsor & Maidenhead	8.4	7.7
Bracknell	9.9	6.8
Wokingham	5.6	6.2
West Berks	9.2	7.4

Source: DFE 2011/12

Attainment and free school meals

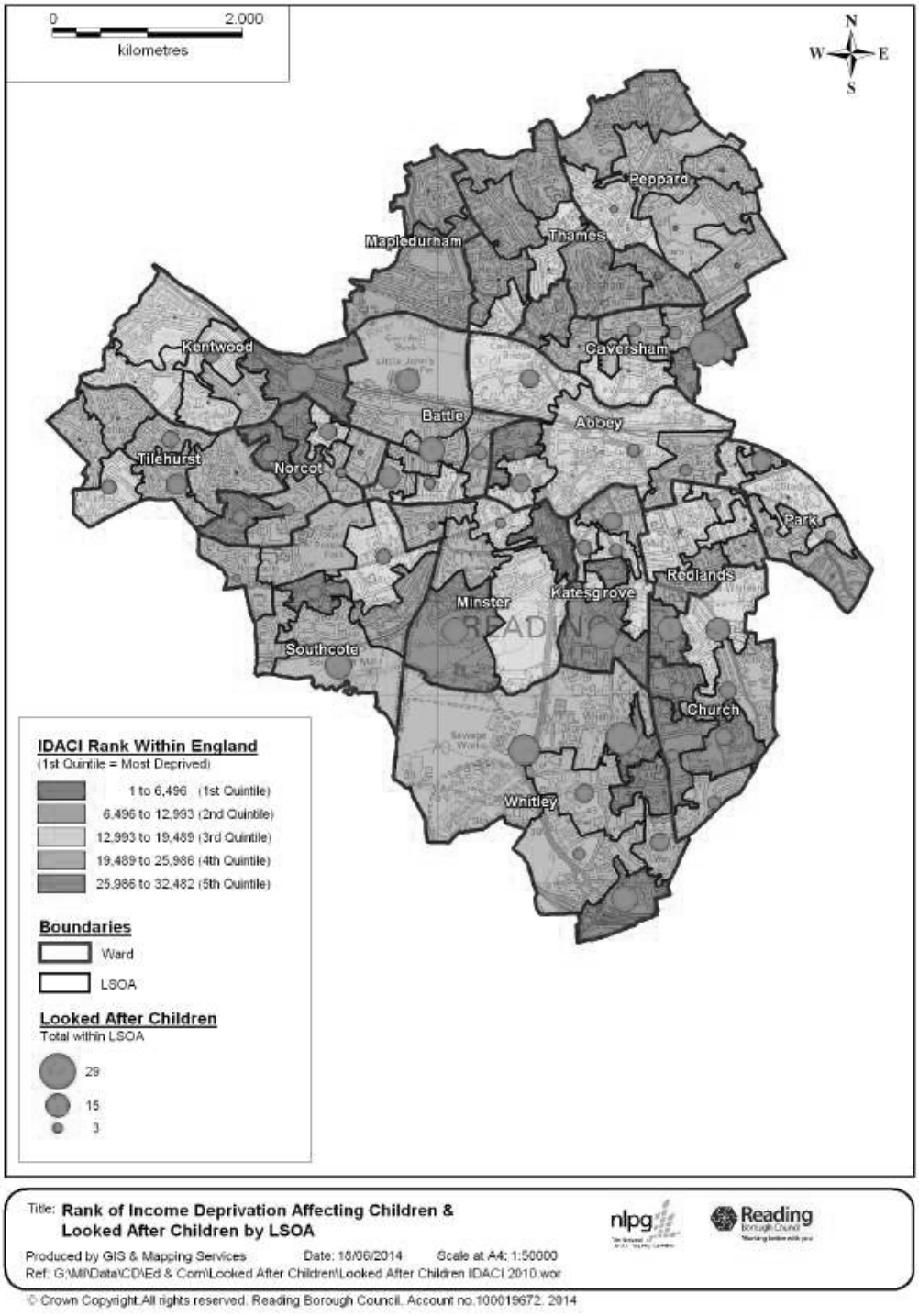
	***Foundation stage** - good level of development (% children achieving at least the expected level)*		***Key Stage 2** - level 4+ (% achieving level 4 or above)*		***GCSEs** - % 5+ A*-C including English and mathematics GCSEs*	
	All	*30% most deprived national areas*[18]	*All*	*Eligible for free school meals*	*All*	*Eligible for free school meals*
Reading	**51**	**45**	**83**	**74**	**63.6**	**35.1**
England	52	44	86	75	60.8	38.1
SE	54	45	87	72	62.5	33.0

Source: DFE 2012/13

[18] *The percentage of children in each Local Authority who reside in the 30% most disadvantaged Super Output Areas in England based, on the 2010 Index of Multiple Deprivation.*

Looked after children

The map below plots the home addresses of children who were 'looked after' by Reading Borough Council in 2013/14. These cases have been mapped against the IDACI data, which shows that the majority of children becoming 'looked after' come from addresses where deprivation is highest in Reading.



Source: Reading Borough Council 2013/14

Youth offending

In 2012, 71 children entered the **youth justice system** for the first time. This is a similar rate to the England average for young people receiving their first reprimand, warning or conviction.

In 2013, the figure had reduced to 63. Whilst nationally there has been a reduction in first time entrants to the youth justice system, the reduction in Reading was at a greater rate.

Cost of child poverty

There is a financial as well as a moral imperative for tackling poverty. Failing to prevent children growing up in poor families is expensive for society, both in terms of direct costs to services during and after childhood and in costs to the economy when children grow up.

The Child Poverty Action Group[19] estimates that each child living below the poverty line costs around £10,861.42 annually, with the current, national cost of child poverty estimated at £29 billion per year.

This figure represents the total amount of money that is 'lost' due to child poverty – reflecting extra expenditure by social services, housing and health care services, as well as lost income, including lost earnings and reduced tax receipts; in effect, the amount of money that is drained from each area due to child poverty.

For Reading Borough Council, this is estimated to total £85 million a year.

[19] *The Cost of a Child in 2013, Child Poverty Action Group, August 2013*

UNEMPLOYMENT AND IN-WORK POVERTY

The evidence is clear that the main root causes of poverty are worklessness and low earnings.

According to the Child Poverty Action Group[20], it costs a minimum of £148,000 in total - around £160 per week - to bring up a child to age 18 and meet the child's minimum needs. The minimum necessary cost rose by 4% in 2013, while the minimum wage rose by 1.8%; average earnings by 1.5%; benefits for families and children by just 1%, and child benefit did not rise at all.

Although the numbers of children in relative poverty have fallen recently, those in absolute poverty increased by more than 275,000 in 2011/12. Since 2010 there has been a dramatic 15 per cent decline in the number of children in workless households but a big rise in the proportion of poor children who are in families where someone is in work. Two-thirds of poor children are now in working households[21], though this should be viewed in the context that the large majority of children are from families with at least one adult in work.

OUT OF WORK POVERTY

Latest statistics from the DWP for 2013 show that **almost 9% of the resident working age population in Reading is claiming a key out of work benefit, and 5% of all households[22].**

17.6% of children aged under 16 (5,580) are in out of work families[23].

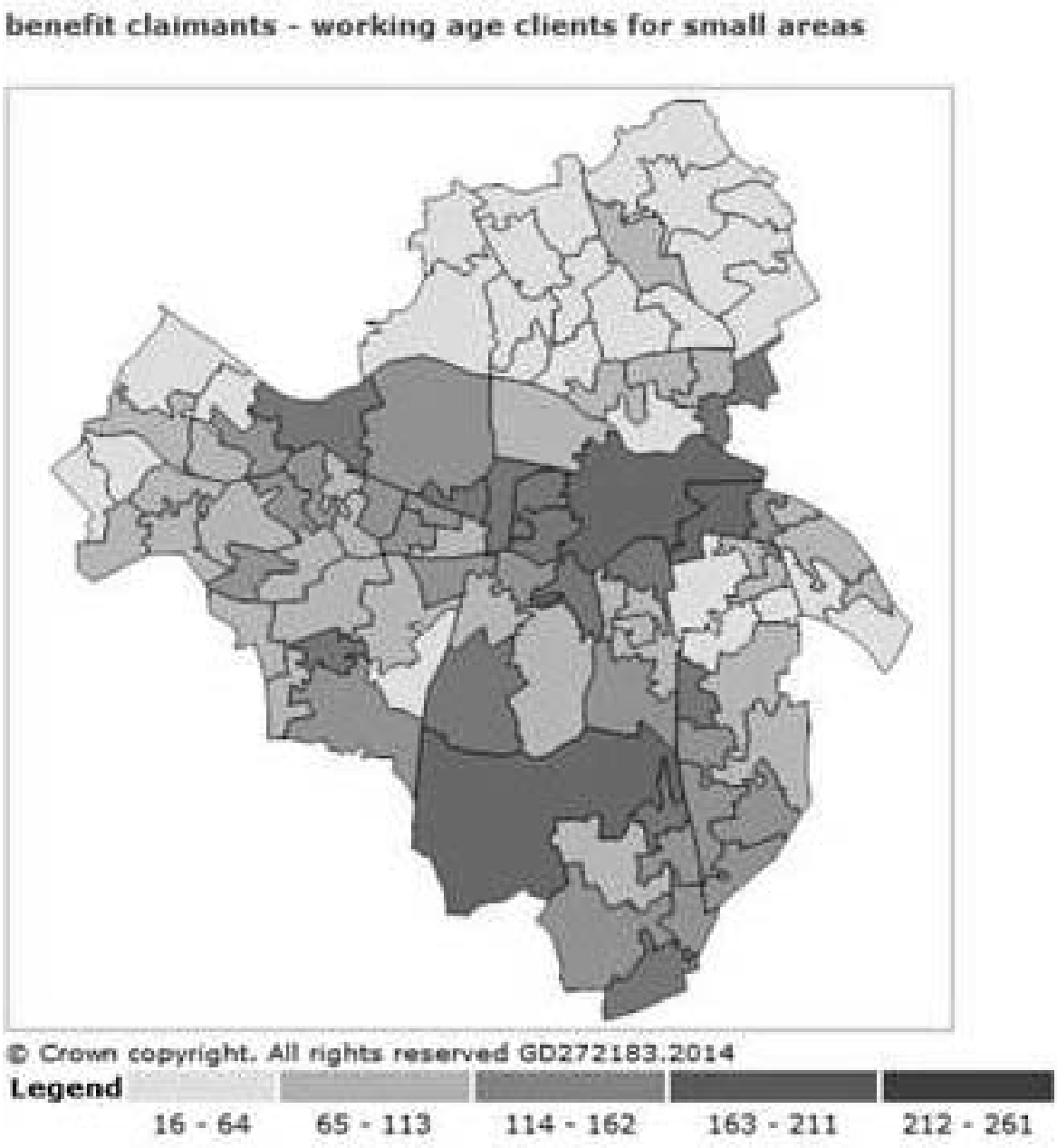
Key out-of-work benefits (Aug 2013)

Benefit	*Reading number*	*Reading rate (Proportion of resident population aged 16-64 estimate)*	*SE rate*	*England rate*
job seeker	2,690	2.5		
ESA and incapacity benefits	4,920	4.6		
lone parent	1,540	1.4		
others on income related benefit	330	0.3		
total key out-of-work benefits[24]	**9,480**	**8.8**	**7.6**	**10.6**

Source: NOMIS 2013

[20] *The Cost of a Child in 2013, Child Poverty Action Group*
[21] *State of Nation Report, Social Mobility and Child Poverty in Great Britain, 2013*
[22] *gov.uk, DWP May 2013*
[23] *gov.uk, DWP May 2013*
[24] *consists of the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits*

Key out of work benefits 2013



Legend = number of claimants at LSOA level
Source: NOMIS 2013

Those people claiming key out of work benefits across Reading fit closely with the areas reported to have higher levels of child poverty.

JSA claimant count (March 2014)

Reading count	*Reading rate*	*SE rate*	*GB rate*
2,335	**1.8**	2.2	2.9

Source: NOMIS

Following a peak in February 2012, the claimant count has reduced steadily. There are now 1305 fewer claimants than in March 2013. In particular, Reading has shown the 11th greatest year on year reduction of youth unemployment nationally[25].

The table below shows the percentage of out of work claimants for Reading with dependent children.

JSA claimants with dependent children (Nov 2013)

	% claimants with children
Bracknell Forest	21.7%
Reading	**21.4%**
Slough	26.5%
West Berkshire	20.2%
Windsor and Maidenhead	18.2%
Wokingham	19.1%

Source: NOMIS

IN-WORK POVERTY

Nationally since 2010, there has been a big rise in the proportion of poor children who are in families where someone is in work, with two-thirds of poor children now in working households[26], though this should be viewed in the context that the large majority of children are from families with at least one adult in work.

In 2011, **365 children in Reading were living in families in receipt of both Child Tax Credit and Working Tax Credit with income less that 60% median income,** though there are likely to be a higher number of children in total in working households in poverty.

Children in families in receipt of Child Tax Credit and Working Tax Credit and income less than 60% of median income

	No of children
2011	**365**
2010	415
2009	395
2008	510

Source: gov.uk

[25] *NOMIS, June 2014*
[26] *State of Nation Report, Social Mobility and Child Poverty in Great Britain, 2013*

Median Pay 2013

Reading has an above average level of median earnings of employees, higher than both the national and regional averages.

Median pay

	Reading	*SE*	*England*
Weekly pay - gross	**£583.9**	£559.7	£520.7
Weekly pay - basic	**£543.6**	£527.0	£487.1
Hourly pay - gross	**£14.91**	£14.37	£13.26
Annual pay - gross	**£32,146**	£29,732	£27,375

Source: annual survey of hours and earnings - resident analysis 2013 (full time workers)

Economic activity rate

Since the previous Census in 2001, part time employment has increased and full time employment decreased. The most significant increase has been for those who are economically active but unemployed from 2.5% to 4.6%. Those who are self employed have also increased.

Percentage of people aged 16 -74 economically active and inactive						
	England		*South East*		*Reading*	
	2001	*2011*	*2001*	*2011*	*2001*	*2011*
Economically active: Employee: Part-time	11.8	**13.7**	12.2	**13.8**	10.2	**11.9**
Economically active: Employee: Full-time	40.8	**38.6**	43.2	**40.4**	48.1	**44.6**
Economically active: Self-employed	8.3	**9.8**	9.6	**11.0**	6.9	**7.9**
Economically active: Unemployed	3.3	**4.4**	2.3	**3.4**	2.5	**4.6**
Economically active: Full-time student	2.6	**3.4**	2.7	**3.3**	4.1	**5.0**
Economically inactive: Retired	13.5	**13.7**	13.4	**13.7**	9.8	**8.6**
Economically inactive: Student (including full-time students)	4.7	**5.8**	4.2	**5.2**	7	**8.0**
Economically inactive: Looking after home or family	6.5	**4.4**	6.5	**4.4**	5.6	**4.6**
Economically inactive: Long-term sick or disabled	5.3	**4.0**	4.4	**2.9**	3	**2.8**
Economically inactive: Other	3.1	**2.2**	2.4	**1.8**	2.8	**2.2**

Source: 2011 Census

SKILLS AND QUALIFICATIONS

A primary cause of poverty is the lack of opportunities for those with low skills and low qualifications. Low skills also act as a significant brake on the ability of Reading to fulfil its economic potential.

Despite an unemployment rate well below the national average, Reading continues to have pockets of structural unemployment in a predominantly high growth economy. This is associated with under achievement and low skill levels. This masks a far more serious and widespread issue of low income amongst the employed.

The general educational quality in Reading is considered below England average, except at GCSE level, with low educational attainment in some schools at Key Stages 1, 2 and 3 (see child poverty chapter).

The percentage of residents with no qualifications has decreased from 22.8% to 17.4% since the last census *(see map)*. This mirrors the national picture. **Residents achieving level 3 and level 4 qualifications have increased** with the most significant increase for those achieving level 4 and above with a 6.5% increase from 2001 to 34.8%. This is above the level achieved for the South East (29.9%) and England (27.4%).

Percentage of people aged 16 - 74 achieving qualifications

Highest Level of Qualification	*England*		*South East*		*Reading*	
	2001	*2011*	*2001*	*2011*	*2001*	*2011*
No qualifications	28.9	**22.5**	23.9	**19.1**	22.8	17.4
Highest level of qualification: Level 1 qualifications	16.6	**13.3**	17.1	**13.5**	15	12.2
Highest level of qualification: Level 2 qualifications	19.4	**15.2**	21.2	**15.9**	17.4	12.3
Highest level of qualification: Apprenticeship	N/A	**3.6**	N/A	**3.6**	N/A	2.5
Highest level of qualification: Level 3 qualifications	8.3	**12.4**	9.2	**12.8**	11.5	13.4
Highest level of qualification: Level 4 qualifications and above	19.9	**27.4**	21.7	**29.9**	28.3	34.8
Highest level of qualification: Other qualifications	6.9	**5.7**	6.8	**5.2**	5	7.4

Source 2011 Census Table KS501EW, 2001 table KS13

% residents aged 16+ with no qualifications

	% residents aged 16+ with no qualifications
SE	**19.1**
England	22.5
Reading	**17.4**
Bracknell Forest	16.3
Slough	20.1
West Berkshire	17.2
Windsor and Maidenhead	15.6
Wokingham	13.2

Source: 2011 Census

%19 year olds gaining level 2 and 3 qualifications

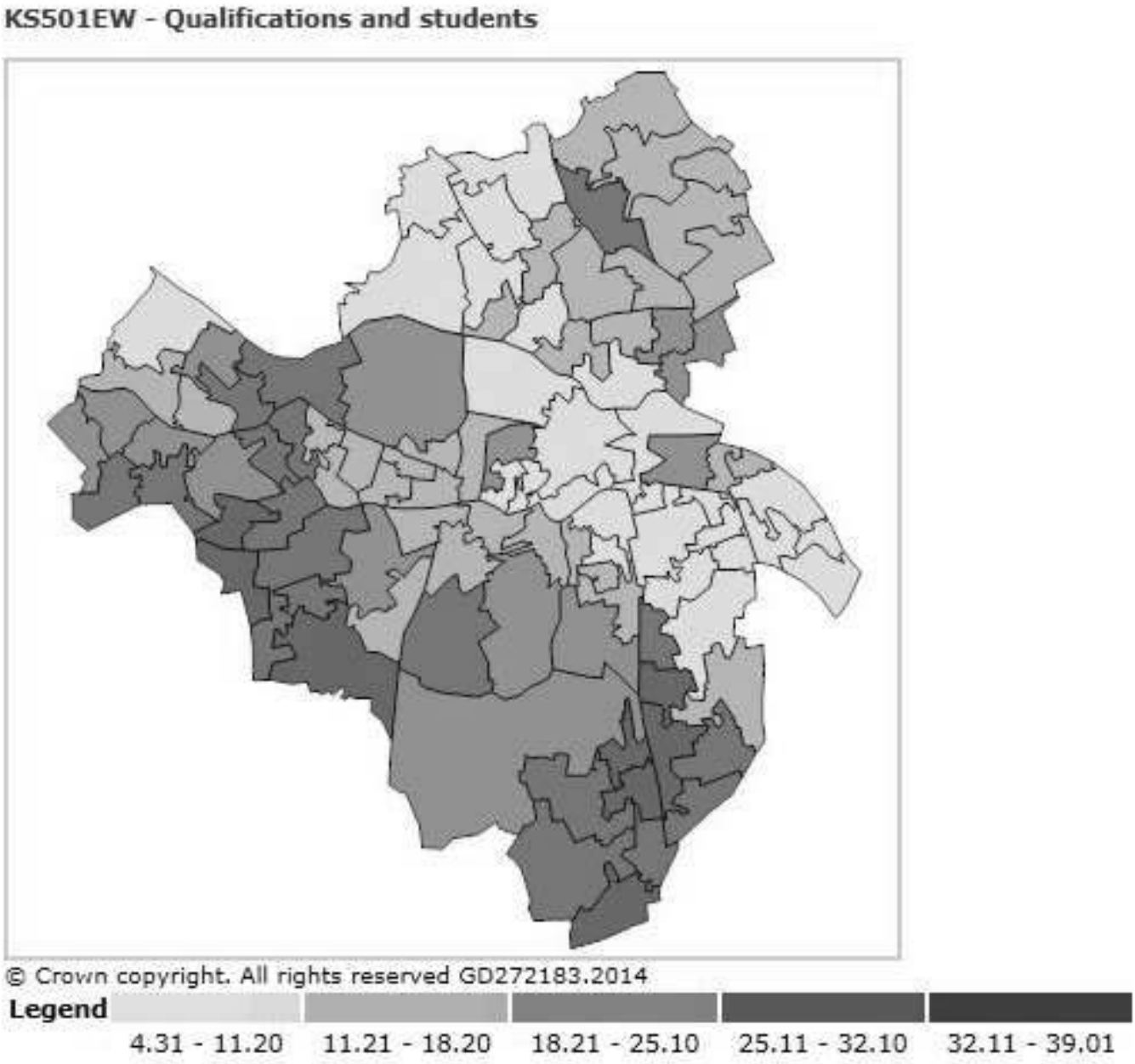
82% of young people aged 19 gain a level 2 qualification: this is slightly below the national and regional averages, though at level 3, Reading's performance is in line with SE. Fewer of those eligible for free school meals achieve level 2 or 3 qualifications at age 19.

%19 year olds gaining level 2 and 3 qualifications

	Level 2		*Level 3*	
	All	*Eligible for free school meals*	*All*	*Eligible for free school meals*
Reading	**82%**	**60%**	**58%**	**29%**
SE	85%	65%	58%	28%
England	85%	71%	56%	35%

Source: DFE 2013, gov.uk

% residents aged 16+ with no qualifications



Source: 2011 Census

Reading's occupation profile

Reading's occupation profile has changed since 2001 Census, with **professional occupation types showing the most significant increase** with 24.5% of the Reading population now employed in this sector, well above the regional and England percentages of 18.7% and 17.5% respectively. Service occupations have increased and administrative occupations decreased.

Percentage of working population aged 16 -74 by occupation type

Occupation Type	*England*		*South East*		*Reading*	
	2001	**2011**	**2001**	**2011**	**2001**	2011
1. Managers, directors and senior officials	15	10.9	17	12.3	15	9.0
2. Professional occupations	11	17.5	12	18.7	16	24.5
3. Associate professional and technical occupations	14	12.8	15	13.8	15	13.5
4. Administrative and secretarial occupations	13	11.5	14	11.5	14	10.0
5. Skilled trades occupations	12	11.4	11	11.1	9	9.0
6. Caring, leisure and other service occupations	7	9.3	7	9.3	5	8.5
7. Sales and customer service occupations	8	8.4	7	7.9	9	9.0
8. Process, plant and machine operatives	8	7.2	6	5.7	6	5.1
9. Elementary occupations	12	11.1	10	9.7	11	11.4

Source: 2011 Census

NEETS (Not in Education, Employment or Training)

Despite the decrease in the percentage of residents with no qualifications and the increase in those with level 3 and 4 qualifications, **Reading has a significant number of young people aged between 16 and 18 who are NEET.** The figures for Reading have been reducing consistently over the last few years but are still higher than both the national and regional average. However, Reading has shown the 11th greatest year on year reduction of youth unemployment (claimant count) nationally.

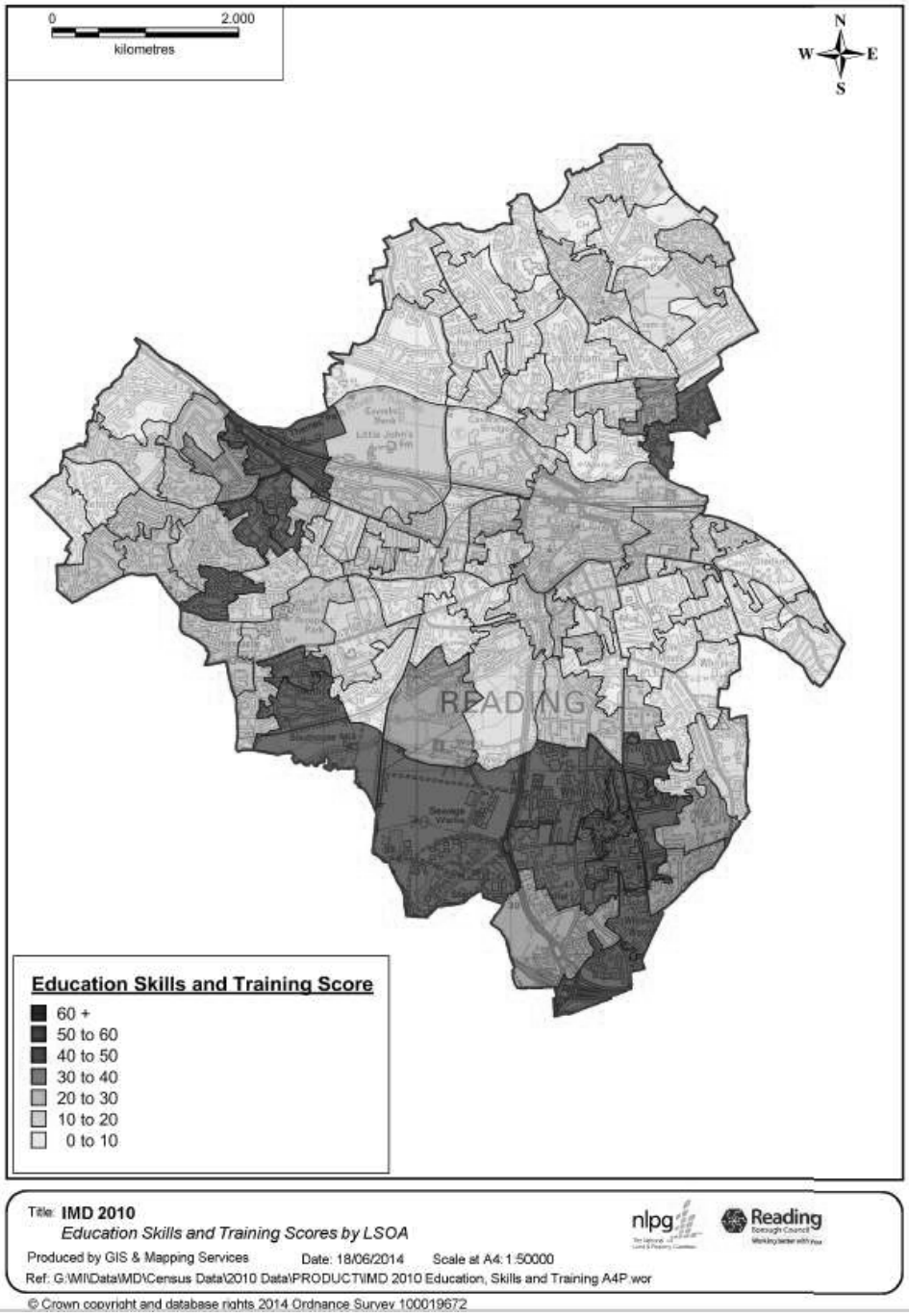
Percentage of NEETs

	Estimated number	*%*
South East	**13,620**	**5.1%**
Reading	270	6.3%
Bracknell Forest	140	4.0%
Slough	280	6.1%
West Berkshire	150	3.1%
Windsor & Maidenhead	150	4.1%
Wokingham	150	3.1%

Source: Dept for Education (GOV.UK), 2013

Index of Education, Skills and Training Deprivation 2010

The Education, Skills and Training Deprivation domain is one of seven distinct domains of deprivation which are combined to form the Index of Multiple Deprivation 2010. This domain measures the extent of education, skills and training deprivation in an area relating to both children and young people and adult skills. Areas low on this domain tend to be areas of higher deprivation on the general IMD.

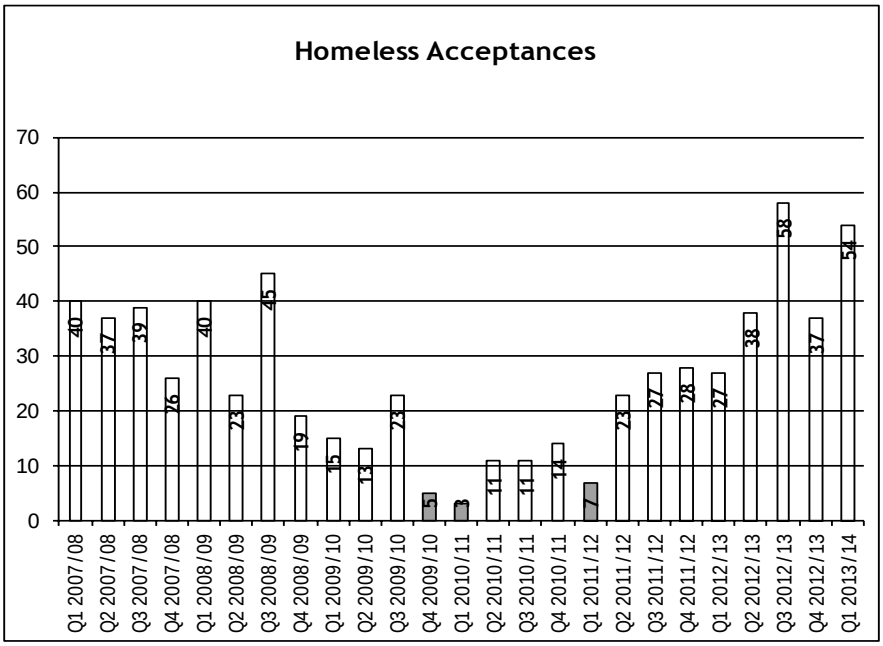


Source: Index of Multiple Deprivation 2010

MEETING BASIC NEEDS

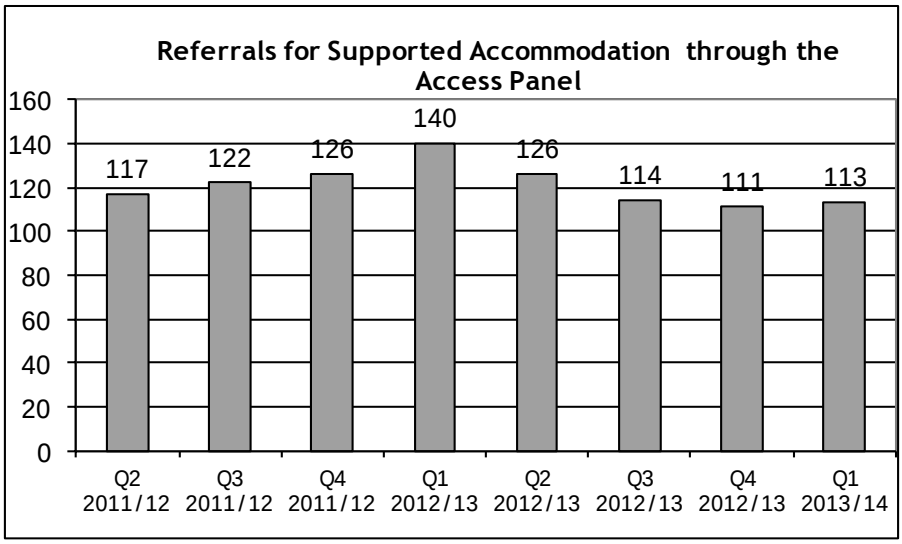
Homelessness

The number of people accepted as statutorily homeless has increased significantly over the past two year; figures have doubled since quarter 1 2012/13 and increased by 700% since quarter 1 2011/12.



Source: Reading Borough Council

The table below shows the number of single people who have been referred to supported accommodation[27].



Source: Reading Borough Council

[27] *e.g. Hamble Court, Salvation Army, Launch Pad, Waylen St.*

Housing conditions

According to the Children's Society, in 2013 over half of all children in the UK who say they are in poverty are living in homes that are too cold, and a quarter live in damp or mould-ridden conditions[28].

Census 2011

The 2011 Census provides a measure of under-occupancy and over-crowding. An occupancy rating of -1 implies that there is one room too few for the number of people living in the household. **Reading has a higher proportion of households with an occupancy rating of -1** than either the South east of England *(see map)*.

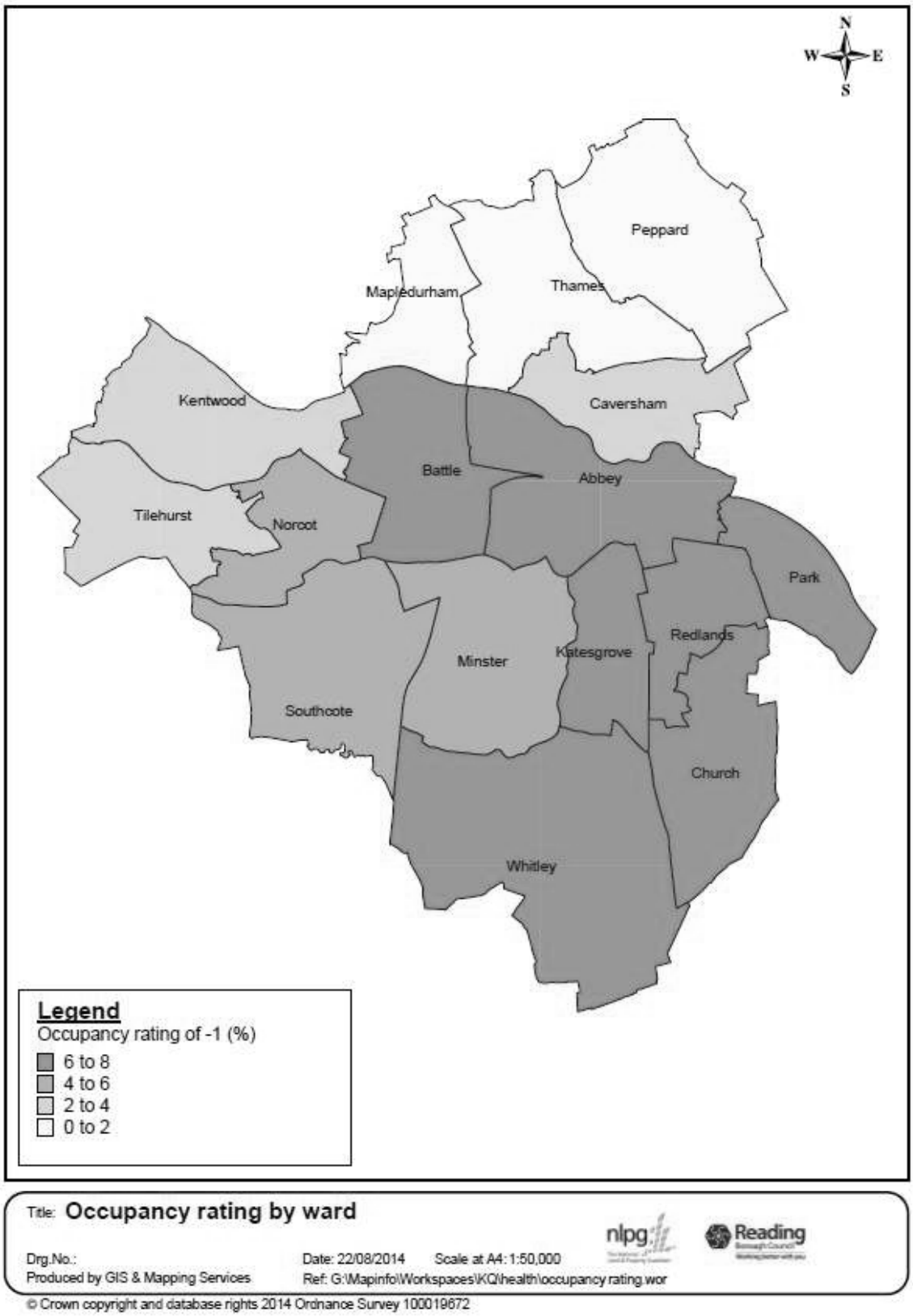
Central heating and occupancy rating

Area	*No central heating* *% of total in area*	*Occupancy rating (extra bedrooms) of -1*	*Occupancy rating (extra bedrooms) of -2 or less*
England	**2.69%**	**4.06%**	**0.75%**
South East	**2.38%**	**3.29%**	**0.47%**
Reading	**3.16%**	**5.26%**	**0.97%**
Abbey	5.35%	6.44%	1.11%
Battle	4.64%	7.75%	1.88%
Caversham	3.67%	3.76%	0.33%
Church	1.95%	7.12%	1.28%
Katesgrove	5.60%	7.02%	1.91%
Kentwood	2.03%	3.50%	0.75%
Mapledurham	0.85%	0.51%	0.08%
Minster	4.19%	5.67%	0.84%
Norcot	2.77%	5.35%	0.63%
Park	3.90%	7.52%	1.98%
Peppard	1.01%	1.69%	0.23%
Redlands	3.64%	6.76%	1.04%
Southcote	2.32%	5.00%	0.87%
Thames	1.26%	1.21%	0.14%
Tilehurst	1.67%	2.37%	0.19%
Whitley	1.79%	7.52%	1.39%

Source: Census 2011

[28] *Through Young Eyes, the Children's Commission on Poverty, the Children's Society 2013*

Percentage of households with an occupancy rating of -1



Source: Census 2011

Private sector house condition survey 2013

A sample of a thousand private sector properties in Reading were surveyed over a 3 month period in 2013.

The number of non decent[29] homes has reduced by 40% since the last stock condition survey in 2006. However, 12,200 dwellings (23.4% of total private sector housing) still fail to meet the requirements of the decent homes standard. This compares with 25% for England (2011/12).

.

- 5,265 dwellings (10.1%) exhibit Category 1 hazards within the Housing Health and Safety Rating System (HHSRS);
- 6,164 dwellings (11.8%) are in disrepair;
- 596 dwellings (1.1%) lack modern facilities and services;
- 4,531 dwellings (8.7%) fail to provide a reasonable degree of thermal comfort

Rates of non decency in the private rented sector are around the national average at 34.8% (national average 35%), but significantly higher than the private sector owner occupied average of 21.9%.

31.5% of vulnerable households live in non-decent homes. 7.4% households have insufficient bedrooms to meet family needs and are therefore overcrowded.

The estimated cost to meet the decency standard in the private sector in Reading is £85 million.

The highest rates of decent homes failure are recorded for the wards of Battle, Park, Caversham and Redlands. Failure rates in these wards exceed one-third of ward housing stock.

Fuel poverty

At the sub-regional level, a household is said to be fuel poor if it needs to spend more than 10% of its income on fuel to maintain a satisfactory heating regime (usually 21 degrees for the main living area, and 18 degrees for other occupied rooms)[30].

[29] *A decent home is one that satisfies all of the following four criteria: it meets the current statutory minimum standard for housing; it is in a reasonable state of repair; it has reasonably modern facilities and services; it provides a reasonable degree of thermal comfort.*

[30] *At the national level, a household is said to be in fuel poverty if:*

• they have required fuel costs that are above average (the national median level)

• were they to spend that amount they would be left with a residual income below the official poverty line

According to **Department of Energy and Climate Change**, in 2011 an estimated 6,000 households in Reading were considered fuel poor, equating to 9.8% of households in the Borough.

Fuel poverty 2011

	Fuel Poor Households	*Percent Fuel Poor*
Reading	**6,239**	**9.8%**
Berks	27,962	8.2%
SE	363,556	10.3%

Source: DECC 2011

However, according to the **Private Sector House Condition Survey (2013),** while energy efficiency levels have improved since the previous survey in 2006, fuel poverty has increased in the Borough, primarily related to increases in energy tariffs and the economic circumstances of households affected.

A total of 10,573 households in Reading (17.9%) spend in excess of 10% of their annual income on domestic fuel and are defined as being in fuel poverty. Levels of fuel poverty have increased from 5,600 households or 11% as reported by the 2006 survey.

See also Financial Crisis Support Service in this chapter and excess winter deaths in the Poverty and Older People chapter.

Food poverty

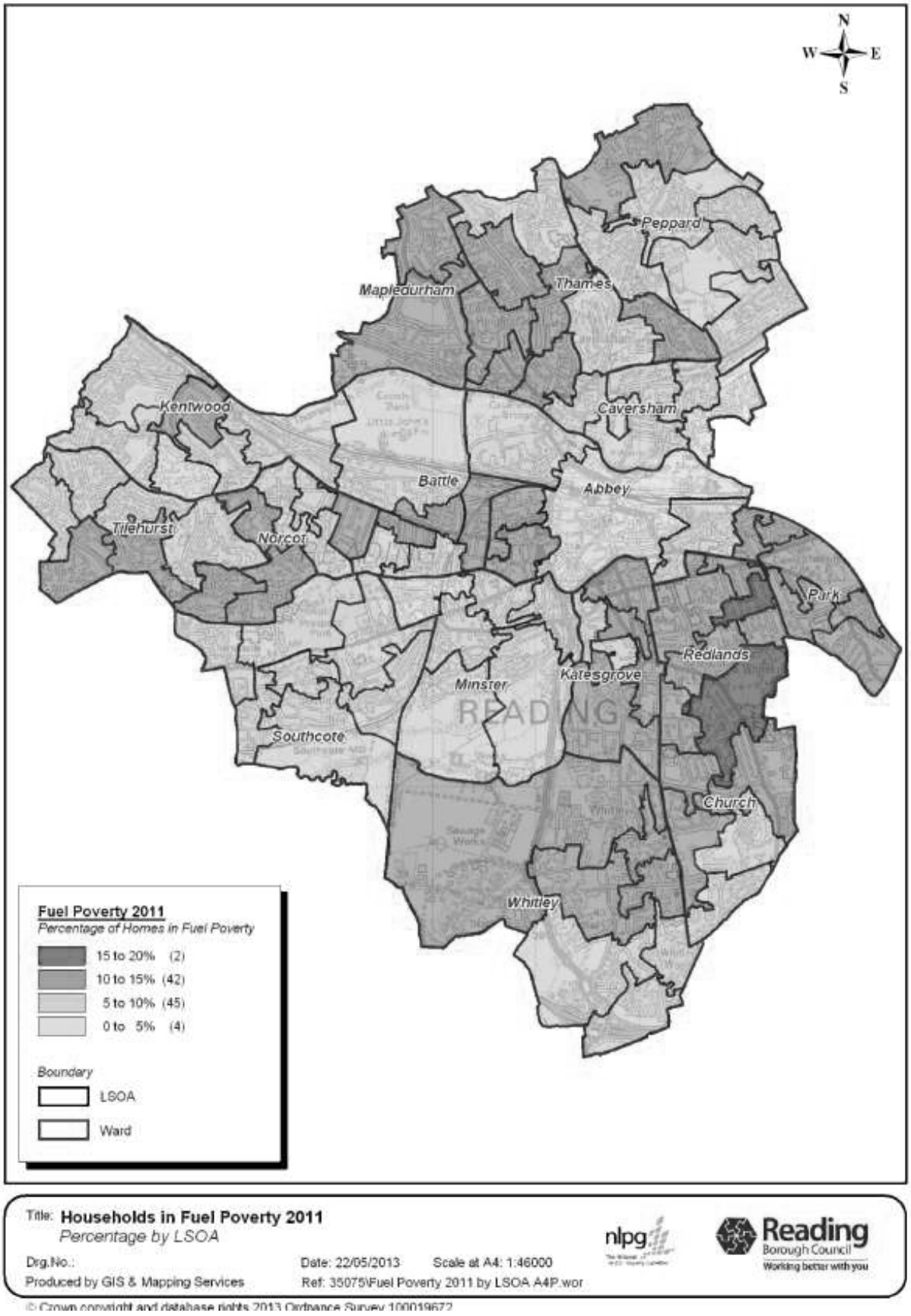
Readifood

Readifood provide emergency food parcels to families and individuals across greater Reading and have seen unprecedented growth in demand over the past 18 months. **Demand for food parcels has risen by almost 400% over the past two years**, from 25 parcels per week to a current 97 parcels per week. This is at least partly due to sanctions relating to Job Seekers Allowance or Employment Support Allowance.

From April to December 2013 Readifood provided:

- 1875 single person parcels (60%)
- 527 couple parcels (17%)
- 712 family parcels (23%)

Households in fuel poverty



Source: DECC 2011

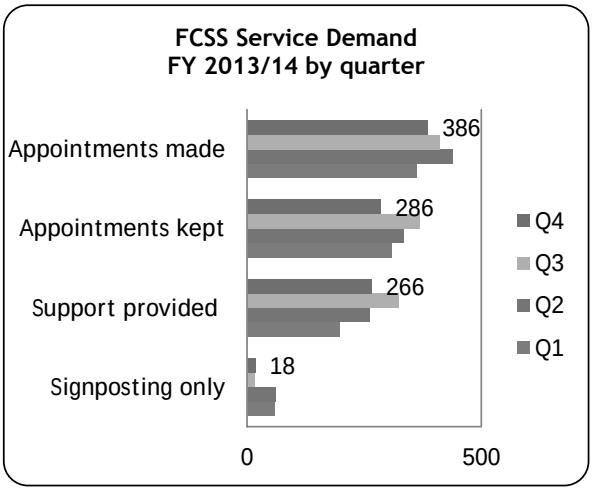
Financial Crisis Support Service

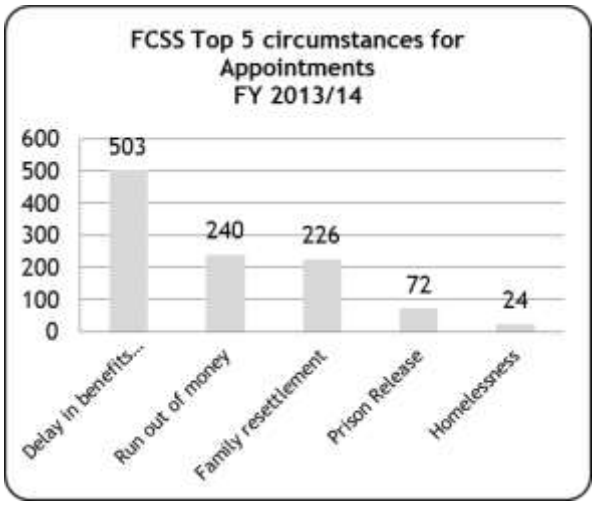
The Council's Financial Crisis Support Service was launched in April 2013, following the abolition of Dept of Work and Pension's Crisis Loans and Community Care Grants, to create local support for vulnerable households that require financial support where there are no other avenues available to them. In terms of type of support, customers are most often provided with food parcels, gas/electricity top up, cash for white goods and furniture.

From April 2013 to March 2014 FCSS provided:

- 486 food parcels
- 291 customers provided with gas/electricity top up

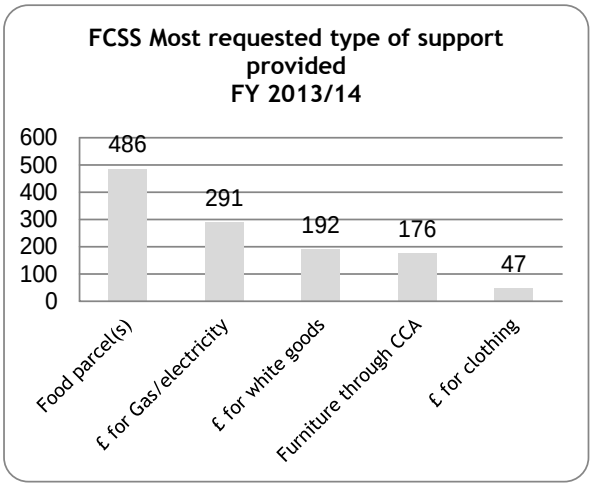
Financial Crisis Support Service 2013/14

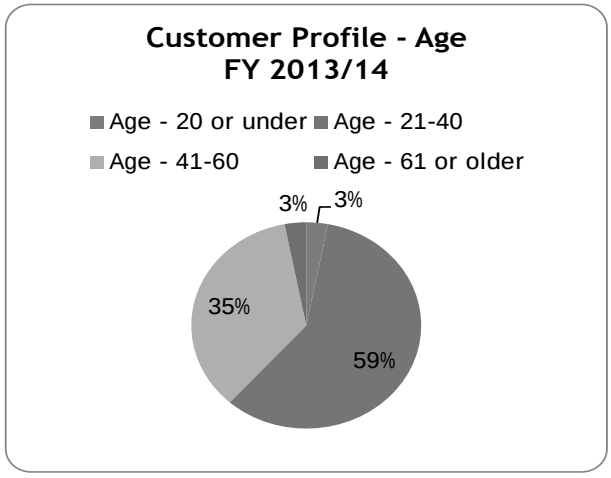




Service Demand
Appointments made, and support provided, through the scheme were highest during Q3. During Q4 74% of appointments were kept and support provided in 93%.

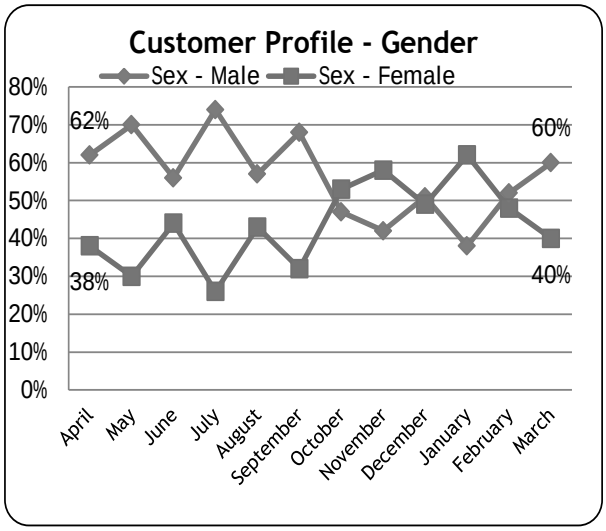
Appointments – Circumstances
The most common circumstances leading to an appointment is delay in benefits payment, this is more than double the those who require an appointment as have run out of money.

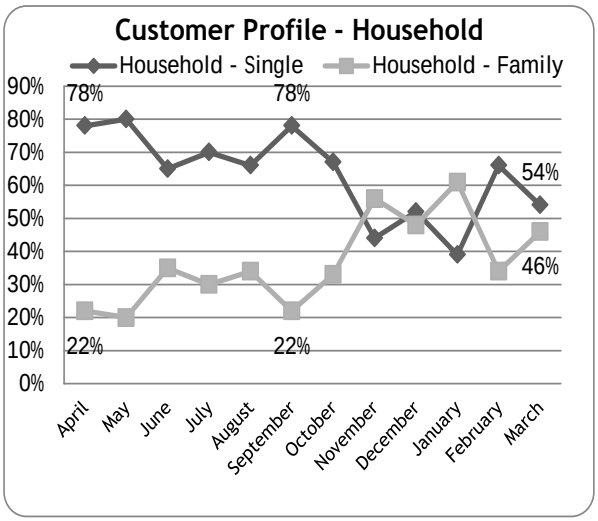




Type of support provided
Food parcels have been requested most and 486 issued during 2013/14. This is just a small proportion of the total provided with Readifood and other organisations also supplying parcels

Customer Profile – Age
The majority of claimants are aged 21-40 (59%) followed by those aged 41-60 make up 35%





Customer Profile - Gender
The gender profile of customers has varied throughout the year at the end. In March 60% of customers were male and 40% female

Customer Profile – Household
The household profile has changed significantly during the year. The majority of customers were single (78%) now the split is fairly even between single (54%) and family 46%.

HEALTH

Children living in income-deprived families are prone to significantly worse health outcomes, both during childhood and later in life. The adverse impact of unemployment, for example, on physical and mental health of individuals in term of higher risk of depression and increased morbidity is well documented. Poor parental health combined with financial hardship has an inevitable effect on the wellbeing of children. Deprivation can influence behavioural choices that are known to impact on the health of adults and children such as breastfeeding, eating habits and participation in sports and exercise.

Census Overview

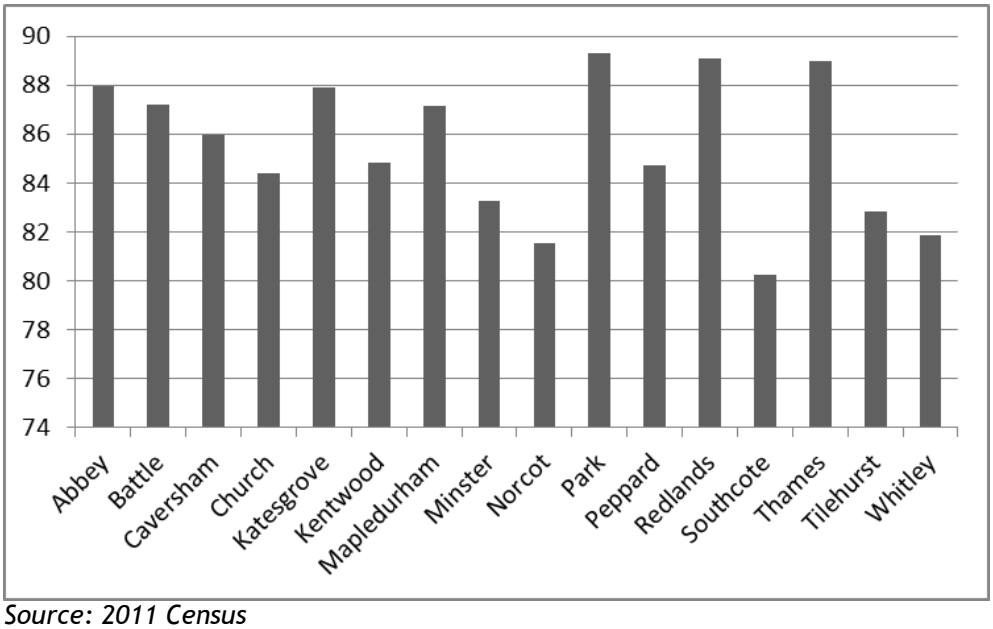
Proportion of population reporting good or very good health by ward

On average, the 2011 Census shows that **a higher percentage of residents report good or very good health** than in either the South East or nationally.

	% reporting good or very good health
England	81%
South East	84%
Reading	86%

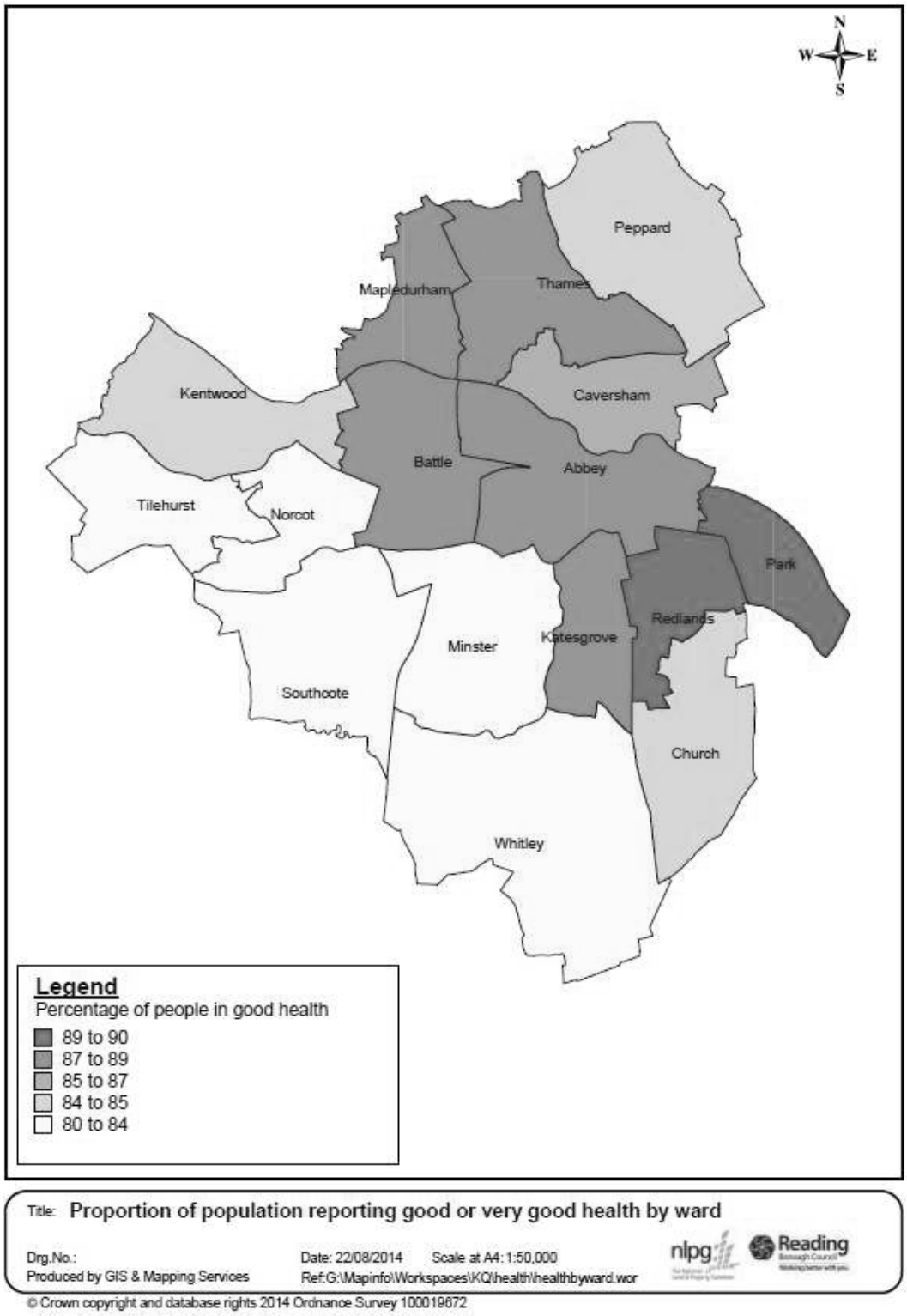
Source: 2011 Census

However, there are significant geographical differences within Reading *(see map)*. The areas reporting the highest percentage of residents reporting good or very good health are Park, Redlands and Thames. In Park and Redlands this may be due to the higher number of younger people, particularly students, in these areas.



Source: 2011 Census

Proportion of population reporting good or very good health



Source: Census 2011

Reading residents' health

The health of people in Reading compares favourably with the England average in some areas and less favourably in others:

- **Life expectancy** for women is similar to the England average, but lower for men. However, life expectancy is 9.2 years lower for men and 6.3 years lower for women in the most deprived areas of Reading than in the least deprived areas.

- Over the last 10 years, all cause mortality rates have fallen. The early death rate from **heart disease and stroke** has fallen and is close to the England average.

- In year 6, 19.3% (265) of children are classified as **obese**.

- Levels of **alcohol specific hospital stays** among those under 18, **breast feeding** and **smoking in pregnancy** are better than the England average.

- The estimated level of **adult obesity** is better than the England average.

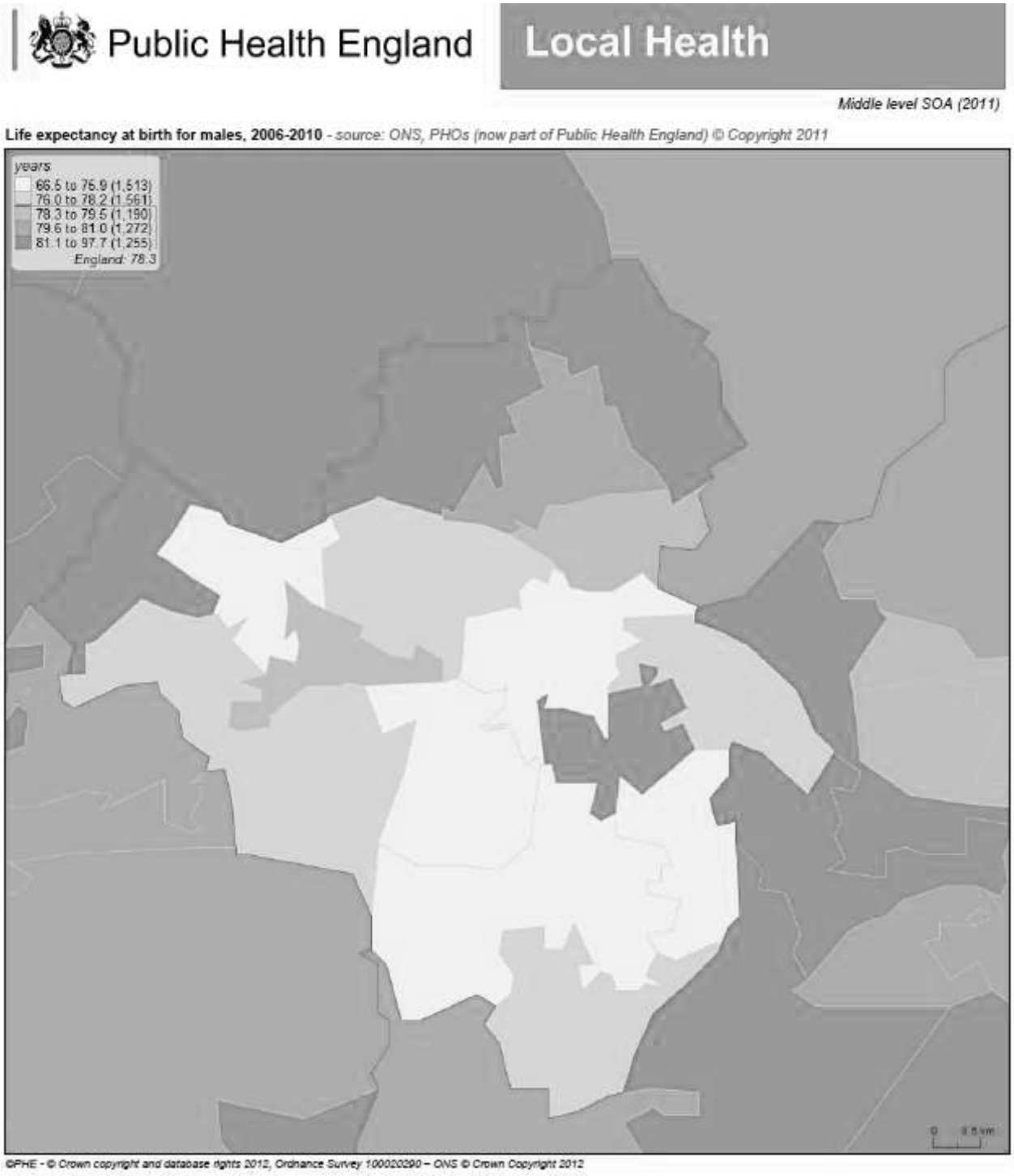
- The rate of **sexually transmitted infections** and TB is significantly worse than the England average.

- Rates of **road injuries and deaths** and **hospital stays for alcohol related harm** are better than the England average.

- Priorities in Reading include **crime, drugs and alcohol and identification and management of respiratory disease**.

Source: Public Health England health profile 2014

Life expectancy for males



Source: Public health England, 2006-2010

Life expectancy for females

Source: Public health England, 2006-2010

Child health

Children and young people under the age of 20 years make up 24.6% of the population of Reading.

The picture of the health and wellbeing of children in Reading is mixed compared with the England average.

- Infant and child **mortality rates** are similar to the England average.
- As discussed in the first chapter, the level of **child poverty** is worse than the England average with 20.8% of children[31] living in poverty.
- The rate of **family homelessness** is worse than the England average.
- Children in Reading have average levels of **obesity**: 9.8% of children aged 4-5 years and 18.8% of children aged 10-11 years are classified as obese.
- In 2012, 71 children entered the **youth justice system** for the first time. This is a similar rate when compared to the England average for young people receiving their first reprimand, warning or conviction.
- In 2011/12, there were 4,503 **A&E attendances** by children aged 4 years and under. This gives a rate which is lower than the England average. The hospital admission rate for injury in children is lower than the England average, and the admission rate for injury in young people is lower than the England average.
- The level of **teenage pregnancy** is significantly worse than the England average.
- Reading is significantly worse that the England average for **acute sexually transmitted infections, 16-18 year old NEETs (not in education, employment or training), and children with one or more decayed, missing or filled teeth**.

Source: Public Health England Child Health Profile, 2014 (except child poverty)

[31] *Under the age of 20*

POVERTY AND ETHNICITY

Children from ethnic minorities face a particularly high risk of growing up in poverty. Risks of poverty are highest for those from Bangladeshi, Pakistani and Black African communities, but are also above average for those from Caribbean, Indian and Chinese communities.

Overview - Census

Reading's population has increased in ethnic diversity. **35% of the population now belong to a Black and Minority Ethnic community.** Reading has the third highest Black and Minority Ethnic population in the South East after Slough and Oxford.

Ethnicity

	Reading 2001	*Reading 2011*	*England 2011*
White British	86.80%	66.9%	80.9%
Other White	4.2%	7.9%	4.6%
Mixed	2.4%	3.9%	2.2%
Indian	1.7%	4.2%	2.6%
Pakistani	2.7%	4.5%	2.1%
Other Asian	0.8%	3.9%	2.3%
Black Caribbean	2.2%	2.1%	1.1%
Black African	1.6%	4.9%	1.8%
Black other	0.4%	0.7%	0.5
Chinese	0.7%	1%	0.7%
Other ethnic group	0.7%	0.9%	1.%

Source: 2011 Census

According to the School Census 2013**, 49.4% of school children are from a Black and Minority Ethnic group.**

Ethnicity and attainment

Research[32] shows that nationally White children who are eligible for free school meals are consistently the lowest performing group in the country, and the difference between their educational performance and that of their less-deprived White peers is larger than for any other ethnic group. The gap exists at age five and widens as children get older.

The table below highlights that, in Reading, attainment by young people from Mixed race backgrounds at Key Stage 2 is lower than that of their peers. It also indicates that this gap continues through to GCSE level. Children from Black communities at Key Stage 2 have a similar attainment level to their peers, though attainment is lower at GCSE level.

Attainment by ethnic group

		White	*Mixed*	*Asian*	*Black*	*Chinese*	*All pupils*
Key Stage 2 - Percentage achieving level 4 or above	**Reading**	**84**	**78**	**83**	**84**	**x**	**83**
	England	86	87	85	85	92	86
Percentage achieving 5+ A*-C grades inc. English & mathematics GCSEs	**Reading**	**63**	**56**	**67**	**59**	**x**	**64**
	England	60.4	62.7	64.9	58.7	80.1	60.8

Source: Department for Education 2012/13

Free school meals

A higher proportion of Mixed race and Black children are eligible for free school meals than White children, but a lower proportion of Asian and Chinese children.

Eligibility for free school meals by ethnic group

	Eligible for FSM	*Not eligible for FSM*
White	16%	84%
Mixed	29%	71%
Asian	10%	90%
Black	21%	79%
Chinese	2%	98%

Source: RBC school census 2014

[32] *the Government's Education Committee, 'Underachievement in Education by White Working Class Children'*

Health

This table shows the percentage of hospital admissions in 2011/12 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. **There is a higher proportion of admissions by residents from Asian and Black communities** than by all ethnic groups, in both Reading and nationally.

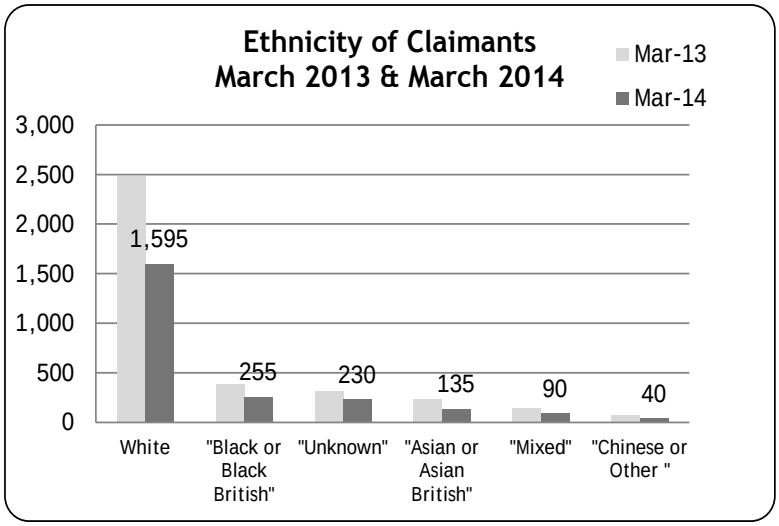
Percentage of hospital admissions in 2011/12 by ethnic group

	All ethnic groups	*White*	*Mixed*	*Asian*	*Black*	*Chinese*	*Other*	*Un known*
No of emergency admissions	11393	8662	138	961	523	38	111	960
Reading %	**42.5%**	**42.9%**	**39.4%**	**46.2%**	**44.0%**	**38.0%**	**49.2%**	**35.6%**
England %	40.6%	41.1%	40.0%	45.3%	44.4%	38.0%	46.4%	30.1%

Source: Reading Health Profile 2013, Public Health England

Job Seekers Allowance claimant count

In March 2014, 61.2% of people claiming JSA were White British, with **29.1% from Black and Minority Ethnic groups.**



Source: NOMIS, March 2014

JSA claimants by ethnic group

Ethnicity	*Male*	*Female*	*Total*	*% total claimants*
White	**1015**	**585**	**1595**	**68.3**
British	935	515	1,450	62.1
Irish	10	10	20	0.9
Other	70	60	125	5.4
Mixed	**60**	**30**	**95**	**4.1**
Asian or Asian British	**80**	**75**	**150**	**6.4**
Indian	20	15	35	1.5
Pakastani	45	40	80	3.4
Bangladeshi	5	5	10	0.4
Other Asian	10	15	25	1.1
Black or Black British	**185**	**85**	**270**	**11.6**
Caribbean	110	45	155	6.6
African	50	30	80	3.4
Other Black	25	10	35	1.5
Chinese or Other	**30**	**25**	**55**	**2.4**
Unknown	125	85	205	8.8

Source: NOMIS, March 2014

POVERTY AMONGST OLDER PEOPLE

According to the International Longevity Centre UK, whilst 1.6 million pensioners nationally are still experiencing relatively low incomes, pensioner poverty has fallen drastically over the last 15 years, with pensioner households less likely to be on a low income than households with working age adults or households with children[33].

Census Overview

The 60-74 age group has increased by 8% since 2001. There has been a slight decrease in the 75+ age group. According to the ONS 2012 population projections, **the 90+ age group will rise from forming 0.6% of the population to 1.3% in 2030**.

Residents in older age bands

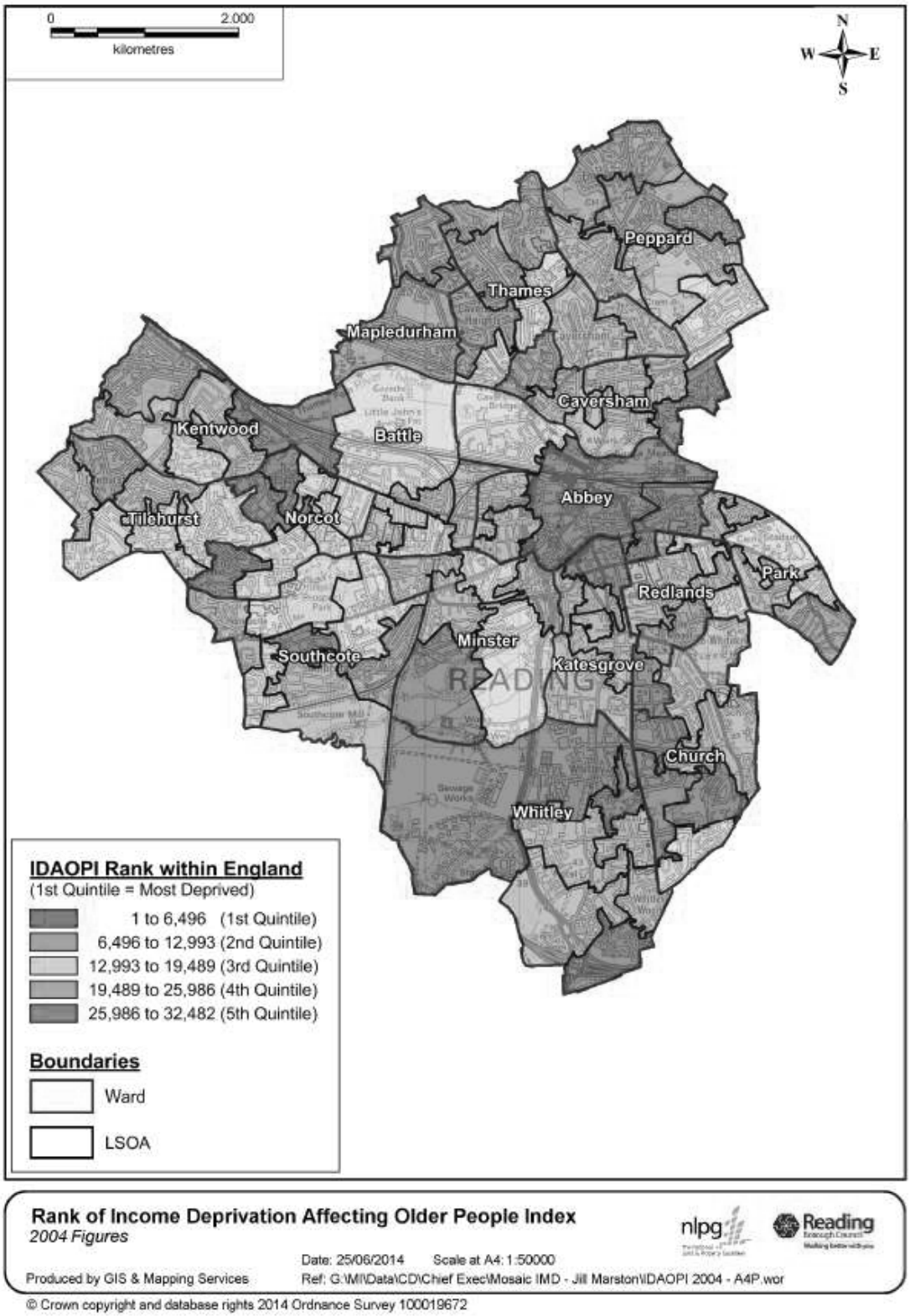
	number	*%*
All usual residents	155,698	100.0
Age 60 to 64	6,373	4.1
Age 65 to 74	9,058	5.8
Age 75 to 84	6,132	3.9
Age 85 to 89	1,704	1.1
Age 90 and over	938	0.6
All residents 60+	**24,205**	**15.5**

Source: Census 2011

[33] *Mapping Demographic Change - A Factpack of statistics from the International Longevity Centre - UK, July 2014*

Index of Income Deprivation Affecting Older People 2010

Reading residents high on this scale tend to be in areas of high general deprivation.



Source: Index of Multiple Deprivation, 2010

Excess winter deaths

The ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths in Reading is one of the highest in the country, though this has improved from the actual highest in 2013.

Extreme winter deaths in Reading have increased since 2007/08. However, overall, the number of deaths are decreasing year on year, and analysis shows that the rise in Reading has been due to a combination of high winter deaths and low non-winter deaths, with non-winter deaths decreasing at a faster rate than winter deaths.

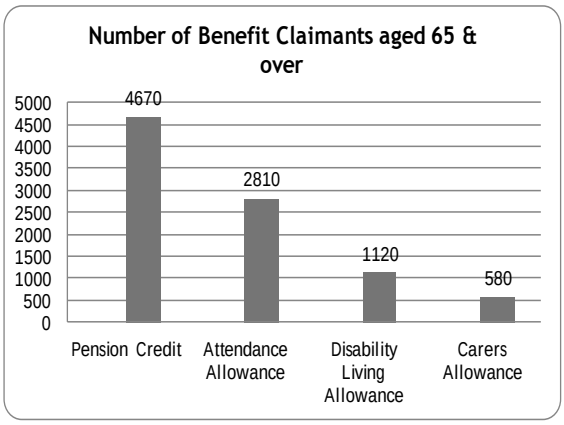
Excess winter deaths 2009-2012

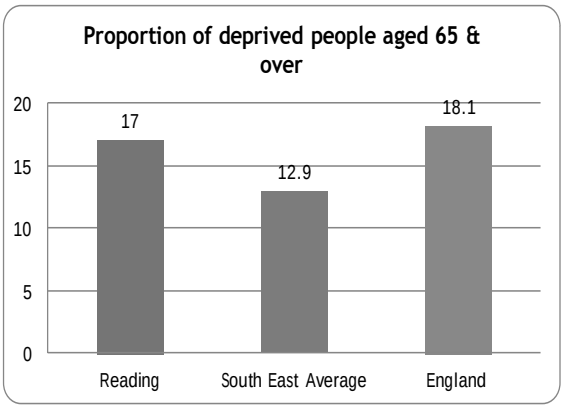
Reading	*England average*	*England worst*
27.4	16.5	32.1

Source: Health Profile 2014, Public Health England

Benefits claimants

Although pensioner poverty may have fallen at a national level, the **proportion of deprived people aged 65 and over in Reading is well above the average for South East.**



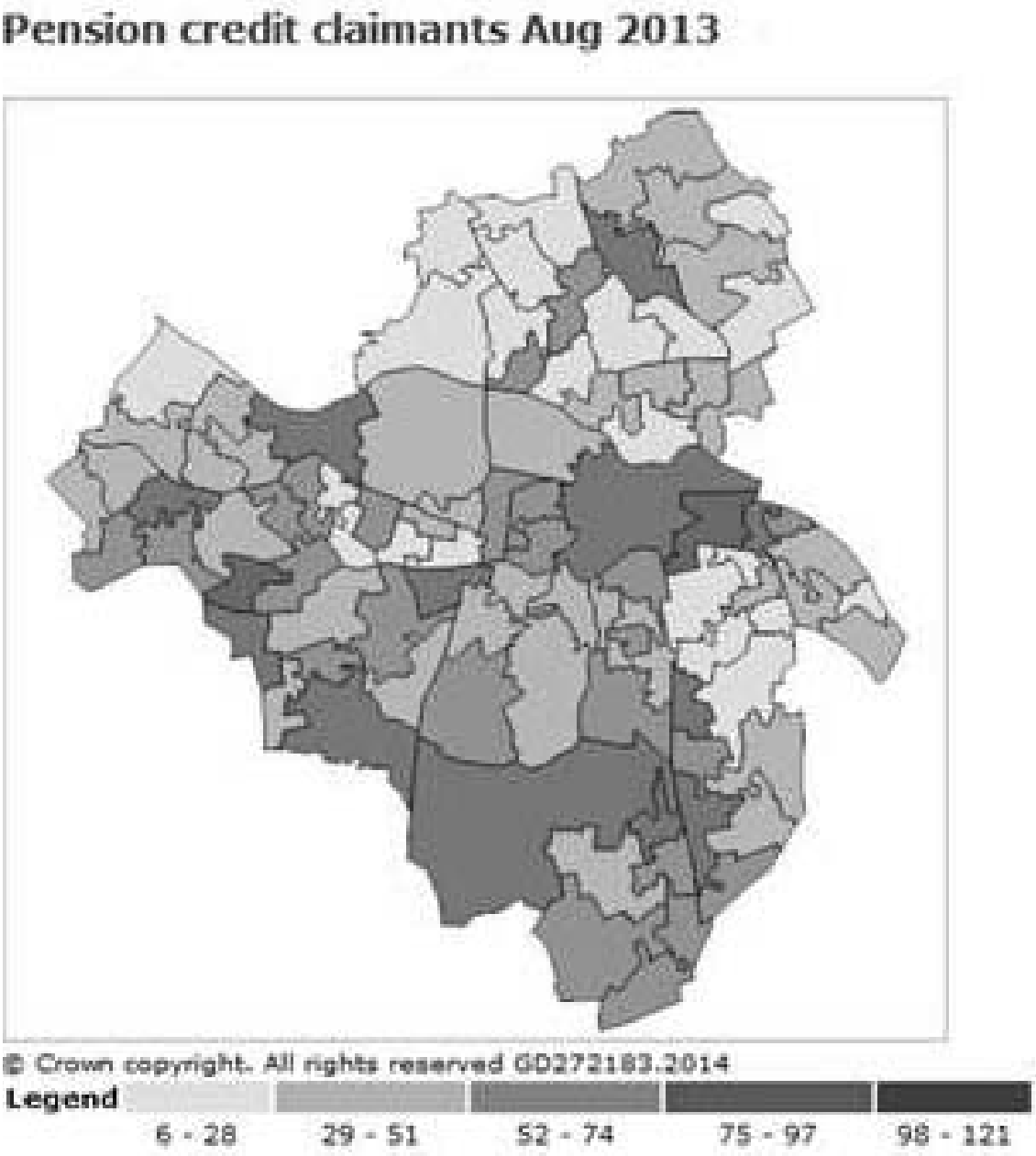


Source: Age UK Reading profile 2013, data Aug 2012

Nationally, many older people are not claiming benefits to which they are entitled. According to DWP data for 2009/10, up to 38% of older people were failing to claim Pension Credit and up to 46% were failing to claim Council Tax Benefit.

Pension credit

The map below shows the distribution of Reading's 4,510 Pension Credit claimants in August 2013.



Source: Nomis 2013 (aged 60+)

JSA claimants

The rate for JSA claimants in Reading over 50 is higher than both the South East and GB (July 2014). The rate was also the second highest in the local area when compared to the other Berkshire authorities, in March 2013.

JSA claimants over 50

	claimant rate
Reading	2%
South East	1%
GB	1.6%

Source: NOMIS July 2014

See also the section on fuel poverty in the Meeting Basic Needs chapter.

POVERTY AND DISABILITY

A third of all disabled adults aged 25 to retirement are living in low income in 2008/09 - around one and a half million people. This low-income rate is around double that for non-disabled adults and, unlike that for children and pensioners, is higher than a decade ago[34]. In relation to physical disabilities, it is estimated by 2025, 50% of the national population will have at least one long-term condition[35].

Census Overview

The rates of limiting long term illness and provision of unpaid care have changed little since 2001 and are below the average for England.

Extent to which illness or disability is limiting, by proportion and ward

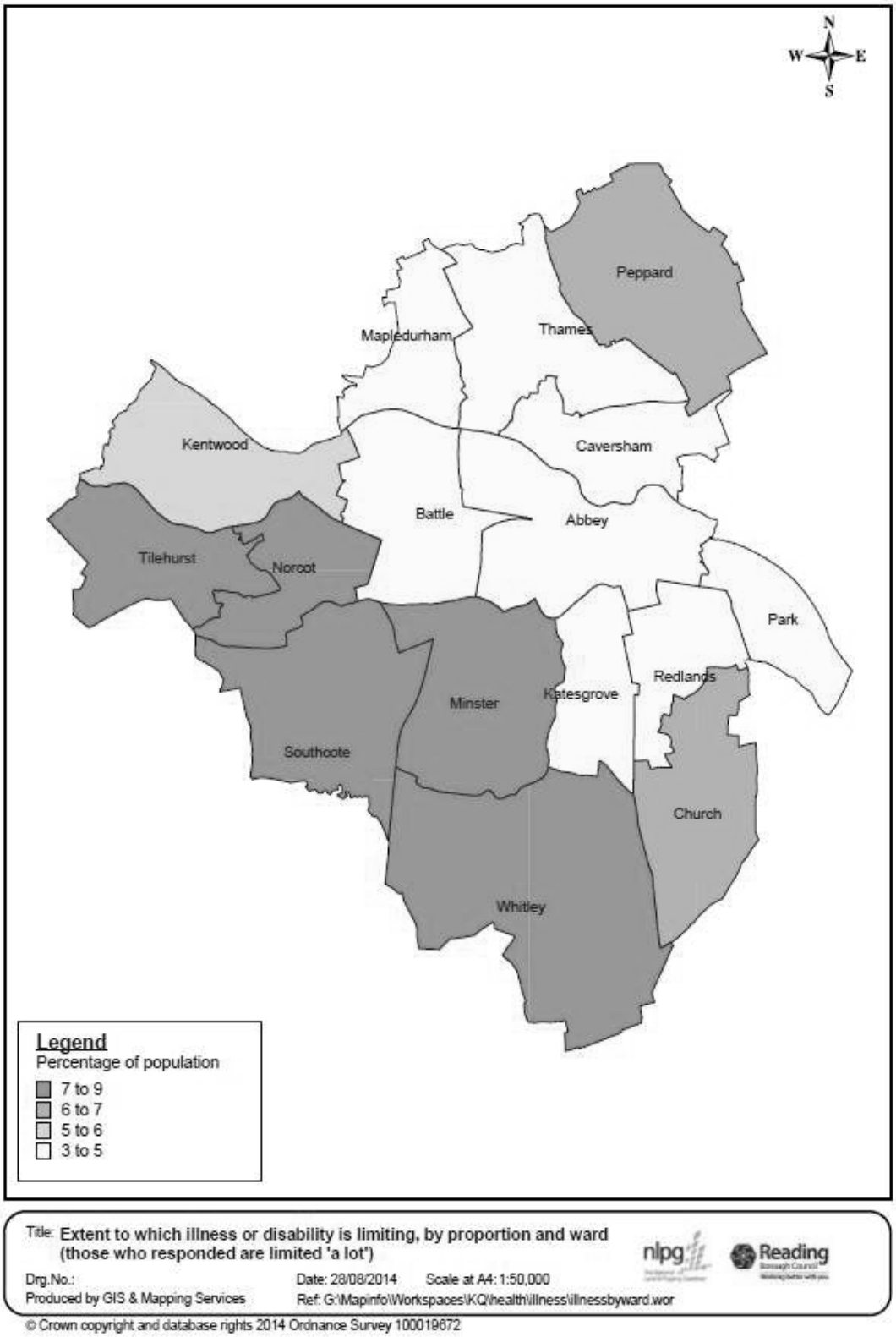
	% of resident population		
Ward	*A lot*	*A little*	*Not at all*
Reading	**5.66**	**7.25**	**87.08**
Abbey	4.51	5.38	90.11
Battle	4.13	5.98	89.89
Caversham	4.94	7.33	87.73
Church	6.33	7.77	85.90
Katesgrove	4.06	6.01	89.92
Kentwood	5.84	7.47	86.68
Mapledurham	4.59	9.55	85.86
Minster	7.43	7.39	85.19
Norcot	7.48	9.28	83.24
Park	4.09	5.01	90.90
Peppard	6.08	8.29	85.63
Redlands	3.65	5.48	90.87
Southcote	8.96	9.77	81.27
Thames	4.06	6.53	89.41
Tilehurst	7.15	9.11	83.74
Whitley	7.36	8.51	84.14

Source: 2011 Census

[34] *'A route out of poverty? Disabled people, work and welfare reform', New Policy Institute and Child Poverty Action Group, 2006 (updated)*

[35] *The Hidden Need in Berkshire, Overcoming Social Deprivation, Berkshire Community foundation, December 2010*

Percentage of residents who feel that they are limited 'a lot' by their illness or disability



© Crown copyright and database rights 2014 Ordnance Survey 100019672

Source: 2011 Census

Those who feel that they are limited 'a lot' by their illness or disability tend to be concentrated in the south and west of the borough.

Limiting long term illness and unpaid care

	Reading 2001	*Reading 2011*	*England 2011*
People with limiting long-term illness	13.5%	13.0%	17.6%
Provision of unpaid care: % persons	7.7%	8.0%	10.3%

Source: 2011 Census

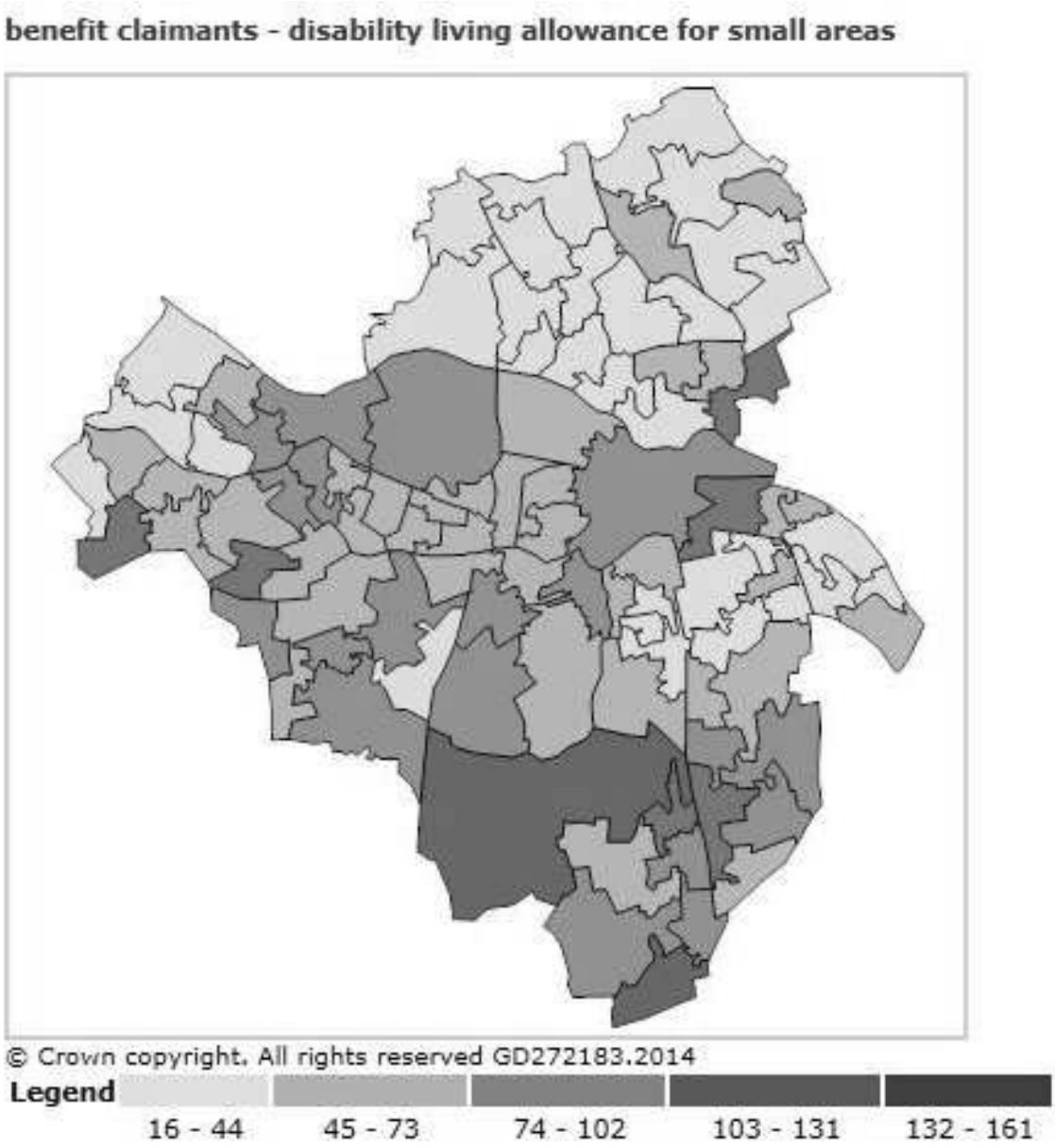
Benefits claimants

In Feb 2014, 5,650 people in Reading were claiming Disability Living allowance, 5.2% of the working age population[36]. Their distribution is shown in the following map.

570 people were claiming Incapacity Benefit or Severe Disablement Allowance, 0.5% of the working population.

[36] *Based on ONS population projections 2014 (age 16-64)*

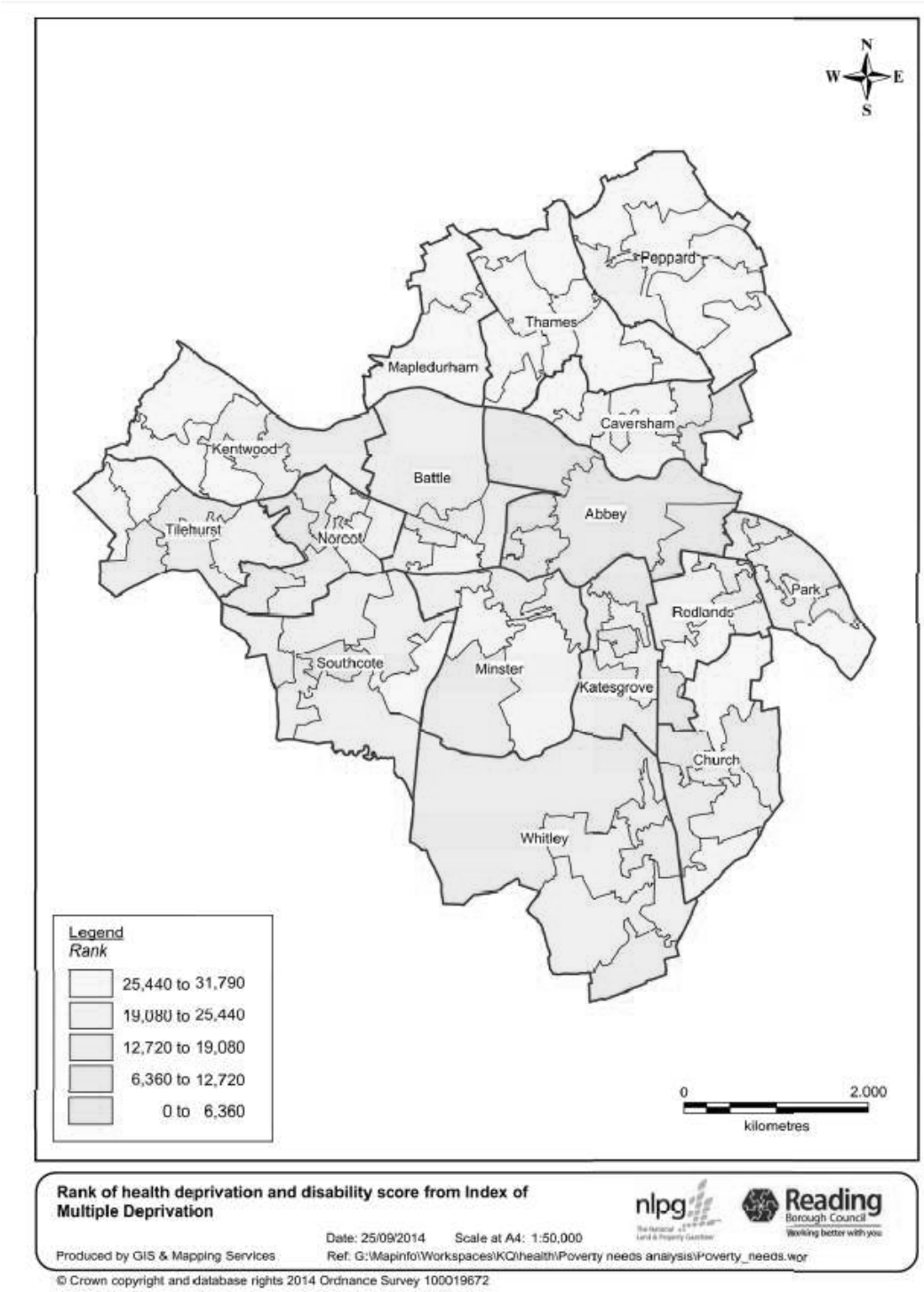
Disability Living Allowance claimants 2013



Source: NOMIS 2014

Index of Health Deprivation and Disability 2010

This domain measures rates of poor health, early mortality and disability in an area and covers the entire age range, though areas high on this index tend to be those with a higher proportion of older residents.



Source: Index of Multiple Deprivation, 2010

DEBT

According to the International Longevity Centre UK[37]:

- One in five of all households (21 per cent) headed by someone aged 50 or over had outstanding mortgage borrowing on their main home in 2008-10.
- Among the over 50s with outstanding mortgages, the mean average owed was £62,200.
- 13 per cent of all older mortgaged households were struggling to repay their mortgage

According to the Citizens Advice Bureau (CAB), nationally Council Tax arrears has become the number one debt problem faced by many households across the country, overtaking credit card and unsecured personal loans. Between January and March 2014, CAB supported 27,000 people with a Council Tax arrears problem - a 17% increase on the same period last year.

In 2012/13, **the debts of clients coming to Reading CAB and Reading Welfare Rights Unit in 2012/13 totalled £2,245,231**. Financial gains achieved for clients totalled £2,669,840.

Citizens Advice Bureau (CAB)

Throughout Berkshire, Local Citizen Advice Bureaus (CABs) report increasing number of problems relating to debt, from young families with high mortgages, to older, asset-rich/cash poor households.

Debit is the 2nd most common issue that clients seek help with and formed 17% of the workload in 2013/14. Benefits issues form 30% of the workload and has significantly increased.

Top 10 types of debt issue:

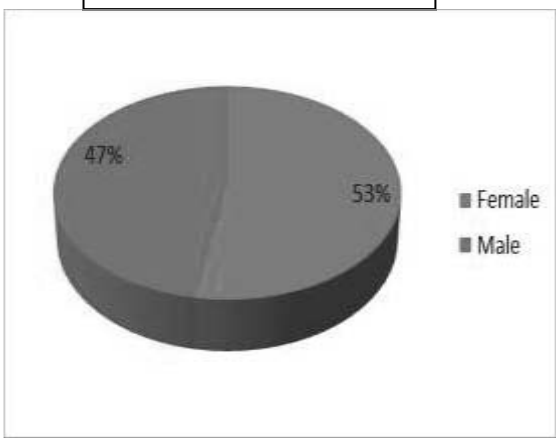
Council tax	310
Credit, store & charge card	220
Rent arrears (social housing)	197
Unsecured personal loan	191
Mortgage and secured loan	173
Bank and building soc OD	116
Fuel debt	113
Water supply	109
Magistrate court fines	99
Rent arrears (private landlords)	92

Source: Reading CAB, Aug 2014

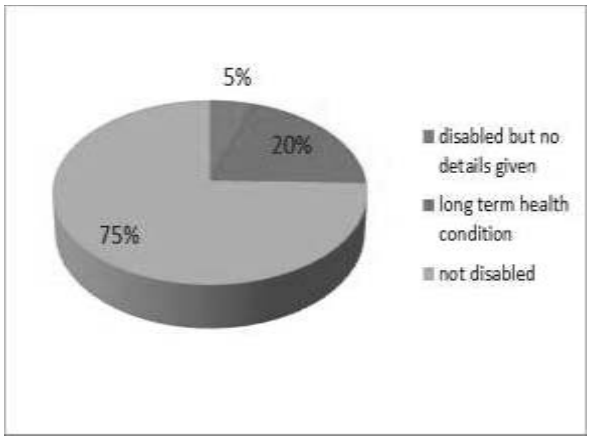
[37] *Mapping Demographic Change - A Factpack of statistics from the International Longevity Centre - UK, July 2014*

CAB Customer Profile

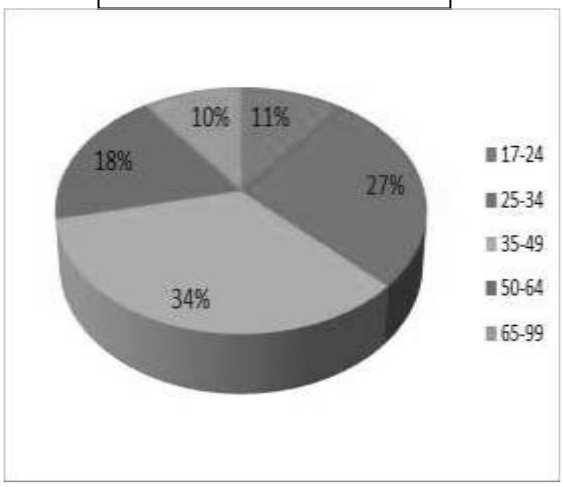
Gender



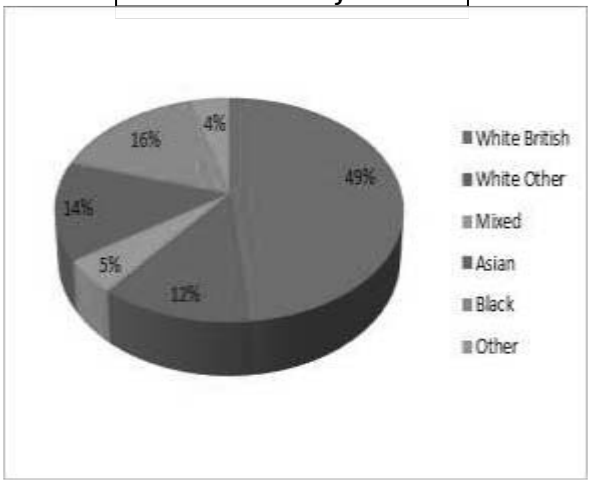
Health and Disability



Age Profile



Ethnicity



Source: Reading CAB, 2014

Ethnicity of CAB clients

	% Reading residents	*% CAB clients*
White	74.5%	49%
Mixed	3.9%	5%
Asian	12.5%	14%
Black	6.3%	16%
Other	2.0%	4%

Source: Reading CAB, 2014

Welfare Rights Unit

According to the Reading Welfare Rights Unit, the demand for specialist debt advice is continuing to grow and debt currently makes up 32.4% of total workload. More service users, both in work and in receipt of welfare benefits, are struggling to cover their basic living costs (fuel, water, food, toiletries, etc). It is becoming harder to find solutions to break the spiral of debt, and charity applications for help with rent arrears, bankruptcy deposit fees and debt relief orders are becoming a regular occurrence in order to implement a debt strategy that will give the client a long term solution.

There has also been a significant change in the makeup of the debts that clients have. Historically, it was not unusual for a client to bring a carrier bag of debt letters from non priority creditors, and whilst this still happens, there is nowadays a regular pile of priority debts letters too. Dealing with multiple priority debts, when there is little surplus money for debt repayment requires different skills because of the consequences of non payment.

See also Financial Crisis Support Service in Meeting Basic Needs chapter

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, SOCIAL SERVICES AND HOUSING

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**30 January 2015**	**AGENDA ITEM:**	**12**
TITLE:	**UPDATE ON FEMALE GENITAL MUTILATION**		
LEAD COUNCILLOR:	**CLLRS HOSKIN, EDEN, GAVIN,TERRY**	**PORTFOLIO:**	**Health, Children's Social Care,Adult Social Care, Community Safety**
SERVICE:	**CHILDRENS SOCIAL CARE, PUBLIC HEALTH and ADULT SOCIAL CARE**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**VICKI LAWSON, ASMAT NISA and SUZANNE WESTHEAD**	**TEL:**	**01189372258 (ext 72258)**
JOB TITLE:	**HEAD OF CHILDRENS SOCIAL CARE, CONSULTANT IN PUBLIC HEALTH and ADULT SOCIAL CARE**	**E-MAIL:**	**Vicki.lawson@reading.gov.uk Suzanne.westhead@reading.gov.uk Asmat.nisa@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To appraise and update the Health and Wellbeing Board on the current position in Reading in relation to Female Genital Mutilation (FGM). In December 2014, the Thames Valley Police and Crime Panel wrote to the Chair of the Reading Health and Wellbeing Board to request the Board have a regular overview item on the agenda for FGM.

This report sets out the work that is already in place and planned, in respect of FGM, and notes that the Children's Safeguarding Board and Adult Safeguarding Board will develop an action plan. This plan will be scrutinised by the Health and Wellbeing Board in its quality assurance role. The action plan will also be open to scrutiny by the Council's Adult's, Children's and Education Committee (ACE) which leads on health scrutiny for the Council.

2. RECOMMENDED ACTION

2.1	**The Health and Wellbeing Board notes the content of the report and agrees to have a continual annual overview of the Female Genital Mutilation issues in Reading to help tackle FGM.**
2.2	**The Health and Wellbeing Board notes that the Children's Safeguarding Board and the Adult Safeguarding Board will develop an action plan to proactively address FGM in Reading and the Health and Wellbeing Board will have an overview of the action plan.**

3. POLICY CONTEXT

FGM is defined by the World Health Organisation (WHO) as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

According to the World Health Organisation , FGM is practiced in up to 28 African countries and in some countries in the Middle East and Asia.

FGM is performed on women and girls at different ages, depending on the community or ethnic group that carries it out, though it is mostly carried out on girls between the ages for 5 and 8 years old. The procedure is traditionally carried out by women with no medical training.

It is recognised that women and girls may also be at risk of having FGM performed on them in the UK, or being taken from the UK to have the procedure performed overseas.

There are a number of different reasons why FGM is performed. The process is often seen as part of the family's culture, it is also seen as a right of passage. FGM is often important for the cultural identity of girls and women and may also impact a sense of pride, a coming of age and a feeling of community. Those girls and women who refuse can often face being ostracised and condemned by their communities. Religion can also be a justification for FGM, though it is practised by both religious and secular communities.

In the UK, FGM tends to occur in areas with large population of FGM practicing communities. The home office has identified girls from Somali, Guinean, Kenyan, Sudanese, Sierra Leonean, Egyptian, Nigerian, Eritrean, Yemeni, Kurdish and Indonesian communities as the most at risk of FGM. These are just some and not all of the communities at risk, however appendix 1 shows a map of known countries where FGM is practiced throughout the world and highlights other vulnerable communities too.

FGM can impact on the health of girls and women both long and short term. Short term health consequences of the practice can include infections, severe pain, emotional and psychological shock. Longer term consequences for women can be severe and wide ranging, including, chronic infections, renal impairment, complications during pregnancy and childbirth, psychological

issues, including depression and post stress-traumatic stress disorder , increased risk of sexually transmitted infections.

4. Background and Progress update on work to date

4.1 Local prevalence

There is an estimate of over 125,000 women in England and Wales to be living with the consequences of FGM, and 60,000 girls born in England and Wales to mothers who have undergone FGM. Locally in Reading we are unable to estimate prevalence of FGM. This is because there are current challenges in breaking down local census data by an individual's country of origin. This data issue is under national review so that estimates of local prevalence can be obtained in the future. Multi Agency Practice Guidelines published in 2011 (HM Government) identified Reading as an area of potential high prevalence of women and girls who might have suffered, or are at risk of suffering, FGM. This is because of the diverse population of Reading.

4.2 Local response

In February 2014 the Designated Nurse Safeguarding for the four CCGs in Berkshire West brought to the attention of the LSCBs, an intercollegiate report published by the Royal College of Midwives (RCM) entitled 'Tackling FGM in the UK'.

The Chair of the LSCBs requested a task and finish group be formed to review the abovementioned report with reference to the three Councils across Berkshire West.

The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the RCM document. The action plan contained in the intercollegiate document (attached at appendix 2) was used as a starting point to review the local response to FGM. The RCM report is therefore the starting point in developing a robust multi-agency and community approach to safeguarding children at risk of FGM across Berkshire West.

4.3 Findings from the Task and Finish Group

The LSCB task and finish group has established that across Berkshire West there is some awareness of FGM amongst local agencies and that some agencies are developing good practice to recognise and respond to women who have suffered FGM. The Berkshire LSCBs Child Protection Procedures support practitioners in referring girls at risk of FGM to Children's Social Care Services who then inform Thames Valley Police.

However, there is much still to be done locally. The key policy recommendations contained in the 2013 document are not yet fully addressed locally.

The group was unable to find evidence that routine enquiries about FGM are made across all healthcare settings.

Schools have a crucial part to play in recognising and responding to girls at risk of FGM. Peer support and education within schools will contribute to protecting and preventing girls suffering FGM.

Although individual organisations attempt to raise awareness of FGM there appears to be a lack of a co-ordinated and consistent approach.

A co-ordinated strategic direction is required to progress local developments that will ensure girls living in Berkshire West who might be at risk of FGM are identified and protected. Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

The task and finish group recommend to the LSCBs that the local response to FGM should be a matter raised at the Health & Wellbeing Boards in order to ensure that addressing FGM is a priority for all agencies. Thereafter, in each of the three areas of Berkshire West quarterly FGM delivery and safeguarding partnership meetings are initiated to include developing policy and practice, awareness- raising, intelligence gathering and sharing and data monitoring. This will require commitment from Directorates of Public Health. It is essential that affected communities are represented from the start.

Without such co-ordinated strategic direction it will be difficult to progress key policy recommendations locally. An action plan is being developed under the LSCB which will require endorsement and input from the Adult Safeguarding Board and the Health and Wellbeing Board. The task group identified a number of actions

- **Update Child Protection procedures**
- **Increased training to improve recognition by the NHS and Social care and Education services of FMG**
- **Closer working with voluntary to improve services for young girls and women who have suffered FMG or are at risk of FMG**
- **Improved data collection**

- **Informed commissioning of local services for women and girls who have suffered, or might be at risk of suffering, FGM.**

- **Improved information and awareness of FMG in the communty**

4.4 Actions taken to date

Since April 2014 all NHS hospitals are required to record:

• If a patient has had Female Genital Mutilation
• If there is a family history of Female Genital Mutilation
• If a Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals are required to submit this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

The child protection procedures were amended in June 2014 to reflect the 2013 intercollegiate document .

The Royal Berkshire Hospital NHS Foundation Trust (RBH) has encompassed routine questioning about FGM into all pregnancy bookings. Guidelines for midwives including a referral flowchart for midwives, following identification of pregnant women who have suffered FGM, have been developed for use within midwifery services.

A form adopted from the Bolton FGM Assessment Tool, has been developed at RBH to be used to support referrals to Children's Social Care Services. The form is currently being reviewed within RBH internal governance processes.

There is also a wealth of online resources. The Home Office has recently circulated free web based training. This has been advertised within individual agencies. National conferences specific to FGM are available but it is apparent that information about FGM is not currently contained in the LSCBs training programme. There is an opportunity here to provide information on FGM through level 1 and 2 domestic abuse training and via adult safeguarding training for wider coverage.

One member of the task and finish group met with representatives from two community groups in Reading, ACRE (Alliance for Cohesion and Racial Equality) and Utilivu Woman's Group, to learn more about their response to FGM.

Addressing FGM is seen as a priority within both of these organisations who have emerged as key partners in addressing the issue with those affected.
It has not been possible to locate representatives from affected groups or community based groups in Wokingham or West Berkshire.

4.5 Recommendations to the Children's and Adults Safeguarding Boards

The recommendations below will form the basis of the action plan drawn up by the two Boards

- Further clarity is required for frontline practitioners about the need to refer all female children in cultures where FGM is known to be practised to Children's Social Care Services. This must be done with respect and sensitivity to enable a professional assessment of risk to female children within that family.

- It is recommended that recognition and response to FGM is included in the LSCB training programme.

- It is apparent that whilst FGM is recognised within RBH maternity services, there is potential to increase recognition and response throughout other departments within the hospital. In particular, key clinical environments such as Urology, Gynaecology and the Emergency Department.

- There are opportunities for health care professionals to make sensitive enquiries about FGM at every contact with patients. Healthcare professionals need to follow the **'one chance rule'.** This states that the attending professional may only have one chance to speak to the victim and prevent future harm. Health visitors may visit homes of children and women affected by FGM. This gives them an opportunity to follow the 'One Chance ' rule. There is also an opportunity for FGM issues to be picked up in General Practice settings and for appropriate referral for example to domestic abuse services/interventions.

- Leaflets containing information about FGM and additional resources for help and support should be developed and made available within professional and community settings. This literature should be made available in a range of languages. This will require a commitment for funding.

- There is an opportunity here for school nurses to follow the 'One Chance' rule and identify young girls who may have undergone FGM or

are at future risk of FGM. In addition, other staff members from partner agencies such as Berkshire Women's Association, Children's Action Team and youth workers could be trained to pick up on issues around FGM and relay this knowledge and information to help onward referral where appropriate. There will be a further opportunity for to improve service when the council take over the role of commissioning school nurses

- The RBH is not currently listed on NHS Choices as a hospital where services for women who have suffered FGM, can be accessed. This is likely to be because there is not a specific FGM clinic at RBH and which is offered in some London hospitals. This is an issue for consideration by CCGs as commissioners of local health services, and also Directors of Public Health.

- Amendments are made to section 5 of the Berkshire LSCBs Child Protection Procedures.

- Training courses to raise awareness about FGM is made available through the LSCBs training group.

- Sources of funding are explored to progress the development of literature explaining about the consequences of FGM. Such literature needs to be available in a variety of relevant languages.

The group recommend emulating the 'Bristol Model' to address the issues relating to FGM. Key components of this approach include:

- ✓ The empowerment of affected communities utilising an educative approach
- ✓ Collective ownership – commitment from all key stakeholders
- ✓ A strategic overview Plans are in place to link in with the Domestic Abuse strategy Group (DASG) in early February . Service development and commissioning of support services eg. specialist FGM clinics for women and girls who have suffered FGM can be referred or self- refer, for discussion about surgical interventions and where psychological support can be made available.
- ✓ Training and resource development – websites, guidelines, lesson plans and leaflets to support learning and campaigning

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 & This work is aligned with the strategic priorities of Reading Borough Council and the Reading Health and Wellbeing Strategy 2013-16.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1& Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

7. LEGAL IMPLICATIONS

7.1 & FGM is illegal in the UK. It's also illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this. FGM has been illegal in the UK for decades, it is only now that agencies are starting to openly talk about the practice, what it involves, the reasons some communities carry it out, and how we can work together towards eliminating it.

Prohibition of Female Circumcision Act 1985
Female Genital Mutilation (FGM) has been a specific criminal offence since 1985, with the introduction of the Prohibition of Female Circumcision Act 1985. However a 'loophole' was identified in the legislation, in that taking girls who were settled in the UK abroad for FGM was not a criminal offence. It is this 'loophole' that the Female Genital Mutilation Act 2003 (the Act') intended to close.

Female Genital Mutilation Act 2003
The Act was brought into force on 3 March 2004 by the Female Genital Mutilation Act 2003 (Commencement) Order 2004. The provisions of the Act only apply to offences committed on or after the date of commencement. For offences committed before 3 March 2004 the Prohibition of Female Circumcision 1985, as re-enacted in the Female Genital Mutilation Act 2003, continues to apply.

The Act affirms that it is illegal for FGM to be performed, and that it is also an offence for UK nationals or permanent UK residents to carry out, or aid, abet, counsel or procure the carrying out of FGM abroad on a UK national or permanent UK resident, even in countries where the practice is legal.

8. FINANCIAL IMPLICATIONS

8.1 These need to be determined

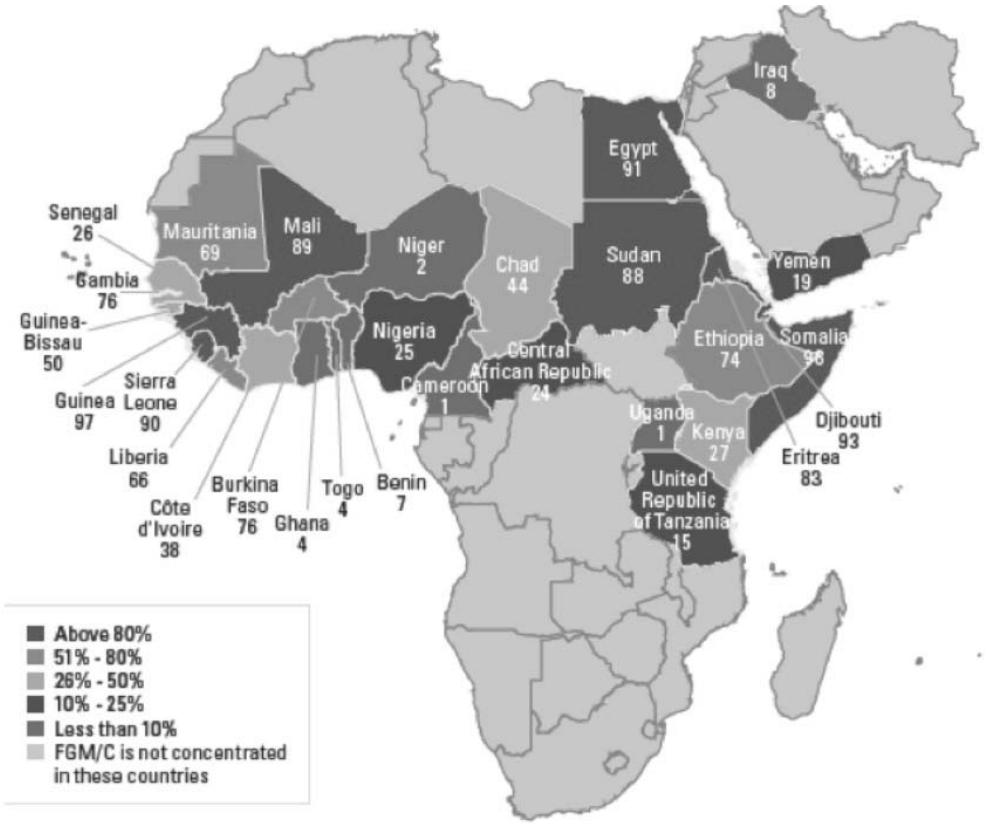
Background papers

- RCM, RCN, RCOG, Equality Now, '
- UNITE (2013) Tackling FGM in the UK: '

- Intercollegiate Recommendations for Identifying, Recording and Reporting. London: Royal College of Midwives. (Available at www.rcm.org.uk)
- HM Government (2011) Multi-Agency Practice Guidelines:
- Female Genital Mutilation. (Available at www.gov.uk)
- Berkshire Local Safeguarding Children Boards Child Protection Procedures. (Available at http://berks.proceduresonline.com/index.htm)

- Crown Prosecution Services website: http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/#legislation

Appendix 1.



Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2012.

Appendix 2 Key Policies Recommendations (contained in Tackling FGM in the UK 2013)

Target Audience	Policy Recommendations/Rationale	Expectations of Action to carry out recommendation	Berkshire West Progress
All Agencies	**Treat FGM as Child Abuse** and integrate it into to all safeguarding procedures across the 4 countries of the UK (England, Northern Ireland, Scotland and Wales) outlined in Working Together to Safeguard Children (2013) (England), Co-operating to Safeguard Children (2010) (Northern Ireland), Child Protection in Scotland (2010) (Scotland) and All Wales Child Protection procedures (2008)	• NICE should revise their guidance on 'When to suspect Child Maltreatment' (Clinical Guidance CG89) to include FGM. • Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the child protection system until they are at an age when they can speak about FGM and are able to seek protection for themselves. • Lead Social Work agencies should urgently work to revise and clarify referral thresholds when risk of FGM is a concern or suspicion, including conducting assessments and monitoring of the child at risk. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	Berkshire LSCBs Child Protection Procedures updated July 2014. Suggested amendment to be made to Policy and Procedure Group. When agreed, accompanying flow chart to be incorporated. Need to develop generic risk assessment tool. RBH have developed one for use in maternity services.
NHS	**Document and collect information on FGM and its associated complications in a consistent and rigorous way:** Good documentation is important for planning and commissioning services on FGM, providing quality care for girls and women affected, for research and for monitoring trends of FGM in the UK.	• The Health and Social Care Information centre should develop specifications to code FGM in hospital episode statistics and in maternity and child health datasets. • Every woman from practicing community who books for maternity care should be asked in a sensitive manner about FGM and the discussion recorded in paper based and electronic records, to include action taken or referral to the appropriate professional. • All new patient registrations in primary and secondary care, including A&E of young girls/women, should include detailed enquiry about country of origin. If the family is from FGM practicing community, document any presence of FGM to establish	Since September 2014 RBH submit monthly returns re FGM to DH. Routine questioning about FGM at all antenatal bookings. Guidelines and referral flowchart for pregnant women developed and

		a baseline for monitoring and sharing information with relevant agencies. • This information should be captured at all pregnancy bookings • The Royal College of Paediatrics and Child Health (RCPCH) should update the specifications for the 'Personal Child Health Record' (the Red Book) to include a code for the mother having FGM. This should include FGM in the electronic 'Red Book' (Personal Child Health Record) • Health practitioners in maternity services should ensure FGM is coded in electronic records and information shared with child health teams. • Adequate language translation services are required in areas of high prevalence.	implemented for midwives to use at RBH. Midwives record risk of FGM in maternity discharge records that are sent to GPs and Health Visitors. RBH staff have access to interpreter services via Prestige Network. Information Sharing processes re FGM requires further exploration and development. PCHR is not currently used to document risk of FGM.
Health, Social Care, education and the Police	**Share information on FGM systematically:** There is a need to develop information sharing protocols between health, the police and other relevant agencies such as social care and education.	• The NHS should develop protocols for sharing information about girls at risk – or girls who have already undergone FGM with other health and social care agencies, the Department for Education and the police. • These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Information sharing processes re FGM requires further exploration and development.
Healthcare Professionals	**Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and girls' protection of girls at risk of FGM:**	• Health and Social Care staff must work to the WHO guidelines for nurses and midwives, the UK multi-agency practice guidelines and CPS legal guidance. www.who.int/reproductivehealth/publications/fgm/en/index.html • On the opening and re-suturing of women with Type III FGM, WHO	FGM guidelines in place at RBH. FGM awareness incorporated in ingle

	Ensure that health professional know how to provide quality care for girls who suffer complications of FGM.	guidelines should be followed. Guidelines can be accessed from the WHO website as follows: www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_03/en/index.html • Refer all women identified with FGM for support and further medical and psychological assessment as appropriate. This must be done very sensitively. • A multi-agency and multi-professional approach should include the Medical Royal Colleges, professional organisations and trade unions for incorporating FGM into pre-registration education/undergraduate level training and continue professional development appropriate to the individuals' levels of responsibility and accountability. This should include a mix of face to face and the development of e-learning resources on FGM, which all relevant frontline professionals can access. • A lead agency should be involved in producing e-learning materials for healthcare and other practitioners. This agency should inv9olve the main health professional bodies such as the relevant medical royal colleges and health trade unions in developing training materials. • High quality information on the effects of FGM (health, psychological and rights-based) should be provided to all women identified as having FGM. • Healthcare practitioners need to consider the needs of both the future child as well as any other female children who may already be born or resident in the household with the woman. • Healthcare practitioners need to follow the 'one chance' rule. This states that the attending professional may only have one chance to speak to the victim and prevent future harm.	agency safeguarding children training. Access to Home Office FGM e-learning course circulated to the LSCB Training Group with the request to consider provision of multi-agency training about FGM. RBH has developed a leaflet for pregnant women. BHFT have developed a leaflet about diversity and cultural norms.
Health, Social Care, Education and	**Identify girls at risk and refer them as part of the safeguarding children obligation:**	• Professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should	Incorporated in Berkshire LSCBs Child Protection procedures.

the Police	Early identification of risks of FGM to girls, referral, planned and sustained information and support to families are needed to protect girls from undergoing FGM.	be given to families to protect girls at risk. • In cases where FGM is identified in a woman who presents at maternity services, the implications for the woman and her future child should be discussed by the midwife or doctor and a clear plan of action including communication with relevant agencies detailed in paper and electronic records. • Professionals should refer all women identified as having undergone FGM who give birth the female children to the Multi-Agency Safeguarding Hub (MASH) for discussion and review. A home visit should be made by social services and further information on the law on FGM and support provided to women. This has been tried in Waltham Forest before the FGM Services closed down. Such visits have been welcomed by women. • It is important to share this information with the GP, the health visitor, school nurse and safeguarding leads in Schools so that they can engage in continuous dialogue and provide information to parents about illegality of FGM and monitor girls at risk. • Health practitioners offering travel vaccinations to children from practising communities for travel to countries where FGM is prevalent must be sensitive to the possible risk of FGM. • Girls from FGM practising communities who are put on child protection registers for other forms of abuse and those who come into contact with youth offending teams and CAMHS should be asked about their risk or experiences of FGM by trained professionals. • All responsible agencies should promote and sign post at risk girls and women to age appropriate information and support services such as the NSPCC helpline and specialist FGM clinics. • Refer all girls and women identified with FGM for support and further medical and psychological assessment as appropriate. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and	RBH have developed a flow chart to support decision making and referral. Midwives inform health visitors and GPs of pregnant women who have suffered FGM.

		responsibilities.	
All Agencies	**All girls and women presenting with FGM within the NHS must be considered as potential victims of crime and should be referred to the police and support services.** FGM is illegal in the UK. All professionals to be aware of the FGM Act (2003) and able to act on cases of FGM where a crime has been committed. All girls and women who were UK residents since March 2004 and have had FGM are victims of crime, with rights to redress, regardless of whether FGM was committed in the UK or abroad.	Protocols for information sharing between health, the police and other relevant agencies such as social care and education should be developed. These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Requires further development. Currently referrals are made to CSC who then convenes a strategy meeting with the police.
Local Authorities, Service Commissioners and Social Services	**The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor progress of implementing these recommendations.** Directors of Public Health, Health and wellbeing Board and Clinical Commissioning Groups to consider the needs of people affected by FGM with Joint Strategic Needs	• Directors of Public Health, Directors of Social Care and Children's Services, Clinical Commissioning Groups, Health and Wellbeing Boards should include FGM in the Strategic Needs Assessments (JSNA) and Violence against Women and Children strategies. • JSNAs should inform preventative strategies led by the Local Safeguarding Children Boards in collaborations with the local authority and Health and Wellbeing Boards. • In the absence of local prevalence data, local authorities to use socio-demographic data; e.g. Primary Level Annual Schools Census (PLASC), to map communities affected by FGM in their local area, and to plan for services to meet those needs. • In all areas, training on FGM should be integrated into all safeguarding training conducted by LSCBs. • Practitioners should be aware of their role in prevention during the	Refer to Health and wellbeing Boards

	Assessment (JSNA) and local strategies (e.g. Violence against Women and Girls strategies) particularly in areas where communities affected by FGM reside. Local Safeguarding Children Boards should be charged with leading a preventative response to FGM, including ensuring that information on girls at-risk is shared across health, social care and education with information sharing protocols based on national guidance, and regular reviews of how information is shared and used. Practitioners should refer all women from FGM affected communities who have had FGM and who have female children to the Multi-Agency Safeguarding Hub (MASH) for discussion, review and assessment	life-course of the girl at risk and be able to sensitively discuss FGM and prevention of harm with them. • In areas with high densities of communities affected by FGM, preventions should be explicit in local child protection policies. • LSCBs should publish and share their strategies in high density areas. • Preventative agendas should consider the need for empowering girls at risk to prevent harm, as well as support services for those affected by FGM. • The NSPCCs dedicated FGM helpline service is promoted across all settings, including health, social care and education as a resource for practitioners with concerns and girls at risk to claim their rights to protection. • Some practitioners – teachers, school nurses, GPs – are well placed to talk with girls at risk about prevention of harm. LSCBs should support such interventions. • Strategies for early identification of girls at risk should be put in place: At national level – health, Social Care and education performance in these areas should be monitored against the CQC and Ofsted inspections regime which are published. At local level – Develop FGM into quality standards for commissioning, by which health and social care institutions/service providers can be judged.	
UK departments for education	**Empowering and supporting affected girls and young women should be a priority consideration.** Many girls are too young to understand the implications of	• In areas where affected communities reside, schools should explicitly include discussions and information on FGM within Personal, Social and Health Education (PSHE) curriculum. Teachers, School Nurses, Health Visitors, Counsellors and Safeguarding Leads in schools should provide time for 1:1 conversations and information	Refer to Schools

	FGM for them. Young people may support FGM because they lack fact about it.	to girls from practising communities. These could be integrated into other messages (MSPCC Pants Campaign), encouraging girls and young women to report harm such as in the preventions of physical and sexual abuse. Young people should be signposted to the MSPCC FGM Helpline on 0800 028 3550 for advice, information and counselling.	
Home Office, UK Public Health Authorities and Social Services	**Develop and implement national public health and legal awareness campaigns in FGM, similar to previous campaigns on domestic abuse and HIV.** Current information provision about the health consequences is not reaching the affected communities and the general public is not aware of the illegality of FGM. There is support for stringer and effective action by the governments, particularly among young women from affected communities, who want to see the practice stopped.	Well-designed public health and legal awareness campaign about FG<, targeted at women and girls from at risk communities about the health and legal implications of FGM. These campaigns should also emphasise to the general public that FGM is illegal in the UK, a message endorsed by key professional organisation and NGOs.	

REPORT BY WEST OF BERKSHIRE ADULTS SAFEGUARDING PARTNERSHIP BOARD

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**30 JANUARY 2015**	**AGENDA ITEM:**	**13**
TITLE:	**PROTOCOL AGREEMENT BETWEEN READING HEALTH AND WELLBEING BOARD AND WEST OF BERKSHIRE ADULTS SAFEGUARDING PARTNERSHIP BOARD (SAPB)**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**ADULT CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**SUZANNE WESTHEAD**	**TEL:**	**0118 937 4164**
JOB TITLE:	**HEAD OF ADULT CARE**	**E-MAIL:**	**Suzanne.westhead@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 & The attached protocol sets out the expectation of the relationship and working arrangements between Reading Health and Wellbeing Board and the West of Berkshire Safeguarding Adults Partnership Board.

1.3 & The Health and Wellbeing Board are asked to endorse the protocol, which has already been agreed by the West of Berkshire Safeguarding Adults Partnership Board.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board endorse the attached protocol agreement.

3. POLICY CONTEXT

3.1 & A protocol agreement has been developed to ensure that priorities will be discussed and consulted with each board and the annual reports for each board will presented to the other for discussion and challenge where necessary.

4. THE PROPOSAL

4.1 The shared principles for this working protocol are that the boards:

- Have an ongoing and direct relationship, communicating regularly.

- Share a commitment to a strategic approach to understanding needs, in a way that includes analysis of data and effective engagement with frontline practitioners and local communities.
- Are committed to developing a joined up approach to understanding the effectiveness of current services and identifying priorities for change, including where services need to be improved, reshaped or developed.
- Commit to working together to ensure there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.
- Will work together to provide constructive challenge to one another and partners.
- Will work together to ensure action taken by one body does not duplicate that taken by another.

4.2 & The protocol lists the key responsibilities of each board, and how each one should interact with the other. The protocol details the key lines of communication between the boards and describes the interconnectedness of senior management representation on each board which ensures key topics for discussion/concern are made aware across the partnerships.

4.3 & It also describes the route by which concerns highlighted by one board can be raised with one of the other boards.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 & This protocol contributes to the following Council strategic aims:

- To promote equality, social inclusion and a safe and healthy environment for all.

5.2& It also contributes to the Local Strategic Partnership delivery themes of Community Safety and Health.

5.3& The protocol itself does not refer specifically to these strategic aims and delivery themes, but the strategic plans produced by each board (the Health and Wellbeing Strategy and the SAPB Business Plan) do detail the aims and priorities of the work undertaken by board partners. These strategic aims and delivery themes are clearly embedded within each document.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 & Consultation on this protocol has been carried out with the members of the Safeguarding Adults Partnership Board.

6.2 & The strategic plans of the Health and Wellbeing Board and the West of Berkshire Safeguarding Adults Partnership Board are consulted on within the community. A current aim of the SAPB is to ensure we listen and respond to our communities in relation to their safeguarding needs.

7. EQUALITY IMPACT ASSESSMENT

7.1 & An Equality Impact Assessment (EIA) is not relevant to the recommendation of this protocol. The protocol itself will not have a differential impact on: racial groups; gender; people with disabilities; people of a particular sexual orientation; people due to their age; people due to their religious belief. However, equality and diversity are key themes for the both boards, ensuring that any changes to practice or service recommended by the boards will not disadvantage any particular group.

8. LEGAL IMPLICATIONS

8.1 & Although there is no legal requirement to have a protocol in place, the Care Act 2014 requires that partners work effectively together to safeguard and provide appropriate services for adults at risk.

9. FINANCIAL IMPLICATIONS

9.1 None.

10. BACKGROUND PAPERS

- Reading Health and Wellbeing Board Terms of Reference
- West of Berkshire Safeguarding Adults Partnership Board Terms of Reference
- West of Berkshire Safeguarding Adults Partnership Board Business Plan

Appendix 1

Protocol Agreement between Reading Health and Well-being Board and West of Berkshire Safeguarding Adult Partnership Board

Health and Well-being Board

The Health and Well-being Board aims to improve health and well-being for people in Reading. It is a partnership that brings together the Council, NHS and the local Healthwatch organisation. By working together on the delivery of national and local priorities, the Health and Well-being Board's purpose is to make existing services more effective through influencing future joint commissioning and provision of services.

The Health and Well-being Board will be responsible for overseeing the production of a Joint Strategic Needs Assessment (JSNA) for Reading, and for developing a Health and Well-being Strategy and Delivery Plan as the basis for achieving these aims. The focus will be on reducing health inequalities, early intervention and prevention of poor health and promotion of health and well-being.

The Health and Well-being Board is responsible to the Council and will reflect the need to promote health and well-being across health and Council departments, including housing, social care, schools, community services, environment, transport, planning, licensing, culture and leisure.

The Health and Well-being Board will be expected to improve outcomes for residents, carers and the population through closer integration between health services and the Council.

Stronger joint commissioning offers scope for more flexible, preventative and integrated services for children and adults with long-term conditions and those living in vulnerable circumstances.

The Health and Well-being Board will work with the Safeguarding Adults Partnership Board (SAPB) to ensure that:

- Issues which affect how vulnerable adults are safeguarded and their welfare promoted are consulted upon;
- Recommendations and identified areas for improvement made by the SAPB are noted and that subsequent progress is reported back to the SAPB;
- The Chair of the SAPB is invited to attend the Health and Well-being Board meetings, as needed and at least once a year to present the SAPB Annual Report;
- A senior manager with responsibility for safeguarding adults is a member of the Health and Well-being Board;
- Messages and information provided by the SAPB are appropriately disseminated within Health and Well-being Board member organisations;
- Work undertaken by the SAPB is considered as part of the monitoring arrangements of the Health and Well-being Board.

Safeguarding Adults Partnership Board

The Safeguarding Adults Partnership Board is one of the key mechanisms for safeguarding vulnerable adults from abuse and neglect across the West of Berkshire.

Safeguarding Adults is everyone's business and all relevant agencies operating within the area work together to ensure they provide the best possible holistic response to service users and their carers. There is a shared responsibility for ensuring that all efforts to keep vulnerable adults safe are effective and well co-ordinated.

Safeguarding Adults work is about preventing abuse and neglect as well as promoting good practice in identifying and responding to concerns on a multi-agency basis.

The SAPB will work with the Health and Well-being Board when appropriate to:

- Monitor actions to improve safeguarding practice, including action plans arising from Serious Case Reviews;
- Ensure the Chair of the SAPB attends the HWB meetings as required;
- Ensure that messages and information are appropriately disseminated within SAPB member organisations;
- Hold the Health and Well-being Board to account on matters of safeguarding adults in all its activities, providing appropriate challenge on performance;
- Undertake audits and feedback results to the Health and Well-being Board, advising on ways to improve and highlighting areas of underperformance;
- Share learning from Serious Case Reviews and ensure that partner agencies are taking appropriate action in response to the findings;
- Highlight gaps in service for the Health and Well-being Board to consider as part of its joint commissioning process.
- Escalate serious matters relating to safeguarding to the Health and Well-being Board for action as appropriate.

Both organisations will:

- Have an ongoing and direct relationship, communicating regularly.
- Work together to ensure action taken by one body does not duplicate that taken by another.
- Commit to working together to ensure there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.

Signed by:

Chair of Health and Well Being Board **Chair of West of Berkshire SAPB**

Date: 30 January 2015

Date of Protocol Review November 2015

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF PUBLIC HEALTH

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**30 January 2015**	**AGENDA ITEM:**	**14**
TITLE:	**Pharmaceutical Needs Assessment – final document**		
LEAD COUNCILLOR:	**CLLR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**DR LISE LLEWELLYN**	**TEL:**	**01344 355206**
JOB TITLE:	**STRATEGIC DIRECTOR OF PUBLIC HEALTH**	**E-MAIL:**	**lise.llewellyn@bracknell-forest.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Purpose of this report

This report sets out the outline of the Pharmaceutical Needs Assessment (PNA). It states what will be included in the PNA, the methodology that has been used and the timeline for delivery of the project. The Consultation period for the PNA in Reading ended on 16th December 2014 and this report now includes the key issues identified form the consultation and the final amended PNA to be agreed and published.

2. RECOMMENDED ACTION

2.1 To approve the final document following consultation and revisions

3. POLICY CONTEXT

3.1. The Health and Social Care Act 2012 transferred responsibility for developing and updating the Pharmaceutical Needs Assessments (PNAs) to health and wellbeing boards (HWBs). Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list was transferred from PCTs (Primary Care Trusts) to NHS England from 1 April 2013. The first HWBs' PNA needs to be published by 1st April 2015. It needs to be kept up-to-date through supplementary updates and fully revised every three years. It should be noted that failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about community services and new pharmacy openings.

PNA's are useful for the NHS to help make decisions on which NHS funded services need to be provided by local community pharmacies. Their services are part of the local health care and public health and affect NHS budgets.

3.2. Each Health and Well-being Board must in accordance with Department of Health regulations—

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment

3.3. The PNA will provide information on the current pharmaceutical services in Berkshire and identify gaps in the current service provisions, taking into account any known future needs.

4.

4.1. Purpose of the PNA

The PNA will be used by NHS to commission pharmaceutical services in Berkshire. It will also be used by the public health team in Reading Unitary Authority to commission local services.

4.2. PNA Consultation in Reading

Each of the six unitary authorities across Berkshire has developed a PNA for its area and have gone out to consultation. The formal second consultation period in Reading commenced In September 2014 and ended 16th December.

It should be noted that the PNA included in its development a survey of users, which informed the draft recommendations of the PNA. In total there were 2048 user responses across Berkshire – with 468 from Reading. The second stage of consultation was focussed on getting views on the document.

As part of the second stage of the consultation process, the PNA and supporting information have been displayed on Reading Borough Council's *Open Consultation* pod online since early November 2014. It is available in easy read and spoken version, and, individuals are provided with a contact number/email address for those requiring a paper copy.

The PNA consultation and supporting information was also displayed at the recent public 'Narrowing the Gap' event, hosted by Reading Borough Council. The event took place on 18th November , was widely advertised and was open to the general public, community and faith groups, not-for-profit organisation, local businesses and service providers. The consultation was displayed on a pod in the main entrance of the event and was attended by 263 participants.

4.3. What to expect in the PNA

There is one PNA document for each UA in Berkshire

.

The document contains

1) Existing pharmaceutical services in Berkshire mapped against population

2) A review of the demography and Joint Strategic Needs Assessment (JSNA) - used to identify health needs of the population

4) Users' views obtained through a questionnaire for the public using pharmacy services.
5) Professional views obtained through questionnaire for the pharmacists
6) Key stakeholders input through steering group

The Draft report was sent to the Health and Wellbeing Board for approval before sending it out for stakeholder consultations

The final report with recommendations is presented to the Health and Wellbeing Boards in Berkshire for approval before publication.

The following stakeholders were consulted:

- Local Pharmaceutical Committee for Berkshire
- Berkshire Local Medical Committee
- Berkshire CCGs
- Any persons on the pharmaceutical lists and any dispensing doctors list for Berkshire population
- Any LPS chemist with whom the NHS England has made arrangements for the provision of any local pharmaceutical services for Berkshire population
- Local Health Watch organisations, and any other patient, consumer or community group in Berkshire, which has an interest in the provision of pharmaceutical services in Berkshire
- NHS Trusts
- Thames Valley NHS England Area Team
- Neighbouring Health and Wellbeing Boards

4.5. Timelines:

Milestones	Deadline	Completed?
User and pharmacist surveys	Summer 2014	
Writing first draft and outline paper to HWBB	September 2014	
Consultation period	September - December 2014	
Analysis of consultation results	December 2014	
Final report	January 2015	

4.6 Consultation responses

Whilst the number of written responses were very limited - only 16 - responses were received from the major stakeholders (e.g Local Medical Committee, Local

Pharmaceutical Committee, neighbouring Health and Wellbeing boards. The major areas highlighted in the responses were:
Need to identify and publish the individual opening hours of pharmacies in the area – *this has been included in the final document (see appendix 3)*
Need to give further description on the population growth and specific housing developments - *amendments to demographic profile undertaken*
Need to clarify future needs and any gaps that may occur – *addressed in recommendations*
Need to clarify that the assessment covers community pharmacy, appliance contractors and dispensing doctors – *page 3 amended*

References:

1. &Department of Health: Pharmaceutical Needs Assessment Information Pack May 2013

https://www.gov.uk/government/publications/pharmaceutical-needs-' assessments-information-pack (last accessed on 5th November 2013) '

2. UK Legislations: National Health Service (Pharmaceutical and Local ' Pharmaceutical Services) Regulations 2013 '

http://www.legislation.gov.uk/uksi/2013/349/regulation/8/made (last accessed on 5th November 2013)

Appendix 1
Detailed Consultation responses
Only 16 respondents -

Is the purpose of the PNA explained sufficiently within the draft PNA document (section 1)?
93 - yes - no response 7%

One detailed response suggested that further clarity that dispensing doctors were also part of this survey was needed - the scope of the document is clarified by an amendment on page 3

Does the document clearly set out the scope of the PNA (section 4)? -
75% agreed - the comments were focussed on clarifying the range of services addressed in this document and the purpose - both of these issues have been addressed by minor amendments on page 3

Does the document clearly set out the local context and the implications for the PNA (section 5)?

74% agreed that the document did this - the comments suggested that the document should strengthen the potential fro pharmacy to improve services and also identify the impact of future housing. Whilst housing growth is not a major issue in Reading the document now included a revised section on population growth and an assessment of pharmacy provision against the national England average

Does the information provide a reasonable description of the services which are provided by pharmacies and dispensing appliance contractors in your local authority (section 8)?

Only 33% of respondents though that the document gave an accurate reflection on the level of services - the major concern was that the document did not include a description of opening hours by pharmacy - this has now been included.
There was concern that the range of services provided by dispensing doctors was under described - again this has been strengthened.
One area of concern was raised regarding the provision of care home support by medicine management in the CCG rather than community pharmacy – this was not addressed in the final document as the document does not set out to evaluate different forms of services but does set out to describe potential impact of community pharmacy. It is the role of the commissioner to decide the most appropriate response to a community need.

Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?
50% of respondents identified that the New medicines review (NMS) service had not been included in the advanced service section - this has now been included.

Do you think the pharmaceutical needs of the population have been accurately reflected throughout the PNA
In this section 10 respondents felt that the needs were not addressed as there was not an accurate reflection of population growth and that access times needed further description - this has now been included in the final document.

Do you agree with the recommendations?

Essential and advanced services - 40% agree - main issue is lack of information on opening hours does not allow any gap in service provision to be identified - final document includes this information.
Local service recommendations - 60% agree - main issue raised in lack of commitment to commissioning the services identified.

DRAFT

Pharmaceutical Needs Assessment

Reading Borough Council

2015 – 18

Public Health Services for Berkshire
Six Local Authorities working together for the health and wellbeing of residents in Berkshire

Pharmaceutical Needs Assessment
Reading Borough Council
2015

Contents

Introduction

What is Pharmaceutical Needs Assessment (PNA)?

PNA is the statement for the needs of pharmaceutical services of the population in a specific area - this includes services provided by community pharmacies, dispensing doctors and appliance contractors. It sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population.

From 1 April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to keep an up to date statement of the PNA.

This PNA describes the needs of the population of Reading Borough Council and is different from the previous PNA which was West Berkshire focussed. This PNA will also give a view across Berkshire as people move between Local Authorities for work and health care.

Purpose of PNA :

The PNA has several purposes:

- To provide a clear picture of community pharmacy services currently provided
- To provide a good understanding of population needs and where pharmacy services could assist in improving health and well being and reducing inequalities
- To deliver a process of consultation with local stakeholders and the public to agree priorities
- An assessment of existing pharmaceutical services and making recommendations to address any identified gaps if appropriate and suggesting improvements to address future needs
- It will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements.
- It will inform interested parties of the pharmaceutical needs in Berkshire and enable work to plan, develop and deliver pharmaceutical services for the population.
- It will influence commissioning decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs) in the potential role of pharmacy in service redesign.

Background: Statutory Requirements

Section 126 of the NHS Act 2006 places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section of the Act also describes the types of healthcare professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

The first PNAs were published by NHS Primary Care Trusts (PCTs) according to the requirements in the 2006 Act. NHS Berkshire West & East published their first PNA in 2010.

The Health and Social Care Act 2012 amended the NHS Act 2006. The 2012 Act established the Health and Wellbeing Boards (HWBs) and transferred to them the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013.

The 2012 Act also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Needs Assessments (JSNAs). The preparation and consultation on the PNA should take account of the JSNA and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public.

The development of PNAs is a separate duty to that of developing JSNAs. As a separate statutory requirement, PNAs cannot be subsumed as part of these other documents.

The PNA must be published by the HWB by April 2015, and will have a maximum lifetime of three years. The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Such decisions are appealable to the NHS Litigation Authority's Family Health Services Appeal Unit (FHSAU) and decisions made on appeal can be challenged through the courts.

PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the local authority and other local commissioners for example, CCGs.

The 2013 Regulations 5 list those persons and organisations that the HWB must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the HWB area.
- Any local medical committee (LMC) for the HWB area.
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area.

- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area.
- Any NHS trust or NHS foundation trust in the HWB area.
- NHS England.
- Any neighbouring HWB.

Definition of Pharmaceutical services

The pharmaceutical services to be included in the pharmaceutical needs assessment are defined by the reference to the regulations governing pharmaceutical services provided by community pharmacies, dispensing doctors and appliance contractors.

Pharmaceutical services are provided through the National Pharmacy Contract which has three tiers:

- Essential Services
- Advanced services – currently Medicines Use Reviews and Appliance Use Reviews
- Locally commissioned services

Essential Services- set out in 2013 NHS Pharmaceutical Services Regulations 2013 include:

- Dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted / waste drugs
- Public Health (Promotion of healthy lifestyles)
- Signposting
- Support for self care
- Clinical governance

All contractors must provide full range of essential services.

Advanced Services- set out in 2013 NHS Pharmaceutical Services Regulations 2013 include:

- Medicines Use Review and Prescription Intervention (MURs)
- New medicine service (NMS)
- Appliance Use Reviews (AURs)
- Stoma Appliance Customisation Services (SACs)

Enhanced Services-- set out in Directions made subsequent to the NHS Pharmaceutical Services Regulations 2013 include:

- Anticoagulant monitoring service
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support service
- Minor ailments service
- Needle syringe exchange service
- On demand availability of specialist drugs service
- Out of hours service
- Patient group directions service
- Prescriber support service
- Schools service
- Screening service
- Stop smoking service
- Supervised administration service
- Supplementary prescribing services

Whilst the National Pharmacy Contract is held and managed by the NHS England, local Thames Valley Area Team and can only be used by NHS England, local commissioners such as Reading Borough Council and the 2 CCGs can commission local services using other contracts to address additional needs.

Process for developing the PNA

The PNA is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies.

The scope will include recommendations for action to meet the current needs of Reading and across Berkshire highlighting any areas of current provision which could be improved and potential areas for development that could assist the HWB in its duty to improve the health of population and reduce inequalities.

A key part of the process for this PNA is to summarise the health needs of the local population using the joint strategic needs assessments of the findings of the HWB board.

The PNA has five main objectives:

1. Identifying local needs
2. Mapping current provision
3. Consultations with partners, patients and the public
4. Obtaining clinical input from Clinical Commissioning Groups (CCGs) and the Local Pharmaceutical Committee

5. Identifying services that are not currently provided or need to be improved in the local area.

The PNA summarises the national vision for community pharmacy also summarises the key priorities in the Health and Wellbeing Strategy which details the local priorities for our community.

Principles of Development

The PNA will be published on the Reading Borough Council website once agreed and is a public facing document communicating to both an NHS and a non-NHS audience.

The key stages involved in the development of this PNA were:

- Survey of public to ascertain views on services - web and paper based surveys
- Survey of community pharmacies to map current service provision
- Public Consultation on the initial findings and draft PNA
- Agreement of final PNA by the Reading Health and Wellbeing Board

The process for the development of the PNA was agreed with the HWB Board. A small task and finish group was set up to over see the development of the PNA Member included.

- Director of Public Health
- Medicines Management – CCG
- NHS England pharmaceutical commissioner
- Representative from the Local Pharmaceutical Committee
- Public Health Informatics Advisor

During the consultation the following stakeholders will be included in addition to the public consultation:

- The Local Authorities within Berkshire
- The Clinical Commissioning Groups in Berkshire
- The Local Pharmaceutical Committee (LPC)
- The Local Medical Committee (LMC)
- The persons on the pharmaceutical list (pharmacy contractors) and its dispensing doctors list
- Health watch
- NHS Foundation Trusts in Berkshire

National Pharmacy Commissioning

Commissioning Arrangements

NHS England is the only organisation that can commission NHS Pharmaceutical Services through the National Pharmacy Contract.

They are therefore responsible for managing and performance monitoring the Community Pharmacy Contractual Framework. This is a regulatory framework based on the Terms of Service set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.

Pharmaceutical Services are those services set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013:

- Essential services - set out in Part 2, Schedule 4 of the Regulations
- Advanced services - set out in the Directions
- Enhanced services - set out in the Directions

There are four ways in which pharmaceutical services are commissioned:

NHS England
- Sets legal framework for system, including regulations for pharmacy
- Secures funding from HM Treasury
- Determines NHS reimbursement price of medicines & appliances

NHS England area team (AT) –
- securing continuously improving quality from the services commissioned, including community pharmacy enhanced services

Local Authority –
- Provision of public health services in line with local health and well being strategy

CCGs -
- Locally commissioned in line with local needs and CCG strategy

This ensures that the public have access to comprehensive pharmaceutical services.

Local Professional Networks

In addition as part the National changes in the NHS in 2013 Local Professional Networks (LPNs) for pharmacy, optometry and dentistry were established within each AT. They are intended to provide clinical input into the operation of the AT and local commissioning decisions.

In general they:

- support the implementation of national strategy and policy at a local level
- work with other key stakeholders on the development and delivery of local priorities, which may go beyond the scope of primary care commissioning providing local clinical leadership

The specific functions of the Pharmacy LPN include:

- supporting LAs with the development of the Pharmaceutical Needs Assessment (PNA)
- considering new programmes of work around self-care and long term conditions management in community pharmacy to achieve Outcome 2 of the NHS Outcomes Framework
- working with CCGs and others on medicines optimisation
- 'holding the ring' on services commissioned locally by LAs and CCGs, highlighting inappropriate gaps or overlaps (*PSNC Pharmacy Commissioning 2013*).

Contribution of Pharmacy

Pharmacists play a key role in providing quality healthcare. They are experts in medicines and will use their clinical expertise, together with their practical knowledge, to ensure the safe supply and use of medicines by the public. There are more than 1.6 million visits a day to pharmacies in Great Britain (*General Pharmaceutical Council Annual Report 2012/13*).

A pharmacist has to have undertaken a four year degree and have worked for at least a year under the supervision of an experienced and qualified pharmacist and e registered with the General Pharmaceutical Council (GPhC). Pharmacists work in a variety of settings including in a hospital or community pharmacy such as a supermarket or high street pharmacy. See NHS Choices at http://www.nhs.uk/Pages/HomePage.aspx for your local ones.

In December 2013 NHS England held a Call to Action for community pharmacy that aimed through local debate, to shape local strategies for community pharmacy and to inform NHS England's strategic framework for commissioning community pharmacy (http://www.england.nhs.uk/wp-content/uploads/2013/12/community-pharmacy-cta.pdf).

The aim was to uncover how best to develop high quality, efficient services in a community pharmacy setting that can improve patient outcomes delivered by pharmacists and their teams.

Pressures on primary care as a whole are increasing and the vision is for Community pharmacy to play a full role in the NHS transformational agenda by:

- providing a range of clinical and public health services that will deliver improved health and consistently high quality;
- playing a stronger role in the management of long term conditions;
- playing a significant role in a new approach to urgent and emergency care and access to general practice;
- providing services that will contribute more to out of hospital care; and
- supporting the delivery of improved efficiencies across a range of services.

The Call to Action consultation has now finished and the response is awaited from the department of Health.

National Outcomes Frameworks

Pharmacy has a key role in supporting the achievement of the NHS Outcomes Framework, which measures the success of the NHS in improving the health of the population

NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

And similarly contributes to the success against the Public Health Outcomes Framework.

Public Health Outcomes Framework

Domain 1	Life expectancy and healthy life expectancy
Domain 2	Tackling the wider determinants of Health
Domain 3	Health Improvement
Domain 4	Health Protection
Domain 5	Healthcare and preventing premature mortality

Control of Market Entry

The regulations that govern the provision of pharmacy places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons.

It is not possible for a community pharmacy to be set up without agreement from NHS England. From 1 April 2013, pharmaceutical lists are maintained by NHS England and so applications for new, additional or relocated premises must be made to the local NHS England Area Team.

NHS England must ensure that they have arrangements in place for:

- the provision of proper and sufficient drugs, medicines and listed appliances which are ordered on NHS prescriptions by doctors;
- the provision of proper and sufficient drugs, medicines which are ordered on NHS prescriptions by dentists;
- the provision of proper and sufficient drugs, medicines and listed appliances which are ordered on NHS prescriptions by other specified descriptions of healthcare professionals; and
- such other services that may be prescribed.

In April 2013 there was a change in how pharmacy applications are controlled. Applications for inclusion in pharmaceutical lists are now considered by NHS England (through their Area Teams) and the 'market entry test' is now an assessment against the pharmaceutical needs assessment. The exemptions introduced in 2005 have been removed (other than the exception for distance selling pharmacies) (*Regulations under the Health and Social Care Act 2012: Market entry by means of Pharmaceutical Needs Assessments - Medicines, Pharmacy and Industry – Pharmacy Team).*

The market entry test now assesses whether an application offers to:

- meet an identified current or future need or needs;
- meet identified current or future improvements or better access to pharmaceutical services; or
- provide unforeseen benefits, i.e. applications that offer to meet a need that is not identified in a PNA but which NHS England is satisfied would lead to significant benefits to people living in the relevant HWB area (*Policy for determining applications received for new or additional premises under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*).

The change in the market entry test means that it is no longer necessary to have exemptions to the test for the large out of town retail developments, the one stop primary medical centres, or the pharmacies undertaking to provide pharmaceutical services for at least 100 hours per week. These exemptions therefore cannot be used by an applicant (although existing pharmacies and those granted under the exemption continue). The regulations make it clear that 100 hour pharmacies granted under old exemptions cannot apply to reduce their hours.

The only exemption that now exists is for distance selling pharmacies as it is argued they provide a national service and so their contribution cannot be measured adequately by a local pharmacy needs assessment.

Geography Covered by Reading PNA

Each PNA has to define its geographic scope. This year the Reading PNA is following the boundaries of the Local Authority, as is each PNA for the Berkshire Local Authorities. The services are mapped for each Local Authority and a composite picture is given for Berkshire. Results are also compared for Local Authorities against the whole of Berkshire. Appendix 1 shows a map of the pharmacies in Reading PNA.

Figure 1: Map of Reading showing ward boundaries

The wards in Reading include:

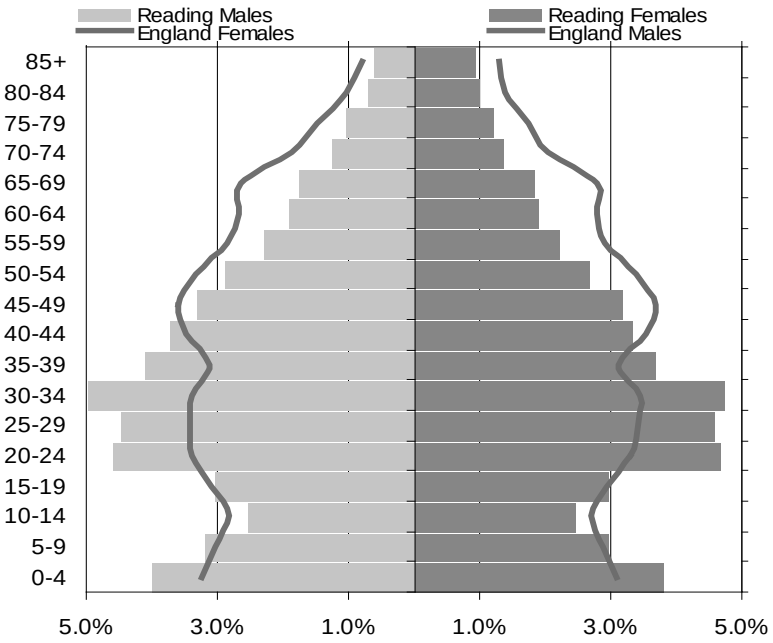
Abbey	Minster	Tilehurst
Battle	Norcot	Whitley
Caversham	Park	
Church	Peppard	
Katesgrove	Redlands	
Kentwood	Southcote	

Reading Borough Demographics

The population of Reading is now 159,247.

Reading has population structure that is very different to the national average. It has a much larger population of young adults and very young children. The older population is also much smaller than the national average.

Figure 2: Reading Borough Council's Population pyramid, compared to the national profile



Source: Annual Mid-Year Population Estimates for the UK, Office for National Statistics 2014

The registered population differs to resident as this is the number of people registered with GP practices based in Reading.

Figure 3: Resident and registered population of Reading Borough Council and other Berkshire Local Authorities

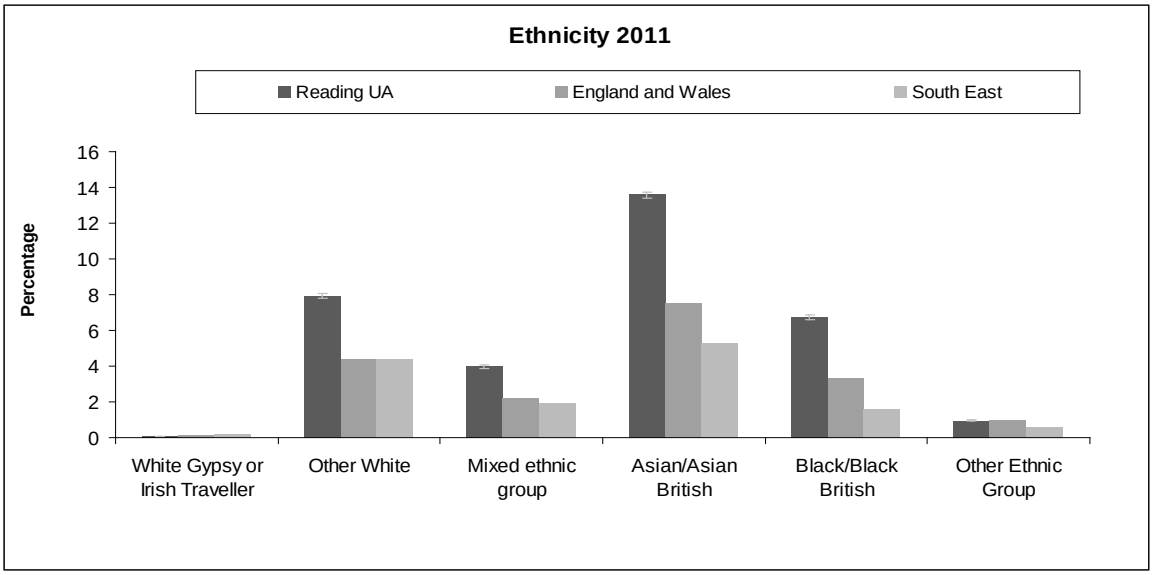
Local Authority	Resident population	Registered population
Reading	**159,247**	**205,209**
Bracknell Forest	116,567	110,216
Slough	143,024	145,848
West Berkshire	155,392	148,126
Windsor & Maidenhead	146,335	165,936
Wokingham	157,866	156,123

Source: Office for National Statistics (2014)

Ethnicity

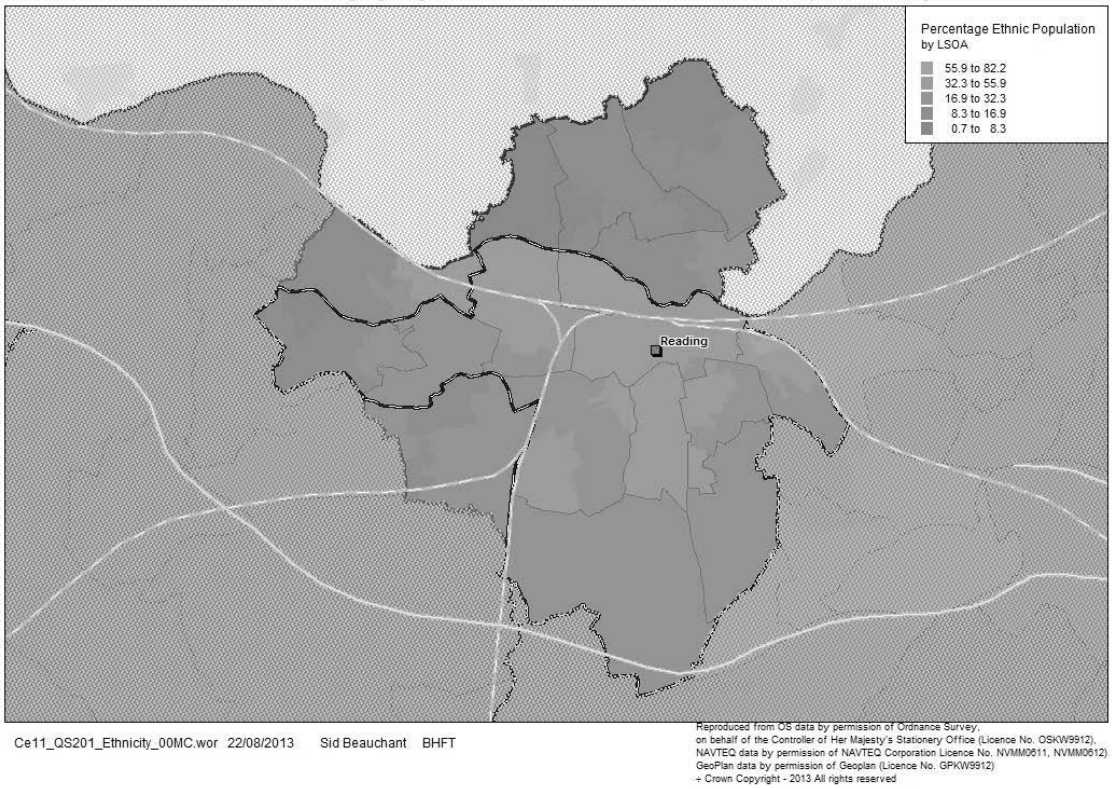
The 2011 Census indicates that the largest ethnic category in Reading is White British (66.79%). The next largest is Asian or Asian British representing nearly 14% of the population. 14.8% (9,256) of households contain multiple ethnic groups compared to 8.9% nationally. With the exception of people who classify themselves as 'Other White', there is a higher proportion of people from all ethnic minority groups living in Reading, than there are nationally and in the South East Region.

Figure 4: Ethnic Origin of non-White British resident population in Reading



Source: Office for National Statistics (2011)

Figure 5: Ethnic minority population in Reading shown at a Lower Super Output Area



Source: Office for National Statistics (2011)

Population growth

Total population growth - Cumulative – ONS midyear estimates

Local authority	2015	2016	2017	2018
Bracknell Forest	120,036	124,044	127,906	131,879
West Berkshire	158,105	160,136	162,434	164,836
Reading	**161,515**	**164,824**	**167,923**	**171,364**
Slough	149,811	154,078	157,768	160,764
Royal Borough Windsor Maidenhead	151,166	154,216	156,460	158,568
Wokingham	162,695	166,547	171,417	177,112

Life Expectancy

Life expectancy for men and women in Reading is lower than the national average.

Figure 6: Life Expectancy for men and women in Reading Borough Council and other Berkshire Local Authorities (2010-12)

Local Authority	Males	Females
Reading	78.4	82.7
Bracknell Forest	80.8	84.0
Slough	78.5	82.7
West Berkshire	80.8	84.6
Windsor and Maidenhead	81.1	84.6
Wokingham	81.6	84.5

Source: Office for National Statistics (2014)

Children

Children in poverty

Child poverty and deprivation can be measured in a number of different ways. Figure 7 shows the percentage of children (dependent children under the age of 20), who live in households where income is less than 60% of average household income. This is termed as living in 'relative poverty'. Figure 7 also shows the Income of Deprivation Affecting Children Index score (IDACI score), which measures the proportion of under

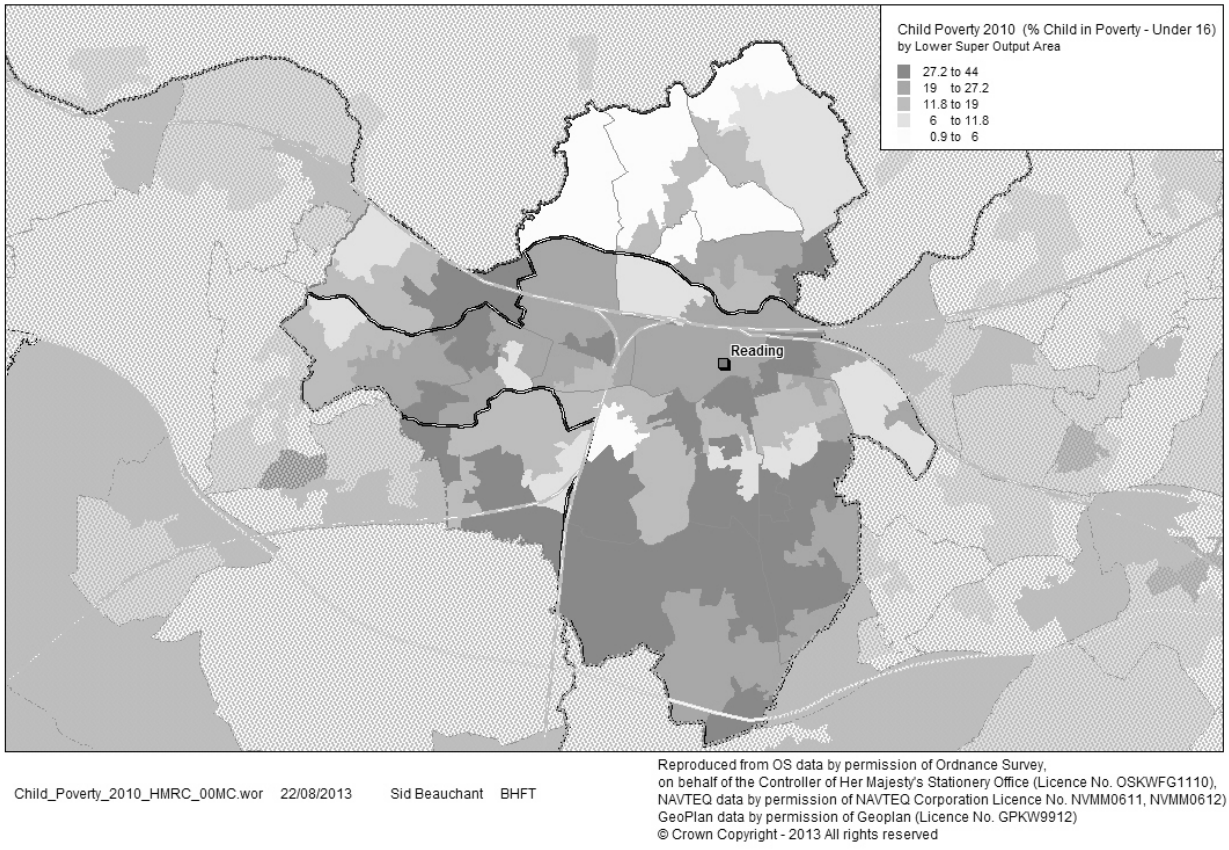
16s living in low income households. A higher score indicates higher levels of child deprivation in an area.

Figure 7: Level of Child Poverty in the Reading and other Berkshire Local Authorities (2010-12)

Local Authority	% of Children in "Poverty"	IDACI score
Reading	20.7%	0.21
Bracknell Forest	11.7%	0.11
Slough	22.2%	0.26
West Berkshire	10.8%	0.10
Windsor & Maidenhead	9.4%	0.09
Wokingham	6.9%	0.06

Source: HM Revenue and Customs (2011) and Department for Communities and Local Government (2010)

Figure 8: Map to show level of Child Poverty in Reading at a Lower Super Output Area (2010)



Source: Department for Communities and Local Government (2010)

Teenage pregnancies

Figure 9: Under 18 conceptions and conception rates in Reading and other Berkshire Local Authorities (3 year aggregates: 2010-2012)

Area of usual residence	Number of Conceptions	Conception rate per 1,000 women in age group	Percentage of conceptions leading to abortion
Reading	260	36.9	47.3
Bracknell Forest	127	18.4	57.5
Slough	196	25.3	64.8
West Berkshire	217	23.0	48.8
Windsor and Maidenhead	117	14.5	70.9
Wokingham	122	13.8	46.7

Source: Office for National Statistics (2014)

Educational Attainment

Figure 10: Percentage achieving 5+ A*-C GCSE grades, including English and mathematics

Area	%
Reading	**63.6**
Bracknell Forest	63.4
Slough	71.4
West Berkshire	61.3
Windsor and Maidenhead	68.3
Wokingham	70.6

Source: Department for Education (2012/13)

Figure 11: Key Stage 2 results – Percentage achieving level 4 or above by Local Authority

Area	%
Reading	**69**
Bracknell Forest	78
Slough	74
West Berkshire	77
Windsor and Maidenhead	79
Wokingham	81

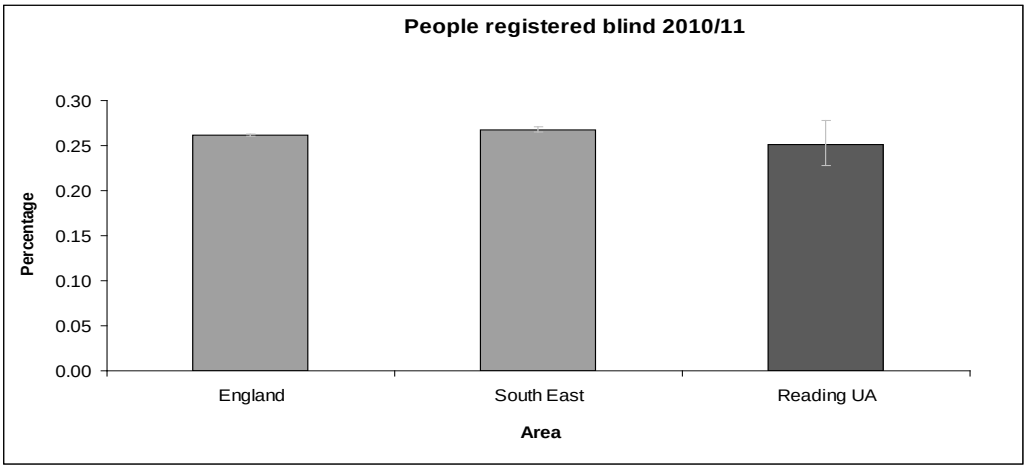
Source: Department for Education (2013)

Physical disability and sensory impairment

Figures 12 and 13 show the number of people registered as being blind, partially sighted, deaf or hard of hearing as a proportion of the total population. Similar levels of people in Reading are registered as blind, compared with the national average. Fewer people are registered as being hard of hearing or deaf compared to the national

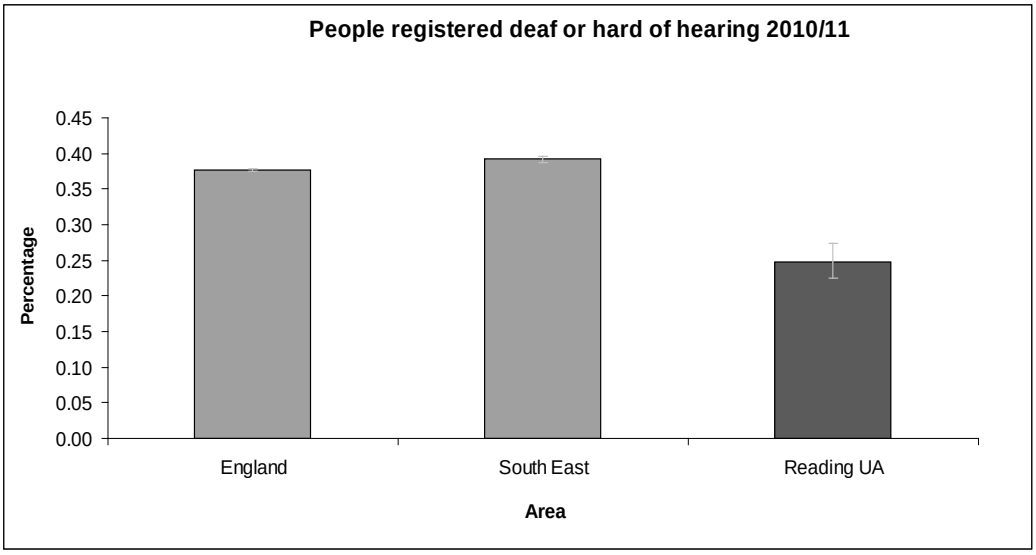
average. It is worth noting that registration is voluntary, so there may be people who are blind or partially sighted that have chosen not to be on the register or who are unaware of it.

Figure 12: Percentage of people registered as blind in Reading (2010/11)



Source: Health and Social Care Information Centre (2011)

Figure 13: Percentage of people registered as deaf or hard of hearing in Reading



Source: Health and Social Care Information Centre (2011)

The Projecting Adult Needs and Services Information website uses population projections to estimate how many people aged 18 to 64 will have a visual or hearing impairment from 2012 to 2020. Around 3,050 adults in the Reading Borough are estimated to have moderate or severe hearing impairment in 2012 with 24 estimated to have a profound hearing impairment. These figures are expected to rise to around 3,250 and 27 by 2020. 67 adults are estimated to have a serious visual impairment. The same system also projects how many people aged 18 to 64 will have a physical disability from 2012 to 2020. Around 7,100 people in Reading are estimated to have a moderate physical disability in 2012 with 1,920 estimated to have a serious physical disability. These figures are expected to rise to around 7,250 and 2,000 by 2020.

Provision of unpaid care

7.9% of Reading's population stated that they provided unpaid care to a family member, friend or neighbour in the 2011 Census. Figure 14 provides a breakdown to show the levels of unpaid care provided.

Figure 14: Percentage of people providing unpaid care in Reading and other Berkshire Local Authorities (Census 2011)

Local Authority	All categories: Provision of unpaid care	Provides no unpaid care	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Reading	**155,698**	**143,383**	**8,074**	**1,642**	**2,599**
Bracknell Forest	113,205	103,531	6,719	1,098	1,857
Slough	140,205	128,579	7,058	1,977	2,591
West Berkshire	153,822	139,534	10,313	1,466	2,509
Windsor and Maidenhead	144,560	131,325	9,604	1,432	2,199
Wokingham	154,380	140,478	10,190	1,397	2,315

Source: Office for National Statistics (2012)

Reading Needs Assessment

Reading at a glance

The health of people in Reading is varied compared with the England average. Deprivation is lower than average, however about 6,400 children live in poverty.

Life expectancy for both men and women is similar to the England average. Life expectancy is 8.5 years lower for men and 7.0 years lower for women in the most deprived areas of Reading than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average.

In Year 6, 19.6% of children are classified as obese. The level of teenage pregnancy is worse than the England average. Levels of alcohol-specific hospital stays among those under 18, breast feeding and smoking in pregnancy are better than the England average.

The estimated level of adult obesity is better than the England average. The rate of sexually transmitted infections is worse than the England average. Rates of road injuries and deaths and hospital stays for alcohol related harm are better than the England average.

Life Expectancy

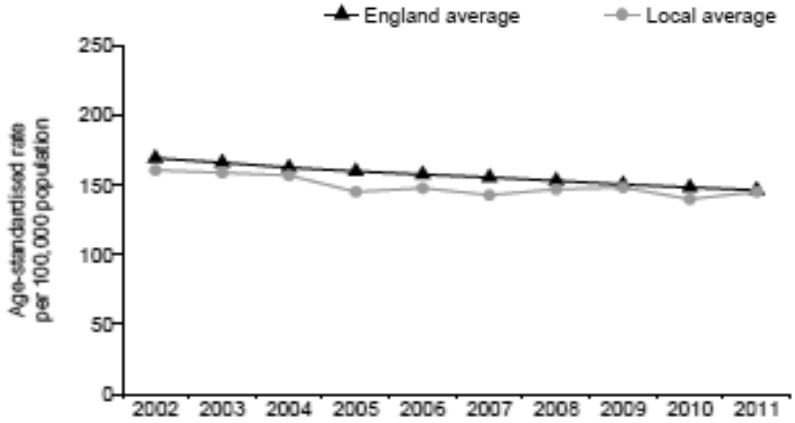
Life expectancy at birth is lower for both males and females at birth than the national average. This is significantly lower for males in Reading.

In line with its neighbours the three common causes of early death (deaths before aged 75 years) are cancer, heart disease and stroke, and lung disease.

Cancer

Cancer is the single largest cause of early preventable deaths (145 per 100,000 population) 815 deaths in Reading between 2008 and 2010 were cancer related (*APHO Local health profile, 2013*).

Figure 15: Rate of deaths from cancer for people aged under 75 in Reading (2002-2011)



Source: Association of Public Health Observatories, 2014 Local Health profile

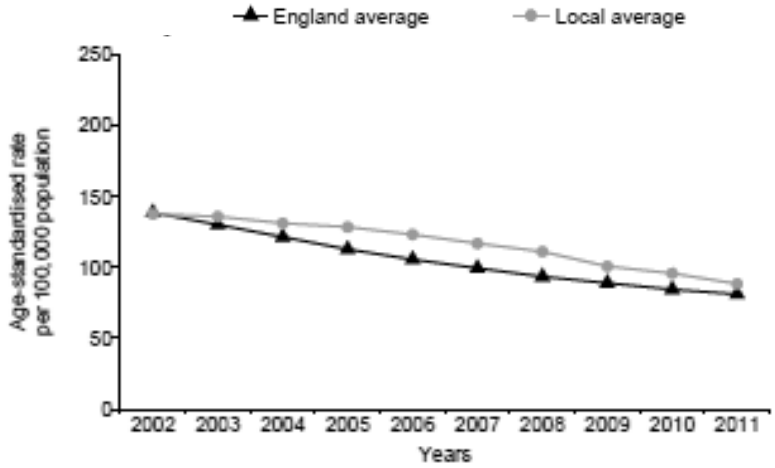
There is a significant focus on the prevention and early diagnosis of cancer as well as more rapid treatment in line with national standards. Screening has reduced deaths for some cancers. Cancer is more survivable if people are aware of symptoms and present to health services at an earlier stage of the disease.

In Reading screening uptake is lower than the national average in both breast and cervical screening, however uptake of the bowel cancer screening, a newer programme, has not delivered against the national target of 60% uptake (uptake in North West Reading CCG is 56% since the start of programme and 44% in South Reading CCG area).

Heart disease and stroke

Heart disease mortality is reducing, but it still is the second leading cause of early death causing 88 deaths per 100,000 in Reading.

Figure 16: Rate of deaths from heart disease and stroke for people aged under 75 in Reading (2002-2011)



Source: Association of Public Health Observatories, 2014 Local Health Profile

The development of cardiovascular disease (CVD) is linked to lifestyle factors such as risky behaviours such as excessive smoking, drinking, poor diet and physical inactivity (*Department of Health, 2013*).

In Reading at least 50 in every 100,000 deaths from CVD for people aged less than 75 years are preventable. This is higher than the national average and similar Local Authorities. An increase in local awareness and uptake of NHS Health Checks programme for eligible population of 40 – 74 year olds would at least in part address this issue.

Long term Conditions

A significant proportion of the population in the Reading Borough will be living with a long term condition. The table below shows the estimated prevalence of the Reading population with the following long term conditions: Coronary Heart Disease (CHD), Coronary Obstructive Pulmonary Disease (COPD), Cardiovascular Disease (CVD), Hypertension and Stroke in comparison with National average.

Figure 17: Prevalence of long term conditions for people aged 16 and over in Reading (2011)

	CHD	COPD	CVD	Hypertension	Stroke
Reading	3.85%	3.42%	9.01%	24.69%	1.74%
England	5.80%	3.64%	11.76%	30.54%	2.55%

Source: Public Health England (2012)

Lifestyle

Smoking

Smoking has long been known to be a major risk factor in many diseases including cardiovascular disease, respiratory diseases and many cancers.

Tobacco use is the single most preventable cause of death in the England – killing over 80,000 people per year. This is greater than the combined total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections (*Action on Smoking and Health, 2013*).

Smoking prevalence in Reading is higher than the national average - 20% of the population smoke and approximately 280 per 100,000 people aged over 35 years will die due to smoking related illnesses. In addition 1,100 people will be admitted to hospital with smoking related illnesses *(Local Tobacco Control Profile 2013*).

Alcohol

Alcohol consumption above these recommended levels is associated with numerous health and social problems. This includes several types of cancer, gastrointestinal and cardiovascular conditions as well as psychiatric and neurological conditions. The social effects of alcohol have been associated with road accidents, domestic violence, antisocial behaviour, crime, poor productivity and child neglect.

Modelled figures show Reading to have higher levels of increasing risk higher risk and binge drinking. Whilst Reading has significantly higher number of violent crimes than the national average, violent crime estimated to be due to alcohol has seen a fall in Reading and this reduction was at its most dramatic between 2011 and 2012 when it fell to under 8 crimes per every 1,000 people.

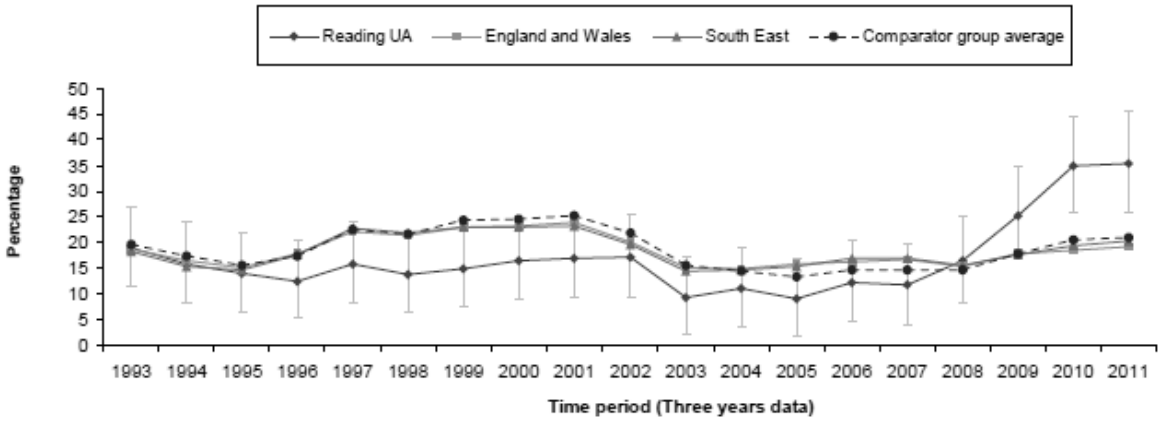
Communicable disease

- **Sexually transmitted disease** - Reading has significantly higher notifications of sexually transmitted diseases than the England average.
- **HIV** - In 2012, there were 324 residents accessing HIV related care in Reading and less than 10 people were newly diagnosed with HIV. Significant numbers of people among them were diagnosed late.
- **Blood-borne Viruses (BBVs)** - In 2012, there were 38 hepatitis B virus cases (acute and chronic) and significantly lower than in the previous years (44 in 2010). Hepatitis C is a major Public Health problem with estimates of large numbers of undiagnosed infections, the majority of which are in current or former injecting drug users. Reading has significantly higher numbers of drug misusers.
- **Tuberculosis** - There were 42 cases of Tuberculosis (TB) among Reading residents in 2012 with an incidence rate of 27 per 100,000 population. Three quarters of TB cases were born outside of the UK. The quality of TB services is high.

Older population

'Excess Winter Death' data show the number of deaths in winter (December to March) compared with non-winter months. Reading has in the past three years seen increasing number of excess winter deaths, and the recent figures show that the numbers are significantly above the national average.

Figure 18: Excess Winter Deaths in Reading (1993 to 2010)



Source: Public Health England (2012)

Flu Vaccination

Public Health England's report Excess Winter Mortality 2012-13 concluded that excess deaths were found predominantly in the elderly and in deaths coded as resulting from respiratory causes. Their analysis showed influenza to be a major explanatory factor.

Flu immunisation is a Public Health programme that aims to reduce the mortality and morbidity form the influenza virus each year. Whilst targets are almost achieved in the older age groups, there are gaps in the programme aimed at children and those with long term conditions and at higher risk.

Figure 19: Seasonal flu immunisation uptake in Reading (2012/13)

Area	Aged 65 years and over	Aged 6 months to 64 years in clinical risk groups	Pregnant women
Target uptake	75%	70%	70%
Reading	75.4%	56.2%	42.7%
North & West Reading CCG	*77%*		
South Reading CCG	*73%*		
Berkshire West	75.9%	56.4%	48.3%

Source: IMMFORM, Jan 2013. All figures are derived from data as extracted from records on GP systems or as submitted by GP practices or former Primary Care Trusts.

Monitoring against the Public Health Outcomes Framework (PHOF)

The Public Health Outcomes Framework includes over 60 indicators, which measure key aspects of public health within a Local Authority area. In August 2014, Reading Borough was seen to be "significantly worse" than the England figures on the following measures:

0.1ii	Life Expectancy at birth (Male)
0.1ii	Life Expectancy at 65 (Male)
0.2iv	Gap in life expectancy at birth between each LA and England (Male)
1.01i	Children in poverty (under 20)
1.01ii	Children in poverty (under 16s)
1.02ii	School readiness - % of Year 1 pupils achieving the expected level in the phonics screening check
1.02ii	School readiness - % of Year 1 pupils with FSM status achieving the expected level in the phonics screening check
1.05	16-8 year olds not in education, employment or training (NEET)
1.17	Fuel poverty
2.04	Under 18 conceptions
2.04	Under 16 conceptions
2.20i	Breast cancer screening coverage
2.20ii	Cervical cancer screening coverage
2.21vii	Access to Diabetic Eye Screening
3.05ii	Incidence of TB
4.02	Tooth decay in children aged 5
4.03	Mortality rate from causes considered preventable (Male)
4.08	Mortality from communicable disease (All people, Male, Female)
4.15iii	Excess Winter Deaths (3 years, all ages)

The PHOF uses Berkshire West figures for all of the immunisation indicators, so these cannot be directly attributed to Reading. Most of Berkshire West's childhood immunisation figures are significantly better than the England average and meet the national target.

Local Commissioning Strategies

Reading Health and Wellbeing Strategy

Working in partnership the Reading Health and Wellbeing Board published its first Health and Wellbeing Strategy. The vision of the Board is for:

A healthier Reading with communities and agencies working together to make the most efficient use of available resources, to improve life expectancy, reduce health inequalities and improve health and wellbeing across the life course.

The Strategy recognises that health is impacted by many aspects of normal daily living for example, where you live, your links with your community and your experience of loneliness. Working with and through communities underpins the approaches in the Health and Wellbeing Strategy.

The key health needs identified in the Strategy are:

Children:

- low child immunisation numbers in Reading
- under 18 conceptions are significantly more than the England average
- There are significantly more children living in poverty that the England average
- There are 4 times the number of children on child protection plans that the South East average

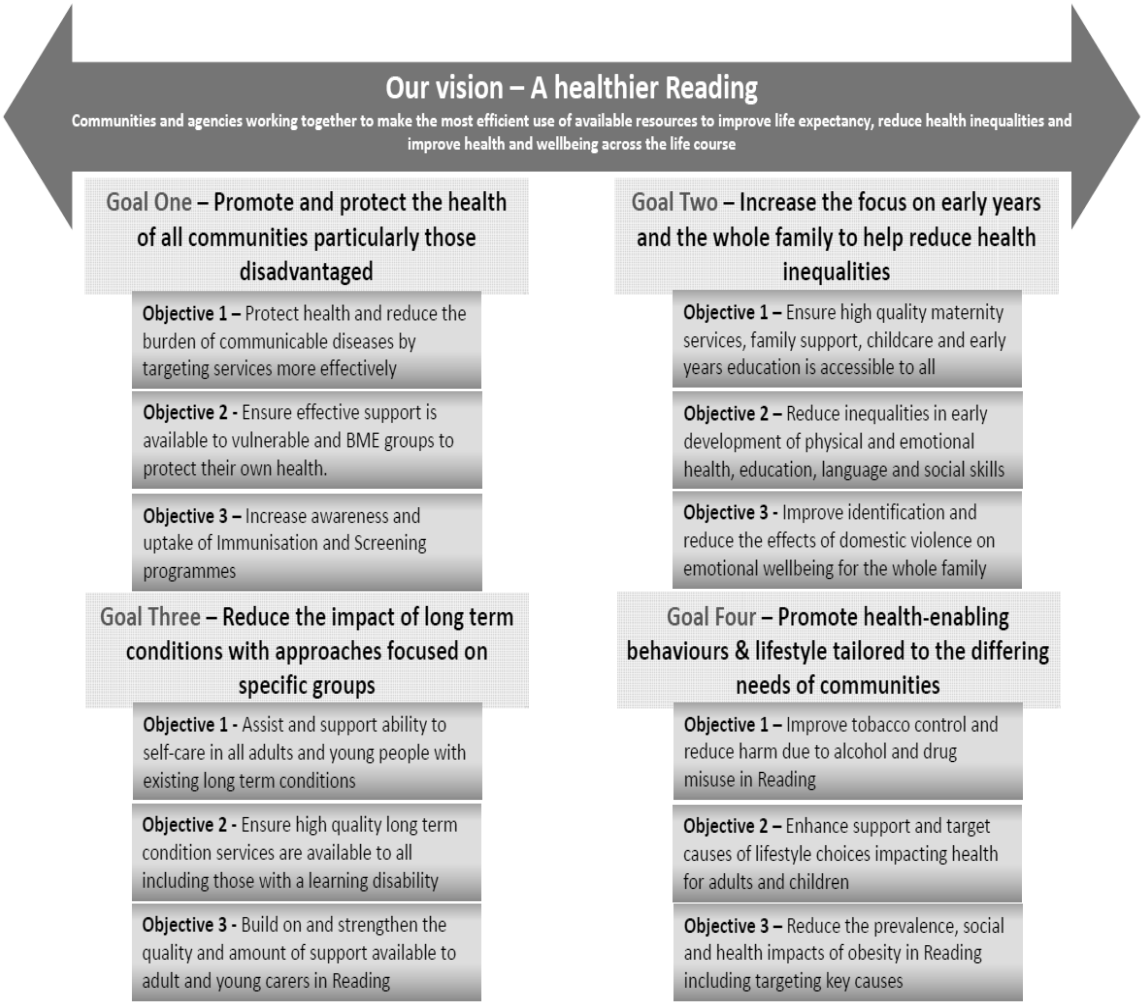
Adults

- Tuberculosis rates have remained stable at high levels in Reading - over double the national average
- Acute sexually transmitted illnesses are 50% above the England average
- Drug misuse is 50% higher than England average
- Rates of violent crime are higher than the England average
- Increasing rates of diabetes and other long term conditions

Older adults

- Reading has higher than expected numbers of winter deaths (more people are dying in winter than in the warmer months), which may be related to the relatively high number of older homes,
- Lower than targeted numbers of older people having a seasonal flu vaccine

Figure 20: Goals of the Health and Wellbeing Strategy in Reading



CCG Strategy

The Operational Plans for North & West Reading CCG and South Reading CCG are attached at Appendix 2 and Appendix 3 respectively.

Current Pharmacy Provision

Core Pharmaceutical services are provided through the National Pharmacy Contract which has three tiers:

- Essential Services
- Advanced services
- Enhanced Services

This contract is managed by NHS England (Thames Valley Area Team locally)

However in addition community pharmacy can be commissioned by

- CCGs - local commissioned services to support local needs and service transformation
- Local authorities - locally commissioned services to support local needs

There are currently 33 community pharmacies in Reading and 162 across Berkshire. These provide the essential services and a range of advanced and enhanced services. The types of businesses vary from multiple store organisations to independent contractors. There are three 100 hour pharmacies in Reading.

Pharmacy of course is also available at our Hospital sites across Berkshire: There are pharmacies at Wexham Park Hospital, Royal Berkshire Hospital and Frimley Park Hospital. These are open to 6pm on weekdays and limited hours at weekends. However, they only dispense hospital prescriptions and will not do Standard Operating Procedure FP10 Prescriptions (prescriptions that can be taken to any community pharmacy to be dispensed). They do not sell any products and do not offer any additional services to the public.

<u>Essential Services</u>

The following services form the core service provision required of all 33 Reading pharmacies as specified by the NHS Community Pharmacy Contract 2005.

- **Dispensing** - Supply of medicines and devices ordered through NHS prescriptions together with information and advice to enable safe and effective use by patients. This also includes the use of electronic RX (electronic prescriptions). Community pharmacies support people with disabilities who may be unable to cope with the day-to-day activity of taking their prescribed medicines.
- **Repeat dispensing** – Management of repeat medication in partnership with the patient and prescriber.
- **Disposal of unwanted medicines** – acceptance, by community pharmacies, of unwanted medicines which require safe disposal from households and individuals.

- **Signposting** - The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy.
- **Public Health promotion** – Opportunistic one to one advice given on healthy lifestyle topics such as smoking cessation.
- **Support for self care** - Opportunistic advice and support to enable people to care for themselves or other family members.
- **Clinical governance** – Requirements include use of standard operating procedures, ensuring compliance with the Disability Discrimination Act and following quality frameworks to ensure safe delivery of services

Advanced Services

Currently the only Advanced Services which are commissioned nationally are new medicines review (NMS) Medicine Use Review (MUR), Appliance Use Review (AUR) and Prescription Intervention Service. The MUR and AUR services provided by pharmacists are to help patients in the use of their medication and appliances. A MUR includes what each medicine is used for, side effects and if the patient has any problem taking them. The Prescription Intervention Service is in essence the same as the MUR service, but conducted on an ad hoc basis, when a significant problem with a patient's medication is highlighted during the dispensing process.

Local Services

The following enhanced services that are currently commissioned, as at August 2014 by:

Public Health within the council:

- **Supervised consumption** - This service requires the pharmacist to supervise the consumption of opiate substitute prescribed medicines at the point of dispensing in the pharmacy so ensuring that the dose has been administered to the patient.
- **Needle exchange** - The pharmacy provides access to sterile needles and syringes, and sharps containers for return of used equipment. The aim of the service is to reduce the risk of blood borne infections that are prevalent in people who inject drugs.
- **Chlamydia Screening** – Pharmacists supply Chlamydia Screening Postal Kits to any person aged between 15 and 24 upon request and will opportunistically offer Chlamydia Screening Postal Kits to young people attending the pharmacy who may be sexually active. This service aims to improve access to Chlamydia screening and so reduce the prevalence of Chlamydia.
- **Emergency Hormonal Contraception** - Pharmacists supply Emergency Hormonal Contraception (EHC) also known as the 'morning after pill', when appropriate to patients in line with the requirements of a locally agreed Patient Group Direction (PGD).

- **Smoking Cessation Services** – Working with the main provider of Smoking cessation services pharmacies provide a range of support including medication to people who want to give up smoking.
- **NHS Health Checks** - Pharmacies are commissioned to deliver NHS health checks to anyone aged 40 – 74, who does not have an existing cardiovascular condition. This provides the individual with an assessment of their risk on developing heart disease and allows signposting to GP follow up or health promotion services e.g. weight reduction / smoking cessation

The CCGs within Berkshire:

- **Palliative Care Urgent Drugs Scheme** - making available locally a list of medication that may be required urgently for palliative care patients. A number of pharmacies ensure they keep the items in stock and can be accessed out of hours if required.

Advice to care homes is not available through community pharmacy but is provided by the medicines management teams in each CCG. This service provides support to staff within care homes, over and above the Dispensing Essential Service, to ensure the proper and effective ordering of drugs and appliances and their clinical and cost effective use, their safe storage, supply and administration and proper record keeping. This service is to improve patient safety within the care home and to ensure the safe storage, supply and administration of medicines.

NHS England:

- **Flu Immunisation** - A pilot scheme was developed to increase flu vaccination availability in high risk groups through community pharmacy. In 2014 this scheme is being extended across Berkshire.

Private Services**:**

Some pharmacies offer private services, which are not commissioned, but are available to customers for additional payment e.g. diabetes screening.

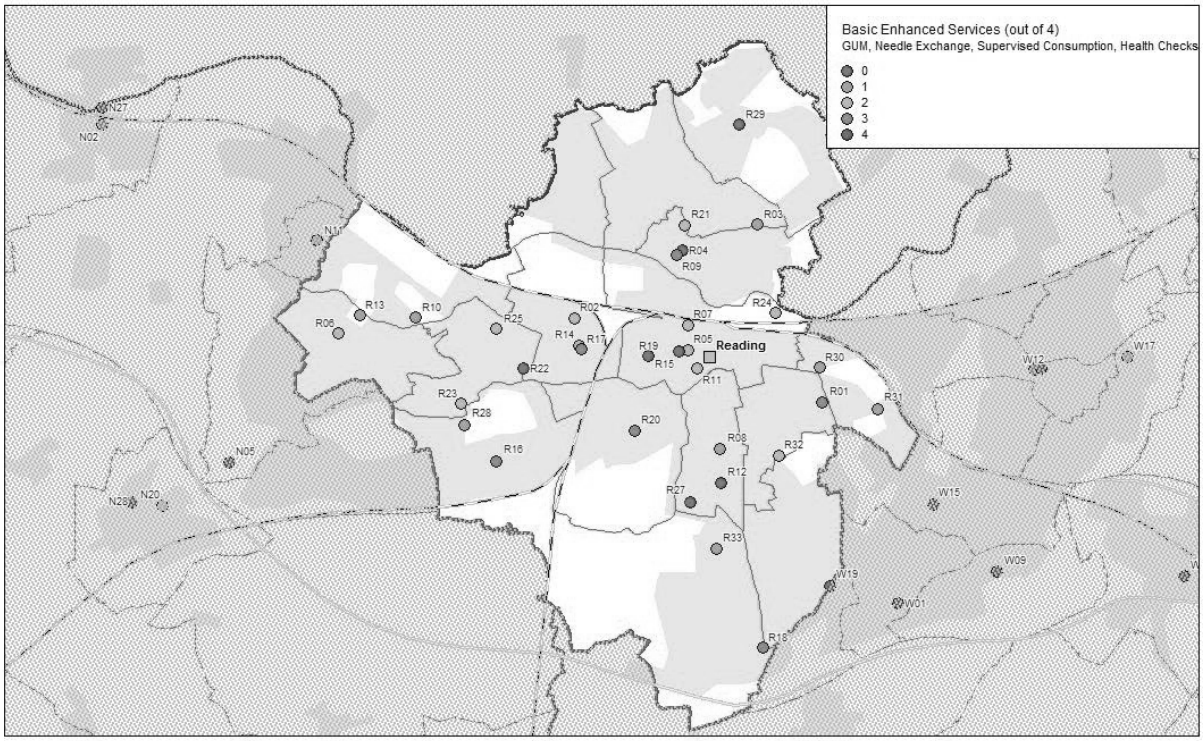
Pharmacy provision - current

Identified Health Needs	Current service provision Community pharmacy
Adults Self care	Signposting is part of core contract
	Medicine utilisation reviews
	Health Promotion campaign part of core contract
Smoking	Solutions for Health sub contract
Alcohol	Pilot programme in pharmacies raising awareness of alcohol units
Cancer	Health promotion campaigns - Bowel Screening as part of core contract.
Cardiovascular disease	NHS Health Checks
Chronic Obstructive Pulmonary Disease (COPD)	Medicine utilisation reviews
Older people Winter excess death Winter warmth Flu Immunisations Falls	Pilot of Flu immunisation to at risk groups
Dementia	Friends trained
Sexual Health	Emergency hormonal contraception Access to condoms - C Card scheme Signposting to Chlamydia screening
Substance misuse	Needle exchange Supervised consumption

Current Pattern of Enhanced services

For more details see Appendix 4.

Figure 21: Map of Pharmacies in Reading to show how many of the Enhanced Services are provided



Other Service Providers

Dispensing Contractors

In addition to community pharmacies, to ensure access in defined rural areas (controlled localities) - GPs may provide dispensing services to patient who live more than 1.6km from a pharmacy. Reading however does not have any rural areas that meet the required definition and so Reading does not have any dispensing doctors

Out of area service providers
Residents can of course access pharmacies in other areas, and Reading borders with the following authorities:

Oxfordshire
Wokingham
West Berkshire

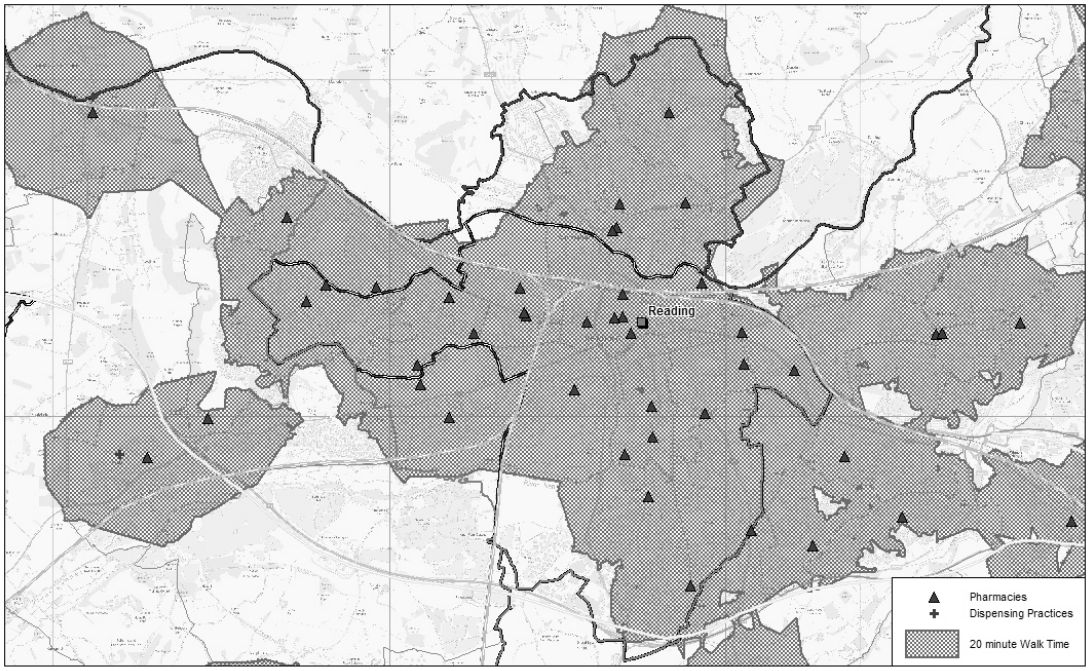
Pharmacy Access and Services

Reading has more than the England average number of pharmacies per 100,000 population (21 pharmacies per 100,000 population v 20 per 100,000 population) .

One measure of accessibility is the number of patients that can get to a pharmacy within 20 minutes driving time (see Appendix 5 - drive time calculated by software Chronomap). For Reading it can be seen that all of the population can access a pharmacist within this time.

Within Reading we have also mapped the access within 20 minutes walking time.

Figure 22: Population of Reading that can get to a pharmacy within a 20-minute walk time



Berks_PNA_Jul14_v1.wor 14/07/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

In this analysis it can be seen that the there are two areas with limited accessibility: North West (part of Caversham Heights) and South West - however at this time the Southern area has limited housing. It is estimated that only 5,000 people cannot access a pharmacy under this much more stringent measure.

<u>Opening Hours</u>
A survey was undertaken of all pharmacists in Reading. 28 providers out of 33 providers took part on this survey. The following information is taken from the survey.

All respondents are open Monday to Friday between 9am and 5pm depending on the day of the week. 86% of providers are open on Saturdays, with 43% open on a Sunday. In addition Reading has three '100 hour per week' pharmacists. A detailed list of the opening hours of pharmacies is given in appendix 5

Consultation Facilities

To deliver the advanced services e.g. medicines utilisation reviews and to potentially support patients with more knowledge on their illnesses and increase patient confidence in self care, pharmacist will need an area to provide this level of support in a confidential setting.

In Reading 79% of providers have wheelchair accessible consultation facilities, an additional 7% have a consultation space however it is not wheelchair accessible. Only 7% do not have consultation space available.

Advanced services

Within Reading a significant number of pharmacies provide advanced services for medicines, though this is not the case for appliance care and customisation services.

Figure 23: Reading Pharmacy response to question about the provision of advanced services

	Yes	Soon	No
Medicines Use Review service	25 (89.3%)	2 (7.1%)	1 (3.6%)
New Medicine Service	24 (85.7%)	2 (7.1%)	2 (7.1%)
Appliance Use Review service	0 (0%)	3 (10.7%)	25 (89.3%)
Stoma Appliance Customisation service	0 (0%)	1 (3.6%)	27 (96.4%)

Additional language availability

There are a wide range of additional languages spoken within the community pharmacy setting which is important in Reading given its large number of BME communities. These include a wide range of Asian and European languages

Collection and Delivery Services

Many patients with long term conditions have ongoing medication requirements. For them collection and delivery services may be crucial for accessing their prescriptions – having the prescription collected from the GP surgery and then delivered to their home. 93% of pharmacies in Reading offer free collection from the surgery services.

In addition 86% of community pharmacies offer free delivery to patients when requested usually to patients with limited mobility. An additional 7% of pharmacists will offer this service but will charge for the service.

IT connectivity

IT connectivity refers to the ability of the pharmacy to link to the NHS information systems so allowing easier transfer of information e.g electronic prescriptions
Moving forward service integration will require sharing of information and so it will become increasingly important for pharmacy to have IT connectivity if they are to play a role in transformed services. 92% of pharmacies in Reading have IT connectivity, and the rest are updating to have good connectivity in the coming year.

Analysis of User Survey

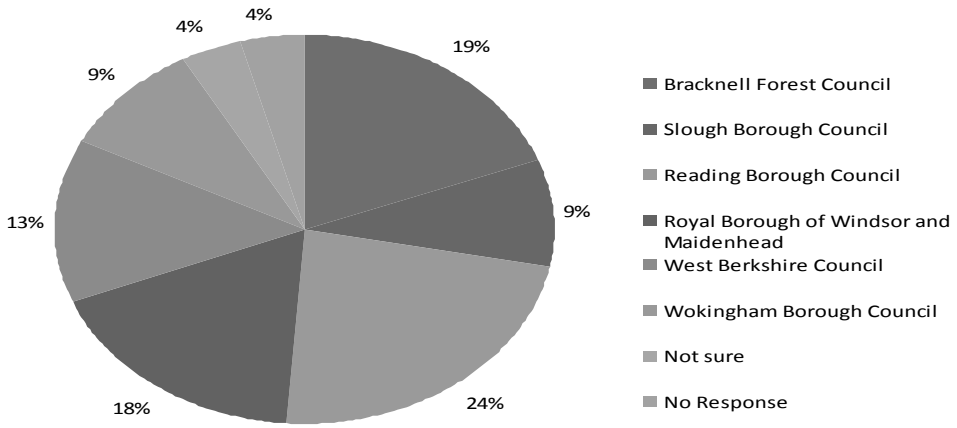
A key part of the PNA is to obtain the views of residents who use our community pharmacy and dispensing doctor services.

The survey was circulated in a number of ways. The survey was available at all of the local community pharmacists; the anonymous paper based surveys were then collected from these locations by courier. In addition the survey was available electronically on the Councils website. Posters in the pharmacies and press releases in the local papers tried to increase local awareness of the survey and to encourage participation.

Respondents

The survey was sent out across Berkshire, with 2,048 people responding. The responses by Local Authority are shown below.

Figure 24: Which local authority area do you live in?



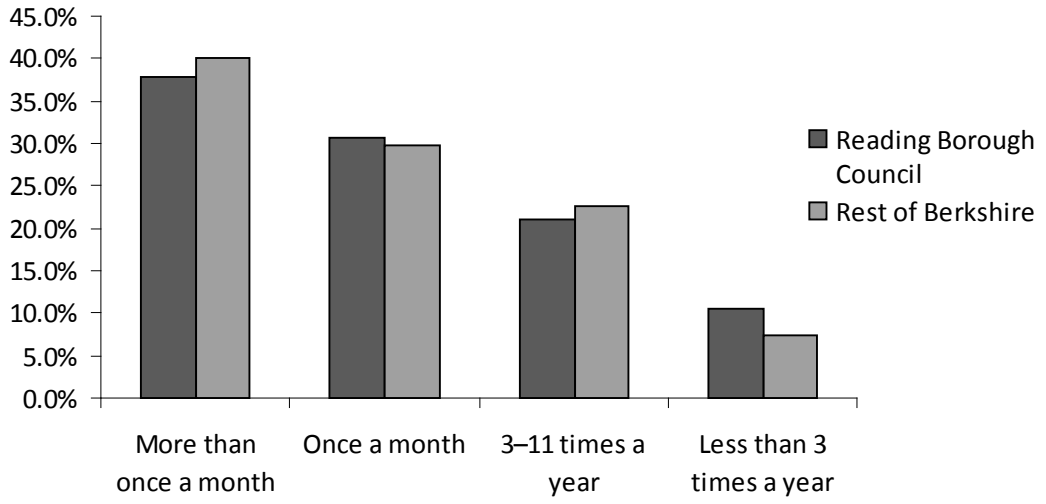
In Reading there were 468 responses making up 23% of the total replies. Of these 75% were from respondents that classed themselves as white British and 6% as white other. The most common age groups that responded in Reading were younger than the rest of Berkshire with 20% being 35-44 and 19% aged 45-54.

Pattern of use

Residents were asked what services they used: 94% replied that they used community pharmacy, 4% a dispensing appliance supplier (someone who supplies appliances such as incontinence and stoma products) and 3% internet pharmacy. These results are a similar pattern of use to the rest of Berkshire.

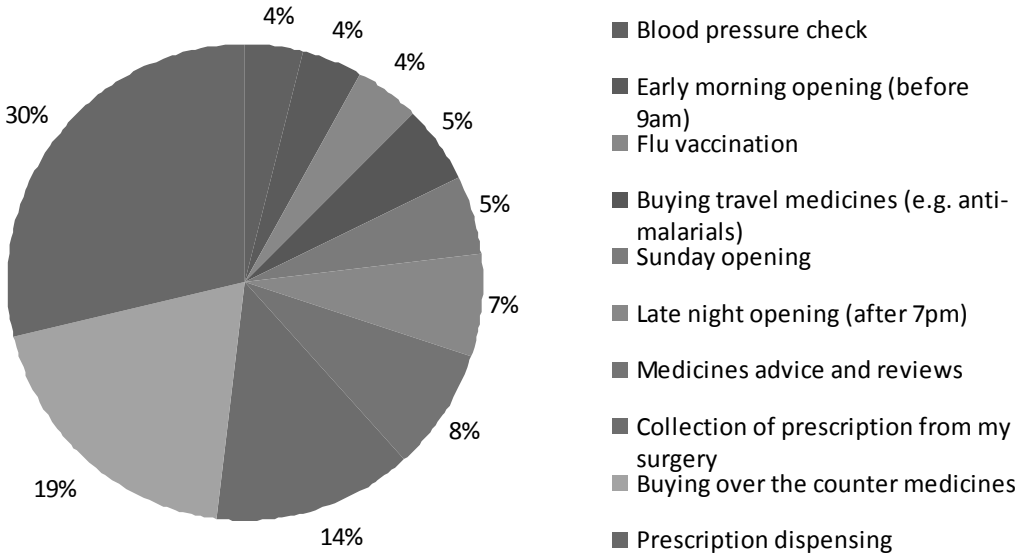
When residents were asked how often they used a community pharmacy they gave the following replies, which shows a slightly lower usage than the rest of Berkshire but not significantly.

Figure 25: How often do you use a pharmacy?



Additionally residents were asked about the type of services they currently use at their local pharmacy: As could have been expected the most common reason is to get prescriptions dispensed (30%) and buying over the counter medicines (19%). The results show how the respondents value to (voluntary) collection of prescription service provided by pharmacists.

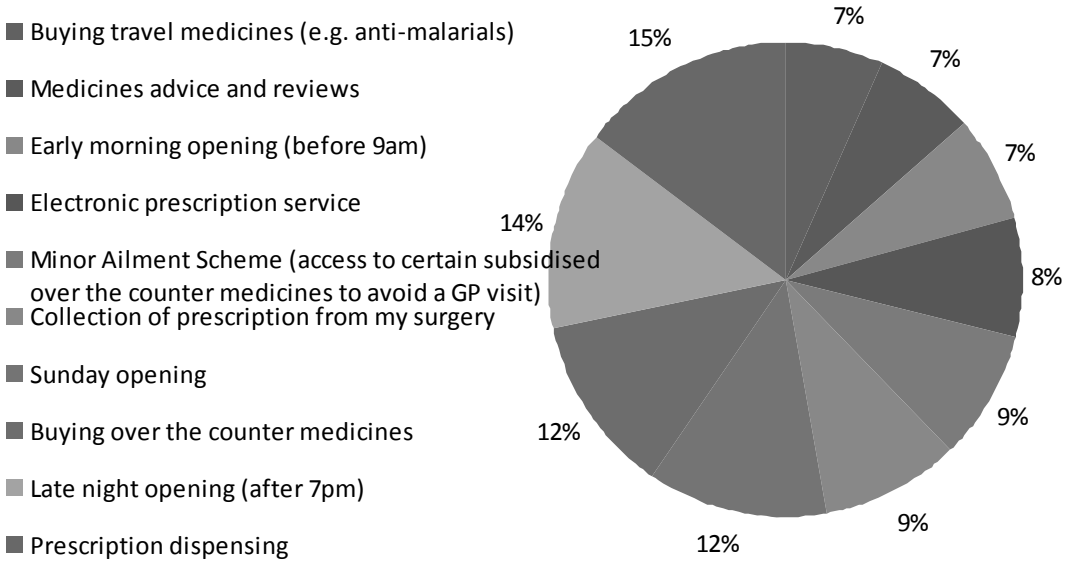
Figure 26: Which of the following service do you currently use at a pharmacy?



We also asked respondents' about the type of services they would like to see at a community pharmacy, whilst dispensing and medicines are still important

and respondents again wish to see extended opening times, 14% would like to see late night opening and 12% Sunday opening.

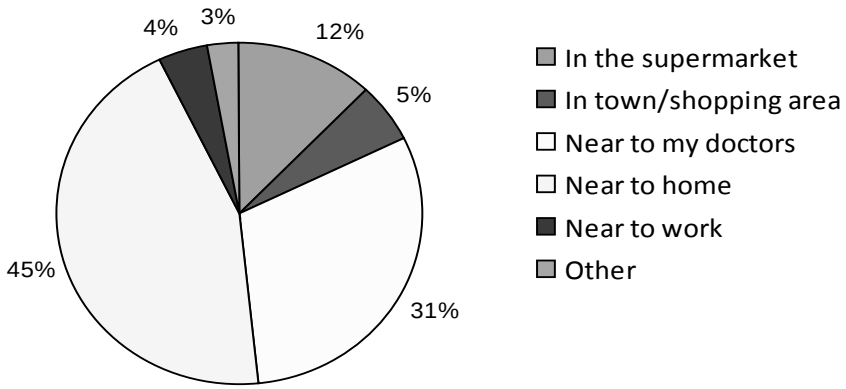
Figure 27: Which of the following services would you use at a pharmacy, if available? (Top 10 responses)



Access to pharmacy

Respondents state they have good access to services with 99% being able to access the pharmacy of their choice, which is slightly higher than the rest of Berkshire response (98%). The commonest reason was proximity to home (45%) with 30% stating that proximity to GP was the key factor.

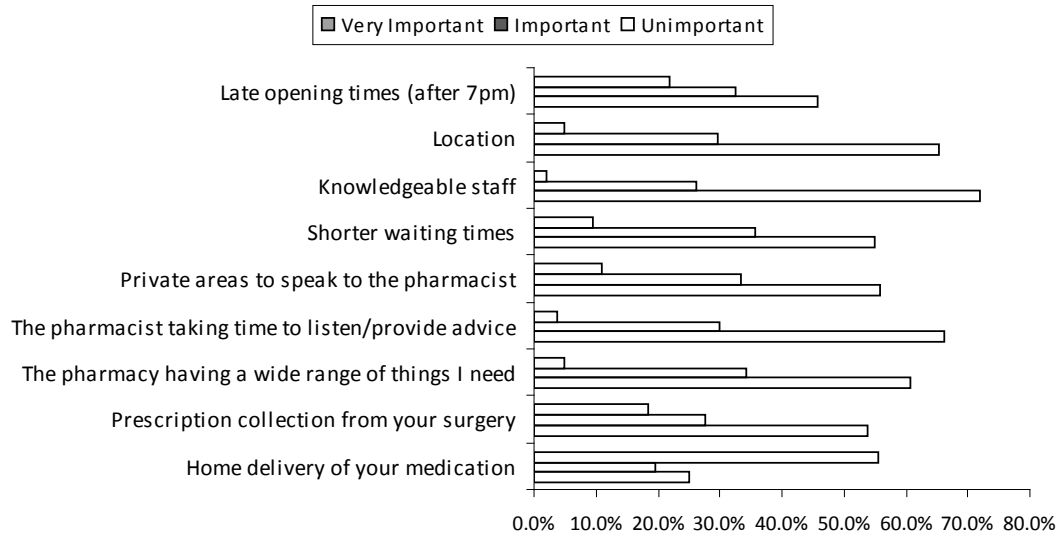
Figure 28: Reason for choice of pharmacy



More respondents' access pharmacy on foot (52%) with 36% using the car. 84% of respondents can access services within 15 minutes and 14% within 15-30 minutes.

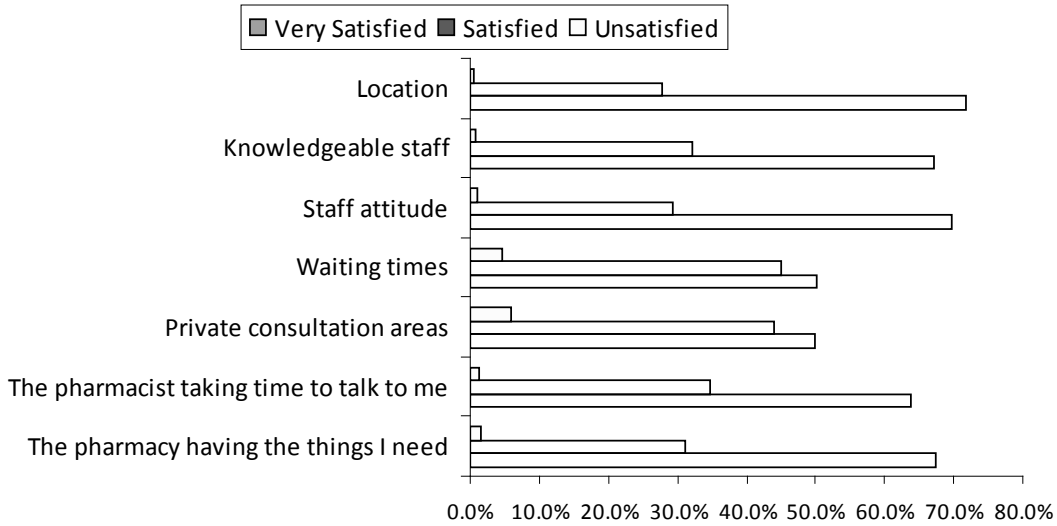
We asked respondents to rate the importance of the various services that pharmacies offer. Key is the availability of knowledgeable staff, closely followed staff having time to listen and give advice and convenient location.

Figure 29: How important are the following pharmacy services?



The final section of the survey tested the respondents' satisfaction with services. As has been seen there is a high level of satisfaction across all areas, the lowest level of satisfaction was with the waiting times and private consultation space – for waiting time 5% expressed dissatisfaction and consultation space 6%.

Figure 30: How satisfied were you with the following services at your regular pharmacy?



Recommendations

The regulations governing the development of pharmaceutical needs assessments requires an assessment of pharmaceutical services in terms of:

- Services currently commissioned that are necessary to meet a current need
- Services not currently commissioned that may be necessary in specified future circumstance
- Services not currently commissioned that may be relevant in the future because they would secure improvements or better access to pharmaceutical services to address needs identified in the population.

Essential services

In order to assess the provision of essential services against the needs of our population we mapped and assessed the location of pharmacies, their opening hours and the provision of other dispensing services, see appendix 1. These are the factors that we consider to be key factors in determining the extent to which the current provision of essential services meets the needs of our current population.

Access

Current pattern of services provides good physical access to patients, with no gaps in the 20 minute drive time test. Reading, in comparison to Berkshire is not as affluent (see Appendix 8), car ownership is therefore lower so we have also mapped the walking times. As has been shown access to pharmaceutical services is still good with low housing density in one of these areas meaning few residents being unable to access a pharmacy under this measure. Though if significant housing developments occur in these areas the situation my need to be reviewed .
In addition Reading has 21 pharmacies per 100,000 population (England average - 20 per 100,000).

Opening Hours

All respondents are open Monday to Friday between 9 am and 5 pm depending on the day of the week. 86% of providers are open on Saturdays, with 43% open on a Sunday. In addition Reading has three ‘100 hour per week’ pharmacists. With the extension of the working week for general practice then consideration may need to be given to supporting an extension to the number of pharmacists open at similar hours.

Patient views

94% of respondents used community pharmacy. The user survey shows that respondents are generally very satisfied with pharmacy services in the Borough. 99% are able to access the pharmacy of their choice, with 84%

being able to access services within 15 minutes. There were lowest levels of satisfaction were seen with private consultation space 6% and waiting times 5% though the levels of dissatisfaction are low.

Conclusion - Essential services

Overall the findings show that the pharmacy services currently provided are comprehensive and address the needs of Reading residents. Reading provision is slightly higher than the England average and will continue to match the England average up until 2018 if the ONS forecast population growth is accurate, however this population growth should be monitored to assess adequacy of provision during this period to ensure no gaps in service provision occur.

In addition it is noted that in both the Health and Wellbeing Strategy and the CCG commissioning plans there is a focus on self care, health promotion and early intervention services. In essence making it easier for residents to access information to understand and manage their own condition with expert professional advice and intervention as needed. Pharmacists have a key role to play in this and as this is a core essential service we would encourage all commissioners to work collaboratively with community pharmacy in this endeavour.

- Promotion of healthy lifestyles
- Prescription linked interventions
- Public health campaigns
- Signposting
- Support for self care

Advanced services

The advanced services are:

- New medicine service
- Medicines Use Review and Prescription Intervention (MURs)
- Appliance Use Reviews (AURs)
- Stoma Appliance Customisation Services (SACs)

These services aim to improve patients' understanding of their medicines; highlight problematic side effects & propose solutions where appropriate; improve adherence; and reduce medicines wastage, usually by encouraging the patient only to order the medicines they require and highlighting any appropriate changes to the patient's GP to change their prescription.

An important feature in the provision of advanced services is the provision of consultation areas within pharmacies; this was explored in some depth in the pharmacy contractor survey. 86% of pharmacies in Reading provide access to consultation areas. Currently there is good provision of MUR medicine

services with a minimum of 86% of respondents providing this care which is of particular importance to patients with long term conditions.

Conclusion - advanced services

Again the purpose of advanced services fits well with the local population and the increasing numbers of residents with ongoing conditions and fits with the Health and Wellbeing Strategy and CCG strategic plans.

Pharmacists through their role in dispensing and NMS , MUR services can identify key residents at risk of complications and support their care. Current service provision is good. However in future the growth in the total population with growth also predicted in the number of residents with long term conditions service gaps may appear. This may require an extension of the current limit of the MUR service able to be supplied by pharmacies (current limit 400).

Work with pharmacy contractors, the LPC and LMC to improve understanding and awareness of MUR among patients and the public will be needed.

Locally Commissioned Services

Whilst it seems that there are sufficient numbers of pharmacies within Reading the JSNA has identified a number of needs that in the future pharmacists could potentially address. These services should be made available across Reading to allow maximum access and choice for residents

Figure 31: Summary of identified health needs and potential developments in Reading

Identified Health Needs	**Current service provision Community pharmacy**	**Potential community pharmacy development**
Adults Self care	Signposting is part of core contract	Strengthen use of community pharmacy as information hub for community contact - access to voluntary sector groups, exercise advice, "Making every contact Count" – building on the home delivery services offered freely through many pharmacies to identify frail patients at risks and support preventative integrated care
	Medicine utilisation reviews	To build on MUR and support wider information

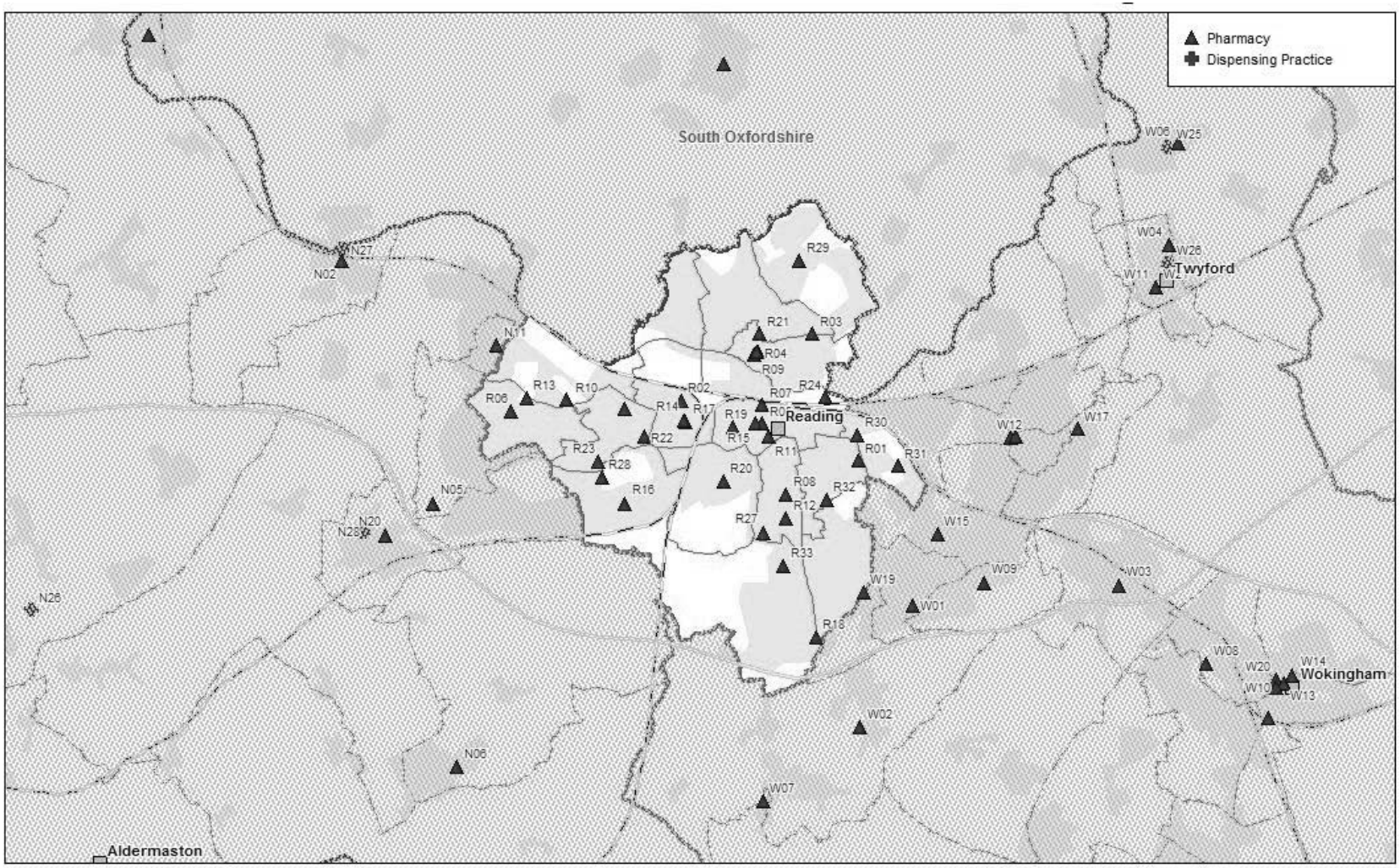
Identified Health Needs	Current service provision Community pharmacy	Potential community pharmacy development
		on the specific illness / motivational interviewing etc – e.g diabetes,
	Health promotion campaign	Develop skills to increase capacity and capacity of pharmacies teams to provide information and support healthy lifestyle choice - Making every count
Smoking	Solutions for health sub contract	Widen participation of community pharmacy
Alcohol	Pilot programme in pharmacies raising awareness of alcohol units	Expansion of this programme into a full Alcohol Intervention and Brief Advice Service
Cancer	Health promotion campaigns - bowel screening as part of core contract.	Build on dispensing opportunities to identify worrying symptoms to sign post to care
Cardiovascular disease	NHS health checks	Expansion of provision within the communities focussing on the more deprived communities
Chronic Obstructive Pulmonary Disease (COPD)	Medicine utilisation reviews	Develop capacity and techniques to support inhaler technique
Anxiety and depression		Opportunistic identification of at risk groups to sign post to support services
High use of accident and emergency Minor Ailments	Previous minor ailment pilots	Potential of pharmacy to act as first port of call in a range of minor ailments to reduce use of GP and A&E to
Older people Winter excess death Winter warmth		Sign post vulnerable groups to support services

Identified Health Needs	Current service provision Community pharmacy	Potential community pharmacy development
Flu Immunisations	Pilot of Flu immunisation to at risk groups	Widen availability of flu immunisation to all groups
Sexual Health	Emergency hormonal contraception Access to condoms - C Card scheme Chlamydia screening and treatment by PGD	LARC
Substance misuse	Needle exchange Supervised consumption	PGD - naloxone therapy BBV testing and treatment
Infectious diseases TB Blood borne viruses HIV		Potential opportunity to increase and sign post new residents at risk of TB to screening services TB Supervision Potential opportunity to increase and sign post new residents at risk of BBV to screening services Potential opportunity to increase and sign post new residents at risk of HIV to sexual health services

Figure 32 shows identified health needs that could be addressed through commissioning of pharmaceutical services subject to a robust business case and contractual negotiations.

Appendix 1: Map of Pharmacy Services in Reading Borough

Figure 1: Map of Pharmacies and Dispensing Practices in Reading Borough

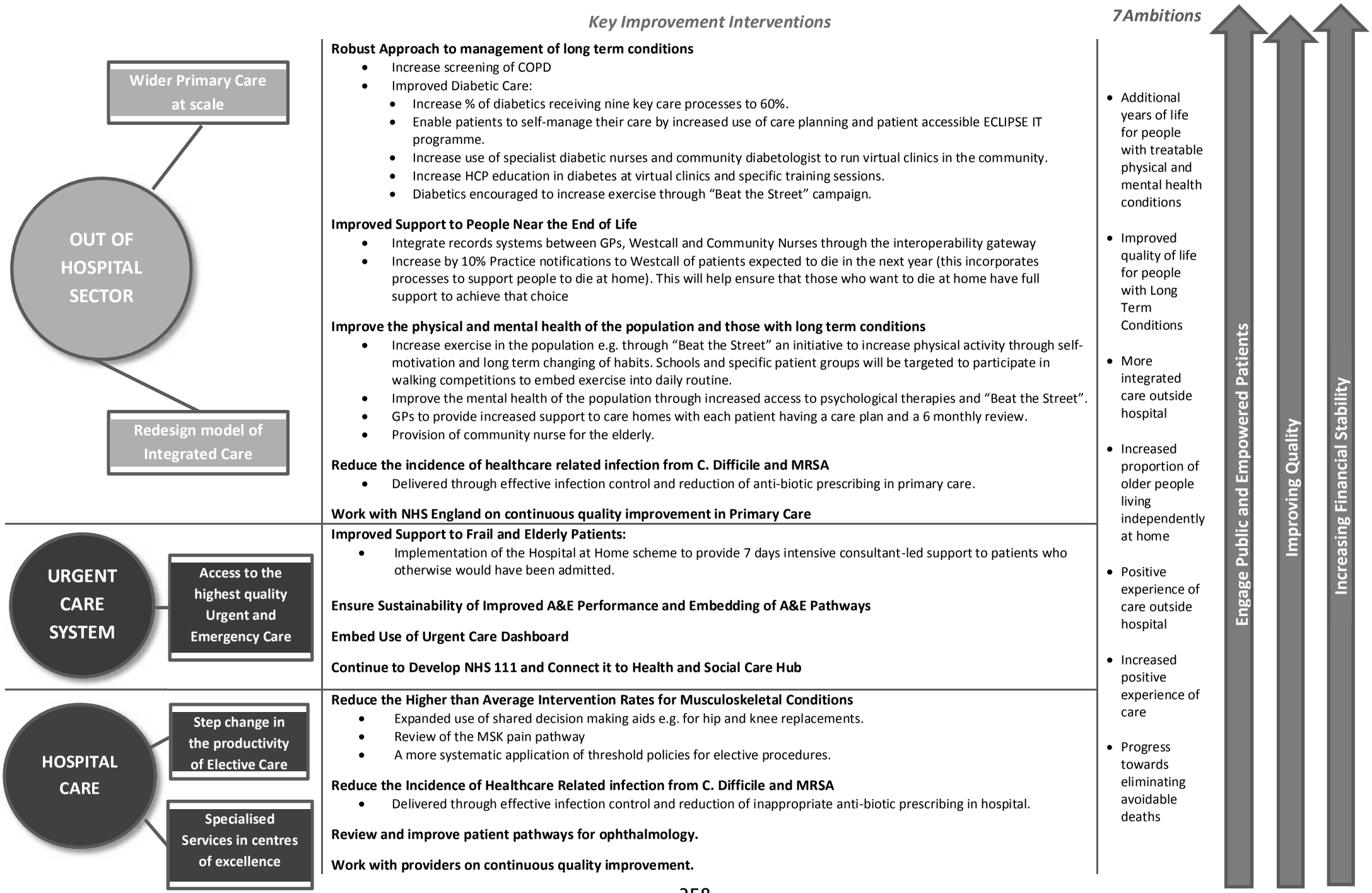


Berks_PNA_ES_Aug14_r2.wor 27/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

ID	CODE	TRADING NAME	ADDRESS	TOWN	POSTCODE
R01	FA288	Erleigh Road Pharmacy	85 Erleigh Road	Reading	RG1 5NW
R02	FA368	Tesco Pharmacy	Portman Road	Reading	RG30 1AH
R03	FA597	Markand Pharmacy	122 Henley Road	Caversham	RG4 6DH
R04	FC305	Day Lewis Rankin Pharmacy	30 Church Street	Caversham	RG4 8AU
R05	FDT21	Boots the Chemists	47-48 Broad Street	Reading	RG1 2AA
R06	FDX71	Triangle Pharmacy	88-90 School Road	Tilehurst	RG31 5AW
R07	FE816	Boots the Chemists	Unit 7, Brunel Arcade (Reading Station)	Reading	RG1 1LT
R08	FEK05	Lloyds Pharmacy	Milman Road Health Centre, Milman Road	Reading	RG2 0AY
R09	FEX35	Boots the Chemists	45 Church Street	Caversham	RG4 8BA
R10	FF110	Lloyds Pharmacy	2a Tylers Place, Pottery Road	Tilehurst	RG30 6BW
R11	FFY65	Boots the Chemists	25 Town Mall Walk, The Oracle	Reading	RG1 2AH
R12	FGD71	Basingstoke Road Pharmacy	71 Basingstoke Road	Reading	RG2 0ER
R13	FGF17	Tilehurst Pharmacy	7 School Road	Tilehurst	RG31 5AR
R14	FGW06	Lloyds Pharmacy	266-268 Oxford Road	Reading	RG30 1AD
R15	FGX83	Superdrug Pharmacy	55-59 Broad Street	Reading	RG1 2AF
R16	FHF90	Southcote Pharmacy	36 Coronation Square	Reading	RG30 3QN
R17	FK294	Lloyds Pharmacy	351-353 Oxford Road	Reading	RG30 1AY
R18	FLG15	Whitley Wood Pharmacy	Whitley Wood 534 Northumberland Avenue	Reading	RG2 8NY
R19	FLK26	Saood Pharmacy	104A Oxford Road	Reading	RG1 7LL
R20	FLR49	Newdays Pharmacy	60 Wensley Road, Coley Park	Reading	RG1 6DJ
R21	FMJ89	Rowlands Pharmacy	59A Hemdean Road	Caversham	RG4 7SS
R22	FMV40	Fittleworth Medical Ltd	2 Lundy Lane	Reading	RG30 2RR
R23	FNR10	Boots the Chemists	32 Meadway Precinct	Tilehurst	RG30 4AA
R24	FPG88	Tesco Pharmacy	Napier Road	Reading	RG1 8DF
R25	FQD26	Grovelands Pharmacy	Grovelands Pharmacy 2 Grovelands Road	Reading	RG30 2NY
R26	FQP38	Oxford Road Pharmacy	272-274 Oxford Road	Reading	RG30 1AD
R27	FRF51	Manichem Online	47, Boulton Road		RG2 0NH
R28	FT293	Asda Stores Ltd	Honey End Lane	Tilehurst	RG30 4EL
R29	FT878	Lloyds Pharmacy	The Broadway	Caversham	RG4 8XW
R30	FTK19	Lloyds Pharmacy	195 London Road	Reading	RG1 3NY
R31	FVH81	Lloyds Pharmacy	105 Wokingham Road	Reading	RG6 1LN
R32	FWT36	Lloyds Pharmacy	68 Christchurch Road	Reading	RG2 7AZ
R33	FXQ15	Lloyds Pharmacy	277 Basingstoke Road	Reading	RG2 0JA
R34	FT878	Lloyds Pharmacy	5 Cavendish Road, Caversham Park	Reading	RG4 8XU

"Supporting our population to improve and optimise their own personal health by encouraging self-care and commissioning high quality integrated health care"



VISION of SOUTH READING Clinical Commissioning Group (CCG)

Working innovatively with patients and partners to improve the health of our local community

High level Objectives

- To provide equitable, high- quality, primary medical care.
- To deliver more services in the community, with less patients being seen in hospitals.
- To use the finite NHS resources wisely based on clinical evidence and need

Strategic Context

125,328 people registered with 20 GP practices.

South Reading CCG:
a **younger ethnically diverse population** (just 4.3% over 75 years; 27% ethnic minorities)

11% live in a ward in one of the 20% **most deprived** in England.

CCG Benchmarks well against national rates for GP referrals, elective and non-elective admissions.

CCG underperforms for childhood immunisations and cancer screening

Health inequality from mortality from cardiovascular disease (CVD) with an 8.5 year and 7 year difference in life expectancy for men and women respectively from the most to the least deprived areas of Reading.

87% of hospital care is from the **Royal Berkshire NHS Foundation Trust.**

Berkshire Healthcare Foundation Trust: main provider of community and mental health services.

Member of **Reading** Health and Wellbeing Board

Total Budget £115m with 1% Quality , Innovation, Productivity, & Prevention (QIPP) savings target for 13/14

Priorities with target improved outcomes

National:
Hospital acquired infections e.g. C Diff and MRSA levels in line or less than nationally set targets.

Reduce avoidable emergency admissions by 1 patient per day.

Quality Premium:

Increase uptake of immunisations from 93% to 95%

Carry out an extra 804 CVD health checks

Achieve 45% coverage of the 9 care processes for diabetes , an increase of 9%

Improving Health inequalities in Children:

Reduce health impact of childhood obesity.

Increase uptake of Breastfeeding from 53% to 54%.

Increased input from Speech and Language Therapists into nurseries and schools

Other areas identified in our Joint Strategic Needs Assessment (JSNA)

Increase bowel cancer screening uptake from 44% to at least 54%

Increase numbers of smoking quitters

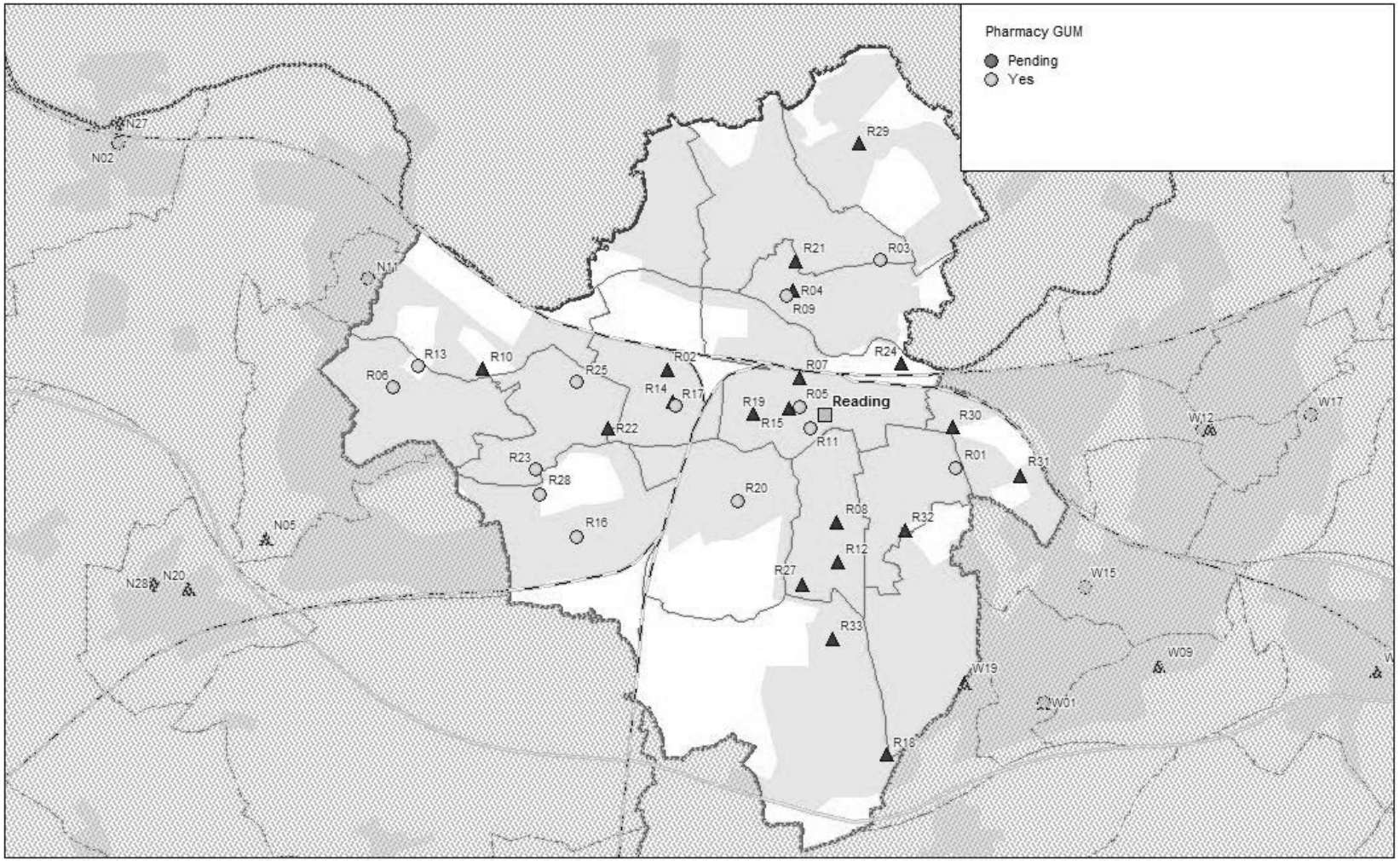
Commissioning priority
Improve patient satisfaction in mental health services from 25% to 50%

Increase Patient & Public Engagement across our diverse population

"What will we Do?" in 13/14		"How will it look?" in 15/16
Planned Care	Increase the use of Shared Decision Aids for Hip and Knee replacement	Improved Patient Reported Outcome measures for knees
	Review the Musculoskeletal (MSK) pathway	A Multidisciplinary Team (MDT) community pain clinic part of MSK pathway
	Reduce routine follow-ups for Breast cancer with rapid access appointments to replace them	Improved patient experience .Royal Berkshire Hospital benchmarking Ratio for new: follow-ups improved
Urgent Care	Successfully implement NHS111	An Integrated Urgent care system
	7 day admission avoidance service	Reduction in avoidable emergency admissions
	Reissue Paediatric Guidelines for GPs with training	Reduce numbers of children who inappropriately attend A and E
	Review of minor injury service provision	Minor injury service that meets the health needs of the population
Long Term Condition (LTC)	Increased Patient education to self-care and access to information	Patients and their carers are well informed and know where to access information and support
	Care-Co-ordinators to identify highest risk patients through the ACG tool and organise MDT meetings	Less people with Long term conditions requiring an emergency hospital admission associated with disease progression
	Training for Primary care to promote Care-planning	Patients' "own " their Care plan with their results available electronically
	Increased capacity in Memory clinics for diagnosis of Dementia followed by support and treatment Organise	Enhanced quality of life for people with dementia and their carers
	Conference for patients on "Dementia & Elderly Care "	Functioning integrated " Frail Elderly Pathway"
Joint Commissioning	Increased access to Talking Therapies and reduction in waiting times for Talking Therapies	Over 15% of people with anxiety or depression receive Talking Therapies
	Development of further services for Personality Disorder	Improved use of mental health and GP services for patients with Personality Disorder
		Mental Health services measured on patient outcomes
		Integrated health and social care with a single point of access.

Appendix 4: Enhanced Services in Reading Borough

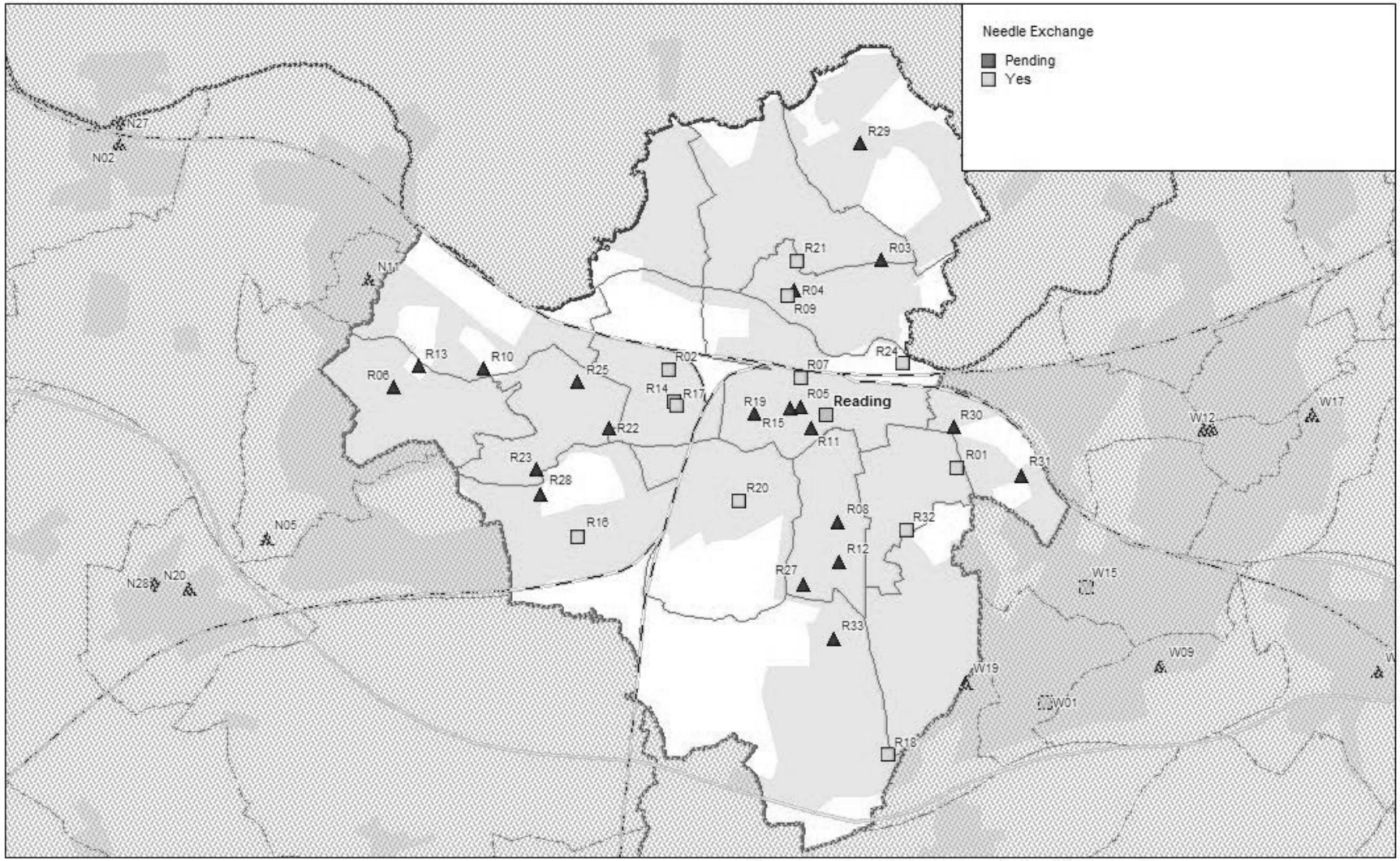
Figure 1: Map of Pharmacies in Reading Borough who provide GUM Services



Berks_PNA_ES_Aug14_r1.wor 26/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2014 All rights reserved

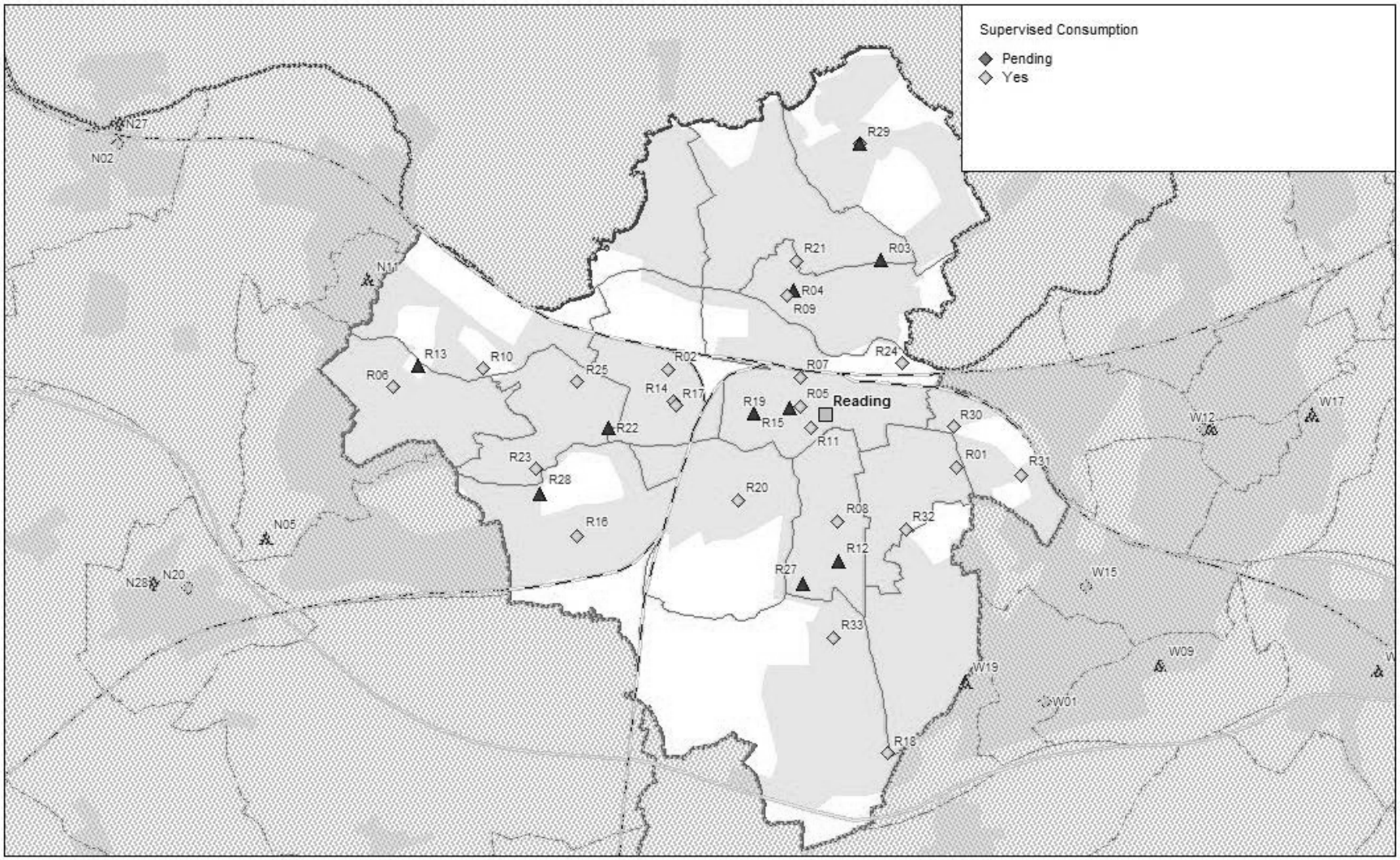
Figure 2: Map of Pharmacies in Reading Borough who provide Needle Exchange Services



Berks_PNA_ES_Aug14_r1.wor 26/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2014 All rights reserved

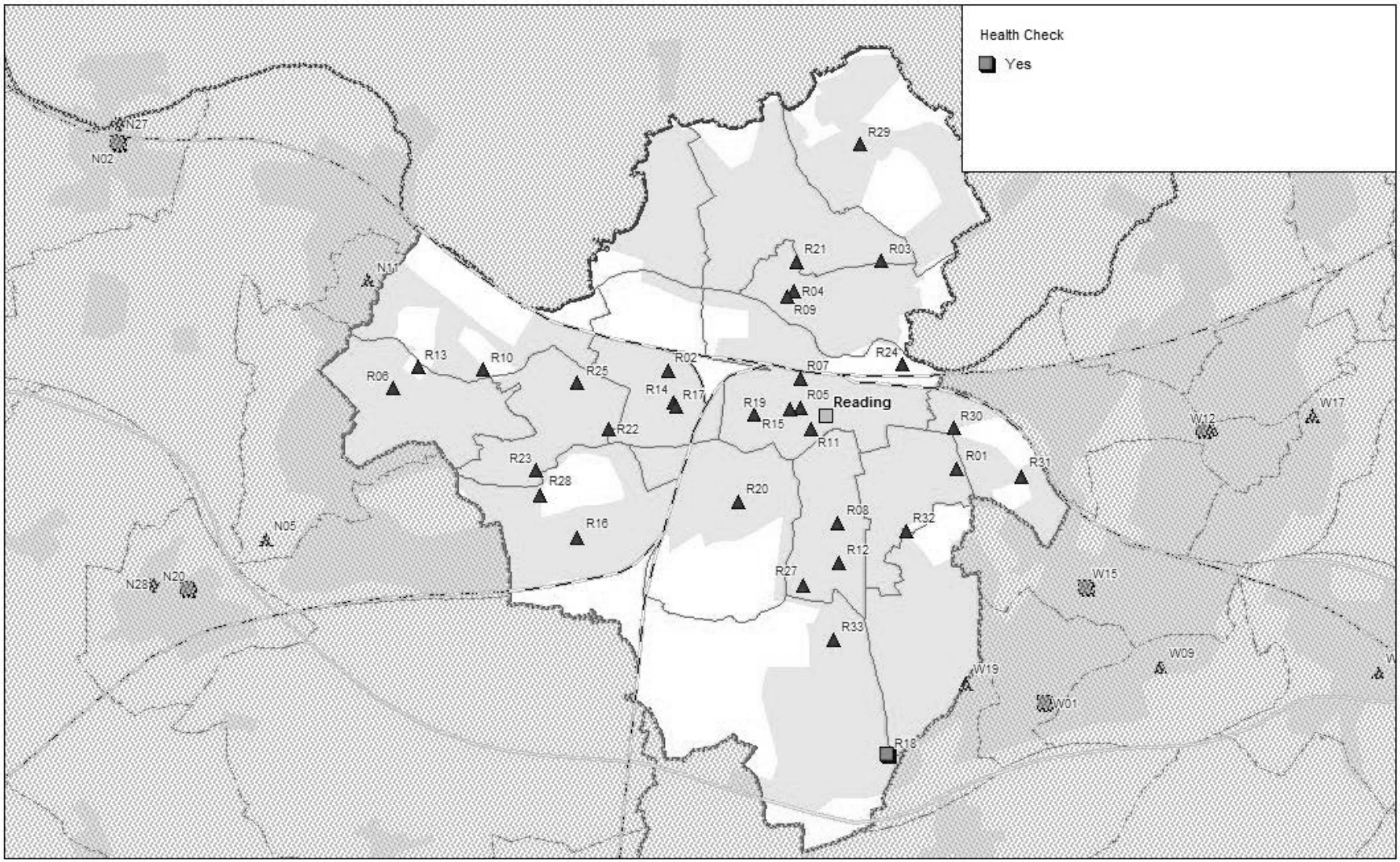
Figure 3: Map of Pharmacies in Reading Borough who provide Supervised Consumption Services



Berks_PNA_ES_Aug14_r1.wor 26/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2014 All rights reserved

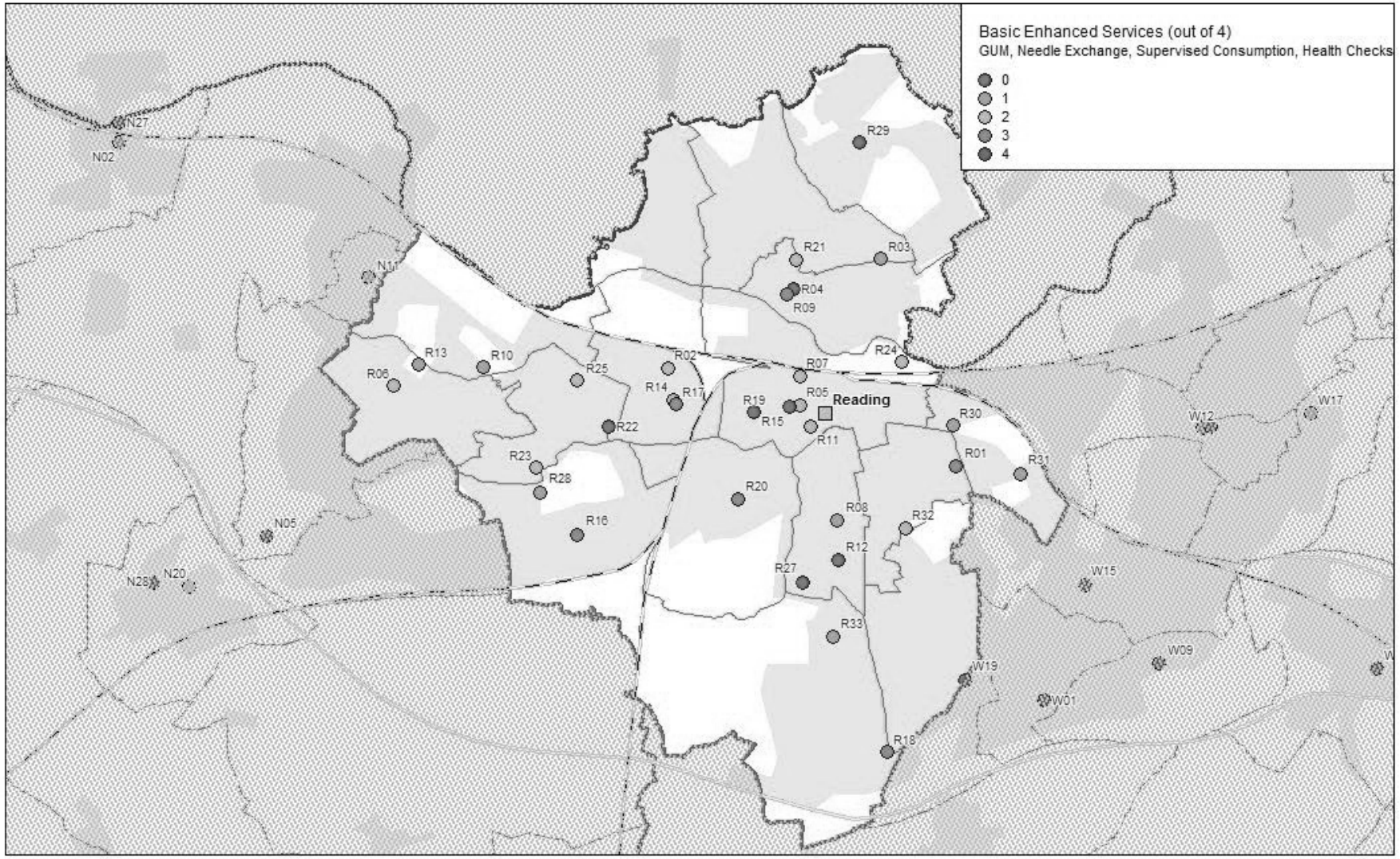
Figure 4: Map of Pharmacies in Reading Borough who provide the NHS Health Check Programme



Berks_PNA_ES_Aug14_r1.wor 26/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2014 All rights reserved

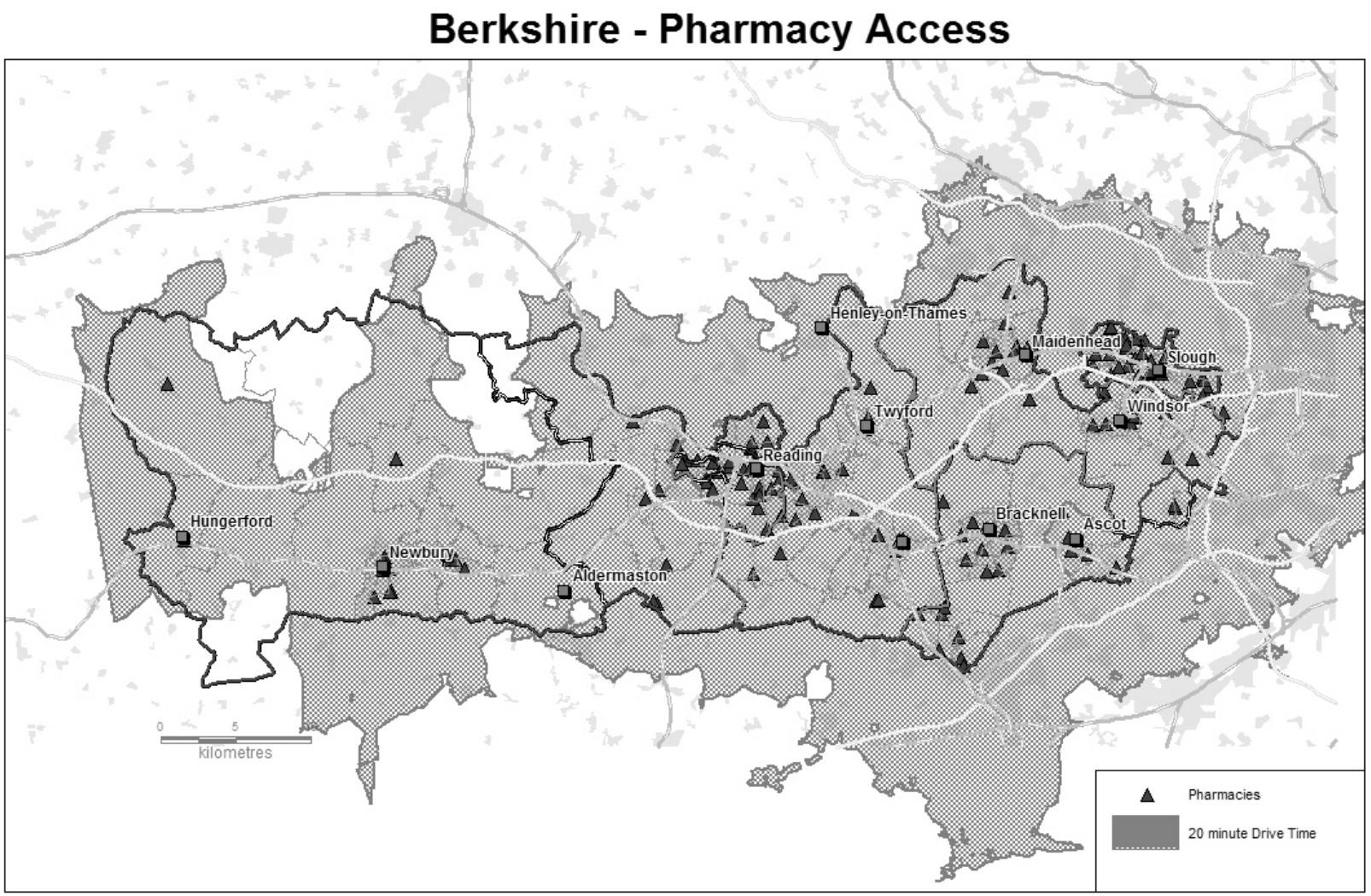
Figure 5: Map of Pharmacies in Reading Borough to show how many of the Basic Enhanced Services are provided



Berks_PNA_ES_Aug14_r1.wor 26/08/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2014 All rights reserved

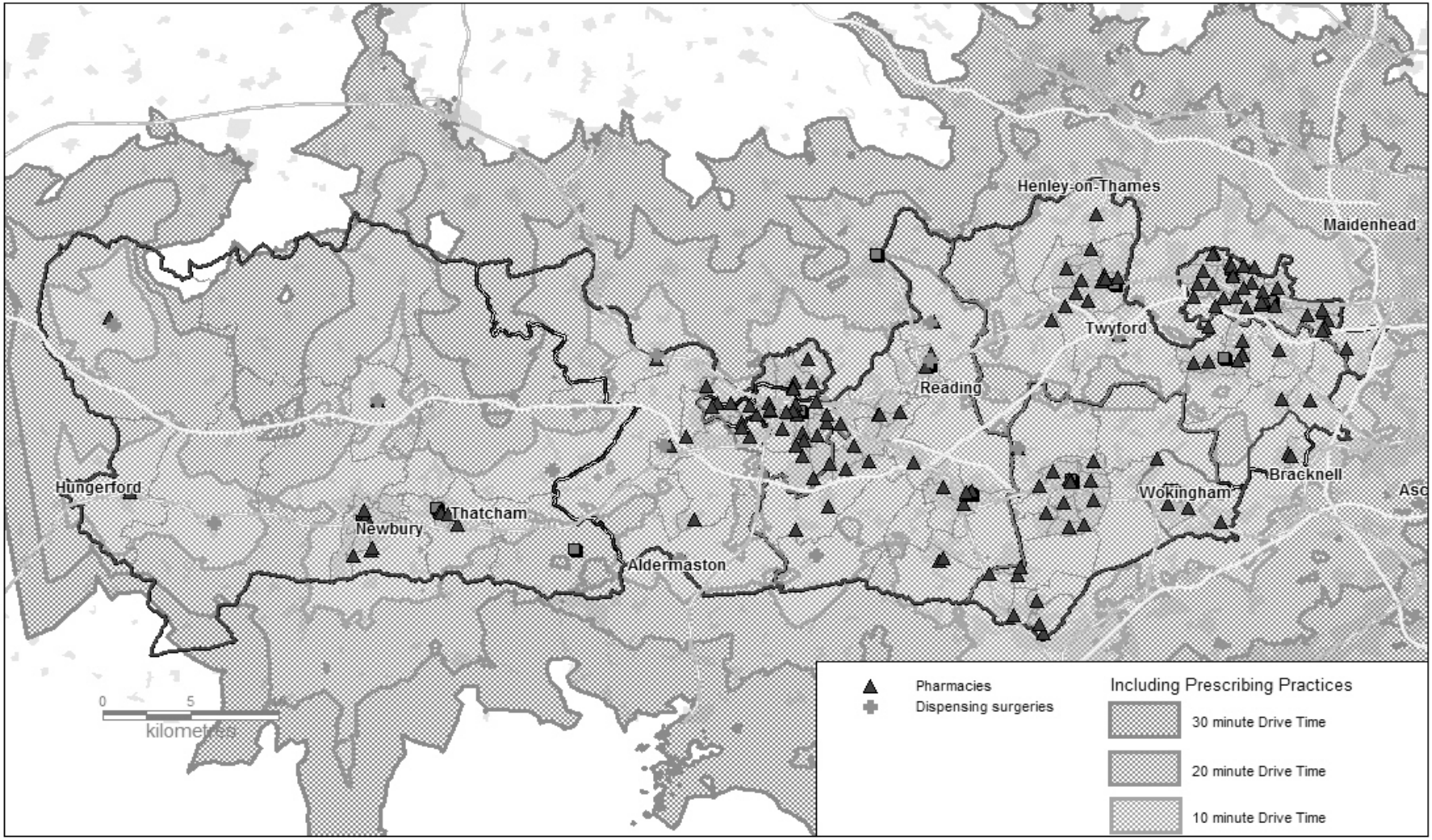
Appendix 5 – Reading



Berks_PNA_Apr14_v1.wor 15/05/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

Berkshire - Pharmacy Access



Berks_PNA_Aug14_DT_v2.wor 17/12/2014 Sid Beauchant BHFT

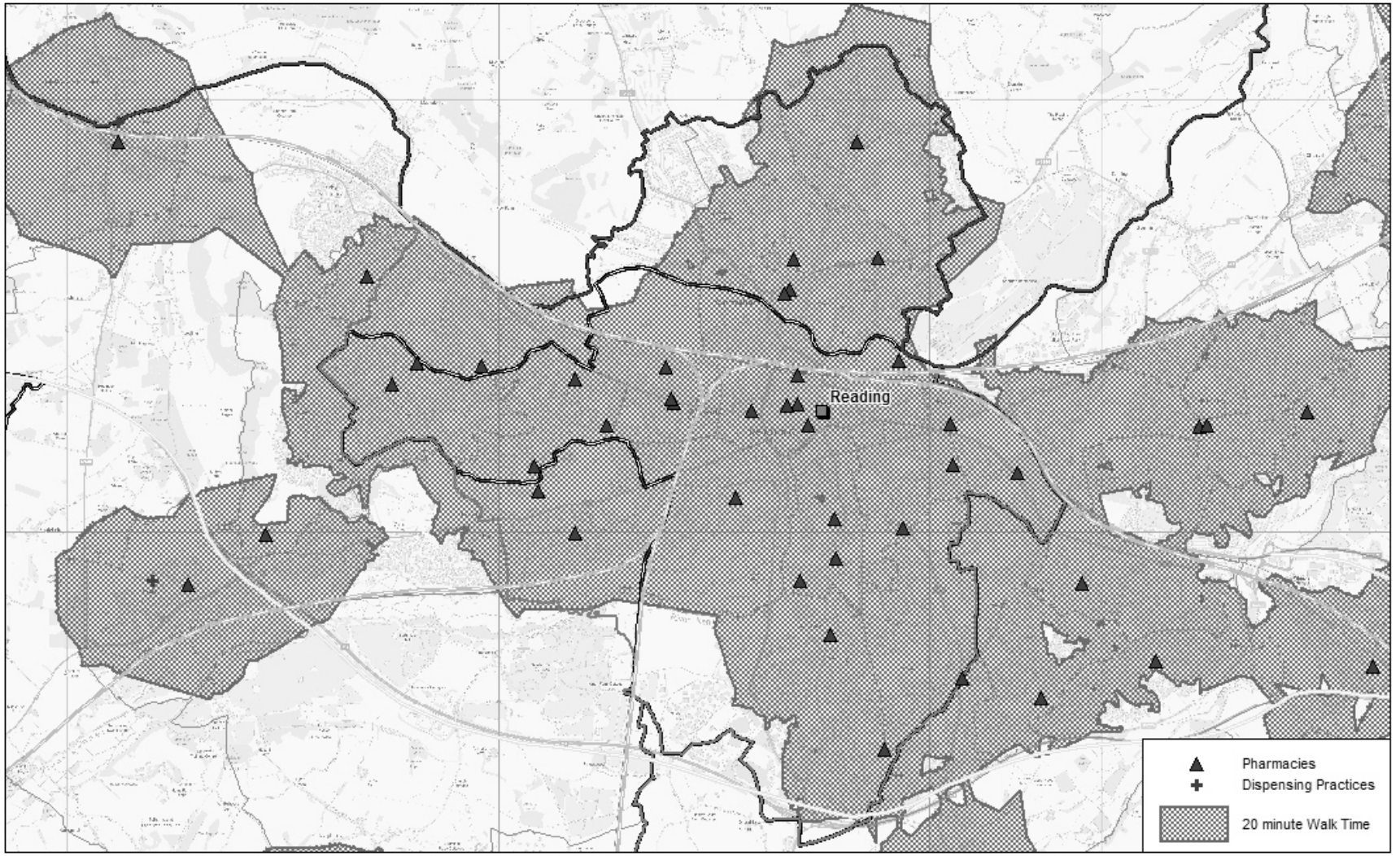
Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

Opening Times

CODE	ADDRESS	POSTCODE	TOWN	TRADING NAME	OPENING HOURS - Saturday	OPENING HOURS - Sunday
FGD71	71 Basingstoke Road	RG2 0ER	Reading	Basingstoke Pharmacy Limited	9:00-14:00	Closed
FT293	Honey End Lane	RG30 4EL	Reading	Asda Stores Ltd	7:00-22:00	10:00-16:00
FDT21	47-48 Broad Street	RG1 2AE	Reading	Boots the Chemists	8:00-18:00	11:00-17:00
FE816	Unit 7, Brunel Arcade	RG1 1LT	Reading	Boots the Chemists	7:00-19:00	Closed
FFY65	Unit 5 Upper Ground Level	RG1 2AH	Reading	Boots the Chemists	9:00-19:00	11:00-17:00
FMV40	2 Lundy Lane	RG30 2RR	Reading	Fittleworth Medical Ltd	Closed	Closed
FQP38	Oxford Road Pharmacy	RG30 1AD	Reading	Oxford Road Pharmacy	8:00-23:59	8:00-20:00
FEK05	Milman Road Health Centre	RG2 0AY	Reading	Lloydspharmacy	Closed	Closed
FGW06	266-268 Oxford Road	RG30 1AD	Reading	Lloydspharmacy	9:00-13:00; 14:00-17:30	Closed
FK294	351-353 Oxford Road	RG30 1AY	Reading	Lloydspharmacy	9:00-14:00	Closed
FTK19	195 London Road	RG1 3NY	Reading	Lloydspharmacy	9:00-13:00	Closed
FVH81	105 Wokingham Road	RG6 1LN	Reading	Lloydspharmacy	9:00-13:00	Closed
FWT36	68 Christchurch Road	RG2 7AZ	Reading	Lloydspharmacy	8:30-13:00; 14:00-17:00	Closed
FXQ15	277 Basingstoke Road	RG2 0JA	Reading	Lloydspharmacy	9:00-14:00	Closed
FA288	85-87 Erleigh Road	RG1 5NW	Reading	Erleigh Road Pharmacy	9:00-17:00	Closed
FLG15	534 Northumberland Avenue	RG2 8NY	Reading	Whitley Wood Pharmacy	9:00-17:30	Closed
FQD26	2 Grovelands Road	RG30 2NY	Reading	Grovelands Pharmacy	9:00-13:00	Closed
FRF51	Manichem Ltd	RG2 0NH	Reading	Manichem Online	Closed	Closed
FLR49	60 Wensley Road	RG1 6DJ	Reading	Newdays Pharmacy	9:00-13:00	Closed
FRP45	231 Shinfield Road	RG2 8HD	Reading	Vantage Chemist	9:00-17:00	Closed
FLK26	104A Oxford Road	RG1 7LL	Reading	Saood Pharmacy	Closed	Closed
FHF90	36 Coronation Square	RG30 3QN	Reading	Southcote Pharmacy	9:00-13:00	Closed
FGX83	55-59 Broad Street	RG1 2AF	Reading	Superdrug Pharmacy	9:00-13:30; 14:00-17:30	Closed
FA368	Tesco Extra	RG30 1AH	Reading	Tesco Instore Pharmacy	8:00-21:00	10:00-16:00

FPG88	Tesco Extra	RG1 8DF	Reading	Tesco Instore Pharmacy	6:30-22:00	10:00-16:00
FEX35	45 St Martins Precinct Church Street	RG4 8BA	Caversham	Boots the Chemists	9:00-17:30	Closed
FMJ89	59A Hemdean Road	RG4 7SS	Caversham	Rowlands Pharmacy	Closed	Closed
FC305	30 Church Street	RG4 8AU	Caversham	Day Lewis Rankin Pharmacy	9:00-13:00	Closed
FA597	122 Henley Road	RG4 6DH	Caversham	Markand Pharmacy	9:00-13:00; 14:00-18:00	Closed
FT878	5 Cavendish Road	RG4 8XW	Caversham	Lloydspharmacy	9:00-17:00	Closed
FNR10	32 Meadway Precinct	RG30 4AA	Tilehurst	Boots the Chemists	9:00-14:00; 15:00-17:30	Closed
FF110	2a Tylers Place	RG30 6BW	Tilehurst	Lloydspharmacy	9:00-13:00	Closed
FDX71	88-90 School Road	RG31 5AW	Tilehurst	Triangle Pharmacy	9:00-17:30	Closed
FGF17	7 School Road	RG31 5AR	Tilehurst	Tilehurst Pharmacy	9:00-13:00	Closed

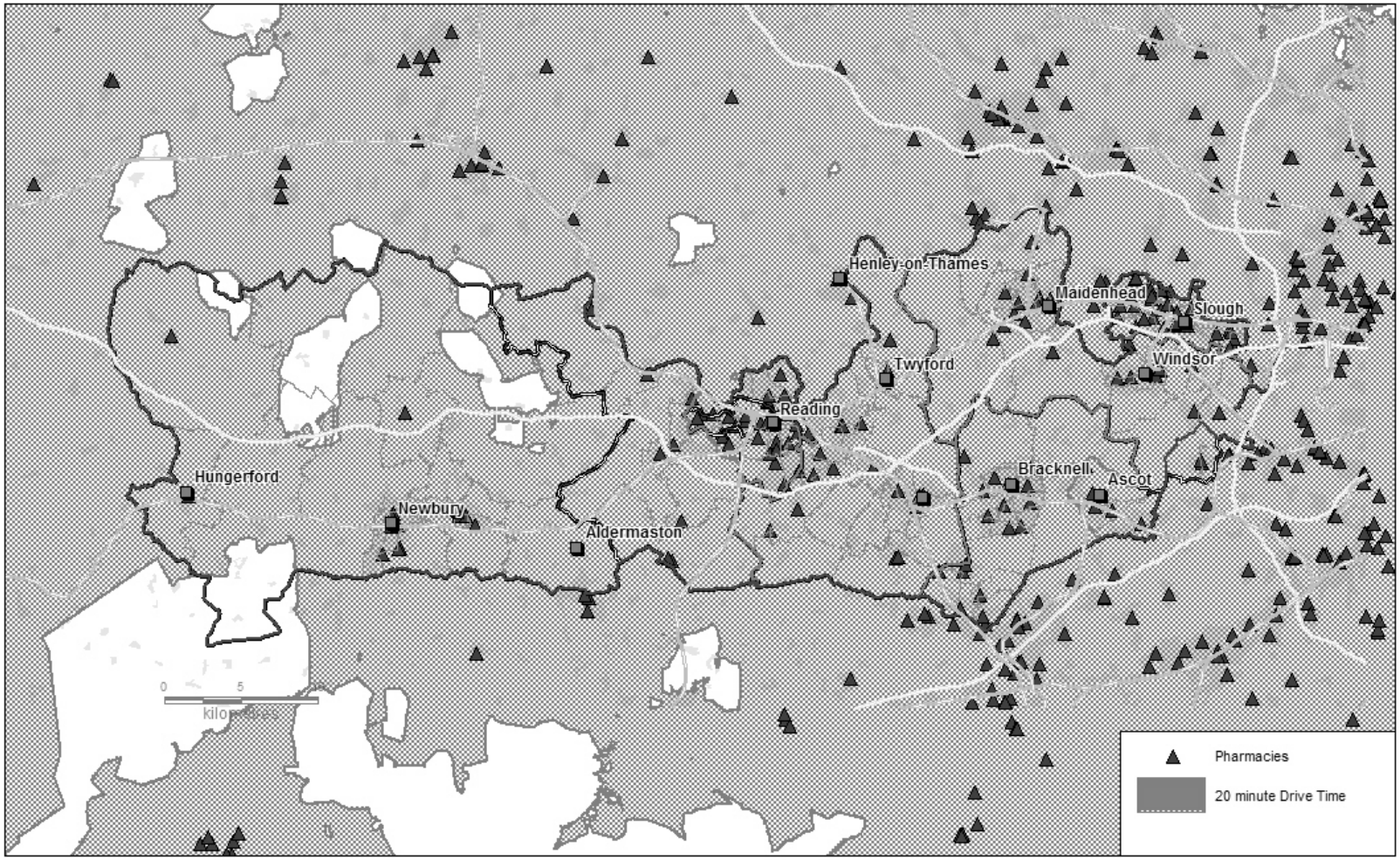
Berkshire - Pharmacy Access



Berks_PNA_Jul14_v1.wor 14/07/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

Berkshire - Pharmacy Access



Berks_PNA_Apr14_v1.wor 15/05/2014 Sid Beauchant BHFT

Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKWFG1110),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
© Crown Copyright - 2014 All rights reserved

Map showing pharmacies and dispensing doctors outside Reading which shows improved access

Pharmacy Users Survey

Public Health Berkshire

The local Pharmaceutical needs assessment is a survey that Public Health within local government is undertaking to make sure that pharmacies across Berkshire are providing the right services, in the right locations, to support residents.

As part of this confidential survey we want to get your views on services, so your answers are important to us. The survey is confidential and will be used to plan our services.

Please complete this survey and place it into the collection box

1 Do you use?

- Community pharmacy ☐
- A dispensing appliance supplier? (someone who supplies appliances such as incontinence and stoma products) ☐
- An internet pharmacy? (a service where medicines are ordered on-line and delivered by post) ☐

2 How often do you use a pharmacy?

- More than once a month ☐
- Once a mont ☐
- 3–11 times a yea ☐
- Less than 3 times a year ☐

3 Which of the following services do you currently use at a pharmacy?

- Sunday opening ☐
- Late night opening (after 7pm) ☐
- Early morning opening (before 9am) ☐
- Prescription dispensing ☐
- Buying over the counter medicines ☐
- Buying travel medicines (e.g. anti-malarials) ☐
- Medicines advice and reviews ☐
- Delivery of medicines to my home ☐
- Collection of prescription from my surgery ☐
- Long-term condition advice (e.g. help with your diabetes/asthma) ☐
- Respiratory Services ☐
- Emergency hormonal contraception (morning-after pill) ☐
- Cancer treatment support services ☐
- Substance misuse Service ☐
- Alcohol support services ☐
- Stop smoking service ☐
- Health tests, e.g. cholesterol, blood pressure ☐
- Healthy weight advice ☐
- 'Flu vaccination ☐
- Diabetes screening - Private ☐ NHS ☐
- Blood pressure check - Private ☐ NHS ☐

4 Which of the following services would you use at a pharmacy, if available?

- Sunday opening ☐
- Late night opening (after 7pm) ☐
- Early morning opening (before 9am) ☐
- Prescription dispensing ☐
- Buying over the counter medicines ☐
- Buying travel medicines (e.g. anti-malarials) ☐
- Minor Ailment Scheme (access to certain subsidised over the counter medicines to avoid a GP visit) ☐
- Electronic prescription service ☐
- Medicines advice and reviews ☐
- Delivery of medicines to my home ☐
- Collection of prescription from my surgery ☐
- Long-term condition advice (e.g. help with your diabetes/asthma) ☐
- Respiratory services ☐
- Emergency hormonal contraception (morning-after pill) ☐
- Cancer treatment support services ☐
- Substance misuse service ☐
- Alcohol support services ☐
- Stop smoking service ☐
- Health tests, e.g. cholesterol, blood pressure ☐
- Healthy weight advice ☐
- 'Flu vaccination ☐
- Diabetes screening ☐
- Blood pressure check ☐
- Other (please specify) ☐

continued...

5 Are you able to get to a pharmacy of your choice?

Yes ☐ No ☐

6 Do you use one pharmacy regularly?

Yes ☐ No ☐

7 Reason for using your regular pharmacy

Location

- In the supermarket ☐
- In town/shopping area ☐
- Near to my doctors ☐
- Near to home ☐
- Near to work ☐
- Other ☐

Services

- They offer a delivery service ☐
- They offer a collection service ☐
- The staff speak my first language ☐
- The staff are knowledgeable ☐
- The staff are friendly ☐
- Other ☐

8 How do you usually travel to your usual pharmacy?

- Walk ☐
- Car (passenger) ☐
- Car (driver) ☐
- Taxi ☐
- Bus ☐
- Bicycle ☐

9 How long does it take you to travel to your pharmacy?

- Less than 15 mins ☐
- 15 – 30 mins ☐
- 30-60 mins ☐
- Over an hour ☐

10 How important are the following pharmacy services?

	Very Important	Important	Unimportant
Home delivery of your medication	☐	☐	☐
Prescription collection from your surgery	☐	☐	☐
The pharmacy having a wide range of things I need	☐	☐	☐
The pharmacist taking time to listen/provide advice	☐	☐	☐
Private areas to speak to the pharmacist	☐	☐	☐
Shorter waiting times	☐	☐	☐
Knowledgeable staff	☐	☐	☐
Location	☐	☐	☐
Late opening times (after 7pm)	☐	☐	☐

11 How satisfied were you with the following services at your regular pharmacy?

	Very Satisfied	Satisfied	Unsatisfied
The pharmacy having the things I need	☐	☐	☐
The pharmacist taking time to talk to me	☐	☐	☐
Private consultation areas	☐	☐	☐
Waiting times	☐	☐	☐
Staff attitude	☐	☐	☐
Knowledgeable staff	☐	☐	☐
Location	☐	☐	☐

continued...

12 About You

My age is:

- Prefer not to say ☐
- 65-74 ☐
- 55-64 ☐
- 45-54 ☐
- 70+ ☐
- 35-44 ☐
- 25-34 ☐
- 18-24 ☐

I would describe my sexuality as:

- Prefer not to say ☐
- Heterosexual (Straight) ☐
- Lesbian ☐
- Gay ☐
- Bisexual ☐
- Other ☐

Please tell us your faith or religion:

- Prefer not to say ☐
- Christian ☐
- Muslim ☐
- Hindu ☐
- No faith or religion ☐
- Other ☐

I would describe my ethnic origin as:

- British White ☐
- White Other ☐
- Irish ☐
- Pakistani ☐
- Asian ☐
- Indian ☐
- Bangladeshi ☐
- Black Caribbean ☐
- Black African ☐
- Gypsy/Irish Traveller ☐
- Other ☐

Do you consider yourself to be disabled?

Yes ☐ No ☐

What is your marital status?

- Single ☐
- Married ☐
- Life-partner ☐
- Civil Partnership ☐
- Other ☐
- Prefer not to say ☐

Which of the following best describes your working situation?

- I work as volunteer ☐
- I am working part-time ☐
- I am working full-time ☐
- I am retired ☐
- I am not working ☐
- Prefer not to say ☐

Thank you!

PharmOutcomes - Live System

Exit

PharmOutcomes® Delivering Evidence

Home Services Assessments Reports Claims Admin Gallery Help

Service Design

- Go to Service Design page
- Edit Service Accreditations

Provision Reports Preview

Basic Provision Record (Sample)

Service Support

Pharmacy Questionnaire-PNA
Please complete this questionnaire **ONCE** only to report the facilities and services offered by your pharmacy.

For technical support on the use of this data capture set please contact Pinnacle Support via the "Help" tab

PNA Questionnaire (Preview)

Date of completion 01-Sep-2014

Trading Name

Post Code

Is this a Distance Selling Pharmacy? ○ Yes ○ No
(i.e. it cannot provide Essential Services to persons present at the pharmacy)

Pharmacy email address
If no email write no email

Pharmacy telephone

Pharmacy fax

Pharmacy website address
If no website write no website

Can we store the above information and use this to contact you?

Consent to store ○ Yes ○ No

Core hours of opening

Please complete your core hours of opening.
Enter closed if closed

Monday Open		**Monday Close**	
		Monday Lunchtime (from - to)	
Tuesday Open		**Tuesday Close**	
		Tuesday Lunchtime (from - to)	
Wednesday Open		**Wednesday Close**	
		Wednesday Lunchtime (from - to)	
Thursday Open		**Thursday Close**	
		Thursday Lunchtime (from - to)	
Friday Open		**Friday Close**	
		Friday Lunchtime (from - to)	
Saturday Open		**Saturday Close**	
		Saturday Lunchtime (from - to)	

Sunday Open | Sunday Close

Sunday Lunchtime (from - to)

Total hours of opening (Core + Supplementary)

Please complete your total hours of opening

Monday Open | Monday Close

Monday Lunchtime (from - to)

Tuesday Open | Tuesday Close

Tuesday Lunchtime (from - to)

Wednesday Open | Wednesday Close

Wednesday Lunchtime (from - to)

Thursday Open | Thursday Close

Thursday Lunchtime (from - to)

Friday Open | Friday Close

Friday Lunchtime (from - to)

Saturday Open | Saturday Close

Saturday Lunchtime (from - to)

Sunday Open | Sunday Close

Sunday Lunchtime (from - to)

Consultation Facilities

Consultation areas should meet the standard set out in the contractual framework to offer advanced services

Is there a consultation area?

- ○ Available (including wheelchair access) on the premises
- ○ Available (without wheelchair access) on premises
- ○ Planned within next 12 months
- ○ No consultation room available
- ○ Other

If Other please specify

Where there is a consultation area

Is this enclosed? ○ Yes ○ No ○ N/A

N/A if no consultation room

Off-site arrangements

- ○ Off-site consultation room approved by NHS
- ○ Willing to undertake consultations in patients home/ other suitable site
- ○ None apply
- ○ Other

If Other please specify

Hand washing and toilet facilities

What facilities are available to patients during consultations?

Facilities available

- ☐ Handwashing in consultation area
- ☐ Hand washing facilities close to consultation area
- ☐ Have access to toilet facilities
- ☐ None

Tick all that apply

Information Technology

Is the pharmacy EPS* R2 enabled?

- ○ Yes, EPS R2 enabled
- ○ Planning to become EPS R2 enabled in the next 12 months
- ○ No current plans to provide EPS R2

EPS R2: Electronic Prescription Service Release 2

Information is often distributed to pharmacies as email attachments or via websites. Please indicate whether you are able to use the following common file formats in your pharmacy:

File format types

- ☐ Microsoft word
- ☐ Microsoft Excel
- ☐ Microsoft Access
- ☐ PDF
- ☐ Unable to open or view any file formats

Please tick all that apply

Essential Services (appliances)

In this section, please give details of the essential services your pharmacy provides.

Does the pharmacy dispense appliances?

- ○ Yes - All types, or
- ○ Yes, excluding stoma appliances, or
- ○ Yes, excluding incontinence appliances, or
- ○ Yes, excluding stoma and incontinence appliances, or
- ○ Yes, just dressings, or
- ○ None
- ○ Other

If Other please specify

Advanced Services

Please give details of the Advanced Services provided by your pharmacy.
Please tick the box that applies for each service.

Yes - Currently providing
Soon - Intending to begin within the next 12 months
No - Not intending to provide

Medicines Use Review service	☐ Yes	☐ Soon	☐ No
New Medicine Service	☐ Yes	☐ Soon	☐ No
Appliance Use Review service	☐ Yes	☐ Soon	☐ No
Stoma Appliance Customisation service	☐ Yes	☐ Soon	☐ No

Commissioned Services

Use this section to record which Local services you currently deliver or would like to deliver at your pharmacy. These can be Enhanced Services, commissioned by the NHS England Area Team, Public Health Services commissioned by a Local Authority or CCG services.
Please tick the box that applies for each service.

CP - Currently Providing NHS funded service
WA - Willing and able to provide if commissioned
WT - Willing to provide if commissioned but would need training
WF - Willing to provide if commissioned but require facilities adjustment
PP - Currently providing private service
If you are not willing or able to provide please leave blank.

Anticoagulant Monitoring Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Anti-viral Distribution Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Care Home Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Chlamydia Treatment Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Contraception Service (not an EHC service)	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP

Local Authority Commissioned Services
List services already commissioned in your locality here

Disease Specific Medicines Management Service:

Allergies	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Alzheimer's/dementia	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Asthma	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
CHD	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Depression	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Diabetes type I	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP

Diabetes type II ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Epilepsy ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Heart Failure ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hypertension ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Parkinson's disease ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other (please state - including funding source)

End of Disease specific Medicines Management Service options.

Area Team Services
List your Area Team commissioned services here

Emergency Hormonal Contraception Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Gluten Free Food Supply Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(i.e. not supply on FP10)

Home Delivery Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(not appliances)

Independent Prescribing Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Therapeutic areas covered (if providing)

Language Access Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Note: This is not the NMS or MUR service.

Medication Review Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Medicines Assessment and Compliance Support Service:

Medicines Management Support Service: ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
i.e. the EL23 service (previously the Vulnerable Elderly / Adults Service)

DomMAR Carer's Charts ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Medicines Assessment and Compliance Support options.

Minor Ailments Scheme ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

MUR Plus/Medicines Optimisation Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Therapeutic areas covered (if providing)

Needle and Syringe Exchange Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Obesity management (adults and children) ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

On Demand Availability of Specialist Drugs Service:

Directly Observed Therapy ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

If yes state which medicines

Out of hours services ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Palliative Care scheme ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of On Demand Availability of Specialist Drugs Service options

Patient group directions

Many Local Services involve the supply of a POM using a PGD. please list those provided by the pharmacy in the text box below but indicate who commissions the service by ticking the boxes below and annotating each service name with the key:

AT=Area Team
LA=Local Authority
CCG=Clinical Commissioning Group
Pr=Offers a Private Service

Patient Group Direction Service ☐ AT ☐ LA ☐ CCG ☐ Pr
Not including EHC (see separate question)

Please list the names of the medicines available if providing PGD services

Medicines available

Phlebotomy Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Prescriber Support Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Schools Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Screening Service:

Alcohol ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Chlamydia ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Cholesterol ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Diabetes ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Gonorrhoea ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

H. pylori ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HbA1C ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hepatitis ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HIV ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other Screening (please state - including funding source)

End of screening service options

Seasonal Influenza Vaccination Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other vaccinations

Childhood vaccinations ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HPV ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hepatitis B ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(at risk workers or patients)

Travel vaccines ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other (please state - including funding source)

End of Other vaccinations options

Sharps Disposal Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Stop Smoking Service:

NRT Voucher Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Smoking Cessation Counselling Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Stop Smoking Service options

Supervised Administration ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Of methadone,buprenorphine etc.

End of Supervised Administration Service options

Supplementary prescribing ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Which therapy area

Vascular Risk Assessment Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
NHS Healthchecks

Healthy Living Pharmacy

Is this a Healthy Living Pharmacy

- ○ Yes
- ○ Currently working towards HLP status
- ○ No

If Yes, how many Healthy Living Champions do you currently have? ____ Full Time Equivalents

Collection and Delivery services

Does the pharmacy provide any of the following?

Collection of prescriptions from surgeries ○ Yes ○ No

Delivery of dispensed medicines - Free of charge on request ○ Yes ○ No

Delivery of dispensed medicines - Selected patient groups
List criteria

Delivery of dispensed medicines - Selected areas
List areas

Delivery of dispensed medicines - chargeable ○ Yes ○ No

Languages

One potential barrier to accessing services at a pharmacy can be language. To help the local authority better understand any access issues caused by language please answer the following two questions:

What languages other than English are spoken in the pharmacy

What languages other than English are spoken by the community your pharmacy serves

Almost done

If you have anything else you would like to tell us that you think would be useful in the formulation of the PNA, please include it here:

Other

Please tell us who has completed this form in case we need to contact you.

Contact name

Contact telephone
For person completing the form, if different to pharmacy number given above

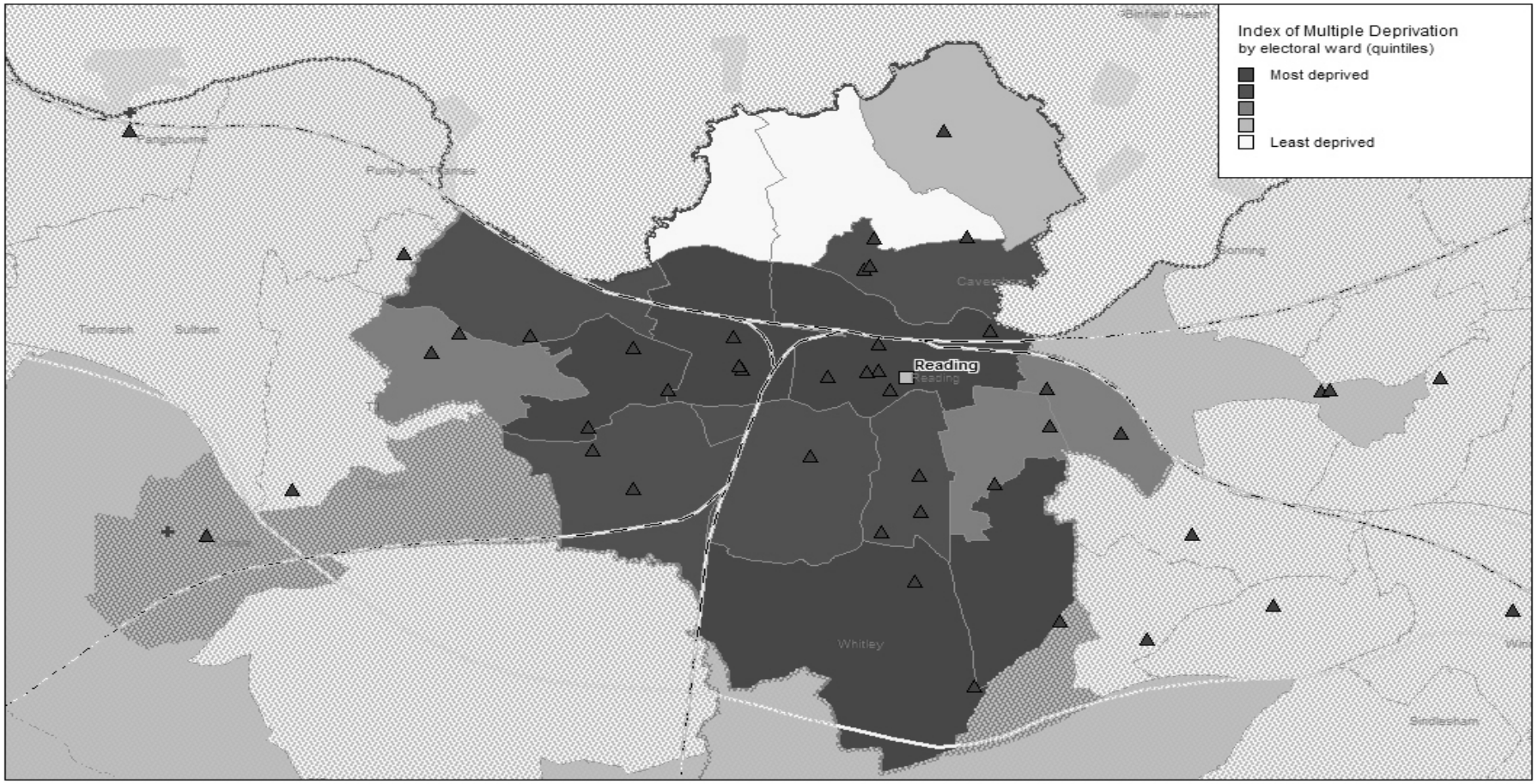
Thank you for completing this PNA questionnaire.

Test Values

EULA License Agreement • Cookie Policy • CSS • XHTML • GlobalSign 00650971/195.59.13.75 • 87 in 0.511 seconds
© Copyright 2007-14 Pinnacle Health Partnership LLP - Supporting Community Pharmacy and Partners

Appendix 8: Deprivation Map of Reading Borough

Figure 1: Map of Reading Borough to show the levels of deprivation by ward



Reproduced from OS data by permission of Ordnance Survey,
on behalf of the Controller of Her Majesty's Stationery Office (Licence No. OSKW9912),
NAVTEQ data by permission of NAVTEQ Corporation Licence No. NVMM0611, NVMM0612)
GeoPlan data by permission of Geoplan (Licence No. GPKW9912)
÷ Crown Copyright - 2011 All rights reserved

Source: Index of Multiple Deprivation, Department of Communities and Local Government (2010)