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

14 January 2016

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 22 JANUARY 2016

A meeting of the Health & Wellbeing Board will be held on **Friday 22 January 2016 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

		PAGE NO
1.	**DECLARATIONS OF INTEREST**	-
2.	**MINUTES OF THE HEALTH & WELLBEING BOARD MEETING HELD ON 9 OCTOBER 2015**	1
3.	**QUESTIONS** Consideration of formally submitted questions from members of the public or Councillors under Standing Order 36.	-
4.	**PETITIONS** Consideration of any petitions submitted under Standing Order 36 in relation to matters falling within the Committee's Powers & Duties which have been received by Head of Legal & Democratic Services no later than four clear working days before the meeting.	-

Cont/..

the building.

../Cont

5. WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15 13

A report presenting the 2014/15 annual report of the West of Berkshire Safeguarding Adults Board (SAB).

6. LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014/15 79

A report presenting the 2014/15 annual report of the Reading Local Safeguarding Children Board.

7. UPDATE ON TACKLING FEMALE GENITAL MUTILATION (FGM) 133

A report providing a summary of the work planned and undertaken in relation to tackling Female Genital Mutilation since January 2015.

8. COMMISSIONING INTENTIONS 2016-17 137

A report that summarises the key themes, features and potential areas for alignment across the Health and Social Care Commissioning intentions of Reading Borough Council and the Clinical Commissioning Group.

Berkshire West CCGs Commission Ambitions 142
Adult Social Care Commissioning Intentions 163
Children's Services Commissioning Intentions 177
Public Health Commissioning Intentions – Initial Proposals 185

9. BEKRSHIRE WEST PRIMARY CARE STRATEGY 2015-19 – UPDATE REPORT 197

A report updating the Board on the development of the Berkshire West Primary Care Strategy. Following further engagement with the public, the strategy has now been signed off by the Joint Primary Care Co-Commissioning Committee.

10. URGENT AND EMERGENCY CARE REVIEW – PROGRESS REPORT 240

A report to inform the Board about the Urgent and Emergency Care Review and the action being taken at national and local level in implementing this.

Cont/..

../Cont

11. READING INTEGRATION UPDATE 250

A report providing the Board with an update on integration in Reading. There will be a presentation from Mark Sellman regarding the status of one particular project that spans the West of Berkshire, namely Connected Care. The report also highlights the requirements for the 2016-17 Better Care Fund.

12. READING HEALTH & WELLBEING STRATEGY – NEXT STEPS 257

A report providing a headline summary on proposals for the next steps to produce the next Reading Health and Wellbeing Strategy. The report builds on progress to date from the current strategy and follows the action plan summary report presented at the October 2015 Board meeting.

13. ADULT WELLBEING POSITION STATEMENT 308

A report presenting Reading's local approach to prevention, as stipulated in the Care Act (2014) regulations, in the form of a draft Adult Wellbeing Position Statement. The proposal is that the Council's approach to promoting adult wellbeing is developed through public consultation on the draft Position Statement, to include the addition of an Action Plan based on priorities agreed with stakeholders.

14. MENTAL HEALTH CHALLENGE PROPOSAL 314

A report informing the Board of the Mental Health Challenge, a national initiative which was set up by a group of key mental health organisations. It is funded by the Department of Health, Public Health England and NHS England, through the 'Voluntary Sector Strategic Partnership Programme'. The initiative is asking all local authorities to undertake this important function through the Mental Health Champion role.

Cont/..

../Cont

15. READING DRUG & ALCOHOL MISUSE ASSESSMENT 317

A report setting out the drug and alcohol misuse needs assessment, which quantifies the extent of misuse of alcohol and drugs in Reading; the effect this is likely to have on people and thus on health and social care and other services, and on prevention and early interventions and, the nature of current services and treatment demand for substance misuse; and what might be done to better meet identified needs. The needs assessment is a precursor to a revised strategy for drug and alcohol services in Reading which will be developed in the near future.

16. INFORMATION ITEM - SMOKING CESSATION SERVICE RE-PROCUREMENT 402

A report to confirm the contract award for smoking cessation service contract to Solutions 4 Health.

17. INFORMATION ITEM – CHILD HEALTHY LIFESTYLE AND WEIGHT MANAGEMENT CONTRACT AWARD 403

A report to confirm the contract award for the child healthy lifestyle and weight management programme to Solutions 4 Health.

18. REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARD 404

A report on the current arrangements and suggested issues for consideration by the Board.

19. DATE OF NEXT MEETING -

Friday 15 April 2016 at 2pm

READING HEALTH & WELLBEING BOARD MINUTES – 9 OCTOBER 2015

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Andy Ciecerski	Chair, North & West Reading Clinical Commissioning Group (CCG)
Sylvia Chew	Director of Children, Education & Early Help Services, RBC
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Lovelock	Leader of the Council, RBC
Ishak Nadeem	Chair, South Reading CCG
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Andrew Burnett	Interim Consultant in Public Health, RBC
Barbara Barrie	End of Life Lead for Thames Valley Strategic Clinical Network and Berkshire West CCGs
Andy Fitton	Acting Head of Early Help and Family Intervention, RBC
Jill Marston	Senior Policy Officer, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Sally Murray	Head of Children's Commissioning Support, Berkshire West CCGs
Melanie O'Rourke	Head of Adult Social Care, RBC
Caroline Penfold	Disability Service Manager (Adults & Children), RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Capt Paul Woolman	Regimental Operations Support Officer, 7 Rifles

Apologies:

Eleanor Mitchell	Operations Director, South Reading CCG
Jean O'Callaghan	Chief Executive, Royal Berkshire NHS Foundation Trust
Ian Wardle	Managing Director, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

1. MINUTES & MATTERS ARISING

The Minutes of the meeting held on 17 July 2015 were confirmed as a correct record and signed by the Chair.

Further to Minute 2 (a) of the meeting on 17 July 2015, it was reported that the full year data on Abdominal Aortic Aneurysm (AAA) screening in South Reading which had been expected to be ready in August 2015 was not yet available but was nearly ready.

Resolved - That the position be noted.

2. QUESTION IN ACCORDANCE WITH STANDING ORDER 36

The following question was asked by Sarah Morland in accordance with Standing Order 36:

Health and Wellbeing Strategy Development – Voluntary Sector Involvement

"Reading's current Health and Wellbeing Strategy covers the period 2013 - 2016. At the first Wellbeing Forum for the voluntary sector in June this year, Cllr Hoskin confirmed the importance of involving the sector in the development of the new strategy. Voluntary sector organisations can make a valuable contribution to the new strategy by representing the needs of their service users and as providers of services that support health and wellbeing.

Please can you give details of the Board's plans to involve voluntary sector organisations in the development of the new Health and Wellbeing Strategy, including the timescales and process for engagement and consultation?"

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

"I can confirm again my belief that the voluntary and community sector play a critical role in delivering improved health and wellbeing for the residents of our town. It therefore stands to reason that for our next Health and Wellbeing Strategy to be successful it is vital that we get a strong input from those groups in developing and shaping that strategy. This is more vital than ever in the face of massive government cuts to Reading Borough Council and the NHS facing substantial pressures.

The next Health and Wellbeing Strategy will be informed by a full Joint Strategic Needs Assessment which we expect to be completed for the March Health and Wellbeing Board. We will be developing a plan and a process for a new Health and Wellbeing Strategy and these will include details of how we will involve and consult all stakeholders including the voluntary sector in the next few months. "

3. END OF LIFE CARE

Melanie O'Rourke submitted a report on End of Life Care and Dr Barbara Barrie gave a presentation on the role of Health and Wellbeing Boards in Palliative and End of Life Care. Copies of the presentation slides were appended to the report.

The report summarised work around End of Life Care nationally, giving details of the "National Palliative and End of Life Care: A national framework for local action 2015-2020", which had been launched in September 2015 and set out the following six 'ambitions' – principles for how care for those nearing death should be delivered at a local level:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

The report stated that Reading's Re-ablement and Intermediate Care teams provided high quality End of Life Care, which was often not included in re-ablement services. This provided a good basis on which the whole health and social care system could support high quality End of Life Care. At a local level, an infrastructure was in place to improve how End of Life Care was delivered, led by Dr Barrie. The report stated that the presentation would give key facts and information about End of Life Care, to

aid discussion on how the Reading locality could further develop care and support for those at the end of life.

The report proposed the formation of a Reading Locality Steering Group to do a stocktake on the current local End of Life Services and how this area of work was communicated, map the local offer within nationally-recognised frameworks, identify areas of development and bring an action plan to a future Health and Wellbeing Board. It proposed that the membership should include participants from Clinical Commissioning Groups, the Local Authority, Berkshire Healthcare Foundation Trust, carers and the voluntary sector. The report noted that, although many references to End of Life Care were centred around older people, people of all ages (from birth) would be included in the scope of the work.

Dr Barrie gave a presentation on key facts and information about End of Life Care, and showed a short film which looked at the experience of a local resident whose mother had passed away recently. The presentation covered a number of areas, including:

- A case study on one person's End of Life Care
- The national framework and its six ambitions for Palliative and End of Life Care, as well as other recently published documents on End of Life Care for the Board to consider
- Information about what was considered a good death from a national survey of bereaved people, which included:
    - dying in preferred place
    - having as much information as possible
    - choosing who makes decisions about care
- Various statistics on places of death, past and projected numbers of births and deaths, causes of death and loss of function prior to death
- Reasons why End of Life Care should be prioritised by Health and Wellbeing Boards
- Suggestions for actions for Health and Wellbeing Boards to carry out on assessing needs, assessing commissioning decisions and innovating and integrating in terms of End of Life Care, including designating a member of the Health and Wellbeing Board as End of Life Care Champion and forming an End of Life Working Group

It was suggested that it would also be important to involve others who had a role at the end of life, such as funeral directors, lawyers, the Alzheimers Society etc, and Dr Barrie said that it might also be useful to have a public meeting at some point, to involve such people in a public debate.

Resolved -

(1) That the report be noted and Dr Barrie be thanked for her presentation;

(2) That the creation of a Reading Locality Steering Group on End of Life Care be endorsed, with the membership proposed in the report;

(3) That Councillor Eden be on the Steering Group and be the End of Life Care Champion for the Board;

(4) That the Steering Group bring an action plan on End of Life Care to a future meeting of the Board.

4. READING'S ARMED FORCES COMMUNITY COVENANT AND ACTION PLAN – MONITORING REPORT

Jill Marston submitted a report giving a six-monthly update on the progress against the actions outlined in the Armed Forces Community Covenant Action plan, which included a number of health related actions, and on the general development of the Covenant.

The report explained that a covenant was a voluntary statement of mutual support between a civilian community and its local armed forces community, and Reading's Armed Forces Community Covenant had been launched on 7 July 2012 at the Afghanistan Homecoming Parade at Brock Barracks. The aims of an Armed Forces Community Covenant were to:

- encourage local communities to support the armed forces community in their areas
- nurture public understanding and awareness amongst the public of issues affecting the armed forces community
- recognise and remember the sacrifices faced by the armed forces community
- encourage activities which help to integrate the armed forces community into local life
- encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

The report stated that, although Reading did not have a large military 'footprint', with no regular forces stationed in the town, Brock Barracks was the headquarters for the Territorial Army unit 7th Battalion The Rifles and Reading was home to a large ex-Gurkha community. Reading's Covenant therefore focused on Veterans and Reservists and aimed to be proportionate in its scope to the size of the Armed Forces community in Reading.

Progress to date against the actions in the Covenant's Action Plan was shown in Appendix A to the report, which showed that several of the actions relating to health and wellbeing had now been completed, with some still ongoing.

The report explained that 7 Rifles were considering the best way for the Armed Forces to input into the Health & Wellbeing Board, if required. The Battalion's Regimental Operations Support Officer was present at the meeting and the report stated that the Battalion's Medical Officer might attend in future.

The report also gave details of a new Community Covenant grant fund which had recently been launched, with £10m of funding available each year. The current year's priorities were:

1. Community integration projects
2. The coordination and delivery of support to the armed forces community
3. Projects which addressed issues facing veterans in the criminal justice system

The report gave details of the application routes and deadlines for the fund and stated that 7 Rifles were interested in applying for funding for a public concert, to be organised by the Council with the band provided by the Armed Forces, under the priority of community integration. 7 Rifles would also like to bid for funding to produce some display boards to install outside Brock Barracks, showing the history of the Barracks, and a bid around mental health services for Veterans was in development.

A meeting of organisations working with the ex-Gurkha community had taken place in February 2015 with a view to starting to identify common needs that might be addressed through the Community Covenant fund. It had been agreed that a working group would meet periodically, organised by the main ex-Gurkha groups in rotation.

Resolved - That the progress against the actions set out in the Armed Forces Community Covenant Action Plan be noted.

(Councillor Stanford-Beale declared an interest in the above item, as she volunteered for the Southcote Gurkha Ladies Project.)

5. UPDATE REPORT ON COMPREHENSIVE CAMHS

Further to Minute 6 of the Health and Wellbeing Board meeting on 17 April 2015, Andy Fitton and Sally Murray submitted a report giving a six-monthly update on service development and improvement across the comprehensive CAMHS (Child and Adolescent Mental Health Services) system. Appendix 1 set out acronyms used in the report, Appendices 2 & 3 set out details of Tier 1-4 services and Appendix 4 set out details of progress to date against the Action Plan to Improve CAMHS Service Delivery.

The report also explained that, in August 2015, NHS England had published guidance on how Local Transformation Plans should be developed, assured and publicised, following the launch of the report of the Government's Children & Young People Mental Health Taskforce in March 2015 "Future in Mind – promoting, protecting and improving our children and young people's mental health and wellbeing". There was a requirement for system-wide transformation over five years with plans to be signed off by the local Health and Wellbeing Boards before additional recurrent funding was released to CCGs.

The report explained that the Action Plan had been updated with current progress since April 2015 and it highlighted key points of progress, including the holding of a Children's Trust workshop in July 2015 which had focused on a partnership response to the Future in Mind document and had brought out some key partnership learning and commitments relevant for the coming months.

The report explained that the first draft of the Transformation Plans had had to be submitted by 18 September 2015. Feedback would then be provided by the regional team on the plans so that a final version could be submitted by 16 October 2015. Plans had to be signed off by Health and Wellbeing Boards as part of the assurance process, but due to Committee timescales, the report recommended that the Director of Children, Education and Early Help Services be authorised to approve the Reading Transformation Plan, in consultation with the Lead Councillors for Children's Services & Families and Health. It also recommended that the final Transformation Plan should replace the short term CAMHS Action Plan for future reporting on service improvements to the Board.

Resolved -

(1) That the progress made in CAMHS in terms of strategic direction and service improvement be noted;

(2) That the Director of Children, Education and Early Help Services be authorised to approve the Reading Transformation Plan for submission, in consultation with the Lead Councillors for Children's Services & Families and Health;

(3) That the final Transformation Plan replace the Action Plan to Improve CAMHS Service Delivery for future reporting to the Board on service improvements in CAMHS.

6. UPDATE ON JOINT WORKING TO SUPPORT CHILDREN & FAMILIES

Andy Fitton submitted a report giving an update on joint working to support children and families.

The report explained that, on 20 September 2013, a report to the Health & Wellbeing Board had 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. The Board had agreed that a sub-group should be set up to progress the opportunities and to report back regularly and the last report on progress had been given to the Board in January 2015, giving an update on the revised action plan.

The report gave details of progress to date made against the following key themes:

1. Improved access and knowledge of family services (across both Health and Reading Borough Council)
2. Education Opportunities and Support for Families
3. Increasing our quality and impact in specific areas (supporting breastfeeding/ uptake of immunisations/ reducing Post Natal Depression (PND)/ reducing obesity)

It stated that the sub-group now felt that its task and finish approach had come to an end as stronger professional relationships had been formed between partners and all recognised that children's health improvements were important. There were also now other places, most notably the Children's Centre Strategy Group and the emerging CAMHS Transformation Plan, which had partnership meetings and processes that would monitor the key issues and projects that the sub-group had been sponsoring. The report therefore recommended that the sub-group should end as a task and finish group.

Resolved -

(1) That the progress made against the sub-group's three key themes in its action plan be noted;

(2) That the sub-group be thanked for its hard work and the progress made;

(3) That the sub-group end as a task and finish group.

7. READING'S AUTISM STRATEGY AND ACTION PLAN

Caroline Penfold submitted a report presenting the Autism Strategy Action Plan.

The report explained that Reading's Autism Strategy had been approved by the Health and Wellbeing Board on 17 April 2015 (Minute 7 refers) and an Autism Partnership Board had been established to progress the delivery of the Strategy through an Action Plan. The Autism Partnership Board had now developed an Action Plan, which was appended to the report.

The Action Plan aimed to present focused areas of work that were deliverable by partners on the Board, and would allow for progress against the following six priorities for improving support for people with autism in Reading identified in the Strategy:

1. Increasing awareness and understanding of autism
2. Improving access to diagnosis
3. Supporting better outcomes for people with autism
4. Supporting people with autism to live safely and as independently as possible
5. Supporting families and carers of people with autism
6. Improving how we plan and manage support

The report noted that the Action Plan had been developed in the context of reducing budgets and making the most of existing resources. There was no additional resource available to deliver the Action Plan and so the Plan was focused on how existing resources across partners could be used most effectively.

The Action Plan included information on what the impact of achieving the actions would be on the outcomes for people with autism and how this would be measured. Some of the actions referred to new services and approaches where an initial baseline measure would need to be identified. Further work would be carried out by the Autism Partnership Board to agree these measures and the way that information such as service user feedback could best be collected and analysed, which would be used to report progress on delivery of the Strategy, and the report proposed that yearly updates be brought to the Health and Wellbeing Board. The report stated that the Autism Partnership Board recognised that the Action Plan would need to be updated on a regular basis as progress was made to deliver the objectives set out in the Autism Strategy.

The Board discussed the membership and reporting lines of the Autism Partnership Board. It was reported that CAMHS (Child and Adolescent Mental Health Services), Adult Social Care, Children's Social Care, Education, people with autism and carers were represented on the Board, but it was suggested that possible political representation and the representation of the Health and Wellbeing Board on the Board should be considered, and that copies of agendas and minutes could be circulated appropriately. It was also suggested that how and where the Autism Partnership Board reported internally in the Council and into its decision-making structure, as well as to the Health and Wellbeing Board, should be considered further.

Resolved -

(1) That the Autism Strategy Action Plan, produced by the Autism Partnership Board and that set out areas for progress to deliver the Autism Strategy's key objectives, be noted;

(2) That the Autism Partnership Board continue to progress work on the Action Plan and bring yearly updates to the Health and Wellbeing Board;

(3) That the Autism Partnership Board be asked to review its membership and reporting lines.

(Councillor Stanford-Beale declared an interest in the above item as she was Chair of the Berkshire Autistic Society.)

8. READING HEALTH & WELLBEING STRATEGY ACTION PLAN – SUMMARY UPDATE

Andrew Burnett submitted a report giving a summary of progress made against the Reading Health and Wellbeing Strategy Action Plan and presenting the full Health and Wellbeing Strategy Action Plan update, attached at Appendix A to the report.

The report summarised what had been achieved against each of the following four goals in the Strategy, as well as what still needed to be done, and the full Action Plan gave further details, including a RAG status for each action:

- Goal One: Promote and protect the health of all communities particularly those disadvantaged: communicable diseases, immunisations and screening, BME groups
- Goal Two: Increase the focus on early years and the whole family to help reduce health inequalities: maternity, family support, emotional heath, domestic violence
- Goal Three: Reduce the impact of long term conditions with approaches focused on specific groups: self-care, carers, learning disability
- Goal Four: Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities: tobacco, drugs and alcohol, obesity

The report stated that the next iteration of the Reading Health and Wellbeing Strategy would be based on a full Joint Strategic Needs Assessment, which was expected to be completed for the March 2016 meeting of the Board. A plan and process for the new Strategy would be developed, which would include details of how stakeholders would be involved and consulted, including the voluntary sector, in the next few months.

Resolved - That the progress made on delivery of the Reading Health and Wellbeing Strategy Action Plan be noted.

9. READING JOINT STRATEGIC NEEDS ASSESSMENT POSITION STATEMENT

Andrew Burnett submitted a report giving an interim, high-level position statement on the health needs of the people of Reading. The report explained that a comprehensive Joint Strategic Needs Assessment (JSNA) for 2016-19 would be produced in the coming months. An initial data specification for this was set out in Appendix 1 and a proposed implementation plan for the JSNA was set out in Appendix

2, which showed that the final JSNA would be brought to the Board on 18 March 2016 and would then be taken to full Council for final sign-off.

The statement gave summary details of:

- Reading's population – age structure, changes and life expectancy
- Deaths from cardiovascular disease
- Diabetes
- Cancers
- Mental wellbeing
- Physical activity
- Social Care provision

It summarised the headline issues as:

- Reading's people generally experienced poorer health and more could be done to encourage and enable healthier lifestyles to reduce the risks of largely avoidable disease and disability – services needed to be targeted and tailored to reduce health inequalities in the borough;

- Most mental ill health had its origins in child and young-adulthood and, especially in view of Reading's proportionately younger population, it was important to ensure that all that was reasonable was being done, within available resources, to reduce the risks of people developing long-term mental health problems; and

- Reading would appear to be providing above-average levels of social care services; it was important to ascertain the reasons for this and that other service provision was appropriate for the composition of the local population.

The statement indicated that, pending the completion of the full JSNA for 2016-19, which would identify a wider range of issues, and in more detail, consideration should therefore be given to:

- Reviewing the current provision of assessment of need for, and the commissioning of, services intended to encourage and enable large numbers of people to live healthier lives and thus reduce the risk of avoidable disease and disability, especially to ensure that such services were appropriately targeted at those who could benefit most;

- Reviewing the levels of mental ill-health amongst children and young people and identifying whether more needed to be done, within the resources available, from a preventive perspective; and

- Reviewing the provision of social care services to ensure that these maximised opportunities to enable people to be as independent as possible for as long as possible, and to be able to provide appropriate care when needed within the resources available.

Resolved - That the position statement be noted.

10. INTEGRATION UPDATE

Melanie O'Rourke submitted a report giving an update on Health and Social Care Integration, acting as a half year progress report on the Better Care Fund (BCF) which had been in operational status since April 2015 and giving the opportunity to plan for the BCF 2016/17.

The report set out progress to date on BCF projects, noting that the Discharge to Assess service had enabled people to be discharged from care sooner, with time to consider their long terms needs either in their own home or the Willows Independent Living Service. The scheme had reduced Delayed Transfers of Care and the number of people who needed to move into a long term placement in residential care and the report gave details of the numbers involved.

The report stated that the Reading Integration Board had met as a workshop on 19 August 2015, gave details of the session and explained that the key findings had been captured into an action plan. The report gave an overview of some of the key themes and future areas of work for the Integration Board in dealing with blockages and challenges, under the following headings:

- Lack of robust data sets to measure impact
- Improved access to services 7 days a week
- Neighbourhood Clusters
- Workforce

The report listed the following key imperatives necessary to enable successful integration locally:

a) Ensure the efficient use of resources so that all schemes evidence value for money
b) That we have a skilled available workforce
c) That services are available 7 days a week
d) Health and social care do not duplicate tasks
e) Primary care and community services are central to care and explored fully before people need to use the acute hospital setting (Royal Berkshire Hospital)

It listed the performance indicators for the BCF, noting that there had been a reduction in both the number of people who were formally identified as being a delayed discharge of care and the amount of time people spent in hospital when they no longer needed to be there.

The report also gave details of future work on the BCF, noting that the size and scale of the BCF for 2016/17 was not yet known, with guidance expected to be announced in the Autumn Statement. It was reported at the meeting that this was now more likely to be a 'Winter' Statement. As it was possible that the next BCF submission would need to be made before the next Health and Wellbeing Board meeting, it was suggested that the Director of Adult Care & Health Services be authorised to approve the submission for the second year of the BCF, if necessary, in consultation with members of the Board.

Resolved -

(1) That the current status of the Reading Integration agenda be noted;

(2) That the blockages and challenges that needed to be remedied to enable a successful health and social care system be noted;

(3) That the key imperatives for adult social care and health set out in the report be agreed;

(4) That, if necessary, the Director of Adult Care & Health Services be authorised to approve the submission for the second year of the BCF in consultation with members of the Board and to report back to the next meeting of the Board.

11. REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARDS

Wendy Fabbro submitted a report on a proposal to carry out a review of the effectiveness and efficiency of the Health and Wellbeing Board in terms of delivering the aims and objectives of the Health and Wellbeing Strategy, through a Local Government Association (LGA) Peer Challenge.

The report explained the role of Health and Wellbeing Boards, which had been introduced by the Health and Social Care Act 2012 and whose aim was to improve integration between practitioners in local health care, social care, public health and related public services so that patients and other service-users experienced more 'joined-up' care, particularly in transitions between health care and social care. It stated that the Boards were also responsible for leading locally on reducing health inequalities, and explained how the Boards had a role in shaping the local public health landscape and helping Clinical Commissioning Groups to commission services in an effective and targeted manner.

It stated that Reading's Health and Wellbeing Board had now been operating in its formally constituted role for more than 18 months and proposed that it was timely to review the effectiveness and efficiency of the Health and Wellbeing Board in terms of delivering the aims and objectives of the Health and Wellbeing Strategy (which were set out in Appendix 1 to the report) and to support the development of the Board leadership. It proposed that the review should be undertaken collaboratively with the other two Health and Wellbeing Boards in the West of Berkshire, (Wokingham and West Berkshire Health and Wellbeing Boards) in order to identify any potential opportunities for future synergies or integrated working.

The report proposed that the methodology for the review should be the LGA Peer Challenge, which was a voluntary and flexible process commissioned by a council or partnership to aid their improvement and learning. The report gave further details of the process, which involved a team of peers acting as 'critical friends' spending time on-site in an area to reflect back and challenge in order to help the area to reflect on and improve the way it worked and made an impact. The report described the health and wellbeing peer challenge, which would be focused on enabling the leadership of Health and Wellbeing Boards to be in the driving seat of local system leadership, able to take on a place-based approach to commissioning Adult Social Care and health, and address the wider determinants of health.

In this context, the peer challenge would focus on the following elements:

- ensuring clarity of purpose of the Board

- building a model of shared leadership within the Board
- working with partners to develop the systems leadership role
- ensuring delivery and impact
- integration and system redesign

The peer challenge would focus on a set of headline questions (set out below) and more detailed prompts, from which to frame the preliminary review of materials, the interviews, and the workshops that made up a peer challenge. They would be discussed and tailored in the context of each council and Health and Wellbeing Board:

1. To what extent is the purpose and role of the Health and Wellbeing Board established?
2. How strong is work with key partners to develop system leadership?
3. To what extent is the Health and Wellbeing Board ensuring the delivery of the health and wellbeing strategy?
4. To what extent is there a clear approach to engagement and communication?
5. To what extent is the Health and Wellbeing Board enabling closer integration and the change to a cohesive and effective health system?

The report stated that the Peer Challenge would be fully subsidised by the Department of Health.

Resolved -

(1) That the proposal for a review of the Health and Wellbeing Board's effectiveness and efficiency by LGA Peer Challenge be approved, to be undertaken collaboratively with Wokingham and West Berkshire Health and Wellbeing Boards, and the LGA be appointed to conduct an 'on-site' visit in early-mid March 2016;

(2) That a Task & Finish Group be appointed to oversee the specific focus for the Peer Challenge questions and their programme of interviews and focus groups;

(3) That members of the Board consider appropriate representatives to be members of the Task & Finish Group in (2) above, and send nominations to Wendy Fabbro.

12. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 22 January 2016.

(The meeting started at 2.00pm and closed at 3.58pm)

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**5**
TITLE:	**HIGHLIGHT REPORT - WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2014/15**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**MELANIE O'ROURKE**	**TEL:**	**0118 937 4053**
JOB TITLE:	**HEAD OF ADULT SOCIAL CARE**	**E-MAIL:**	**melanie.o'rourke@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Attached is the 2014/15 Annual Report of the West of Berkshire Safeguarding Adults Board (SAB) covering the local authority areas of Reading, Wokingham and West Berkshire.

1.2 The Health and Wellbeing Board are asked to accept the report for information. The report was approved by the SAB on 1st December 2015.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board note the attached report for information.

3. POLICY CONTEXT

3.1 The Annual Report is a statutory requirement of the Board and provides detail of the performance of RBC as well as local partner authorities. The information informs future strategy by highlighting positive performance as well as areas of challenge where the council is not performing as well.

4. HIGHLIGHTED INFORMATION

4.1 The key achievements of the SAB are described on p.2, Para 2.

4.2 Of note is the launch of the new SAB website, the Social Care Institute for Excellence (SCIE) training that some members have benefitted from in the Learning Together model for reviewing and learning lessons from Safeguarding Adult Reviews (formerly Serious Case Reviews) and the Joint Children's and Adults Safeguarding Conference on Domestic Abuse which was rated highly by the many attendees.

4.3 A full description of how the partners have achieved the 4 goals of the Board follows (pp. 3 – 6) demonstrating that the board now enjoys improved governance structures, has developed oversight of its activities in order to improve safeguarding outcomes, is busy raising awareness of the work of the SAB and of safeguarding generally and finally ensures

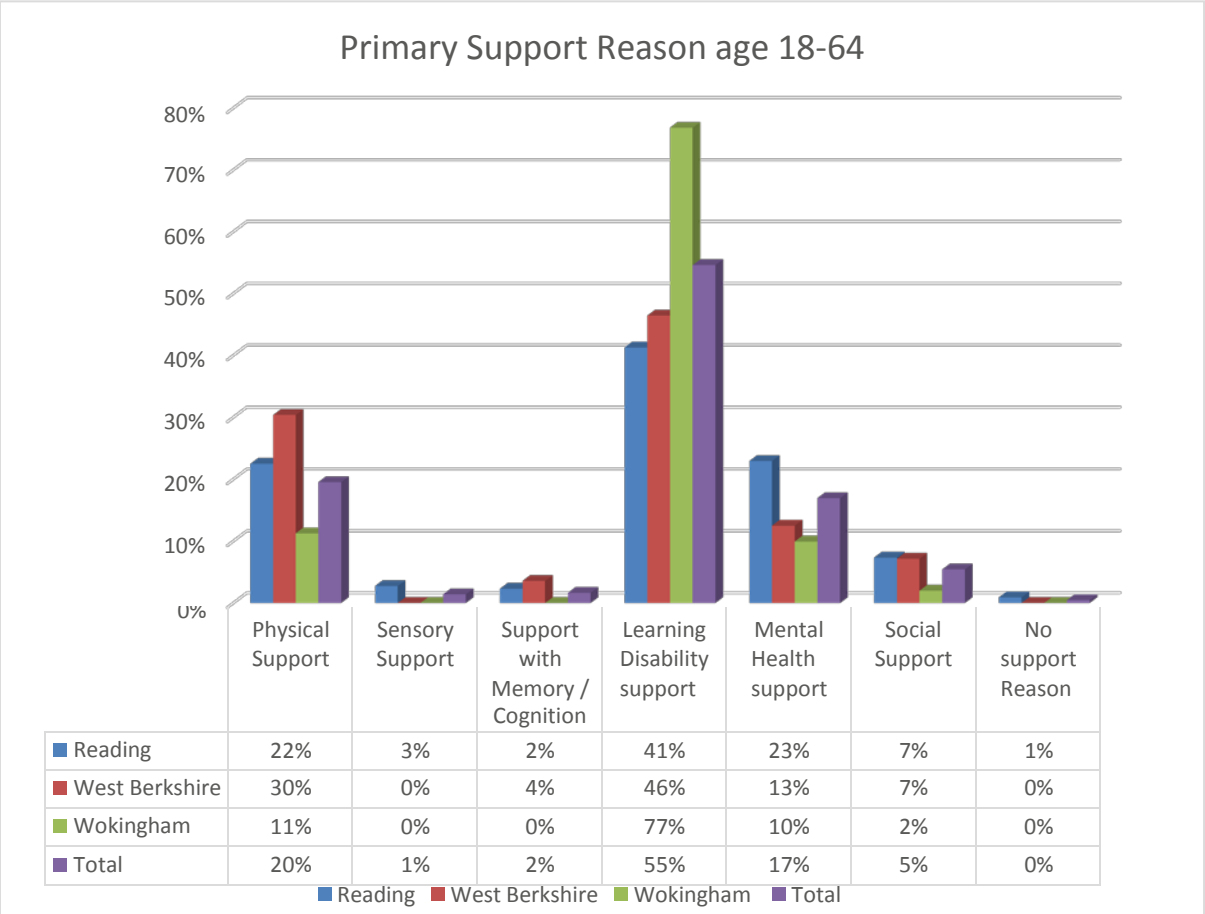
that effective learning happens from both good and bad practice in order to improve outcomes for service users across the sector.

4.4 Making Safeguarding Personal (p.6) is a noteworthy initiative that has been championed nationally by Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA). It seeks to shift safeguarding practice to be increasingly person centred, outcome-focused and ensure that the person's wishes and desires are central to the whole process, something which has not always been the case. RBC has helped develop and deliver mandatory training for Adult Social Care staff by a nationally recognised expert beginning in December. The training programme including all costs is shared with Wokingham and West Berkshire councils making excellent value for money as well as enhancing a consistent approach across the West of Berkshire.

5. COMBINED HEADLINE DATA INCLUDING RBC PERFORMANCE (pp. 9 – 18)

5.1 Across the 3 local authority areas 2171 alerts were made, an 18 per cent increase on the previous year and the Reading share of these was 702 contrasting with a 2013/14 figure of 654 (p.9). Of the 702 safeguarding alerts, 527 became referrals meaning that they were considered appropriate to investigate as adult safeguarding incidents. This is a higher proportion than the other 2 local authorities demonstrating that RBC took a more risk averse approach than our local partners.

5.2 Data on Primary Support Reason was collected this year for the first time. People with a learning disability between the ages of 18 and 64 account for by far the highest proportion of people referred across the SAB area at 55% of all referrals. Reading's figures are consistent with its neighbours (p.11). The table is reproduced below. People with a mental health problem account for 50 individual referrals in Reading according to the table however it is important to note that this describes primary support reason, not referring organisation. A recent independent audit of safeguarding process in Reading revealed that for the period May to August 2015 only 1.75% of safeguarding alerts originated from mental health services. This is extremely low against a national average of 25%.



	Physical Support	Sensory Support	Support with Memory / Cognition	Learning Disability support	Mental Health support	Social Support	No support Reason
Reading	22%	3%	2%	41%	23%	7%	1%
West Berkshire	30%	0%	4%	46%	13%	7%	0%
Wokingham	11%	0%	0%	77%	10%	2%	0%
Total	20%	1%	2%	55%	17%	5%	0%

5.3 Reading is by far the most diverse borough out of local partners and whilst this is reflected in the ethnicity of referrals (p.13) the breakdown still does not reflect the actual makeup of the population of Reading e.g. the 2011 census puts the Asian population of Reading at 14% whilst people from an Asian background account for only 3% of safeguarding referrals, an under representation of 11%. It should be noted that the 10% of referrals with an unknown ethnicity hampers reliability of the information.

5.4 Types of abuse (p.13) locally are in line with national trends for the year and the top 4 remain the same as last year i.e. Neglect, Physical, Emotional/Psychological and Financial. The category of Neglect has risen almost every year in line with a growing awareness of it as a safeguarding matter. It is worth noting that there is supposedly 0% discriminatory abuse in Reading, a statistic which may point to a lack of engagement with and awareness of discriminatory abuse as experienced by black and minority ethnic, LGBT, disabled residents and others subject to discrimination. It is also a category that has steadily decreased since 2011 when it was recorded as 3%.

5.5 Most alleged abuse took place in the person's own home (57%) a trend which is decreasing (70% in 2012/13 and 65% in 2013/14) whilst the trend of abuse occurring in a care home (21%) is increasing (14% in 2012/13 and 17% in 2013/14). This may reflect better recording and awareness particularly among care staff and managers rather than an actual increase in abuse in care home settings.

5.6 For the Reading area most sources of referral (p. 16) have remained stable over recent years. However, there has been a slight dip in self-referrals from 10% to 6% and a rise in those classed as "Other" which raises questions of recording accuracy.

5.7 A case conclusion is the outcome of the investigation for a concluded referral and is categorised as Substantiated, Partly Substantiated, Inconclusive (or Not Determined) or Not Substantiated. There has been little change in the proportion of cases in each category from the previous year in the West of Berkshire. This category will not be recorded after this year as from now on we will be collecting data according to Making Safeguarding Personal outcome measures (see 4.4).

5.8 Deprivation of Liberty Safeguards (DoLS - p.18) figures will by now be out of date since the numbers continue to rise following what is known as the Cheshire West ruling (case law). DoLS present an on-going challenge to all local authorities as to how to safely manage such a large cohort of individuals who may not have the capacity to make decisions about their own care or to agree or disagree with how that care is provided including in locked environments. Reading continues to manage the situation proportionately, in line with legislation and with the safety and wellbeing of its residents foremost.

6 APPENDICES

6.1 Various appendices complete the Annual Report.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EIA) is not relevant to this report. The annual report 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.

8. LEGAL IMPLICATIONS

8.1 The Care Act 2014 requires that partners work effectively together to safeguard and provide appropriate services for adults at risk and that the SAB produce an Annual Report.

9. FINANCIAL IMPLICATIONS

There are no financial implications.

West of Berkshire Safeguarding Adults Board

Annual Report 2014-15

West of Berkshire Safeguarding Adults Board Annual Report 2014-15

Contents

1. Introduction Page 2

2. Key Achievements Page 2

3. Partner Contribution to delivery of the Board's Goals Page 3

4. Safeguarding Adults Reviews Page 8

5. Priorities for 2015-16 Page 8

6. Combined headline data Page 9

7. Appendices

A Strategy for Safeguarding Adults in the West of Berkshire 2015-2018 Page 20

B Learning from Safeguarding Adults Reviews - The Case of Ms F Page 25

C Membership of Board and Subgroups Page 32

D Reading Borough Council Safeguarding Adults Annual Summary 2014/15 Page 34

E West Berkshire Council Safeguarding Performance Executive Summary Page 45

F Wokingham Annual Performance Report 2014-15 Page 54

1. Introduction

The West of Berkshire Safeguarding Adults Board (SAB) covers the three local authority areas of Reading, West Berkshire and Wokingham. It is a statutory mechanism for ensuring that there is a robust multi-agency safeguarding framework in place and for monitoring the effect this has on protecting adults.

Care Act 2014

With the introduction of the Care Act 2014, Safeguarding Adults is now based on a legal framework. The safeguarding provisions of the Care Act include:

- ☐ A requirement for all areas to establish a Safeguarding Adults Board to bring together the local authority, NHS and police to coordinate activity to protect adults from abuse and neglect.
- ☐ A duty for local authorities to carry out enquiries (or cause others to do so) where it suspects an adult is at risk of abuse or neglect.
- ☐ A duty for Local Safeguarding Adults Boards to carry out safeguarding adults reviews into cases where someone who experienced abuse or neglect died or was seriously harmed, and there are concerns about how authorities acted, to ensure lessons are learned.
- ☐ A new ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews of cases or other functions.

A development session took place in June 2014 to ensure a shared understanding of the SAB's functions as outlined in the Care Act. Between June 2014 and March 2015, the Board undertook a self-assessment exercise which has served as a foundation for the Strategic Plan 2015-2018.

2. Key Achievements of 2014-15

- Independent Safeguarding Adults Board website.
- Board's Constitution and Memorandum of Understanding.
- Safeguarding Adults Review Panel and supporting guidance and processes.
- Participation in SCIE Learning Together training.
- Multi-agency Performance Indicator set.
- Joint Children's and Adults Safeguarding Conference on Domestic Abuse.
- Threshold Guidance document.
- Out of Area Reviews Guidance document.

Partner Contribution to delivery of the Board's Goals

Through single- and multi- agency initiatives and an ongoing commitment to the work of the subgroups, partner agencies have contributed to the delivery of the SAB's four goals, to embedding Making Safeguarding Personal and to the learning and development of the workforce. Highlights are presented below.

Goal 1 - Establish effective governance structures to align the Board to new statutory requirements, improve accountability and ensure the safeguarding adults agenda is embedded within other organisations, forums and Boards.

- Representation of all six funding partner agencies on the Governance Subgroup. Review of function and Terms of Reference of the Governance Subgroup.

- Promotion of safeguarding adults through representation of Board members on a range of local boards, forums and network meetings.

- Development of stronger links between operational safeguarding and care governance frameworks within the three Local Authorities, enabling earlier identification of emerging themes and concerns and proactive quality assurance intervention in line with the prevention principles of the Care Act.

- Care Act training delivered to adult social care front line staff, providers and forums, including information about the Board and its statutory responsibilities.

- Safeguarding adults embedded within the CCG provider contracts, supported by a quality assurance schedule through which key areas for safeguarding are monitored quarterly.

- Annual Safeguarding Audit and Action Plan monitored by the CCG for Health Care Providers include adult and children safeguarding.

- Development of stronger links between health and social care professionals through quarterly meetings of the Partnership Group.

- Quarterly meeting of the Berkshire Healthcare Foundation Trust (BHFT) Safeguarding Group feed into the Trust governance structure.

- Six monthly meetings of the Royal Berkshire Foundation Trust (RBFT) Strategic Safeguarding Committee, chaired by the Executive Director of Nursing, with external scrutiny provided by a Designated Professional for Safeguarding provides Board assurance including monitoring the annual safeguarding plan and managing emerging safeguarding issues and risks.

Goal 2 – Develop oversight of safeguarding activity and need in order to target resources effectively and improve safeguarding outcomes.

- Development of forms, templates and IT systems to improve collection and analysis of key safeguarding data. Information from a range of reports generated from case recording and referral information provides detailed operational data and contributes to strategic oversight.

- Improved links between some partner agencies' IT systems allow the efficient extraction of more meaningful and relevant information on safeguarding.

- Monthly audits of 10% of safeguarding enquiries focussing on quality, outcomes and the voice of the person, their family and advocate. Themes arising from audits inform training.

- Sharing of performance and practice development information at the Berkshire Health and Social Care Safeguarding Leads group, enabling early identification of and appropriate response to interagency issues.

- Implementation of the CCGs' self-assessment safeguarding tool for adults and children for contracted providers. 100% of commissioned health service providers submitted a completed self-assessment, establishing a base line for compliance which will continue to be built upon and monitored in 2015-2016.

- Identification of local issues that may develop into safeguarding by the Care Quality Intelligence Group which includes a range of partners, including the CQC and local health representatives.

- Oversight of performance of contracted provider health services provided by the CCG's quality schedule, which includes information from on-site visits and the views of patients.

- Production of the CCGs' supervision policy for staff working in Continuing Health Care with the aim of improving oversight, participation and collaborative working across health and social care.

- Joint assessment and quality visits by the Continuing Health Care Team and Local Authority colleagues aimed at improving oversight and outcomes for adults in residential and nursing care.

- Implementation of Quality Assurance framework and audit programmes to meet the requirements of the Care Act and Making Safeguarding Personal. Performance information reported to management teams, committees and Health and Wellbeing Board Boards.

Goal 3 - Raise awareness of safeguarding adults, the work of the SAB and improve engagement with a wider range of stakeholders

- Care Act and Safeguarding training include reference to the SAB and its statutory role, with a focus on multi-agency participation in learning from local reviews.

- Introduction of a health network meeting for independent and contracted providers, to increase awareness of the SAB across the independent sector.

- Further development and widening membership of local authority safeguarding forums.

- Better Care Fund established and implemented locally to transform integration between health and social care with a focus on people's wellbeing. Safeguarding processes and the role of the SAB highlighted in the local implementation document.

- Links established with the Independent Trauma Advisor Steering Group, (pan-Thames Valley group supporting a Police and Crime Commissioner funded pilot to identify and support victims of Modern Slaver), leading to improved understanding, identification and support for people identified as living in conditions of modern slavery. Multi-agency support for survivors of modern slavery, involving Berkshire Healthcare Foundation Trust, Thames Valley Police and the voluntary sector organisation, Rahab.

- Development of toolkit for Trading Standards Officers by Wokingham's prevention worker in conjunction with the Chartered Trading Standards Institute, to aid understanding of Adult Safeguarding and provide examples of good practice.

- Good outcomes achieved by the "Choice Champions" project, an initiative delivered by people who use services to raise awareness of personal budgets, safer recruitment and safeguarding. The Champions attended many community events, delivering their own presentation to a wide range of stakeholders.

- New awareness raising publicity material has been developed. Members of Wokingham's CLASP (Caring Listening and Supporting Partnership) supported the production of "easy read" formats for awareness raising publicity material. "Easy read" publicity material will be published in West Berkshire and Reading in the following year.

- Raising awareness of safeguarding issues by health commissioners through the quarterly Safeguarding Practice Lead meetings at local GP surgeries that include safeguarding topics, external speakers and shared learning.

Goal 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

- Establishment of a Safeguarding Adults Review (SAR) Panel, chaired by an Independent Chair.

- Development of Berkshire-wide Guidance for Multi-Agency Reviews of Serious Cases to ensure:
  - Processes for learning and reviewing are flexible, proportionate and open to professional and public challenge.
  - Local decision about what type of review is appropriate, dependent on the nature of the case and the agencies involved.
  - A culture of transparency and shared learning.

- Increased local capacity for carrying out safeguarding adults reviews through participation of 16 staff in a three-day SCIE Learning Together Foundation Training. Two members of staff attained lead reviewer accreditation with two more committed to achieving it in the following year.

- Following the completed Safeguarding Adult Review (SAR) in 2014, bespoke workshops held to share findings and encourage staff to reflect on implications for practice and learning. The findings informed safeguarding refresher training, giving attendees the most relevant and up to date knowledge.

- Development of a learning log by the West Berkshire forum to share learning from local and national reviews.

- Learning reports provided for CCG committee meetings, board meetings, GP forums and training events. Care Quality Commission inspection reports and other local intelligence shared with health commissioners.

- Information from audits used to improve practice. A feedback mechanism aligned with line management structures developed between community and safeguarding teams.

- HealthWatch Reading presented to the Board during 2014 as part of an initiative to help bring alive the service user's voice. The story of 'Dorothy' was presented, a case study from a project on delayed discharges, which highlighted her journey from falling in sheltered housing to eventually dying in a care home, with many failures in care and missed opportunities to support her.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. Locally, steps have been taken to develop person centred, outcome-focused practice, including:

- Sign up to the national LGA Making Safeguarding Personal project by the three Local Authorities.

- Review and amendment of level 1, 2 and 3 training to reflect the MSP agenda and promote broader understanding of duty of care and legal requirements.

- Revision of internal templates, forms and processes to support frontline workers and promote best practice to ensure that people have an opportunity to discuss the outcomes they want at the start of safeguarding activity and have follow-up discussion at end of safeguarding activity to see to what extent their desired outcomes have been met.

- Development of data collection forms to scrutinise how MSP has been approached, recording the results in a way that can be used to inform practice and provide aggregated outcomes information.

- Implementation of QA audit tool designed to evaluate application of the six principles and give direct feedback to workers and supervisors.

- Review of the *Safeguarding Children and Adults At Risk Policy* by the CCGs to include MSP.

- The Continuing Health Care team have supported LAs in quality assurance visits and safeguarding cases allowing a more personalised approach by clinicians who know their patients.

- Choice Champions have received training and aim to promote MSP in all aspects of partnership work.

Learning and Development Activities

The annual Joint Adult and Children's Safeguarding Conference, planned with the three West of Berkshire's Local Safeguarding Children's Boards, took place on Friday 26 September at Easthampstead Park in Wokingham. The conference was based on the theme of domestic abuse and was again a well-attended and thought provoking event where delegates also had the opportunity to learn about support services available locally.

- Review of the Workforce Development Strategy and publication of the updated version in April 2014 .

- Safeguarding training level 1, 2 and 3 reviewed and delivered to a wide range of stakeholders from various sectors with very positive feedback. Training data is included in section 5 below. Specifically, targeted training was delivered to providers

of concern to promote partnership working, engagement and compliance with the West of Berkshire safeguarding policy and procedures.

- Safeguarding Adults Train the Trainer programme reviewed to make the standards for the Level 1 Train the Trainer more robust and consistent in line with changes required to meet the Care Act. Train the Trainer programme offered to the independent sector to develop skills to deliver in-house training, to the SAB's agreed training standards. 10 delegates from the independent sector attended sessions in the reporting year. Quality assurance processes in place to ensure continued good practice.

- Royal Berkshire Hospital NHS Foundation Trust (RBFT) is the only Trust in the Thames Valley to have met Health Education England's target to train 75% of staff on the issues faced by patients with dementia by December 2014. As a result the Trust received £25k funding that has been used to employ a nurse to deliver level 2 dementia training. From April 2015, this additional training will be provided for staff who work frequently with patients who have dementia, including training in the simulation centre and e-Learning.

- Prevent awareness forms part of the level 1 training with the 1 hour WRAP training as part of the level 2 day. Additional WRAP (3) sessions delivered to Emergency Department staff.

- Reading BC contributed funding to the development of an e-learning safeguarding module through its partnership with Log onto Care, which is freely available across the sector.

- Mental Capacity task and finish group established by RBFT to identify which staff needed enhanced MCA training and agree structure and content of training. New awareness leaflet highlighting the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards published.

- Secured funding via the Mental Capacity Act innovations bid to deliver two focused conferences to promote application in practice of the MCA across partnership agencies in Berkshire.

3. Safeguarding Adults Reviews

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults Boards get the full picture of what went wrong, so that all organisations involved can improve their practice. Under the Care Act, each member of the SAB must co-operate in and contribute to the carrying out of a review.

In the past 12 months, the Board has undertaken and completed one Safeguarding Adult Review. The circumstances leading to this review had a devastating impact on the lives of the individual and her family, as well as all the carers and professionals involved.

An executive summary of the review is included as Appendix B. Partner agencies have cascaded the findings to staff and have considered how the learning can be embedded in their agency, leading to the development of action plans and also the delivery of workshop style learning sessions.

4. Priorities for 2015-16

Priority 1 - Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and Boards.

Priority 2 – Making Safeguarding Personal.

Priority 3 - Raise awareness of safeguarding adults, the work of the Board and improve engagement with a wider range of stakeholders.

Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

Priority 5 – Co-ordinate and ensure the effectiveness of what each agency does.

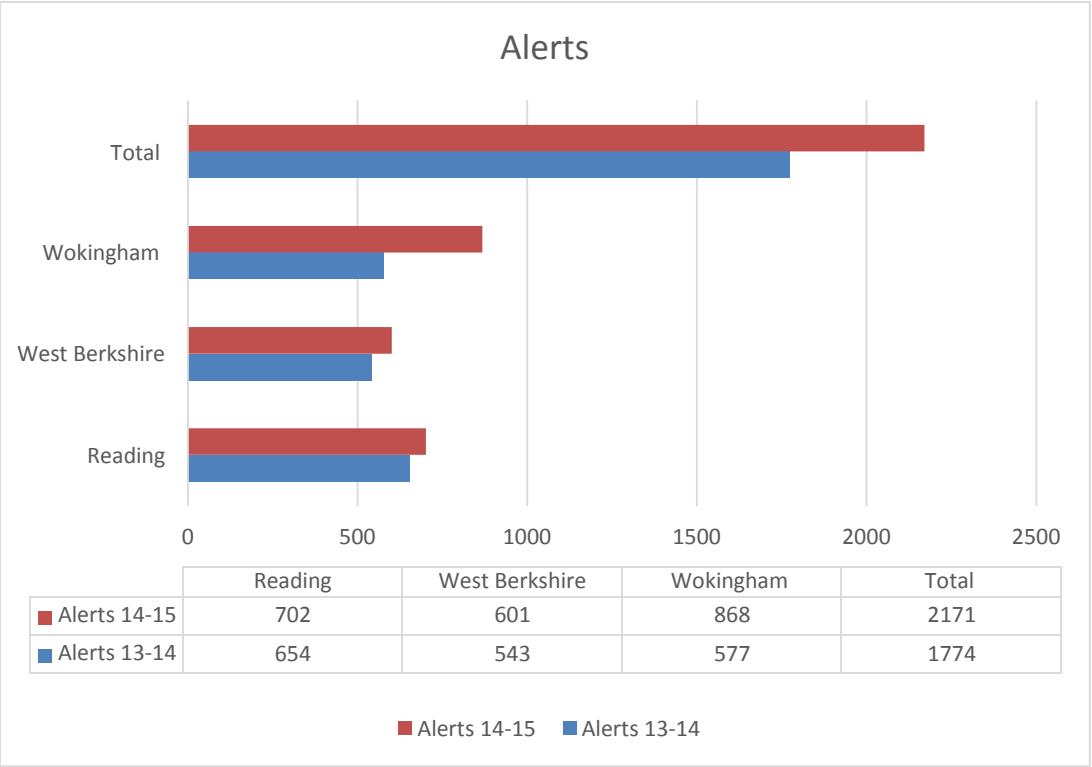
The Board's **Safeguarding Strategy 2015-18** is included as Appendix A. Further details about the way in which partner agencies will contribute to delivering these priorities can be found in the Business Plan 2015-16.

5. 2014-15 Combined Headline Data

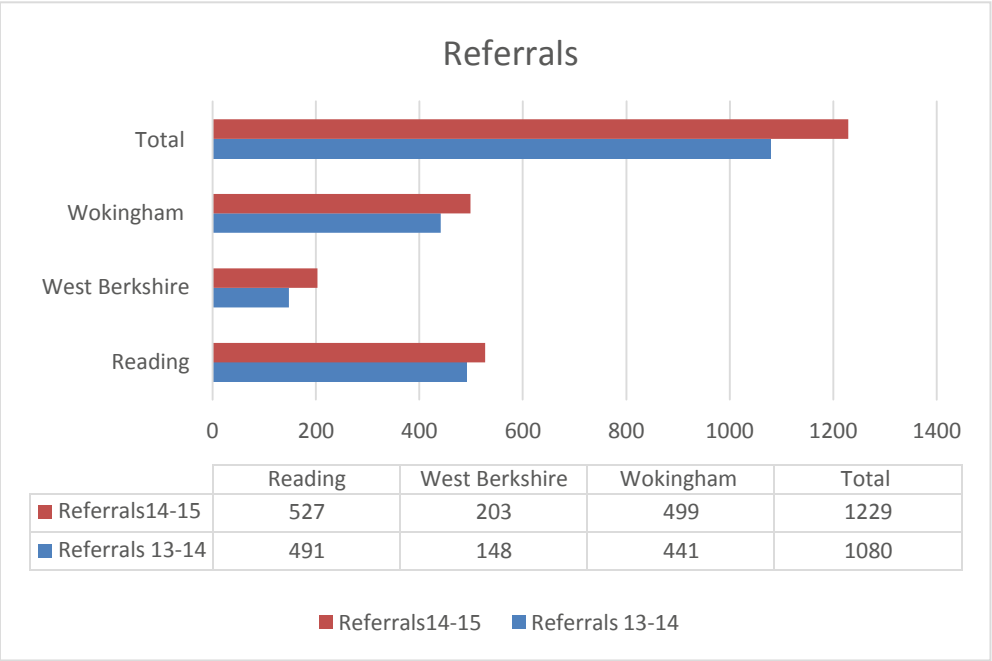
This report covers the year 2014-15, the last year before safeguarding adults became a statutory duty under the Care Act (2014). Much of the terminology used in this report, therefore, is no longer in use under current practices. Direct comparison with previous years cannot always be achieved due to changes in reporting requirements. However, it is envisaged with the introduction of new Safeguarding Adults Collection requirements for 2015/2016 greater consistency will be achieved.

Total no. Alerts and Referrals,

Last year, 2171 alerts were made, an 18 per cent increase on the previous year. 1229 referrals were made, a 12 per cent increase on the previous year.



	Reading	West Berkshire	Wokingham	Total
Alerts 14-15	702	601	868	2171
Alerts 13-14	654	543	577	1774



	Reading	West Berkshire	Wokingham	Total
Referrals14-15	527	203	499	1229
Referrals 13-14	491	148	441	1080

Referrals by Age and Primary Client Group

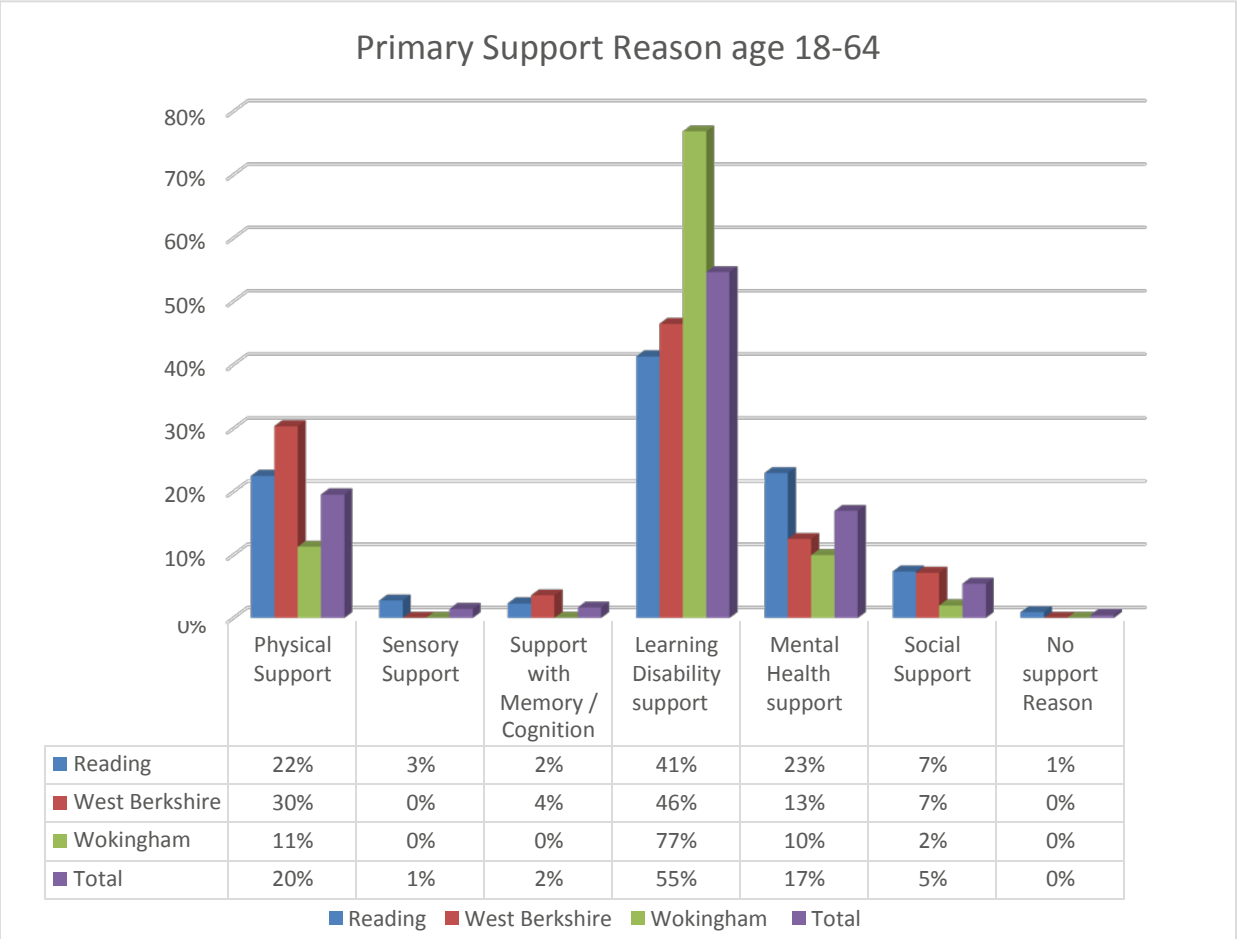
For the first time in 2014-15, data were collected on Primary Support Reason. This classification focusses on the main reason that a person requires social care services at any particular time and provides a better description of the impairment impacting on the individual's quality of life and creating a need for support and assistive care. It may not be related to any underlying health conditions.

The tables below shows the breakdown of individuals with referrals by Primary Support Reason and Age.

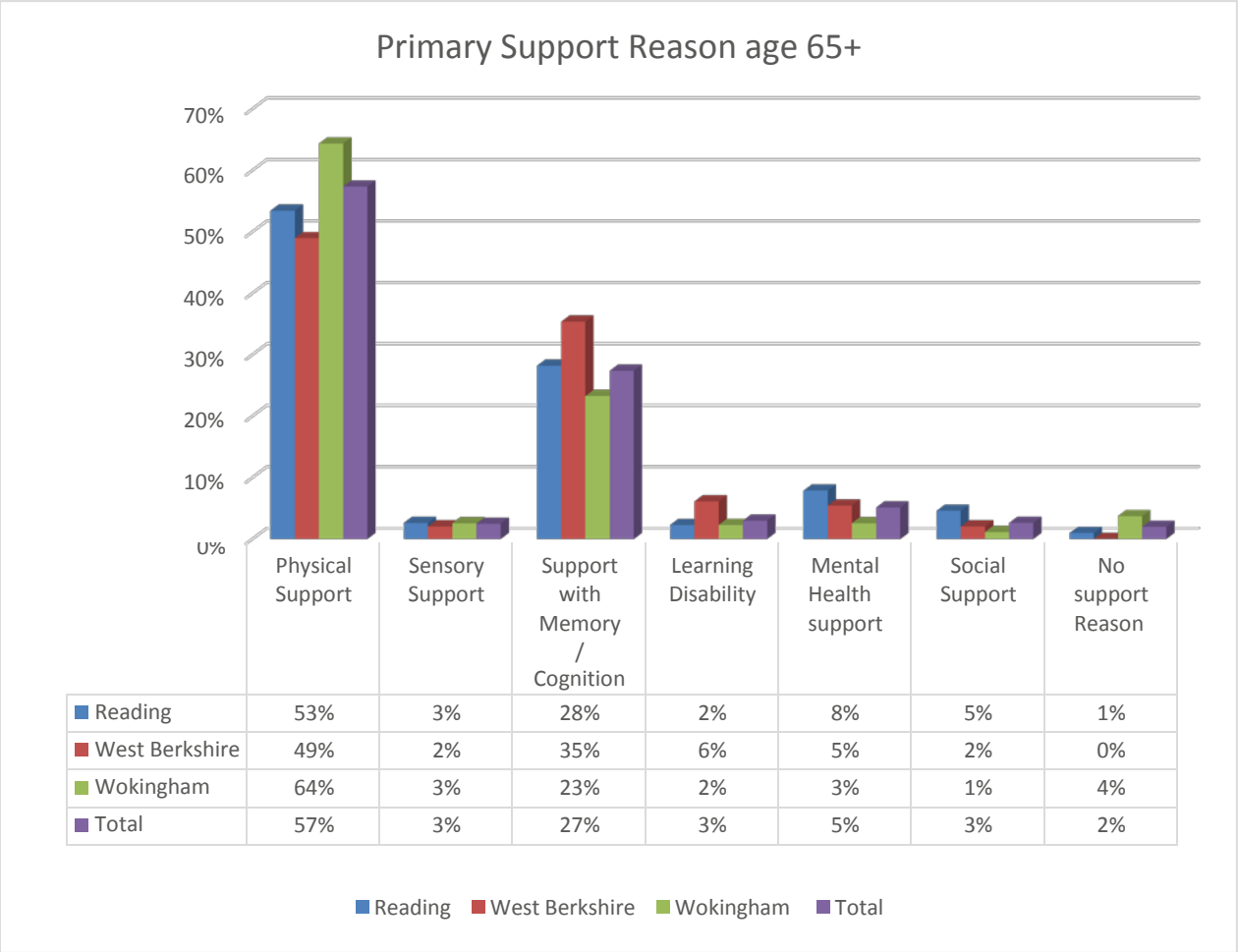
At 55 per cent, Learning Disability accounts for the majority of cases involving individuals aged between 18 and 64, with Physical Support next at 20 per cent.

In the 65 plus age group, Physical Support accounts for the majority of cases with 37 per cent of individuals, and those with support needs for memory / cognition next at 18 per cent.

Trends are largely in line with last year, although additional categories have been included for 2014-15 making direct comparisons difficult especially for Mental Health data.



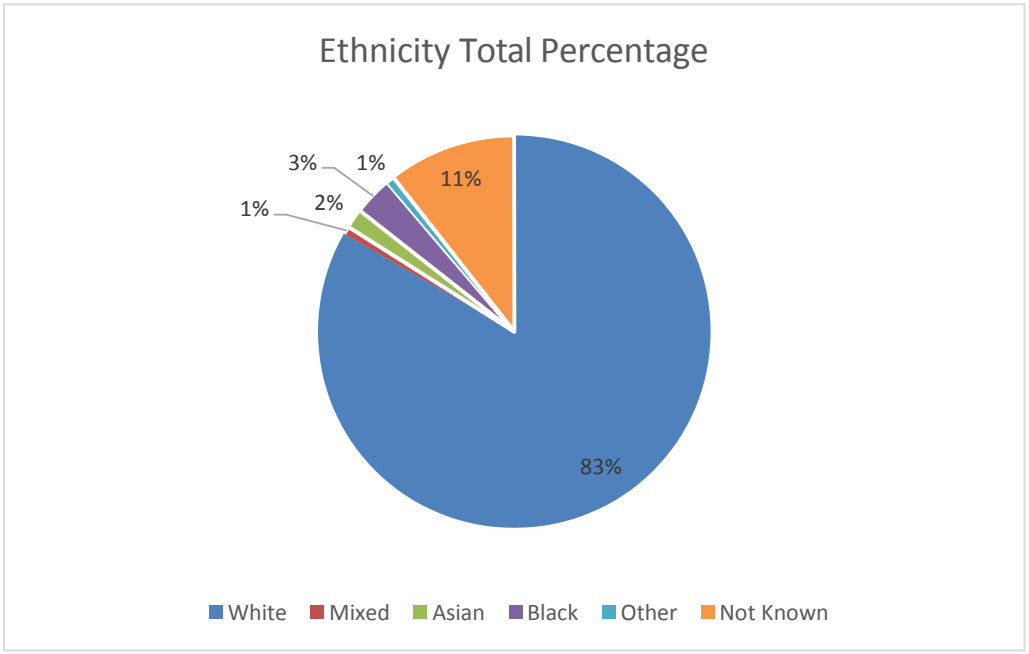
	Physical Support	Sensory Support	Support with Memory / Cognition	Learning Disability support	Mental Health support	Social Support	No support Reason
Reading	22%	3%	2%	41%	23%	7%	1%
West Berkshire	30%	0%	4%	46%	13%	7%	0%
Wokingham	11%	0%	0%	77%	10%	2%	0%
Total	20%	1%	2%	55%	17%	5%	0%

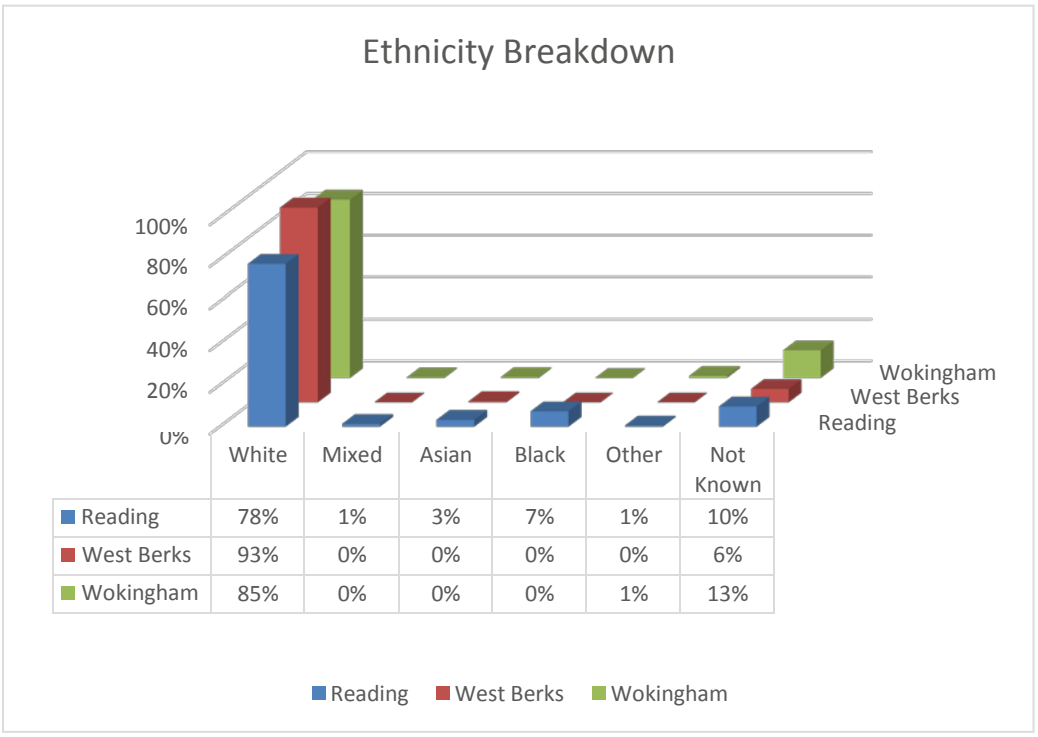


	Physical Support	Sensory Support	Support with Memory / Cognition	Learning Disability	Mental Health support	Social Support	No support Reason
Reading	53%	3%	28%	2%	8%	5%	1%
West Berkshire	49%	2%	35%	6%	5%	2%	0%
Wokingham	64%	3%	23%	2%	3%	1%	4%
Total	57%	3%	27%	3%	5%	3%	2%

Referrals by Ethnicity

The charts below show how many referrals there were for individuals from different demographic categories in 2014-15. We aim to reduce the number of cases where ethnicity is categorised as *Not Known* in future years.

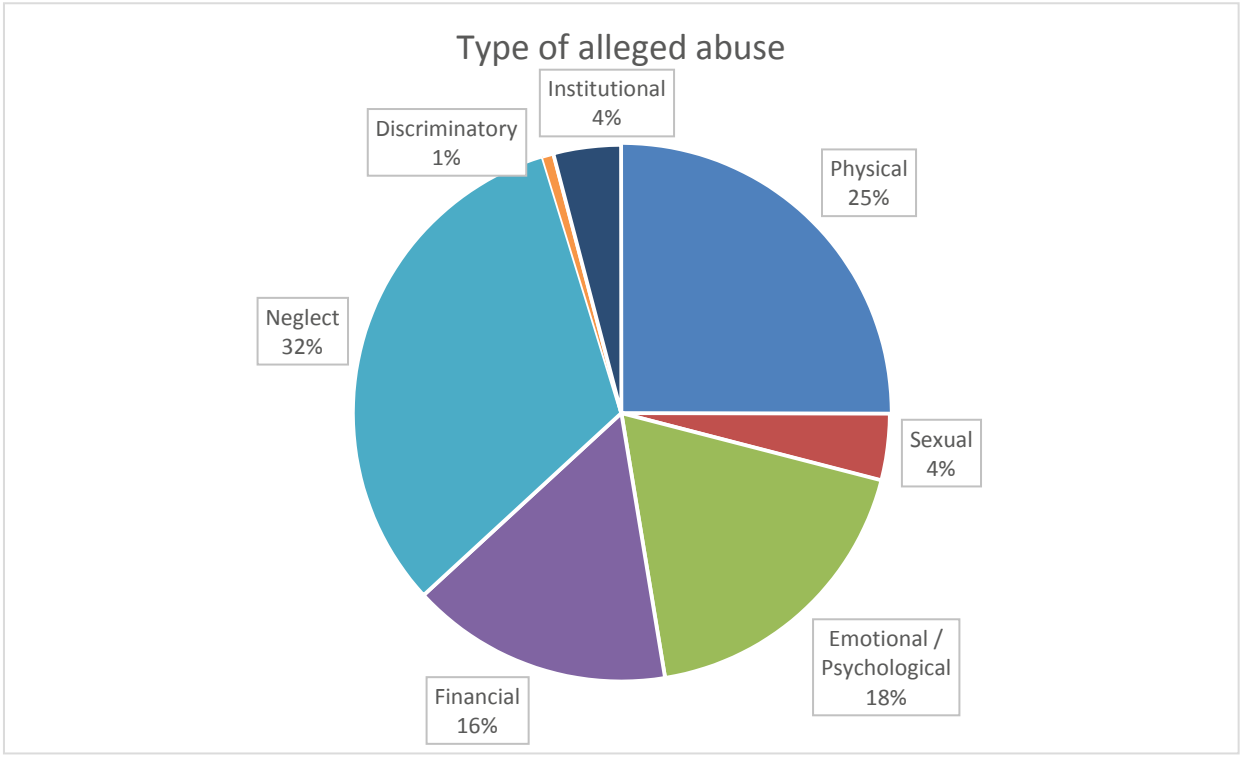


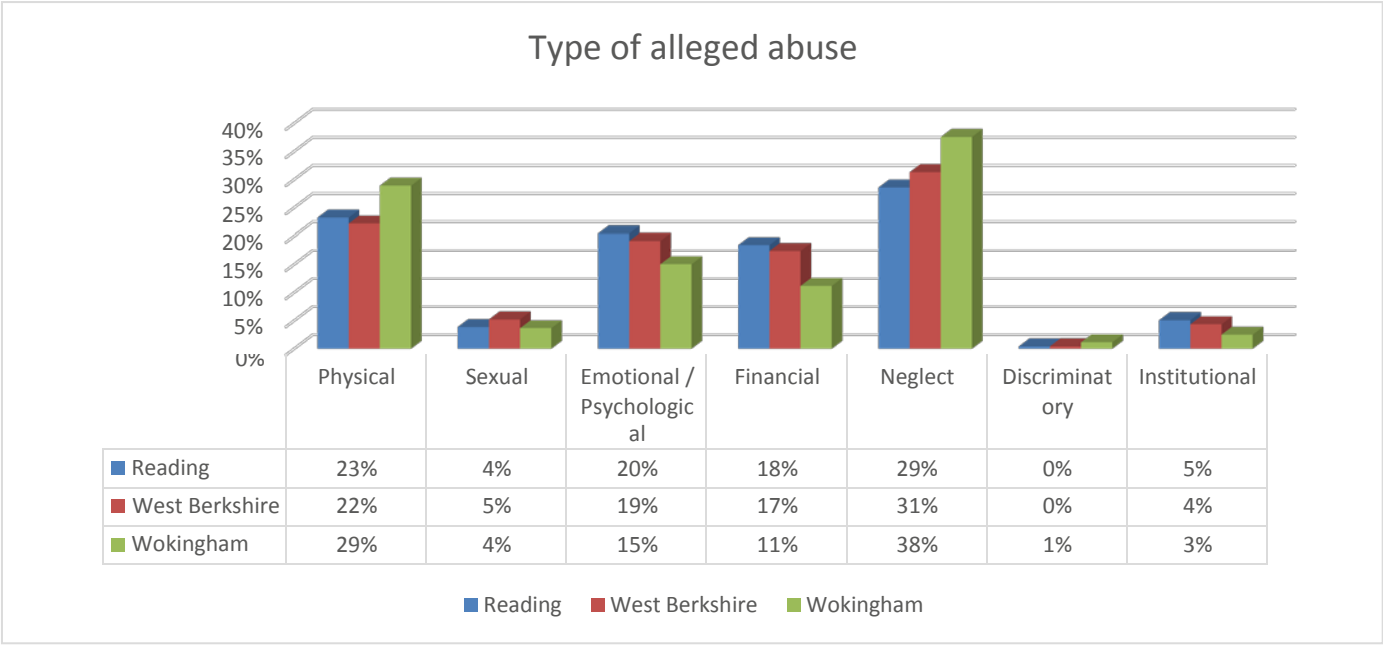


	White	Mixed	Asian	Black	Other	Not Known
Reading	78%	1%	3%	7%	1%	10%
West Berks	93%	0%	0%	0%	0%	6%
Wokingham	85%	0%	0%	0%	1%	13%

Type of Alleged Abuse

The most common type of alleged abuse was neglect and acts of omission, which accounted for 32 percent of allegations, followed by physical abuse with 25 percent. This is in line with national trends for the year. In the previous year the most common type of alleged abuse locally was physical abuse (27 per cent) followed by neglect (26 per cent.) Financial abuse has dropped by 3 per cent from last year and emotional and psychological has dropped by 2 per cent.





	Physical	Sexual	Emotional / Psychological	Financial	Neglect	Discriminatory	Institutional
Reading	23%	4%	20%	18%	29%	0%	5%
West Berkshire	22%	5%	19%	17%	31%	0%	4%
Wokingham	29%	4%	15%	11%	38%	1%	3%

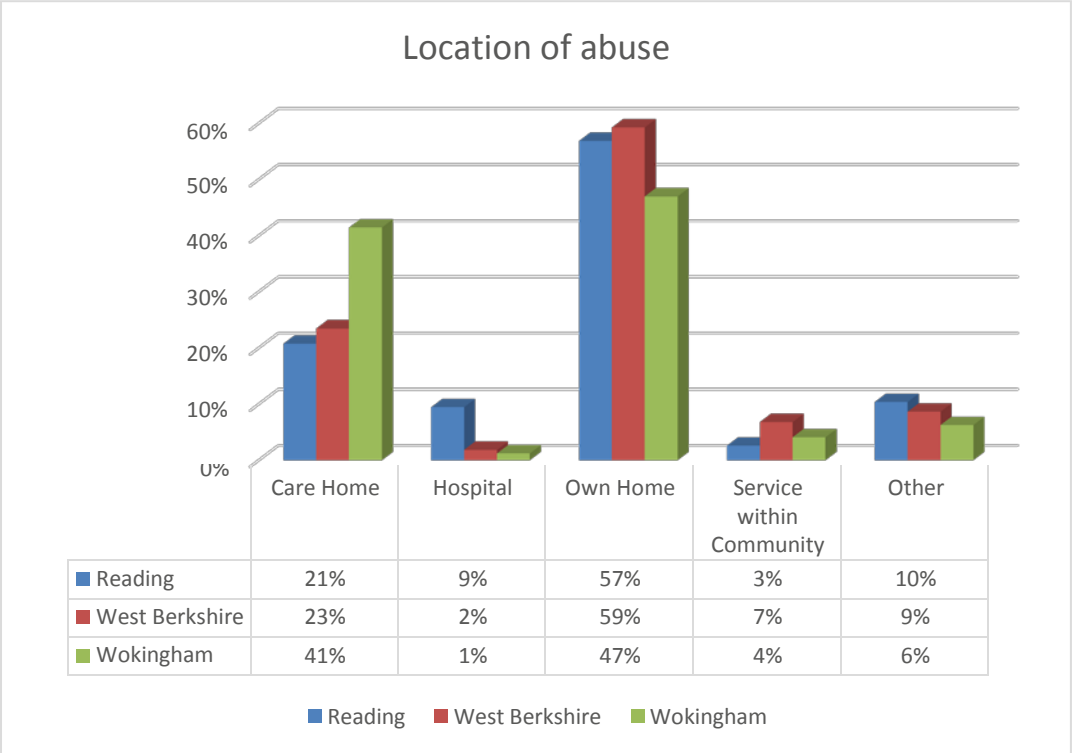
West Berkshire data in the table above includes 27% multiple types of abuse and Reading 27% multiple types of abuse. No examples of multiple types of abuse were recorded in Wokingham.

From 2015-16 four new voluntary categories will be added to this section of the national data collection (domestic abuse, sexual exploitation, modern slavery and self-neglect). Some

of these new categories may have been previously recorded under one of the other categories, so this is likely to impact on comparable data next year.

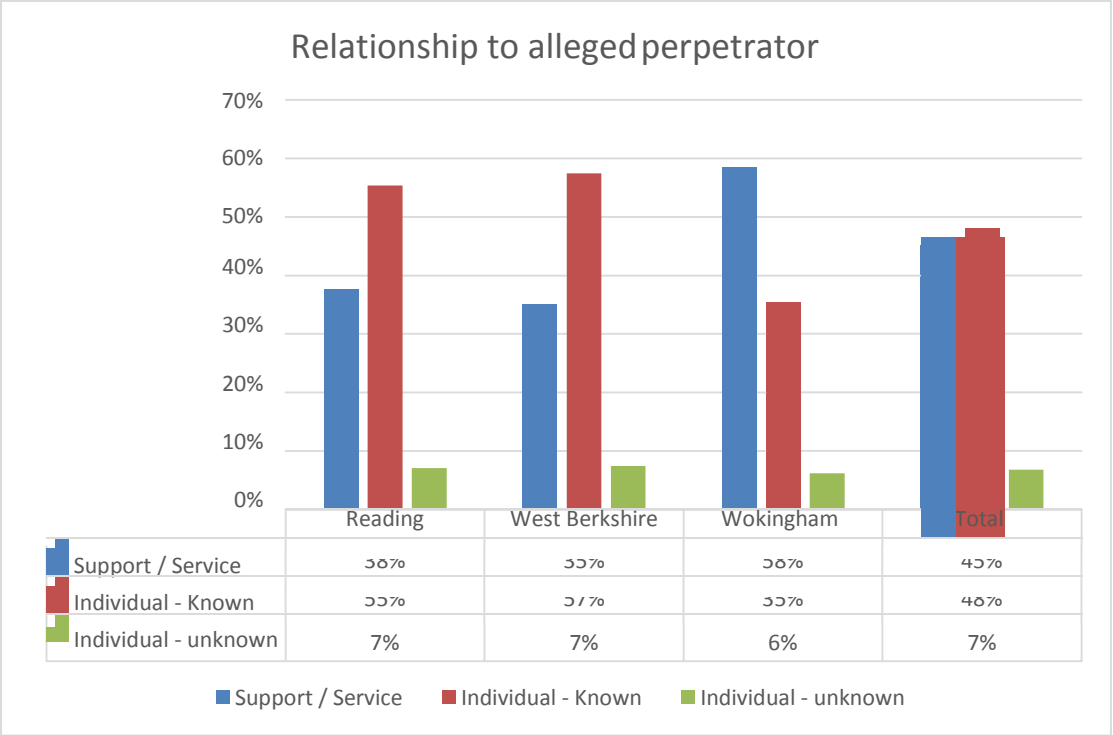
Location of Abuse

Data taken from completed referrals shows that the location of risk was most frequently the home of the adult at risk (54 per cent of allegations in total) or in a care home (29 per cent). Nationally, although the pattern is the same, the margin between these two locations is narrower, with the home of the adult at risk 43 per cent and care home 36 per cent.



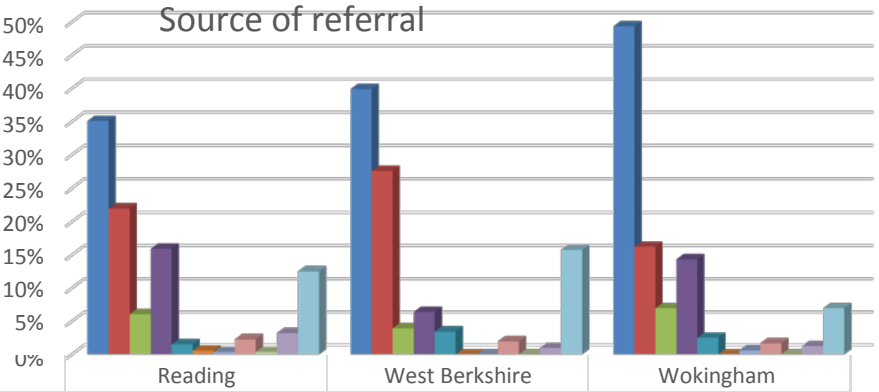
Relationship of Alleged Perpetrator to Vulnerable Adult

The source of risk was most commonly someone known to the adult but not providing a support service, accounting for 48 per cent of referrals. Someone providing support service was the source of risk in 45 per cent of referrals and for the remaining 7 per cent the source was someone unknown to the individual. This is largely in line with the national trend. The pattern in Wokingham is different to the other two areas.



Source of Referral

In 2014-15, 42 per cent of referrals were reported by social care staff (compared to 46 per cent in the previous year) and 21 per cent were from health care staff (compared to 17 per cent in the previous year.) Trends across all other sources are very stable.

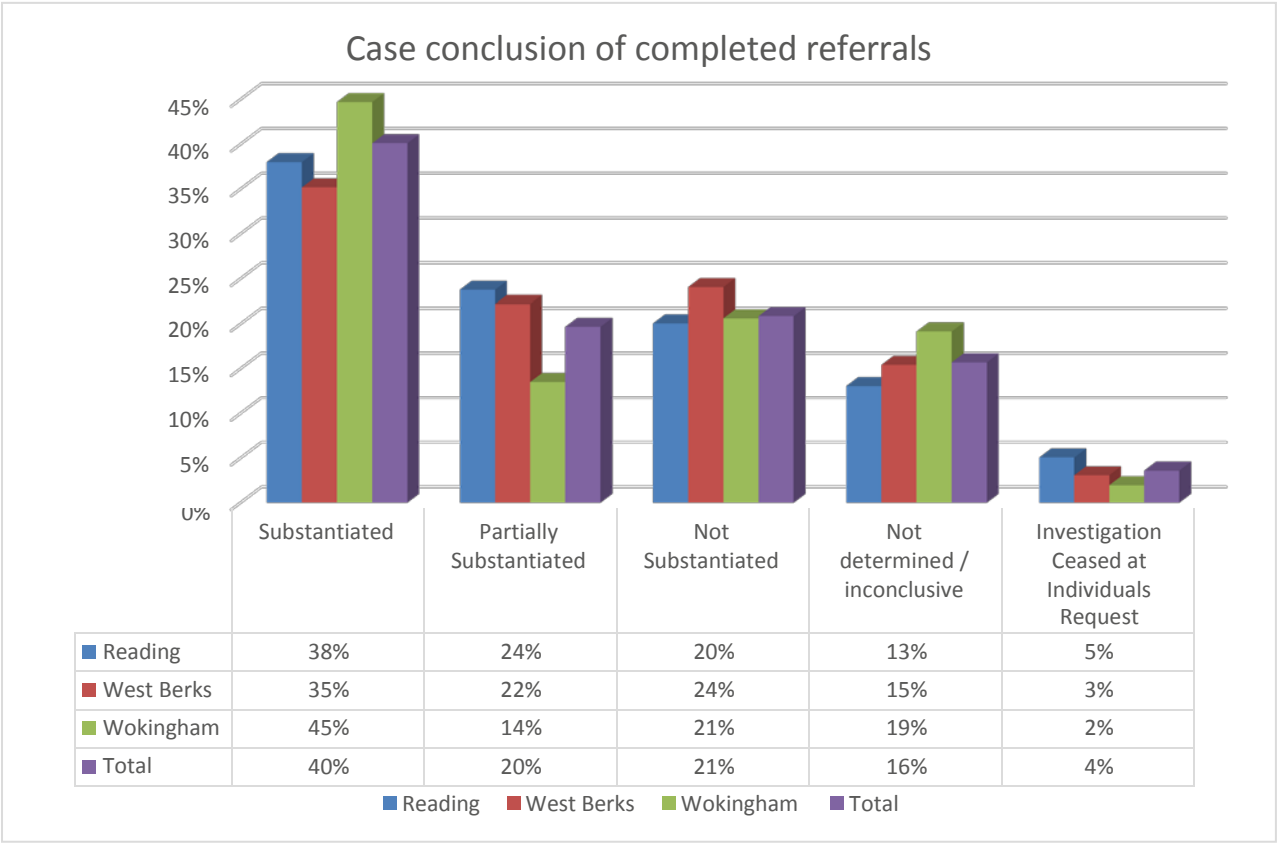


	Reading	West Berkshire	Wokingham
Social Care	35%	40%	49%
Health	22%	28%	16%
Self-referral	6%	4%	7%
Family Member	16%	6%	14%
Neighbour Friend	2%	3%	3%
Other service user	1%	0%	0%
CQC	0%	0%	1%
Housing	2%	2%	2%
Education training workplace	0%	0%	0%
Police	3%	1%	1%
Other	13%	16%	7%

Case Conclusion of Completed Referrals

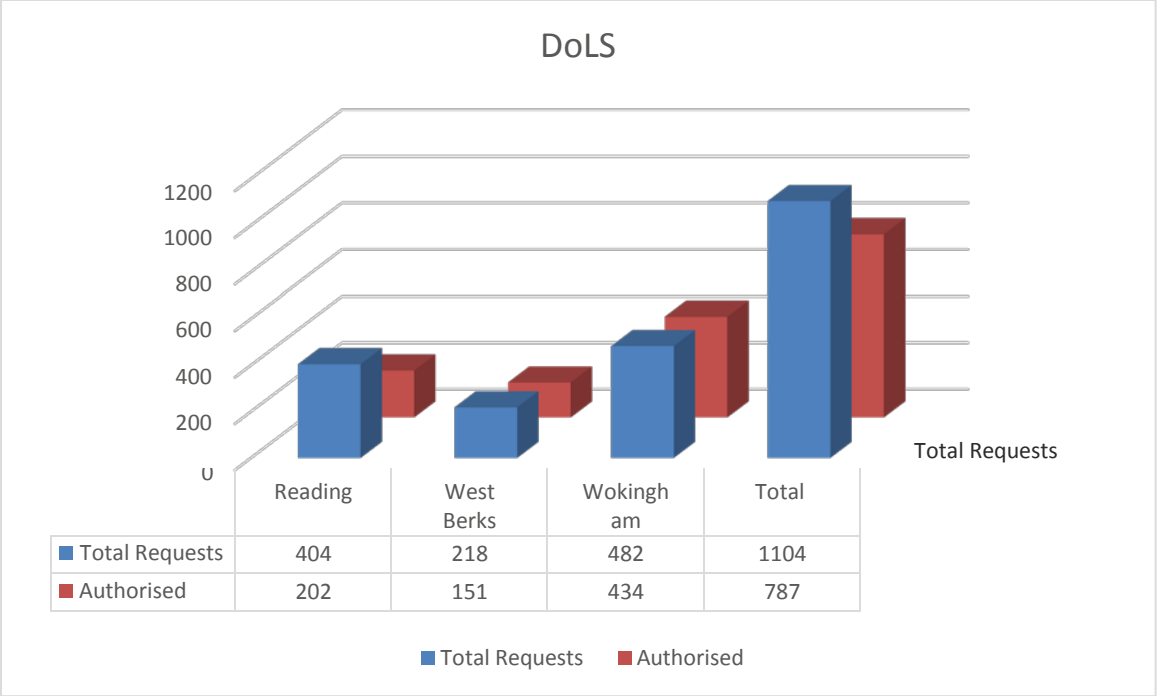
A case conclusion is the outcome of the investigation for a concluded referral and is categorised as Substantiated, Partly Substantiated, Inconclusive (or Not Determined) or Not Substantiated. The decision around substantiation is based on the 'balance of probabilities'. If an allegation of abuse can be proved on the balance of probabilities then it can be categorised as substantiated.

The table below shows the case conclusions for concluded referrals in 2014-15. There has been little change in the proportion of cases in each category from the previous year in the West of Berkshire. The allegations in over 40 per cent of cases were fully substantiated compared to 30 per cent nationally. 20 per cent of cases were partially substantiated compared to 10 per cent nationally and 21 per cent not substantiated, compared to 29 per cent nationally. Nationally, 22 per cent of cases were categorised as inconclusive, compared to 16 per cent locally.



	Substantiated	Partially Substantiated	Not Substantiated	Not determined / inconclusive	Investigation Ceased at Individuals Request
Reading	38%	24%	20%	13%	5%
West Berks	35%	22%	24%	15%	3%
Wokingham	45%	14%	21%	19%	2%
Total	40%	20%	21%	16%	4%

Deprivation of Liberty Safeguards (DoLS)



	Reading	West Berks	Wokingham	Total
Total Requests	404	218	482	1104
Authorised	202	151	434	787

During 2013-14, the total number of requests across the three areas was 27, with 13 of these applications authorised. The dramatic rise in applications is as a result of the Supreme Court's judgement in March 2014 which suggests that the definition of a deprivation of liberty is wider than previously thought.

Safeguarding Adults Training Activity

From 1st April 2014 to 31st March 2015

	Number of staff attended training in 2012-13, per sector						
Reading Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	75	253	0	0	0	134	
Level 1 Refresher N/A							
Level 1 E-learning							
Level 2	26	45	1	0	1	73	
Level 3	4	29	0	0	2	35	
Advanced refresher	11	3	0	0	0	14	
Level 1 Train the Trainer	1	13		0	0	14	
RBC Total	**117**	**343**	**1**	**0**	**3**	**270**	**734**
West Berkshire Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	55	80		0	6	188	
Level 1 Refresher	46	61	1	0	0	0	
Level 1 E-learning	65	88		0	0	0	
Level 2	8	5		0	0	0	
Level 3	3	2		0	0	0	
Level 1 Train the Trainer	0	0	0	0	0	0	
WeBC Total	**177**	**236**	**1**	**0**	**6**	**188**	**608**
Wokingham Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	93	74	1	0	0	87	
Level 1 Refresher N/A					0	0	
Level1 E-learning N/A					0	0	
Level 2	60	24	3	0	6	0	
Level 3	12	0	1	0	0	0	
Level 1 Train the Trainer	0	0	0	0	0	0	
WoBC Total	**165**	**98**	**5**	**0**	**6**	**87**	**361**
Berkshire Healthcare NHS Foundation Trust	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	318	0	0		1		
Level1 E-learning	709	0	0	0	0		
Level 2	46	0	0	0	0		
BHFT Total	**1073**				**1**		**1074**
Royal Berkshire Hospital NHS Foundation Trust	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	0	0	0	0	0		
Level 1 E-learning	0	0	0	0	0		
Level 2	0	0	0	0	0		
RBH Total	**0**	**0**			**0**		
West Berkshire CCG	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	0	0	0	0	247	GPs	
Level 1 E-learning	18	0	0	0	0	CCG	
Level 2 (if deliver?)	0	0	0	0	0		
West Berks CCG Total	**18**	**0**	**0**	**0**	**247**		

6. Appendices

Appendix A

Strategy for Safeguarding Adults in the West of Berkshire 2015-2018

Commitment by the West of Berkshire Safeguarding Adults Board

The West of Berkshire Safeguarding Adults Board is a partnership committed to working together to ensure that adults who may be at risk are:

- Able to live independently by being supported to manage risk;
- Able to protect themselves from abuse and neglect;
- Treated with dignity and respect; and
- Properly supported by agencies when they need protection.

The Safeguarding Adults Board and its partners will achieve the above commitment through the delivery of the following strategic priorities and objectives:

Priority 1 - Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and Boards.

Objective 1.1 Develop oversight of the quality of safeguarding performance.

Outcomes for 2015-16 include:

a. Quality Assurance Audit used for cases across social care teams who carry out safeguarding investigations will assure staff, managers, elected members and the community that all investigations are carried out to a high standard and comply with legislation in terms of quality and timeliness.
b. Safeguarding Forums will encourage group conversation and reflective practice.
c. Royal Berkshire Hospital Foundation Trust multidisciplinary adult safeguarding clinical governance committee established with responsibility for oversight of clinical performance.
d. Quality performance measures developed by Protecting Vulnerable People Senior Managers in Thames Valley Police to review size of current investigations, workloads and themes.
e. Internal quality assurance framework will give direct feedback to staff and managers, inform on-going training and development needs, improve practice around standards in line with Berkshire safeguarding policy and improve staff recording.

Objective 1.2 Have in place an effective framework of policies, procedures and processes for safeguarding adults.

Outcomes for 2015-16 include:

a. Review of Adult Safeguarding Policy in response to the Care Act 2014 will provide assurance that compliant policies and processes are in place across agencies.
b. Review of the new operational process for Individual and Organisational safeguarding investigations and the Safeguarding Team duties in Reading Borough Council will allow amendments to be made based on real issues that have occurred.
c. Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital Foundation Trust Mental Capacity Act Policies will provide clarity concerning the MCA, including training to support knowledge, audit of practice and interdependency with other policies.
d. Review of current practice and gap analysis report and action plan in response to report on *Jimmy Saville NHS investigations: Lessons Learnt, Feb 2015*, will provide additional assurance and clear lines of accountability concerning the lessons learnt in other organisations.

Priority 2 – Making Safeguarding Personal

Objective 2.1 The views of adults at risk, their family/carers are specifically taken into account concerning both individual decisions and the provision of services.

Outcomes for 2015-16 include:

a. Programme of external information and support planned for providers and service users in West Berkshire Council will ensure the Making Safeguarding Personal agenda is central to their understanding when raising safeguarding concerns.
b. The views of adults at risk and their family/carers will be reviewed as part of the Quality Assurance Audit in Reading Borough Council.
c. Achieve, as a minimum, bronze level compliance with the Making Safeguarding Personal programme in Reading Borough Council.
d. Safeguarding Forum meetings will provide service users and their representatives with an opportunity to share their views in a safe environment.
e. Audit of individual patient journeys by Royal Berkshire Hospital Foundation Trust will identify good practice and gaps, improve learning, and ensure patient focused actions.
f. Duty of Candour is applied to safeguarding investigations within Berkshire Healthcare Foundation Trust.
g. Feedback as a result of the implementation of the fire safety guide for adults used to identify good practice and gaps by Royal Berkshire Fire and Rescue Service.

Priority 3 - Raise awareness of safeguarding adults, the work of the Safeguarding Adults Board and improve engagement with a wider range of stakeholders

Objective 3.1 Raise awareness of safeguarding adults and the work of the Board within all organisations.

Outcomes for 2015-16 include:

a. Redeveloped Safeguarding Adults Forum in West Berkshire with renewed focus on membership and action planning to reflect the priorities of the Board, will increase awareness and understanding across the professional sector.

b. Links developed from staff intranets to Safeguarding Adults Board's website.
c. Awareness raising of safeguarding adults and improved communication to improve learning and practice.
d. Review of feedback systems within adult social care and joint health and social care teams in Wokingham to improve practice.

Objective 3.2 Increase public awareness of safeguarding adults and the work of the Board.

The Board has a Communication Strategy which outlines its aims and objectives for clear communication, its target audiences, the types of information it needs to share and the methods of communication. In addition, outcomes for 2015-16 include:

a. Launch of the Safeguarding Adults Board website.
b. Review and update safeguarding literature and promotional material to raise awareness amongst services users, families and the public.

Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

Objective 4.1 Continue to ensure staff receive appropriate and effective level of safeguarding and other relevant training.

Outcomes for 2015-16 include:

a. Events to embed learning from reviews of significant incidents will ensure staff have various opportunities to access learning outside of the formal training programme.
b. Partners contribute to the work of the Learning and Development Subgroup and support peer observations and reviews of training across the area.
c. Improved safeguarding knowledge, competence and confidence within Royal Berkshire Hospital Foundation Trust workforce through a review of safeguarding training and a Strategy and Training Plan for 2015/16.
d. Training requirements for Berkshire Healthcare Foundation Trust reviewed in light of the Care Act.
e. Content and intentions of the Royal Berkshire Fire and Rescue Service's 'Adult At Risk' and associated 'Memorandum of Understanding' documents are understood by staff and partners.

Objective 4.2 Improve mechanisms to critique good and bad practice and share learning more widely.

Outcomes for 2015-16 include:

a. Maximise learning from reviews of significant incidents across the partnership using the Learning Together model.
b. Development of the operational Care Quality Intelligence Partnership Group and the strategic Care Quality Board in West Berkshire to identify good and bad practice and share

learning.

c. Quality Assurance Audits used in Reading to critique practice in order to ensure all investigations are carried out to a high standard which complies with legislation in terms of quality and timeliness.
d. Opportunities for sharing learning, concerns and best practice in a safe environment via Reading's Safeguarding Working Group and Forum will increase staff confidence in their practice.
e. Safeguarding practice included in Royal Berkshire Hospital Foundation Trust CQC peer review of wards/units will enable testing of knowledge and practice and targeted improvement.
f. Royal Berkshire Fire and Rescue Service embed 'Fatal Fires and Near Misses' process and associated communications for staff and partners.
g. Good and bad practice used to inform safeguarding training in Royal Berkshire Hospital Foundation Trust so that it is more relevant and supports staff development.

Priority 5 – Coordinate and ensure the effectiveness of what each agency does

Objective 5.1 Challenge staff and organisations where poor practice is identified.

Outcomes for 2015-16 include:

a. In West Berkshire, improved information sharing processes between teams, operational and strategic groups, to co-ordinate opportunities to challenge poor practice.
b. Improved information sharing between Safeguarding and Contract and Commissioning teams in Reading to support timely identification of potential organisational abuse and appropriate action.
c. Performance information collected and submitted by partners will be understood by Board members and used to inform planning.
d. Processes are reviewed to ensure pathways and responsibilities are clear and agreed by all parties in Wokingham.
e. Evidence from external reviews in Wokingham is used to improve service design.

Objective 5.2 Develop the role of the Forums to provide feedback on the effectiveness of what each agency does.

Outcomes for 2015-16 include:

a. Redeveloped and well-attended Safeguarding Adults Forums across all three localities, with functions and actions aligned with the Board's priorities.
b. Through the Forums, opportunities for feed-back by organisations and service users will ensure that practice is aligned to what works best for partners and service users.

Key actions in support of the strategy:

- ☐ Awareness raising and communication of key information to the public and professionals.
- ☐ Workforce planning by all member agencies to meet the demands of safeguarding work and develop the necessary knowledge and skills at all levels. Each organisation to have in place a training strategy.

- ☐ Collection and analysis of annual safeguarding performance data by the relevant agencies.
- ☐ Governance arrangements in place in each member organisation to monitor the standards of practice to safeguard vulnerable adults from abuse. These arrangements will include: formal links between the Board, senior managers and Local Authority Members; regular audits; clear responses to local and national incidents and inquiries; quality assurance process and data to inform forward planning and service development; information dissemination; prevention and intervention.
- ☐ Prevention is key: there is a clear programme of work to reduce the risk of abuse/neglect across the range of settings.
- ☐ The inclusion of safeguarding in commissioning strategies and in contracts.
- ☐ Continually updating policy and procedures in line with national and local developments both within safeguarding and in other key agendas.
- ☐ Carrying out Safeguarding Adults Reviews and acting on them.
- ☐ Development of services capable of responding to those who have been abused or are at risk of abuse or neglect, or those who are perpetrators of abuse or neglect.
- ☐ Engagement with the whole range of stakeholders including service users and carers.

Implementation and Monitoring

Implementation of this Strategic Plan will be achieved through the work of the Subgroups and through delivery of the actions in the Business Plan.

An annual Business Plan has been developed which gives detail about how the priorities of this Strategic Plan will be implemented. The Business Plan includes key actions that partner agencies have committed to delivering in the next year.

Progress against the Business Plan will be reported to the Safeguarding Adults Board at six monthly intervals and the Annual Report will provide an overview of achievements and any areas for further development.

Although the Strategic Plan is a three-year plan, it will be reviewed on an annual basis and updated where necessary.

Glossary:

BHFT – Berkshire Healthcare Foundation Trust

CQC – Care Quality Commission

MCA – Mental Capacity Act

RBFT – Royal Berkshire Foundation Trust

RBFRS – Royal Berkshire Fire and Rescue Service

SAB – Safeguarding Adults Board

SE ADASS – South East Association of Directors of Adult Social Services

Further information about how partner agencies will contribute to the delivery of this Strategic Plan can be found in the Business Plan 2015-16.

Appendix B

Learning from Safeguarding Adults Reviews - The Case of Ms F

1. Purpose of the Safeguarding Adult Review

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults' Boards get the full picture of what went wrong, so that all organisations involved can improve their practice.

Organisational systems are complex. Therefore findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation.

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. Case Review findings say something more about local agencies and their usual patterns of working. They exist in the present and potentially impact in the future. **The six findings are presented in section 4 below.**

It is important that local agencies review the findings from a Safeguarding Adult Review and consider what changes can be made in local processes and practices to prevent such a case reoccurring.

2. Succinct summary of case

Ms F was a woman of 22 at the time of her death. She had a baby removed and adopted in 2010 and she was not open to any service until just before her death, with the exception of her GP, when she was referred to Adult Social Care by the Police. She subsequently died of sepsis in May 2013. Other members of the household were well known to many services in Reading including Antisocial Behaviour and the Police, both as victims and perpetrators.

3. Appraisal of professional practice in this case – a synopsis

Various members of Ms F's household were well known separately as individuals to agencies for many years and many appropriate interventions were offered to them prior to the period under review and during it. The focus of these services was around the tenancy, in particular the state of the property and rent arrears, as well as the impact of anti-social behaviour on neighbours. **The differing drivers for services are explored further in Finding 2**.

This cycle of intervention and engagement is explored in Finding 2.

It is notable that for much of the review period, professional engagement was focused on other individuals in the family unit of which Ms F was a part, without specific interventions for her. It is also notable that the strong interdependency between members of the family went unrecognised, although this is not unexpected given that adult assessments are about individuals only. **This is explored in Finding 6.**

Prior to the period under review the case has some unique aspects. The treatment of another member of the family led to the first case that Reading Borough Council took to the Court of Protection on grounds of neglect, and one of the first Deprivation of Liberty Safeguards that was carried out on another member. Neither of these people forms part of the family unit during the

period under review but the historical background is significant. **The consequences of historical knowledge is explored further in Finding 6**

Ms F gave birth in 2010 but her baby was removed because of concerns of neglect and subsequently adopted in December 2011 and the case closed by Children's Services. Following this, Ms F had no subsequent support, with the exception of her GP who had prescribed anti-depressants. This was standard practice at the time. Since then the importance of support following removal and adoption of children has been recognised, and has led to the establishment of the Future Families Project.

In February 2012, the Police were called to the household after Ms F had reportedly attempted to cut her wrists with a knife. The Police response was compassionate and well-judged: they took Ms F to A&E away from the chaotic home situation.

After this event, no further services were requested or provided to Ms F in her own right until May 2013. Between February 2012 and March 2013 professionals from a number of different agencies attended the family home, largely as part of plans to implement an eviction on the grounds of antisocial behaviour and rent arrears. Ms F was present during all of these visits, but usually as a 'background' member of the household: most interventions were targeted at her mother, as she was the tenant, and mother's partner who had a diagnosed learning disability.

The Review Team has considered carefully whether any of these professionals could have picked up at any earlier stages that Ms F, or any other members of the family were at risk, and this is discussed below. However, in general it seems that there were no reasons why visiting professionals would have singled Ms F out within the family. Ms F appeared articulate and had a reasonable level of cognition compared to other individuals living in the household. **The impact that an individual's presentation can have on assessments of vulnerability is further discussed in Finding 5.**

The Police were called to the house on numerous occasions during the review period following alleged ASB or domestic abuse and drunken behaviour.

ASB visits were made at intervals during the Review period for the clear purpose of reducing anti-social behaviour. The ASB Officers were concerned about the vulnerability of the family as a whole, and in October 2012 contacted Safeguarding Adults to check if any household members were known to ASC because of concerns about their possible vulnerability. Whilst ASB were beginning to prepare the case for eviction, the Rents Section of Housing had already gained a possession order from the Courts for substantial arrears. This had been suspended as the household had undertaken to pay back arrears. The Neighbourhood Officer did not act effectively as the conduit between the Rents Team and ASB to pull the two eviction processes (via ASB and via rent arrears) together. This was in part due to the blurring of the role of Neighbourhood Officer and ASB Officer in terms of antisocial behaviour for Council tenants at the time. Roles have been subsequently defined.

It was not until ASB formally approached the Council's Legal Team to begin the Court process in June 2012 that they became aware that the tenant was already being taken through the eviction process due to substantial rent arrears. The current reorganisation of Housing to bring the Recovery Team into the Department rather than remain in Finance should prevent this dislocation occurring.

At the same time Recovery Officers continued to try to engage the tenant using a variety of methods including phone calls and visits as well as standard letters. There is a strange effect of the Court process that Council Officers have to repeat attempts to engage and support tenants time and again because they know that the Court will refuse the eviction unless they can prove over time that the actions have not been effective by citing non-payment of arrears, state of the property, or ASB. In order to evict, the ASB Team had to establish a large body of evidence of extreme behaviour as well as the poor state of the property. They also have to prove that they have tried to provide support to vulnerable tenants. **This is explored further in Finding 2**

In December ASB visited the house. They noticed that Ms F looked unwell and advised her to contact her GP. This was appropriate and above expected standards.

ASB contacted Safeguarding Adults again in December 2012 to discuss their concerns about family member's vulnerability as the eviction process was continuing. They were aware that a person with a Learning Disability (the tenant's partner) was living in the house but they were concerned about the tenant and her sister. They had no concerns about Ms F. This led directly to a series of joint visits between ASB and Community Learning Disability Team (CLDT).

The decision by CLDT to assess both the tenant and her partner was above expected standards. Historical knowledge indicated that only one household member was potentially eligible for community care support but consideration was given that the tenant's needs may have changed over the time. **See Finding 4 for further exploration of this.**

CLDT and ASB joint visits and attempts to engage were tenacious and beyond what would have been expected and were made as a genuine effort to support the family. During the visit when they were given entry, Ms F was sitting on the sofa, but it was the only furniture in the room. On that occasion in February Ms F's mother volunteered that she thought Ms F was unwell and she was advised to contact the GP and ask her to visit. This was appropriate given that both women had mobile phones, and from medication on the table it was clear that Ms F was in contact with her GP.

In February 2012, ASB took the case to the ASB Multi Agency Panel (MAP), a panel established in order to agree eviction of tenants who may have implications for other agencies. This was the only forum where there was a wider discussion of needs of the family as a group rather than individuals. The Review Team felt multi agency discussion would have been helpful much earlier. There is no structure to support this but a multi-agency strategy meeting could have been convened. MAP is not designed to take a holistic view of alternative actions, although this did in fact occur e.g. the decision to refer Ms F, her mother and aunt to the ASC Risk Enablement Panel (REP). REP is designed to examine 'stuck' cases and is used for individuals who don't necessarily reach community care criteria but who are high risk or resource intensive. In fact the referral did not take place and in any case was too late to impact on the subsequent eviction.

It is notable that the referrals to REP were INDIVIDUALS not as a family group. Ms F again does not feature as being of concern compared to others. **See Findings 1 and 2 where there is consideration of panel use, Finding 5 which explores innate bias and Finding 6 which explores the impact of assessment of individuals only**.

In May 2013 the Police were called to the house due to a neighbour dispute. During this visit, the Police Officer became concerned about Ms F because she appeared unwell. There was appropriate practice in recognition and referral of Ms F to ASC by the Police via the Protection of Vulnerable Adults Unit. It took almost 24 hours for the referral to be passed to Adult Social Care which was appropriate as the Police Officers attending had no reason to suspect the severity of Ms F's illness.

However, this meant that referral was sent late on a Friday afternoon prior to a Bank Holiday and was not picked up by the Single Point of Contact in ASC until the following Tuesday morning, below acceptable standards. The system for receipt of police referral has since been changed.

Once the referral had been triaged it was swiftly passed appropriately to CLDT as they knew the household. Because the referral was not marked as urgent, CLDT appropriately researched the household. It was appropriate to include a nurse as part of the joint visit that same afternoon given the nature of the referral. It was luck that the nurse was male and that Ms F's mother assumed he was a GP and allowed them access into the house. They chose not to insist on a physical examination due to the distress of Ms F but obtained permission to contact Ms F's GP.

The GP had Ms F flagged on the system as having LD which was incorrect but it meant she acted swiftly to make a home visit that evening, above appropriate standards. She called paramedics who took Ms F to hospital.

Safeguarding alerts made by paramedics and acute hospital staff, and the subsequent multi-agency safeguarding investigation adhered to the Berkshire Safeguarding Adults' Policy and Procedures.

Staff at RBH made every effort to understand Ms F's wishes and responded to these despite being understandably shocked at Ms F's physical condition. There was a strong multi-agency communication and joint working throughout the time period around the criminal investigation.

The efforts by Housing Needs to develop a supportive relationship and to ensure that the tenant understood the eviction process were above the expected standards particularly when the remaining family members were living in temporary accommodation.

What is notable was that the eviction process continued in parallel throughout the criminal investigation. To some extent officers were constrained by the statutory framework within which they operate but nevertheless the Review Team were surprised that the process continued. The death of her daughter coupled with the criminal investigation would have had a considerable impact on the tenant's ability to comply with the process.

Findings

FINDING 1

In Reading, the Multi-Agency Pathway for non-engagement is not consistently followed, with the consequence that multi-agency perspectives and resources are not brought to bear when previously-managed risk becomes less controllable.

SUMMARY

Reading has substantial numbers of adults who are either vulnerable or at risk, and who do not engage with services. Whilst this Safeguarding Adults Review was under way, the Safeguarding Adults' Partnership revised and re-launched an existing pathway to try and increase the likelihood of professionals, led by a senior practitioner, thinking collectively about possible new solutions in each instance of non-engaging adults where risk starts to increase. If practitioners and their managers are not familiar with the pathway, it cannot drive improvements.

Questions

- How do practitioners view the issue of non-engagement? How much of a block and a risk is it to the local safeguarding adults' system?
- What attempts have there been to tackle the safeguarding risks that can come with non-engagement?
- How can the development of the Multi-Agency Safeguarding Hub promote earlier professionals' meetings?
- How do we empower practitioners to make decisions about service users?

FINDING 2

Assessment tools cannot predict the impact of the eviction process, which results in years of preventative work being swept aside in response to a crisis

SUMMARY

Numbers of evictions are growing nationally and there is insufficient understanding of the impact of eviction on vulnerable adults. This is particularly concerning because despite recognition that the boundaries between antisocial behaviour and safeguarding are blurred, it is hard to find any analysis of existing assessment tools and how they can predict the effects of eviction on adults with vulnerabilities.

Questions

- Do Board members know of any examples of assessment tools that can help predict the impact of eviction on vulnerable adults?
- How will the Care Act 2014 be implemented, particularly around prevention?

What can be done to encourage multi-disciplinary assessments in line with the practice seen in the case at the centre of this Review?

FINDING 3

When agencies with different drivers are all working with a complex family, managerial panels do not always have their intended effect and vulnerabilities get lost

SUMMARY

The Review Team examined the role of the various managerial panels in Reading. For many cases these are working effectively to manage risk. However some agencies are either referring too late or not at all which means that safeguarding risks are not being anticipated and managed, and this is a heightened risk if certain panels receive the bulk of their referrals from the agency that convenes them.

Questions

- How can agencies ensure that workers refer early to panels?
- Are the criteria for referral clearly understood?
- Could referral sources to each of the panels listed above be explored, to see if the patterns mean that some cases are not being referred at all?

How can the use of panels improve joint working between agencies?

FINDING 4

Are chaotic childless families losing out because there are fewer tools or mechanisms such as the Troubled Families initiative for professionals to use compared to when a child is present, leading to less alternatives for those adults?

SUMMARY

The risk in the safeguarding system is that when professionals in adult services are focussed on individuals (as set out in Finding 6), and in addition, lack the resources that come with programmes like Troubled Families, those professionals are more likely to struggle with services and solutions for the chaotic childless families, who according to the Case Group, are becoming an ever larger cohort within their caseloads.

Questions

- ☐ What learning from the Turnaround Families programme can be transferred across to vulnerable adults without children, whose antisocial behaviour is problematic for all agencies?
- Do agencies think a 'think family' approach is important?
- How can we reconcile the tension between focus on the service user and consideration of their wider family's needs, particularly in complex situations?

FINDING 5

Young and assertive service users are less likely to be seen as vulnerable, even in the face of known risk factors, and this has the consequence that crises are missed.

SUMMARY

The way some individuals present may preclude their being judged as vulnerable. Ms F had particular vulnerabilities due to events in her life, and for professionals working with adult service users, it is a complex task to assess what different sorts of vulnerabilities lie behind the way in which young and assertive service users present. Understanding and responding to those vulnerabilities might reduce the risk of a distressing crisis for that young person in the future.

Questions

- When do you have to intervene?
- How can we ensure a shared understanding of what constitutes vulnerable?
- Do workers understand the impact of obesity on Mental and physical health?
- How can we skill staff up to allow them to differentiate between 'vulnerability' they perceive but cannot use to ensure support through Adult Social Care?
- Do practitioners understand the impact of situational incapacity?

FINDING 6

Assessment for adults is about individuals, without scope for focussing on co-dependent needs, which means services struggle to understand patterns of need and behaviour amongst co-dependent groups of adults.

SUMMARY

Assessment is a crucial opportunity to understand the world of an adult service user, and most families have interdependencies of some kind which it could be fruitful for assessment to explore. Doing this consistently, perhaps considering what approaches have been effective in children's services, enables professionals to understand risks that otherwise are not made transparent.

Questions

- How can we provide young people with a self-protection strategy when they live in chaotic household?
- How can staff balance being inquisitive about households and being driven by the process of individual assessment?
- Should agencies begin to map adult households with multiple needs in the same way as the troubled Families Programme has mapped households with children?

Appendix C

Membership of Board and Subgroups

The Safeguarding Board itself is made up of senior managers from a wide range of partners and agencies. As in previous years, attendance at the Board has been high. The Board is made up of representatives from the following agencies:

- Berkshire Healthcare Foundation Trust
- Berkshire West Clinical Commissioning Groups
- Emergency Duty Service
- HealthWatch Reading
- Joint Legal Services
- Reading Borough Council
- Royal Berkshire Fire and Rescue Service
- Royal Berkshire NHS Foundation Trust
- South Central Ambulance Trust
- Thames Valley Community Rehabilitation Company
- Thames Valley Police
- National Probation Service
- West Berkshire District Council
- Wokingham Borough Council

Membership of subgroups in 2014-15

Partnership and Best Practice Subgroup

The Partnership and Best Practice Subgroup assists the Board in promoting good quality safeguarding practice.

Sylvia Stone (Chair)	Kathy Kelly - CCG	Sarah O Connor - WBC
Natalie Madden (minutes)	Sue Brain - WBDC	Jo Wilkins – RBC
Elizabeth Rhodes – RBFRS	Elizabeth Porter – RBFT	Cathy Haynes - BHFT

Performance and Quality Subgroup

The Performance and Quality Subgroup oversees performance of adult safeguarding activity in the West of Berkshire, highlighting the effectiveness and risks of key processes and practices.

Natalie Madden (Chair and minutes)	Jessica Higson - RBFT	Nailah Mukhtar - WBDC
Debbie Ferguson – RBC	Kathy Kelly - CCG	Sairah Parkar - WBC
Sarah O'Connor - WBC	Michelle Tenreiro Perez – RBC	

Governance Subgroup

The purpose of the Governance Subgroup is to ensure the Board has robust governance arrangements, with clarity of purpose and public accountability.

June Graves – WBDC (Chair)	Michelle Tenreiro Perez – RBC	Natalie Madden (minutes)
Kathy Kelly – CCG	Patricia Pease – RBFT	Nancy Barber –BHFT
Suzanne Westhead - RBC	Sarah O'Connor – WBC	

Communication and Publicity Subgroup

The Communication and Publicity Subgroup supports the messages that safeguarding is everyone's business and that good communication is the responsibility of all partners sitting on the Safeguarding Adults Board.

Sylvia Stone - SAB (Chair)	Sarah O'Connor –WBC	Natalie Madden – SAB (minutes)
Nikki Malin – BHFT	Peta Stoddart- Compton - WBDC	Kathy Kelly – CCG

Learning and Development Subgroup

The purpose of the Learning and Development Subgroup is to develop, implement, review and update the multi-agency Workforce Development Strategy for the protection of adults at risk. The aim of this Strategy is to provide an effective, coordinated approach to learning in order to support all agencies to prevent abuse and respond to safeguarding concerns with timely, proportionate and appropriate action.

Eve McIlmoyle – RBC (Chair & minutes)	Kathy Kelly - CCG	Catherine Haynes - BHFT
Jo Wilkins – RBC	Natalie Madden – SAB	Edwin Fernandes – WBC
Neil Dewdney – WBDC	Sue Brain – West Berks Council	Elizabeth Porter – RBFT
Stefan McLaughlin - TVP	Johan Baker - Wokingham BC	Kathy Gonzalez-Atowo – BHFT
Joy Baker – Bracknell & Wokingham College (PVI rep)		

Reading Borough Council Safeguarding Adults Annual Summary 2014/15

Performance Data

This summary is based on the data used to collate the SAR (Safeguarding Adult Return) for 2014/15 and previous SAR/AVA (Abuse of Vulnerable Adults) returns for earlier years.

Please note this is provisional data as the final results have not yet been published (as at Sept 15).

The figures in this summary do not match the SAR submission but is based on the same data. The SAR looks at individuals rather than individual safeguarding incidents. In order to conduct a fair comparison to previous results, the data reported below is looking at incidents too.

From 2015/16 the SAR is changing to the SAC (Safeguarding Adults Concerns) and will be looking at slightly different things and the terminology will be changing, from Alerts and Referrals to Concerns and Enquiries.

Volumes

Reading only began recording "Alert only" cases from 2012/13 prior to this all safeguarding incidents were recorded as a Referral.

The figures below are looking at Alerts and Referrals started in period (1st April – 31st March) and Closed Referrals are referrals ended during the period regardless of when they started.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Alerts only	-	-	-	87	163	175
Referrals	219	523	668	538	491	527
Total	219	523	668	625	654	702
Closed Referrals	225	532	662	539	451	513

- ☐ Alert Only -
  - o Numbers have increased slightly on last year, but are almost double what was recorded in 2012/13. We think this increase is due to better recording and better understanding of what constitutes a safeguarding referral.
- ☐ Referrals -
  - o Numbers of actual referrals have shown a slight increase this year (approx. 6%).

- The total of alert only's and referrals in period has shown a steady increase over the last 3 years - 625 in 12/13, 654 in 13/14 and 702 this year (approx. 6.8% increase on last year's total.

- These total figures work out at approx. 54 reports per month in 13/14 and 58 per month this year.

- The percentage of Alerts which go on to become referrals had reduced since 12/13 and this year remains at the same level - 86% in 12/13, 75% in 13/14 and 75% this year.

- Closed Referrals –

  - The percentage of completed referrals of all referrals is 91% for 13/14 and 97% for 14/15 indicating better use of documentation.

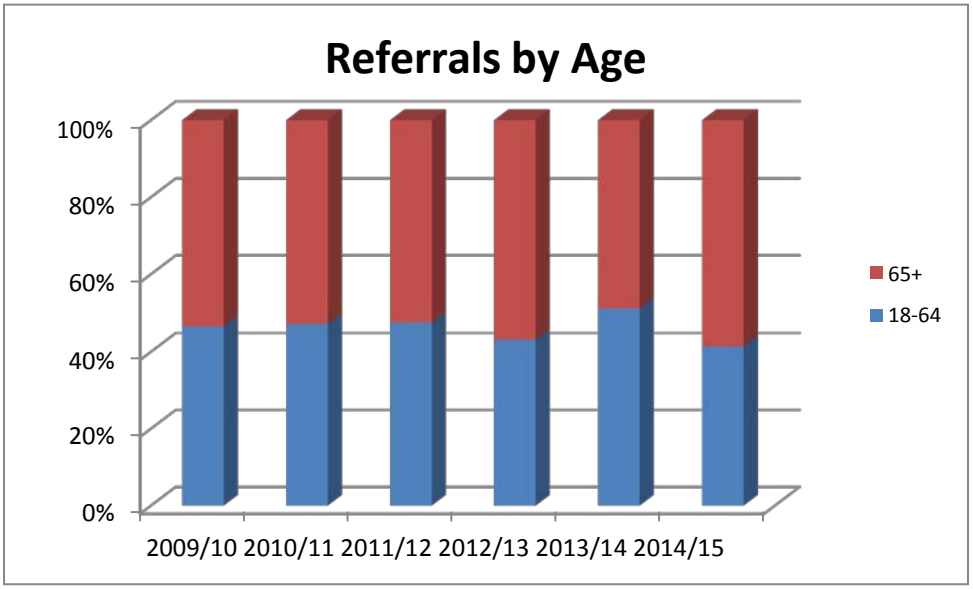
Referral Data

The next set of tables look at referrals received in the year broken down into different categorisations.

☐ Age Grouping

- Last year was the first time the 18-64 group had more referrals than the 65+. This year it has reverted back to the norm.

Numbers by Age	2012/13		2013/14		2014/15	
	No's	%	No's	%	No's	%
18-64	232	43%	251	51%	218	41%
65+	306	57%	240	49%	309	59%
Total	**538**		**491**		**527**	



☐ Gender

- The trend for this has remained the same – there is a higher proportion of referrals for females than males, with percentages this year matching last year's figures.

Percentages - Gender	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
M	-	44%	38%	40%	44%	44%
F	-	56%	62%	60%	56%	56%
Total	**0%**	**100%**	**100%**	**100%**	**100%**	**100%**

☐ Ethnicity

- Again the continuing trend with ethnic origin is mostly white (78%) – percentages are not much different to previous years.

- However the "not known" percentage is creeping up and may need to be monitored.

Percentages - Ethnicity	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2001 Census (ONS)
White	78%	82%	77%	80%	79%	78%	75%
Mixed	3%	1%	1%	1%	2%	1%	4%
Asian	6%	7%	6%	5%	5%	3%	14%
Black	5%	5%	5%	7%	6%	7%	7%
Other	2%	1%	0%	1%	0%	1%	1%
Not Known	6%	4%	12%	6%	7%	10%	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- We can see that Asian residents are under represented by 11% when compared to the data from 2011 Census, however the 10% of referrals whose ethnic identity is not known significantly hampers the reliability of performance information in this area.

☐ Client Group / Primary Support Reason

The categorisations for 14/15 have changed to previous years as the reports are now looking at Primary Support Reasons which makes direct comparison to previous returns much harder.

- However we have seen that most remain in the Physical Support Category 41%.

Percentages - Support Reasons	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
PDFS (incl sensory **pre** 2014/15)	61%	46%	45%	57%	47%	41%

Sensory Support						3%
MH (incl Dementia **pre** 2014/15)	9%	24%	25%	20%	24%	15%
Support with Memory/Cognition (new 2014/15)						17%
LD	22%	23%	22%	19%	24%	19%
Subs Misuse	0%	3%	5%	1%	3%	
Social Support (New 2014/15)						6%
Other Vulnerable	7%	4%	3%	4%	1%	
No Support Reason (new 2014/15)						1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

☐ Repeat Referrals

This looks at the number of repeat referrals as a percentage of all referrals received in the period.

Referrals are counted regardless of the incident so it could be the same incident being re-referred or different incidents involving the same safeguarding adult.

Percentages - Repeat Referrals	2010/11	2011/12	2012/13	2013/14	2014/15
Percentage	12.5%	15.4%	19.5%	16.5%	9.9%

- The numbers of repeat referrals have been dropping which potentially demonstrates more effective resolution and risk management of issues reported.

☐ Source of Referral

The table below looks at the source of referrals i.e. who raised the concern.

Source of Referral	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Social Care	**34.8%**	**32.6%**	**33.5%**	**37.7%**	**35.1%**
Health	**12.6%**	**22.6%**	**16.5%**	**22.0%**	**22.0%**
Self Referral	15.3%	12.1%	10.2%	10.2%	6.1%
Family Member	17.8%	15.1%	16.4%	14.9%	15.9%
Friend/Neighbour	2.9%	3.9%	4.3%	1.8%	1.5%
Other Service User	0.8%	0.0%	0.2%	0.6%	0.6%
CQC	0.6%	0.4%	0.2%	0.8%	0.4%
Housing	4.2%	3.9%	5.8%	5.7%	2.3%
Education/Training/Workplace	0.0%	0.4%	0.2%	0.4%	0.4%
Police	3.1%	4.2%	5.8%	2.4%	3.2%
Other	8.0%	4.6%	7.1%	3.5%	12.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

- Most years the figures have remained fairly settled although for this year we can see a slight dip in Self Referrals from 10% to 6%, and a significant rise in "Other" referrals from 3.5% to 12.5%, which may be a recording issue but may need monitoring.

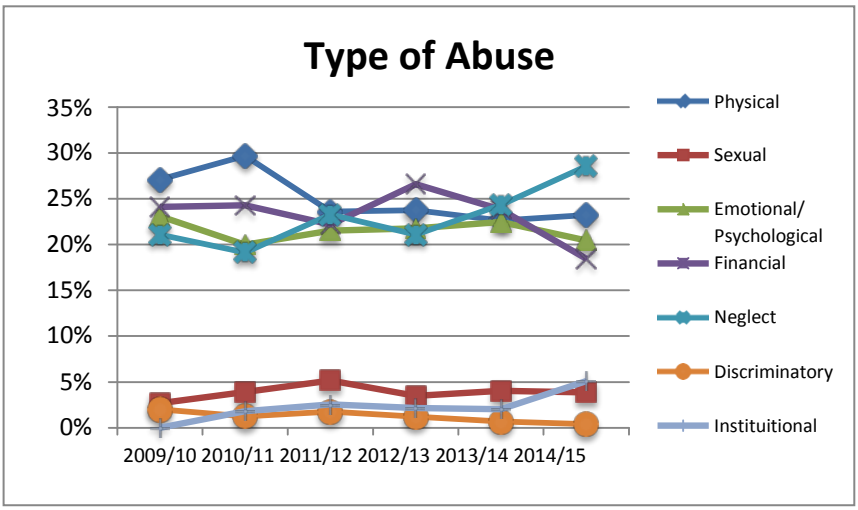
Closed Referral Data

The new SAR for 13/14 and 14/15 return looks at closed referrals during the period for the next tables (most of these would've come from cases opened in previous year's results which may skew the comparison a little.

☐ Abuse Types

Percentages - Abuse Types	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Physical	27%	30%	24%	24%	23%	23%
Sexual	3%	4%	5%	3%	4%	4%
Emotional/ Psychological	23%	20%	22%	22%	22%	20%
Financial	24%	24%	22%	27%	24%	18%
Neglect	21%	19%	23%	21%	24%	29%
Discriminatory	2%	1%	2%	1%	1%	0%
Institutional	0%	2%	3%	2%	2%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- The top 4 remain the same. Last year however the top 4 had very similar percentages (22-24%) this year they cover a much larger range (19-29%):
  - Neglect (29%)
  - Physical (23%)
  - Emotional/Psychological (20%)
  - Financial (19%)
- Financial abuse has been declining over the last 3 years – from 27% in 2012/13 to 18% this year.
- Neglect has increased over the same 3 year period from 21% in 2012/13 to 29% this year.
- Organisational abuse has more than doubled from 2% to 5% from last year reflecting, we believe, an improved identification and investigation process. This increase is also reflected in Location of Abuse information which is also showing increases in Care Home (Res/Nurs) and Hospital location percentages and Alleged Perpetrator statistics showing an increase in abusers from Social Care Support.



☐ Location of Abuse

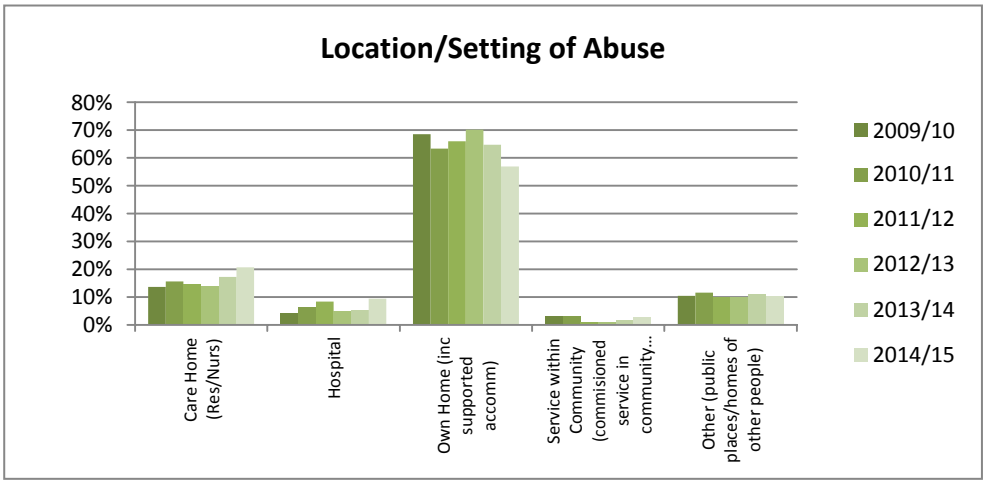
The categorisations for this option were reduced for SAR 13/14, so we have mapped previous year's options into the reduced options.

Percentages - Location/Setting	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Care Home (Res/Nurs)	14%	16%	15%	14%	17%	21%
Hospital	4%	6%	8%	5%	5%	9%
Own Home (inc supported accomm)	68%	63%	66%	70%	65%	57%
Service within Community (commissioned service in community setting)	3%	3%	1%	1%	2%	3%
Other (public places/homes of other people)	11%	12%	10%	10%	11%	10%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Most alleged abuse occurred in "Own Home" (57%) although this is decreasing year on year since 2012/13.

- Alleged Abuse in Care Homes and Hospital locations has shown an increasing trend over the same period from 14% in 2012/13 to 21% this year in Care Homes and from 5% in 2012/13 to 9% this year for Hospitals.

This may not mean that more abuse is occurring within these institutions but may just be that recording/reporting of incidents has improved.



☐ Action under Safeguarding

This is a new question which was added to the SAR from 2013/14.

Percentages – Risk Action	2013/14	2014/15
No further action under Safeguarding	54%	21%
Action Taken - Risk Remains	8%	9%
Action Taken - Risk Reduced	32%	55%
Action Taken - Risk Removed	6%	15%
Total	**100%**	**100%**

- Last year we were concerned that 54% were recorded as "no further action" even though we were confident action would've been taken. We think this was a lack of understanding within the teams. This has decreased significantly to 21% this year, evidence of improved training and process changes therefore making more skilled staff.

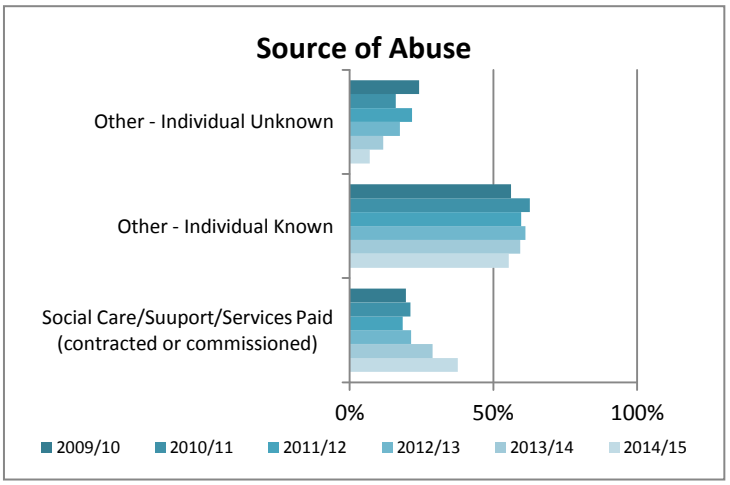
- "Risks Reduced" has increased significantly from 32% last year to 55% and "risk removed" has also increased from 6% to 15% this year.

☐ Source of Abuse

These options have been reduced for SAR (13/14) so we have mapped previous year's options into the reduced listing for easier comparison. However there are 2 graphs at the end of this section looking at the options in a bit more detail.

Percentages - Source of Risk	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Social Care/Support/Services Paid (contracted or commissioned)	20%	21%	19%	21%	29%	38%
Other - Individual Known	56%	63%	60%	61%	59%	55%
Other - Individual Unknown	24%	16%	22%	17%	12%	7%

Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

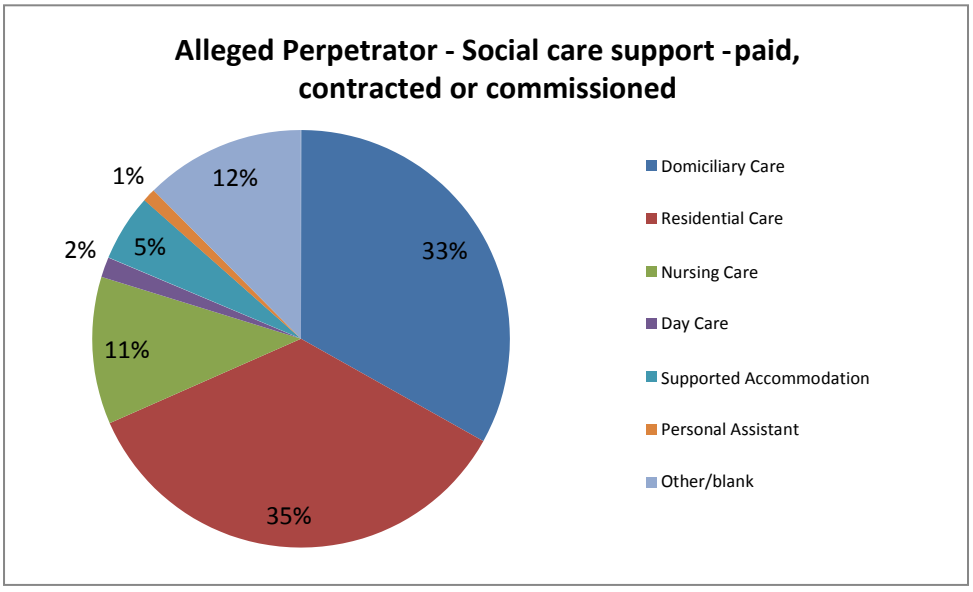


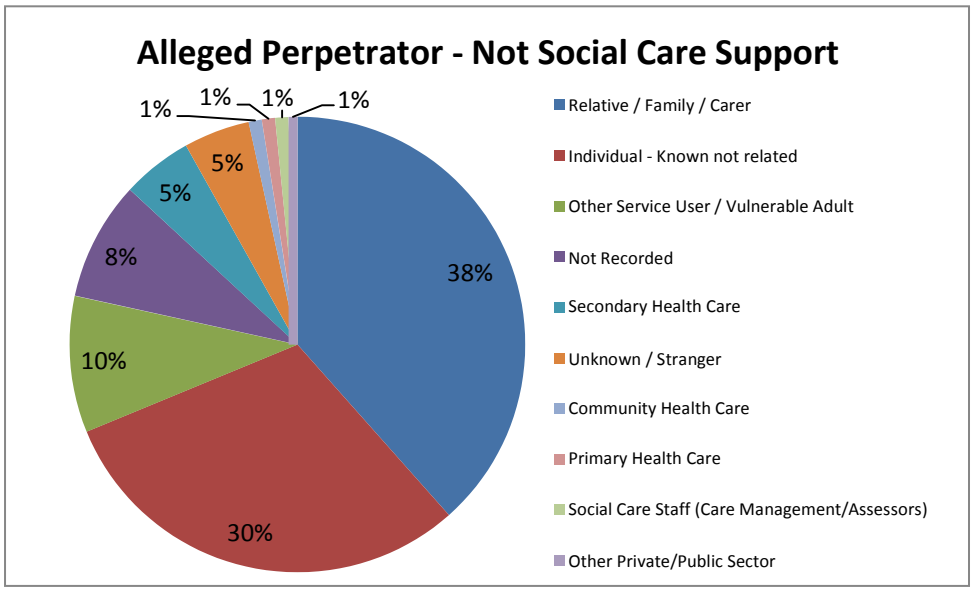
- The majority of alleged abusers are – known individual (55%) as in previous years, although this is showing a declining trend.

- Social Care/Support/Services Paid – has been increasing over the last 4 years from 19% in 2011/12 to 38% this year, which links in with the increase we have seen in care home abuse.

- Unknown Individual – has been decreasing over the last 4 years from 22% in 2011/12 to 7% this year. This is an improving picture which provides evidence of more consistent and tenacious work by our staff.

Below are two graphs breaking down the relationship of the alleged perpetrator in more detail.





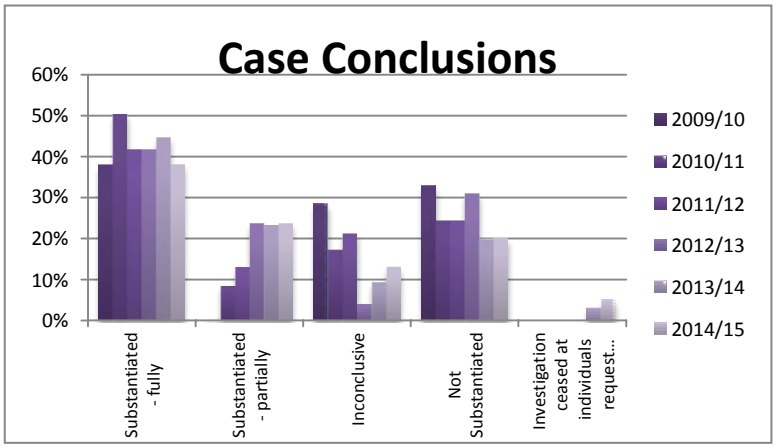
☐ Case Conclusion

This is no longer being counted in the return after this year. From next year we will be looking at Making Safeguarding Personal outcomes.

Percentages - Case Conclusions	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Substantiated - fully	38%	50%	42%	42%	44%	38%
Substantiated - partially	1%	8%	13%	24%	23%	24%
Inconclusive	28%	17%	21%	4%	9%	13%
Not Substantiated	33%	24%	24%	31%	20%	20%
Investigation ceased at individuals request (new for 13/14)	0%	0%	0%	0%	3%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Most cases were Substantiated fully (38%) although this is a decrease on last year's 44%.

- Inconclusive has increased over last 3 years from 4% in 2012/13 to 13% this year.

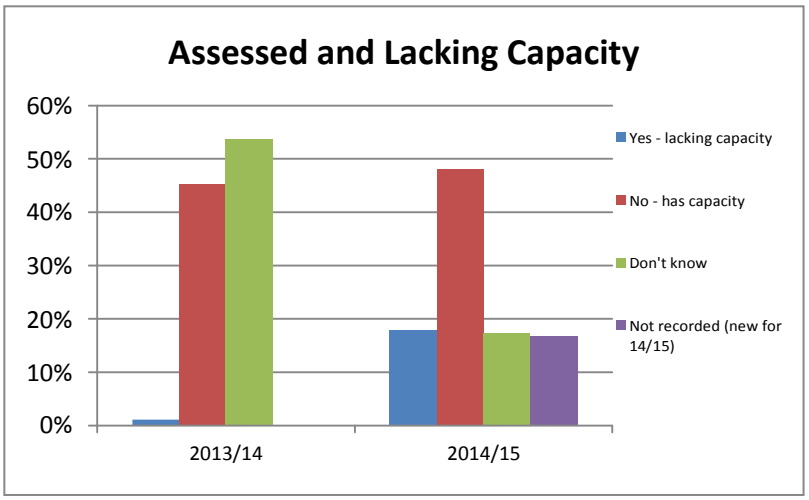


☐ Capacity

This is a new question added to the SAR from 2013/14. Not Recorded is a new categorisation added for this year (14/15).

Percentages - Capacity	2013/14	2014/15
Yes assessed and lacking capacity	1%	18%
No not assessed - has capacity	45%	48%
Don't know	54%	17%
Not recorded (new for 14/15)		17%
Total	**100%**	**100%**

- Most recorded as "Having Capacity" – 48%, similar to last year.
- Those lacking capacity has increased from 1% to 18% - we believe this to be better recording and understanding of this question from when it was introduced last year.
- "Don't knows" decreased significantly from 54% last year to 17% (although an additional 17% were not recorded at all this year).
- We expect this picture will continue to improve next year as renewed training on MCA takes effect.


Assessed and Lacking Capacity
60%
50%
40%
30%
20%
10%
0%
2013/14
2014/15
Yes - lacking capacity
No - has capacity
Don't know
Not recorded (new for 14/15)

West Berkshire Council Safeguarding Performance Executive Summary

1. Performance in 2014/2015 (based on SAR statutory reporting)

The data is sourced from the statutory SAR (Safeguarding Adults Return) for 2014/15. This is still provisional data as the DoH have not published the final cut and includes all episodes of alerts and referrals.

It should be noted that the data provided below for SAPB reports on safeguarding episodes to allow comparison with previous years reporting.

The data published in the SAR only reports on client numbers and can therefore not be directly compared.

With the introduction of the new SAC (Safeguarding Adults Collection) for 2015/16, and the SAB dashboard there will be greater consistency.

1.1 Volume of Episodes for Safeguarding Adults

The overall number of alerts and referral episodes has increased by 12% (707 in 2013/14 to 804 in 2014/15).

Alerts saw an increase in volume of 10% on the previous year (601 compared to 543 in 2013/14)

Referrals have increased by 19% in 2014/15; this is as a result of a higher number of alerts but also a higher conversion rate of alert to referral (34%). A higher alert to referral conversion rate suggests improved recording of alerts requiring referral stage 2 investigations.

Completed referrals as a percentage of all referrals was 82% this year compared to 76% last year.

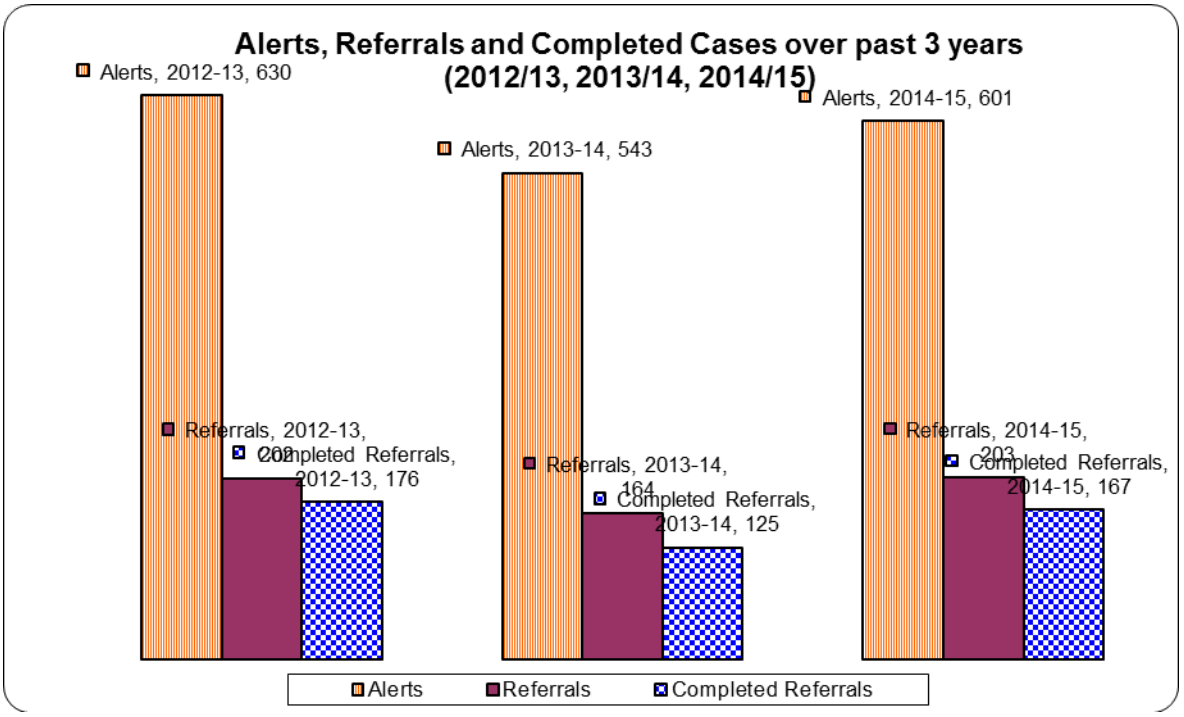
Number of alerts, referrals and completed referrals over past 3 years

(includes repeat referrals)

	Alerts	Referrals	Total	Concluded Referrals	% Alerts leading to Referral
2012-13	630	202	832	176	***32%***
2013-14	543	164	707	125	***30%***
2014-15	601	203	804	167	***34%***
% increase from previous year	***10%***	***19%***	***12%***	***25%***	

Completed referrals are the number of referral and strategy meeting forms that have been closed within the reporting period. The completed referral total is often different from the total number of referrals because it can include those referrals opened in the previous reporting year that then end in the current reporting year.

.



1.2 Alerts and Referrals by Age, Client Group and Gender

	2013/14			
Alerts and Referrals	18 - 64	65 and over	Total	%
Physical Disability	41	255	296	*42%*
Mental Health (excluding dementia)	50	35	85	*12%*
Dementia	4	161	165	*23%*
Learning Disability	83	5	88	*12%*
Other (inc Vul People and Substance Misuse)	30	43	73	*10%*
Total	208	499	707	
	29%	71%		

	2014/15			
Alerts and Referrals	18 - 64	65 and over	Total	%
Physical Support (including Sensory)	52	257	309	*39%*
Mental Health Support	38	41	79	*10%*
Memory and Cognition Support	5	185	190	*24%*
Learning Disability Support	109	22	131	*17%*
Other (inc Social support)	8	7	15	*2%*
Not Know n	6	54	60	*8%*
Total	218	566	784	
	28%	72%		

Changes in statutory reporting means that we no longer report on 'Client group' and now report in relation to 'Primary Support Reason'. This distinction can be seen in the tables above.

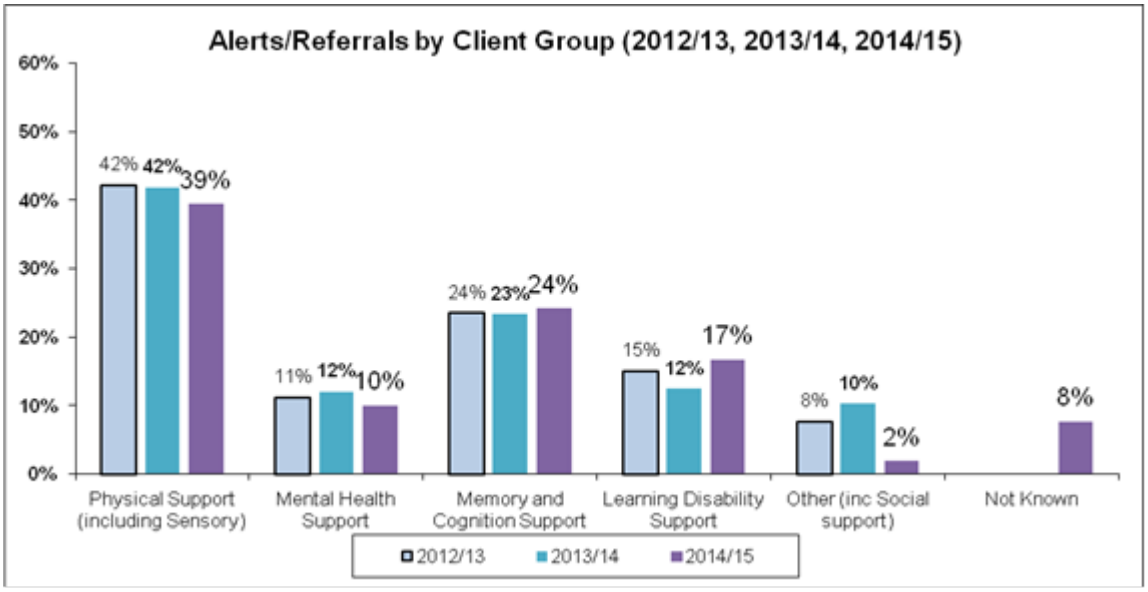
In 2014/15:

Client Primary Support reason

- The highest percentage of alerts and referrals were in the physical support category which remains static compared to the previous year category of 'physical disability'.

- There has been an increase in the percentage of alerts / referrals from learning disability clients this year (17% compared to 12% in the previous year).

- The number of alerts/referrals by clients with a PSR of Memory and Cognition (previously under dementia) has increased – the proportion increased from 23% to 24%)



Age Group

- ☐ The number of alerts/referrals by age group 18-64 (28%) and 65+ (72%) has remained relatively static this year.

Gender

- ☐ The overall number of alerts/referrals by gender remains static, 40% male and 60% female.

	2013/14		
Alerts and Referrals	**Female**	**Male**	**Total**
18 - 64	111	97	**208**
65+	316	183	**499**
Total	**427**	**280**	**707**
	60%	40%	

	2014/15		
Alerts and Referrals	**Female**	**Male**	**Total**
18 - 64	121	101	**222**
65+	360	222	**582**
Total	**481**	**323**	**804**
	60%	40%	

1.3 Repeat Referrals

Referrals are classed as repeat referrals when they involve a separate incident about the same vulnerable adult within the same reporting period. A low level of repeat referrals can demonstrate effective resolution and risk management of issues.

The repeat referral rate this year was 11.3% compared to 9.8% in the previous year. A target of 8% or below was set for 2014/15 and although this has not been achieved, there is continued monitoring around the numbers of repeat referrals.

Further analysis of the repeat safeguarding referrals shows that this relates to a small number of individual that fall into three broad categories.

1. Chronic, multiple allegations where, for example a person with capacity continues to act unwisely with their finances and they prove difficult to engage / help or where a carer and cared for person continue to live together by choice but the carer has their own health or other problems that generate multiple expressions of concern.

2. Repeat referrals for the same incident are being reported by different agencies

3. Repeat referrals that are entirely unrelated, for example, the behaviour of a daughter towards her mother when visiting her in her care home and a minor assault on the mother by another resident of the care home.

Number of repeat referrals by age band of vulnerable adult

	18 - 64	65 - 74	75 - 84	85 and over	Total	% Referrals that are Repeats
2012/13	5	0	5	10	**20**	***9.9%***
2013/14	5	2	6	3	**16**	***9.8%***
2014/15	4	5	8	6	**23**	***11.3%***

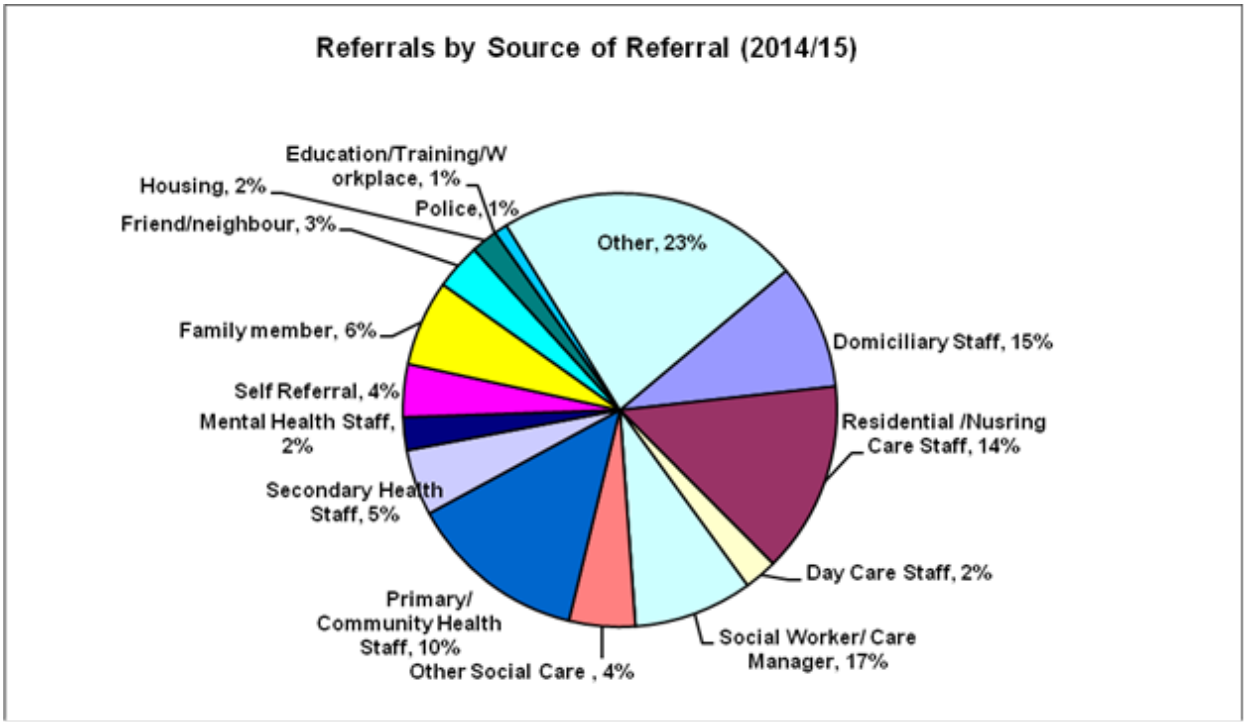
Analysis of those repeat referrals on a monthly basis ensures patterns and trends are identified and acted upon at the earliest opportunity. However, it is recognised this is not a particularly useful measure of overall performance because of the uncontrollable nature of the client group. As a result, the Department of Health has decided this measure is no longer required from April 2015 and therefore it will not feature in future reports.

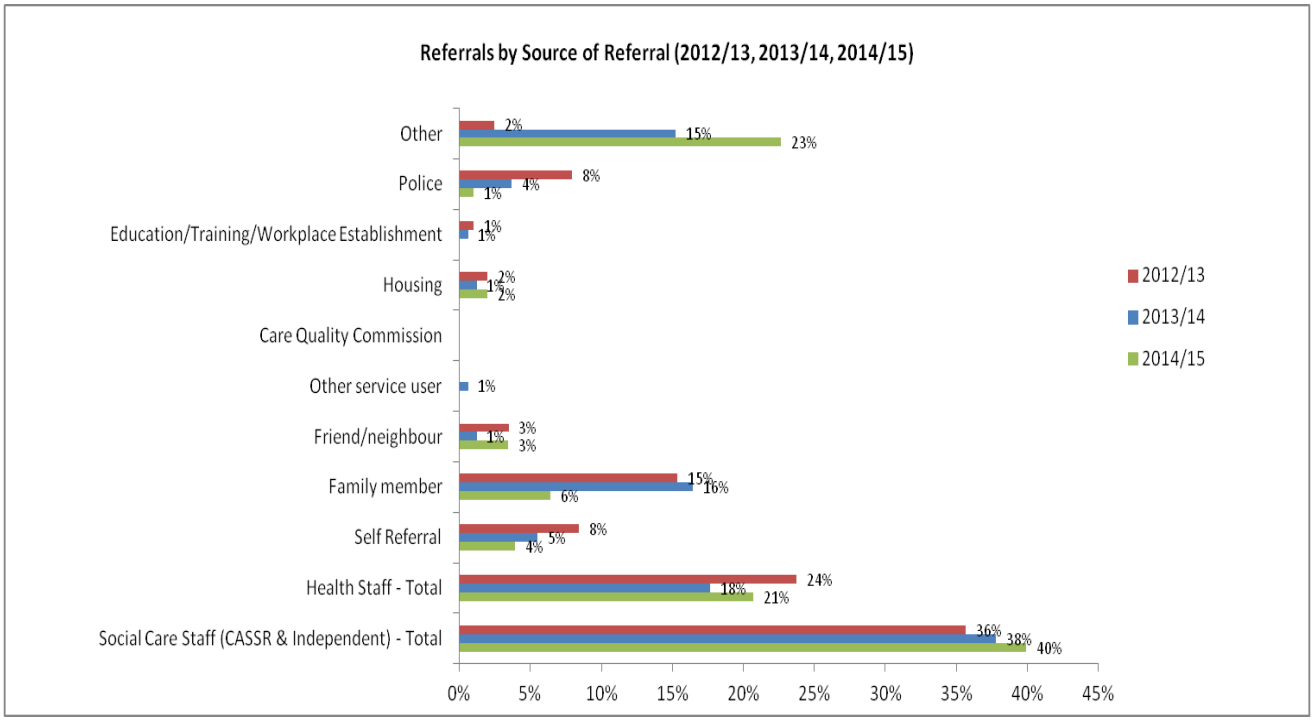
1.4 Referrals by Referrers/Source of Referral (who reported the concern)

This year, there has been an increase in the number of referrals where the abuse was reported by Social Care staff (40% compared to 38% in the previous year) and a significant increase in the number of referrals reported by other sources (23% compared to 15% in the previous year). This increase may indicate that there is a wider awareness of safeguarding within the community.

The number reported by self, family, friends and neighbours has decreased this year (14% compared to 23% last year) and our referrals from the Police have also decreased from 4% to 1% this year. The referrals from Housing have increased to 2% from 1% last year.

	Referrals	2012/13	2013/14	2014/15	2012/13	2013/14	2014/15
Social care staff	Social Care Staff (CASSR & Independent) - Total	72	62	81	36%	38%	40%
	of which: Domiciliary Staff	15	21	19	7%	13%	9%
	Residential /Nusring Care Staff	35	14	29	17%	9%	14%
	Day Care Staff	5	5	5	2%	3%	2%
	Social Worker/Care Manager	9	18	18	4%	11%	9%
	Self -Directed Care Staff	0	2	0	0%	1%	0%
	Other	8	2	10	4%	1%	5%
Health staff	Health Staff - Total	48	29	42	24%	18%	21%
	of which: Primary/Community Health Staff	23	18	27	11%	11%	13%
	Secondary Health Staff	19	6	10	9%	4%	5%
	Mental Health Staff	6	5	5	3%	3%	2%
Other sources of referral	Self Referral	17	9	8	8%	5%	4%
	Family member	31	27	13	15%	16%	6%
	Friend/neighbour	7	2	7	3%	1%	3%
	Other service user	0	1	0	0%	1%	0%
	Care Quality Commission	0	0	0	0%	0%	0%
	Housing	4	2	4	2%	1%	2%
	Education/Training/Workplace Establishment	2	1	0	1%	1%	0%
	Police	16	6	2	8%	4%	1%
	Other	5	25	46	2%	15%	23%
	Total	202	164	203			





1.5 Referrals by Alleged Abuse Type and Multiple Abuse

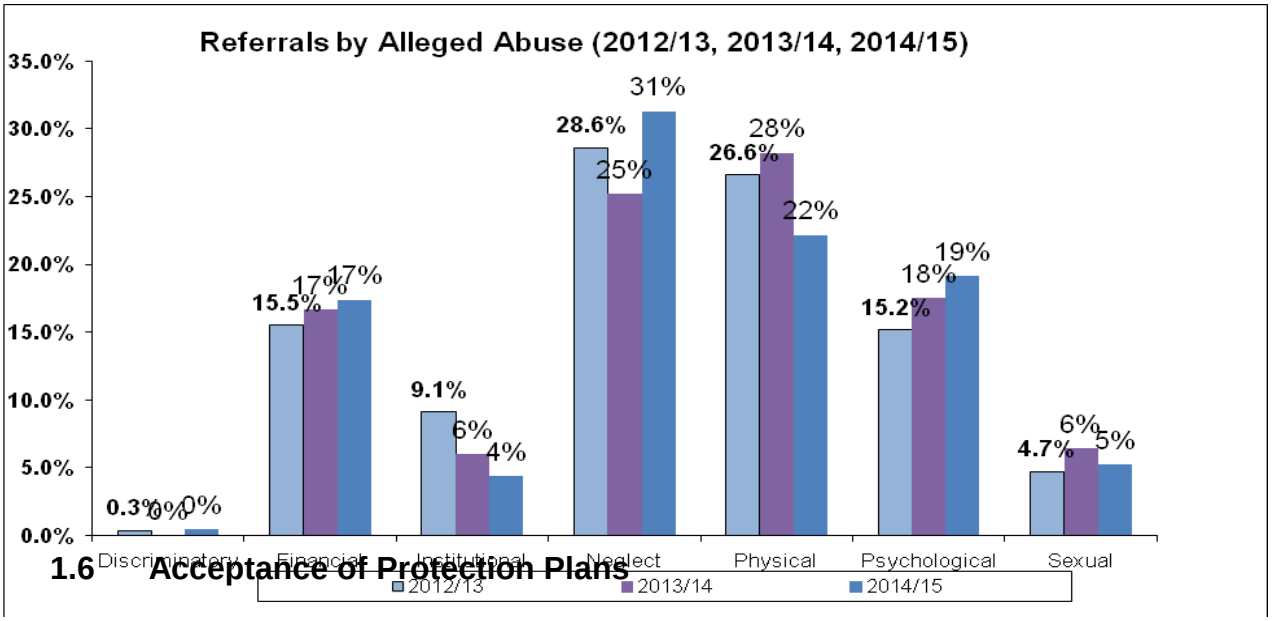
- ☐ Referrals reporting neglect has increased (31% this year compared to 25% in the previous year)
- ☐ Alleged psychological abuse has increased (19% psychological compared to 18% last year).
- ☐ Financial abuse has remained static at 17%
- ☐ Referrals reporting alleged institutional abuse has decreased this year (4% institutional compared to 6% last year)
- ☐ Physical abuse has also decreased from 28% to 22% in 2014/15

The two most prevalent types of abuse are **neglect** and **physical abuse,** closely followed by financial and psychological abuse. This is the same as the trend indicated in previous years.

Cases which recorded multiple abuses increased from 30% to 31% in 2014/15, indicating that there are a high number of referrals received by safeguarding which have an increased complexity (% calculated as a proportion of referrals started in the reporting period).

Number of Referrals by alleged abuse type

Referrals	2012/13	2013/14	2014/15	% 2012/13	% 2013/14	% 2014/15
Discriminatory	1	0	1	***0.3%***	***0%***	***0%***
Financial	46	39	40	***15.5%***	***17%***	***17%***
Institutional	27	14	10	***9.1%***	***6%***	***4%***
Neglect	85	59	72	***28.6%***	***25%***	***31%***
Physical	79	66	51	***26.6%***	***28%***	***22%***
Psychological	45	41	44	***15.2%***	***18%***	***19%***
Sexual	14	15	12	***4.7%***	***6%***	***5%***
Total Abuse	297	234	230			
Of which:- Multiple	69	50	63			

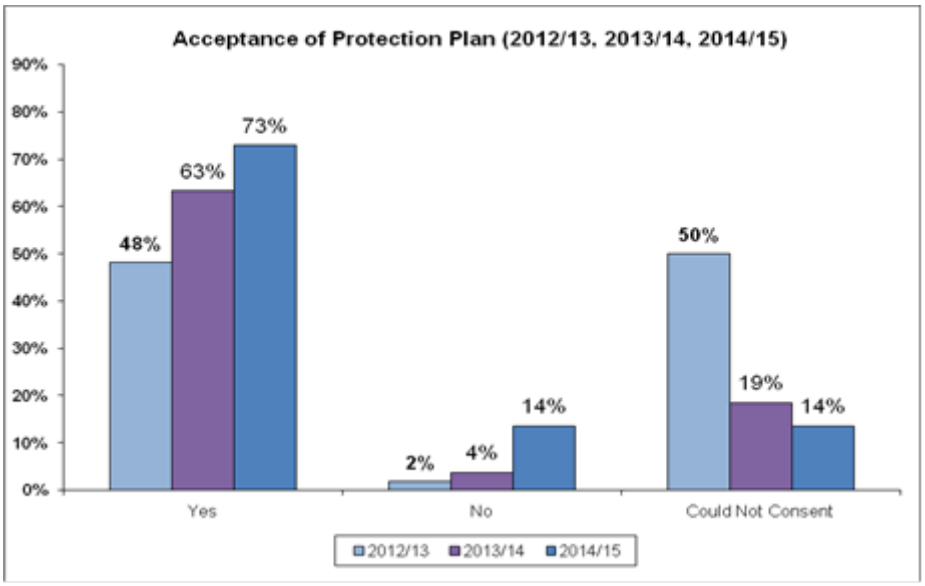


1.6 Acceptance of Protection Plans

The percentage of protection plans accepted by those with the capacity to consent is shown below. This demonstrates the level to which the adult at risk engages with the safeguarding process.

Acceptance of Protection Plan (completed referrals where plan offered)

Acceptance of Protection Plan?	*2014/15*	2013/14	2012/13
Yes	86	62	78
No	16	6	3
Could Not Consent	16	30	81
Total Plans	**118**	**98**	**162**
84.31% of protection plans offered where there was capacity to consent were accepted			



Theoretically, a high percentage indicates a high level of service user involvement in the risk management and decision making process in line with best practice for service user engagement. However, it is important to note that the numbers are small and so therefore can have a significant impact on the overall % figure. It is also important to note that not all successful safeguarding interventions result in a protection plan being offered and accepted.

With the new SAC return, protection plans will no longer be reported on and there is a move towards reporting on outcomes

Wokingham Annual Performance Report 2014-15

Executive Summary

Annual Performance Report 2014-15 Safeguarding Adults At Risk

Performance in 2014/2015 is based on SAR statutory reporting.

The data provided within this report is sourced from the Safeguarding Adults Return (SAR) for 2014/2015. The data is currently provisional pending Department of Health release of final publication.

Data provided within this report is for the purpose of the Safeguarding Adults Board to enable comparison with previous years reporting. Direct comparison cannot be achieved due to changes in reporting requirements however it is envisaged with the introduction of new Safeguarding Adults Collection requirements for 2015/2016 greater consistency will be achieved.

Volume of episodes for Safeguarding-Alerts and referrals

(Alerts are safeguarding concerns received by the Local Authority; Referrals are episodes which progressed into a Safeguarding investigation.)

Alerts and referrals

There were 868 alerts received by Wokingham Borough Council in 2014-15. 57% of these alerts progressed on to a referral (499 out of 868 alerts progressed to a part 2 investigation). There were 408 individuals who received a safeguarding referral in 2014-15.

Referrals increased by 13% in 2014-15 (499 compared to 441 referrals in 2013-14). The number of repeat referrals increased from 15% in 2013-14 to 18% this year.

	2012-13	2013-14	2014-15
Alerts		577	868
Referrals	812	441	499
Individuals who had referral	558	373	408
% of repeats	31%	15%	18%

Gender

61% of referrals started in the year were for females and 39% were for males. As with the previous year there were more referrals for females than males.

Age groups

The table below shows age groups for individuals referred in 2014-15 and the previous year. Following last year's trend there were more referrals from individuals aged 65 years or over than 18-64.

In 2014-15, 71% of referrals were from people aged 65 years or over. This is an increase from the previous year where 62% of referrals were from the 65+ age group.

Age band	2013-14	*% of total*	2014-15	% of total
18-64	143	38%	117	29%
65-74	31	8%	36	9%
75-84	81	22%	98	24%
85-94	106	28%	131	32%
95+	12	3%	23	6%
Age unknown	0	0%	3	1%
Grand total	373		408	

Ethnicity

85% of all individuals with referrals started in period were of white ethnicity and 2% were of other ethnic groups. 13% did not have any ethnicity recorded.

Primary support reason

For 2014-15 we have changed from the previous categorisation of primary client group (PCG) to primary support reason (PSR) so there are no direct comparisons with last year. The majority of people who had a referral in 2014-15 had a primary support reason of physical support or learning disability support. 48% of referrals were for individuals who had a primary support reason of physical support.

Primary support reason	Individuals	% of total
Physical support	197	48%
Sensory support	8	2%
Support with memory and cognition	69	17%
Learning disability support	99	24%
Mental health support	17	4%
Social support	6	1%
No support reason	12	3%
	408	

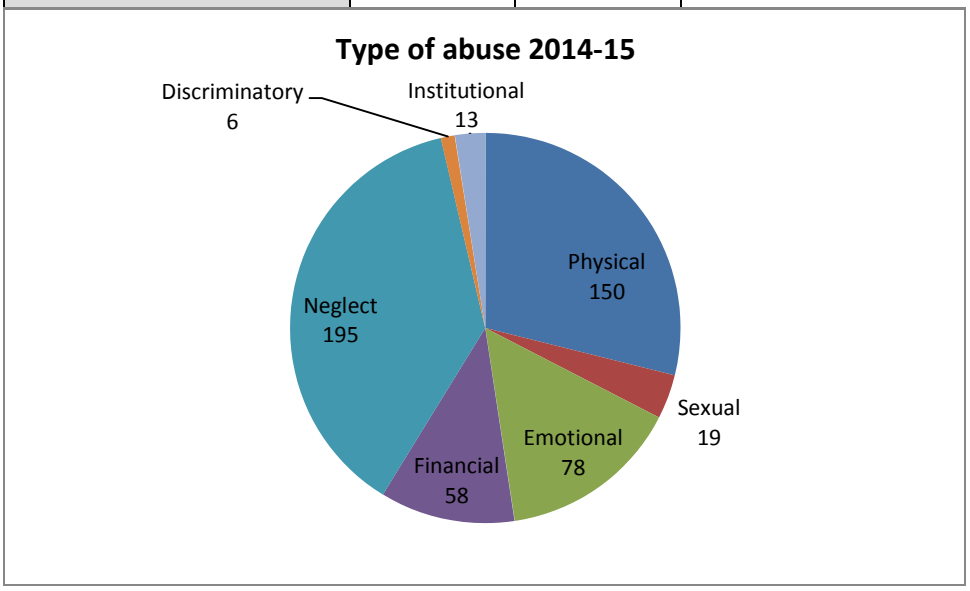
Reported health conditions

There were 11 people who had a safeguarding referral in 2014-15 with a reported health condition of Autism or Asperger's syndrome.

Type of alleged abuse

Referrals	2013-14	2014-15

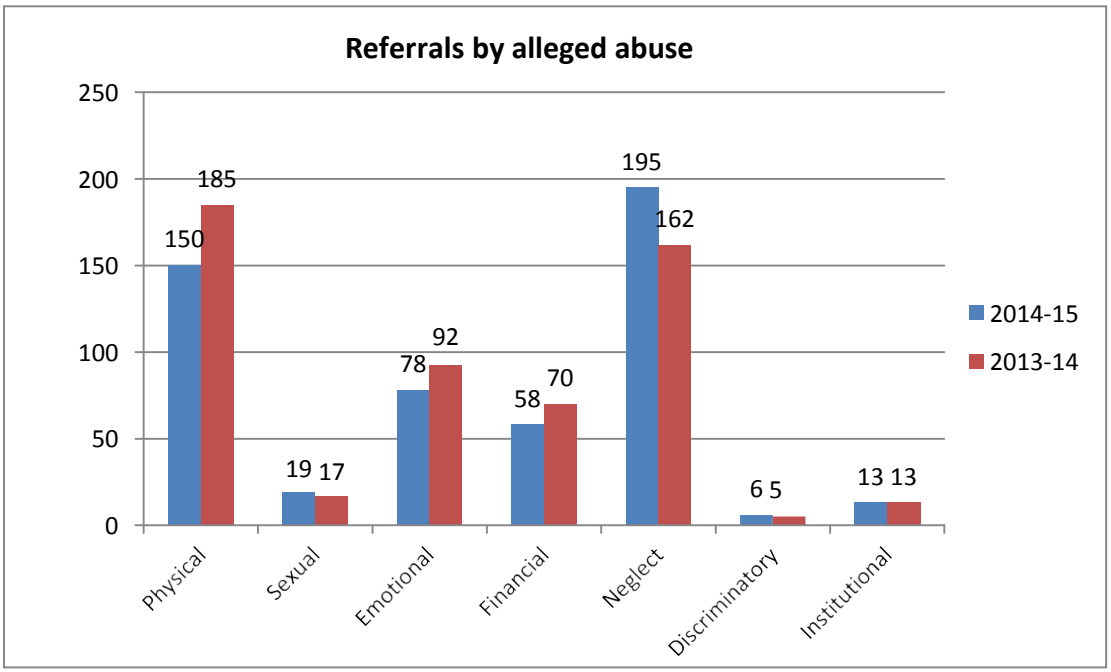
Physical	185	150
Sexual	17	19
Emotional/Psychological	92	78
Financial	70	58
Neglect	162	195
Discriminatory	5	6
Institutional	13	13



As with previous years the highest levels of alleged abuse remain in the physical and neglect categories.

- ☐ Referrals for physical abuse have decreased by 19% from previous year.
- ☐ Referrals for neglect have increased by 20% from previous year.

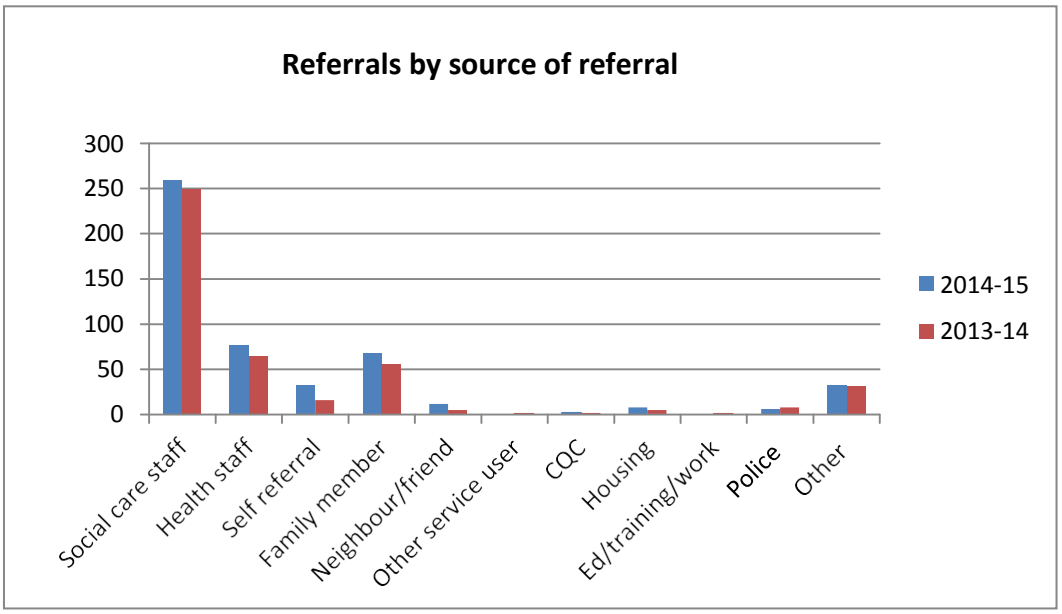
From 2015-16 four new voluntary categories will be added which will be domestic abuse, sexual exploitation, modern slavery and self-neglect. This may impact comparable data as some of these new categories may have been previously recorded under one of the other categories.



Referral Source

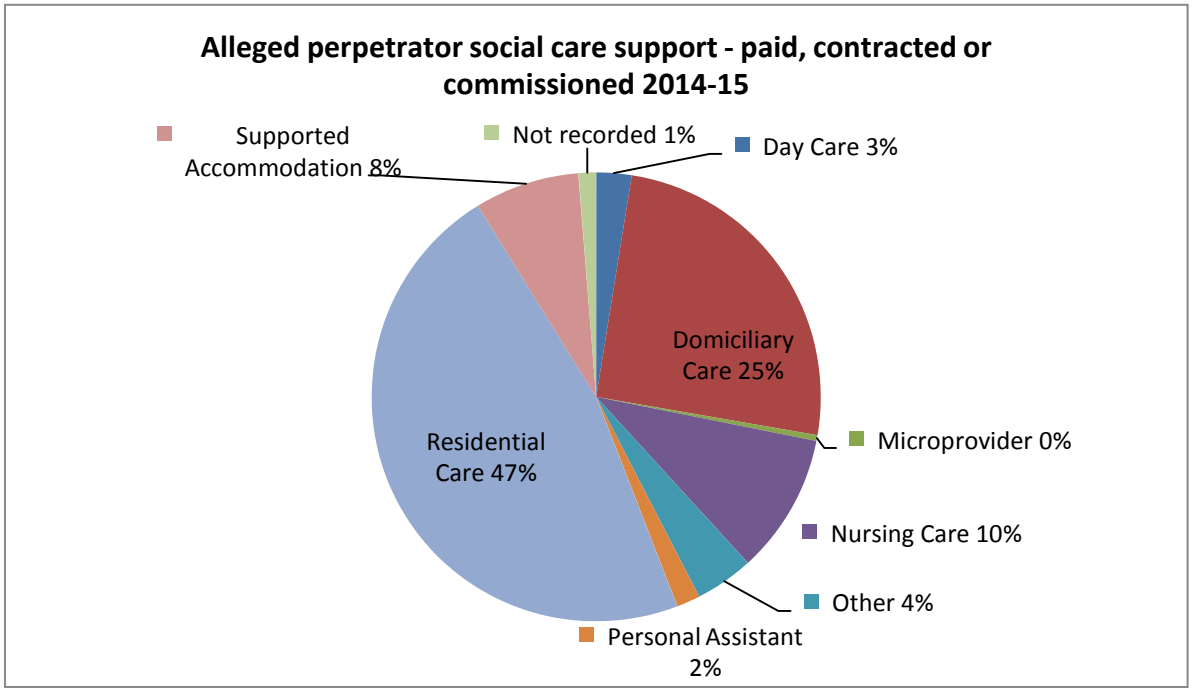
In 2014-15 52% of referrals were reported by social care staff and 15% were from health care staff. The number of self-referrals has increased this year (7% compared to 4% in 2013-14) showing an increasing awareness and leading to self-reporting of perceived abuse.

	Referrals	2013/14	2014/15
Social Care Staff	Social Care Staff total (CASSR & Independent)	249	259
	Of which: Domiciliary Staff	37	48
	Residential/ Nursing Care Staff	155	139
	Day Care Staff	12	21
	Social Worker/ Care Manager	25	25
	Self-Directed Care Staff	2	3
	Other	18	23
Health Staff	Health Staff - Total	65	77
	Of which: Primary/ Community Health Staff	41	38
	Secondary Health Staff	10	21
	Mental Health Staff	14	18
Other sources of referral	Self-Referral	16	33
	Family member	56	68
	Friend/ Neighbour	5	12
	Other service user	2	0
	Care Quality Commission	2	3
	Housing	5	8
	Education/ Training/ Workplace Establishment	2	0
	Police	8	6
	Other	31	33
	Total	**441**	**499**

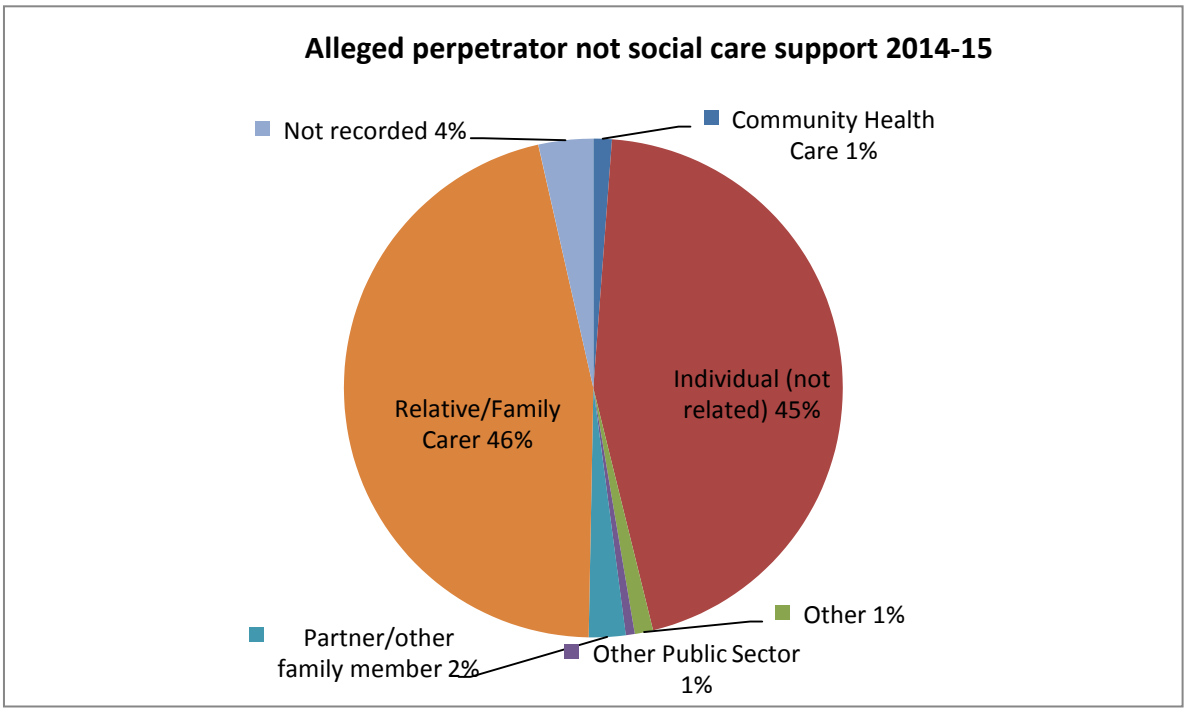


Alleged perpetrator

The chart below shows the service type where the alleged perpetrator was social care support and refers to any individual or organisation paid, contracted or commissioned to provide social care support.



The following chart shows where the alleged perpetrator was not paid, contracted or commissioned social care support.



Location of alleged abuse

The table below shows the location the alleged abuse was reported to have taken place for 2014-15. As with previous years the main locations where the alleged abuse took place was in the persons own home and care home.

Location of abuse	2013/14	2014/15
Care home	195	172
Hospital	6	5
Own home	166	195
Community service	38	17
Other	40	26

Case conclusions and outcomes

There were 407 concluded referrals in 2014-15.

The table below shows case conclusions for 2014-15 by result.

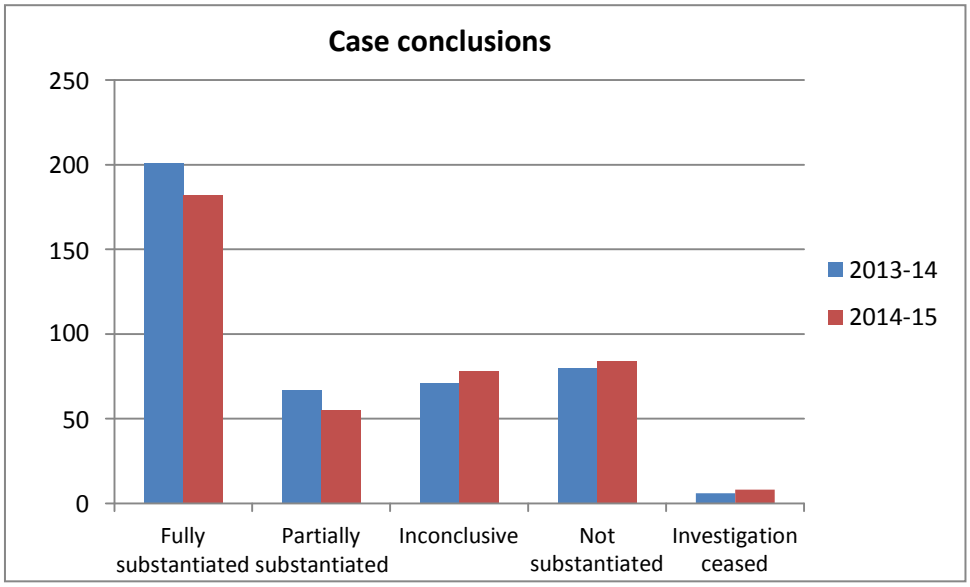
Result	2013/14	2014/15
Action Under Safeguarding: Risk Reduced	333	265
Action Under Safeguarding: Risk Removed	40	46
Action Under Safeguarding: Risk Unchanged	14	20
No Further Action Under Safeguarding	38	76
Total	425	407

In 2014-15, in 65% of referrals risk to the individual was reduced as a result of action taken.

The majority of cases in 2014-15 were fully substantiated. However this is a decrease from last year's figures (45% of cases were fully substantiated in 2014-15 compared to 47% last year).

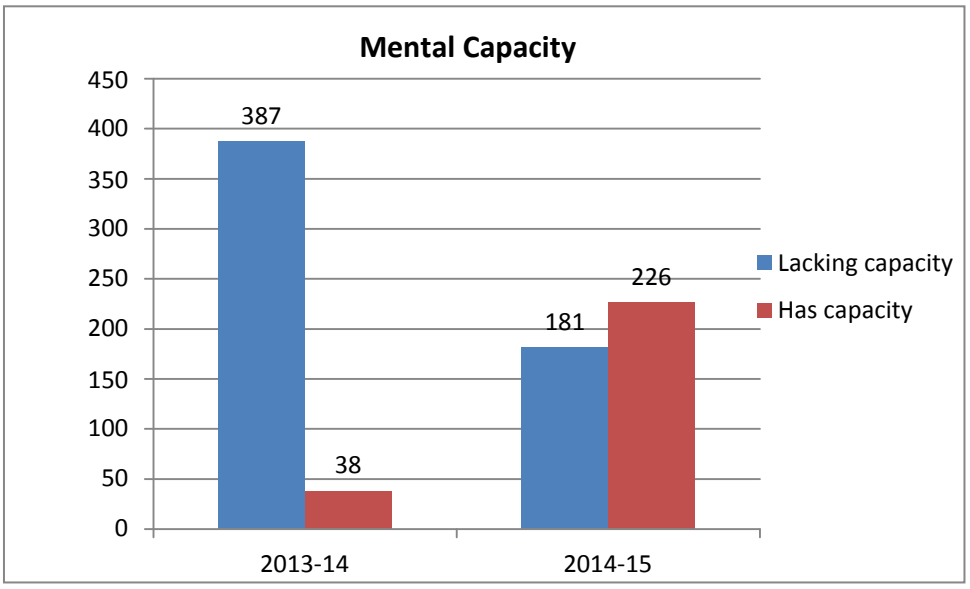
Conclusion	2013-14	2014-15
Fully substantiated	201	182
Partially substantiated	67	55
Inconclusive	71	78
Not substantiated	80	84
Investigation ceased	6	8

The chart below shows that the number of cases not substantiated has increased slightly from 19% last year to 21% in 2014-15.

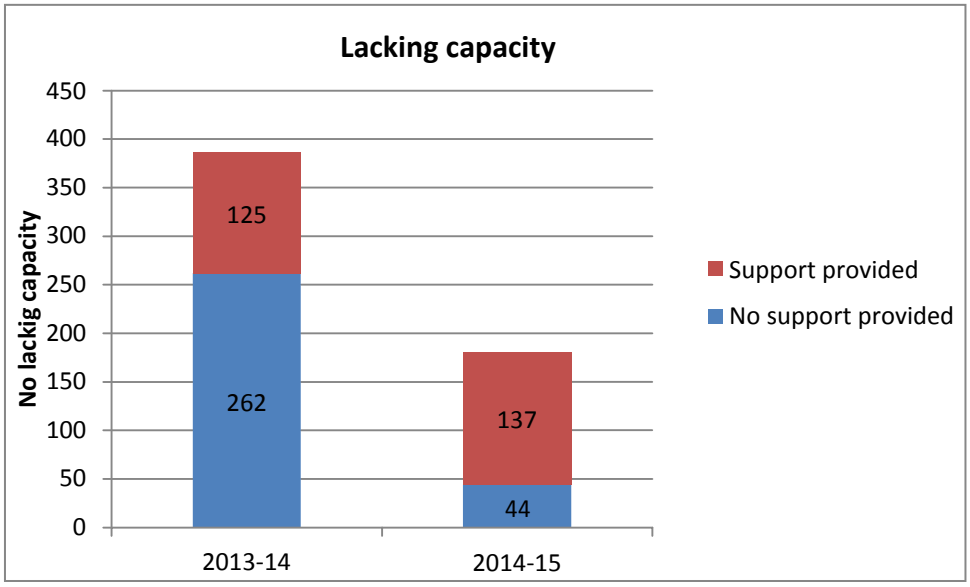


Mental capacity

Of the 407 concluded referrals in 2014-15, there were 181 referrals where the individual lacked capacity.



Of those lacking capacity in 2014-15, 76% of individuals were provided support by an independent advocate, friend or family member. This is an increase from 32% last year, it is likely that is a result of focused training and awareness raising of requirements under the Mental Capacity Act 2005.



READING BOROUGH COUNCIL

REPORT BY DIRECTIOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**6**
TITLE:	**Reading Local safeguarding Children Board Annual Report**		
LEAD COUNCILLOR:	**Cllr Jan Gavin**	**PORTFOLIO:**	**Children's Services**
SERVICE:	**Children's Services**	**WARDS:**	**Boroughwide**
LEAD OFFICER:	**Esther Blake**	**TEL:**	**X73269**
JOB TITLE:	**Business Manager for Reading LSCB and Children's Trust Partnership**	**E-MAIL:**	**Esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Reading Local Safeguarding Children Board is the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in Reading and for ensuring the effectiveness of what they do (Working Together To Safeguard Children 2015).

1.2 This Annual Report is being presented to the Health and Wellbeing Board to ensure Board members are informed about the achievements of the LSCB for the 2014/2015 financial year. The Annual Report has a wide distribution and is sent to key stakeholders and partners so that they can be informed about the work and use the information in planning within their own organisations to keep children and young people safe.

1.3 This year, one of our Young Carers groups produced a young person's version of the annual report in video form. This video can be seen on the LSCB website home page (www.readinglscb.org.uk) and will be shown at the Health and Wellbeing Board to accompany this report.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board note the attached annual report.

3. POLICY CONTEXT

3.1 As required by Working Together 2015, the LSCB Chair is required to publish an annual report on the effectiveness of child safeguarding and promoting welfare of children in Reading.

3.2 In line with this statutory guidance and our protocol agreement, the report is presented to the Health and Wellbeing Board for information. It has also been

presented to the Children's Trust Board and the Adult Social Care, Children's Services and Education Committee.

4. THE PROPOSAL

4.1 Partnership working is a vital ingredient for an effective LSCB and this report contains information on some of the activities and achievements which have taken place that demonstrate this. Board members both champion and lead the safeguarding agenda within their agency and bring to the LSCB issues regarding safeguarding that relate primarily to their own agency, but which have implications for the co-operation between agencies and the monitoring role of the Board.

4.2 Unlike previous years, this report focusses on the achievements and ongoing challenges for the LSCB and partners specifically against our priorities. These priorities were reviewed and revised in October 2014 and are:

Priority 1. Domestic Abuse
Priority 2. Strengthening the Child's Journey and Voice
Priority 3. Child Sexual Exploitation (CSE) and other Particularly Vulnerable Groups
Priority 4. Neglect
Priority 5. Effectiveness and Impact of Reading LSCB

4.3 Evidencing the impact of safeguarding work is key to understanding what works and how we can improve. Throughout this report the impact of work is highlighted.

4.4 In summary, key LSCB achievements for 2014/15 are listed below. Also listed are the ongoing concerns which the LSCB will continue to challenge in 2015/16.

LSCB Achievements:

Domestic Abuse

- LSCB input and endorsement of the Domestic Abuse Strategy 2015-18.
- Continued support for the Family Choices Programme for families affected by domestic abuse.
- Support, through Public Health, for the IRIS project to support and training GP practices in how to identify domestic abuse and make referrals.
- RBC Early Help services able to show clear improvements in families where domestic abuse is a feature.

Strengthening the Child's Journey and Voice

- Recruitment campaigns for potential adopters and foster carers has improved outcomes for children and young people needing permanency.
- The Robust Challenge process was signed off by the LSCB. It enables Independent Reviewing Officers and Child Protection Conference Chairs to improve the lived experience of the child by strengthening the challenge to the Local Authority.
- Children's Action Team key workers use the My Star/Family Star to inform support plans and directly capture the child's voice in the case file.
- The Youth Cabinet carried out a domestic abuse survey which was presented to the Board and recommendations discussed and agreed.

CSE and other Particularly Vulnerable Groups

- LSCB governance and oversight of the CSE and Missing Strategic group was established, along with an operational group which focusses clearly on individual cases.
- A clear multi-agency LSCB CSE strategy is now in place with a live action plan.
- CSE training has been rolled out throughout the LSCB partners at universal, targeted and specialist levels, with attendees reporting that their knowledge had either significantly or very significantly improved.
- The CSE toolkit and screening tool has been devised and rolled out.
- There is improved knowledge of the numbers of CSE victims and their levels of risk, and perpetrators have been charged.
- A Virtual Head for Children Missing out on Education has been appointed to ensure oversight of all cases of children and young people missing education, as they are particularly vulnerable to exploitation.
- An LSCB task and finish group was established to gain a better understanding of the risk of Female Genital Mutilation in Reading, establish the processes already in place and what improvements are required. This is an ongoing area for concern with further work continuing.

Neglect

- The LSCB have produced a Neglect Protocol with clear recommendations for all partners.
- RBC Early Help Services work with many cases where neglect is an underlying issue. The use of outcome measuring tools enables the service to highlight particular areas for improvement which contribute towards neglect, such as domestic abuse, mental health issues, substance misuse, worklessness in the household and housing.
- Partner agencies have carried out training on neglect with their workforce.

Effectiveness and Impact of Reading LSCB

- LSCB structure was re-structured to ensure decision making and accountability rested with the LSCB Board. Board members have been instructed to be more openly challenging in meetings.
- A risk and concern log has been established which is reviewed at each Board meeting to ensure any concerns are kept live until resolved.
- LSCB Sub Groups have been restructured to ensure a local focus on quality assurance and performance. Performance data and auditing outcomes are expected at every Board meeting.
- The LSCB training offer has been discussed at Board level to ensure all Board members had oversight of this vital element of the LSCB.
- The thresholds for access to children's services has been reviewed and revised by the LSCB and is now a multi-agency owned document.
- A new LSCB website has been established which contains a wealth of information and support for professionals, families, children and young people.
- Partner's financial contribution to the LSCB has been challenged with some success but there is still great disparity between the Local Authority contribution and that of partners.

Key Ongoing Challenges identified and captured in the Risk/Concern Log :

- Multi-agency and community informed approach to Female Genital Mutilation is required.
- The numbers of known privately fostered children remains extremely low.

- Children's Social Care staffing concerns remain.
- Significant progress is required to address the issue of neglect.
- Young people's involvement with the Board needs to be strengthened.
- LSCB communication needs to be improved to ensure the right safeguarding information gets to the right people.
- Partner contribution to the LSCB both financially and engagement in meetings and auditing.
- Clear and meaningful data, with commentary, is required to ensure effective review and challenge.

4.5 The Annual Report relates specifically to the 2014/15 year, however there have been a number of developments since March. These include:

- CSE strategy and Screening Tools launch event in June to a hundred managers across the partnership.
- CSE Champions are established in a range of agencies, providing support for front line workers and the CSE Coordinator is now in place, providing a central strategic support to progress the CSE action plan.
- CSE Training pathway has been agreed by the Board and workshops for the CSE Screening Tool are currently being organised.
- 11 sessions of the Chelsea's Choice theatre production are being organised and offered to schools.
- CSE awareness business cards have being produced and shared with all partner agencies, including taxi drivers, schools, GPs.
- Return home interviews are now taking place through the RBC Youth Service and have been well received. Reports are now regularly being reported to the CSE and Missing Sub Group and the LSCB Board.
- Key CSE documentation is available on the website, along with a progress report from the CSE Coordinator: http://www.readinglscb.org.uk/information-professionals/child-sexual-exploitation/
- The review of the thresholds has been completed and signed off by the Board. A guidance booklet has been produced to accompany the existing thresholds poster. Workshops in October and November 2015 launched the revised thresholds and guidance and clearly showed how they link to the new Early Help Hub and pathway and the Troubled Families Programme (phase 2). Hundreds of front line staff from across the partnership attended. Documentation from the workshops and the guidance can be found on the website:

  http://www.readinglscb.org.uk/information-professionals/threshold-criteria/
- A virtual communications sub group is being established and time has been secured from a National Management Trainee to work on improving LSCB communications. Work is being undertaken with Reading Football Club, including the use of a safeguarding video to be shown before matches.
- Our Lay Member organised a successful event with local BME groups to raise awareness of safeguarding issues in the BME community.
- Private Fostering workshops have been organised with agencies with improved take up following discussions at the LSCB Board meetings.
- The issue of Female Genital Mutilation is high on the list of key issues to address, with a new task and finish group being established to progress work. RBC, with partners, have already produced an action plan which has been shared across the West of Berkshire. The voluntary sector are very involved with this work, and are key in progressing the community awareness raising aspects.
- The LSCB dataset has been reviewed to ensure the right information is being received. A new format for reporting on data has been agreed which should

allow for a more coherent and comprehensive data report to come to Board meetings. New Chair of the QA & P group has taken post and is driving forward the required progress.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The work of the LSCB aligns with the Council strategic aim of Narrowing the Gap and two of its service priorities:

- Safeguarding and protecting those that are most vulnerable and;
- Providing the best life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 This report has been written with contributions from all LSCB partners and circulated to the Board. It will be disseminated to all partners, the Health and Wellbeing Board and Children's Trust Board.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EIA) has not been carried out for this report however, equality and diversity continues to be a key theme for the LSCB.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications with this report. Working Together to Safeguard Children 2015 requires that the LSCB to produce an annual report and that it be submitted to the Chair of the Health and Wellbeing Board.

9. FINANCIAL IMPLICATIONS

9.1 None

10. BACKGROUND PAPERS

- Reading LSCB Annual Report 2014/15

Reading Local Safeguarding Children Board

Annual Report 2014-2015

Contents

Foreword 2
Local context 4
Our Board 8
Our Priorities 9
Our Compliance with Statutory Functions 25
Update from RBC's Participation Team 34
Lay Member Perspective 35
Appendices 36

Foreword

Welcome to the Annual Report of Reading Safeguarding Children's Board for 2014/15. This report provides an account of the work undertaken by the Board and its multi-agency partners over the last year and the extent to which it is making a difference in terms of safeguarding children and young people and the effectiveness of front line services. Our vision is that every child and young person in Reading grows up safe from abuse, exploitation, neglect and crime. We aim to build and sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting early help and support. The report also seeks to summarise the journey of the Board to become more effective and to better evidence the impact it is having.

At the heart of our plan is a strong integrated approach to early intervention and prevention underpinned by the Children's Trust Partnership's 'Think Family' Strategy. This is set in the context of the need to target resources in the most effective and efficient way. The Board has set the direction and commitment by agency partners to this vision which isevidenced in the breadth of work outlined in this report.

I was delighted to take over as the new Independent chair of Reading's LSCB in October 2014. It was immediately evident that while there was a high level of commitment across the partner agencies in the work of the Board and its sub-groups, there was not always the evidence to show the added value the Board was giving local people and accountabilities were not as clear as they needed to be. Since that time the Board arrangements have been streamlined with more emphasis on work across the Partnership to accelerate the rate of progress. Significant work has taken place to strengthen the information available to the Board on the quality and performance oflocal services in safeguarding children and to drive

and inform the Board's priorities. Priorities have been reviewed and five priorities were agreed by the Board for 2015-17. These are: Domestic Violence, Neglect, Child Sexual Exploitation, the Voice and Journey of the Children and Improving the impact and effectiveness of the Board.

Significant further work is required across the Partnership to make all the improvements we know are required. Examples include the need to further strengthen the contribution and influence of young people in the work of the Board; to implement and embed new approaches to tackling neglect and further developing our approach to child sexual exploitation and female genital mutilation.

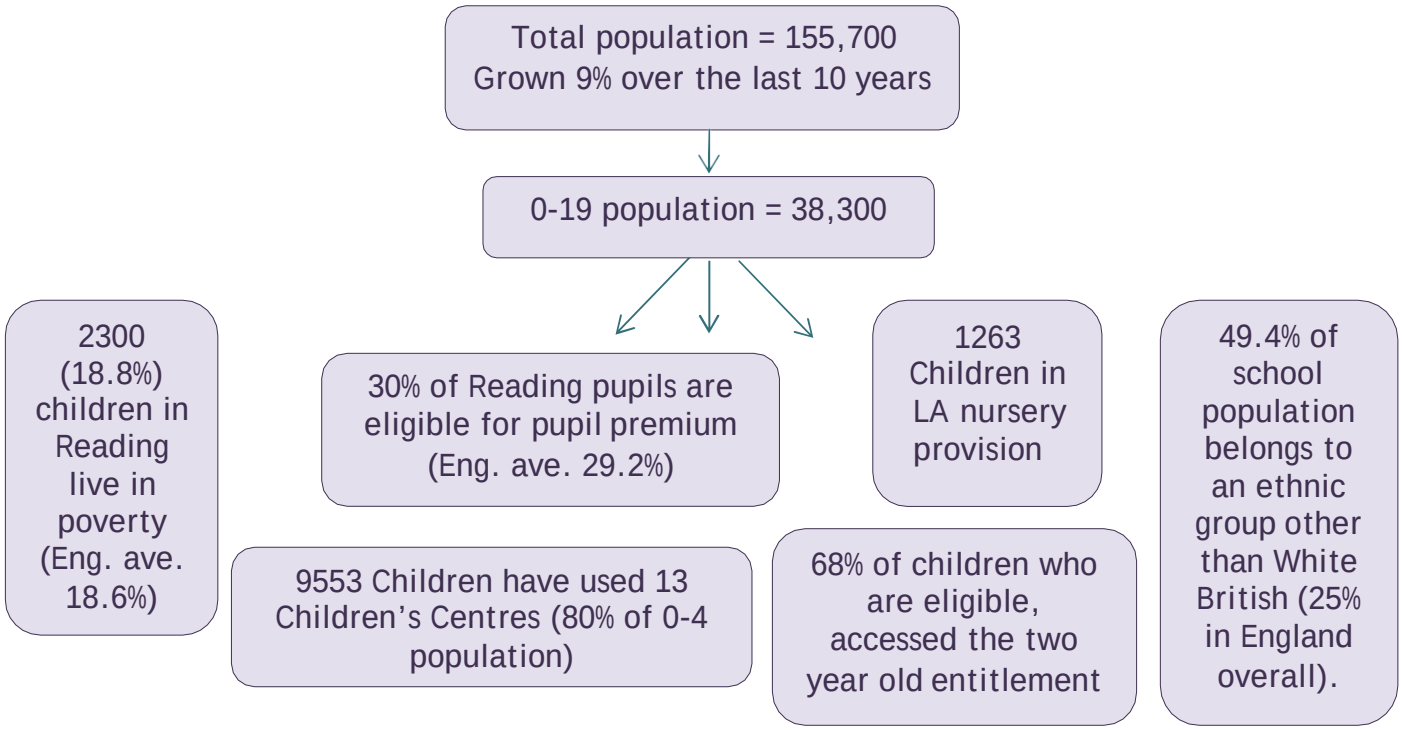
Some of the highlights for me through this last year include: spending time and listening to the views of staff in front line services; the energy and commitment of over a hundredstaff from across agencies and the voluntary, community and faith sector at the launch of the Child Sexual Exploitation Strategy; and the event jointly hosted with the Barbados Association and Reading Borough Council to raise awareness of all aspects of safeguarding with members of Reading's black and minority ethnic communities.

I would also like to thank and recognise the contributions of the LSCB Team andSub-Group Chairs and members who play such a huge role in delivering the Board's priorities and in supporting and challenging agency practice.

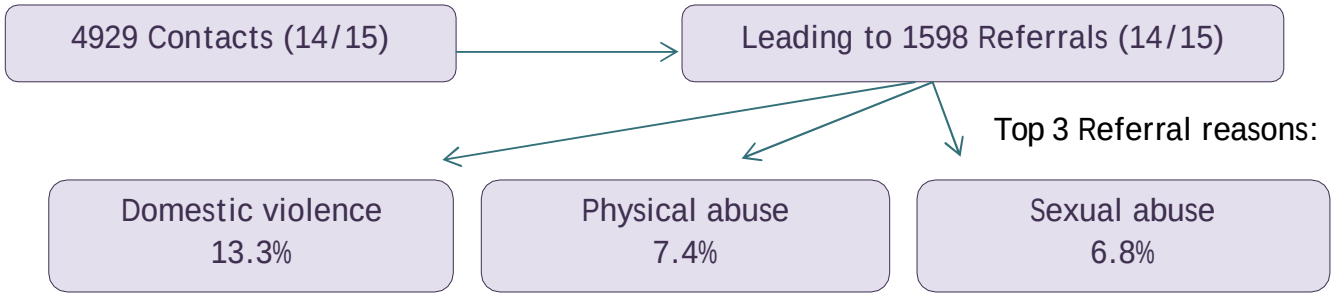
Fran Gosling-Thomas
Independent Chair, Reading Local Safeguarding Children Board

Local context

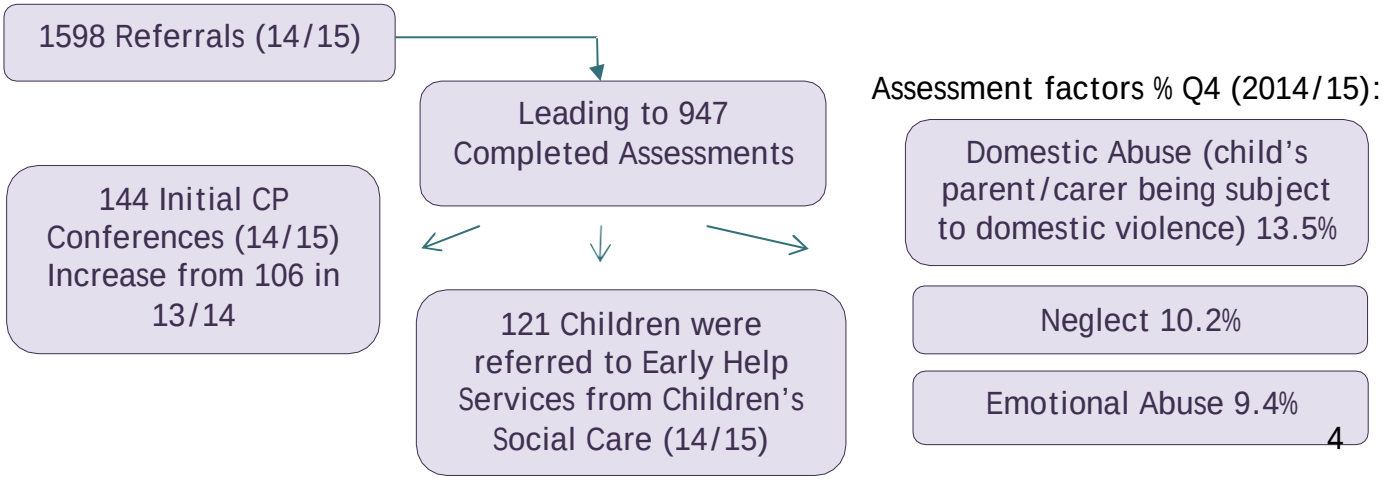
Reading is a vibrant multi-cultural town: the second most ethnically diverse in the SouthEast outside London. Reading has a history of good community relations and is a place where diversity and cohesion are celebrated and embraced.



What's coming in our Children's Services front door?



What happens next?



What are the needs? (Figures as at 31st March 2015)

203 children and young people subject to Child Protection Plan

481 children and young people identified as 'Children in Need' by Children's Services

501 identified Young Carers

104 Looked After Children and Young People are known to the Special Educational Needs (SEN) Team with 47 having a statement of SEN

26 Families (56 children including unborn) engaging with Reading Borough Council (RBC) Edge of Care Service

100 Young Offenders

23 Looked After Children and Young People have a disability (March 15)

207 Looked After Children

4 Unaccompanied Asylum seekers

123 young people engaged with Source - RBC drug and alcohol service

289 reported incidents of missing or absent relating to 146 actual children and young people

56 Teenage Conceptions (2013)

21 Child Sexual Exploitation cases (March 15)

0 known Privately Fostered Children

During 2014 there were 100 children admitted to the children's ward with mental health related concerns. This includes self harm, psychosis, eating disorders and anxiety.

Approx. 600 children and young people related Domestic Abuse notifications received from Thames Valley Police (Q4)

297 referrals to Child and Adolescent Mental Health Service (CAMHS) common point of entry (Q3)

134 Cases Reviewed by MARAC (Multi-Agency Risk Assessment Conference, for domestic abuse cases), with 182 children and young people in the household

275 -Parents/carers receiving drug, alcohol or substance misuse support (Q4)

13.3% of Missing children and young people episodes are for over 24 hours

24 (18%) of cases to the MARAC are repeat cases

10% of initial and 11% of review Health Assessments for Looked After Children completed on time

6 CIN have been missing 3 times in 90 days

33% of Looked after Children are placed more than 20 miles away from their home address

74.7% of Looked After Children are in stable placements

47.8% of children and young people are on a child protection plan for neglect

Description of Need:

Early Help

RBC Early Help is a developing service with a positive trajectory in relation to increased referrals from a range of services and a reduced level of repeat referrals. There were 294 Early Help Referrals in this final quarter compared to 257 in the previous quarter which is reflective of a steady increase throughout the year. Regular 'Team Around the Child' meetings take place and performance information indicates that the service is making an impact for children and families. There is evidence of step up processes taking place and cases being escalated by Early Help managers who hold a good grip on cases. All referrals from the Early Help Service now come through the Multi-Agency Safeguarding Hub (MASH) to ensure a greater consistency of thresholds. This shows the positive impact of the work in Early Help to simplify processes for referral and will be further built on by the work currently ongoing in respect of the Early Help Pathways.

Children on Protection Plans

At the end of Quarter 4, 203 children and young people had Child Protection Plans. Of those children, 47.8% were subject to plans under the category of Neglect. A multi-agency neglect audit was completed in January 2015 and the findings were considered by the LSCB in May 2015. The audit findings and recommendations helped to inform the Neglect Protocol (see page 20).

An embedded Children's Services audit cycle includes auditing Child Protection Plans that are of 18 months plus duration. The result is that Child Protection Plans lasting two years or more continue to decrease from 8.9% in 2012-13 to 6.2% in 2014-15.

Looked After Children (LAC)

On the 31st March 2015 there were 207 children and young people who were Looked After. This is a decrease from the 31st March 2014 where the number of Looked After Children and young people was 211 (a decrease of 1.9%)

The number of LAC children and young people can vary from month to month as children and young people move in and out of the system. During the last reporting year 1st April 2014 to 31st March 2015 there were 79 new LAC entrants and 87 children and young people who ceased to be looked after. Children and young people can cease to be looked after for a number of reasons for example returning home to live with parents, adoption or leaving care.

As at the 31st March 2015 comparing the rate of LAC per 10,000 of the populationReading was at the same rate as its Statistical Neighbours and the England average - 60, however higher than South East Benchmarking which sat at 48.2. 139 (61%) out of 207 of Looked After Children are described as White British and 68 (39%) are BME. 105 were male and 102 were female

In March 2015 only 27% of LAC were in Reading Borough Council placements, excluding Family & Friends. The use of Independent Fostering Agencies over the same period was 37%. Looked after Children's Sufficiency Statement Strategy 2015-2017 demonstrates how RBC plans to

take steps that secure, as far as reasonably practicable, sufficient accommodationwithin the authority's area which meets the needs of children that the local authority is looking after. The lack of local placements in the Reading Borough Council area is demonstrated by the fact that 33% of our Looked after Children are placed more than 20 miles away from their home address. While this may be for a positive reason (such as children in adoptive placements orin specialist residential settings) this overall percentage figure is too high and must be reduced. It is important for children and young people to live locally so that they can remain in contact with their family and community and retain stability in education provision, receive local health services.

74.7 % of our children and young people are in stable placements (placements for 2 years plus or are placed for adoption) which compares favourably with the most recent South East Benchmark of 65% and Statistical Neighbour figure of 67.7% (as at Quarter 1).

Children Leaving Care

At Quarter 4 there were 64 young people entitled to services under the Children Leaving Care Act 2000 aged 19-21, which is a stable figure. 39.1% are not in suitable employment, education or training which is slightly higher than the 39.0% average for comparative areas. 6 are in Higher Education and are supported via a bursary from the Local Authority. 79.7% were in suitable accommodation, which is broadly in line with statistic neighbours. The work of the leaving care team is being re-focused with more dedicated staff available to support this cohort of young people.

Adoption

Performance for the 2014-15 financial year remained strong in terms of the numbers of children adopted (19 children). However, when looking at the cohort of adopted children, the performance (in terms of timescales to achieve adoption for children) declined in comparison to the previous year. The Reading 3 year average time between a child entering care and moving in with their adoptive family from April 2012-2015 was 669 days against 628 which was the England average. In-service analysis identified that for the 19 children who were adopted during 2014-2015, the national timescale targets were met for approximately one third, they were missed (by a margin of between a few days to 4 months) for another third and for the remaining third (7 children) there was substantial delay. A review of those 7 cases shows that there were a number of different reasons for the delay.

A more positive picture however is developing for the next cohort in terms of timescales. Looking at those children matched and placed with adopters (not yet adopted) at the end of the last financial year and the first quarter of 2015-2016 the children were predominantly younger and have been placed much quicker. This will begin to appear in the nationally collated data as these children are adopted.

There has been a significant increase in the number of Special Guardianship orders (SGO) which is positive as a permanent option for children. The cumulative total at the end of March 2015 is 16 which is a total of 20%.

Further diagnostic work has been commissioned and actions arising from the work will be included in the RBC Children's Services Improvement Plan. This information will provide a strong foundation for consistently improving permanency outcomes for children.

Our Board

Reading's Local Safeguarding Children Board (LSCB) makes sure that key agencies work together to keep local children and young people safe. Our job is to safeguard and promote the welfare of children, and ensure the effectiveness of what is done by each agency that works with children.

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in appendix 4.

Partners in the Board financially contribute specifically to the LSCB to enable it to operate and undertake work against the priorities. Information relating to financial contributions can be found in appendix 5. Some further work is needed to increase both the overall level of funding to the Board and agency contributions to enable the Board to meet all its statutory duties.

Reading LSCB meets up to six times per year for standard Board meetings, where updates on the work against priorities is expected, performance and audit information is reviewed and emerging issues discussed. The Board also convenes at least once a year for business planning sessions. These sessions allow us to review our impact, recent performance data and audit evidence, to decide if our priorities remain relevant. In October 2014 we agreed our current priorities:

Priority 1. Domestic Abuse
Priority 2. Strengthening the Child's Journey and Voice
Priority 3. Child Sexual Exploitation (CSE) and other Particularly Vulnerable Groups
Priority 4. Neglect
Priority 5. Effectiveness and Impact of Reading LSCB

Reading is one of six Unitary Authorities in Berkshire and the Board endeavours to work collaboratively with our neighbours to ensure a more joined up approach to safeguarding concerns. This is particularly necessary for example on relation to child sexual exploitation and female genital mutilation, where there are common concerns and where some partner agencies work across several LSCBs.

The six Berkshire LSCBs work closely together and many partners are represented on all six Boards. We have three sub-groups of the Board which operate across the whole of the county, and two which focus on the West of Berkshire. Specific sub groups for quality assurance and performance, and child sexual exploitation are Reading specific to maintain a local focus on current issues. Our LSCB Structure chart can be found in appendix 3.

LSCB Business Managers and Chairs from across the county, and Thames Valley wide, meet regularly to ensure issues and protocols are shared along with examples of good practice.

The LSCB has clear links with Reading Children's Trust and the Health and Wellbeing Board. This relationship was strengthened in 2014 with the introduction of the 3 way protocol agreement which details how we work effectively together. The protocol can be found on the LSCB website: www.readinglscb.org.uk.

Our Priorities

Priority 1: Domestic Abuse

Why this is a priority: Reading has a high prevalence of domestic abuse and this is also one of the two key areas resulting in children being subject to a Child Protection Plan. The Board needs to scrutinise partner agencies responses to domestic abuse advising agencies when change is required to improve safeguarding of children and young people.

LSCB Challenge on Domestic Abuse:

In 2014 the Domestic Abuse strategy (2011-14) came to an end, with some notable achievements including the Family Choices programme and commissioning of the IRIS project. However, the prevalence of domestic abuse as a referral reason or as an aspect of a case remains as high as ever. A revised strategy is required to effectively join up the approach to this issue across children's and adult services, and across both the children's and adults safeguarding board partners and the Community Safety Partnership. This has been identified as a priority for a challenge session later in 2015.

Domestic Abuse Strategy 2015-18

The new strategy has been produced during 2014/15, with input from LSCB partners and extensive consultation. It outlines key areas for the Domestic Abuse Strategy group to focus on and incudes a clear action plan.

Key themes relating to children and young people:
Priority 1 relates to improving information and education, with a particular focus on continuing to improve the level and quality of PSCHE education in schools. Learning what a healthy relationship looks like and how to keep safe. The LSCB Education Task and Finish Group has been tasked with taking this forward in view of the key role schools can play and as the approach taken by schools is variable.

Priority 2 relates to providing the right response the first time, and the Multi-Agency Safeguarding Hub (MASH) takes a key role in this process. In autumn 2015 the single pathway for Early Help will be created which together with the MASH should improve referral processing and will mean the right support is offered to children and families at the right time.

Impact: The strategy is in the final stages of sign-off so it is too early to see direct impact. However that doesn't mean that the work hasn't yet started, as many projects, services and programmes continue to support victims and their families.

In general

All safeguarding training includes domestic abuse, this includes the LSCB training and that offered by individual agencies. Partners are aware that disclosures of domestic abuse involving children should lead to a discussion with Children's Social Care. A range of partners are included on the Multi-agency risk assessment conference (MARAC) meetings.

Berkshire Healthcare Foundation Trust (BHFT) employ a Specialist Practitioner for Domestic Abuse who provides training across the organisation regarding basic awareness, asking the question, completing the screening tool (DASH form) and the MARAC. BHFT receive all Police Domestic Abuse notifications for families with children under the age of five years which are cascaded to Health Visitors, School Nurses and health partners such as GP's and Midwives. BHFT staff have regular discussions with Children's Social Care regarding joint working with families to reduce the impact of domestic abuse on children. Information about known domestic abuse in families will be available to all staff from September 2015 with the amalgamation of the RIO patient record.

CAFCASS report that all private law applications made to court are screened and assessed at the first point of contact for signs indicating Domestic Abuse, with referrals and signposting undertaken as appropriate. The area figures show that over 60% of these applications indicate domestic abuse. Staff are trained in providing signposting advice to all parties including those affected by domestic abuse. This includes referral to local and national domestic abuse services.

The National Probation Service, Public Protection Unit in Reading is tasked to manage local high risk offenders who have been convicted of sexual and violent offences, including the serious end of Domestic Violence. They are often subject to Multi-Agency Public Protection management which ensures robust risk management plans for offenders, including access to appropriate offending behaviour programmes. With regard to those convicted of domestic violence, if suitable, capable and eligible, they are referred on to the local Community Rehabilitation Company for inclusion onto the Building Better Relationships (BBR) programme. The delivery of this programme is based on the tested "What Works" principles in changing offending behaviour and has been accredited by the Ministry of Justice through the Correctional Services Accreditation Panel. BBR is an updated programme rolled out across the country in the past 18 months. We have as yet to see definitive research to state its positive effectiveness, however it is widely believed to have a positive impact on reducing re-offending and preventing further victims.

Impact: With increasing awareness raising, training and clear actions to tackle the issues, the stigma surrounding domestic abuse can start to lift. Victims should be able to receive appropriate support to allow them to become survivors.

Identification of domestic abuse in court applications has improved in both quantity of number of cases identified and the quality of support.

Robust risk management plans for offenders, including access to appropriate offending behaviour programs has a positive impact on reducing re-offending and preventing further victims.

Family Choices Programme

This programme is for families affected by domestic abuse, offering support to the whole family. Support is provided via group work and 1:1 sessions, looking at parallel themes including - different forms of domestic abuse, the impact abusive relationships have on partners and children, and ways to resolve conflict in a non-abusive way.

Impact: Feedback from those attending the programme suggest that families find it helpful in a number of ways. Perpetrators have commented on how the work undertaken has had a positive impact on their behaviour, highlighting increases in respect for their partners, with understanding of how to control anger and alternative non abusive ways of behaving. Victims have found the support particularly helpful in overcoming isolation through the opportunity to meet others with similar experiences. Learning how to identify signs and traits of Domestic Abuse has led to participants feeling more able to set appropriate boundaries within their relationship with their partner, and a subsequent improvement in relationships with their children.

IRIS Project

Public Health currently jointly fund and commission the IRIS Domestic Abuse GP referral programme, provided by Berkshire Women's Aid. GP practice staff are trained in recognising signs of potential domestic abuse and are given the skills to discuss issues with patients coming into the practice. Practice staff can then offer to make a referral to local DA services. The Clinical Commissioning Groups (CCGs) actively encourage the GPs to engage with this programme, and provide support to GPs and clinicians working with families where domestic abuse is occurring.

The steering group review referral numbers coming from GP practices and identify actions to make improvements. The service co-ordinator works with and supports individual practiceswith the intention to improve their skills and confidence to engage effectively with patients who may be victims of domestic abuse.

Challenges: Budget limits and staff capacity only allow so many practices to be engaged with. Practices have received session 1 training so far (session 2 to follow) and referral rates to services by practice are currently inconsistent. A more focused, key partner, steering group is now in place to support and deliver improvements where identified.

Impact: To date, only 38 referrals have been made from GP practices in Reading (24 from one practice). However the programme has raised awareness with GPs, helps them to ask the right questions in the right way and challenges stereotypes. Clients of the service receive practical advice and support on how to deal with their particular DA issue.

Early Help Services

Many of the families referred to RBC Children's Action Team (Early Help) services have domestic abuse as an underlying issue.

By changing the way impact is monitored it is now possible to identify how many families have made positive changes, against clear categories, as a result of the work of the Children's Actions Team (CAT) workers. This year the Outcome Star tool has been introduced which helps families and their workers agree on the range of changes in key areas such as 'your wellbeing' and 'keeping your children safe'. In addition, at the end of case closure the CAT worker will identify whether there has been a range of improvement from 'significant' to 'none' against established criteria in key areas such as domestic abuse, mental health or substance misuse.

Training in the Outcome Star is going to be rolled out across the whole of RBC Children's Services which should enable greater impact evidence to be collated.

Impact: 54% of cases using Family Star Plus demonstrated significant change, and 17% of cases using My Star demonstrating significant change and 50% demonstrating smaller change.

Out of 692 cases closed, there were 95 cases where domestic abuse was identified. Out of these 71% showed an improved outcome. In where there were recorded mental health issues there was evidence to support 80% with improved outcomes. 74 cases with issues of substance misuse issues, 51% showed an improved outcome.

Priority 2: Strengthening the Child's Journey and Voice

Purpose: To evaluate the effectiveness of different aspects of the child's journey into help and services, the quality of the decisions made by individual agencies and the quality of multi-agency processes.

LSCB Challenge:

How do we improve accessibility of services and the journey through services for our children and young people? Can we hear the child's voice in our case work, and how do they contribute to service design and delivery and the priorities of the LSCB?

Transition Planning for Looked After Children (LAC) at Key Stage 2/3

The move from primary to secondary school can be stressful, especially for children with additional vulnerabilities.

Achievements: Support and advice has been given to carers/social workers to select most appropriate secondary school placement, with extra visits to schools as required. 1:1 meetings with the Year 6 LAC pupils identify any anxieties about transition, and offer support to help children to complete the RBC transition booklet. 1:1 meetings with year 7 LAC pupils allow children to express any difficulties at their new school and discuss strategies for overcoming these.

Impact: There has been increased targeted interventions through Pupil Premium Plus, improved safeguarding in relation to attendance and missing children, and increased stability of placements. It is hoped that key stage 3 results will also show improvement.

Fostering and Permanency

Drift and delay in permanency planning has been an issue, as has the recruitment of sufficient numbers of local foster carers. All children who require long term fostering have been allocated to Permanency Fostering Social Workers in order to achieve this.

Achievements: Recruitment campaigns for potential adopters and foster carers have improved performance to meet more challenging targets. Investment in a partnership with a charitable organisation representing local churches has begun to generate results in terms of targeted recruitment (the Home for Good project). The implementation of "KEEPSafe" training (4 month, evidence based programmes) now provides high quality training for foster carers and those with Special Guardianship Orders in order to support stability for placements for 11-17 year olds. Likewise the delivery of therapeutic support services to foster carers by a dedicated multi-disciplinary team based in the Fostering Service has produced positive feedback in terms of supporting placements.

Impact: 16 Special Guardianship Orders (as at 31st March 2015) and 19 adoptions in 2014/15 has meant stability and permanency for young people within a family environment.

The Home for Good project aims to identify, encourage and support people from church and other faith communities to foster and adopt children. In the 7 months since launch enquiries from this scheme have led to one couple and two single people attending preparation groups, 1 enquirer has been approved as an adopter and a couple are being assessed as a family and friends carers.

Two Year Old Entitlement Offer

This statutory scheme offers childcare to certain eligible groups. This early intervention will provide real developmental benefits for children and progress their readiness for school. However, in spring 2014 the percentage take up was only around 30%.

Achievements: A partnership task group was set up to focus on improving take up and access. Outreach and engagement with families has been sharper and marketing has improved. Matching families to open childcare has improved access to available spaces.

Impact: The percentage of take up has now increased to 68%. The pilot programmes for South Reading for the first cohorts of children has shown real impact by tracking them into reception.

Robust Challenge (Dispute Resolution)

The Robust Challenge (RC) process referred to in the IRO Handbook as the Local Dispute Resolution Process has now been rolled out through the Child Protection process, signed off by the LSCB in December 2014. The Robust Challenge Process enables Independent Reviewing Officers (IROs) and Child Protection Chairs (CPCs) to effectively improve the lived experience of children. The process strengthens challenge to delay and drift in the Local Authority's approach to LAC, and has introduced greater monitoring and challenge.

Achievements: This year has seen an increase in challenges made from the Reviewing and Quality Assurance Service. Challenges have been made at all levels from the informal stage through to formal stages (27) escalated at all levels from level 1 Social Worker and Assistant Team Manager through to level 5 the Director of Children's Services. Themes have included delay in progressing to permanency, drift and delay in assessments, challenges in relation to case decisions, visits not happening, lack of input onto the child's record, drift in assessing risk, including Chair seeking independent legal advice and lack of Health Assessments / Health Care Plans.

Impact: There were 27 robust challenges in 2014/15, including a collective challenge in relation to 37 children. The group challenge identified systemic failures and deficiencies in permanency planning. The outcome of the challenge was the allocation of additional resources within the Fostering Service.

Focus for 2015/16:

- IROs continue to use the Robust Challenge process, ensuring that the service maintains a tracking sheet and that there is evidence of challenges and resolution to challenges on Frameworki.
- IROs ensuring that challenges are escalated within timeframes if the initial response is not satisfactory or has not been received.
- Reviewing and Quality Assurance Service to identify any patterns or themes to the challenges which can be fed back to Children's Services.

Voice of the child in services

We can only improve services when we know what works and what doesn't for the children and young people concerned.

Achievements: Children's Action Team key workers use My Star/Family Star to inform support plans and capture the child's voice in the case file. To help incorporate the lived experience of the child in foster carer reviews new forms have been implemented to request feedback from the child that are more child friendly and signs of safety compliant. The LSCB has funded the MOMO app, which allows looked after children to directly feedback their experiences. Health services have dedicated parent forums and routinely ask young people for their views on services and opinions on the development of new services or on their transition from one service to another. Health for Youth offers tours for young people to experience and see what is available in hospital. GPs are encouraged to speak directly to children, use accredited/approved translators when needed and use alternative means of communication where a child, young person or parent has a learning difficulty.

Impact: Family Plans (CAT service) focus on the wishes and feelings of the children, and they have a role in their own planning and intervention. LAC children's views and experiences are being fed into their reviews either indirectly from the Independent Reviewing Officers, or directly through the new forms. The MOMO app is an example of providing more flexible ways for LAC children to communicate with us, and although use has so far been limited it is increasing. Children and young people are given a say in health services.

Cafcass Young People's Board

Achievements: The Young People's Board has been successful in developing work tools, training materials and undertaking audits and inspections of the work done. This has now been expanded to the wider justice system including judges, court staff and legal representatives to ensure that that child's voice is always heard in legal proceedings.

Impact: The work done so far in supporting the Child's Voice in practice has been positively commented upon by Ofsted and the development of a child focussed approach to Family Justice is supported by the President of the Family Division.

Voice of the child in relation to priorities and work of the LSCB

It was clear that we needed to improve our ability to hear the voice of children & young people at the Board, and there had been no direct input from children and young people at Board level.

Achievements:

- The Youth Cabinet carried out a Domestic Abuse survey and a number of recommendations were made. The Member of Youth Parliament reported the survey finding to the LSCB at a Board meeting and the recommendations were discussed and agreed.
- The Youth Cabinet were consulted and their recommendations regarding engagement with the LSCB have been accepted by the Board.
- The Youth Cabinet will attend later in 2015 to provide an update on their campaigns.
- The LSCB Independent Chair and Business Manager regularly meet with the Youth Cabinet.

Message from the Member of Youth Parliament, Adrian Rodriguez:

As the Member of Youth Parliament for Reading, and as a young person myself, I recognise the relevance of the priorities set by the LSCB in October 2014. It is paramount that we aim to alleviate the difficulties that young people in Reading face, in order to allow us all to achieve our potential - ensuring that are no barriers to success. Having lived in Reading for almost all of my life, I believe that the priorities set by the LSCB are ones which need tackling urgently, therefore I welcome them and am willing to do as much as possible. Iwill continue to offer my support to generate the strongest, most impactful outcome that the board can achieve.

Ongoing LSCB Challenge:

Looked After Children Health Assessments

Data relating to the timeliness of LAC health assessments presented to the Board in March 2015, raised significant concerns in relation to the timeliness of health assessment for Looked After Children. The Board has requested immediate action to be undertaken in order to meet the required timeframes and ultimately ensure that the health needs of our Looked After population are met.

Young people's involvement with the Board

Although engagement has increased (as described above) further work is required to ensure that the voice of the child is regularly heard at Board meetings.

Priority 3: Child Sexual Exploitation (CSE) and other Particularly Vulnerable Groups

Purpose: To ensure that those children and young people who are particularly vulnerable or likely to be exploited can be identified and supported appropriately.

LSCB Challenge on CSE:

At the beginning of this reporting year there was a limited multi-agency approach to CSE, no strategy or action plan, the CSE Strategic Group did not report to the LSCB and information relating to CSE, particularly the children and young people involved, was poor. This year has seen a huge shift in the prioritising of CSE, raising the profile of the issues and how to address them, understanding the local picture through vital information sharing and clear positive outcomes for individual young people.

Multi-agency approach to CSE

Issues: There was no multi-agency strategy in place, CSE mapping was not effective, levels of awareness needed to be improved and there were uncoordinated approaches when meeting the needs of victims.

Achievements: Clear multi-agency LSCB CSE strategy is now in place with a live action plan. A CSE Mapping meeting was established to better understand the local picture in detail, which then combined with the Missing Children meeting to provide a clearer more joined up view. This is now an LSCB Sub Group which ensures robust LSCB oversight. An operational meeting hasbeen established which identifies young people at risk and potential offenders. CSE training has been rolled out through the LSCB at universal, targeted and specialist levels. 111 staff have attended LSCB CSE training since April 2014. To date 252 staff have attended CSE training hosted by Reading. CSE intelligence training has also been provided and well received by 41 managers and CSE champions. CSE toolkit and screening tool has been widely disseminated and all partners are encouraging staff to use these. 21 CSE Champions have been established to ensure teams have access to a specialist worker when issues/queries arise. Established services are available to support victims, including Targeted Youth Support and Youth Outreach Nurse.

Following the significant work undertaken in 2014/15 (described above), 99 managers from across the partnership attended a multi-agency CSE launch event on 4th June 2015. All the processes and tools were officially launched and the voice of victims at the event clearly reinforced the need make this work for those young people at risk.

Impact: As at 31st March 2015 20 young people have been identified as being at risk of CSE, where appropriate multi-agency support has been provided. There is improved knowledge of the numbers of CSE victims and their levels of risk. Staff training has improved the confidence of the workforce across the partnership. 80% of those who attended LSCB CSE training during 2014/15 stated that their knowledge and confidence in the subject after attending had significantly or very significantly improved.

But most importantly we have cases where perpetrators have been charged (4 cases in the past year where one or more persons have been charged) and positive feedback from victims and parents. One parent explained he felt his worker listened to him. Often his concern for his child would occur late into the evening or at night, and he appreciated having the workers mobile phone number so that he could leave messages on the phone at night, knowing she would pick up the message the following day and discuss his concerns with her. One of the victims told the worker who conducted the return interview that they were “alright….am I going to see you again?” The young person was then allocated to that worker and the number of missing episodes have already significantly reduced.

Children Missing out on Education (CMoE)

Children and young people who are missing education can be more vulnerable and liable to exploitation.

Achievements: A Virtual Head for CMoE has been appointed to ensure clear oversight of all cases. A CMoE tracking group meets regularly to discuss cases and an action and communications plan is now in place. Cross border meetings take place to ensure those moving in and out of our boundaries do not get lost. All those assessed to be at level 1 (highest risk) have a level 1 plan in place, monitored by a lead professional. Pupils in year 12 who are NEET are now tracked, ensuring responsibility is handed over to an appropriate service, such as Adviza (formerly known as Connexions Thames Valley).

The Virtual Head now has the details and monitors all pupils who are on reduced timetables in Reading primary, secondary and special schools for return to full time education. The

Impact: Cross checking CMoE, CSE and Missing Children lists has improved awareness and information sharing, plus the Virtual Head CMoE links directly with schools ensuring that the children are better safeguarded. Through the lead professional, the children are 'case worked' ensuring they do not get lost, and 'stuck' cases can be progressed through multi-agency planning meetings.

LSCB Challenge on Female Genital Mutilation (FGM):

The population profile of Reading indicates that FGM could be a potential issue for certain groups of children and young people. The LSCB initiated a task and finish group in 2014 to gain a better understanding of the issue, identify what processes were already in place and identify a way to widen awareness of the issue. The group reported back to the Board in March 2015.

The task and finish group 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. 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. Without such co-ordinated strategic direction it will be difficult to progress key policy recommendations locally.

FGM awareness training is made available through the annual LSCB training programme and FGM has now been incorporated in to all Universal safeguarding Children training courses

The group recommended 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. This will require commitment from Directorates of Public Health. It is essential that affected communities are represented from the start.

The LSCB Independent Chair has challenged the Health and Wellbeing Boards across the West of Berkshire to take a lead on FGM. A new task and finish group will shortly be formed to clarify next steps and produce recommendations which will be reported to the Board.

Ongoing LSCB Challenge:

CSE Information Sharing

Board members have raised concern that there is no clear protocol in place regarding the appropriate sharing of information in relation to CSE cases. The Board has set up a task and finish group to review this, and in conjunction with neighbouring authorities, develop a suitable pan Berkshire protocol. Work on this is nearing completion and will be reported to the Board in late 2015.

Female Genital Mutilation

As discussed on page 18, the LSCB Chair has challenged the Health and Wellbeing Boards across the West of Berkshire. The LSCB will continue to keep this issue a high risk area until progress is made.

Privately Fostered Children and Young People

The numbers of known privately fostered children are extremely low yet we know there will be more children who are in this arrangement and need additional support. This has been the subject of robust challenge at the Board and a number of initiatives, with Board members support, are now underway. For example, targeted communications with schools, GP surgeries and youth clubs have taken place. Further reports during 2015-16 are expected.

Priority 4: Neglect

Why this is a priority: Neglect remains the highest category for Child Protection planning in Reading. Research has shown the negative impact this can have on children and young people's emotional and physical development. There are many forms and reasons for neglect and the children's workforce must be able to recognise the early signs to ensure support is provided as soon as possible and action taken to safeguard children when required.

LSCB Challenge on Neglect:

Although identified as a key issue in Reading, in 2014 there was no clear strategy or multi-agency approach to its reduction.

Neglect Protocol

To raise the profile of neglect as an issue, in 2015 the LSCB produced a Neglect Protocol for all partners which highlights the effects of neglect, short and long term, plus it reviews national and local learning on this subject.

The protocol makes a number of recommendations for all partners including:

- A regular review of the LSCB threshold document is undertaken to ensure the inclusion of new signs and symptoms of neglect from research or Serious Case Reviews
- That key agencies ensure that their safeguarding policy and protocol adequately addresses the risks related to neglect and the need for timely and proactive intervention
- That all agencies provide access to training for staff in their organisation to assist with the identification and response to neglect.
- That all agencies ensure that staff are briefed or trained on the importance of listening to the voice of the child and mindful of the risks of the child's voice being overshadowed by adult opinion or circumstance.
- That all agencies ensure that there is a record of significant events over time in the form of a chronology or log on order to assist with the identification of neglect and its impact on the child.

There are specific recommendations for Reading Borough Council including training and the use of the 'graded care profile' assessment tool and the consistent use of chronologies in assessment, analysis and decision making.

Challenge: It is not yet possible to assess the impact of this protocol but the LSCB will review progress against the recommendations in 2015/16.

Early Help Services

Many of the families referred to the RBC Children's Action Team (CAT) have neglect as an underlying issue. Three common factors, known as the toxic trio, contribute to neglect – domestic abuse, mental health issues and substance misuse. The CATs are now able to report significant positive change in these areas in a proportion of cases (see Impact). In addition the CATs are also able to report on two other factors, worklessness in the household and housing, which can also impact on neglect for children and young people in the home.

Similarly, for those families where we have used the Family Star outcome measuring tool we have seen significant change in a proportion of families for indicators of poverty, which is also a key factor in neglect.

Impact: Out of 692 cases closed, there were 95 cases where domestic abuse was identified. Out of these 71% showed an improved outcome. In where there were recorded mental health issues there was evidence to support 80% with improved outcomes. 74 cases with issues of substance misuse issues, 51% showed an improved outcome. In relation to 'worklessness in the household' 135 cases, 48%, demonstrated an improved outcome. For 'Housing' 136 cases, 71%, demonstrated an improved outcome.

For those families where the Family Star was used we saw significant changes to 'progress to work' for 34% of our cases and significant change in 'home money' for 36% of cases.

Parental Substance Misuse Service

Substance misuse significantly impairs a parent's ability to bring up their children safely.

Achievements: A range of specialist parenting programmes have been offered, including some targeted at those who are pregnant, to help them understand the impact of substance misuse on an unborn baby and their parenting capacity. Awareness raising training has been delivered to social care staff and Health Visitor and Social Worker students and Safeguarding children where there is Parental Substance Misuse training is included on the annual LSCB training programme.

Impact: 5 mothers with historical established pattern of use were able to retain the care of their children at birth, preventing the child from separation and becoming looked after. The support offered is reported to have prevented relapse in these cases.

In general

GPs have access to information about Early Help resources to allow them to signpost. They continue to refer to MASH in cases where neglect is likely to cause a child significant harm.

The Royal Berkshire Hospital includes neglect in all its safeguarding training. It also ensures children not brought for appointments are monitored and followed up.

Berkshire Healthcare Foundation Trust safeguarding team have put on seminar workshops for all health visitors, school nurses and family nurses (November 2014) on keeping the focus on children where there are multiple adult vulnerabilities and recognising neglect.

Agencies have included neglect training as a requirement which is raising the profile of indicators, risk factors and identifying support.

Ongoing LSCB Challenge:

It is recognised that agencies are undertaking work to begin to address Neglect, it is however identified that there is still significant progress to be made. With the introduction of the Neglect Protocol the LSCB will expect to see significant progress in 2015/16.

Priority 5: Effectiveness and Impact of Reading LSCB

Purpose: To ensure the Board has a stronger focus on scrutiny and challenge of partner agencies services and its own effectiveness, to ensure it meets local and national priorities and is able to evidence impact on outcomes.

LSCB Challenge on the LSCB Structure:

The incoming Independent Chair of the LSCB felt the existing structure of sub-groups and meetings reduced the accountability of the main Board, while leaving key areas of scrutiny without a local focus. The existing LSCB action plan was not 'SMART' and therefore unachievable.

Challenge function of the Board

Board meetings were not challenging of partners/services/Board members, with decisions and responsibility often not held at Board level due to the structure. Performance data, audits and section 11 returns have not routinely provided the evidence required to allow the Board to challenge emerging issues.

Achievements: The LSCB structure was reorganised by the new Chair. The Executive meetings were removed to place decision making and accountability with the Board. Board members have been encouraged to be openly challenging in meetings. A new Top 10 Scorecard ensures data relating to our priorities is seen by the Board at every meeting (see appendix 7), and the result of an audit is expected to be discussed at every Board meeting.

In 2014, a challenge by the Chair regarding the Rapid Response procedure, led to a revised procedure being adopted across Berkshire.

Impact: Improved data and audit information to the main Board will enable us to focus efforts on the most vulnerable and at risk young people. Board meeting minutes reflect the increased level of challenge at meetings.

High Quality Training and Resources

Issues: The previous LSCB structure meant the Board was unsighted on the training programme and had little responsibility for it. Certain groups/service either couldn't access the training or were encouraged not to. There has been limited evidence of the impact of training.

Achievements: LSCB Training Officer now attends all Board meetings, and has presented the training programme which is updated depending on need and LSCB priorities. RCVYS, with funding from Thames Valley Police, are offering safeguarding courses for the voluntary sector, in line with the LSCB training programme. A safeguarding pathways document has been produced which details training available from the LSCB and RCVYS. RBC Learning & Workforce Development have implemented a follow up impact evaluation of course 3 to 6 months after completion, and will ask for specific evidence of the impact of the course on their practice.

The LSCB has also funded access for every Board member to the NWG website, where resources and support around CSE issues are available for use.

Impact: Staff across the partnership receive consistent training on issues that are local to Reading. LSCB members are more aware of the courses available and can market these to appropriate staff. Impact evidence from training will soon be available.

Evaluation of Thresholds

The thresholds document produced by RBC in 2011 has been reviewed and updated and now is a multi-agency document.

Achievements: Through consultation with LSCB partners a revised document has been reissued and circulated widely. Changes were made to ensure that current practice and current risks are reflected. There was agreement on the need for common language. This forms one part of a wider project to introduce the Early Help Pathway, new MASH and phase 2 of the Troubled Families Programme, which will complete in the autumn with the production of clear, easy to understand guidance on what the thresholds are, how to use them, and what happens when you make a referral.

Impact: The updated thresholds (and forthcoming guidance) will enable practitioners to be confident about the safeguarding thresholds, ensuring that referrals are made appropriately – the right service, to the right child, at the right time and in the right place.

Communication

Issues: The LSCB cannot be effective if front line practitioners are not aware of the work and messages it is disseminating.

Achievements: A new stand-alone LSCB website has been produced. This contains a wealth of information not only about the LSCB and what we do, but also support for professionals, families and children and young people. The newsletter has been re-instated and weekly information bulletins are sent to all LSCB members. Members are often asked to confirm when they have disseminated important information.

Ongoing Challenges:

There have been a number of challenges raised at LSCB meetings which are ongoing. These include:

- Children's Social Care staffing concerns – difficulties in recruitment and retention of staff, high levels of agency staff and staff turnover. Specific work has been undertaken to be reported to the Board in September 2015.
- GP attendance at CP conferences - ongoing issue with GPs not attending conferences and often not supplying reports. An action plan is in place and will continue to be reviewed by the Board.
- Partner Engagement – the Chair has raised concerns about the level of partnership engagement in areas such as auditing and contribution to Board meetings.

To enable the Board to effectively monitor the progress of the challenges/concerns raised a Risk/Concern log has been established. This is RAG rated and key issues are followed up at each Board meeting. A copy of the latest Concern log can be found in Appendix 6. All ongoing concerns highlighted in this report are included in the Risk/Concern log.

Our Compliance with Statutory Functions

Statutory Legislation

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in the appendices.

The core objectives of the LSCB are as set out in section 14(1) of the Children Act 2004 as follows:

a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area,

b) to ensure the effectiveness of what is done by each such person or body for that purpose.

The role and function of the LSCB is defined by Working Together to Safeguard Children 2015, and key extracts can be found in the appendices.

Policies and Procedures Sub Group

The purpose of the Pan-Berkshire Policy and Procedures subgroup is to ensure that:

- The six Berkshire LSCBs develop and maintain high quality safeguarding and child protection policies and procedures.
- Safeguarding and child protection policies and procedures remain in line with key national policy and legislative changes.

The subgroup has met on four occasions during the year, hosted by Slough Borough Council. The group has continued to work towards ensuring that all those working with children, young people and families within Berkshire have access to accessible, thorough and comprehensive policies and procedural guidance to support safe, timely and effective interventions.

New procedures for responding to Child Sexual Exploitation, including a Pan Berkshire CSE Indicator Tool, were completed and implemented during the year, providing consistent guidance for all agencies which has linked to the continued development of SERAC (Sexual Exploitation Risk Assessment Conference) panels across the county.

Challenges:

The subgroup faces a number of challenges for the year ahead, and proposes the following solutions for 2015-16:

- Contract renewal – the contract with Tri.X is due for renewal in September 2015. Current fees are based on the original "early-adopter" pricing which has now been revised. It is anticipated that the cost for delivering the manual will increase significantly – with a consequential call on each of the constituent LSCBs for additional funding

- Scale and size of the manual – the manual has grown in size and diversity in recent years making searches for specific elements of guidance more complex for practitioners. In addition key documents require updating. Some procedures appear to have more direct relevance to only one or two constituent agencies – suggesting that these topics might be best addressed outside the Pan Berkshire P&P process. A detailed review of the content and scale of the manual will be undertaken to ensure that all key procedures are fully up-to-date and that the content is rationalised
- Frequent changes in attendance and representation – the work of the subgroup has been compromised by the continuing flux in membership. This has led to additional demands being placed on a small group of more regular participants and has reduced the scope for pieces of work to be taken forward when capacity has been limited. Constituent agencies to commit dedicated time and resource of sufficiently senior staff to contribute to the work of the subgroup
- Delegated authority to approve and agree a) LSCB; b) LA – progressing changes and additions to the manual has proved challenging when the membership has not had delegated authority to approve these. Each constituent LSCB to ensure that governance arrangements are in place to support the decision-making of the subgroup and each constituent local authority to ensure representation at a sufficient level of seniority from Operational services management to authorise procedural changes

Ongoing Challenges:

The subgroup has identified three priorities for 2015-16:

- Rationalisation of the procedures manual
- Continuing funding for Pan Berkshire procedures
- Review of key procedures.

Learning and Development Sub Group

In order to fulfil its statutory functions under Regulation 5 an LSCB should monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Reading, Wokingham and West Berkshire LSCBs share a Learning and Development sub group whose purpose is to lead the strategic planning and oversee the operational delivery of Learning and Development (L&D). The aim of the group is to coordinate the provision of sufficient high-quality learning and development opportunities that are appropriate to local needs and have a positive impact on safeguarding outcomes; holding partner organisations to account for operational delivery and uptake.

Specific activity that has been undertaken over the year includes;

- Support given to organise and deliver the annual Safeguarding Conference
- Daniel Pelka SCR learning shared
- Training sub-group away day held to review past, present and future
- Training sub-group split in to east and west
- Priorities for action agreed in line with revised LSCB Business Plan

- Voluntary sector became part of sub-group membership
- Current and emerging needs discussed and prioritised for future L&D opportunities
- Training programme for 2015-16 created and approved
- A new action plan agreed for 2015-16

The training programme was created by the Operational L&D Sub-Group, based on past trends and emerging needs. The headline figures associated with the programme include;

- 21 courses were run through the LSCB programme
- 332 candidates attended the courses, (over 16 candidates per course)
- 46% of the places were taken by Local Authority workers, with 21% from Health and 33% from others (12% of these being from PVI)
- Allegations management was the most popular course for other agencies, including schools (32 candidates)
- 53% of people felt the immediate impact of the training was significant or very significant with 45% stating there was some immediate impact.

The e-Learning offer for the LSCB Programme focused on two main learning opportunities, this being CSE (Child Sexual Exploitation) and USC (Universal Safeguarding Children). The headline figures for the programme include;

- 1965 candidates across Reading, Wokingham and West Berkshire completed the USC e-learning
- 44 candidates completed the CSE e-learning
- 21% of candidates who started the course completed it

The figures have highlighted an issue in the management information as well as behaviours, relating to candidates starting the courses but not completing them at the first attempt.

Impact:

SCR learning has been shared within the sub-group and used to inform revisions to learning and development interventions (e.g. training courses or e-learning content). This has meant that candidates were aware of current cases and the learning they provide, thereby influencing work practices and behaviour and so having a positive impact on the outcomes for Children and Young People.

The training figures suggest the learning and development programme has had an impact on a significant number of attendees, meaning that that candidates work practices and behaviour are influenced, leading to a positive impact on the outcomes for Children and Young People.

Child Death Overview Panel

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP). The CDOP will have a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.

In Berkshire as a whole, there has been an overall reduction in reviewed deaths from 57 in 2012/13 to 60 in 2013/14 to 50 in 2014/15 It is difficult to attribute causes for the reduction however the panel took consistent action to promote;

- neonatal reviews and thematic risk factor monitoring;
- the 'one at a time' message for those undergoing IVF treatment
- a consistent set of recommendations for 'safe sleeping' – which all agencies adopted

The annual number of child deaths reported in Reading in 2014-15 was 5 which compares with a total of 15 deaths in 2013-14. Of those reviewed so far, none were unexpected/ unexplained. Infant mortality was statistically lower than England in Reading in 14/15 in the CDOP records and as reported in the child health profile for 2015 the main categories of death are; chromosomal, genetic and congenital anomalies, perinatal and neonatal deaths, malignancies and that as yet no deaths have been reported with modifiable risk factors.

Achievements:

- Regular reporting on risk and preventative factors for infant and child deaths through the CDOP newsletter and JSNA
- Facilitating the development of an asthma and viral wheeze website/ app for the Thames Valley as a response to two local child deaths in Berkshire in 2013-14. This is now live at www.puffell.com
- Asthma and viral wheeze GP and practice training is being implemented across the Thames Valley which will ensure that all children have an asthma plan in line with national recommendations.
- Designing and testing an emotional health and wellbeing website/app which includes sections on self harm, anxiety and depression, anti-bullying and domestic abuse as part of the public mental health approach to CAMHS service redesign.
- A paper was presented at the national CDOP conference based on a detailed analysis of all child deaths in relation to congenital anomalies and is planning to audit the implementation of the consanguinity programme in secondary schools this year
- The genetics programme has been disseminated through the LSCB to secondary schools and an audit will be carried out in 2015-16 to explore whether this has been adopted into school curricula.
- All cancer deaths have been reviewed by an external expert panel and no trends of common modifiable factors have been found
- The panel have shared learning from the Thames Valley Cancer Network on culturally appropriate ways of marking a child's death. This has been circulated to social care and health staff and shared with education colleagues.
- The service continues to promote safe sleeping advice
- A GP practice improvement programme for the early identification of sepsis has been rolled out via the network

Ongoing Challenges:

The key challenge remains the reduction of pre-term births and the death of children in their first year of life. The panel are assured that work on reducing pre term births is also a regional health priority as many of the risk factors relate to the health of the mother antenatally and the care she receives within that period. The Thames Valley Children's and Maternity network has been promoting training to increase awareness of the optimum way to measure fundal height through the midwifery services.

Section 11 Panel

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Pan Berkshire Approach

The six Berkshire LSCBs work together through the Section 11 (S11) Panel. Its purpose is to:

- To oversee the S11 process for all pan Berkshire organisations and to support improvement. This currently involves Berkshire wide statutory and voluntary organisations of which there are 9 of a significant size and scope.
- To set clear expectations with the LSCBs and those organisations about the timeframe and process for submission of a self-assessment section 11 audit, and ongoing development towards compliance.
- Review and evaluate S 11 returns of the full three yearly audit (including a mid-term review) of s11 Children Act 2004 for pan Berkshire organisations, in order to make an assessment of agencies compliance with the duty to safeguard. New round of assessments to commence from May 2015.

Achievements:
The terms of reference of the subgroup were reviewed at a S11 Workshop in December 2014. Membership was also reviewed at this point and it was decided that each LSCB should have representation as should pan Berkshire organisations. The panel now has an ongoing role in improving the self-assessment process for organisations. The self-assessment tool has been updated and as the panel embarks on the new round of reviews the new assessment format will be adopted. The panel also decided that going forward organisations should attend to present their audit so that questions can be asked and resolved at the same time.

Over the past year, the panel has achieved a number of priorities. These include clarifying membership and expectation of members; reviewing the Panel's terms of reference; improving consistency of attendance; and ensuring clarity around form and function.

Impact:
The impact of the subgroup's work has included achieving clarity around new 3 year cycle; and ensuring wider organisational engagement with, and ownership of, S11 compliance. This has included achieving agreement over LA submissions, CCG submissions and some national organisations submissions.

Challenges:

- Format of CCG submissions – after discussion, the subgroup took the decision to accept the CCG template to be submitted to panel.
- Local authority submission format – agreement around submissions was gained and will be part of next three-year cycle.
- Subgroup membership attendance and representation – expectations were clarified and requests for representation made by the Chair.
- SARC assurance now to be brought to panel.
- British Transport Police submission and follow up.

- New commissioning arrangements in health have proved to be an ongoing challenge. The plan is for the Panel Chair to write to the Local Area Team (LAT) to gain clarity around assurances of compliance.
- The subgroup has also raised concerns about pan-Berkshire arrangements regarding local induction of LSCB members and therefore understanding of policies etc. may be absent – each LSCB will ensure induction of new members is robust.

Themes from the first round of S11 returns (2012-2015):

- There is a need for greater understanding of 'safeguarding supervision' across the children's workforce and explore opportunities for multi-agency developmental supervision or case supervision
- There is a need for easy access to safer recruitment training. Although this is happening, it does not appear to be sufficiently well co-ordinated. It is suggested that all partner agencies are cognisant of their individual responsibilities and that LSCB's incorporate this into their training strategy. It would seem essential that responsibility for commissioning and delivering training is evident, and its quality is routinely monitored.
- S11 Submissions from Local Authorities were variable, although with the new methodology going forward a standard expectation will become clearer
- CAF and early help arrangements appear to differed across organisational boundaries, which can be of challenge to pan-Berkshire organisations utilising different referral methods and subsequent pathways.
- Although organisations did have a named senior person responsible for safeguarding, but at times it was unclear how this influenced operational practice. The responsibility to have a named person was well understood but there was little evidence of understanding of the actual range of responsibilities this entailed.
- The process for obtaining DBS checks, particularly for those in smaller voluntary organisations needs to be made clearer. This is intelligence that has come from individual LSCB's.
- While training is available the demand for multi-agency training appears to be greater than the volume of staff in some organisations demands. The need for employers to clarify the required pathways together with clearer guidance regarding the relevance of inter-agency training by LSCBs would appear to be important as delivery of such events becomes separated across the East and West of the region.
- Information sharing is a feature in SCR's but this did not come out strongly as an issue in Section 11. Going forward this should be explored further when returns are being presented.

Future Plans for the Panel for 15/16

- 3 year cycle of S11 audits to be commenced on an ongoing rolling programme which incorporates an 18 month mid-term review to monitor progress of action plans.
- Agencies to be invited to present their S11 self-assessments to the Panel to enable scrutiny and challenge of each agency enabling greater discussion and learning.
- Agree a process to ensure that best practice evidence is incorporated into Berkshire processes and that learning is shared.

Local Approach

Reading LSCB is responsible for the undertaking S11 returns for local organisations not included in the S11 Panel above. In 2014 schools were asked to confirm their designated safeguarding lead, and the level of training undertaken by key staff. Concerns from the

review were followed up directly with the schools. A full Section 175 (Section 11 equivalent for Schools) is scheduled in for the autumn term 2015.

Early Years providers, including playgroups, are required to complete an annual safeguarding and welfare requirement audit as part of the EYFS requirements. A worker in the early years team reviews these audits to ensure all safeguarding requirements are met and this is scheduled to report to the Board in 2015.

Case Review Group

The Case Review Group receives and reviews all cases referred to the group where staff from any partner agency of the Safeguarding Children Boards in Berkshire West have identified potential learning. The group will also consider cases where a referral has been made to the group from the Berkshire Child Death Overview Panel (CDOP)

Recommendations will be made to the Chair of the Berkshire West Local Safeguarding Children Boards (LSCBs) when the group agrees that the criteria has been met to undertake a serious case review (SCR) as defined in Working Together to Safeguard Children (2015). Where the group agrees that the criteria for a SCR has not been met it might recommend a partnership review of the case.

Learning from published SCRs will be shared by the group for dissemination across partner agencies of the LSCBs.

The Berkshire West Case Review Group was formed from an amalgamation of the three previous serious case review groups across Berkshire West at the beginning of 2015. The group currently meets every two months, and has so far met three times. In this time six cases have been reviewed, with a recommendation to the LSCB Chair that consideration be given to undertaking an SCR in two cases, although one had a query regarding the criteria. In one of these cases, further information became available that meant that an SCR was no longer appropriate but a partnership review will be completed. In the other case, the National Panel of Independent Experts in Serious case Reviews was consulted and they confirmed it did not meet the SCR criteria. A partnership review will be undertaken instead. One further case identified good practice and a storyboard will be produced to aid learning.

Impact:

This is a new group and therefore its impact and outcomes are yet to be measured. It is envisaged that the amalgamation of the previous three SCR groups will:

- enable a shared process for referral to the group and;
- enable shared learning from serious case reviews and partnership reviews across the three areas of Berkshire West and ultimately across Berkshire, via the Learning and Development sub group of the three LSCBs.
- consider recommendations and shared learning from national SCRs

Ongoing Challenges:

- Representation from the local authorities has not been consistent for the meetings.
- Representation from Early Years has now been agreed.
- LSCBs to be clear about the content and regularity of reports from the group to the LSCB.

Quality Assurance and Performance Sub Group

Working Together states that in order to fulfil its statutory functions under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned;

The role of the Reading LSCB Quality Assurance and Performance Subgroup is to ensure there are sound mechanisms for monitoring, evaluating and auditing safeguarding activity in place, particularly in relation to front line services, and ensuring that improvements are made to deliver better outcomes for children. Also, its role is to demonstrate that the LSCB is a 'learning partnership' that has a strong focus on impact and effectiveness, and when necessary, escalate any identified risk in order to provide assurance to the Board to enable them to carry out their statutory responsibilities.

Achievements:

- Restructuring and merging of the Quality Assurance and Performance & Scrutiny subgroups into one subgroup with a local focus
- Approved monitoring Dataset and implementation of a top 10 reporting scorecard with direct input from the LSCB Independent Chair, linked to the LSBC key priorities (see appendix 7)
- Development and implementation of an Audit programme linked to the LSCB core priorities which included a basic audit tool methodology
- Completion and reporting on audits including action plans for example:
  - o Domestic Abuse/MARAC Audit
  - o Audit of GP Services
  - o LAC Exclusions Audit
  - o Multi-Agency Child Neglect Audit
- Lessons learnt from the Neglect Audit have been disseminated across the workforce and the MARAC audit results have fed into the new Domestic Abuse Strategy

Challenges:

In relation to audits, the availability of resources and untimely responses from agencies present major challenges in the completion of audits within agreed timeframes. An interim solution has been the commissioning of an independent audit to coordinate and facilitate some multi-agency audits.

Obtaining an up-to-date dataset has proved a significant challenge due to lack of forthcoming data from agencies and the quality of the commentary surrounding data received. This has impacted on the group's ability to effectively analyse and report on data trends and impacts to the Board.

Ongoing Challenges:

- Quality and commentary surrounding data reporting continues to be challenging. The solution involves a mixture of escalation and liaising with the data owner.
- The group will continue to push for scheduled multi-agency audits take place in a timely manner but resources and engagement by all partners is key to achieving this.
- The group will monitor Section 11 audits when available, but so far this has not been possible due to the lack of information.

CSE and Missing Sub Group

The aims of this group are:

- To develop a local strategy and effective strategic response to ensure a co-ordinated multi-agency approach to safeguard children and young people from sexual exploitation and those who go missing.
- To reduce the risks to children and young people vulnerable to sexual exploitation through multi agency and collaborative working with LSCB partners.
- In relation to Children who go Missing the strategic group to have an overview of children who go missing, the reasons why, the multi-agency response and the areas of cross over with those at risk of Child Sexual Exploitation (CSE).
- To agree and oversee a Performance Framework that; informs commissioning and strategic intentions, enables provision of regular reports to Reading Local Safeguarding Children board (LSCB) on the work of the group and its impact for children and young people.

The Children Who Go Missing and CSE Sub Group was combined in July 2014 to recognise the overlap that can occur between these groups of children. At this time the governance of the group also changed to report directly into the LSCB to ensure clear scrutiny at a high level multi-agency forum. This group is co-chaired by Thames Valley Police and RBC.

Achievements:

- Produced the CSE Strategy and action plan, plus information and tools used at a recent launch event.
- The development of the SEMRAC (Sexual Exploitation and Missing Risk Assessment Conference), which reports directly into this group.
- SEMRAC development days included establishing roles and responsibilities, information sharing and the SEMRAC process.
- Agreement to employ a CSE Coordinator, plus joint working with Barnados to provide three CSE workers for a year working directly with those at risk.
- Agreement that return home interviews will be carried out by RBC Youth Service, which have been successfully taking place.
- Further development of the CSE champion role which provides support to the workforce.

Impact:

- Young people at risk, perpetrators and places of interest are being identified earlier, leading to increased disruption of potential CSE activity.
- Increased awareness across the partnership has led to increased intelligence reporting from partners to the police.
- There has been an increase in awareness across the workforce enabling front line staff to better identify at risk young people.
- Return home interviews are taking place, with more offers being accepted and numbers are being regularly reported into the group.

Ongoing Challenges:

- Continued multi-agency funding for the CSE Coordinator has yet to be established.
- Clear CSE Information Sharing Protocol for across Berkshire needs to be agreed.
- Ensure the wider workforce continues to be aware of the risks of CSE and an effective CSE Training Pathway is put in place.

Update from RBC's Participation Team

Achievements:
The Reading Youth Cabinet is made up of 18 elected young people – in the December 2014 elections, 3,800 young people across Reading voted. The youth cabinet campaigns in the last couple of years have focussed on mental health services for young people, and PSHE provision in schools. In 2014, the youth-cabinet undertook some research around Domestic Abuse and the experiences of young people in Reading, which was presented back to the LSCB.

Reading's Children-in-Care Council, now rebranded as Your Destiny Your Choice (YDYC) Lead, meets once every six weeks. The group have helped with the development of the new pledge for young people in care, to develop a new information pack for young people coming into care, and supported the implementation of the MOMO app.

Young people have also been involved in the recruitment of staff by having their own interview panel, including interviewing for the role of Director for Children's, Education and Early Help Services and recently for a new member of staff for the Edge of Care Team.

Young people in care are given the opportunity to complete a feedback sheet after each LAC Review, to comment on the process and how it could be improved. These are collated quarterly by the Participation Co-ordinator, and a report fed back to the IRO team to be able to pick up on any issues or themes.

A range of consultations and surveys are undertaken annually with young people. This includes almost 3,000 young people participating in a survey run in conjunction with theyouth cabinet elections, one for young people in care about the IRO service, and another for young people in care about what should be in the new pledge.

Impact:
Four schools have signed up to the Youth Cabinets Treaty of Mental Health, setting out commitments around what they will do to improve Mental Health education in their school. The Youth Cabinet work around Domestic Abuse has also helped inform, and is referred to, in the new Domestic Abuse strategy.

In a survey looking at how young people in care were experiencing delivery of the pledge, the average response to the 'Listened To' section was 4.4 (on a scale of 1-5, 1 being poor and 5 great). 9 of the 10 sections scored above 4.

The young people involved in recruitment have a genuine influence in the decision on who to employ, meeting with the adult panel to discuss their views and reasoning in an open and two-way fashion.

The work of the Children in Care Council has resulted in the delivery of the new pledge, the new LAC Information Pack, and MOMO which is increasingly being used by young people to prepare for meetings and LAC Reviews, and comment on their care and what could change. Their work has also included the running of an information evening on leaving care run at the Destiny Project, and an improved level of summer activities for young people in care.

Ongoing Challenges:
We want to improve further the voice of young people in the work of the LSCB and the Youth Cabinet is well placed to help us with this. We want to work towards young person periodic representation on the Board and more clear links between the Board and the YouthCabinet.

Lay Member Perspective

2014-2015 has been a year of change for Reading Local Safeguarding Children Board with our new chair taking up the role in the summer of 2014. Members continue to demonstrate commitment, energy and enthusiasm to provide effective and suitable safeguarding services for Reading. As one of two lay members I am privileged to see how the partners work together and to be party to the work of the board.

We refocused our work with a review of our priorities and reorganisation of the structure of the board and its committees. My lay colleague is the chair of the Quality and performance sub-group. Whilst we work closely with the otherWest Berkshire safeguarding children boards we have focused more closely on the local issues of Reading. Lay members from across the Thames Valley meet six monthly to discuss our local boards, for learning, advice and support.

I am encouraged to ask questions – to be the voice of an "ordinary person" of Reading. This is daunting as members are professionals and know their business. We are now getting to a better position to challenge agencies and express our views as we understand what we do know and what we need to know. Data collection, audit and review will improve so that agencies can evidence what difference they are making to children and young people's lives. The development of a risk and assurance log is part of this identification of where we are, what we need to do and what has been done so far. Our challenge now is to include and listen to the voice of young people in what we do as a board as well as in all services.

The new website is a useful tool for disseminating information to staff and local people. Regular newsletters have been reinstated so that staff can keep up to date with work of the board and find links to information and policy documents. I have undertaken a review of documentation for members so that they are easy to read and understand.

I have confidence that we are working together in a constructive way to improve the working of the board.

Anne Farley
Reading LSCB Lay Member

Appendices

1. Glossary

BHFT	Berkshire Healthcare NHS Foundation Trust
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CAT	Children's Action Team
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIC	Children in Care
CIN	Children in Need
CMoE	Children Missing out on Education
CP	Child Protection
CPE	Common Point of Entry
CSC	Children's Social Care
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
DA	Domestic Abuse
DBS	Disclosure and Barring Service
DfE	Department for Education
DV	Domestic Violence
EHC	Education, Health and care Plan
FGC	Family Group Conference
FGM	Female Genital Mutilation
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Child
LADO	Local Authority Designated Officer
LDD	Learning Difficulties and Disabilities
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NEET	Not in Employment, Education or Training
ONS	Office of National Statistics
PSCHE	Personal, Social, Citizenship and Health Education

RBC	Reading Borough Council
RBFT	Royal Berkshire NHS Foundation Trust
RCVYS	Reading Children and Voluntary Youth Services
RSCB	Reading Safeguarding Children Board
SAPB	Safeguarding Adults Partnership Board
SARC	Sexual Assault Referral Centre
SCR	Serious Case Review
SEN	Special Educational Needs
TVP	Thames Valley Police
VCF	Voluntary, Community and Faith
YOT	Youth Offending Team

2. Extracts from Working Together 2015

Chapter 3.1: Statutory objectives and functions of LSCBs

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1 (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

Chapter 3.4: Statutory Board partners and relevant persons and bodies

Section 13 of the Children Act 2004, as amended, sets out that an LSCB must include at least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person). Board partners who must be included in the LSCB are:

- district councils in local government areas which have them;
- the chief officer of police;
- the National Probation Service and Community Rehabilitation Companies;
- the Youth Offending Team;

- NHS England and clinical commissioning groups;
- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;
- Cafcass;
- the governor or director of any secure training centre in the area of the authority; and
- the governor or director of any prison in the area of the authority which ordinarily detains children.

The Apprenticeships, Skills, Children and Learning Act 2009 amended sections 13 and 14 of the Children Act 2004 and provided that the local authority must take reasonable steps to ensure that the LSCB includes two lay members representing the local community.

Section 13(4) of the Children Act 2004, as amended, provides that the local authority must take reasonable steps to ensure the LSCB includes representatives of relevant persons and bodies of such descriptions as may be prescribed. Regulation 3A of the LSCB Regulations prescribes the following persons and bodies:

- the governing body of a maintained school;
- the proprietor of a non-maintained special school;
- the proprietor of a city technology college, a city college for the technology of the arts or an academy; and
- the governing body of a further education institution the main site of which is situated in the authority's area.

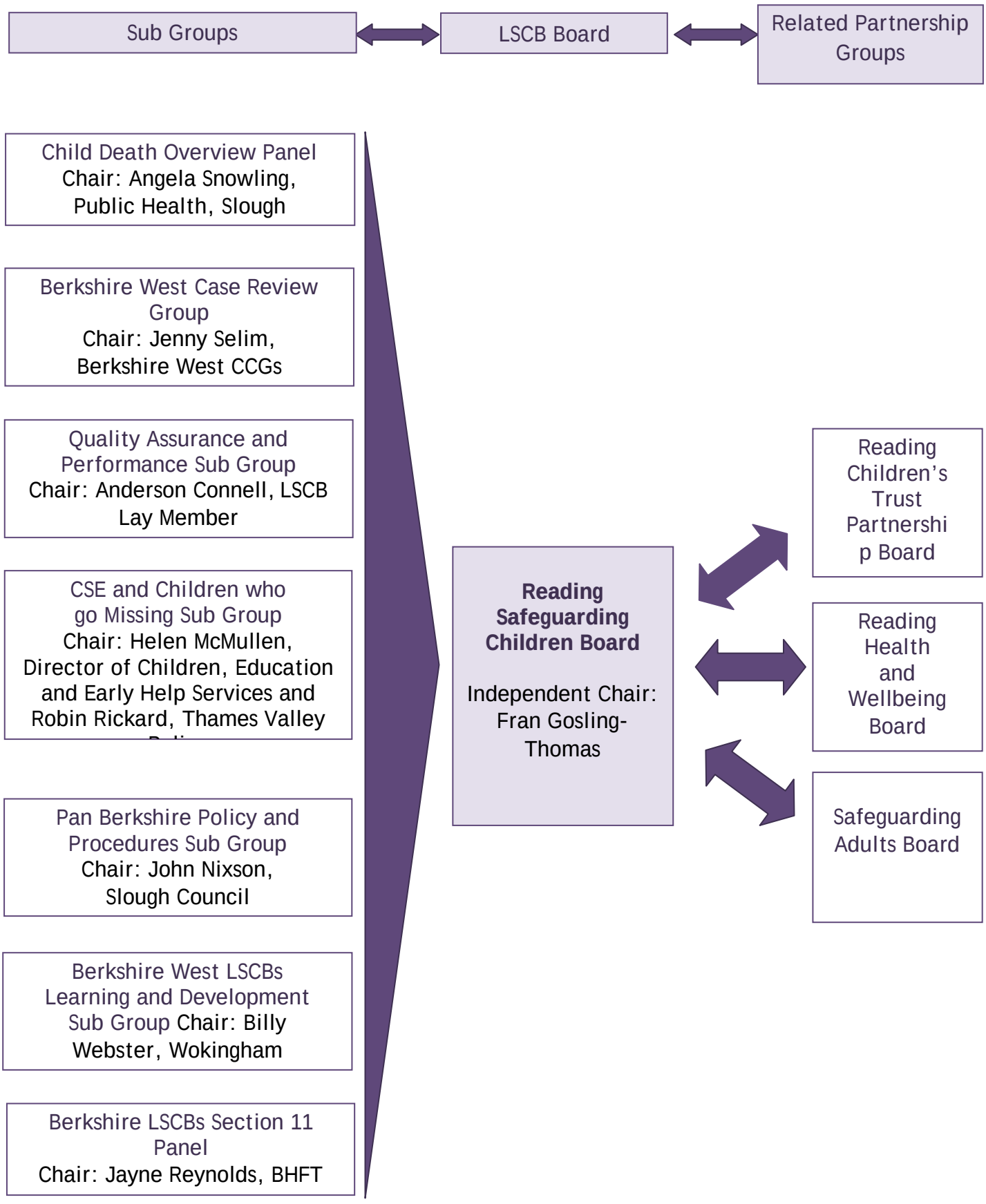
Chapter 5: Child Death Reviews

The Regulations relating to child death reviews:
The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

(a) collecting and analysing information about each death with a view to identifying -
(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Working Together 2015 can be viewed via this link:
http://www.workingtogetheronline.co.uk

3. Structure Chart



4. Board Membership and Attendance Log (March 2015)

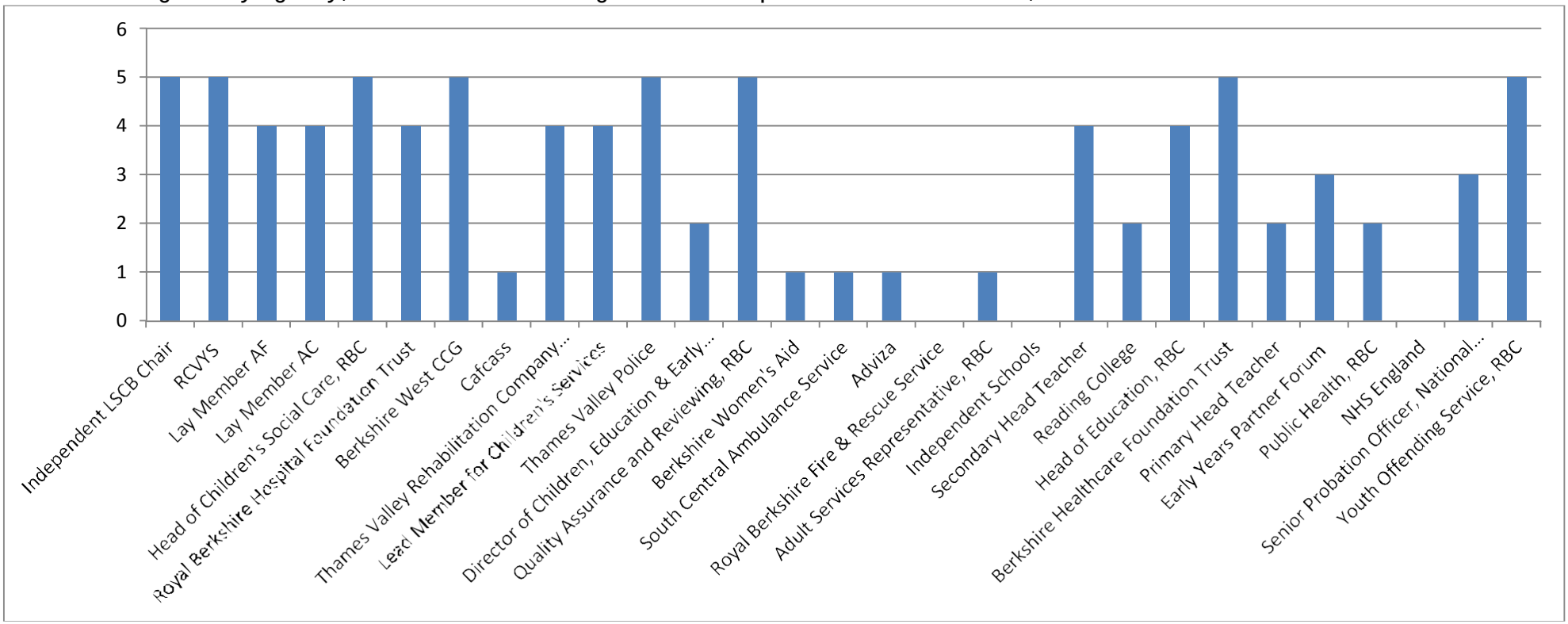
Name	Agency
Francis Gosling-Thomas	Independent LSCB Chair –Reading, West Berkshire, and Wokingham
Avril Wilson/Helen McMullen	Interim Director of Education, Adult and Children's Services - Reading Borough Council (RBC)
Cllr Janet Gavin	Lead Member for Children's Services
Karen Reeve/Vicki Lawson	Interim Head of Children's Social Care, RBC
Bernadette Adams	Service Development Manager - Berkshire Women's Aid
Anderson Connell	Reading LSCB Lay Member
Anne Farley	Reading LSCB Lay Member
Anthony Heselton/Kat Jenkin	South Central Ambulance Service
Helen Taylor/Mike Edwards	RCVYS
Jenny Selim/Debbie Daly	Berkshire West CCG
Kevin McDaniel	Head of Education, Reading Borough Council
Penny Cooper	Head of Children's Universal Services – Reading, Berkshire Healthcare Foundation Trust (BFHT)
Ruth Perry	Head Teacher, Caversham Primary School
Chris Lawrence	Early Years Partner Forum Representative
Anne-Marie Delaney	Service Manager Reviewing and Quality Assurance, RBC
Hannah Powell	Senior Probation Officer, Thames Valley Community Rehabilitation Company
Lise Llewellyn/Peter Dawson	Berkshire Lead Public Health Consultant
Debbie Johnson	National Probation Service South West and South Central
Kevin Gibbs	Head of Service, CAFCASS
Maninder Hayre/Julie Skinner	Adviza
Ashley Robson	Reading Boys School
Patricia Pease	Urgent Care Group Director of Nursing, Royal Berkshire Hospital Foundation Trust (RBHFT)
Elizabeth Rhodes	Fire and Rescue Service
Sarah Gee	Head of Housing, Neighbourhoods and Communities, RBC
Christina Kattirtzki	Kendrick School
Nigel Denning	Interim Service Manager, Youth Offending Service
Gerry Crawford	Regional Director, Berkshire Healthcare Foundation Trust
Gillian Davidson	Reading College
Jan Fowler	NHS England
Julie Kerry	NHS England
Rhoda Nikolay	Crown Prosecution Service
Robin Rickard	Thames Valley Police
Suzanne Westhead	Interim Director of Adult Care and Health Services, RBC

Board Meeting Attendance

LSCB members have a responsibility to attend all meetings and disseminate relevant information within their agency. Attendance at meetings is monitored to ensure attendance is regular and at an appropriate level. These records are presented to members on an annual basis as part of the LSCB's quality assurance process.

Attendance in Reading is generally good and, if a member is unable to attend, they are asked to send a deputy to ensure all messages are disseminated to each agency. Any lack of agency attendance is addressed directly by the Business Manager or escalated to the Chair. In addition, the Designated Doctor and a representative from Adviza attend meetings once a year by arrangement.

Attendance figures by agency, based on five meetings held from April 2014 to March 2015, are shown below.



5. Financial Contributions

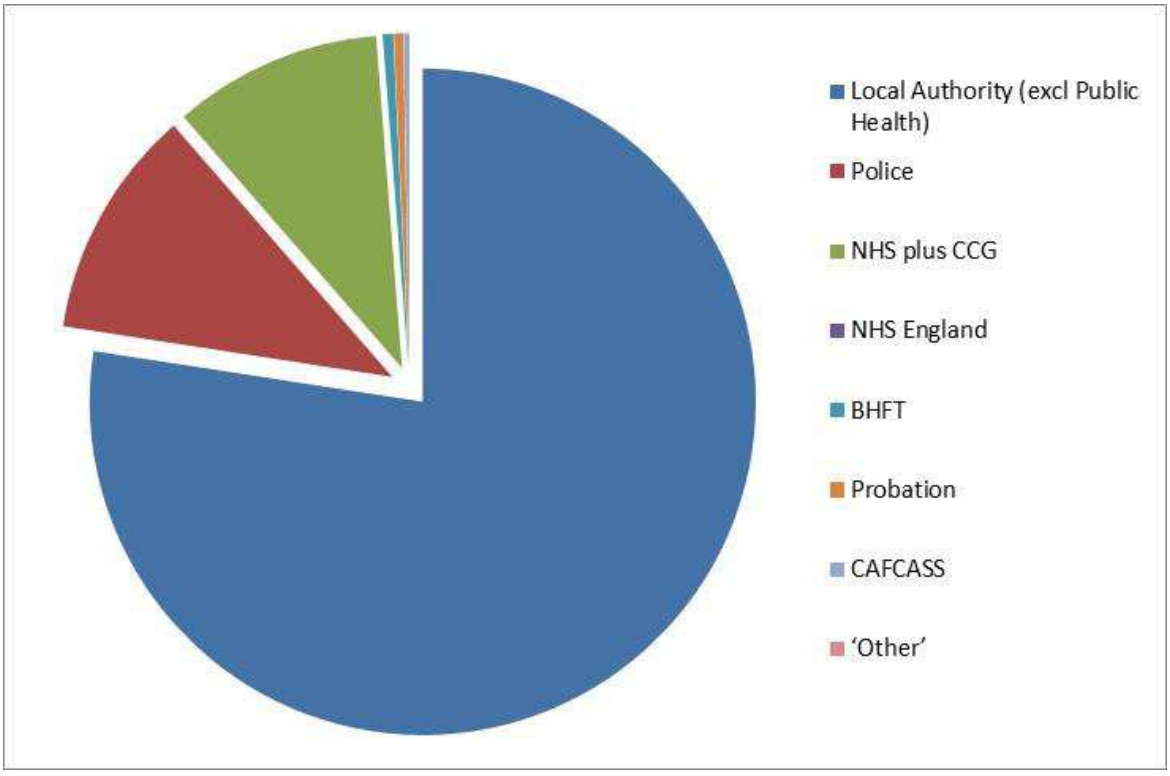
The budget is monitored by the Business Manager with the majority of thebudget spent on staffing to support the work of the Board.

The LSCB budget 2014-2015 is made up of contributions from the Local Authority, the CCG, Police, Probation, CAFCASS and Berkshire Healthcare NHS Foundation Trust.

Supplies and services include expenditure for the cost of an Independent Chair, updates of the child protection procedures and the costs associated with administering the LSCB training programme and the annual conference. This also covers any printing costs for publicity materials and leaflets.

In addition a small amount is spent under premises to cover the hire of meeting rooms, refreshments and venues for LSCB activities and meetings.

Contributing Agency	Contribution Amount
Local Authority (incl. Public Health, all staffing & training)	£152,500
Police (incl. RCVYS training funding and one off contribution to CSE Coordinator post)	£22,000
NHS plus CCG	£20,000
NHS England	£0
BHFT	£1,000
Probation	£895
CAFCASS	£550



Ongoing LSCB Challenge:

The LSCB Chair raised a clear concern that the current budget is not in line with similar authorities and does not allow the LSCB to address its key priorities. A discussion was held at Board and comparative review of the budget undertaken. A zero baseline budget forecast was undertaken to gauge the required level of funding and found a £88k shortfall in our current budget.

As a result, additional contributions were received from TVP (£15k one off to support the appointment of the CSE Coordinator) and CCGs (additional £5k ongoing). Other agencies felt unable to increase contribution for 2015/16 year. Conversations will continue for the 2016/17 year.

6. Risk/Concern Log

The latest version of the risk and concern log can be found on the LSCB website: www.readinglscb.org.uk/about-lscb/board/.

7. Top 10 Scorecard

Reading LSCB Top 10 Scorecard Data Updated 9th September 2015

Priority 1 - Domestic Abuse

1. % repeat referrals to CSC for DA

No benchmarking figures are available as this data is not collected nationally.

Children's Social Care Re Referral Data	Q3 14/15	Q4 14/15	April 15	May 15	June 15	July 15
Repeat referrals to CSC for DA	38%	21.5%	4%	40%	17%	1%
DV Referrals in Quarter	64	65	24	45	53	23

2. MARAC specific data to be obtained from Domestic Abuse Steering Group.

Data included is on a rolling year not quarterly.

MARAC Specific Data	Quarter 1 01/04/14 30/06/14	Quarter 2 01/07/14 30/09/14	Quarter 3 01/10/14 31/12/14	Quarter 4 01/01/15 31/03/15	Quarter 1 01/04/15 30/06/15
Total Number of Cases Reviewed to Date	149	153	155	134	138
Repeat Cases	38	38	34	24	23
% Repeat	26%	25%	22%	18%	17%
Number of Children in Household of MARAC Referrals	199	204	194	182	185

Priority 2 - Strengthening Child's Voice and Journey

3. LAC Health Assessments

Berkshire Healthcare Foundation Trust has provided additional resources to the service. The next quarter figures will show whether this has had an impact. From April 2015 the figures have been taken from the RBC Purple Book.

LAC Health Assessments Figures	Q2 14/15	Q3 14/15	Q4 14/15	April 15	May 15	June 15	July 15
Initial Health Assessment Compliance	53%	69%	10%	0%	0%	65.7%	55.8%
Review Health Assessment Compliance	61%	58%	11%	69.4%	75%	75.7%	74.6%

4. Number of children contributing to/attending case conferences

Monitoring of how often the Child's Voice is included and what work needs to be done to support this. Advocacy Service for CP cases has been commissioned.

	14/15	Q1 15/16
Number of children contribution to/attending case conferences	Initial – 27 Review - 49	Awaiting report from Performance team

Priority 3 - CSE and Other Vulnerable Groups

5. **Number of CSE Level 1/2/3 cases**
6. **Potential new persons of concern**
   Due to the emphasis on Early Help Services Level 1 Data will be collected. Figures are taken from the Purple Book.

CSE Figures	Aug 14	Sep 14	Nov 14	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
LEVEL 3 CASES	9	7	12	6	6	5	9	5	4	5
LEVEL 2 CASES	5	6	5	5	2	4	5	9	10	8
LEVEL 1 CASES	4	3	6	13	12	11	9	8	5	4
REDUCED FROM 2 TO 1	NK	NK	NK	0	3	2	0	2	0	0
RAISED FROM 1 TO 2	NK	NK	NK	1	1	1	0	0	0	0
Potential new persons of concern	NK	NK	NK	2	3	4	12	4	0	1
Potential cases for removal	NK	NK	NK	NK	6	5	8	7	8	2

Priority 4 – Neglect

7. **Outcome Star**
   Outcome Star – Number of users who are included: 82
   This table chows the average first and last scores for the clients included. The difference between these two is the 'change', or outcome, shown in the column on the right.

Scale	Initial	Final	Change
Physical health	6.9	8.1	1.2
Your well-being	5.4	7.1	1.7
Meeting emotional needs	6.4	7.8	1.4
Keeping your children safe	7	8.4	1.5
Social networks	6.2	7.5	1.3
Education and learning	6.4	7.7	1.3
Boundaries and behaviour	5.7	7.4	1.7
Family routine	6.8	8.2	1.4
Home and money	6.9	8	1.1
Progress to work	6.5	7.4	1
Average	6.4	7.8	1.4

8. **% of children on plan as a result of neglect.**
   Graded Care Profile is being introduced in September (an assessment tool developed for practitioners assessing neglect). The implementation of this and the results from the Neglect Audit may see a drop in number for this category.

Children Subject to CP Plan under the category of neglect	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15
	104 or 56.5%	103 or 55.8%	97 or 47.8%	106 or 51.2%	110 52.1%	118 49.8%	110 41.5%
Total Number of CYP subject to a protection plan	184	195	203	207	211	237	241

Priority 5 - Effectiveness and Impact of the Board

9. Number of cases looked at in multi-agency audits

Single Agency audits to highlight multi-agency issues and inform future audits.

Number of cases looked at in multi-agency audits	14/15	15/16
Neglect Audit	10	
Health of LAC	16	
MARAC Audit	13	
CSE Audit		6
Board Effectiveness Survey		103

Number of cases looked at in single-agency audits	14/15	15/16
BHFT Safeguarding Children Training Audit	25	
Entitlement Survey of Children in Care	44	
Audit survey of missing persons Under 18- MISPER alerts	18	
National Standards Audit Submission 2014 Reducing Reoffending	21	
YOS Self Assessment Audit	10	
Lived Experience Snapshot of a sample of Children on Protection Plans	8	
Domestic Violence – audit of threshold application by TVP Risk Assessor in MASH	7	
Audit and Review of CAF Assessments	148	
Audit of clinics to assess process for 'Children Not Brought for Appointments'	5	

10. Number of known children or young people in Private Fostering

The Children Act 1989 (section 66) defines private fostering as occurring when a child under 16 (or under 18 if disabled) is cared for and provided with accommodation, for 28 days or more by somebody other than a close relative, legal guardian or someone with parental responsibility. Close relatives are defined in the Act as step parents, siblings, brothers or sisters of the parents and grandparents. A private fostering arrangement is one which is made privately, that is to say without the involvement of the Local Authority.

Number of known children or young people in Private Fostering	
March 2015	0
April 2015	0
May 2015	1
June 2015	1
July	

8. LSCB Board Information

Independent Chair:	Fran Gosling-Thomas	LSCBChair@reading.gov.uk
LSCB Business Manager:	Esther Blake	esther.blake@reading.gov.uk 0118 937 3269
LSCB Coordinator:	Donna Boseley	LSCB@reading.gov.uk 0118 937 4354

Reading LSCB,
Civic Offices, Bridge Street
Reading, Berkshire, RG1 2LU
Website: www.readinglscb.org.uk

Berkshire Local Safeguarding Children Boards
Child Protection Procedures available on line:
http://berks.proceduresonline.com/index.htm

Author: Esther Blake, LSCB Business Manager
Date published: 12th October 2015

If you have any queries about the report please contact Esther Blake at the contact details above. If you require this information in an alternative format or translation, please contact Esther Blake.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**7**
TITLE:	**UPDATE ON TACKLING FEMALE GENITAL MUTILATION (FGM)**		
LEAD COUNCILLOR:	**Cllr Gavin**	**PORTFOLIO:**	**Children's Services**
SERVICE:	**Children's Services**	**WARDS:**	**All Reading**
LEAD OFFICER:	**Andy Fitton, Victoria Hunter & Esther Blake**	**TEL:**	
JOB TITLE:	**Head of Early Help in Children's Services - RBC Equalities Coordinator – ACRE LSCB Business Manager - RBC**	**E-MAIL:**	

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide a summary of work planned and undertaken in relation to tackling Female Genital Mutilation since January 2015, when a previous report was presented to the Health and Wellbeing Board.

2 RECOMMENDED ACTION

2.1 Endorsement of the work undertaken so far and proposed next steps.

2.2 To recognise progress made, especially the work of ACRE

2.3 Agree to bring a further report in six months to update on the progress

3 POLICY CONTEXT

3.1 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.

3.2 FGM is performed on women and girls at different ages, depending on the community or ethnic group that carries it out. The procedure is traditionally carried out by women with no medical training.

3.3 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.

3.4 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.

3.5 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.

3.6 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.

3.7 More recently there have been new duties placed on teachers, social workers and GPs to report any concerns around FGM. This is particularly pertinent as a recent Barnados survey found that 75% of workforce feels uncomfortable about having or starting a conversation about FGM with families.

3.8 Finally the most recent Ofsted Safeguarding inspection framework has added criteria to understand the Local Authorities and partners approach to tackling FGM. This focuses on the identification of girls at risk and our protective responses and will measure the effectiveness of the LSCB holding partners to account for their practice in this area.

4 PROGRESS ACHIEVED AND CURRENT POSITION

4.1 Two strands have been identified to organise our response to FGM. These are:

- Strand 1 – Prevention and Education
- Strand 2 – Protect and respond

4.2 **Strand 1** has been led by ACRE with partnership support, including sponsorship from the Local Strategic partnership that accepted FGM as a priority in June 2015. Key achievements in the last 6 months are:

4.3 Community engagement work was started by ACRE setting up a community working group of 20 different advocates from across African and Middle Eastern country communities. Discussion has focused on awareness raising, engaging community leaders and young people to effect change. This community group has met 4 times and is well represented. From this group 2 further initiatives have been set up:

- A group of survivors have been engaged to safely discuss the possible consequences of FGM that they are dealing with on a daily basis.
- A men's group of 8 – 10 participants to discuss the importance of a male response to FGM within their communities.

4.4 A partnership Symposium was organised in November 2015 that was extremely well attended. At this event it built on the community engagement model providing an opportunity to discuss the causes and consequences of FGM from both a professionals as well as a survivor's perspective. 2 regional partners provided a road map strategically and operationally as to our journey as a town to tackle FGM. This is building on the wider links that ACRE have been creating to understand the offer in their towns/ cities as well as the starting of resources and ideas on tackling FGM.

4.5 Forward UK, a Foundation for Women's Health Research and Development, will be providing 3 all day sessions for school staff providing an FGM overview, building confidence to identify and safeguard girls at risk and providing support for those affected by FGM.

4.6 Going forward up till April 2016 the expectation is to:

- Organise an FGM focus on Zero Tolerance Day in February 2016 to continue the awareness raising but in the wider population.
- Continue with the Men's group.
- Provide an assembly at Kendrick searching for some young people to begin to support the community engagement approach.

- Begin to research establishing a Reading version of the Oxford Rose project.

4.7 **Strand 2** has been led by Children's Services in Reading Borough Council, with support from the LSCB. A partnership action plan has been devised primarily with Reading in focus. However the LSCB chair has organised for the action plan to be adopted by all 3 West of Berkshire Local Authorities. This enables particular partner organisations who work across the West of Berkshire, e.g. CCG, to work on effectively on the implementation of the plan.

4.8 The action plan has 6 actions relating to protection. These actions primarily focus on:

- updating safeguarding guidance,
- creating assessment and service pathways for adults and children,
- set up information sharing agreements,
- identify a common risk assessment tools for all professionals to use

4.9 The action plan has key 2 actions relating to response. These focus on understanding and if necessary building a range of support in place for Adult and children survivors.

4.10 Going forward up till April 2016 the expectation is to

- Finalise an audit of prevalence based on work in the hospital with public health
- Create clear multi agency pathways for women and children
- Identify current resources and services, but also note gaps in service offers for women and children to discuss with commissioners

4.11 It is recognised, mainly due to experiences of other areas namely Oxford, that more survivors will come forward once community engagement and service provision is put in place. This will place pressure on current infrastructure, both for physical health and psychological service provision to support these women. Of note there is no specialist clinic in Berkshire at the moment as per Oxford to take a lead on FGM response for women.

5 CONTRIBUTION TO STRATEGIC AIMS

5.1 Readings Health & Wellbeing plan identifies 'The promotion and protection of good health of disadvantage communities' in goal 1, creating a clear link to tackling and responding to FGM.

5.2 Tackling FGM in Reading contributes to these RBC corporate aims;

- Safeguarding and protecting those that are most vulnerable;
- Providing the best start in life through education, early help and healthy living;

5.3 In addition the Police and Crime Commissioner priorities for the Thames Valley include 'Protecting vulnerable women & girls from FGM' as a specific item under objective 2 of their plan.

6 COMMUNITY ENGAGEMENT AND INFORMATION

6.1 ACRE is effectively leading a community engagement process with affected women, families and communities. This takes time, but there has been real progress already achieved as noted above.

7 EQUALITY IMPACT ASSESSMENT

7.1 **Not completed for this report.**

8 LEGAL IMPLICATIONS

8.1 None for this report.

9 FINANCIAL IMPLICATIONS

9.1 To note, the funding to ACRE from the LSP ends in March 2016.

10 BACKGROUND PAPERS

10.1 None

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**8**
TITLE:	**ALIGNMENT OF COMMISSIONING INTENTIONS FOR 2016-2017**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**ALL**
LEAD OFFICER:	**WENDY FABBRO**	**TEL:**	**0118 937 2072**
JOB TITLE:	**DIRECTOR OF ADULT SOCIAL CARE**	**E-MAIL:**	**WENDY.FABBRO@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report aims to summarise the key themes, features and potential areas for alignment across the Health and Social Care Commissioning intentions of RBC and the CCG.

2. RECOMMENDED ACTION

2.1 That the Board convenes a workshop in early autumn 2016 to ensure co-creation of commissioning intentions based on HWB strategic aims and priorities

3. POLICY CONTEXT

3.1 The Health and Wellbeing Board is a partnership of the Local Commissioning Authorities in Reading, with accountability to ensure the alignment of all health and social care commissioning activity.

3.2 The remit and accountability of the HWB is defined by the Health and Wellbeing Strategy, and in its terms of reference.

3.3 The commissioning intentions outline the strategic interventions each Authority is planning to improve the way they commission, review, and transform local services. In Health Commissioning Authorities, this focuses on the Five Year Forward View and 5 year Strategic Plan, and local operational plans to deliver sustainable consistent care standards. In Council services this describes a path to putting into operation the ambitions in the Corporate Plan and Service Plans and Commissioning Strategies for various cohorts of customers and wider determinants of Health.

4. CURRENT POSITION

4.1 Decisions relating to the commissioning of health services are made by the CCGs, (Co-commissioning with NHSE for Primary Care, and via NHSE for Specialised Services), and decisions relating to the delivery of Public Health, Adult Social Care, Childrens Services and Education (and many services identified as the wider determinants of health) are made by Reading Borough Council and its sub Committees. Many other stakeholders contribute to these decisions and would ideally have been included in the work to co-create the Commissioning Intentions. These stakeholders include Healthwatch, representatives of the VCS, and major Health care providers. There is potential for greater synergy if, at a local level, all Commissioning authorities and stakeholders work together more closely to develop joint commissioning plans and to jointly operationalise these plans.

Commissioning Intentions have been drafted (and have already been approved by CCG Board for the CCG Commissioning Intentions) by each Commissioning Authority and are attached for members to receive and comment on. Respective schedules for submission of key documents to NHSE, Reading Policy Committee and Council meetings are difficult to align, and it tends to be the case that NHSE require submission of Commissioning Intentions ahead of Reading Borough Council deadlines. It is therefore unfortunate that each document has been separately drafted this cycle, though hopefully with the benefit of the Officers Integration Programme activities to influence alignment

5. THE PROPOSAL

5.1 Key Themes emerge from the Commissioning documents albeit interpreted in different ways in each document. These could be summarised as

- ☐ Prevention
- ☐ Choice and control
- ☐ 7 day working
- ☐ Community resilience/ social capital
- ☐ Efficient use of resources

5.2 A more in depth analysis would be beneficial for the Board, and will be undertaken to inform future commissioning. Critical aspects of this analysis would be:

5.3 Co-ordinated approach (timescales and methodology)
It may be helpful for the HWB to convene a workshop in early autumn to ensure that shared priorities and aspects of commissioning that would enable a more joined up service response are agreed, as authorities determine their constitutional accountabilities.

5.4 Aligning Priorities
The HWB could usefully ask for a report from the Integration programme on the evaluation of the BCF projects, to contribute to a debate on identification of appropriate priorities

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 These documents aim to deliver the Five Year Forward View and 5 year Strategic Plans, the RBC Corporate Plan "Narrowing the Gaps", and support the Integration Programme agenda and Better Care Fund activities.

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 Commissioning Intentions will now be taken to consultation with colleagues in VCS, Care Providers, Health and Well Being Board and Council Members.

8. EQUALITY IMPACT ASSESSMENT

8.1 This paper identifies further opportunities to ensure health inequalities are addressed.

9. LEGAL IMPLICATIONS

9.1 None.

10. FINANCIAL IMPLICATIONS

10.1 This paper seeks to set up procedure to enhance efficiency and better use of resources

11. BACKGROUND PAPERS

11.1 None.

Commissioning Intentions

Goal One: Promote and protect the health of all communities particularly those disadvantaged: communicable diseases, immunisations and screening, BME groups
Goal Two: Increase the focus on early years and the whole family to help reduce health inequalities: maternity, family support, emotional heath, domestic violence
Goal Three: Reduce the impact of long term conditions with approaches focused on specific groups: self-care, carers, learning disability
Goal Four: Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities: tobacco, drugs and alcohol, obesity

Themes	**CCG**	**Adult Social Care**	**Childrens Services**	**Public Health**
Prevention	• Living Well Programme • Mental Health Crisis Concordat • Personal Health Budgets	• Mental Health Crisis Concordat • Right 4 U pilot • Reablement and recovery focus • Personal budget as default • Wellbeing strategy	• Early Help strategy • Prevention of Neglect strategy • Transitioning to independence	• Identifying people at risk of preventable disease and disability and targeting those at greatest risk and tailoring approaches to them in ways most likely to achieve their engagement • Smoking cessation • Overweight and obesity in both children and adults • Identifying and referring people with pre-diabetes to a risk reduction programme • Encouraging and enabling people to be more physically active as part of their everyday lives

				• Encouraging and enabling people to drink alcohol sensibly
Patient/Service User Control and choice (information, person centred,	• Making smarter use of data and intelligence through the West of Berkshire Interoperability Project (Connected Care).	• Learning Disability Transforming Care Programme	• Making smarter use of data and intelligence through the West of Berkshire Interoperability Project (Connected Care). • Place of Safety • Care Homes Enhanced Support	
7 day working				
Financial activity/ resource use/ outcome focused contracts/ evidence base decision making	• Work to manage whole system performance, inc DTOC and DtA	• Work to manage whole system performance, inc DTOC and DtA. • Use of technology, both in front line services and back office functions • Fair Price for Care • National Living Wage	• Use of technology, both in front line services and back office functions • National Living Wage	
Community Enhanced Services from Primary care	• CAMHS Transformation Plan • Care Homes Enhanced Support	• Developing our support for carers, using Care Act requirements	• Developing our support for carers, using Children and Families Act requirements • CAMHS Transformation Plan	• Fully integrated 0-19 service specification • HV/FNP services fully embedded into RBC
Decommissioning		• Market Failure Protocol	• Market Failure Protocol	
Better Care Fund		• Rapid Response and Treatment Service • Frail Elderly Pathway redesign		

NHS SOUTH READING CLINICAL COMMISSIONING GROUP

NHS NORTH AND WEST READING CLINICAL COMMISSIONING GROUP

NHS WOKINGHAM CLINICAL COMMISSIONING GROUP

NHS NEWBURY & DISTRICT CLINICAL COMMISSIONING GROUP

BERKSHIRE WEST CCGs

Commissioning Ambitions 2016-17

Publication Date: 30th October 2015

1. PRINCIPLES

Our commissioning ambitions for 2016/17 outline the strategic interventions we are planning to improve the way we commission, review and transform local services. They respond to both the Five Year Forward View and build on the progress already made through delivery of the Berkshire West CCGs 5 Year Strategic plan and local CCG Operational Plans to deliver sustainable consistent care standards across the CCGs. They also mirror the collective vision of the 10 Berkshire West Health and Social Care partners in our system.

Our message to patients is:

'Together we will support you to stay well and deliver great care when you need us ...'

There will be joined up care and support that meets your needs and helps you to be as independent as possible...

This joined up system, focused on people, will be seamless, and underpinned by an activated, responsible population...'

The priorities set out in the CCGs Five Year Strategy and the NHS England Five Year Forward View remain; the prime focus being on improved quality of patient care provided within a financially sustainable health and care sector. We will reflect national strategies and priorities in all our agreed contracts for 2016/17, and adopt national planning guidance requirements when available.

The following principles will support our commissioning ambitions for 16/17:

- ☐ To put a greater emphasis on prevention and putting patients in control of their own care planning including through the expanded use of technology enabled care, multi-disciplinary care planning led by GPs here (under Anticipatory Care CES), and proactive support for carers and families. This will underpinned through CCG Programme Board led pathway redesign, service line reviews and the development of the CCG QIPP programme for 16/17.
- ☐ We will commission services which provide our populations with more information and choice about the full range of service providers, ensuring care closest to home is offered wherever possible.
- ☐ We will work with providers to explore opportunities to move away from disease specific pathways to care delivery which is person centred and place based.

- ☐ We will work with providers to implement new models of care which better support better integration which expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care.
- ☐ We will work with our providers to ensure that appropriate levels of care and diagnostics are available across the week which enable achievement of improved health outcomes for our populations.
- ☐ We would want to work with providers to ensure that contracts are delivered within the agreed financial and activity envelope.
- ☐ We would want to explore new payment mechanisms which incentivise the delivery of outcome focused care at the right time in the right place, and which support the future sustainability of our local health and care system.
- ☐ We will use 2015/16 forecast outturn as the basis for baseline setting unless there is a clear rationale to do otherwise.
- ☐ We will only purchase treatments and drugs that are evidenced to be cost-effective, either through NICE TAG or evidence reviews that have been specifically accepted and adopted by Commissioners on the recommendation of the Thames Valley Priorities Committee.
- ☐ For non-tariff services, we will uphold the requirements of the National Contract, ensuring that prices paid are transparent, fair and representative of actual costs incurred.
- ☐ We will seek demonstrable improvements in quality across all services and will expect providers to implement a range of best practice pathways for specific treatments and conditions within the agreed contract value.
- ☐ We will continue to commission Community Enhanced Services from primary care where these support delivery of our strategic vision and will continue to co-commission primary care services with NHS England, exploring the benefits of the fully delegated model.
- ☐ We will actively consider decommissioning services that do not deliver the required performance and quality outcomes for patients.

1.1. New Models of Care

We will expect to be in a position to be able to describe our preferred models of care including, actively exploring the feasibility of formally adopting a PACS (Primary, Acute and Community) model where this supports integration with Primary Care and Social Care and offers innovative solutions in the context of the Five Year Forward View (NHS England October 2014) which address both the financial challenges facing our system, and the increasing demand for services.

Having built on the report published by the Kings Fund of our Frail Elderly pathway programme in 14/15, and in partnership with South Central and West Commissioning Support Unit, with Ernst and Young we will accelerate the design of a new model of care for older people as an exemplar cohort, assessing the financial opportunities and setting out the options for future models of care and contracting for delivery from Spring/Summer 2016.

The recently established Joint Primary Care Co-commissioning committee will continue to work to realise the vision for primary care services set out in the CCGs' Five-year Strategic Plan and emerging Primary Care Strategy. This strategy anticipates that primary care will play a pivotal role in a more integrated health and social care system, working to prevent ill-health and support people in the community wherever possible. As such any new model of care will need to interface with general practice. We will continue to assess the benefits associated with the opportunity for fully delegated commissioning of Primary Care.

The increasing number of people with complex health needs is a major challenge and we wish to move to more generic integrated pathways with greater joint working across health and care providers. This will require our main Providers to work together with the public and a range of partners from all sectors including Primary Care, social care the Independent Sector and the third sector to create a fully integrated system delivering new care models.

2. COMMISSIONING AMBITIONS

The prime objectives for the CCGs as set out in our 5 year strategic plan 2014-2019 are:

- Improving the outcomes and experience for people and
- achieving financial sustainability for the health and social care system.

Mindful of the national drive for further financial efficiencies the CCGs will be working with NHS England and other commissioners expecting Providers to continue to adopt recognised national best practice to achieve realistic year-on-year improvements in efficiency, productivity and effectiveness.

We therefore expect to conduct negotiations on our 2016/17 contracts with Providers which enable all parties to:

- ☐ Work within the financial envelope available and have a degree of certainty on income and expenditure
- ☐ Agree shared strategic priorities
- ☐ Improve levels of productivity and efficiency including through the expanded use of technology
- ☐ Eliminate any clinical activity that does not offer maximum patient benefit or cost and clinical effectiveness
- ☐ Review, reconfigure and re-specify services as appropriate

In line with the points set out above, we will continue to closely monitor and report provider quality achievement and will apply contractual actions as required and as set out by the NHS Standard Contract. We will seek to agree with Providers an appropriate balance of sanctions and incentives to maximise improvements in outcomes for patients.

Key areas for collaborative working include:

- ☐ **Better Care Fund:** We have worked with local Health and Wellbeing Boards on the creation of schemes that form our Better Care Fund (BCF) plans and as part of the development process we have engaged with our local providers. In preparation for 16/17 we will be formally reviewing performance against the metrics included in BCF planning requirements to we full understand the impact of the investment in 15/16. As responsible commissioners we will seek to minimise any commissioning risk to the provider in relation to transfer of services or funding into the BCFs. Following discussion at the Berkshire West Integration Finance sub-group, the principles that are proposed to be applied for 2016/17 are as follows:-

(a) Elements from 2015/6 BCF that ***should*** be included in 2016/17:-

(i) Connected Care (value to be determined), on the basis it is a key enabler to integrated working and fulfilment of at least one of the National Conditions specified
(ii) Existing S256 Agreement monies with a review and scrutiny over any funding included for Care Act requirements, with the expectation that any non-recurrent spend for 2015/16 is no longer required. The 2016/17 BCF Plans should also provide greater transparency on the use of funds designated against the Care Act
(iii) Existing DFG and Social care Capital grants (as committed LA spend)
(iv) As a minimum the amount specified by national guidance to be set aside in 2016/17 for the protection of Adult Social Care services, (when known)
(v) CCG and LA Reablement (key to integrated working across social and healthcare)
(vi) Carers funding (existing LA and CCG monies)
(vii) Schemes established in 2015/16 where they can be demonstrated through the evaluation process to deliver their intended outcomes, are assessed as should continue following evaluation using the BCF Self-Assessment tool and are supported locally

(b) Elements currently in the 2015/16 BCF that ***should not*** be included in 2016/17 are as follows:-

(i) Primary care CES re Enhanced Access – although this is an enabler of 7 day working and should probably be continued it is pure health and should not form part of a pooled budget in the BCF. As CCGs potentially move to delegated commissioning CCG Governing Bodies will want to ensure protection of this CCG funding for Primarycare.
(ii) Care Act – CCG contributions re Care Act implications will be limited to that required by the national guidance for 2016/17 when known.

(c) Areas of Existing BHFT spend will be considered in collaboration with BHFT and LAs for inclusion in the 2016/17 BCF include but may not be limited to:-

(i) Adult Speech and Language Therapy
(ii) Community geriatricians
(iii) Intermediate care – (night sitting, rapid response, reablement & falls)
(iv) Intermediate Care and Rapid response service
(v) Health Hub

(vi) Hard to reach and homeless service
(vii) Intermediate care
(viii) Care Homes In-reach services

(d) Potential areas for possible future discussion for inclusion in 2016/17 BCF could include but may not be limited to:-

a. Safeguarding (LA)
b. EOL Care (LAs and CCGs)
c. Community Equipment (CCGs and LAs)
d. Prevention/Public Health (LAs)

(e) Areas of BCF spend not budgeted in 2015/16 but which should be considered to be included in the 2016/17 budget

i) Project Management costs
ii) Monthly metrics and data reporting
iii) IMHA Grant
iv) Veterans Grant
v) 7 Day Services as specified by the national guidance to meet the National Conditions

The financial values of the BCFs will be as set out in the NHSE Planning Guidance. For initial planning purposes, and pending receipt of that guidance, 2015/16 guidance will be used.

The finalisation of the 2016/17 BCF budget will be subject to detailed discussions between each Local Authority, its respective CCG and healthcare providers, taking into consideration the anticipated overall financial position of each organisation for 2016/17.

☐ **Frail Elderly Pathway Redesign:** The Frail Elderly work is system wide across the 10 BW partners. The intention is to determine the optimal pathway for this cohort of the population, identify how investment would need to change to deliver this, identify the optimal delivery model or new model of care, and recommend an appropriate contracting and funding approach. Frail elderly were selected as the cohort following the work by Capita two years ago which should that this group are the biggest cost driver in the system. The rationale was that this group would be an exemplar and the learning could be extrapolated more widely to determine the right model of care across the whole system. A contract has been let to the CSU in partnership with Ernst Young to undertake this work. The outputs of this programme which will be emerging over the

coming months including identified opportunities for "quick wins" will be used where possible to inform commissioning decisions for 16/17 and these will be explored with providers over the coming months.

- ☐ **Support for Carers**

  The CCGs, Reading Borough Council and West Berkshire Council will be recommissioning the advice and information service for Carers. Following Carers consultation a new commissioning model was agreed that will focus on developing the market through offering 2 year grants to voluntary organisations. This has been developed from previous discussions and intended to offer a consistent level of service, ease of access/referral across Berkshire West, and the opportunity to draw on local knowledge and expertise. To date, the bulk of our carers information advice and support services have been delivered by a single provider operating across Reading, West Berkshire and Wokingham.

  From April 2016, it the commissioners' intention that carers across Berkshire West (wherever they live) will be able to access local services that adhere to the same specifications and deliver the same high-quality standards, These services will be accessed through a common access number to simplify referrals and signposting into carers support by other agencies.

- ☐ **Voluntary Sector Commissioning**

  The CCG is the process of setting up the 2016-17 commissioning process for the Partnership Development Fund. This process will be aligned to the 2016-17 commissioning intentions to achieve health and wellbeing outcomes. The commissioning process will run from November 2015 to January 2016 and 1 year grant agreements will be issued for services to commence from April 2016. The CCG will look to improve the way that its commissions' wellbeing and preventative services from the voluntary sector and will run a fair and transparent process.

- ☐ **Berkshire Interoperability Project (Connected Care):**
- ☐ Interoperability is key to the delivery of the CCG strategy, underpinning our plans for Integration, our Better Care Fund plans and key programmes. It will enhance patient safety and quality of care, improve patient experience and provide significant opportunity for efficient use of clinical time. We are committed to rapid progress within and between providers and it is our expectation that all providers support the implementation in this critical enabler to all system strategies.
- ☐ **Technology Enabled Care:** The Commissioner will take a new coordinating role for the production and implementation of the Local Digital Roadmap as set out by the National Information Board and the Five Year Forward View. All Providers will be expected to participate in the production of Digital Maturity Self-Assessment and the emerging Digital System Board Technology Enabled Care will be key to the roadmap and will include the role of Telemedicine, TeleHealth and Tele Coaching. The Commissioner will seek to maximise the role of the Technology Enabled Care, expanding the role to support patients with Long term Conditions.
- ☐ **Personal Health Budgets:** The CCGs are committed to working with our Local Authority colleagues to implement Personal Health Budgets. We have commissioned external support for this work. Scoping work across our three local authorities has

taken place. Areas of focus will include Learning Disabilities / Children with Complex Needs. Pilot sites will be identified and a Berkshire West Personalisation Steering Group is being set up and a co-design Workshop in being held.

2.1. Out of Hospital

Mental Health and Learning Disabilities:

- ☐ **Transforming care:** We recognise the scale of change required to transform the care for adults and children with learning disabilities. Our Post Winterbourne Transformation Plan is being delivered through a multi-agency working group including our Local Authorities. The key deliverables include delivery of the 6 elements of the Positive Living Model which includes positive behaviour/support, intensive intervention service, special social care, advocacy, carer support and person led transition plan.
- ☐ **Placement Budget and the governance of MH and LD:** We wish to continue to carry out a collaborative review of approaches to the management of mental health and learning disability placements.
- ☐ **Mental Health Crisis Care Concordat:** The national Mental Health Crisis Concordat launched in 2014/15, provides a blueprint for an effective pathway for people with mental health problems. We wish to explore opportunities to further strengthen the approach to crisis management across the whole system, and, to that effect expect as part of the signatories of the concordat declaration to continue working collaboratively.
- ☐ **Place of safety:** As part of its commitment to improve mental health services, we intend to work with the Provider to review Section 136 place of safety arrangements. The CCGs and LAs have already invested in a one year Street Triage Pilot Scheme which was launched in June 2015, with the aim that this will reduce inappropriate use of Section 136 and decrease use of place of safety; we will evaluate this service in Q3 and with a view to considering funding this service as recurrent investment.
- ☐ **New standards for Mental Health Services:** we have been working with the provider to implement the new access standards covering early intervention in psychosis programmes (EIP) and Improving Access to Psychological Therapies (IAPT). These new standards are mandated in 2016/17 and we expect that these standards to be achieved from 1 April 2016. Additional funding has been invested in improving psychiatric liaison service and we will be reviewing the impact this investment is having in terms of counting and coding of people with a mental health diagnosis receiving care in hospital which is currently driving up costs for the CCGs, as well as ensuring we are compliant with the Core 24 service model as recommended by NHSE. We are expecting to access National Funding to support delivery of a Paediatric Liaison Service for those below the age of 16 yrs>.

- **Patient Choice in Mental Health:** Full Implementation of a patients' right to choose any clinically appropriate provider of mental health services. We require the provider to be fully compliant with recognised best practice by April 1 2016, if not before, including full implementation of Choose and Book operational procedures so as to facilitate the introduction of choice. There is no new funding available and any changes to service design and delivery will need to be found within the existing resources. Should a patient chose a provider other than a local provider, the funding will follow the patient and we are in discussions with our main providers as to the mechanics of this. We have agreed with the provider that by end of Q3 the need to refresh the NHS Choice website to facilitate choice to those new patient presenting at their GP surgery with mental health problems to encourage choice of services and service provider.
- **CAMHS (Future in Mind):** The CCGs have worked in partnership with the commissioners and providers of comprehensive CAMHs to develop a 5 year local Transformation Plan for Children and Young People's Mental Health and Wellbeing. The priorities for 16/17 include reducing waiting times; improving access to mental healthcare in a crisis; workforce development across the children's workforce (to include schools, early year's settings, healthcare, social care) to reduce the number of children and young people who require a specialist response; improving pathways to help across the system and implementing the access and waiting time standard for children and young people with an Eating Disorder.

☐ **Perinatal Mental Health:** The Berkshire West CCGs will continue working with partners to consider the commissioning of a perinatal mental health service in Berkshire West.

Children and Young Peoples Services

- **Transition**. CCGs will work with providers to implement the expected NICE guideline on transition from children's to adults' services for young people using health or social care services (draft for consultation came out Sept 2015). This will improve the planning, delivery and experience of care of young people in their move from children's' to adults' services using person centred approaches.

☐ **Crisis response and Urgent Care:** CCGs will work with hospital, community and primary care providers to review and improve the effectiveness of local unscheduled care services for children and young people. We will look at ways in which community based healthcare can reduce the number of children and young people requiring admission to hospital and reduce lengths of stay.

Long Term Care

- ☐ **Care Homes Enhanced Support.** Further work will continue to address current issues around high admission rates from care home, including early detection of Urinary tract infections and pneumonia through further enhanced support to care homes in the Berkshire West geography.
- ☐ **Respiratory.** The option to create an integrated respiratory team across the system will be further explored for patients with COPD and Asthma.
- ☐ **Kidney disease.** We will aim to reduce first to follow up ratio for chronic kidney disease through improved education and intervention in primary care
- ☐ **End of Life/Specialist Palliative Care.** We will be exploring different models of care which promotes a single point of access to a range of end of life care services.
- ☐ **Neurology.** Reviews of current neurology pathways during 15/16 has identified service redesign opportunities to improve patient experience, equality of access and better integration of care, and we will work with providers to exploit these opportunities in 16/17.
- ☐ **Cardiology: Cardiology:** We will review the detection, diagnosis and management of Atrial Fibrillation, a major precursor to Stroke and identify opportunities for more effective whole system approach.

Primary Care

- ☐ Through the Joint Primary Care Co-Commissioning Committee, we will work to align contractual models with delivery of our strategic vision, aligning payment levels and working to improve quality and sustainability.
- ☐ Over the next 18 months we will be re-procuring four APMS contracts using a locally-developed service specification which will reflect our Primary Care Strategy.
- We will also be reinvesting 'premium' funding released through NHS England's review of PMS contracts in such a way as to support sustainable primary care services able to take on enhanced roles and will develop an associated investment plan for GMS practices.
- ☐ We will look to review and further develop the new Community Enhanced Services for Anticipatory Care Planning and Enhanced Access, ensuring that all patients have access to these. We will also work to consolidate commissioning arrangements for the other CESs and to develop new processes for supporting quality improvement in primary care.
- ☐ As part of the delivery of our Primary Care Strategy we will undertake redesign projects aiming to support providers to address current challenges through new workforce models and new approaches to managing demand and promoting self-

care. In so doing we will link very strongly with the Connected Care, Digital Roadmap and Technology Enabled Care workstreams described above.

- ☐ We will also work with NHS England to develop a clearer strategy for primary care premises, supporting providers to access local and national funding streams as appropriate.
- ☐ We will continue to work with NHSE to commission primary care services under GMS/PMS and APMS contracts with uplifts applied as agreed nationally.
- ☐ We will continue to commission CESs using the NHS Standard Contract with monitoring and payment arrangements as set out in the service specifications.
- ☐ We will work with NHSE to monitor the quality of services provided under primary care contracts, and we would look for providers to support delivery of QIPP schemes
- ☐ We will be developing detailed requirements around PMS reinvestment as referred to above which are likely to include a new quality-based CES along with transformational funding.

2.2. Urgent and Emergency Care

Our commissioning intentions in relation to Urgent and Emergency Care have been informed by the publication of the following important documents:

- **"Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent care and emergency care. A guide for local health and social care communities":** This is a practical summary of the design principles that local health and social care communities need to adopt to deliver safer, faster and better urgent and emergency care. These principles are drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. We will use the guidance to inform commissioning decisions for the coming year**,** alongside the recently published NHSE/Monitor document on new payment models for Urgent and Emergency care.

- **"Commissioning Standards for Integrated Urgent Care"** These standards build on the success of NHS 111 and will help us deliver locally the benefits for patients set out in the Urgent and Emergency Care Review led by Sir Bruce Keogh.

Our local ambition is aligned with these documents and describes an integrated 24/7 urgent care service that is the "front door" of the NHS and which provides the public with access to both treatment and clinical advice.

It is intended that the Urgent Care Co-ordination centre will be in place by October 2016 and in preparation for this we will be developing a Thames Valley wide NHS 111 service specification and a new GP out of Hours Service Specification.

2.3. Hospital Services

- ☐ **Elective Services.** We plan to:
  - o Continue working with Providers to modernise the provision of elective care pathways optimising the use of technology.
  - o To review and transform current pathways in the context of pressures on demand and capacity which will include but may not be limited to dermatology, urology, gynaecology, gastroenterology and diagnostics.
  - o Commission the most effective and efficient ophthalmology model to meet our local population needs.
  - o Work with providers to review Cancer services to ensure the priorities in "Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020" of prevention, earlier diagnosis, improving patient experience and living with and beyond cancer are implemented and tailored for local requirements through a local cancer framework.
- ☐ **7 Day services:** we will continue to work with Providers to achieve the clinical standards for seven day services. During 16/17 we will build on the progress made in 15/16 on those standards we have identified as having the greatest impact locally, within the resources available.

2.4. Capacity Planning

- ☐ 2015/16 Activity Plans were mutually agreed as a reasonable reflection of anticipated activity. 15/16 outturn will be used as the basis for 2016/17, except by mutual agreement, or to reflect contract variations agreed during 2015/16
- ☐ We will undertake a continuous programme of efficiency benchmarking to ensure value for money and cost effectiveness.
- ☐ Key assumptions will include: In the event that non- recurrent or extraordinary patterns of activity are noted, these will be considered for exclusion from the baseline
- ☐ Impact of repatriations of patients to local services and clinical pathway redesign will inform contract activity,
- ☐ The impact of new technologies and service developments, evidence-based practice, locally developed best practice pathways and national guidelines, Impact of any specific Thames Valley initiatives or changes, including demand management initiatives will also inform activity plans for 16/17

- ☐ Where activity is transferring between commissioning organisations, the 2015/16 plan will be used as the basis for this transfer, except by mutual agreement.

2.5. Market Management Activities

- ☐ To re-procure the Physiotherapy services procured via an Any Willing Provider model. Current providers will be required to provide transparency of activity and cost information in compliance with the competition and cooperation guidance.
- ☐ APMS contracts for Priory Avenue, Circuit Lane, Shinfield and the Walk-in Centre as part of the current co-commissioning arrangements with NHS England. The procurement process for the first three of these contracts will start in 2015/16. The Walk-in Centre re-procurement will take account of the broader work on urgent care described above and is expected to be undertaken in 2016/17.
- ☐ To re-procure the current AQP and Tier 2 contracts for Audiology, Podiatry, Ultrasound, ENT, non-sedative flexible sigmoidoscopy, non-sedation gastro endoscopy, Gynaecology, Minor Ops, intraocular pressure refinements and Vasectomy ensuring compliance with the procurement, choice and competition regulations.
- ☐ Connected Care: The CCGs are working with the Berkshire East CCGs to jointly procure an interoperability solution which will enable health and social care data to be shared across care settings, thereby supporting delivery of the national requirement that by 2020, all care records will be digital, real-time and interoperable. A full portal solution will be procured using previously identified BCF funding together with funding identified through the Primary Care Infrastructure Fund. It is our expectation that savings benefits identified and realised with provider organisations will be released and utilised to contribute to the funding of this programme. The solution will allow for interoperability and information exchange between organisations as well the creation of a person-held health and social care record enabling the individual to hold and manage information about their care. The procurement exercise is due to be completed by March 2016.
- ☐ **Procurement of Thames Valley Urgent Care Centre:** Working in partnership with the other CCGs in Thames Valley we will commission an integrated Urgent Care Co-ordination Centre for Thames Valley. This will handle NHS 111 calls and interface with OOH services. The Centre will provide patients with enhanced clinical assessment from a wide range of health care professionals. It will support patients to self-manage or route them swiftly and accurately to the right part of the system whether this is an ambulance response, primary care, community services or a high street pharmacist. The Urgent Care Co-ordination Centre will interface with a number of GP Out of Hours Providers including Westcall. These OOHs will have a common core specification to ensure that they deliver a consistent interface with the UCCC. It is recognised that there is additional local variation with some OOHs providing medical cover to community hospitals for example and these arrangements will remain. This will lead to a model where GP OOH services are largely dealing with patients who need to be

seen at the base surgery or have a home visit. The UCCC will have GPs within it or in a local hub arrangement and will have dealt with any patient whose problem can be addressed by telephone advice. The concept of the "trusted assessor" will be embedded so that receiving OOH services can be confident that all referrals they receive are appropriate and likely to require face to face contact. This should support the most efficient use of the scarce GP workforce across the Thames valley system.

2.6. Quality and Performance

We expect Providers to engage with the CCGs to develop jointly agreed plans to ensure the effective delivery of Policy and Planning requirements as well as local QIPP/CIP savings which will lead to a more sustainable and equitable health economy. Key areas where providers are expected to provide such support will be detailed in the 2016-17 Service Development and Improvement Plans (SDIP) and may form the basis of our CQUINs for the coming contractual year.

The Commissioners expect all providers to uphold the rights and responsibilities contained in the NHS Constitution and comply with the national quality and performance standards and targets included in the Planning Guidance and Operating and Outcomes Frameworks for 2016/17. In addition, CCGs may wish to agree a number of local performance measures intended to either address particular issues with performance locally, or support delivery of their improvement priorities.

- ☐ We will work with providers to ensure that all NHS Constitutional standards are achieved. This will include Referral to Treatment, Cancer wait time and ambulance response time standards that have been particularly challenging during 2015/16. Where constitutional standards are not achieved, we will expect providers to put in place remedial action plans that ensure recovery in performance at the earliest opportunity.
- ☐ We will work jointly with providers to deliver the improvements across the five domains in the NHS Outcomes Framework.
- ☐ We will closely monitor and report Trust quality achievement to our constituent CCGs.
- ☐ Notwithstanding patient choice, where quality concerns are identified and not rectified in a timely manner we will look to redirect CCG activity.
- ☐ We will regularly review Provider services to ensure that NICE Quality Standards and recommended pathways are being delivered.
- ☐ We will work with Providers to ensure patients who are receiving care out of area are offered the opportunity of repatriation as early as is clinically possible
- ☐ We will seek full provision of referral information from Providers in SUS to enable effective demand management strategies.

- ☐ We will look to reduce the first: follow up ratios at Providers that remain an outlier against benchmarks and seek performance in the upper 10%.
- ☐ We will require Providers to ensure patients are offered a choice of local provider for ongoing treatment and care wherever this is appropriate.
- ☐ We will seek to develop innovative shared care arrangements between local secondary, primary and community care services, to reduce the requirement for patients to travel out of area for a range of treatments and drugs.
- ☐ We require all Providers to ensure that they adhere to our prior approval and individual funding request process to ensure consistency. Commissioners will not be financially viable for procedures when providers have failed to adhere to those policies.

2.7. CQUIN, SDIPs and Quality Schedule

We expect to reflect national guidance on CQUINs in our contract for 2016/17 and as we have done in previous years, secure a mutually acceptable but challenging agreement around CQUIN that reflects national and local clinical commissioning priorities. Our plan is to identify a list of CQUINs via our Transformation Boards and to use contracting levers to accelerate the adoption of best practice and to drive innovation and improvement where this supports better clinical outcomes.. In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2016/17 contract, as well as new priorities for CQUIN development for 2016/17. We would welcome provider input into the development of our proposals for 2016/17, noting that the number of local CQUINs will be relatively limited.

Given the complexity of the contract documentation and supporting schedules our overall objective for 2015/16 is to keep to a minimum the renegotiation of contract terms and schedules, noting that a number of key areas – CQUIN, KPIs, quality indicators, information requirements, SDIP and DQIP plans will require a review and likely renegotiation of targets and indicators, with an expectation that the outcome of our 2016/17 agreements will represent a year on year improvement in efficiency, productivity, effectiveness and quality of care. We will also expect to reflect any nationally prescribed changes to standard terms and conditions, including contract penalties, in agreed contracts for the year. Any nationally revised or newly prescribed measures will be incorporated into contracts accordingly.

2.8. Business Rules/Counting and Coding

All Counting and Coding changes to Contract Terms must be supported by impact data showing the expected activity, and associated costs at least 6 months prior to the proposed effective date unless we have been specifically consulted on such changes, prior to agreement being reached. Commissioners expect that any service changes or developments are supported by a business case and approved by the relevant CCGs together with technical agreement on counting and coding before services commence. The developments and changes must be evidenced to be affordable by the health economy. Where this process is not followed Commissioners will not pay any additional costs or charges

- ☐ We will hold Providers to account for their responsibilities in managing activity in line with the overall plan, including withholding of payment for provider generated demand.
- We will agree Contract Terms that mitigate financial risk for both parties, including marginal rates and 'floors and ceilings' where contractually appropriate.
- ☐ We will validate all invoices and withhold monies where we believe charges do not comply with the Contract or the rules governing the national tariff payment system, counting and coding.
- ☐ We will include thresholds within our Activity plans where national terms permit and require implementation of plans to manage activity where thresholds are breached, to ensure Contracts are managed to the agreed plan.
- ☐ We will require providers to have systems in place to routinely alert us to high-cost, long stay patients (>14 days in critical care) (>40 days) who have not been discharged at Month end.

Providers should strive to procure drugs and devices at the minimum cost while ensuring optimum patient outcomes. The commissioners wish to work in partnership with Providers to explore the use of biosimilar and generic alternatives to ensure best value for money is delivered. It is the Commissioners expectation that the Provider will realise the savings, when available, through Patient Access Schemes.

Non-tariff services for Acute Providers

- ☐ We will only agree bespoke local prices with Providers where full costings are provided, demonstrating the make-up of those prices and these are agreed to be fully supportable, fair and reasonable. We ask that all Providers provide satisfactory

reassurance to commissioners that they follow relevant national guidance. We will audit Providers against the costings they provide us, to ensure that these are reflective of the true costs incurred.

- Where Providers are unable to provide backing information to ensure that prices are transparent and fair, we will either pay national average price (adjusted for regional price variation) less 5% or the previous year's prices, less 1.9%, whichever is the lower. We will look to apply penalties where data fields essential for commissioning are not provided

☐ Where a patient is referred on to a different consultant for the same condition the first attendance with the second consultant will be paid as a follow up attendance (although it should be recorded as a first as per NHS Data Dictionary guidance) in line with the locally agreed consultant to consultant policy.

- It is an expectation that providers comply with the recommendations of the Thames Valley Priorities Committee in relation to pricing and agree 'fair' and 'reasonable' prices where tariffs are deemed to be excessive in relation to costs incurred.

2.9. Data Quality and Information

☐ We require Providers to provide complete, accurate and timely data to support contracts and patient level clinical validation and to examine their performance and put arrangements in place to ensure that they comply with the data and information sharing clauses of the contract and the best practice behaviour set out within the Code of Conduct for Payment by Results. We will raise this as a significant performance issue, with full contractual financial penalties being imposed; where providers fail to provide data and information on a monthly basis, in line with the requirements of commissioners to effectively performance manage the contract.

☐ In line with the national contract template, providers are expected to comply with the reporting requirements of Secondary Uses Service (SUS) and UNIFY. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs) where applicable to the services being provided. As a minimum, providers will be expected to flow admitted patient care, intensive care data extensions and outpatient data to SUS for all activity that can be evidenced in that manner even if the method for payment of the activity is outside the national tariff payment system.

☐ We expect that the Provider shall meet the NTPS monthly reporting requirements as set out in NTPS Guidance. Where activity is outside national tariff scope, providers should make returns of equivalent data in CDS format through local monitoring direct to the Commissioner by the nationally agreed SUS inclusion dates. If any non-specialised activity is not submitted through to SUS, this should be identified via SLAM monitoring, including all of the fields set out within our SLAM monitoring template

- ☐ In accordance with the NHS Standard Contract providers must ensure that each dataset that they provide for monthly reporting requirements contains the ODS organisation code for the relevant Commissioner. We require all data to be submitted on a month actual and cumulative basis each month at flex and freeze.
- ☐ To counter issues encountered in 2015/16, where the Provider submits data more than two months after the final reconciliation date the CCGs will not pay against the activity. We expect the variance between first and final reconciliation dates to vary by no more than 1% and un-coded activity at first reconciliation to be less than 5% of the months total activity (in activity terms by POD). In the event this is exceeded, the CCGs will pay 50% of the activity exceeding the threshold.
- ☐ In order to validate data, we may also request more information regarding the clinical reasons for admission, outpatient attendances etc. We expect providers to comply with these requests.
- ☐ A&E observation ward activity where the bed does not appear on a KH03 return will be paid as an A&E attendance and not an admission. If the patient is subsequently admitted then this should generate a new FCE rather than a readmission.
- ☐ Maternity admissions to a nurse led ward will be recorded as outpatients (as per the NHS Data Dictionary) and paid at the appropriate national mandated outpatient HRG tariff or 60% of the national mandated inpatient per diem tariff if no such outpatient tariff exists
- ☐ Ward attenders. These will be recorded as outpatients (as per the NHS Data Dictionary) and will be paid at the appropriate national mandated outpatient HRG tariff or 60% of the national mandated inpatient per diem tariff if no such outpatient tariff exists.
- ☐ Regular day / night activity should be counted as such and the appropriate locally agreed tariff applied.
- ☐ Procedures that take place in an outpatient setting will be reimbursed at either national mandated outpatient HRG tariff or a tariff to be agreed between the provider and the CCGs. The nature of the procedure does not affect the data set the activity is reported in.
- ☐ Non-consultant led outpatient clinics will be reimbursed at a tariff of not more than 40% of the consultant-led tariff with the exception of activity that already has a national mandated tariff.

2.10. Specialised Commissioning

From 16/17 CCGs will be responsible for Commissioning Severe and Complex Obesity Services. It is our intention to adopt the current Thames Valley access policy and to undertake an in year review via the Thames Valley Priorities Committee. The commissioning of Specialist Neurology services will also transfer on the 1st April 2016.

It is recognised that discussions are taking place at national level in relation to the co-commissioning of specialised services, and that these include commissioning of Tier 4 CAMHS, Secure Mental Health, Cancer, Adult Critical care, Spinal transformation project . It is too early at this point to assess the full extent to which national guidance or expectation in relation to co-commissioning will impact of 2016/17 contracts.

- ☐ We will be participating in the Strategic Services Review Programme and will be working with NHS England to enable collaborative commissioning arrangements for specialised services where appropriate.
- ☐ We will be utilising the evidence based Commissioning for Value and Right Care data and reduce unnecessary variation.
- ☐ Services previously commissioned by CCGs will no longer be commissioned by CCGs from 01/04/16 include
    - Highly specialist adult male urological procedures
    - Primary ciliary dyskinesia management services for adults
    - Highly specialist adult haematology services

2.11. Contracting Timetable

Subject to any guidance received from NHS England after the date of this letter, the Commissioners will provide the Provider with the intended timelines and framework to be followed for the 2016/17 contracting round no later than the end of November 2015. Commissioners expect to meet national requirements for delivery and completion of contract negotiations and expect the Provider to work towards the same in good faith.

Key Milestones:

- ☐ End November 2015 CCGs aim to circulate further details of commissioning intentions, QIPP plans and financial planning assumptions. These plans will be relatively high level with further work undertaken over November and December to finalise definitive and granular level plans.

- ☐ End of December agreement of a recurrent baseline plus agreement of methodology for costed proposals.

- ☐ Early January 2016 for an agreed joint assessment and interpretation of national policy guidance and implications for the 2016/17 contract and for the submission to CCGs of provider costed proposals.

☐ Mid-February to secure agreement in relation to key contract issues CCG counter proposals and confirmed financial envelopes. In principle agreements on key contract terms and conditions and key schedule changes (information, quality, CQUIN, SDIP and DQIP) also to be reached for this date.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**Health and Wellbeing Board**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**8**
TITLE:	**Adult Social Care Commissioning Intentions 2016-17**		
LEAD COUNCILLOR:	**Cllr Eden**	**PORTFOLIO:**	**Adult Social Care**
SERVICE:	**Adult Social Care**	**WARDS:**	**Borough wide**
LEAD OFFICER:	**Angela Dakin**	**TEL:**	**011809374752**
JOB TITLE:	**Head of Commissioning and Improvement (Interim)**	**E-MAIL:**	**Angela.dakin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report is intended to introduce a summary of the Adult Social Care Commissioning Intentions for 2016-17 for review and comment by Health and Wellbeing Board, alongside the Berkshire West CCGs Commissioning Ambitions 2016-17.

1.2 The Commissioning Intentions form part of our suite of documents which outline the approach and activities we expect to take to review, improve and commission services for Reading citizens during the next financial year, and to demonstrate compliance with the market management duties as set out in the Care Act 2014.

1.3 The suite of documents (referenced at paragraph 10.2) forms a framework within which the Directorate of Adult Social Care and Health Services delivers its services within a balanced budget.

1.4 The document is a high level indicator of our key commissioning priorities and of the strategic direction that our commissioning activities will take over the coming year. It will be supported by an operational commissioning work plan, which is currently under development.

1.5 A draft version of the Adult Social Care Commissioning Intentions 2016-17 is attached to this report at Appendix A.

2. RECOMMENDED ACTION

2.1 Health and Wellbeing Board is asked to review and comment on the Adult Social Care Commissioning Intentions for 2016-17, in order that a final version published and shared with partners and providers.

3. POLICY CONTEXT

3.1 The Adult Social Care Commissioning Intentions are based on delivering services within the context of the Adult Social Care Vision, referenced on page 1 of the document. The three key drivers influencing these intentions are:

a) Embedding changes and new requirements under The Care Act 2014
b) Integration with Health partners
c) Delivering agreed savings

4. THE PROPOSAL

4.1 The Commissioning Intentions serve to set out for all potential and current providers the information and intelligence that will enable businesses to plan how they might offer to meet the assessed needs of vulnerable people in Reading in future tenders and contract negotiations.

4.2 The Commissioning Intentions also provide opportunity for commissioning authorities to ensure alignment. Once they are approved and alignment has been agreed by Health and Wellbeing Board, this document will be published and shared with partners and providers to assist in service planning for the coming year.

4.3 The document outlines Reading Borough Council's Commissioning Intentions for the coming financial year. The commissioning activities undertaken during this period will serve to inform the next round of Commissioning Intentions for future years.

4.4 The Commissioning Intentions do not constitute a contractual obligation to providers and can be amended at any time. They are intended to support providers in their planning, as required under the market management duties under the Care Act.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Adult Social Care Commissioning Intentions are informed by the development and delivery of a range of services which primarily support numbers 1,2,3 and 6 of the following Corporate priorities:

1. Safeguarding and protecting those that are most vulnerable;
2. Providing the best start in life through education, early help and healthy living;
3. Providing homes for those in most need;
4. Keeping the town clean, safe, green and active;
5. Providing infrastructure to support the economy; and
6. Remaining financially sustainable to deliver these service priorities.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The document makes specific reference to integration with Health colleagues and to co-production with service users, their families and carers.

6.2 The principles outlined on pages 5-6 are intended to give clear indication of the expectations on which we will be basing our commissioning decisions.

Where services are to be re-commissioned or re-designed, the commissioning cycle makes provision for consultation and engagement as part of the process.

6.3 Any service changes resulting from delivery of the Commissioning Intentions will be undertaken with sensitivity and consideration of the impact on individual service users and their carers / families

7. EQUALITY IMPACT ASSESSMENT

7.1 The Commissioning Intentions document in itself does not specifically impact any protected groups and is informed by the EIAs completed for individual service strategies.

7.2 It is likely that some individual re-commissioning exercises will require an Equality Impact Assessment, depending on changes determined as part of the specification process. An EIA will therefore be undertaken for each relevant exercise as appropriate.

8. LEGAL IMPLICATIONS

8.1 Under the Council's Contract Procedure Rules some of the proposed commissioning projects will be regarded as high value procurements and will be dealt with in accordance with the rules referred to.

9. FINANCIAL IMPLICATIONS

9.1 Services to be re-commissioned under the proposed Commissioning Intentions will be funded from confirmed budgets within Adult Social Care or other service areas. A number of these services are identified as contributing to the 3 year savings programme and will be re-commissioned in alignment with their individual savings targets.

10. BACKGROUND PAPERS

10.1 ***Appendix 1*** – Adult Social Care Commissioning Intentions 2016-17

10.2 Background Papers

Corporate Plan 2016-2019 (Draft November 2015)
Strategic Approach to Adult Social Care 3-5 Year Plan (September 2014)
Market Position Statement (March 2015)
Berkshire West CCGs Commissioning Ambitions 2016-17 (October 2015)
Care Act Implementation Update (November 2015)
Adult Social Care Transformation Programme – Policy Implications (November 2015)
Learning Disability Transformation Programme Update (November 2015)

Adult Social Care

Commissioning Intentions 2016-17

December 2015

Commissioning Intentions Key Messages

These Commissioning Intentions form part of Reading Borough Council's suite of documents which outline the approach and activities we expect to take to review, improve and commission services for Reading citizens during the next financial year, and to demonstrate compliance with the market management duties as set out in the Care Act 2014.

The document is a high level indicator of our key commissioning priorities and of the strategic direction that our commissioning activities will take over the coming year. It will be supported by an operational commissioning work plan, which is currently under development.

Key focus areas include:

- Using an asset-based approach to service provision which capitalises on the resources and support that people already have around them
- Integration with Health via a range of projects which are designed to align services and the processes behind them
- Embedding the Care Act 2014 requirements
- Making smarter use of data and intelligence to understand the needs people have and how effective we are at achieving their desired outcomes
- Re-shaping our accommodation offer to give more people an alternative option to residential care
- Furthering personalisation and maximising independence, in particular through increasing Direct Payments
- Developing our support for carers, especially our information and advice services
- Use of technology, both in front line services and back office functions
- Using our Adult Social Care Transformation Programme to achieve identified savings and deliver services within a balanced budget
- Providing quality services which keep people safe, prevent or delay escalation of needs and allow people to be in control of their lives

1) Strategic Priorities

The commissioning ambitions described in this document are aligned with the new priorities outlined in our Corporate Plan for 2016-19, in particular:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Remaining financially sustainable to deliver these service priorities

Adult Social Care in Reading is transforming the way we commission and provide social care services over the next few years. This work will be informed by the Reading Adult Social care vision:

- Our purpose is to **support**, care and help people to stay safe and well, and **recover independence** so that they can live their lives with purpose and meaning.
- We do this **collaboratively** with customers, carers, communities and partners; **tailoring** a response to meet needs and to **effectively** deliver targets and outcomes.
- In delivering these services we will be **fair**, **efficient** and **proportionate** in allocating our resources.

The **key drivers** supporting this transformation are:

The Care Act	**Integration**	**Savings and Finance**
• National eligibility criteria • New rights for carers • Legal right to a personal budget and direct payment • Introduction of the 'wellbeing duty' • Lifetime cap on care costs (deferred to 2020) • Responsibilities for councils to develop and manage the local market for services under the market management duty • Expectation that services will be co-produced with providers and customers in strategy development, contract awards and quality assurance	• Better Care Fund – pooled budgets to support local health and social care integration • Berkshire West 10 Integration Board • Reading Integration Board • Reablement and recovery focus • Delivering key performance indicators which are relevant to the whole system (e.g. Delayed Transfers of Care, 'Discharge to Assess', 'Fit List')	• Adult Social Care savings target of £6,709,000 over 3 years to March 2018 • Fair Price for Care • National Living Wage

2) Our Commissioning Priorities

Accommodation

1. In order to support the vision of cohesive, attractive and vibrant neighbourhoods, we will begin to shift the balance of accommodation provision from residential care to extra care housing and supported living options. We will aim to reduce the number of residential beds, with specific focus on learning disability.

2. We will work with providers who develop efficient and effective supported living options to offer care and support in the community, wherever that is feasible to meet someone's needs.
3. We will continue to work jointly with health partners in delivering the Learning Disability Transforming Care Programme, which enables people to live in their own homes rather than hospital or institutional settings.
4. We will reduce number of beds in residential care homes by 20. This may in part be achieved through shorter duration of stay.
5. We will re-commission the care element of our Extra Care Housing provision across all sites during 2016-17, as well as our block contracts for residential and nursing services. This is to ensure adequate supply at calculated value for money to specified quality and scope.
6. We will expand our Shared Lives model of care to offer support to a wider range of people, including Mental Health clients. This will involve further developing models to support people living in the community under their own tenancies wherever possible.
7. We will ensure sufficient supply of nursing home care provision, to include services for people with dementia
8. We will work across Berkshire West to review and develop provision for people with learning disabilities and challenging behaviour
9. We will review and re-commission our suite of services relating to domestic abuse, to include refuge provision.

Personalisation and Independence

10. We will use personal budgets to ensure that people requiring longer term care can take as much control over their lives as their needs allow, in line with Care Act requirements. We will review our approach to Direct Payments to increase take-up, including assessing the provision of a pre-paid card option and review of the related support services
11. We will further develop the Reading Services Guide, whilst also reviewing the overall design, content and functionality with a view to including a broader range of providers and supporting the move towards self-directed support and an e-marketplace. This project will include evaluating the potential for supporting access to assessments for small packages of care, facilitating networks, provision of mentors and opportunities to connect with others.
12. We will support younger adults with a learning disability who have sufficient ability to maximise their independence by moving into work environments
13. We will review advocacy provision across all our adult social care services in order to be able to offer a more cohesive and efficient service from 2017
14. We will have a revised offer for voluntary sector preventative support via the Narrowing the Gap Framework which is currently open for bids.

Carers

15. We will lead on the re-commissioning of a revised Carers Information and Advice service across Reading and West Berkshire Local Authorities and the associated CCGs for a 2 year period from April 2016. The revised service is designed to accommodate new requirements relating to carers under The Care Act.

Integration

16. We will review the use and effectiveness of our current 'Discharge to Assess' provision to determine whether additional capacity will support more effective discharge from hospital and sustainable care in community settings
17. We will support our providers to engage with the Rapid Response and Treatment service currently being piloted to reduce unnecessary hospital admissions
18. We will continue to develop our range of wellbeing services in alignment with our duties under the Care Act and with the principles of the national Living Well Pioneer Programme.
19. We will participate fully with Health partners in the delivery of the West of Berkshire Interoperability Project (Connected Care), to enable professionals to share case information and planning intelligence.
20. We will ensure that the Transforming Care initiative is fully embedded within our Learning Disability Services Transformation project and will apply relentless focus to moving remaining clients out of long term assessment facilities and into real homes

Home Care and Day Services

21. We will continue to explore how new technological solutions can give residents better care, ensure their safety and enable us to deliver services more efficiently. This will include scoping and planning for an Electronic Time Recording system across home care providers, as well as the use of telecare, and other services and equipment to reduce the need for multiple carers.
22. Following on from the review and transfer of the Maples Day Service[1] for older people, we will expand this work to include learning disability, physical disability and mental health day services. The new model will provide professional care to those who need it and support from community services to others.
23. We will review our support for mental health day opportunities to focus on a Recovery approach
24. We will continue to work with providers on the Home Care Framework to implement the Ethical Care Charter in Reading. We wish to ensure that our workforce is valued and respected and in receipt of fair wages and decent conditions of employment

[1] Improving Day Opportunities in Reading (Adults, Children's and Education Committee 5th November 2015)

3) Working with Health Partners

We will wherever relevant align our commissioning priorities and activity with health partners, having particular focus on supporting the following elements of the **Berkshire West CCGs Commissioning Ambitions 2016-17:**

- Better Care Fund
- Frail Elderly Pathway Redesign
- Support for Carers
- Berkshire Interoperability Project (Connected Care)
- Personal Health Budgets
- Transforming Care
- Placement Budget and the governance of Mental Health and Learning Disabilities
- Mental Health Crisis Concordat
- Place of Safety
- Transition
- Care Homes Enhanced Support
- 'Transforming urgent and emergency care services in England. Safer, faster, better good practice in delivering urgent care and emergency care. A guide for local health and social care communities'.

The full extract from the Berkshire West CCGs' document is attached at Annex 1

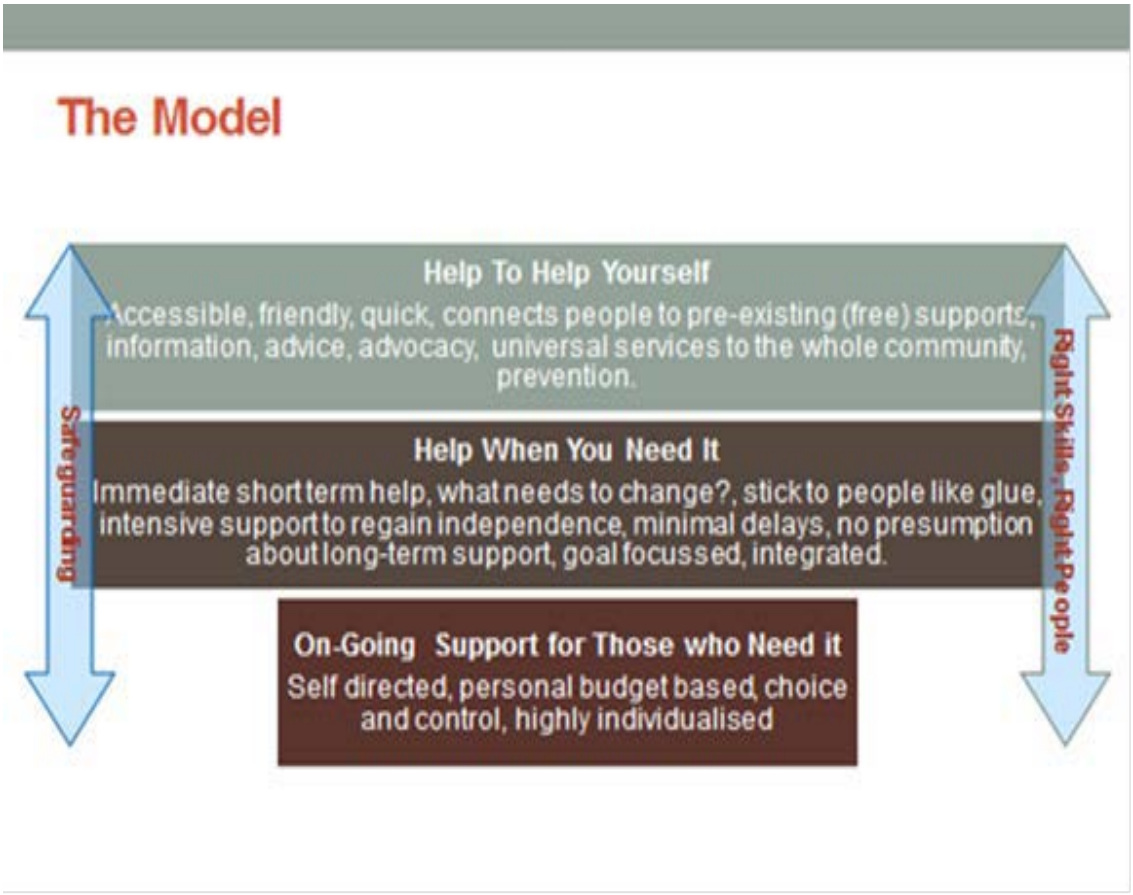
4) Principles – how we will support delivery of our Commissioning Intentions

The principles underpinning our commissioning approach include:

a) Assessing our commissioning functions against the **standards** outlined in 'Commissioning For Better Outcomes'[2]

b) **Asset-based approach**. With specific focus on our 'Right for You' model of care, we will pay particular attention to the resources and support that people already have around them, within their family, community, universal and preventative services. This model seeks to resolve problems that the individual and their families / carers perceive as barriers to wellbeing and independence – enabling a wider range of options to be offered. Our diagram representing the Right for You model is found below:

[2] A template for good practice devised jointly by Department of Health, Local Government Association, Think Local Act Personal, Association for Directors of Adult Social Services and University of Birmingham



c) **Measured risk model**. We will review our packages of care to ensure that we are not over-providing and creating unnecessary dependence. We will work with providers to develop a measured risk model.

d) **Co-production**. Building further on our consultation work we will develop models to enable service users and their carers / families to co-produce services directly with us, and to participate in monitoring and evaluation

e) **Intelligence / performance management**. We will aim to become an intelligence rich commissioner, so that we have reliable and relevant knowledge on which to base our commissioning decisions. This will also involve changes to our contracting approach to develop clearer expectations from providers in relation to quality, performance, use of technology, reporting expectations etc. We will make use of the Berkshire-wide shared intelligence function provided by Public Health to support this aim

f) Specifically, in home care, we will expect information **on time recording and consistency of carers** – the two quality factors that our service users report are most important to them

g) We will work closely with providers to improve or maintain good quality services that demonstrate **value for money**, ensuring that service users are safe, well cared for and involved in their own care. Our contracts will set out expected **quality standards** and how **performance** against those standards will be measured.

h) We will focus our efforts on supporting more service users through the use of providers on our **approved frameworks** (Home Care Framework and Supported Living Accredited Select List) for improved efficiency
i) We will review and develop our **Market Failure Protocol**[3] in collaboration with partners and providers so that we have sound monitoring and early warning of changes requiring action
j) We will apply a model of **full cost recovery** in line with the national eligibility criteria, ensuring that those who can afford to pay for their care do so
k) Any service changes resulting from delivery of the Commissioning Intentions will be undertaken with **sensitivity and consideration** of the impact on individual service users and their carers / families
l) We will undertake commissioning and re-commissioning exercises with **improved timeliness**, to enable us to proactively source appropriate services in a considered and informed manner, with specific focus on reducing instances of contract extensions
m) We will actively review and **consider de-commissioning** services that do not meet required expectations relating to quality, performance and customer outcomes
n) All of our commissioning decisions will be in alignment with savings targets previously published for Adult Social Care which will enable us to deliver a **balanced budget** for the year

The overall strategic direction in this document derives from values which:

- Puts adult social care services within the context of the community and neighbourhood that the person requiring care lives within
- Recognises service users who require support as being people who still contribute to their family and community
- Is centred on the person – not on the convenience of service providers
- Promotes independence and focuses on what people can achieve
- Values and recognises the central role that carers play
- Safeguards people
- Promotes a 'good life', and
- Plans for and enables a 'good death'

Annex 1 (attached)

Extract from Berkshire West CCGs Commissioning Ambitions 2016-17

[3] The Care Act 2014 places new duties on Councils relating to market oversight, response to provider closures (planned and emergency) and a 'temporary duty' to ensure that needs are met in the event of provider failure. The Market Failure Protocol is a key tool in the contingency planning process.

Annex 1

Extract from Berkshire West CCGs Commissioning Ambitions 2016-17:

Principles

- To put a greater emphasis on prevention and putting patients in control of their own care planning including through the expanded use of technology enabled care, multi-disciplinary care planning led by GPs here (under Anticipatory Care CES), and proactive support for carers and families. This will underpinned through CCG Programme Board led pathway redesign, service line reviews and the development of the CCG QIPP programme for 16/17.
- We will commission services which provide our populations with more information and choice about the full range of service providers, ensuring care closest to home is offered wherever possible.
- We will work with providers to implement new models of care which better support better integration which expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care.
- We will work with our providers to ensure that appropriate levels of care and diagnostics are available across the week which enable achievement of improved health outcomes for our populations.

Commissioning Ambitions

- **Better Care Fund:** We have worked with local Health and Wellbeing Boards on the creation of schemes that form our Better Care Fund (BCF) plans and as part of the development process we have engaged with our local providers. In preparation for 16/17 we will be formally reviewing performance against the metrics included in BCF planning requirements to we full understand the impact of the investment in 15/16. As responsible commissioners we will seek to minimise any commissioning risk to the provider in relation to transfer of services or funding into the BCFs.

- **Frail Elderly Pathway Redesign:** The Frail Elderly work is system wide across the 10 BW partners. The intention is to determine the optimal pathway for this cohort of the population, identify how investment would need to change to deliver this, identify the optimal delivery model or new model of care, and recommend an appropriate contracting and funding approach. Frail elderly were selected as the cohort following the work by Capita two years ago which should that this group are the biggest cost driver in the system. The rationale was that this group would be an exemplar and the learning could be extrapolated more widely to determine the right model of care across the whole system. A contract has been let to the CSU in partnership with Ernst Young to undertake this work. The outputs of this programme which will be emerging over the coming months including identified opportunities for “quick wins” will be used where possible to inform commissioning decisions for 16/17 and these will be explored with providers over the coming months.
-

- **Support for Carers**
  The CCGs, Reading Borough Council and West Berkshire Council will be re-commissioning the advice and information service for Carers. Following Carers consultation a new commissioning model was agreed that will focus on developing the market through offering 2 year grants to voluntary organisations. This has been developed from previous discussions and intended to offer a consistent level of service, ease of access/referral across Berkshire West, and the opportunity to draw on local knowledge and expertise. To date, the bulk of our carers information advice and support services have been delivered by a single provider operating across Reading, West Berkshire and Wokingham.
  From April 2016, it the commissioners' intention that carers across Berkshire West (wherever they live) will be able to access local services that adhere to the same specifications and deliver the same high-quality standards, These services will be accessed through a common access number to simplify referrals and signposting into carers support by other agencies.
- **Berkshire Interoperability Project (Connected Care):**
  Interoperability is key to the delivery of the CCG strategy, underpinning our plans for Integration, our Better Care Fund plans and key programmes. It will enhance patient safety and quality of care, improve patient experience and provide significant opportunity for efficient use of clinical time. We are committed to rapid progress within and between providers and it is our expectation that all providers support the implementation in this critical enabler to all system strategies.
- **Personal Health Budgets:** The CCGs are committed to working with our Local Authority colleagues to implement Personal Health Budgets. We have commissioned external support for this work. Scoping work across our three local authorities has taken place. Areas of focus will include Learning Disabilities / Children with Complex Needs. Pilot sites will be identified and a Berkshire West Personalisation Steering Group is being set up and a co-design Workshop in being held.
- **Transforming care:** We recognise the scale of change required to transform the care for adults and children with learning disabilities. Our Post Winterbourne Transformation Plan is being delivered through a multi-agency working group including our Local Authorities. The key deliverables include delivery of the 6 elements of the Positive Living Model which includes positive behaviour/support, intensive intervention service, special social care, advocacy, carer support and person led transition plan.
- **Placement Budget and the governance of MH and LD:** We wish to continue to carry out a collaborative review of approaches to the management of mental health and learning disability placements.
- **Mental Health Crisis Care Concordat:** The national Mental Health Crisis Concordat launched in 2014/15, provides a blueprint for an effective pathway for people with mental health problems. We wish to explore opportunities to further strengthen the approach to crisis management across the whole system, and, to that effect expect as part of the signatories of the concordat declaration to continue working collaboratively.

- **Place of safety:** As part of its commitment to improve mental health services, we intend to work with the Provider to review Section 136 place of safety arrangements. The CCGs and LAs have already invested in a one year Street Triage Pilot Scheme which was launched in June 2015, with the aim that this will reduce inappropriate use of Section 136 and decrease use of place of safety; we will evaluate this service in Q3 and with a view to considering funding this service as recurrent investment.
- **Transition**. CCGs will work with providers to implement the expected NICE guideline on transition from children's to adults' services for young people using health or social care services (draft for consultation came out Sept 2015). This will improve the planning, delivery and experience of care of young people in their move from children's' to adults' services using person centred approaches.
- **Care Homes Enhanced Support.** Further work will continue to address current issues around high admission rates from care home, including early detection of Urinary tract infections and pneumonia through further enhanced support to care homes in the Berkshire West geography
- **"Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent care and emergency care. A guide for local health and social care communities":** This is a practical summary of the design principles that local health and social care communities need to adopt to deliver safer, faster and better urgent and emergency care. These principles are drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. We will use the guidance to inform commissioning decisions for the coming year**,** alongside the recently published NHSE/Monitor document on new payment models for Urgent and Emergency care.
- **Connected Care:** The CCGs are working with the Berkshire East CCGs to jointly procure an interoperability solution which will enable health and social care data to be shared across care settings, thereby supporting delivery of the national requirement that by 2020, all care records will be digital, real-time and interoperable. A full portal solution will be procured using previously identified BCF funding together with funding identified through the Primary Care Infrastructure Fund. It is our expectation that savings benefits identified and realised with provider organisations will be released and utilised to contribute to the funding of this programme. The solution will allow for interoperability and information exchange between organisations as well the creation of a person-held health and social care record enabling the individual to hold and manage information about their care. The procurement exercise is due to be completed by March 2016.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION AND EARLY HELP SERVICES

TO:	**Health and Wellbeing Board**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**8**
TITLE:	**Children's Services Commissioning Intentions Update 2016-17**		
LEAD COUNCILLOR:	**Cllr Gavin**	**PORTFOLIO:**	**Children's Services and Families**
SERVICE:	**Children's Services**	**WARDS:**	**Borough wide**
LEAD OFFICER:	**Angela Dakin**	**TEL:**	**011809374752**
JOB TITLE:	**Head of Commissioning and Improvement**	**E-MAIL:**	**Angela.dakin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report is intended to provide an update on the development of a set of commissioning intentions for children's services, for noting and comment by Health and Wellbeing Board.

1.2 When finalised, the Commissioning Intentions will form part of our suite of documents which outline the approach and activities we expect to take to review, improve and commission services for children and young people in Reading during the next financial year.

1.3 This document includes an initial indication of our key priority focus areas and of the strategic direction that our commissioning activities for children and young people will take over the coming year. It will be supported by an operational commissioning work plan, which is also currently under development.

1.4 A full set of commissioning intentions will be developed for the beginning of the new financial year. These will be informed by the Joint Strategic Needs Assessment currently under development and emerging themes from the Access to Resources Panel which considers requests for placements and packages of support for children and young people.

2. RECOMMENDED ACTION

2.1 Health and Wellbeing Board is asked to note the current position regarding development of commissioning intentions for children and young people, and to comment on the indicative priority areas for commissioning of services during 2016-17, in order that a final version of commissioning intentions can be published and shared with partners and providers.

3. POLICY CONTEXT

3.1 The Children's Services Commissioning Intentions will be based on delivering services within the context of the Children's Services Vision, which is to work to achieve:

- All Reading children are *safe*, reach their *full potential* and lead *fulfilling lives*.
- Families are helped to *take control*, and that we have a *positive impact* on their lives
- We will aim for the *right outcome* for each child working in a child centred, transparent, timely and inclusive way.

4. THE PROPOSAL

4.1 The Commissioning Intentions will serve to set out for all potential and current providers the information and intelligence that will enable businesses to plan how they might offer to meet the assessed needs of children and young people in Reading in future tenders and contract negotiations.

4.2 The full Commissioning Intentions for 2016-17 will incorporate priorities already set out in the following documents:

a) Reading Borough Council Sufficiency Strategy for Looked After Children 2015-2017
b) Project Initiation Document for Move on for 16+ and Care Leaver Housing Project (and resulting Young People's Housing Strategy)
c) Short Breaks Process 2016-17

4.3 In addition, the following priority areas will be incorporated into the final Commissioning Intentions document:

a) Children and young people's mental health

Our partners in the CCGs have added £1m recurrent funding to tackle capacity issues. We are working on a comprehensive CAMHS transformation plan (Future in Mind) with our health partners. We have decided to pool our funding for youth counselling.

b) Health visiting/school nursing

These services will be reviewed in the coming year to ensure they are fully embedded within RBC and that service specifications are considered within the context of developing a 0-19 service.

c) SEN provision

A sub-group of Schools Forum is leading a review to examine how we can better meet the needs of our young people with SEN locally, and how we reprioritise our spend in this area.

d) NEET

Through our City Deal programme called 'Elevate' we will provide more job and training opportunities for 16-24 year olds who are not in education, employment or training, along with a joined-up offer of support across

agencies. We will be reviewing our contract with Adviza to enable our work to be more targeted.

e) Independent Fostering Agency framework

The current framework for Independent Fostering Agencies ends in March 2017. Work is underway with our partners across the 11 south central local authorities in the framework to plan the retendering of the contract.

f) Framework for residential and independent special schools

Our continued participation in this framework will be reviewed over the coming year.

g) Children's social care placement costs

We will be engaging cost analysis experts to carry out more detailed work on individual placement costs.

h) Domestic Abuse

Reading Borough Council is in the first stages of a procurement exercise for Domestic Abuse Services in Reading. As part of this Reading is intending to combine all three current domestic abuse related contracts, and associated funding, into one commissioning cycle.

New contract arrangements are due to be in place by April 2017 and will ensure that the appropriate support is available for those experiencing domestic abuse, perpetrating abuse or living within a household where it is taking place. This will include, but is not limited to:

- Refuge provision
- Outreach support/ drop in facilities
- Ongoing support for all the family including young people
- Perpetrator support
- Training and awareness raising

i) Advocacy/Independent Visitors for Looked After Children

This contract is coming to an end and we are currently reviewing our options for re-commissioning the service – possibly in conjunction with the tender for advocacy for adult services, or in collaboration with other local authorities.

j) Youth Services

Reading Borough Council will be undertaking a full review of the range of youth services currently provided with a view to re-shaping the service to create significant efficiencies

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Children's Services Commissioning Intentions will be informed by the development and delivery of a range of services which primarily support numbers 1,2,3 and 6 of the following Corporate priorities:

1. Safeguarding and protecting those that are most vulnerable;
2. Providing the best start in life through education, early help and healthy living;

3. Providing homes for those in most need;
4. Keeping the town clean, safe, green and active;
5. Providing infrastructure to support the economy; and
6. Remaining financially sustainable to deliver these service priorities.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The final document will make specific reference to integration with Health colleagues and to co-production with service users, their families and carers. It will also contain a set of principles (in line with the Adult Social care Commissioning Intentions) which capture the expectations on which we will be basing our commissioning decisions. These principles will include specific reference to safeguarding requirements, co-production, voice of the child and use of direct payments and other personalisation tools.

6.3 Any service changes resulting from delivery of the final Commissioning Intentions will be undertaken with sensitivity and consideration of the impact on individual children and young people and their carers / families

7. EQUALITY IMPACT ASSESSMENT

7.1 The Commissioning Intentions document in itself will not specifically impact any protected groups and will be informed by the EIAs completed for individual service strategies.

7.2 It is likely that some individual re-commissioning exercises will require an Equality Impact Assessment, depending on changes determined as part of the specification process. An EIA will therefore be undertaken for each relevant exercise as appropriate.

8. LEGAL IMPLICATIONS

8.1 Under the Council's Contract Procedure Rules some of the proposed commissioning projects may be regarded as high value procurements and will be dealt with in accordance with the rules referred to.

9. FINANCIAL IMPLICATIONS

9.1 Services to be re-commissioned under the proposed Commissioning Intentions will be funded from confirmed budgets within Children's Services or other service areas.

10. BACKGROUND PAPERS

- Reading Borough Council Sufficiency Strategy for Looked after Children 2015-2017 (ACE 29th June 2015)
- Project Initiation Document for Move on for 16+ and Care Leaver Housing Project (and resulting Young People's Housing Strategy)
- Short Breaks Commissioning Process 2016-17 (attached)

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP SERVICES

LEAD COUNCILLOR:	**COUNCILLOR GAVIN**		
DATE:	**JANUARY 2016**		
TITLE:	**SHORT BREAKS PROCESS 2016/17**		
SERVICE:	**CHILDREN, EDUCATION & EARLY HELP SERVICES**		
AUTHOR:	**DAN COOK**	**TEL:**	**01189 374 531**
JOB TITLE:	**COMMISSIONING OFFICER**	**E-MAIL:**	**dan.cook@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the plan to create a more personalised approach to short breaks services in Reading through the creation of unique and individualised packages for families. The current traditional approach to 'grant funding' organisations will need to evolve to enable families with direct payments to purchase the care they want at the time and quality which is right for them, and to purchase those services from their chosen provider. The consultation process will determine a timeline, but we plan to have the Direct Payment funded groups in place during 2016/17.

1.2 In 2015/16 Reading Borough Council's spend on short breaks was £102,000. This budget supported around 200 families using short breaks services. The number of young people in Reading aged 0-19 living with a disability or longstanding illness is estimated at 6,635 *(Public Health England, 2011)*. Better value for money through improved choice and control for service users will be achieved by delivering services through Direct Payments to those who are eligible.

2. RECOMMENDED ACTION

2.1 It is the recommendation of the Director of Children, Education and Early Help services, in consultation with the Lead Councillor for Children's Services and Families, for Reading Borough Council to evolve the current short break grants mechanism into specified contracts and to start providing short break services through Direct Payments. Further consultation work will take place with key stakeholders and timescales will be announced. It is proposed that this recommendation is agreed by the ACE Committee.

3. CONTEXT

3.1 The Council has a statutory obligation to provide short breaks care for children with disabilities and their families/carers. Care options will continue to be provided to those in need, both directly and through VCS organisations and other providers. In the increased uptake of Direct Payments, freedom is provided to those in receipt to buy and choose services tailored to their needs, rather than solely those provided by the Council and or its partners.

3.2 The current grants with short break providers expire on 31 March 2016.

3.3 In 2015/16 approximately 200 of Reading's young people have taken part in a short break by attending an afterschool, evening, weekend or holiday club. This is out of an estimated 6,635 children with disabilities or longstanding illnesses. There are currently eight providers receiving funding.

4. THE PROPOSAL

4.1 Discussions with family forums, the voluntary sector and short break providers will take place from January through to April 2016. RBC will identify the organisations, groups and families that will be affected. Families will be made aware of the Direct Payment process and given links to the Family Information Service. They will give families options on where short breaks can be purchased.

4.2 Providers will go through a bidding process to demonstrate how they plan to run the new Direct Payment funded short break groups. RBC will be represented at meetings for key stakeholders to explain what this bidding process will look like.

4.3 Consultations will identify any stand-alone services that need to be commissioned. For example, a BME service may need to be purchased separately.

4.4 We anticipate that tendering will commence from June 2016. Bidders will be notified whether successful or not. Talks on setting up groups will follow, as will exit strategies.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 RBC has already consulted with with Reading Families' Forum, the voluntary sector and short break providers. The Short Breaks Working Group met a number of times in 2015. This group discussed the future of short breaks for Reading. The current services were reviewed and gaps for certain demographics were identified. We hope to continue these relationships and work together through the proposed changes.

5.2 RBC will have representatives at meetings for each of the key community groups to discuss short breaks and consult on how we plan to move forward into a Direct Payment funded service. We want to know thoughts, questions, risks, etc.

5.3 All parties included in the consultation process will be kept in the loop. RBC will send out information including a 'You Said, We Did' document.

6. LEGAL IMPLICATIONS

6.1 The current grants expire on 31 March 2016, so some contracts will need to be extended and VCS and other providers will need to prepare for a formal bidding and contracting process.

7. FINANCIAL IMPLICATIONS

7.1 The total spend on voluntary sector short break groups for 2015/16 is currently at £ £102,000.

7.2 RBC hopes to save money in certain service areas for short breaks. We expect to achieve better value for money by providing services to only those eligible for a Direct Payment, and by ensuring that families have better choice and control over the services they wish to purchase.

8. RISK ASSESSMENT

8.1 Parents at Reading Families' Forum who use these services have advised that they consider moving to Direct Payments will cost the council more in the long-run. It was speculated that the cost of a short break for one child could fund a whole group.

8.2 It is not clear whether providers will get on board and put their time into a short breaks group funded only by children with Direct Payments.

8.4 Will there be an approved list of short breaks providers? If so, who will manage and quality assure this list?

8.5 Will the CYPDT have capacity to cover all assessments for Direct Payments?

9. BACKGROUND PAPERS

9.1 Additional short breaks data for 2015/16 and previous papers/timelines on changes to the short breaks process are available from the Children's Commissioning Team on request.

APPENDIX 1

Proposed timeline for consultation:

Stage 1	**Stage 2**	**Stage 3**
January – June 2016	July – November 2016	December 2016 – March 2017
Preparation & consultation	Bidding for start-up funding	Successful bidders are notified and set up their operations in Reading.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**8**
TITLE:	**PUBLIC HEALTH COMMISSIONING INTENTIONS: INITIAL PROPOSALS**		
LEAD COUNCILLOR:	**Graeme Hoskin**	**PORTFOLIO:**	**Health**
SERVICE:	**Public health**	**WARDS:**	**Borough-wide**
LEAD OFFICER:	**Dr Andrew Burnett**	**TEL:**	**0118 937 3623**
JOB TITLE:	**Interim Consultant in Public Health Medicine**	**E-MAIL:**	**andrew.burnett@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out an initial prioritisation of current areas of public health services commissioning for probable continuation in 2016/17 in order to contribute to improving the health of local residents and to reduce health inequalities.

1.2 Notwithstanding the government's cuts to the Public Health Grant and other financial pressures that the council is under, it is prudent to review the appropriateness of current public health-commissioned services. The purpose is to ensure that (i) what we commission can reasonably be expected to have a significant beneficial impact, and (ii) we reduce or stop commissioning less effective services in order to free-up resources to concentrate population-level interventions where they will have the greatest benefit for the greatest number.

1.3 The Reading Joint Strategic Needs Assessment (JSNA) Position Statement, presented to the health and well-being board in October, is one source of information about local health needs. A full JSNA is in preparation with a view to presentation at the March 2016 health and well-being board meeting. (This JSNA will include the findings of the now nearly completed detailed drugs and alcohol needs assessment.) Arising from the position statement and emerging from work on the full JSNA, the key health needs in Reading include:

- above-average death rates from largely avoidable causes, especially cardiovascular disease (principally heart attack and stroke), especially in the borough's more deprived areas;
- levels of poor mental well-being that could be improved;
- prevalences of conditions such as overweight and obesity, and diabetes, that need attention if we are to reduce the complications and disability and raised mortality associated with these; and
- high levels of substance misuse and unmet need, especially for alcohol misuse.

1.4 It is important to note that the prioritisation tool is still in development and some of the topics assessed were scored by a group and some by different individuals. We need to check the scoring of all the topics assessed in a group to check the consistency of the application of the prioritisation criteria. We also intend to add another criterion to assess the implication on other council and NHS services should a public health-commissioned service be recommended for stopping.

1.5 Appendix 1 – Assessment framework

Appendix 2 – Outcome of assessment of public health-commissioned population interventions

2. **RECOMMENDED ACTION**

That Health Sub-group:

2.1 Approves the need for prioritisation and the development of the proposed method for it; and

2.2 Agrees that further work is required, especially in terms of matching population-level interventions with need.

3. POLICY CONTEXT

The recommendations in this paper will help the Council meet obligations including:

3.1 National Policy & legislation:

- National Health Service Act (2006)[1] and Health & Social Care Act (2012)[2] – mandates local authorities to improve life expectancy and reduce health inequalities.

3.2 Reading's Health & Wellbeing Strategy:

- Promote and protect the health of all communities, particularly those disadvantaged;
- Reduce the impact of long term conditions with approaches focused on specific groups; and
- Promote health-enabling behaviours & lifestyles tailored to the differing needs of communities.

3.3 The Public Health Outcomes Framework, which councils are required 'to have regard to, including specific indicators concerning:

- improvement of the wider determinants of health;

1 *National Health Service Act 2006.* London, HMSO. Available at: http://www.legislation.gov.uk/ukpga/2006/41/contents (accessed 18 December 2015)

2 *Health and Social Care Act 2012, c.7*. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed: 18 December 2015).

- health improvement;
- health protection; and
- preventing premature mortality.

4. THE PROPOSAL

4.1 Method:

Using a scoring framework that can be found in Appendix 1, we assessed our current broad and specific areas of public health-commissioned work in the context of: local strategic fit; fit with priority areas in the King's Fund document *Improving the public's health – a resource for local authorities*; level of assessed need; strength of evidence of clinical effectiveness; likely impact on health inequalities; likely magnitude of benefit; likely number of people (or proportion of the population) to benefit; impact on access to services; likelihood of improving the quality of services; feasibility; risk; and cost-effectiveness.

4.2 Assessment of current public health-commissioned interventions

Public health-commissioned service area	Score
Mental health and well-being	49
Sexual health	49
Smoking cessation and tobacco control	46
Physical activity	45
Flu immunisation	44
0-19 years services	40
National Child Measurement Programme	40
Substance misuse services	33
Breast feeding	30
Making every contact count	29
Health checks	29
Excess winter deaths	29
TB	22
Dental health	14

We will review the individual components of current interventions to ensure the appropriateness of the scoring in terms of prioritisation. For example, the National Child Measurement Campaign (which is a mandatory service) does not, of itself, provide a population-level intervention to reduce overweight and obesity, it simply measures prevalence. The relative low score for the health checks programme (also a mandatory service) probably relates to its need for greater targetting and the greater provision of services for people with identified risks. And sexual health services (which are also mandatory), whilst important, have little significant impact on mortality and overall health inequalities.

From this work, we will develop proposals for reducing/stopping the commissioning of some interventions in order to increase (i) the appropriateness of those interventions that we do commission, and (ii) the number of people who can benefit from them.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Public health interventions at a population level contribute to Corporate Priority 2: *Providing the best life through education, early help and healthy living*.

5.2 They also enable the council to significantly contribute to other obligations, including improving the health of the population and reducing health inequalities.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Community engagement and consultation will be appropriate once specific proposals have been drawn up.

7. EQUALITY IMPACT ASSESSMENT

7.2 An equality impact assessment is not relevant at this stage.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications at this stage.

9. FINANCIAL IMPLICATIONS

9.1 Not applicable at this stage.

Appendix 1: Prioritisation framework for health improvement initiatives

This prioritisation framework is intended for use within the public health team to help identify potential high-impact health improvement programmes for implementation on an industrial scale. Each proposal needs to be marked against each of the criteria in the first column for a high, medium or low fit with the description in either the second, third or fourth columns, scoring 3, 1 and 0 points respectively. Some criteria are weighted and double the basic number of points should be applied for a high or medium fit, as referred to in the relevant rows.

Criterion	HIGH FIT 3 points (basic)	MEDIUM FIT 1 point (basic)	LOW FIT 0 points
Local strategic fit (apply points to each one met): • Reading Health & Wellbeing Strategy priority • JSNA priority • Reading CCGs' operating plans priority • Council Corporate Business Plan priority • Delivery of one or more Public Health Outcome Indicators	3 points for each strategy supported in a significant way	1 point for each strategy supported in a minor way	No points if no strategy supported in any way
Fit with priority areas in *Improving the public's health – a resource for local authorities* by the King's Fund (apply double points for <u>one</u> of the following criteria): • the best start in life • healthy schools and pupils • helping people find good jobs and stay in work • active and safe travel • warmer and safer homes • access to green and open spaces and the role of leisure services	Proposed intervention meets at least two 'possible priority actions' identified in any of the 8 priority areas in *Improving the public's health* for the relevant area or one or more close equivalent actions 6 points only for one priority area met this way	Proposed intervention meets at least one 'possible priority actions' identified in any of the 8 priority areas in *Improving the public's health* for the relevant area or one or more close equivalent actions 2 points only for one priority area met this way	Proposed intervention meets none of the 'possible priority actions' in any of the 8 priority areas identified in *Improving the public's health* for the relevant area or close equivalent actions No points

• public protection and regulatory services (including takeaway/fast food, air pollution, fire safety) • health and spatial planning • Strong communities, well-being and resilience			
Assessed need	Quantified evidence of high local need based on incidence; mortality/morbidity impact; unmet service need	Local need not well defined/quantified, such as extrapolated/inferred from other data or other populations or solely based on demographic profiles	No clear evidence of need
Clinical effectiveness of proposed population-level intervention	High-quality evidence (such as randomised controlled trials, large cohort studies) or fully meets specific NICE guidance	Only medium or low-grade evidence of effectiveness, such as small-scale trials or professional opinion	No significant evidence of effectiveness
Impact on health inequalities (apply double points if criterion met)	Clear evidence that the proposal will sustainably and significantly reduce health inequalities 6 points	There is some evidence that the proposal will reduce health inequalities 2 points	Small or even negligible impact on health inequalities likely No points

Magnitude of benefit (apply double points if criterion met)	Significant improvements in health outcomes will accrue, such as increases in life expectancy, reduced death rates, especially for conditions where death rates are currently relatively high 6 points	Moderate improvement in health outcomes can be expected 2 points	Small or negligible impact on health outcomes likely No points
How many people are likely to benefit? (apply double points if criterion met)	5,000+ (or at least 3% of the population) 6 points	2,000+ (or at least 1.5% of the population) 2 points	1,000+ (or at least 0.75% of the population) No points
Access to services	Health equity audit shows that access to services for hard-to-reach groups and/or those who are affected by health inequalities will significantly improve	Health equity audit shows that a moderate impact on access to services for hard-to-reach groups and/or those who are affected by health inequalities is likely	Health equity audit not done
Improving quality of services (apply points to each one met): • patient/client safety • patient/client experience • integration between services on a pathway	Strong, good quality evidence from large-scale work elsewhere that the proposed service will have a significant benefit	Some good quality evidence that the proposed service will have a significant benefit	Little or no evidence that the proposed service will have a significant benefit

Feasibility	There is a realistic scheme to deliver the proposed intervention with meaningful milestones and effective outcome measures	There is a scheme to deliver the proposed intervention, with milestones and outcome measures but overall it is ambitious, less likely to succeed and/or progress and outcomes may be difficult to evaluate	There is no realistic scheme to deliver the proposed intervention with meaningful milestones and effective outcome measures
Risks	A comprehensive, quantified risk assessment has been undertaken with realistic mitigation identified for each risk	A risk assessment has been undertaken but it misses one or more significant areas/risks and/or the proposed mitigations are less likely to succeed	No risk assessment undertaken
Cost-effectiveness	Implementation and service costs have been benchmarked to similar or alternative services and are <u>lower for a higher output</u>, and/or the proposed intervention is of proven cost-effectiveness (in the way it is intended to be implemented and delivered) as shown by robust cost-effectiveness evaluations published in	Implementation and service costs have been benchmarked to similar or alternative services and are <u>lower for a comparable output</u>, and/or the proposed intervention is of proven cost-effectiveness (in the way it is intended to be implemented and delivered) as shown by robust cost-effectiveness	There is no cost-effectiveness evaluation or implementation and service costs have been benchmarked to similar or alternative services and are <u>higher for a better or a comparable output</u>

	peer-reviewed journals and/or by an organisation such as NICE	evaluations published in peer-reviewed journals and/or by an organisation such as NICE and is not replacing any currently commissioned service for the same indication	

Appendix 2: Public health commissioned services: outcome of prioritisation scoring

	PHYSICAL ACTIVITY	MENTAL HEALTH & WELLBEING/NEIGHBOURHOODS	SUBSTANCE MISUSE AND LIVER DISEASE	TB	DENTAL	Flu		SEXUAL HEALTH	NCMP	HEALTH CHECKS	0-19's	SMOKING CESSATION/ TOBACCO CONTROL	MECC	BREASTFEEDING
Local strategic fit	MANDATED SERVICE: NO CORPORATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES JSNA Priority: PHOF:YES	MANDATED SERVICE: NO CORPORATE PLAN: YES HWB STRATEGY: NO CCG CORE OFFER: YES BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO CORPORATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: NO BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: NO CCG CORE OFFER: NO BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES BOROUGH PROFILE: YES/NO PHOF: YES/NO	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: NO CCG CORE OFFER: NO BOROUGH PROFILE:? PHOF: NO	MANDATED SERVICE:YES/NO COOPERATE PLAN:NO HWB STRATEGY: YES CCG CORE OFFER: NO BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE:YES COOPERATE PLAN: YES HWB STRATEGY: NO CCG CORE OFFER:NO BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: YES COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES BOROUGH PROFILE: YES PHOF: YES	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: NO BOROUGH PROFILE: NO PHOF: NO	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: YES BOROUGH PROFILE: YES PHOF:NO	MANDATED SERVICE: NO COOPERATE PLAN: YES HWB STRATEGY: YES CCG CORE OFFER: NO BOROUGH PROFILE: NO PHOF: NO
Mandatory Service	0	0	0	0	0	0	0	3	3	3	0	0	0	0
Health & Wellbeing Strategy	3	3	3	1	1	3	0	1	3	3	3	3	3	1
JSNA priority	3	3	3	0	1	0	0	3	3	3	3	3	0	1
CCGs' operating plans	3	3	3	0	0	3	0	0	0	0	1	3	0	0
Corporate Plan	1	3	1	3	1	0	3	3	1	3	3	3	3	1
Public Health Outcome Indicators	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Fit with priority areas in *Improving the public's health*	6	6	3	6	2	6	6	6	6	0	6	6	6	2
Assessed need	3	3	3	0	1	3	2	3	3	1	1	3	2	1
Clinical effectiveness	3	3	3	1	0	3	3	3	3	1	1	3	2	3
Impact on health inequalities	2	6	2	2	0	2	2	2	2	1	2	3	2	2
Magnitude of benefit	2	2	2	6	2	6	2	2	2	2	6	3	2	2
How many people are likely to benefit?	6	2	0	0	2	6	2	6	2	2	6	1	2	2
Access to services	1	3	0	0	0	0	0	1	1	2	1	0	0	2
Improving quality of services	2	4	5		0	2	2	5	1	2	3	4	2	3
Feasibility	3	1	1		1	3	2	3	3	3	1	3	0	3
Risks	1	3	1	0	0	2	0	2	3	0	0	2	0	1
Cost-effectiveness	3	1	0		0	2	2	3	1	0	0	3	2	3
Total	45	49	33	22	14	44	29	49	40	29	40	46	29	30
What would be a good year in terms of outcomes? YEAR 1	1. Reading Lets Get Going programme will be retendered and contract awarded. 2. The Reading Healthy Weight Strategy will be completed . 3. Reading Beat The Street 2015 will have been delivered and evaluated 4. Beat the Street Community Champions Programme. will have been implemented 5. Procurement plan will have been deveoped for Adult Weight Management Services	1. A Mental Health Training Needs Analysis will have been completed, based on needs/recommendations highlighted in the JSNA Annual Position Statement	1. The Community Alcohol Partnership will have been reviewed and evaluated. 2. A Substance Misuse HNA will have been completed.	1. Public Health will have worked with PHE and other local partners to deliver and evaluate a local TB awareness campaign implemented in accordance with the Berkshire TB Board action plan.	1. Brushing for Life evaluation completed (Paul Batchelor)	1. Evaluate impact (if any) of radio ad campaign - increased uptake of immunisations at GP practices. 2. Public Health will have delivered actions set out in the RBC Flu Plan. 3. Have a clear understanding on uptake performance across the range of imms and vacs		1. Public Health will have revised arragements for local condom distribution review and actioned recommendations arising. 2. Sexual Health IT platform will be live.	1. Accurate and timely age specific information to parents on NCMP and related services will be provided to schools as standard as part of the NCMP process.	1. Monitor contract and agree further action to increase uptake via Primary Care	1. Needs analysis for the future service completed 2. A fully integrated 0-19 service specification developed. 3. A procurement and commissioning plan established.	1. Retendering of Berkshire Smoking Cessation services will have been completed and contract awarded. 2. Public Health will have worked with the comms team and supported the delivery of national stop smoking campaigns. 3. PH will have set the strategic direction for the work programme of the Tobacco Control Alliance Co-ordinator - linked to other programmes, e.g. CAP/JMA schools offer.	1. Local model and plan for delivery of MECC training across Reading will be in place. 2. Implementation will have commenced	1. Berkshire West servic specification and contract in place for 2015/2016. 2. If funding agreed beyond 2015/2016, procurement and commissioning exercise completed and new breastfeeding contract in place for 2016/17 and beyond.
What would be a good year in terms of outcomes? YEAR 2	1. Creation of personalised plans for children working with Leisure Services will have been piloted 2. A Clear referal system between NHS Health Checks and phyical activity interventions will be in place f. 3. Workplace Health- .	1. Public Health will have delivered 5 Ways to Wellbeing & National Mental Health Awareness Week Campaigns. 2. More (x number?) cross sector staff across Reading will have been trained in understanding signs and sypmtons of mental health e.g via local roll out of MHFA Lite. Band 6 3. More (x number?) cross sector staff across Reading will have been trained in understanding signs and sypmtons of mental health e.g via local roll out of MHFA Lite. 4. A Reading suicide reductions actions plan will have been developed - To be confirmed- Peter checking timelines. 5. Public Health will have evidenced it's contribution to the production & implementation of a cross council mental health strategy document - with a clear focus on mental health promotion and emotional wellbeing.	1. Review of alcohol screening, needle exhange, shared care and supervised administration primary care services. 2. Alcohol Screening Primary care contracts will have been reviewed 3. (working with DAAT) A local model of Tier 2 brief interventions across Primary care and community will be established						As above	1. Existing provision will have been reviewed and an options appraisal for future delivery model/s completed. 2. Existing quality assurance arrangements will have been reviewed and, where appropriate, recommendations made for improvement. Band 8 and 7 3. Commisioning intentions/retendering of services will be taken forward in line with mandatory guidance and outcomes from local options appraisal 4. Referral pathways from NHS Health Checks into lifestyle interventions. E.g. alcohol/physical activity will have been developed	1. The procurement and commissioning plan established utilised. 2. HV / FNP services fully embedded into Reading Borough Council. 3. A new 0-19 integrated service commissioned.	1. Public Health will have led a review of RBCs smoking policy.	1. More (x number) cross sector staff will have been trained in MECC in line with an agreed local model and the impact of training will have been evaluated	

	PHYSICAL ACTIVITY	ENTAL HEALTH & WELLBEING/NEIGHBOURHOOD	LIVER DISEASE	SCREENING	TB	DIABETES - DRAFT	IMMS/EWD's	SEXUAL HEALTH	NCMP	HEALTH CHECKS	COMMS & MEDIA	0-19's	Carers	Smoking Cessation/Tobacco Control	Advice to Other Departements	Business Management	JSNA & HWB STRATEGY
What would be different?	1. Lets Get Going would be retendered. 2. There will be a clear set of outcomes following completion of Healthy Weight Strategy. 3.This plan will have a defined exit strategy for children post LGG. 4. Beat The Street Participants will maintain a continued lifestyle change. 5. Implementation of refferal system. 6. Increase in training of volunteer walks leaders (Target 10 per month) 7. Members of the public will continue to be engaged in physical activity. - 8.Implementation of workplace and well being chapter into	1. Clear direction of travel - Stakeholders have a mutual understanding of the stratgey. **2. Increased awareness of Mental health & Well being in Reading** 3. Increase in numbers trained. **4. Commisioning Plan - MH Elements of all council undertaking.** 5. Link into other H&SC/PH programmes, campaigns. **6. Promote/raise awareness of national campaigns.**	1. Provide Public Health support in line with CCG Priorities. **2. Understand the impact of CAP** **3. Alcohol Screening PCC work and agree whether to continue as well as improving refferal pathways.** 4. Better intellegence and reccomendations for intervention. Local model based on NICE guidance. **5. Better intellegence and reccomendations for intervention. Local model based on NICE guidance.**	1. Priorities agreed. 2. **PH team would be able to support relevant GP QOF targets achievment.** 3.Clear planand capacity to deliver core offer support linked to screening.	1. Better intellegence. **2. Increased awareness amongst target groups. with a a clearer referal pathway.** 3. Programme in place- Increased assurance that new entrants into Reading are screened effectivily for TB. **4. Fewer late diagnosis cases.**	**1. Targeted intervention delivered and evaluated and recommendations in place.** **2.** Piloted and evaluated. **3. Local option is available for advice and support.**	1. Whole population interveniitons through local campaigns. **2. Targeted group interveniitons through local campaigns.** 3. Whole population interveniitons through campaigns. **4. Local project groups to oversee.** **5.** Activity all year round. **6.Better information to help design and delivery of interventions.** 7.More staff vaccinated. **8.PH response documented and defined.**	**Effective service spec reflecting service improvements detailed in bid.** 2. Reflect service improvement, better and quicker access to services. **3. Increased testing rates = Increased uptake. STI's.** 4. Distribution model agreed. 5. Contract being delivered and monitored. 6. Act upon data accordingly - Timely response to data. **7. Quality managing of all contracted sexual health services.** 8. Better access for residents. **9. Improved Public Health imformation on sexuale**	**1. Improve system to follow up missed children & Auditing our activity against NCMP national outcomes.** **2.** Localising information - Cycle of activity.	2. Confident everyone eligable in Reading has access. 4. Higher conversion rate. 6. Improved data quality.		1. HV / FNP staff commissioned by RBC. 2. Clear accountability and monitoring to deliver relevant services with improved links to internal and external partners/stakeholders. 3. Commissioners will know exactly what 0-19 integrated service is needed for the young people of Reading. 4. Internal and external stakeholders will understand future commissioning intentions and timescales.					
Whats our contribution?	**1. Commisioning and budget holder.** **2.** Project managing the Healthy Weight Strategy **3. Working with partners to define the pathway.** **4.** Joint Commisioner **5. Commisioning 1/3 of the funding.** **6.** Commisioning and providing specialist imput. **7. Commisioning** **8.** Programme Managing	1. Public Health To provide content. - E.g Raising awareness around stigma/signs and symptoms. **2. Commisioners.** 3. **Promotion & awareness raising** 4.Provide advice (PH expert advice to stakeholders) **5. MH included in MECC - Commisioner/Service Design** 6. Commisioning & awareness raising programme	**1. PH Specialist advice/Core offer** **2.** Specialist input to DAAT & CAP. **3.** Specialist input. **4. Needs analysis, scoping and service design.** **5.** Needs analysis, scoping and service design.	1. Support CCG's outcomes through PH advice to help them achieve their outcomes. Scruitiny of their performance. **2.Public Health specialist advice via core offer** 3. Public Health specialist advice via core offer	**1. Project management with PHE. Data analysis and specialist input.** **2.** Project management with PHE. Data analysis and specialist input. Evaluating the campaign - community engagement. **3.Provide support to development of new entrants screening programme.** 4.Specialist Public Health input	**1. Commisioner + Project management.** **2.** Commisioner + Project management. **3. Facilitate, fund and promote.**	**1. Support CCG's in meeting their targets.** **2.** Design, deliver and evaluate campaign (Radio/Website). **3. Design, deliver and evaluate campaign (Radio/Website).** **4.** PH Multi agency group. **5. Commisioning.** **6.** Data analysis, evidence review. **7. Promotion of service throughout the LA.** **8.** Reveiw current business continuity plan.	1.Commisioner 2.Commisioner 3. Commisioner 4.Commisioner/Service redesign 5. Commisioner 6. Commisioner 7. Commisioner 8. Commisioner 9. Commisioner	1. Commisioners- We fund school nurses through shared team. Aligning NCMP with other PH activities. 2. Public Health specialist advice on available services and interventions.			1. Commissioner support to the shared team. 2. Performance monitoring support and decision making as needed. 3. PH specialist advice instolling an evidenced based approach. 4. Commissioing support to develop procurement plan.					

REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP (SRCCG) AND NORTH & WEST READING CLINICAL COMMISSIONING GROUP (NWRCCG)

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**9**
TITLE:	**PRIMARY CARE UPDATE REPORT**		
LEAD:	**CATHY WINFIELD**	**TEL:**	**0118 9822732**
JOB TITLE:	**CHIEF OFFICER, SOUTH READING & NORTH AND WEST READING CCGs**	**E-MAIL:**	**cathywinfield@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report follows previous Health and Wellbeing Board papers on the development of the Berkshire West Primary Care Strategy. Following further engagement with the public, the strategy has now been signed off by the Joint Primary Care Co-Commissioning Committee on which the Health and Wellbeing Board is represented. The wider Health and Wellbeing Board are now asked to endorse the principles set out in the strategy, a copy of which is included with this paper.

The CCGs would also like to highlight that we have applied to move to a fully-delegated co-commissioning arrangement with effect from 1st April 2016. We believe that this will have a positive impact on the development of local primary care services, putting us in a stronger position to implement the vision described in the strategy.

2. RECOMMENDED ACTION

The Health and Wellbeing Board is asked to note and endorse the Berkshire West Primary Care Strategy.

3. POLICY CONTEXT

The Berkshire West Primary Care Strategy reflects the models of care described in NHS England's *Five Year Forward View.*

4. CONTRIBUTION TO STRATEGIC AIMS

The Primary Care Strategy and the approach to primary care commissioning described within it will support delivery of the Berkshire West CCGs' Strategic Plan.

5. COMMUNITY ENGAGEMENT AND INFORMATION

The CCGs have engaged with the public throughout the development of the Strategy. This has intensified in recent months with the distribution of a summary document for patients, a programme of public events and meetings and online engagement through the CCGs' websites. A full engagement report will shortly be published on our websites alongside the strategy itself. This will set out how patients' views have influenced the development of the strategy. It is intended that this initial engagement now develops into an ongoing dialogue with the public regarding specific projects and initiatives as we move towards implementation. Should specific changes to individual practices be proposed the CCGs will also ensure that practices fulfil their responsibility to consult with their registered patients.

6. EQUALITY IMPACT ASSESSMENT

Equality Impact Assessments will be carried out as appropriate for all decisions made under co-commissioning arrangements and in respect of any service changes proposed as a result of the implementation of the Primary Care Strategy.

7. LEGAL IMPLICATIONS

Under the Health and Social Care Act (2012), responsibility for the commissioning of primary care services sits with NHS England. However, the National Health Services Act 2006 (as amended) ("NHS Act") provides, at section 13Z, that NHS England's functions may be delegated to CCGs.

8. FINANCIAL IMPLICATIONS

Not applicable.

9. BACKGROUND PAPERS

Berkshire West Primary Care Strategy (attached)

Five Year Forward View NHS England » Five Year Forward View

Berkshire West Primary Care Strategy

2015 – 2019

1. Introduction

The Berkshire West CCGs' 5 Year Strategic Plan describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health within our local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

The overriding aims of our overarching Berkshire West CCGs plan which underpin this strategy are:

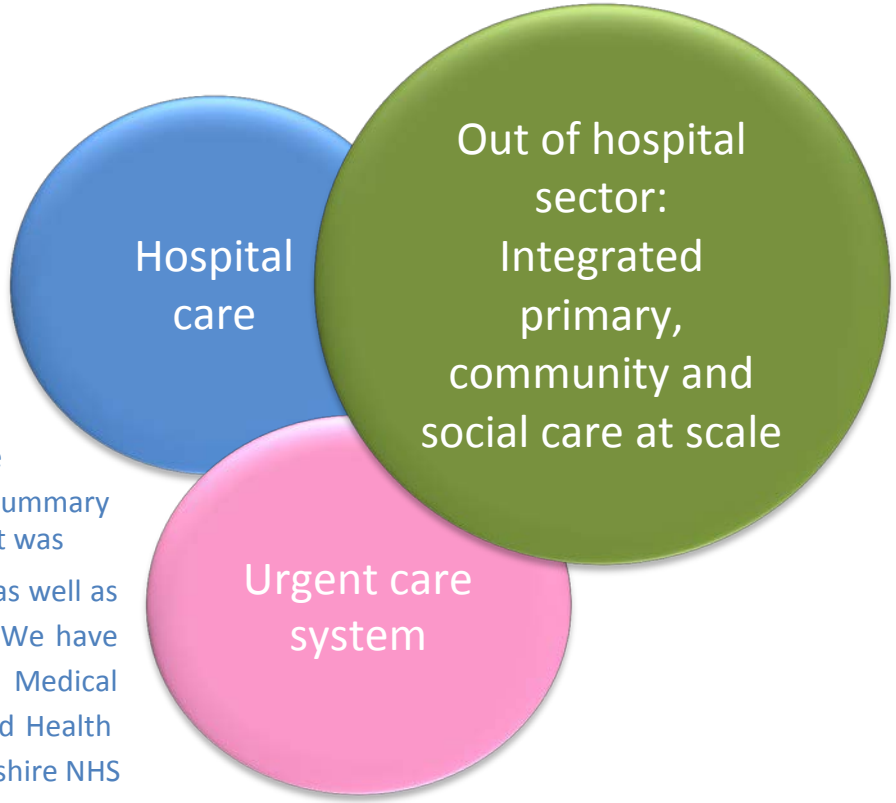
- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary and out of hospital care.
- Development of new payments mechanisms which incentivise the delivery of outcome focused care and which support the future sustainability of the local system.
- Commissioning highly responsive services urgent care services which ensure patients get the right care at the time in the right place.
- Better use of technology and innovation to achieve better outcomes for patients and improved demand management.
- Achieving parity of esteem for people with mental health problems and learning disabilities.

The Berkshire West local health economy is innovative and high performing, benchmarking well on key measures such as non-elective admission rates and prescribing. However it is recognised that the system faces significant operational, clinical and financial challenges to sustainability going forward. The CCGs are therefore working with partners to define a new model of care reflecting the triple aims of the *NHS Five Year Forward View* which are to increase the emphasis on primary prevention, health and wellbeing, to improve the quality of care by improving outcomes and experience for patients and achieving constitutional standards, and to deliver best value for the taxpayer by operating a financially sustainable system. There is an emerging consensus locally that a clinically and financially sustainable health economy can best be delivered through the creation of an Accountable Care System (ACS), bringing together commissioners and providers to assess population need, determine priorities,

redesign services, agree and measure outcomes and allocate resources along care pathways and in such a way as to incentivise all organisations to work towards the same goals. Such a system would ultimately function on the basis of a place-based capitated budget incorporating all aspects of healthcare including primary medical services with providers and commissioners jointly incentivised to deliver specified outcomes in a cost-effective way.

This Strategy builds upon the CCGs' overarching Strategic Plan to describe a detailed vision for primary care services in Berkshire West; anticipating that primary care will play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social care system in the light of increasing demand and financial pressures.

To ensure primary care is able to function in this way, this Strategy also describes what we intend to do to address the current challenges facing the sector including financial issues, growing workload pressures and increasing challenges in recruiting and retaining GPs and other key healthcare professionals.



The Strategy has been jointly developed by the four Berkshire West CCGs, working together with NHS England as the statutory commissioners of primary care services, and with patients and members of the public. Further details of our engagement with the public are included at Appendix 1. This has included a combination of online surveys, public meetings and targeted discussions, as well as the publication of a summary version of this strategy aimed at a patient audience. The development of the document was also guided by a Task and Finish Group including GPs, Practice Managers and Nurses, as well as by discussions in each of the four GP Councils and with the four Governing Bodies. We have also discussed the Strategy with our statutory partners, Healthwatch and the Local Medical Committee through our Joint Primary Care Co-Commissioning Committee (JPCCC) and Health and Wellbeing Board meetings, and have shared it with our local trusts; the Royal Berkshire NHS

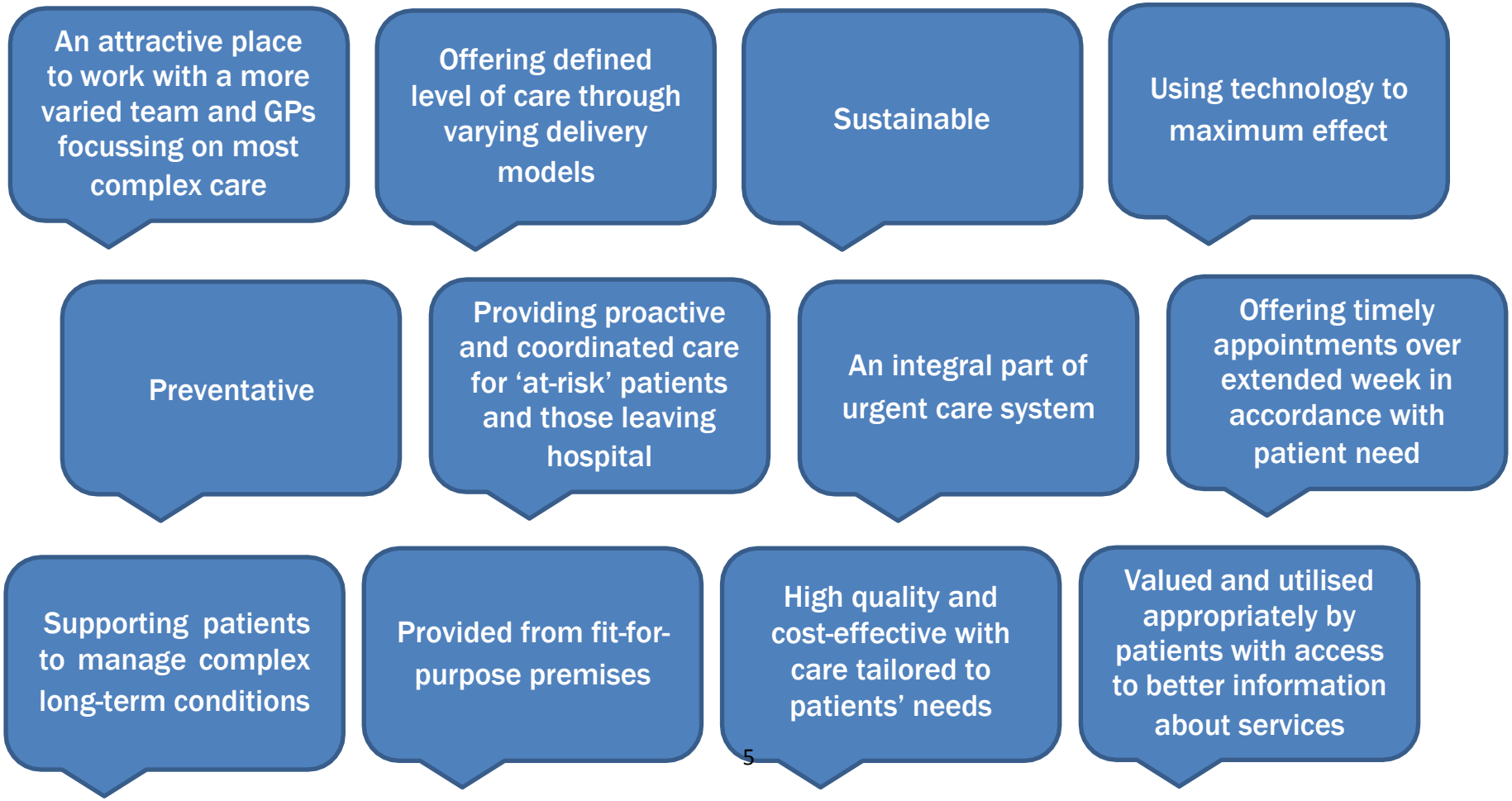
Foundation Trust and the Berkshire Healthcare NHS Foundation Trust.

At this stage the Strategy focuses on primary medical services, and to a lesser extent on community pharmacy, but the opportunities and importance of integrated working with other community services is also a key theme.

Implementation of the Strategy will be overseen by the Joint Primary Care Co-Commissioning Committee (JPCCC), linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at http://www.wokinghamccg.nhs.uk/joint-primary-care-co-commissioning-committee.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:



3. The Case for Change

There are currently 53 GP practices in Berkshire West, providing care to approximately 520,000 patients from 75 surgeries. For 2015-16, the total budget for general practice services in Berkshire West was £66.9m, made up of £61.2m NHS England funding for contractual payments including QOF and enhanced services, and £5.7mm invested by the CCGs in community enhanced services including Admissions Avoidance (care planning for Over 75s), support to care homes, early identification of diabetes and extended hours.

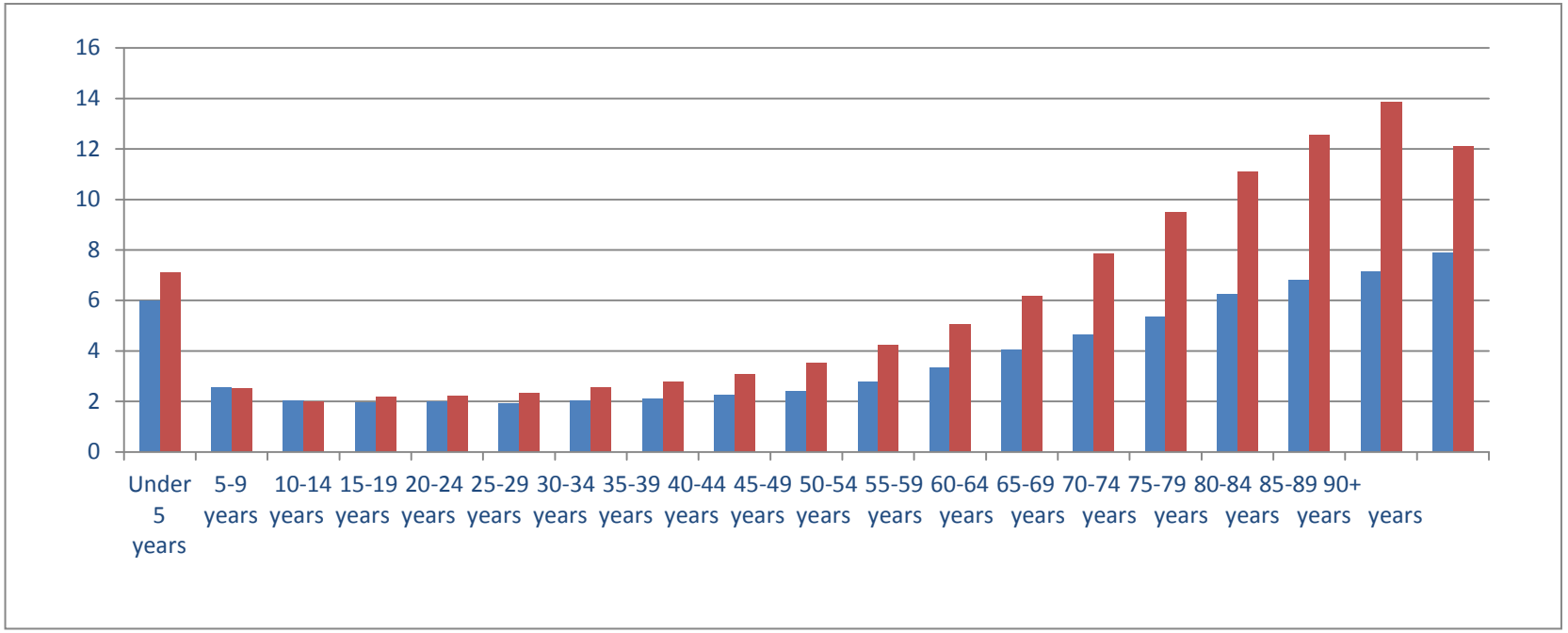
All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). The Walk-in Centre contract will be re-procured during 2016-17 whilst the other three APMS contracts are currently being re-procured with the intention of new contracts commencing from July 2016.

The quality of primary care provision in Berkshire West is generally high. Average QOF achievement exceeded the England average for three of the four CCGs and was also above average in 11 practices in the remaining CCG. The Primary Care Web Tool collates key primary care quality data such as QOF achievement and prevalence, prescribing, screening and immunisation uptake rates, A&E attendances, non-elective admissions for patients with long-term conditions and National Patient Survey results. Practices that are outliers on more than six indicators are identified as requiring further investigation to understand the reasons behind this. No Berkshire West practices are in this group although some are outliers on a smaller number of indicators. There is also some local variation between practices serving similar populations which needs to be understood and addressed as appropriate. 25 practices have so far been visited by the Care Quality Commission (CQC) of which 61% have been rated as good or outstanding. Where practices have been rated as 'Requires Improvement' many of the issues identified have been procedural matters which have been relatively easy to address. A small number of local practices have been placed in special measures in recent months and the CCGs and NHS England have worked closely with the practices on Quality

Improvement Plans which are proving successful in addressing the issues identified. Going forward the CCGs are now working to support all practices to better understand the CQC requirements and inspection process.

Out-of-Hours services are provided by Westcall (part of the Berkshire Healthcare NHS Foundation Trust). Westcall is recognised as being a high quality provider of out-of-hours care and is staffed to a large extent by local GPs. This knowledge of local services and care pathways, together with access to patient records through the Medical Interoperability Gateway and to care plans via Adastra, ensures that the service is able to work effectively to meet urgent care needs and avoid unnecessary admissions to hospital during the out-of-hours period.

It is becoming increasingly evident that pressures affecting the wider UK primary care system are starting to impact upon Berkshire West practices. The national increase in consultation rates, reflecting an ageing population increasingly suffering from one or more long-term conditions (see Figure 1, below), is being replicated in Berkshire West where over the 2014-15 Winter period, practices reported a 25% increase in consultation rates when compared with the previous year. We are undertaking further work locally to understand levels of capacity and demand in primary care which will inform our future commissioning decisions.



Changes in consultation rates 1995-2008 (HSCIC)

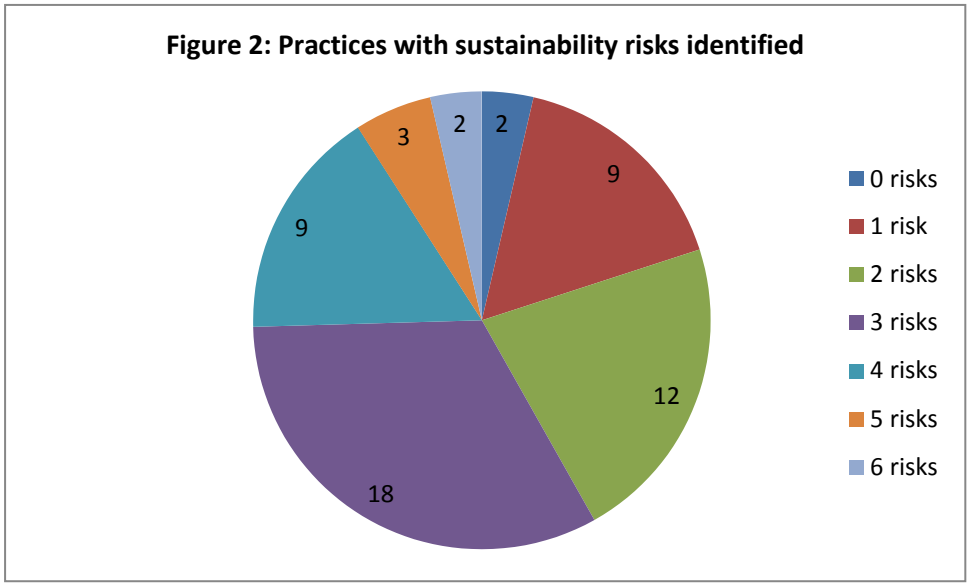
A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third of GPs aged under 50 are considering leaving the profession in the next five years due to workload pressures.[2] There is an increasing trend towards part-time posts with 12% of general practice trainees now working in this way, and towards salaried employment with just 66% of GPs now working as partners compared to 79% in 2006.[i] 27 of the 55 Berkshire West practices have indicated that they are currently experiencing issues with recruiting GPs and other

[1] http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx
[2] *Is Primary Care in Crisis?,* The Nuffield Trust, November 2014

clinical staff and with a high proportion of Berkshire West GPs and Practice Nurses aged over 50 these issues are expected to become more acute over time.

Patients have told us that they are generally happy with the standard of care provided but would like services to be better co-ordinated so that they only have to 'tell their story once'. Around 60% of patients say that current surgery opening times meet their needs. Where weekend access is provided the preference is for Saturdays mornings. Waiting times for appointments and continuity of care are frequent concerns but people are increasingly willing to consider alternative access models such as speaking to GPs over the telephone or seeing different members of the practice team such as pharmacists or physicians' associates. There is also consistent across all age groups feedback that people want to interact with their surgery online although some indicate that they would need help to register for online services. Patients would welcome being supported to take a greater role in their care and also believe that primary care could work more effectively with other organisations including in the voluntary sector to promote health and wellbeing. Further information about the priorities identified through patient engagement, together with details of how these are reflected in the Strategy are included in Appendix 1.

The CCGs recently undertook a 'risk mapping' exercise aiming to assess the stability of the CCGs' GP practices in order to work with them proactively to address risks and avoid potential contract failures. In addition to recruitment and retention and workload pressures associated with serving a deprived or growing population, this took into account CQC risk ratings, practice size, condition of premises and the potential financial impact of contractual changes. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data is now being triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tools and demographic information to establish a dashboard of quality and risk relating to primary care contracts.



The remainder of this document describes the strategic objectives and key workstreams which will enable us to realise our vision for primary care.

4. Strategic objectives

In order to deliver our vision, we have set the following five strategic objectives for primary care:

The following sections describe in more detail the models of care that we intend to develop in relation to each of these strategic objectives or 'asks' of primary care. In delivering these models, we will also address other aspects of our vision, such as ensuring that primary care in Berkshire West is sustainable, cost-effective and an attractive place to work, and that patients value the services provided and are supported to access them appropriately.

☐ Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector.

Innovative solutions will be employed to address the challenges currently facing the primary care sector. We will work to address the current workforce crisis at all levels; improving pre-registration training provision, building job satisfaction through more rewarding continuing professional development processes and working to improve retention of mid-career GPs and others by working with practices to offer more varied and flexible employment opportunities. We will also look to maximise the potential of new roles in primary care including Physicians' Associates, practice-based pharmacists and enhanced administrative and care co-ordination roles. Alongside this we will work to enable practices to respond to demand in new ways (see Strategic Objective 3) and to ensure that the expansion of the role of primary care is accompanied by an increase in primary care investment (see Strategic Objective 2).

Digital systems are the foundation upon which we will build a modern, efficient and responsive primary care sector. Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers and patients, is a key means by which we will achieve a sustainable primary care sector. GP IT systems sit at the heart of primary care technology facilitating and recording thousands of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and recently begun offering online transactions, such as appointment bookings, repeat prescriptions, and online access for patient to their GP- held records.

In a challenging financial environment, IT services must not only improve the quality of care through enhancing the patients' experience of services, but also enable the practice to realise efficiency benefits and reduce administrative burden. Building on the solid foundations which are already in place in primary care, our vision is to support practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.

It is our view that addressing workforce challenges, capitalising on IT developments and providing the models of care set out under the following strategic objectives will require primary care providers to operate at scale. Single-handed and small practices are unlikely to be able to provide the range and breadth of services described, or to manage the communication and relationships required to operate as part of a truly integrated system. Similarly, investment in IT and premises infrastructure is only likely to be cost effective where it serves a large patient population. There is evidence that encouraging the emergence of larger providers is likely to result in sustainable provision and improved outcomes for patients going forward.[3] Our intention is therefore to make commissioning and investment decisions that support the development of providers with at least 6,000 registered patients, and ideally 10,000 or more and to support collaborative working between practices through federations, networks and joint provider organisations.

☐ Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting

Existing community-based care pathways, such as that developed for diabetes, will form the starting point for expanding similar models to other specialties. Virtual outpatient clinics and community-based consultants will become the norm and technology will be used to maximum effect to support self-care and timely liaison between clinicians working in primary and secondary care. Where additional services are commissioned from primary care, the associated investment must follow.

The implications of providing a greater range of services in primary care must be fully factored in to all levels of workforce and premises planning. Larger primary care providers will be better placed to take on expanded roles, and in any case collaboration will be required so that specialists can interface across practices.

[3] *Securing the future of general practice: new models of primary care,* Nuffield Trust and the King's Fund (2013)
Primary Care: Today and tomorrow – Improving general practice by working differently, Deloitte Centre for Health Solutions (2012)
Breaking Boundaries – a manifesto for primary care, NHS Alliance (2013)
Primary Care for the 21st Century, Nuffield Trust (2012)
Does GP practice size matter?, Institute of Fiscal Studies (2014)

☐ **Strategic Objective 3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.**

Primary care will take a more active role in working to improve the health of the population it serves. Practices will provide more primary and secondary prevention services, linking extensively with public health, the voluntary sector and other community organisations to prevent ill-health and promote wellbeing.

Primary care should work as part of the broader health and social care system to avoid patients going into crisis and requiring emergency admission and to support effective discharge from hospital. Proactive care planning for patients with complex needs who may be at risk of admission, including those in care homes, will be further developed to become a core element of primary care provision. A multidisciplinary approach will be taken, with technological solutions supporting the sharing of care plans so that patients only have to 'tell their story' once and different organisations can work together in a co-ordinated way to meet their needs.

Supporting the broader health and social care system will be our programme for information sharing and connecting the health and social care system - "Connected Care". This has already commenced with the introduction of static interoperability, between practices and Out of Hours primary care, and through a proof of concept testing process connecting GP practices with secondary care. Over the next 18 months all practices will join a wider dynamic programme connecting, practice systems with acute, community and social care systems.

☐ **Strategic Objective 4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.**

New technology will enable practices to respond to demand in different ways such as through greater use of the telephone, online consultations and email advice systems (with safeguards in place to ensure these systems are used appropriately), as well as technology enhanced mobile working. Patients

will be supported to self-care where appropriate and to access the right services at the right time. Community pharmacy may also play a greater role in providing advice, guidance and treatment to patients.

The CCGs will encourage practices, especially smaller ones, to work together to respond to same day requests for appointments in a different way, thereby freeing up time for staff to focus on planning care for at-risk patients and on managing long-term conditions. The potential for NHS 111 to take an enhanced role in managing same day demand will be explored through the forthcoming Thames Valley procurement of an Integrated Urgent Care Service. . This service will work with GP practices, out-of-hours, the Walk-in Centre, A&E and other services to meet the needs of people with urgent care needs in accordance with the *Safer, Faster, Better* guidance.[4]

We will continue to commission extended hours primary care provision, reflecting NHS England planning guidance. Currently we are focussing on improving patient experience through bookable appointments to be provided across an extended weekday and at weekends by single providers or through collaborative models. Additional capacity will also continue to be commissioned at peak times in-hours over the Winter period thereby working to reduce demand on other services, particularly A&E.

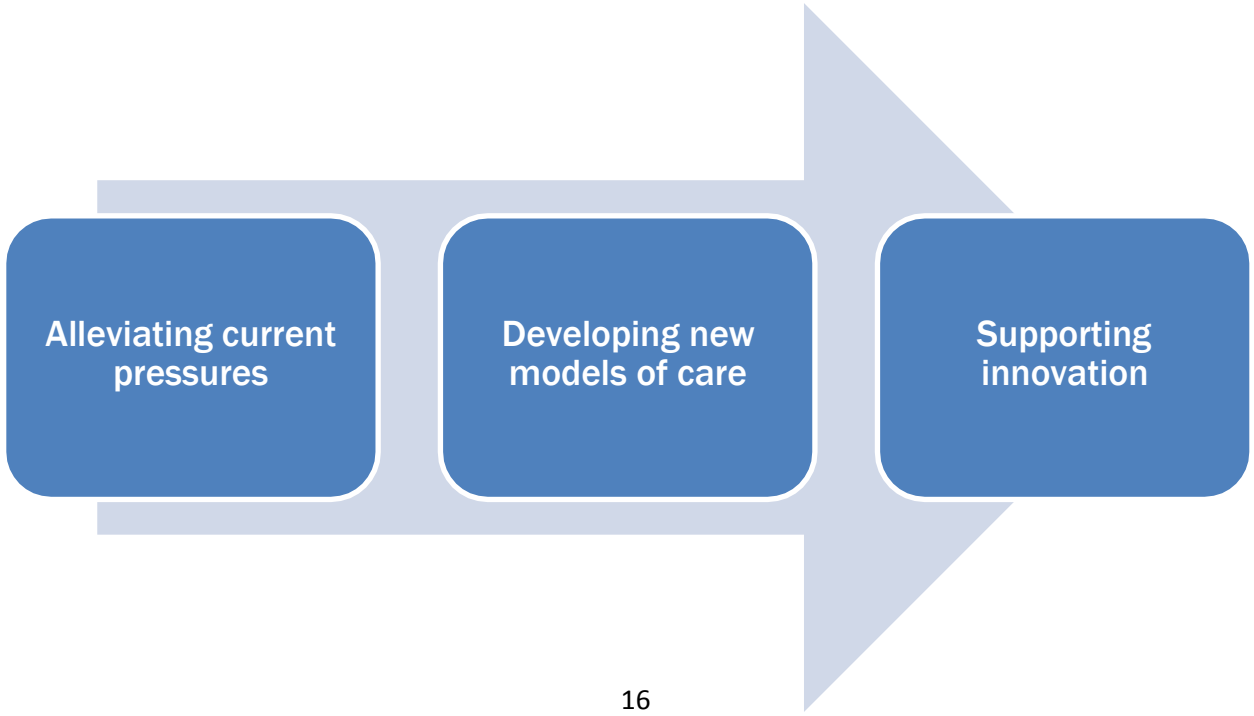
☐ Strategic Objective 5: Making effective referrals to other services when patients will most benefit

The CCGs will work with practices through peer review and closer liaison with secondary care colleagues to reduce unexplained variation in levels of referral between practices and individual clinicians, thereby ensuring that patients are referred to the services that will most benefit them and at the most appropriate stage of their treatment. Support to referrals will be strengthened through the further development of the DXS system which works as an integral part of practice clinical IT systems, providing a directory of services and detailed information on agreed care pathways and local referral criteria.

[4] *Safer, Faster, Better: good practice in delivering urgent and emergency care,* NHS England, 2015, www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

5. Our Strategic Approach

The previous sections have highlighted that there is a real opportunity to build upon the high standards of provision in Berkshire West to create an expanded primary care sector as described in our Strategic Plan, but also a risk that this may be stifled by the pressures currently facing general practice. This strategy therefore takes a maturation approach whereby we will first look to support primary care providers to address the very real challenges they are facing, moving on to develop the new models of care described above, with a view to the primary care sector as a whole then being in a position to take a lead role in the new integrated model of care we envisage operating in Berkshire West by 2019. The outline workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan. The following section also describes how co-commissioning arrangements agreed with NHS England will underpin the delivery of this Strategy.



a) Workstreams to deliver our Strategic Objectives

Strategic objective for primary care	Anticipated workstreams
1: Addressing current pressures and creating a sustainable primary care sector.	Four sets of inter-related workstreams will aim to achieve sustainability for the local primary care sector: Workforce: • Supporting new roles in primary care, e.g. Physicians' Associates, prescribing pharmacists, AHPs. • Development of generic primary care nurse role allowing greater flexibility around where care can be delivered. • Expansion of training provision and development of network of multi-professional training practices or training hubs. • Offering student nurse placements in primary care • Shared training programmes for existing staff including clearer career structures for e.g. practice nurses and administrative staff. Greater sharing of training with other providers / across disciplines. • Development of new roles around care planning and signposting e.g. care navigators, voluntary sector co-ordinators and enhanced case co-ordinator roles • Supporting collaborative approaches to recruitment and development of shared posts and portfolio careers. Shared locum arrangements. • More effective linking with HETV and other appropriate organisations around workforce planning and training provision. • More co-ordinated appraisal system and CPD arrangements including a structured programme to support nursing revalidation and care certification for HCAs. • Further development of specialist nursing and medical roles working across networks of practices. IT (see also other objectives, below): • Maximising potential of self-care/triage apps • Installation of new servers, single domain and Wi-Fi in every practice. This is the biggest upgrade to GP Practice IT in 20 years and will mean Berkshire West has one of the most advanced infrastructures in the country.

	Premises: • Systematic planning for population growth • Maximising investment from housing developments • Maximising investment from national funding streams such as Primary Care Infrastructure Fund • Planned investment in premises which will enable delivery of the models of care described in this document, including underpinning the 'upscaling' of provision as described above. Organisational form: • Developing commissioning approaches that support upscaling and collaborative working between practices e.g. through federations, networks and joint provider organisations as a means of sustaining primary care by achieving economies of scale and efficiencies. This work will also put providers in a better position to take up opportunities to develop an extended role for primary care as part of the broader new model of care we are looking to develop in Berkshire West.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Roll out of existing community-based pathways to other specialties e.g. respiratory medicine. • Development of virtual outpatient clinic model and more community-based clinics • Expansion of community-based consultant roles, building on community geriatrician and community diabetologist models • Improving interface between primary and secondary care clinicians, e.g. greater provision of advice via Choose and Book, E-referral and telephone , using technology to share information between clinicians electronically, psychiatrists to visit practices to jointly review patients with complex mental health needs. • Further developing GP specialist roles working across clusters of practices, including in mental health in order to support effective management of mental health conditions within primary care. • Risk stratification of patients with long-term conditions • Supporting self-care for patients with long-term conditions including through technological means, remote monitoring and wearable devices.

3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Systematic development and implementation of risk profiling and multi-disciplinary care planning for Over 75s and patients with complex health needs, including improved sharing of information and using technology to further develop the role of patient in managing their care. Anticipatory Care CES to support face-to-face care planning, medications review and sharing of information through Adastra. Improving care planning and systematic annual reviews for patients with chronic mental health needs and improved processes to review the health needs of patients with a learning disability. GP job plans to include care planning as a core component of their regular workload. • Improving interface between primary care, community services, social care and the voluntary sector through the development of neighbourhood clusters based around groups of GP practices. • Building on existing preventative work e.g. targeted screening for diabetes and exercise schemes to focus more strongly on promoting health and wellbeing amongst the practice population and ensure such work is appropriately reflected in contractual arrangements. • Supporting practices to better meet the needs of carers, including through provision of Directory of Services enabling improved signposting to voluntary sector support. • Supporting information sharing between practices and the wider health and social care system through the Berkshire West Connected Care Programme.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Practices to be commissioned to offer more bookable appointments in the evenings/early mornings and at weekends , reflecting NHS England planning guidance. Additional capacity to be commissioned at peak times in-hours to support system resilience. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Empowering patients to self-care where possible and to access services appropriately. • Enabling practices to utilise technology to maximum effect to offer patients different options for accessing services e.g. via telephone or online consultations or through email advice portals. • Supporting practices to work together to respond to same-day demand in new ways thereby meeting urgent needs more efficiently and freeing up capacity for other aspects of primary care. To include considering shared call handling / urgent clinic models and potential role of NHS 111 in triaging in-hours calls. • Further exploration of potential role of community pharmacy as part of urgent care response. • Establishing clearer standards and expectations of practices with regard to capacity based on review of current local practice and patient feedback.

	• Supporting practices to deliver care through mobile working • Ensuring availability of a same day primary care response to patients in mental health crisis as part of the implementation of the local action plan linked to the Mental Health Crisis Care Concordat.
5: Making effective referrals to other services when patients will most benefit	• Roll-out of the DXS system and the associated service directory to be available to all practices and to include information on voluntary sector provision and carer support. • QIPP scheme to reduce variation in referrals and non-elective admissions where there is no clinical rationale behind this. To be delivered through peer review, CCG support and education sessions.

b) Co-commissioning

Co-commissioning will be a key enabler for the delivery of this Strategy. The CCGs were approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities are discharged through the Joint Primary Care Co-Commissioning Committee (JPCCC) which follows national guidance with regard to the scope of joint commissioning, governance requirements and arrangements for managing conflicts of interest. We are now considering taking on fully delegated responsibility for commissioning primary medical services from 1st April 2016.

Co-commissioning will enable CCGs to influence the content and management of core and enhanced primary care contracts (within national parameters) and to align the commissioning of primary care with the organisations' broader commissioning intentions, thereby enabling care to be commissioned across the full extent of the patient pathway, and supporting the move towards place-based budgeting as set out above.

The following opportunities and priorities have been identified:

- Through co-commissioning we will work to further develop our local definition of what high quality primary care looks like, what level of service patients can expect and our anticipated outcomes, linking back to the strategic objectives set out in this document. We will then work to reflect this in contractual arrangements including our APMS service specifications and an associated 'contract plus' offer for GMS and PMS practices. This will ensure that providers are paid the same rate where they provide the same level of service irrespective of the type of contract that they hold and that

patients have access to a defined level of service even though delivery models may vary. This 'contract plus' offer will be funded initially through re-invested PMS premium funding but we are committed to working towards aligning funding levels for all practices by also commissioning it from practices that do not have access to this source of investment.

- We will take every opportunity to ensure that the commissioning decisions we make support delivery of strategic objectives for primary care, for example with regard to future practice changes. This will include encouraging 'upscaling' and collaboration between practices as we have recognised that this will best support delivery of the models of care described in this Strategy.

☐ Linked to this, the CCGs will look to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will be based upon CCG-led peer support and sharing of best practice but will also incorporate arrangements to identify and address any ongoing performance issues. By risk mapping practices on an ongoing basis we will also be able to ensure that we offer targeted support to practices experiencing particular issues and work with those most under pressure to develop plans for the future. We will also support practices to prepare for CQC inspections and to make improvements to services where these are identified as a result of visits.

☐ Over time we will explore the potential to re-design QOF and directed enhanced services to better reflect local needs. We will look to consolidate enhanced services commissioning to reduce the bureaucracy associated with managing multiple contracts.

☐ We will work to develop a strategic plan for primary care premises, ensuring that investment is targeted towards premises developments which will underpin delivery of the new models of primary care described in this strategy and that the system is able to respond proactively when national funding streams are made available

c) CCG-level planning

The four GP Councils have engaged with the development of this strategy through a series of workshops and the strategic objectives set out in this document reflect the collective output of these sessions. However whilst the associated workstreams (see above) will span the four CCGs, it is envisaged

that implementation arrangements will vary between them, reflecting their differing population needs and the nature of their existing models of primary care provision.

The following table shows how the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key priorities identified for each CCG area. .

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Supported self-care and automating QOF. Using technology to support self-care for long-term conditions; enabling patients to enter their own data and reminding them to attend for appointments. • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients and work that can only be done by them personally, thereby ensuring they are working 'at the top of their licence'. • Multidisciplinary training environment; learning environment enabling everyone in the team to	• Increase use of pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD, utilising where possible existing programmes run by local trusts • Maintain and develop Nurse and HCA training programme • Explore the potential of the voluntary sector in supporting the needs of patients • Continue to explore the potential of collaborative working arrangements across practices and proactively plan for future provision of services for patients in North	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies. These 'clusters' would share back office functions and provide services jointly where appropriate, thereby creating efficiencies and improving choice for patients. • Part of PMS premium funding to be used to establish Transformation Fund to support service developments aimed at achieving sustainability. Plan for use of this funding being developed across	• Discussions have focussed on how practices can work together to deliver efficiencies. Federated and networked models have been considered but progress to date has been focussed on the neighbourhood cluster model. This would enable practices to work together to create back office and other efficiencies, to jointly address workforce issues and to improve the interface with other services. There will be three clusters, each serving a population of 40-60,000 people. • Key priority is planning for population growth – it is estimated Wokingham will

	benefit from shared expertise, to keep up to date and to develop their skills. • Development of pharmacist roles. • Consideration to be given to collaborative recruitment approaches. • Fostering collaboration between practices as providers to achieve economies of scale and support sustainability.	Caversham. • Work with BHFT to pilot new ways of working across Community Nursing and Practice Nurse services • Support GP manpower by encouraging retiring GPs to join 'bank' arrangements	three key areas of IM&T infrastructure, workforce and premises. • Premises strategy being developed in line with clustering approach.	have an additional 32,000 residents by 2022.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Direct access diagnostics and new ways of working with consultants to reduce the need for referrals. • Geriatrician to support GPs in looking after care homes • Care closer to home using West Berkshire Community Hospital as a hub. Outpatient appointments provided in community by community-based consultants. Aspiration to develop West Berkshire Community Hospital as a Diagnostic and Treatment Centre, avoiding the need for travel to acute hospitals.	• As lead commissioner of urgent care across Berkshire West we will review patient pathways to identify potential improvements in a community setting.	• Hubs (likely to service around 25,000 patients) would have critical mass to offer new services and interface with consultants and others in new ways.	• Clusters would have critical mass to offer new services and interface with consultant and others in new ways. There will be opportunities to further develop GP specialist roles working across practices and linking in new ways with secondary care clinicians.

	• Supporting collaboration between practices as providers to expand the range of services offered by primary care.			
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Continuity when it matters – implemented by an extended team(see above) led by an accountable clinician such as a GP or community matron, focussing on patients from whom continuity is important and could affect clinical outcomes (e.g. those with complex multi-morbidity, enduring mental illness or requiring end-of-life care). • Further development of anticipatory care planning • Personal recovery guide jointly with social care and the voluntary sector.	• Explore potential of care planning for other long-term conditions • Work with Public Health to increase preventive work, including increasing physical activity rates through Beat the Street . • Ensure that all practices utilise the Living Well pilot and evaluate its benefits • Consider the benefits of introducing a specialist GP role for care home patients and the frail/elderly • Instigate/participate in coproduction opportunities as they arise	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. •	• Cluster Care planning working with Care Navigators • Social workers, housing officers etc. would be aligned to clusters enabling services to work together more effectively to meet people's needs in the community. • Voluntary Sector Co-ordinator role being piloted. This role supports practices to signpost patients to the range of voluntary sector services available to them, with a particular focus on reducing social isolation amongst older people and supporting new families moving into Wokingham.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring	• Different length appointments according to patient need • Extended Hours capacity commissioned in accordance with patient need and linked	• Ensure that 80% of practices provide extended access • Discuss and agree how an integrated urgent care system could best support practices to manage patient	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• Considering collaborative approach to call handling and meeting on the day demand through cluster-based urgent care centres. Over time this should ensure GPs have the

urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	to the Out of Hours provision • Exploring triage to prioritise appointments using a combination of the most experienced clinician and enhanced reception roles • Develop collaborative working to deliver improved access across the 11 practices, including exploring potential of shared call handling through hubs (involving GPs, minor illness nurses and Nurse Practitioners) and/or a locally-agreed protocol and thresholds for on-the-day appointments. This would give GPs in practices more control over their day and enable them to focus on most complex or those needing continuity (see above). • Exploring utilising technology to obtain succinct patient history prior to appointments and more use of Skype and telephone consultations.	demand for urgent care	• Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	capacity to focus on providing proactive, community-based care for patients with higher levels of need.

5: Making effective referrals to other services when patients will most benefit	• Directory of Services likely to be delivered as part of DXS system. To facilitate direct access to other professionals (e.g. IAPT, Social Services, Physiotherapy) and to incorporate a service navigation function which will support patients and practices to access the services they need.	• Ensure practices are aware of voluntary sector services available to support their patients and that these are included on DXS • Continue to provide practices with referral benchmarking information at practice visits and as routine every quarter • Through regular reporting of referral benchmarking information reduce levels of variation between practices.		• DXS information will improve co-ordination of care and links with voluntary sector. • Considering how to reduce variation in referral rates for some time and now working with other CCGs on BW QIPP scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2015-16 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £0	QOF and Aspiration £0	PCO Admin £0	GP Drugs Payments £0	GP Premises £0	Misc. Items £0	Enhanced Services £000s	Total Area Team £0
Newbury and District	8,624	1,141	448	914	1,143	339	850	13,459
North and West Reading	8,997	1,170	427	386	1,109	315	669	13,073
South Reading	12,750	1,101	418	74	1,781	300	849	17,273
Wokingham	11,191	1,549	596	442	1,954	438	1,108	17,278
Total	**41,562**	**4,961**	**1,889**	**1,816**	**5,987**	**1,392**	**3,476**	**61,083**

CCG budgets relating to primary care in 2015-16 are set out below. In addition to GPIT funding of £1.3m and established enhanced services funding of £0.5m, we have used the £5 per head funding to support the care of the Over 75s (as per the 2014-15 planning guidance) to invest in an Anticipatory Care CES designed to significantly advance our third Strategic Objective (Managing the health of a population in partnership with others). In addition, we have invested £2.5m to extend GP access into the evenings and weekends as well as at peak times in-hours over the Winter period, following a £1m pilot scheme in 2014-15. These two schemes combined equate to an 8.4% increase in investment in primary care. Further information about current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	Enhanced Access £000	Other Enhanced Services £000	GPIT £000	Total CCG £000
Newbury and District	576	576	101	299	1,552
North and West Reading	560	560	116	279	1,515
South Reading	643	643	94	352	1,732
Wokingham	722	722	187	406	2,037
Total	**2,500**	**2,500**	**498**	**1,336**	**6,836**

In addition, the CCG is responsible for commissioning the Westcall Out-of-Hours service provided by the Berkshire Healthcare NHS Foundation Trust. For 2015-16, £5.02m was spent on commissioning this service.

Further investment in primary care may follow where it is identified that this will result in overall cost savings in other parts of the CCGs' commissioning budgets. It is also intended however that the strategy will be delivered through the re-alignment of existing commissioning budgets to better reflect the strategic objectives described. As set out in the above co-commissioning section, key priorities will include:

- Development of an APMS offer that reflects our strategic objectives with KPIs aligned to local patient need.
- Redesign of QOF to reflect local priorities.
- Ensuring infrastructure investment furthers our strategic aims.

- Re-investment of released PMS premium funding in service models which reflect this strategy, and with the intention of aligning GMS and PMS funding levels in the future. The mechanisms for doing this require further discussion.

7. Delivering the Strategy

The following table summarises the types of outcomes that would result from successful delivery of our strategic objectives for primary. More specific outcomes will be developed as we move towards implementation and progress against these will be monitored by the Joint Primary Care Co-Commissioning Committee. The Committee will also take oversight of the delivery of the Strategy as a whole and will assess progress and review this document periodically in the light of developments in co-commissioning and the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	High-level outcome measures
1: Addressing current pressures and creating a sustainable primary care sector.	• Decreased number of vacancies within practices, application rates improved as primary care is seen as a more attractive place to work. • Staff satisfaction improved • Smaller practices working in federation or other collaborative forms from fewer/better premises serving populations of at least 6,000 but ideally 10,000 patients • No new contracts awarded to single-handed practitioners or practices that would have a list size of less than 6,000 • All primary care premises are fit-for-purpose • Primary care workforce diversified to include pharmacy, nursing, therapists and physicians associates. • Multidisciplinary and joined up arrangements in place for pre-registration training and continuing professional development • Practices receive a consistent level of funding for a defined level of service so that patients in Berkshire West have access to a consistent level of provision. PMS premium funded reinvested to support delivery of models of care set out in this Strategy. • Services provided outside of core contracts are resourced appropriately. • Contractual arrangements simplified and bureaucracy reduced. • Quality standards are maintained or improved and unexplained variation between practices is addressed.

	• Patients supported to access practices online. • Patients are supported to use self-care apps • Opportunities to interface with patients in different ways e.g. through telephone and Skype consultations, patient history-taking apps etc. are utilised to full effect thereby enabling practices to manage growing demand.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• New care pathways in place between primary and secondary care resulting in fewer visits to hospital. • Improved control of long-term conditions e.g. reduced HbA1C level etc. • Positive feedback from patients with long-term conditions
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Directory of Services in place supporting improved links with the voluntary sector and increased signposting to voluntary services. • Risk stratification actively used to identify and develop care plans for at-risk individuals thereby reducing avoidable hospital admissions • Preventative work in place with lower risk groups. • Improved patient feedback regarding co-ordination of care • Interoperability achieved and services therefore able to share information with patient consent
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Bookable GP appointments available from 8am-8pm in the week and at weekends, reflecting NHS England planning guidance • Improved patient survey results / Friends and Family test responses • Practices utilising shared call handling and/or on-the-day provision where appropriate to create efficiencies which free up time for GPs to focus on more complex patients.

5: Making effective referrals to other services when patients will most benefit	• Unwarranted variation in referral and non-elective admission rates reduced for specialties where this has been identified. • DXS utilised to maximum effect to support delivery of agreed care pathways and signposting to other services as appropriate.

8. Next steps

Delivery of the strategy will be overseen by the Joint Primary Care Co-Commissioning Committee. The Committee will develop an implementation plan which will form the basis of a strategic programme for primary care for which it will take lead responsibility, identifying and working to mitigate risks as appropriate. It will also link extensively with the CCGs' other Programme Boards around specific workstreams.

Further engagement with patients around the workstreams set out in this Strategy will be undertaken as part of the CCGs' broader Communications and Engagement Strategy. A communications plan will be developed for each workstream which will aim to build upon the useful information already obtained with regard to many of the themes covered in this Strategy document.

Appendices

Appendix 1: Patient Engagement

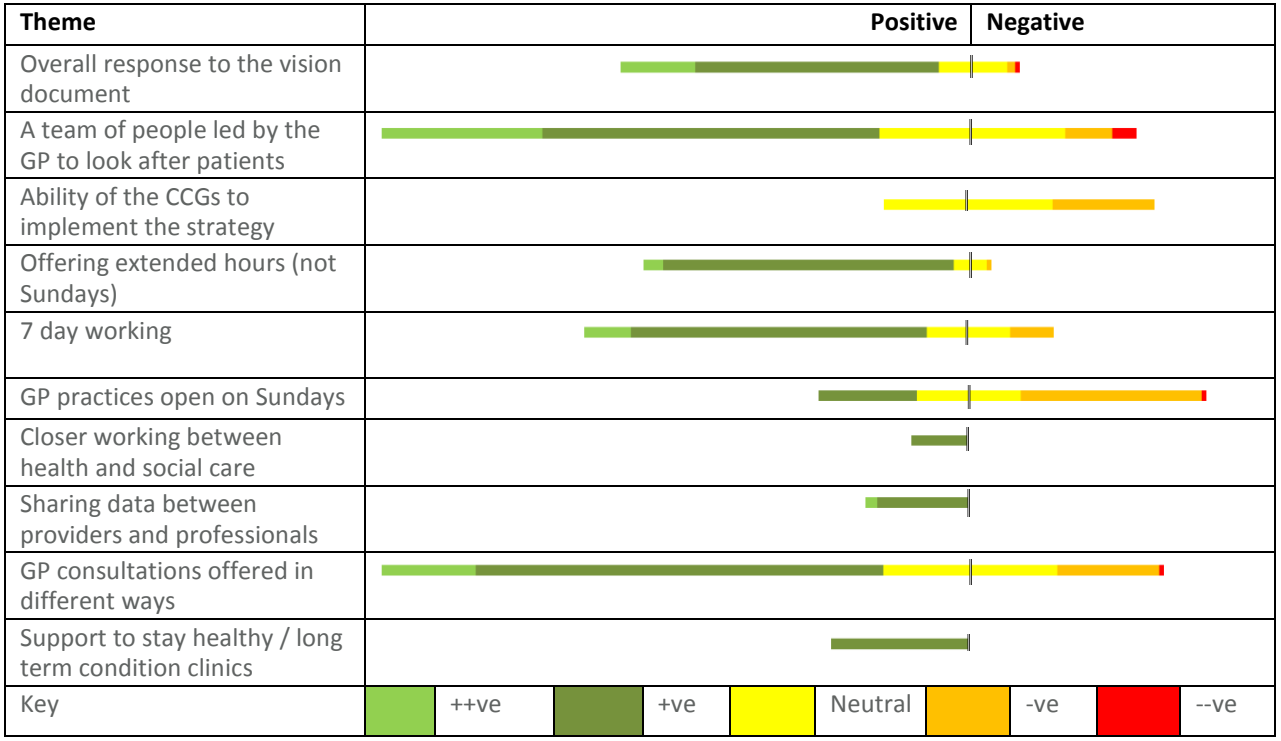
The CCGs' engagement with the public regarding primary care began with the Call to Action events held in 2014. Since this time we have developed an ongoing dialogue with individual Patient Voice Groups and have raised primary care through broader engagement work undertaken as part of the CCGs' overall Communications and Engagement Strategy.

Following production of the draft of this Strategy, a patient-facing version was produced which has formed the basis of an intensive programme of engagement over the last few months, as well as an online survey. Specific engagement has also been undertaken in relation to the three APMS contracts we are procuring in 2015-16 which has elicited useful feedback in terms of our overall direction of travel for primary care commissioning. The following table summarises key recent engagement events and activities which have had a primary care focus:

Date	Event
November 2014	Reading 'GP Question Time' event
March 2015	Wokingham 'Have your say'
March 2015	Newbury Primary Care Event
July 2015	North and West Reading CCG annual meeting and engagement event
August to December 2015	Primary Care Strategy survey live on Berkshire Health Network.
September 2015	South Reading CCG annual meeting and engagement event
July – August 2015	NHS111 engagement
September 2015	APMS engagement: Circuit Lane
September 2015	APMS engagement: Priory Avenue
October 2015	APMS engagement: Shinfield Medical Practice
October 2015	Woosehill Surgery PPG survey
October 2015	Wokingham PCS engagement event
November 2015	South Reading Patient Voice PCS engagement
November 2015	Trinity School, Newbury – sixth form
November 2015	Mailout to more than 70 residential care homes across Berkshire West to promote feedback on the strategy

The heat map below demonstrates the key areas of interest for patients reading the vision document and responding to the online survey. The length of line indicates the volume of responses and the bar colour the sentiment of respondents. The heat map below represents 988 statements (83% of total). The map tells us that respondents were overwhelmingly positive towards the ideas set out in the vision document, welcome a wider range of professionals offering care and are enthusiastic for new styles of GP consultation – including Skype video consultations.

Some online respondents were concerned about our how we will implement the vision. We intend to address this concern through the implementation plans that we put in place to support delivery of the Strategy which will include mechanisms for identifying and addressing risks to delivery. Seven day working was seen as beneficial overall, though many of those in favour felt that Sundays should not be used for routine appointments.



The following table summarises the key themes identified through all of the engagement activities we have undertaken as part of the development of this Strategy (including the online consultation above), and how these are reflected in the final document. A full report is available on the CCG websites.

Key themes identified through patient engagement	How these are reflected in Strategy
People want better co-ordination of care between organisations so that they only have to tell their story once and they are supported to navigate the care system. There is a view that this should be achieved through shared IT system, and should include working to avoid admissions from care homes. Patients with the most complex needs should be prioritised and plans should be in place to ensure they do not have to explain their illness at every consultation. These patients most value continuity of care. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care but respondents did recognise the potential of wearable technology.	• Integration with social care and other services through neighbourhood clusters will improve communication between organisations • Patients identified as being most at risk of admission will have care plans in place which can be accessed by other organisations through Adastra. This will incorporate specific care planning processes for care home residents. • Berkshire West Connected Care Programme currently allows the out-of-hours GP service to access patients' records with their consent. Over time this will be expanded to cover A&E and other organisations. Data confidentiality and information governance are key considerations in all initiatives being progressed under this programme. The programme aims to ensure that technology is used to maximum effect to support patient consultations and enhance patients' overall experience of care. Other elements of our IT programme will ensure we maximise the potential of self-care and monitoring apps and gathering data from wearable devices. • Wokingham and NWR CCGs are piloting voluntary sector co-ordinator roles which will support patients to navigate the system. Learning from these pilots will be shared across Berkshire West.

Whilst satisfaction with opening hours is generally high, a significant proportion of patients would like their GP practice to be open more in the evenings and at weekends, or would be willing to access another surgery at these time. Others felt that good access in-hours with an ability to see their own GP was as important as extended opening. There is limited appetite for Sunday opening. Appointments could also be different lengths according to patient need. People are generally positive about accessing their GP surgery in new ways (email, Skype etc) although some said they would need support to do this and others expressed concerns that it must be voluntary and shouldn't substitute face-to-face care.	• We will commission practices to provide extended hours opening across weekday evenings and on Saturday mornings, in some cases working together to maximise access for patients. Maintaining and expanding capacity in-hours, particularly at peak times, will also be a focus. • Under the 2015-15 GP contract, practices are required to offer patients a named GP responsible for co-ordinating their care. This now applies to all patients; addressing the concerns expressed by some around this previously being limited to Over 75s. • GP practices will make best use of technology such as email, texting, online services such as repeat prescriptions and consultations. Information and support will be available for patients from practices to enable then to get started. • NHS 111 will play an integral role for patients to be able to access the NHS locally out of hours.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately. There is general support for the concept of the NHS 111 service.	• We will use new technology to support self-care as a component of care for patients with long-term conditions. • Our Communications plan will provide more information about self-care for minor ailments and appropriate usage of A&E and other services. • As part of implementing the Strategy the JPCCC will work with the Urgent Care Programme Board to consider the future potential of NHS 111 to respond to on-the-day demand for primary care services.

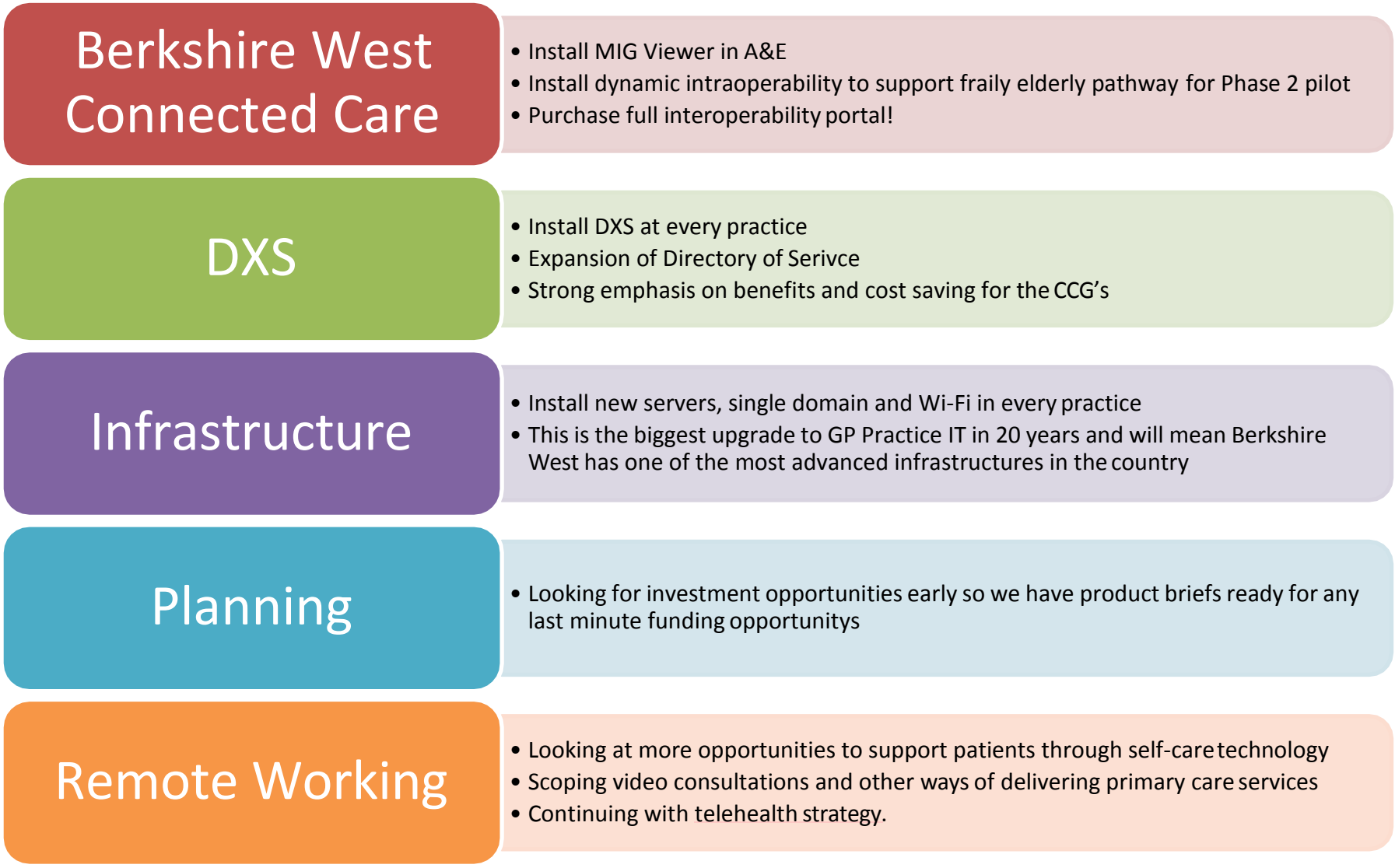
People believe that the voluntary sector could play a greater role in meeting peoples' needs, although there it is important to assure the quality of the services offered and to fund these organisations appropriately. GPs need to be more aware of voluntary sector provision.	• Wokingham CCG are piloting a Voluntary Sector Co-ordinator role as part of their cluster working project. • We are working to improve signposting to voluntary sector provision for example through the Directory of Services linked to the new DXS system and through pilot roles such as the Voluntary Sector Co-ordinator in Wokingham. The provision of information about support to carers through this system is also being explored.
People identified the need for primary care to work with other agencies to support wellbeing and help prevent mental health issues. A particular focus should be ensuring that young families have access to the support they need. Young people were also identified as a priority group. Staff should be supported to understand the needs of particular groups attending practices such as those with learning disabilities. GP practices should work with and support carers; signposting them to other services where appropriate.	• Our vision for primary care involves practices working at the heart of the communities they serve and with other agencies to prevent both physical and mental ill health and to work as proactively as possible to minimise the impact of illness. • Wokingham's pilot Voluntary Sector Co-ordinator role will have a particular focus on the needs of young families moving to the area. • Information on support services and organisations will be better available to practices through the DXS system (see above). Specific action will be taken to ensure GP practices support carers effectively. • We intend to continue to work closely with practices around continued professional development. This could include providing training around the needs of particular groups.
There is also a view that GP practices should routinely offer more information on the benefits of exercise and how to prevent diabetes and that young families need more support. It was recognised that practices should work in partnership with	• NWR and Wokingham GPs are promoting physical exercise through the 'Beat the Street' initiative. We have also commissioned practices to provide support to patients identified as being at risk of diabetes or in the early

other organisations to enable early intervention and prevention of more complex health issues. Some patients also indicated that they would welcome more general health advice and health checks.	stages of diabetes. Through this Strategy we will work with Public Health to further build the role of primary care in preventing ill health (see above).
It is recognised that practices will increasingly involve teams of different healthcare professionals, thereby widening the workforce. Patients feel that this is appropriate as they recognise that they do not always need to see their GP but do want to be assured that appropriate leadership arrangements are in place and there is clarity of roles. Most people were positive nurses and pharmacists in particular taking on enhanced roles. Generally people welcomed the idea of more services being available in their GP surgery from a mixed skill-set team and it was felt that this would also make primary care careers more attractive.	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners may increasingly become involved in the delivery of primary care, with a wider practice team working to support the specific needs of different groups of patients. We will support practices to diversify their teams with clear lines of accountability and information for patients about different professional groups. • The Strategy describes how practices will in future work differently with secondary care consultants and other professionals to provide a much broader range of services in primary care.
People want more planned care for long-term conditions, including continuity of care where possible. Having substantive staff in post supports this.	• The CCGs recognise that continuity of care is important to patients with complex needs and where this improves outcomes practices should endeavour to provide this. Where different professionals are involved in a patient's care, care planning and better sharing of information will improve communication between them (see above). GPs are also now required under their contracts to identify a named GP for all patients. • The Strategy sets out a range of actions that will be taken to support practices to address difficulties in recruiting to substantive posts. We recognise that recruitment is a key challenge for the primary care system and that we need to work as proactively as possible to address this.

People want to understand how the Strategy will play out in rural areas and for smaller GP surgeries which may not be able to host multidisciplinary teams.	• The CCG elements of the Strategy above starts to set out how the vision might be implemented at a local level. This may include smaller practices working together to provide some services, thereby ensuring that patients in all areas have access to the same range of services and supporting practice sustainability. Practical considerations such as a rurality would be taken into account in any such approaches.

We recognise that engagement with the public should be an ongoing process. Going forward we intend to undertake specific engagement around key workstreams resulting from the implementation of this Strategy. This will be in addition to any formal consultation required with regard to service changes. We will build upon our successful approach of combining public meetings, focussed discussions with key groups and online publications and surveys to engage with as broad a range of patients as possible; also working through established mechanisms such as our Patient Voice and PPG Forum groups, the Berkshire Health Network and practice-based participation groups. If you would like to know more please contact the CCGs Patient and Public Involvement Team on 0118 9822709 (8.30am-4.30pm, Monday-Friday) or on ppiteam.berkshirewest@nhs.net. Information about how to register with the Berkshire Health Network is also available at https://www.healthnetwork-berkshire.nhs.uk/consult.ti/system/register.

Appendix 2: IM&T investment plans



READING BOROUGH COUNCIL

REPORT BY NORTH & WEST READING CCG OPERATIONS DIRECTOR

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**10**
TITLE:	**URGENT & EMERGENCY CARE REVIEW – PROGRESS REPORT**		
LEAD:	**MAUREEN MCCARTNEY**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**HEALTH**	**WARDS:**	**ALL**
LEAD OFFICER:	**MAUREEN MCCARTNEY**	**TEL:**	**0118 982 2917**
JOB TITLE:	**N&W READING CCG OPERATIONS DIRECTOR**	**E-MAIL:**	**m.mccartney@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report is to inform the Health & Wellbeing Board about the "*Urgent and Emergency Care Review*" and the action being taken at national and local level in implementing this.

Urgent and emergency care is one of the new models of care set out in the NHS Five Year Forward View (FYFV). "*The Urgent and Emergency Care Review*" (referred to as the *Review)* proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

"…. the NHS will begin joining up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, 7 days a week…" . Simon Stevens, Chief Executive of NHS England.

The patient offer for 2020 will be:

i. A single number – NHS 111 – for all your urgent health needs
ii. Be able to speak to a clinician if needed
iii. That your health records are always available to clinicians treating you wherever you are (111, 999, community, hospital)
iv. To be booked into right service for you when convenient to you
v. Care close to home (at home) unless need a specialist service
vi. Provide specialist decision support and care through a network

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the report and the action being taken nationally and locally to deliver the objectives of the *"Urgent and Emergency Care Review".*

2.2 The Board is also asked to note how the local health and social care system currently works in partnership to support good patient flow around the system, which is critical is to the success of our local urgent and emergency care system. Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges. it is therefore imperative that the Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust and Reading Social Care work closely together to prioritise activities aimed at achieving the earliest possible discharge of patients from hospital.

3. BACKGROUND

Urgent and emergency care is one of the new models of care set out in the Five Year Forward View. The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

In November 2013 the NHS set out its vision for a future system which is safer, sustainable and capable of delivering care closer to home, helping to avoid unnecessary journeys to, or stays in hospital unless clinically appropriate. The *Review* is harnessing an approach of developing urgent and emergency care networks which rely on different parts of the system working together to create a completely new approach to delivering urgent care for physical and mental health.

The vision is simple:

- Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families;
- Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

To do this requires change across the urgent and emergency care system by:

- Providing better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital
- Ensuring that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

4. IMPLEMENTATION OF THE REVIEW

Since November 2013 NHSE has been working with stakeholders from across the urgent and emergency care system to translate the *Review* vision into practical pieces which, when combined, will deliver the objectives of the Review. This is being done through a Delivery Group (which includes NHS England, Monitor, Trust Development Agency, Public Health England and CCGs), the majority of the work being led directly by NHS England, and the rest by system partners such as Monitor and Health Education England.

Implementing this vision is not a 'quick fix' but will instead be a transformational change that will take several years to effect. Delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do. It is also

recognised that this transformation will be occurring in the face of significant demand pressure in general practice, primary care and across the wider health and social care system.

Urgent and Emergency Care Networks: The establishment of Networks, which give strategic oversight of urgent and emergency care and connect all services within the urgent care system, is a key enabler for delivering the objectives of the *Review*. Nationally twenty-four networks have been agreed and are now meeting, bringing together representatives of their constituent system resilience groups (which locally we call the Berkshire West Urgent Care Programme Board), CCGs, acute receiving hospitals, ambulance services, NHS 111, mental health, community healthcare, local authorities, community pharmacy, Local Education and Training Boards and other key stakeholders.

Urgent and Emergency Care Route Map: NHSE has developed a route map that outlines high-level expectations to support networks and System Resilience Groups in prioritising their delivery of the Review. This route map (attached as Appendix A) signals the supporting products on offer from NHS England and partners alongside the expectations on networks and SRGs. This route map will be supported by a detailed implementation plan.

As an initial step in the route map, a stocktake of urgency and emergency care services has been undertaken by NHSE to understand:

- all urgent and emergency care services that are available in the network;
- the commissioning and service arrangements for these services; and
- Operational hours, case mix and facilities.

New commissioning standards for integrated urgent care: Published in October 2015 these support commissioners in delivering a fundamental redesign of the NHS urgent care 'front door'. The standards are built on evidence and what is known to be best practice.

Currently around the country, commissioners have adopted a range of models for the provision of NHS 111, OOH and urgent care services in the community. In most cases, however, there are separate working arrangements between NHS 111 and OOH services, and a lack of interconnectivity with community, emergency departments and ambulance services. This no longer fully meets the needs of patients or health professionals. The new commissioning standards required commissioners to take necessary steps to ensure that functionally integrated 24/7 urgent care access, treatment and clinical advice services are commissioned.

Urgent and Emergency Care Vanguards: Nationally eight urgent and emergency care (UEC) vanguards have been selected to accelerate delivery of the objectives of the *Review,* acting as test beds for new urgent and emergency care initiatives including clinical decision support hubs, a focus on liaison psychiatry, implementing a new payment model and testing new systemic outcome indicators.

Potential New Payment Model: NHS England and Monitor have published "*Urgent and emergency care: a potential new payment model"*, which sets out potential payment options and provides detailed guidance on how a new payment approach might be implemented in practice. This will be tested in Vanguard sites.

Workforce: NHSE is also working with Health Education England to review the UEC workforce and make sure that it is fit for purpose and there is a clear supply of staff to meet future demands. This includes describing and ensuring the supply of a trained alternative workforce

out of hospital and on the interface with emergency departments to support the urgent and emergency care agenda. This involves the development and promotion of roles such as: physician associates, paramedics, pharmacists, and advanced clinical practitioners. They are working to enhance the role of paramedics to support the ambulance service as a treatment service, in line with the paramedic evidence-based education project (PEEP) report. A new single accredited curriculum for paramedics is in development., which academic institutions will begin to deliver from 2016 and will markedly enhance skills for paramedics to 'hear and treat', 'see and treat', as well as to work independently and in wider urgent care, such as primary care, as an alternative to A&E and ambulance conveyance.

Support Products: To support Networks and SRGs, a range of enablers have been, or are being, developed. These include:

- *Safer, Faster, Better: good practice in delivering urgent and emergency care* (published September 2015).
- *Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services*.
- *Integrated Urgent Care Commissioning Standards* (published October 2015)
- *Ambulance service: new clinical models*.
- *Improving referral pathways between urgent and emergency services in England*.
- New system-wide indicators and measures.
- *Urgent and emergency care: a potential new payment model* (published August 2015).
- Standards for commissioning of 24/7 mental health crisis services
- Information technology that supports patients and clinicians to access the right care.
- *Urgent and emergency care: financial modelling methodology*.
- Local capacity planning tool.
- Self-care initiatives.

"'Safer, Faster, Better': good practice in delivering urgent and emergency care: a guide for local health and social care communities":

https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

This important document was published on 1st September. It is one of a suite of documents and tools being produced to support local health systems to implement the recommendations of the Review. It sets out design principles drawn from good practice which have been tried, tested and successfully delivered by the NHS in local areas across England. It's clear that the guide should not be taken as a list of instructions or new mandatory requirements and that implementation should be prioritised taking into account financial implications and local context.

Current position in relation implementation of the *Review* at a local level

Thames Valley Urgent and Emergency Care Network: The Network which is chaired by Dr Annet Gamell, Chief Officer of Chiltern CCG had its inaugural meeting on 21st October 2015. Berkshire West CCGS are represented by Dr Andy Ciecierski, Cathy Winfield and Maureen McCartney. There is also Director of Adult Social Services representation. It meets on a monthly basis and is responsible for delivering key elements of the Urgent and Emergency Care Route Map at Appendix A.

Procurement of a Thames Valley wide Integrated NHS 111/ Urgent Care Service: In 2014 CCGs in Thames Valley agreed to work together to commission the NHS 111 service. Following publication of the new commissioning standards for integrated urgent care in Oct 2015 it was agreed that this work should move to the commissioning of an integrated NHS 111/Urgent Care Service for Thames Valley. This will offer patients who require it immediate access to a wide range of clinicians, both experienced generalists and specialists. This model will also offer advice to health professionals in our local communities, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. Within Thames Valley this new integrated service will have access to a wider range of dispositions including, but not limited to, ambulances, 24/7 primary care, pharmacists, mental health professionals and midwives. Clinicians will be supported by the availability of clinical records through IT system interoperability which will support robust clinical decision making and the direct booking of appointments into other services. This work is being led by the Berkshire West CCGs and it is expected that the new service will be in place by April 2017.

How the local Health and Social Care System works in partnership to support implementation of the Review and the earliest possible discharge of patients from hospital : The Berkshire West Urgent Care Programme Board which has senior level representation from health and social care is responsible for ensuring whole system resilience, the planning and delivery of urgent and emergency care improvement at a local level and delivering the NHS constitutional target that 95% of patient should be admitted, transferred or discharged within 4 hours of their arrival at A&E. There is a system wide strong focus on partnership working to achieve joint discharge planning and timeliness of post-acute transfer with the principle of a "pull" system of discharge.

The Board is supported in its work by an Urgent Care Operational Group made up of key operational managers which meets monthly. Its purpose is to deliver operational improvements and tackle blocks and issues along the urgent care pathway.

Both the Board and the Operational Group have been successful in helping establish and maintain very good working relationships between partner organisations.

The Board has begun the process of assessing where we are as an urgent care system against the best practice listed in "Safer Faster Better" and this was the subject of an Urgent Care Programme Board workshop on 17th December. The outputs of this will also help inform the further development of our local strategy for urgent care services.

Good patient flow around the system is critical to the success of our local urgent and emergency care system. The general principles of good patient flow are described in the document. Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges so it is really important that our local health and social care communities prioritise activities aimed to achieve the earliest possible discharge of patients. Numbers of patients on the *"Fit List"*, i.e. those clinically fit to leave the hospital who are awaiting onward health and/or social care are reviewed on a daily basis and are currently the subject of a daily system wide telephone conference call chaired by the CCG Urgent Care Lead/On call Director. The Berkshire West Health and Social Care system has set itself a target that each Local Authority and the Community Health Trust should have no more than 5 patients on the list with each having an average length of stay on the list of no more than 5 days.

The Discharge to Assess Scheme which provides 12 discharge to assess beds at the at the Willows in Hexham Road, Northumberland Avenue and which is funded by the Better Care Fund is an important enabler in helping our local system achieve this target. The CCGs have also recently provided system resilience funding to support Reading social worker presence at the hospital at weekends and this too is proving successful in expediting timely discharge of patients.

Urgent and Emergency Care Route Map (1)

Appendix A

NHS England

1 System Architecture	Deliverable	Supporting product publication	Timescale for implementation
Establishing U&EC Networks	• Principles of governance to support membership structure and ToRs • Stocktake of U&EC services by networks. • Support for overarching network U&EC plan agreed with regions; Networks to develop plans. • Networks to define consistent pathways for urgent care with equitable access	• Safer Faster Better published	• August 2015 • Nov 2015 • Jan 2016 • Dec 2016
Identifying and piloting system wide outcome metrics	• Development of a single framework for measuring and reporting on system outcomes (nationally, with local trial) • Toolkit to support measurement	• 2016 • 2016	• 2017
Develop a new payment system	• Local payment model for pilot sites, taking into account mental health outcomes (Monitor) • Roll-out of shadow testing model in pilot areas / vanguards • Implementation nationally	• August 2015 – Local payment example produced by Monitor • Sites to be confirmed as part of vanguards	• April 2016 • April 2018
Enhanced summary care record	• Urgent and emergency care services to have greater electronic access to records including summary care record, end of life care records, special patient notes and mental health crisis plans (including patient held plans)		• June 2016
Workforce	• Underpinning work programme with Health Education England		• Ongoing
Accessing the UEC system			
2 **Accessing the UEC System**	• Align or novate existing NHS111 and OOH contracts to deliver a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model **or** plan for migration to full integration when contracts allow • New NHS 111 commissioning standards published nationally • Guidance on the establishment of clinical hubs (within standards) • Guidance on specialist advice (within standards) • Clinical triage of green ambulance calls established (within standards) • Development of Access to Service Information (next generation of the DoS) for timely access to service information and the technical links with ERS to support booking across the urgent care system.. • Deliver the Clinical Triage Platform (next generation of clinical decision support) to reflect an integrated urgent care system • NHS 111 online platform integrated into NHS Choices, with a clear expectation of digital first	• Oct 2015 • Oct 2015 • Oct 2015 • Oct 2015 • OBC March 2016 • OBC March 2016 • OBC March 2016	• Nov 2015 • TBD in local plans • TBD in local plans • TBD in local plans • June 2018 • June 2018 • December 2016

Urgent and Emergency Care Route Map (2)

	UEC Centres	Deliverable	Supporting product publication	Timescale for delivery
3	**Direct booking from 111** to urgent care centres	• SRG to drive adoption of and greater provision of direct appointment booking into UCC, ED and primary care. National support, local delivery		• Ongoing
	Local Directory of Services (DoS)	• Networks / SRGs to ensure maintenance of local DoS	• N/A	• Ongoing
	Ensure **UCCs provide a consistent service**	• Specification to support move to ensure local care centres are consistently called Urgent Care Centres and offer consistent service	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2016 – 2020 in line with local plans
4	**Paramedic at Home**			
	More patients more appropriately dealt with at **home by paramedics**	• Clinical models to support increase in proportion of calls to 999 dealt with via 'see and treat' • Referral pathways set between paramedics and other providers	• Guidance on clinical models – Q3 2015 /16 • Guidance on referral pathways –Q3 2015 /16	• In line with local implementation plans
	Ensure a **clinically appropriate response by ambulance services to 999**	• Ambulance dispatch on disposition evaluated and national standards reviewed • Implementation of recommendations	• Final recommendations by Autumn 2016	• Autumn 16 – Spring 17
5	**Emergency Centres and Specialist Services**			
	Analytical activity	• Analysis of non-elective activity and capacity	• Capacity and demand tool Aug-Dec 2015	• Aug- Dec 2015
	Hospitals providing 7 day services across ten identified specialties	• Compliant with 7DS clinical standards as per NHS Standard Contract • All urgent network specialist services compliant with four mortality clinical standards on every day of the week	• Standard Contract	• Ongoing
	Discharge from hospital	• DTOC plans submitted • Support packages for CCGs and SRGs	• 7DS standards to include discharge planning and consultant review of patients.	• 2017
	Ensure patients are treated in the right networked facilities	• Facility specifications and advice to support designation of network facilities and definition of consistent care pathways	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2017

Urgent and Emergency Care Route Map (3)

6 Mental Health Crisis	Deliverable	Supporting product publication	Timescale for delivery
An access and waiting time standard will be introduced for 24/7 crisis assessment	• Access and waiting time standard for 24/7 crisis assessment response (community based) • Improving access to health-based places of safety following Section 136	• Introduced 16/17 • Prepared in 15/16	• 2017/18 implementation • 16/17 introduction
An access/ waiting time standard will be introduced for liaison mental health services in A&E	• Access and waiting time standard for assessment by liaison mental health services in A&E (as per 7DS standard)	• Introduced 16/17	• 2017/18 implementation
An assessment standard for those with Mental Health needs	• A next generation clinical assessment system specifically designed to support mental health needs and crisis. This will cover Multi – channel access; i.e. voice, face to face/ telephone and online.	• Prepared in 16/17	• 2017/18 implementation
7 Supporting Self Care			
Personalised care and support planning	• People who are most at risk of needing emergency care, including mental health crisis care, will have the option of a person centred care and support plan	• Guidance published January 2015	• 2017
Support for self-management	• Supported self-management guide published with Age UK based on 11 principal risk factors associated with functional decline in older people living at home • Consensus statement and practical guidance to support commissioners and Fire and Rescue Services to use the 670k home visits carried our annually by the FRS to keep people 'safe and well' • Tools to support implementation of key approaches, including self-management education and peer support e.g. commissioning tool / economic model underpinned by a clear evidence base • A series of innovative tools / training packages to support culture change for health and care professionals • An overview and assessment of the levers, barriers and enablers of person-centred care – and a set of recommendations for the future	• Published January 2015. Revision in October 2015 • October 2015 • Beta versions from Spring 2016 • Final products to be developed nationally Autumn 2016	• 2015/16 publication. 2016/17 integration within frailty pathway approach • Implementation support from 2015/16 • Implementation in line with local plans 2016 / 2017
Personalised Health Budgets	• CCGs are developing their local personal health budgets offer and will be introducing PHBs beyond NHS continuing healthcare in line with the 2015/16 planning guidance.	• National roll out from April 2015	• Implementation in line with local plans 2017

Urgent and Emergency Care Route Map (4)

8 Independent Care Sector	Deliverable	Supporting product publication	Timescale for delivery
Local Commissioning Practice	• Guidance to CCGs and LAs on working with the ICS, including encouraging joint winter and future capacity planning • Clarification guidance to be made available on Continuing Healthcare processes – within Quick Guide: Improving Hospital Discharge • Guidance for acute trusts on how to support self-funders (choice protocols)	• Guidance published Q3 2015/16 • Guidance published Q3 2015/16 • Guidance published Q3 2015/16	• Q3 – Q4 2015/16 • Q3 – Q4 2015/16 • Q3 – Q4 2015/16

Better use of care homes	• Guidance for best practice clinical input required for care homes:
	  • Quick Guide: Clinical input into care homes
	  • Phase II – long term models including cost benefit analysis
	• Quick Guide: Identifying local care home placements
	• Quick Guide: Technology in care homes
		Guidance published:
		• Q3 2015/16
		• 2016/17
		• Guidance published Q3 2015/16
			• Q3 2015/16 – Q4 2016/17
			• Q3 – 2015/16

Improving Hospital Discharge	• Quick Guide: Improving Hospital Discharge to the care sector • Quick Guide: Sharing Patient Information	• Q3 2015/16	• Q3 2015/16
Better use of care at home	• Quick Guide: Better use of care at home	• Guidance published Q3 2015/16	• Q3 – Q4 2015/16
9 **Primary Care**			
Improved access to primary care	• 18 million people will have access to weekend and weekday appointments, and/or different modes of accessing general practice • Routine access to GP appointments at evenings and weekends	• Phase 2 PMCF • Primary Care Infrastructure Fund	• March 2016 • 2020
Increased role for pharmacy in urgent care	• Pharmacy access to Summary Care Record • Seasonal Influenza Vaccination Advanced Service for community pharmacy • Quick Guide: Extending the role of Community Pharmacy in UEC	• Refreshed guidance Autumn 2015 • Q3 2015/16	• Autumn 2015-17 • Autumn 2015 • Q3 – 2015/16
Improving oral and dental	• Quick Guide: Best use of unscheduled dental care services	• Guidance published	• Q3 – 2015/16

health		Q3 2015/16	249

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**11**
TITLE:	**READING INTEGRATION UPDATE**		
LEAD COUNCILLOR:	**Cllr Graeme Hoskin / Cllr Rachel Eden**	**PORTFOLIO:**	**Health / Adult Social Care**
SERVICE:	**Adult Social Care & Health**	**WARDS:**	**All**
LEAD OFFICER:	**Melanie O'Rourke**	**TEL:**	**0118 9374053**
JOB TITLE:	**Head of Adult Social Care**	**E-MAIL:**	**Melanie.o'rourke@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out to provide the Health and Wellbeing Board (HWB) with an update of integration in Reading to date. This will include a presentation from Mark Sellman regarding the status of one particular project that spans the West of Berkshire, namely Connected Care. The report will also highlight the requirements for the 2016-17 Better Care Fund (BCF), and ask the board to agree to a process for sign off.

2. RECOMMENDED ACTION

2.1 for board members to acknowledge Better Care Fund progress to date.

2.3 for the HWB to acknowledge the requirement for the 2016-17 BCF submission and the requirements for sign off. Including:
- delegated authority to the chair of the HWB to sign off the quarterly report,
- delegated authority to the chair of the HWB to sanction the first 2 submissions of the 2016/17 Better Care Fund (see 6.2 for detail)
- agree to an extra ordinary HWB (either virtually or in person) to sign off the final submission

2.4 for the HWB to be appraised of the purpose and status of the 'Connected Care' project, including its financial implications

3. POLICY CONTEXT

3.1 Integration between health and social care means the joining up of Health and Social Care services to create better outcomes for those who need support. This approach responds to the well documented difficulties individuals experience such as having to repeat their circumstances multiple times and a lack of coordination between professionals which can cause confusion and delays in care.

the BCF is also a response to the reality that with an increase in those who require support (demand) and a reduction in overall investment into health and social care means that we have to '*do things differently'.*

3.2 Integrated services are a key national and local driver for health and social care services, with the BCF being one of the key drivers to enable delivery. It should however be noted that not all elements of integration are included in the Better Care Fund E.G. developing the workforce through the Generic Care Worker role, and the work across the system to determine a local model through the Frail Elderly Pathway, which originated from the Kings Fund. It should be encouraged to ***not*** restrict opportunity to integrate to BCF elements only.

3.3 The Autumn statement reinforced the government's intention to continue to integrate with the Better Care Fund moving into a second year. This report later goes on to describe the timescales and requirements for the year 2 submission.

3.5 The schemes that have constituted the BCF in 2015/16 are:

Reading specific:

- Discharge to Assess
- Neighbourhood Clusters
- Whole system, whole week
- Improved GP access

Schemes which span the whole of the West of Berkshire are:

- Hospital at Home (now known as RRAT)
- Care Home project
- Connected Care
- Health and Social Care hubs

The key performance indicators for the BCF and their performance to date has been illustrated in table (1):

Table (1)

Target	Baseline 2014/15	Performance 2015/16
Achieve the target of no greater than a 3.3 % increase of Non Elective Admission (NEL)		14%
A reduction of those who are fit to go from hospital (no more than 5 people	8.57 *	4.85 *
A reduction of the amount of time people who are fit to leave hospital are still in hospital (to no more than 5 days)	14.84	9.07
A reduction in those formally reported as a Delayed Discharges from hospital (DTOC)	11,966	12,355 Reduction of 3.5%

*(based on average between April 15 – Oct 15)

Table (2) illustrates which schemes intended to support which performance indicator.

Table (2)

	Hospital at Home BCF01	Care Home BCF02	Connecting care BCF03	Time to decide BCF04	H&SC hubs BCF05a	Neighbour teams BCF05b	Improved GP access BCF05c
Growing population	●	●	●	●	●	●	●
Rise in non elective care	●	●					
Increasing A&E attendances		●				●	●
Delayed transfers of care				●		●	●
Increasing pressure on social care			●	●	●		
Inequity of access throughout the week	●	●			●	●	●

4. INTEGRATION UPDATE:

4.1 The BCF has now been in place for 10 months. The Reading Integration Board provides the local governance for the Better Care Fund. During this first year to the board has taken two opportunities to review the progress of **Reading** schemes. Both meetings had membership from key board members including; health (South Reading & North & West Reading CCGs), Finance

(CCG), Berkshire West 10 SRO, RBC Social Services representatives, Healthwatch Reading, Berkshire Healthcare Foundation trust, Royal Berkshire Hospital and Reading Voluntary Action.

The first workshop was held in August 2015, to look at operational blockages and in year improvements.

A further workshop was held in December 2015. The meeting also received an update on the Hospital At Home project which has now been revised into a new Rapid response and Treatment Service for care homes.

4.2 Utilising the national BCF self-assessment toolkit, the two local schemes were evaluated for 15/16 and recommendations made for 2016/17.

5 UPDATE ON LOCAL SCHEMES

5.1 By undertaking the self-assessment toolkit we were able to measure the success of schemes within their first year. It has enabled the key stakeholders to identify the key imperatives / schemes to take us into the second year.

5.1.1 Discharge To Assess

The Discharge To Assess (DTA) has shown to be a very successful scheme despite the early difficulties in recruiting staff to the scheme. The scheme has enabled individuals to make decisions about their long term care needs outside of the hospital setting, and has evidenced good examples of where people have been able to return to their own home or to extra care housing rather than residential care.

To provide some context to this service:

126 people were admitted to the Discharge to Assess scheme from Royal Berkshire Hospital. Table (3) illustrates the outcome for each of the people using the scheme.

Table (3)

Outcome of Discharge to Assess intervention	Number of people
Returned to their home	78
Self-discharged	2
Moved to extra care sheltered accommodation	3
Moved to residential care	6
Returned to hospital after a further period of illness	19
Admitted to Prospect Park Hospital	1
Moved into nursing care	2
Still within the service	13
Passed away	2

The average age of the individuals was 78 years, with the average length of stay on the schemes being 21 days.

5.1.2 Whole System, Whole Week

Access to health and social care services 7 day per week has improved during the first year of the BCF. Now 9 surgeries in North and West Reading, and 15 surgeries in South Reading, are open with extended hours or during the weekend. Social work presence in the hospital has also been in place to ensure that assessments and discharges are not restricted to Monday – Friday.

5.1.3 Neighbourhoods Clusters

The four Neighbourhood schemes in Reading have been in place for varying lengths of time dependent upon their point of commencement.

These are:

- Social prescribing
- Living Well
- Case Coordination
- Right For You

Two of the four, (Social Prescribing and Living Well), were initiatives commissioned by the CCG prior to the BCF 2015/16 submission already in progress at the time of the initial Better Care Fund and it was agreed to follow the success of these alongside the two specific to BCF.

The evaluation session evidenced some good initial findings through these schemes but a need to greater coordination between health and social care for each scheme.

Although not part of the BCF, we have seen an increase in our rapid response work in the community. This is where the re-ablement team respond, within 2 hours to people who at home and at risk of a hospital admission. The health and social care services work intensively with the individual to ensure that their care needs in this acute phase are well managed.

5.2 Update on West of Berkshire schemes.

5.2.1 The Rapid response and Treatment Service for care homes, has been born out of the evaluation of the Hospital at Home service which was in our initial submission. The conversion of the scheme to concentrate on people who live in care homes, aims to reduce the number of admissions into hospital and help people return quicker where they have needed a stay in hospital.

5.2.2 You will hear later in this item progress for the Connected Care project, which is working on issues of information governance and IT solutions to enable more coordinated and speedier care.

5.2.3 The final imperative relates to customer / patient satisfaction. We would like to develop this further in consultation with Healthwatch to ensure that we gain a meaningful understanding of the personal impact of each scheme.

5.2.4 The review also highlighted a number of areas of development and learning which we wish to build on in to the second year. This includes our ability to

measure the impact and outcomes of the schemes, including user satisfaction; and having adequate project support to be able to oversee all projects and mobilise development of the schemes and their reporting.

6 BETTER CARE FUND 2016/17 (including governance requirements).

6.1 As part of the Autumn Statement published in 2015, the government made the decision to continue with a BCF into 2016/17.

At the time of writing this report the technical guidance to enable the completion of our plans had not been published. This includes the key areas that the local system will be measure against. The recently published NHS planning guidance makes it clear that the BCF should focus on reductions of unplanned admissions and improved performance of Delayed Transfers of Care.

6.2 However, the Better Care Fund taskforce has issued timescales:

08 February 2016	high level objectives submitted
Mid-March*	First draft submission
Mid-April *	Final version submitted

**date not confirmed at the time of this report being completed.*

For the 8th February 2016 submission, officers are requesting the authority of the HWB Chair to provide sign off for this submission to ensure that we can achieve the deadline set down by NHE England.

These are challenging timescales and will require concentrated efforts across Health and Social Care officers and stakeholders.

The final submission to NHS England will require sign of by the Health and Wellbeing Board. We do not know the date for this, but the HWB need to be mindful that the next HWB is scheduled for Friday 18 March 2016, which might be outside of the submission deadline.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 Safeguarding and protecting those that are most vulnerable

Providing the best life through education, early help and healthy living

Remaining financially sustainable to deliver these service priorities

8. LEGAL IMPLICATIONS

8.1 As part of the arrangements to provide integrated services, it is necessary to have a S75 agreement (NHS Act 2006). This was carried out for the present year's activities, and will require a review, amendment and sign off to reflect the new plans.

9. FINANCIAL IMPLICATIONS

9.1 Revenue Implications

The report sets out an over view of the state of the BCF for 15/16 and initial planning for 16/17. The quarterly returns for 15/16 have shown progress but currently there is expected to be a small overall underspend on the programme.

The key issue for 16/17 is the financial pressures faced by both the CCGs and the Council. Whilst the system is awaiting the formal technical guidance for 16/17 the major issue is that whilst the overall BCF funding for 16/17 will be at the same level as it was for 15/16, the fund will need to cover £5m of existing CCG spend and therefore "new schemes" that were funded in 15/16 will need to be reviewed to determine how services will need to be designed to fit the new funding envelopes.

9.2 Capital

Within the BCF there is capital funding for Social care capital and DCGs. This is expected to continue to be funded as per 15/16

9.3 Value for Money

The services being delivered as part of the 15/16 program are being evaluated and as part of this a determination will be made around the effectives of the schemes and their VFM.

9.4 Risks

Both the CCGs and the Council are faced with significant funding issues going into 16/17 and beyond. The need to move £5m of existing CCG expenditure into the BCF for 16/17 will cause potential significant issues to deliver and unless sensible solutions can be found to service deliver with these BHCFT services included this could results in partners with the BCF not being able to agree a programme for 16/17.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 January 2016**	**AGENDA ITEM:**	**12**
TITLE:	**READING HEALTH AND WELLBEING STRATEGY – NEXT STEPS**		
LEAD COUNCILLOR:	**Councillor Hoskin**	**PORTFOLIO:**	**Health**
SERVICE:	**Public Health**	**WARDS:**	**Borough-wide**
LEAD OFFICER:	**Dr Andrew Burnett**	**TEL:**	**0118 937 3623**
JOB TITLE:	**Interim Consultant in Public Health Medicine**	**E-MAIL:**	**andrew.burnett@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide a headline summary to the Reading Health and Wellbeing Board (Board) on proposals for the next steps to produce the next Reading Health and Wellbeing Strategy. The report builds on progress to date from the current strategy and follows the action plan summary report presented at the October 2015 Board meeting.

2. RECOMMENDED ACTION

2.1 The Board is recommended to agree the next steps proposals presented in this report and to give authority for key partners to deliver them as part of the strategy development.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 gave local authorities a much stronger role in shaping services and improving the health of local people. Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments and Health and Wellbeing Strategies through Health and Wellbeing boards. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process. Boards need to work with a wide range of local partners and the community beyond the Board's membership. Working with local partners will support Boards to undertake a thorough and broad assessment of local needs by using the evidence and expertise these partners can provide.

3.2 The Reading Health and Wellbeing Board will need to set out an agreed, integrated health and well-being strategy for the Borough, replacing the existing strategy that runs to March 2016. The strategy will include locally determined priorities and will be used to inform the commissioning of services by the local Clinical Commissioning Groups and the Council. It will also encompass our obligations under the Care Act to have a well-being strategy.

3.3 Local authorities also have opportunities to use their new public health responsibilities and resources to put health and wellbeing at the heart of everything they do, thereby helping people to lead healthier lives, both mentally and physically, including:

- Including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- Investing public health grant in high-quality public health services to reduce incidence of preventable illnesses such as cardio vascular disease, some cancers, diabetes and other priority debilitating diseases
- Encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- Supporting local communities – promoting community renewal and engagement, development of social networks
- Focusing on wellness services that address multiple needs
- Making effective and sustainable use of all resources, using evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent the best possible value for money for the local population.

4. THE PROPOSAL

4.1 Current Position:

The Health and Wellbeing Strategy's vision for a healthy Reading is underpinned by 4 key goals:

- Goal One: Promote and protect the health of all communities particularly those disadvantaged: communicable diseases, immunisations and screening, BME groups
- Goal Two: Increase the focus on early years and the whole family to help reduce health inequalities: maternity, family support, emotional heath, domestic violence
- Goal Three: Reduce the impact of long term conditions with approaches focused on specific groups: self-care, carers, learning disability
- Goal Four: Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities: tobacco, drugs and alcohol, obesity

4.2 Stakeholder Engagement

We need to have a clear understanding of key health improvement priorities for all stakeholders that support the people of Reading. We propose to engage with stakeholders by jointly developing and conducting a survey to inform priorities. The survey will help to:

- seek views of members on what services are required for the people of Reading in the context of the full joint strategic needs assessment due to be considered by the health and well-bing board in March 2016
- clarify the local CCGs priorities and objectives to improve health and reduce health inequalities
- present the views of the voluntary community sector and local action groups
- demonstrate the priorities of internal and external colleagues

We will also make this available online to enable the public to make comments if they wish.

Findings from the survey will be used along with JSNA and primary care commissioning plans and the council's new well-being strategy to inform the production of a new Health & Wellbeing Board Strategy for 2016 and beyond. It is expected that 'prevention' will be a key message. The JSNA update summary, presented in October 2016, identified mental health, physical activity and cost of social care as key priorities. Emphasising the preventative message by encouraging local people to make healthier lifestyle choices will help to prevent and reduce incidence of the illnesses mentioned earlier and reduce the cost of providing social care.

There is an opportunity to engage with other Health & Wellbeing Boards across West of Berkshire. This could be useful in that we could identify potential shared health priorities that may delivered in partnership as some interventions are currently. Examples of these are; Health visitor and school nursing, smoking cessation services, breastfeeding and domestic abuse. It could be worth exploring further shared priorities and continued joint commissioning of preventative services where mutual benefits can be achieved.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The next step proposals above will support the development of ambitions and priorities for the next iteration of the Health and Wellbeing Board Strategy and the overall vision to improve the health and wellbeing of people in Reading. The new Strategy and accompanying action plan will be used to inform the commissioning of services by the local Clinical Commissioning Groups and the Council.

5.2 An accompanying Health and Wellbeing Strategy Action Plan will also be supported by the delivery of the requirement to conduct a JSNA to inform the Reading Health and Wellbeing Strategy and subsequent commissioning plans as set out in the Health and Social Care Act (2012). The next iteration of the Reading Health and Wellbeing Strategy will be based on a full Joint Strategic Needs assessment which we expect to be completed for the March Health and Wellbeing Board. We will be developing a plan and a process for the new Health and Wellbeing Strategy which will include details of how we will involve all stakeholders including the voluntary sector over the next few months.

6. EQUALITY IMPACT ASSESSMENT

6.1 Reading Borough Council must meet the Public Sector Equality Duty under the Equality Act 2010 and consideration will be given to this throughout any engagement activity.

The Health and Wellbeing Strategy will be developed with an awareness of inequalities of health and the JSNA will continue to be a key tool to support the identification of inequalities across the goals.

7. LEGAL IMPLICATIONS

7.1 The Health and Social Care Act 2012 gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Health and Wellbeing Strategy and to take account of the findings of the JSNA in the development of commissioning plans.

8. FINANCIAL IMPLICATIONS

8.1 On the 31 July 2015, the Department of Health (DH) proposed, by way of a consultation, its intention to make in-year savings of £200m from the Public Health Grant across all local authorities. RBC has responded to DH's consultation expressing its preference for DH to devise a formula to claim a larger share of the saving from local authorities that are significantly above their target allocation. Further cuts to the public health grant are proposed over the coming years that will impact on service delivery. Any cuts will need to be considered when prioritising future service commissioning activities. Any newly identified needs will have to be robustly-evaluated projects/services to help address needs identified in the revised RBC joint strategic needs assessment.

9. BACKGROUND PAPERS

None

READING BOROUGH COUNCIL

ADULT WELLBEING POSITION STATEMENT 2016

DRAFT FOR CONSULTATION

Foreword

We are pleased to present this Adult Wellbeing Position Statement, a framework for developing our services to meet our Care Act obligations and so prevent, reduce and delay care and support needs across the local population.

Reading Borough Council provides a great many services which support healthy independent living. These benefit the 'well' population as well as those who are at risk of needing care or who are living with established long term health conditions. This Position Statement sets out our approach particularly to supporting those residents who have current or emerging care needs, and supporting the unpaid or family carers who are helping to keep people well and independent. The Care Act gives us new responsibilities towards those who may need care or support, and our Adult Wellbeing Position Statement describes how we will fulfill these new responsibilities. Individual wellbeing is affected by a range of factors, and our approach recognises the impact of the places where we live, work and play as well as our health and social care provision.

The need to invest in preventative services to delay people's need for social care and health services is widely recognised as key to ensuring that care services are to be sustainable into the future. The challenge of reduced budgets alongside population growth means we need to achieve a significant shift in emphasis across parts of our service offer, and develop our understanding so that we can target our approaches ever more effectively. A major focus now is to identify, at the earliest possible stage, the most vulnerable people in our communities – those who are at risk of poor health and more likely to require social care. Reaching these residents must be a priority within programmes that promote people's capacity to maintain an independent lifestyle.

We are also committed to working better with our residents, and will be engaging service users, carers and others in developing our approach. We will continue to work with residents as we develop our analysis and plans so we ground our approach in the aspirations of the people of Reading. We will also continue to work with partners across health, social care, housing and other community services to offer a joined up approach to empowering people in Reading to live healthy fulfilled lives for longer.

The Position Statement will be accompanied by a high-level implementation plan for 2016-17, which will be refreshed in subsequent years and incorporated into our broader Health and Wellbeing Action Plan.

Rachel Eden
Lead Councillor for Adult Social Care

Graeme Hoskin
Lead Councillor for Health

Contents

	page
1. Introduction	4
2. The evidence base	9
3. The local context	13
4. Achieving our aims	21
4.1 Embed the wellbeing principle throughout the Council's functions	22
Creating a new focus on wellbeing	22
Developing a workforce for wellbeing	22
4.2 Ensure Reading homes support wellbeing	24
Housing Renewal Policy (private sector)	24
Home adaptations	24
Tackling fuel poverty	25
Home safety	25
homelessness	26
Housing options for people with care needs	27
4.3 Harness the assets Reading has to prevent care and support needs from increasing	28
Reading Sports and Leisure	28
Partnership working with other sports and leisure providers	29
Reading Museum	29
Library services	30
4.4 Empower people with care needs to self care and make positive lifestyle choices	31
Improve access to preventative health services	31
Putting emotional wellbeing on an equal footing with physical wellbeing	32
Promoting self care	32
New Directions	33
Reducing loneliness	34
Transport	36
4.5 Support people to prevent their care and support needs from increasing	38
Information & Advice Services	38
Assistive technology	40
Supporting carers	41
4.6 Promote a re-abling approach across care services	44
Changing the conversations we have with people who approach us	44
Re-ablement service	45
Home from Hospital support	45
End of Life Care	46
4.7 Ensure people with care needs and unpaid carers can access services that work well together to support people's independence	47

1. Introduction

Local authorities are facing challenging budget pressures, including increased demand across many service areas. We need to achieve a cultural shift so that our investment is increasingly directed at improving the wellbeing of Reading residents - that is, helping people to prevent ill-health and disability that is avoidable - rather than just treating the effects of poor wellbeing.

1.1 the national policy context

The Care Act (2014) brings in significant reforms to the care and support system, with a strong emphasis on improving independence and wellbeing. Similarly, the NHS Five Year Forward View (2014) sets out a new vision for health care, which brings the prevention of illness to the fore. Both documents highlight the importance of developing integrated models of care to achieve the changes needed for our care system to be sustainable into the future.

This drive towards more integrated care is taken forward through the Better Care Fund (BCF) initiative with local BCF plans in place from April 2015. The BCF transfers significant portions of NHS and social care funding (£3.8bn nationally for 2015-16) into pooled budget arrangements between local authorities and Clinical Commissioning Groups. The BCF includes a 'payment for performance' framework based on reducing emergency admissions to hospital. In addition, local BCF plans must set targets to reduce admissions to residential and care homes, demonstrate the effectiveness of re-ablement services, reduce delayed transfers of care, and show patient / service user satisfaction with care services.

1.2 the local policy context

In 2014, the Council articulated a new way of working with local people and across agencies in 'Capable Communites: a framework for change'. This sets out a commitment to achieving cultural change so that we can invest in tackling the causes of inequality rather than de premise that neither public services nor citizens have – on their own - access to all the resources necessary to deliver public goods. Social support within and between communities is recognised as being critical to physical and emotional wellbeing.

Also in 2014, the Council adopted a 3-5 Year Plan for Adult Social Care which:

- Puts Adult Social Care services within the context of the community and neighbourhood that the person who requires care lives within
- Sees service users who require support as being people who still contribute to their family and community
- Is centred on the person – not the convenience of service providers
- Promotes independence and focuses on what people can achieve

- Values and recognises the central part that carers play
- Safeguards people
- Promotes a good life and a good death

This set out a strategic direction for care in Reading which has, at its heart, practice that highlights re-ablement, recovery and rehabilitation and reduces dependency. Promoting wellbeing becomes key to managing demand under this model. The Council has committed to the effective development of universal services to include provision for people whose needs do not meet the threshold for specialist care services, drawing on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living at home safely.

'Narrowing the Gap' is Reading Borough Council's Corporate Plan for 2015-18 and sets the following priorities for the local authority:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Providing homes for those in most need
- Keeping the town clean, safe, green and active
- Providing infrastructure to support the economy
- Remaining financially sustainable to deliver these service priorities

1.3 the wellbeing principle

The Care Act creates a new statutory duty for local authorities to promote the wellbeing of individuals. This is a guiding principle for the way in which local authorities should perform all of their care and support functions. This includes individual assessments and support planning, but also the discharge of policy functions. The wellbeing duty is not therefore simply a framework for how to meet the needs of those who meet Adult Social Care eligibility criteria; it also directs how the Council should interact with local residents who have lower care or support needs, or who have a risk of developing care and support needs, in order to reduce the likelihood of their developing avoidable illness and disability.

Wellbeing as described in the Care Act is a broad concept. A holistic approach is necessary to understand individual wellbeing, drawing on the expertise which sits across Council services – and beyond. There are nine areas to consider, and these carry equal weight, although some will be more relevant than others to indivuduals at particular points in their lives.:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;

- social and economic wellbeing;
- domestic, family and personal;
- suitability of living accommodation;
- the individual's contribution to society.

1.4 the prevention duty

Alongside the wellbeing duty, the Care Act creates some other general duties on the local authority. The general duty of prevention is:

- to provide or arrange services that reduce needs for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs; and
- to have regard to the importance of identifying service users and carers in the authority's area, irrespective of their need for services.

The prevention duty rests with the local authority as a whole, and is not confined to the exercise of particular functions, e.g. those performed by the social care and public health services.

1.5 the duty to co-operate

The Care Act also introduces the duty to co-operate, which is both a general requirement to cooperate as well as a specific requirement in the case of individuals. The duty to co-operate applies whenever the local authority considers that the integration of services will:

- promote the wellbeing of adults with care and support needs or the wellbeing of carers with support needs in its area;
- contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or;
- improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

Partnership, cooperation and integration need to be key components of a local authority's strategic approach to wellbeing. Wellbeing cuts across local authority functions, and will require new partnerships which draw on the assets of other public sector organisations as well as those in the private voluntary and independent sector.

1.6 our vision for adult wellbeing

Our vision is to narrow the wellbeing gaps in Reading so that adults affected by care and support needs can access early help and enjoy healthy and fulfilling lives.

1.7 our aims

Our key aims are to:

- Embed the wellbeing principle throughout the Council's functions
- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

1.8 objectives

Our key objectives are summarised below in three inter-related categories, often referred to as the 'prevention continuum'.

Prevent (primary prevention) – i.e. avoiding poor health and the development of care and support needs

Reduce (secondary prevention) – i.e. limit the deterioration in individual wellbeing as a result of illness, disability or frailty

Delay (tertiary prevention) – i.e. avoid, or at least delay, the need for intensive support for as long as is safe and appropriate

Prevent	Prevent physical inactivity
	Prevent overweight and obesity
	Prevent loneliness
	Prevent the development of long term conditions where there are known lifestyle factors which put people at risk
Reduce	Reduce the risk of falls
	Reduce the negative impacts of unpaid caring
	Reduce reliance on formal care services
	Reduce the need for hospital admissions
	Reduce delayed transfers of care
	Reduce hospital readmissions after discharge
Delay	Delay the need for people to access social care support
	Delay permanent admissions to residential or nursing care
	Delay self-funders' recourse to public funds

1.9 scope

Although many of the interventions described in this document have the capacity to benefit the entire population, our principal focus is on:

- adults with current or emerging care needs
- unpaid carers with current or emerging support needs

Many universal services contribute to wellbeing for our target groups, and are touched on in this statement. However, the focus is on targeted interventions which are likely to have the greatest impact on preventing, reducing or delaying the need for care.

The 'reduce' and 'delay' objectives are most obviously focused on those members of our community who are intended to benefit from this position statement. As far as the primary prevention ('prevent') objectives are concerned, this statement will consider how approaches can be better targeted and tailored to reach the communities which are within scope.

This position statement builds on and complements several existing strategies as referenced above. It does not set out to replace these. Our Adult Wellbeing Position Statement is intended to promote a more cohesive approach to adult wellbeing across the local authority by bringing existing strands of activity together and identifying priorities to ensure we are as effective as we can be.

2. the evidence base

The evidence base on the outcomes of early intervention, prevention and enablement activities is relatively new and many of the research findings are largely indicative rather than conclusive. Establishing a clear causal link between targeted wellbeing interventions and improved health/care outcomes is a challenge. Developing local schemes against clear criteria will enable us to evaluate these and so develop our understanding of what works and where the benefits clearly outweigh the costs.

In 2008, the Department of Health published a review[1] of learning from projects designed to shift the focus of care onto preventative rather than reactive interventions. This drew particularly on the 'Partnerships for Older People Projects (POPPs)' programme and the 'Linkage Plus' programme. Although focused on promoting the independence and wellbeing of older people, the resulting guide was proposed as one which included transferable learning for other client groups. The interventions which were found to be most effective were:

- Age proofing mainstream services i.e. ensuring they are 'fit' for older people
- Having a range of wellbeing services
- Providing information for all
- Case finding i.e. identifying people who may be at risk
- Case co-ordination / service navigation
- Having a managed pathway for those not eligible for ongoing social care
- Building capacity in local neighbourhoods
- Providing re-ablement support
- Joint health and social care community support for people with long term conditions / complex needs
- Providing support to care homes
- Crisis response services / out of hours services
- Telecare and assistive technology
- Extra Care housing, and housing-related support
- A falls prevention programme
- Support for carers

Evidence from this review indicated that the savings effect seems to be most pronounced where interventions are specifically focussed on hospital avoidance, even though the individual projects may also improve people's quality of life, and be promoted as such (e.g. befriending, peer support). The POPPs evaluation in particular showed that practical help (e.g. small housing repairs, gardening, limited assistive technology and shopping) and exercise programmes increased people's health related quality of life by 12%. Hospital admission can occur when someone has reached breaking point because of a combination of circumstances. Simply fixing the main medical problem does not put the person back in a position to cope. The implication is that when an older or vulnerable person has had a

[1] *Making a strategic shift to prevention and early intervention: a guide* - DH (2008)

hospital admission they need a holistic discharge plan and associated action that addresses *all* the challenges they are facing to their wellbeing.[2]

Supporting people to manage their own healthcare has been found to improve health and quality of life, increase satisfaction and have a significant impact on use of services (visits to the GP can reduce by up to 69%; outpatient visits can reduce by up to 76%; A&E attendances can reduce by up to 54% ; hospital admissions and number of days in hospital may be halved; use of medicines and compliance is improved; days off work can be reduced by up to 50%). However, this requires long-term behaviour change, and initial training programmes for care providers and people with long-term conditions need to be followed up with ongoing support. Self-management support cannot be just an 'add-on' but needs to be embedded within care pathways and commissioning contracts.[3] Given that 30% of the population living with a long term condition account for 70% of health spending, increasing peoples' control and wellbeing through self management may be a cost effective way of working. However, the implication is that any self-management programme would need to be long-term and designed to sustain self-management over time.

The majority of people with learning disabilities make little or no use of formal care services. The extent to which they use social care services is dependent not on the learning disability as such but on additional physical, emotional and behavioural needs.[4] Interventions that address these early in their development can therefore reduce the need for adult social care and/or health supports in the future. Evidence points to a number of potentially effective preventative approaches which include annual health checks, early intervention with people who show development of behavioural difficulties, additional support to families / improving the health of carers, and increasing the opportunities for people to follow a healthy lifestyle.

Promoting the wellbeing of blind and partially sighted people can be effective in avoiding recourse to statutory care. This group has a greater than average propensity to experience depression and also to suffer injuries through falls. Blind and partially sighted people are more likely to live alone than are members of the general population and are more vulnerable to isolation. With early support more could lead independent lives, as described by the RNIB: *"[some] people just need equipment and someone to teach them right at the beginning, just to get them going, not somebody coming in all the time, like somebody who needs bathing and dressing."* [5]

Significant cost avoidance savings have been found for social care services from embedding enablement / re-ablement services into their operating models.[6] If care is required at the

---

[2] *Right Care First Time: Services supporting safe hospital discharge and preventing hospital admission and readmission* – Age UK (2012)

[3] *Avoiding Hospital Admission: What does the research evidence say?* Purdy, The King's Fund (2010)

[4] *Prevention and Social Care for Adults with Learning Disabilities* - Emerson et al (2011)

[5] RNIB submission to DH Review of FACS eligibility criteria (2009)

[6] *Putting People First Operating Models: learning from the early adopters* - ADASS (2009)

end of the re-ablement period people who have been through re-ablement also seem to be better equipped to take control of that care, i.e. they are more receptive to the concept of managing a Personal Budget, possibly because of their direct experience of a very bespoke approach. A study of social care re-ablement programmes[7] found that during the initial reablement period the cost exceeded that of conventional homecare. However, excluding the costs of the re-ablement intervention itself, the costs of social care services used by people in the re-ablement group were 60 percent less than those for people with conventional homecare services. Studies also show that the benefits of re-ablement for many people last up to and beyond 24 months.

Studies have shown that services that reduce loneliness have resulted in:

- fewer GP visits, lower use of medication, lower incidence of falls and reduced risk factors for long term care;[8]
- fewer days in hospital, physician visits and outpatient appointments;[9] and
- fewer admissions to nursing homes and later admissions.[10]

These emerging findings have led to growing interest in building community capacity as part of the broader 'care offer'.

In 2011, a team from the London School of Economics set out to explore whether building community capacity prevents or delays the need for social care, and whether the projects concerned could generate wider cost savings or economic benefits. Using 'decision modelling' to mimic the alternative pathways people might follow, this study showed that:

- timebanking schemes typically cost £450 per member per year but generate savings £1,300 per member per year;
- befriending schemes typically cost £80 per person per year and generate savings of £300 per person per year;
- community navigator schemes typically cost £480 per person per year and save £900 per person per year.

A review by NESTA in 2013[11] estimated that the NHS in England could realise savings of at least £4.4 billion a year if it adopted 'People Powered Health' innovations that involve patients, their families and communities more directly in the management of long term

---

[7] *Homecare re-ablement toolkit* – Care Services Efficiency Delivery, DH (2011)

[8] 'The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults – Cohen et al (2006)

[9] *Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial* – Pitkala et al (2009)

http://biomedgerontology.oxfordjournals.org/content/64A/7/792.abstract

[10] Russell DW, Cutrona CE, de la Mora A, Wallace RB (1997) Loneliness and nursing home admission among rural older adults. Psychol Aging 12(4).

http://www.ncbi.nlm.nih.gov/pubmed/9416627

[11] The Business Case for People Powered Health – NESTA (2013)

health conditions. The financial business case for People Powered Health rests on two key shifts: firstly, mobilising the asset base that is patients, service users and their communities; and, secondly, reducing unplanned admissions to hospital and the requirements for expensive, acute care. Long–term conditions are a major strategic challenge for health systems around the world, and the NESTA review draws on international evidence suggesting that changing the way we work can improve health outcomes in all the most common long–term conditions, including diabetes, COPD, hypertension, heart disease and asthma. As a result, the costs of delivering care can be reduced. NESTA's calculations are based on applying best practice from around the world to England so as to reduce the healthcare budget by 7%.

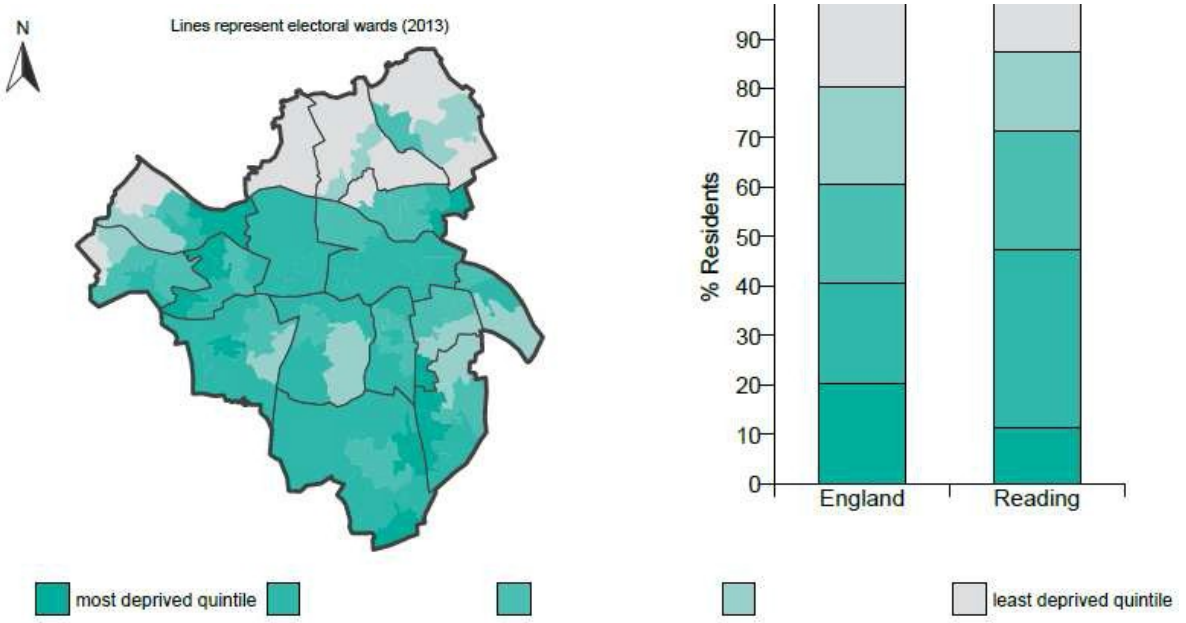
Although communities living in areas of deprivation have greater healthcare needs, the Marmot Review[12] found that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. Instead, actions must be "universal, but with a scale and intensity proportionate to the level of disadvantage". This is also known as "proportionate universalism". The POPP projects evaluation also demonstrated that interventions which address the whole population of older people, and not just the small percentage with complex health and social care needs, can reduce emergency hospital admissions and result in savings. For every £1 spent on the POPP services, there was an average £1.20 additional benefit in savings on emergency hospital stays. The implication is that some targeting of interventions to particular geographical areas / customer groups may be beneficial, but as part of a multi pronged strategy.

[12] *Fair Society, Healthy Lives* - DH (2010)

3. the local context

Poplulation

Reading has a population of 159,200 people living across 63,000 households. The overall health of the people in Reading is varied compared to the national average, as the borough is characterised by extremes of wealth and poverty in a small geographical area. Patterns of inequality are complex with poor outcomes for communities in some of our most deprived neighbourhoods.



Life expectancy in Reading from birth is currently 78 years for males and 83 years for females. These are both below the national and regional averages, indicating there is scope to improve health and wellbeing. There are also some significant differences between wards, with life expectancy being lower (by some 11 years for males – a significant health inequality) and emergency hospital admissions being higher in the more deprived parts of the borough. This helps us to identify how to target interventions to promote wellbeing, although sub-ward level analysis is needed to develop our approach further.

Reading has a younger population than the average for England. There is a smaller proportion of older adults living in the area compared to other localities, although this is less marked for over 75s. The overall population of Reading is projected to increase by 9% between 2011 and 2026. Although Reading expects to see a relatively small increase in the number of older adults in comparison to the average for England, the biggest increase will be seen in the very elderly who are at more likely to have one or more long term conditions. Currently 30% of people in Reading are living with a long term condition such as diabetes, COPD, mental health problems and dementia. There is a growing number of people with both physical and mental health needs.

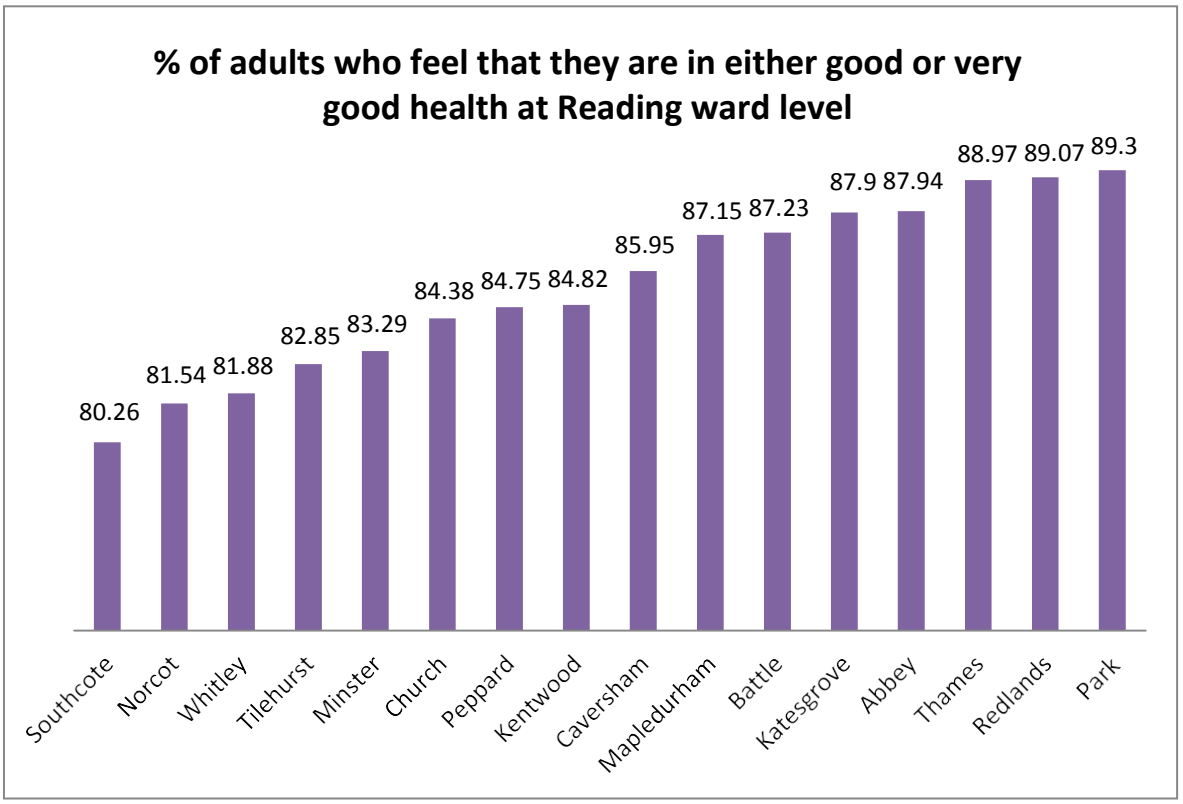
All in all, this means that Reading does not face such severe demographic pressures as other boroughs in terms of future care needs. However, the reduced life expectancy and, especially, the large gap in life expectancy between people living in the more deprived and most affluent areas, is likely to reflect a greater likelihood of poor health and dependency at an earlier age, especially in the more deprived parts of the borough. Unless we can reduce avoidable illness and disability then we can expect an increasing pressure on services as more and more people become dependent.

The chances of requiring a care service rises dramatically for those aged over 80, in part because an older person with a long term health condition is less likely that a younger person to be living with other(s) who are able and willing to support them to continue living independently. Our investment in carers' health is key here. We also have to factor in that children and young people with profound and multiple disabilities and across a range of neurological conditions is rising – these children will find their way into Adult Services over the next 10-15 years (and there has been an increase of 35% in the under 5s population over the last 10 years).

Perceptions of wellbeing

Two questions in the Census (2011) probed the general health and wellbeing of the usual resident population. These were questions asking people to report on their general health and on whether they felt that they were limited at all in performing day-to-day activities by health issues. Almost 90% of respondents living in Reading said that their day to day activities were not limited at all. This is higher than the national average and the average for the South East region. Over 50% of people living in Reading felt that they were in very good health with over 35% feeling that they were in good health. Again, this is higher than the national and South East average with fewer people from Reading reporting that they were in poor health. This is likely to be a reflection of Reading's relatively young population profile.

At ward level the highest levels of reported good/very good health were in Park, Redlands and Thames wards. This is particularly interesting as according to the Indices of deprivation Park is ranked 13, Redlands 11, and Thames 15. Southcote, Whitley and Norcot have the lowest levels of self reported good/very good health, and these are amongst the 6 most deprived wards in Reading.



Source: 2011 Census

The Public Health Outcomes Framework includes a measure of self-reported wellbeing and is identified as a key component of population needs assessments. In 2012, a sample of respondents aged 16 and over were asked four questions related to wellbeing - related to life satisfaction, happiness levels, feelings of anxiety and feelings of worthwhile. Results indicated levels of low happiness (30%) and low feelings of being worthwhile (24%) within the Reading population.

Long term conditions

The leading cause of death in Reading is cardiovascular disease, including heart attack and stroke. Lifestyle changes can reduce the risk of cardiovascular disease and so improve both life expectancy and healthy life expectancy. Although the prevalence of diabetes in Reading is currently below the national average, the rate is increasing. The rate of cancers in Reading is at around the national average, and has been for several years. In line with the rest of the UK, there is scope to reduce the rate by making lifestyle changes to reduce avoidable cancers. People in Reading are as physically active as people in other parts of the country – which means not active enough to reduce the risk of avoidable and delayable long term conditions, i.e. cardiovascular disease, diabetes, depression and dementia.

7,087 people in Reading aged between 18 and 64 are estimated to have a moderate physical disability and 1,928 are estimated to have a severe disability. These figures are expected to increase by 12% and 14% respectively by 2030. In 2013 there were 378 people registered as deaf (including 16 children); 424 people registered as blind (20 children) and 50 residents

registered with dual visual impairment and hearing impairment. During 2012-13, a total of 534 people aged 18 to 64 with a physical disability and/or a sensory need accessed Social Care services. Of these, 515 received community based services.

Learning disabilities and autism

Around 1,800 adults in Reading are estimated to have a learning disability rising to around 1,920 by 2020. Currently there are 554 people with learning disabilities living in Reading known to the Community Learning Disability Team, of which 437 are of working age. (These will be people who meet the threshold for Social Care involvement).

At September 2013 there were 92 adults eligible for Social Care services that had a diagnosis of Autism. Of these, 75 had a learning disability as well and one was known to Mental Health services. (This number should be viewed with caution as the recording of Autism is not always accurate within Social Care systems unless it is a primary disability). This forms a very small proportion of the total number of people in Reading who have an Autism diagnosis and the prevalence is thought to be increasing. Getting specific information and statistics about people with Autism is problematic. Historically many adults have had a primary diagnosis of other symptoms that have masked the Autism traits so they are recorded as having learning disabilities.

Mental health

There is a higher incidence of psychotic mental illness in Reading (affecting 29.3 people per 100,000 population each year) compared to the rest of the South East (19.8 / 100,000) and England as a whole (24.2 / 100,000). The prevalence of other mental illnesses in Reading is comparable to regional and national averages. Mental health provision does not reach all sections of the population evenly with those living in deprived areas, older people, and black and minority ethnic groups (BME) tending to face barriers to access. Stigma and discrimination may play a part in compounding these inequalities.

The number of people with mental health problems supported in residential care in Reading has almost halved since 2010, while those provided with programmes of care within the community has risen by 57%. This shift towards commissioning more community based services reflects service users' wishes to remain independent and in control of the support they require – which, for this group of people, may vary over time. 85% of people are being supported live in their own home or with their family. This is a high proportion compared to the England average of around 60%. Around 13% are in paid employment (again, higher than the England average).

1,535 people who are registered with GP Practices in Reading LA are recorded as having schizophrenia, bi-polar disorder or other psychoses. This equates to a significantly lower proportion of the population than the national average but a higher proportion than the

average in the NHS Berkshire West area (covering Wokingham, West Berkshire and Reading).

Drug and alcohol dependency

According to Public Health England, the estimated number of heroin and/or crack users in England and Wales has fallen since peaking in 2005-06 at 332,090 to 298,752 in 2010-11. In the same period, the estimated number in Reading has risen slightly from 1,271 to 1,363, with the rate per 1,000 population remaining stable (12.36 in 2005/6 and 12.38 in 2010/11). Reading has a high demand for drug treatment, with a higher rate of drug users amongst its population compared to other areas. Around 5.5 people in every 1,000 living in Reading were in drug treatment during 2012, a higher rate than the national average, the South East region and the average of local authorities with a level of deprivation similar to Reading's.

Alcohol-attributable hospital admissions in Reading have risen slightly over the past 5 years. They still remain below the national average and average for local authorities with similar levels of deprivation and are very similar to the averages for the South East. Around 600 in every 100,000 females and 1,000 in every 100,000 males in Reading were admitted to hospital for reasons considered attributable to alcohol in 2011.

Alcohol-specific hospital admissions for females have also increased slightly over the past 5 years, but decreased slightly for males. Figures are not large enough to tell if there has been a significant increase or if it is due to natural changes that have occurred in the data. Both remain below the national average and below the average for the South East. Around 140 in every 100,000 females in Reading were admitted to hospital for reasons considered specific to alcohol in 2011. The rate is much higher in males than females with around 300 in every 100,000 males in Reading admitted to hospital for reasons considered specific to alcohol in 2011.

Carers

12,315 Reading residents identified themselves as a carer in the 2011 Census, which was 7.9% of the Reading resident population. This is an increase on the 2001 census figures of 7.7% and shows that unpaid care has increased at a faster pace than population growth over the last decade. In 2011, most unpaid carers in Reading were providing 1-19 hours of care a week (66%). However, 2,599 carers were providing a high level of care at 50 or more hours of unpaid care per week.

13% of the population in Reading aged over 65 were providing unpaid care at the time of the Census. As the prevalence of health problems and disability is higher among this age group, providing a caring role may have an additional detrimental impact on the health and wellbeing of this group of individuals. Unpaid carers in Reading are more likely to suffer from poorer health with only 75.1% describing their health as "good or very good", compared to 86.5% of people who do not provide unpaid care. The likelihood of reporting poorer health rose with the number of hours of care provided as carers providing 50 or

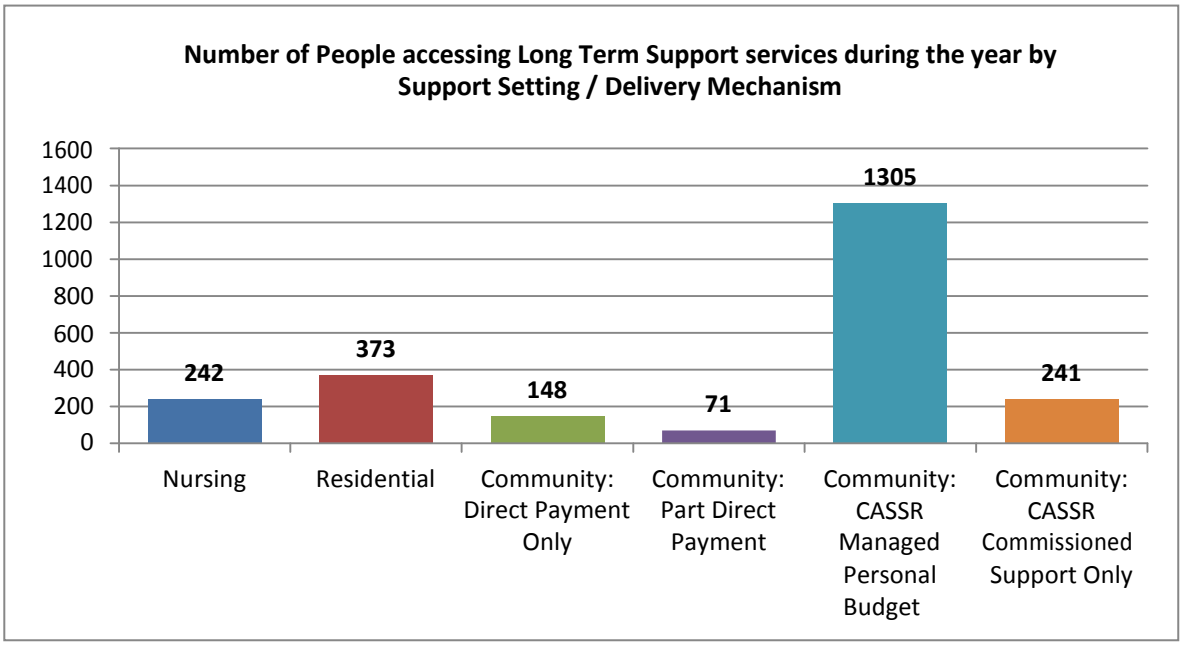
more hours of unpaid care a week were three times as likely to describe their health as "bad or very bad" compared to people who did not provide unpaid care.

Use of Adult Social Care

The number of people accessing Long Term Support from Adult Social Care during the year to 31st March 2015 was 2,380. Reporting requirements for Adult Social Care changed in 2014-15 which means direct comparisons cannot be drawn with previous years. The Long Term Support figures do not include the provision of Equipment and Adaptations or Professional Support, both of which are now recorded as Ongoing Low Level Support or Short term Support (other) depending on the nature of the provision. The Long Term Support figures also exclude short term residential respite which is now counted as Short Term Support (other).

For adults aged 18-24 accessing Long Term Support in 2014-15, the most common primary support need was learning disability (408 service users) followed by mental health support (381 service users) and then physical support/personal care (273 service users). For adults aged 65 or over, the most common primary support need was physical support / personal care (1,068 service users), followed by mental health support (98 service users), support with memory and cognition (80 service users) and then learning disability (33 service users).

The majority of people receiving Long Term Support are living in their own homes in the community and taking control over their support services through Personal Budgets – whether then managed by the local authority or taken by the individual as a Direct Payment.



Public Health services

Under its Health and Social Care Act 2012 responsibilities to improve the population's health, Reading Borough Council commissions services such as:

- health checks (for people aged 40-74 years, who do not have a long-term condition and who have not had a check in the preceding five years) to check for risks such as smoking; overweight and obesity; diabetes; and high blood pressure and to offer help in tackling these;
- smoking cessation services;
- programmes to encourage and enable people to be more physically active as part of their everyday lives;
- programmes to encourage and enable people to eat more healthily;
- sexual health services;
- programmes to promote mental wellbeing; and
- services for people who misuse drugs and/or alcohol.

Many of these programmes are aimed at the whole population, but there are often targeted approaches to reach communities at greater risk of poor health outcomes.

Voluntary, community and faith sector services

Investing in the right community support is a key part of the Council's plan to narrow the gaps between the quality of life enjoyed by different members of our communities. Reading's community providers play a significant role in promoting wellbeing in the borough - connecting communities, stimulating innovation and making a positive difference to people's lives.

Voluntary and community based organisations in Reading have a proud history of supporting people to enjoy healthy lives. Local organisations support people with long term health conditions, those who may need extra support as they get older, and people who provide unpaid care to friends, family and neighbours. In preparation for implementing the Care Act in Reading, we asked people to tell us what their priorities are for these preventative services. This feedback, alongside the population profiles taken from our Joint Strategic Needs Assessment, has been used to develop five 'wellbeing themes' within our Narrowing the Gap Bidding Framework. This Framework covers funding available from the local authority to support cross cutting corporate priorities relating to tackling poverty and thriving communities, as well as meeting Adult Social Care and Public Health outcomes. The aim is to develop this Framework in future years to reflect the emergence of joint commissioning arrangements with Clinical Commissioning Groups and neighbouring local authority partners.

The Council recognises its duties under the Care Act to ensure that local people have a good range of wellbeing services to choose from. Our aspiration is to continue to have a vibrant local market, which is resilient to funding challenges, working with us for the benefit of the Borough and providing grass roots services. There are over 900 voluntary and community

sector organisations listed on Reading Voluntary Action's local directory. In addition, there are 360 social action projects being delivered by faith groups in Reading.[13] These include debt advice, job coaching, delivering emergency food parcels and offering vulnerable people a safe place to belong and to build friendships.

We want to work closely with the voluntary, community and faith sectors through mutually beneficial partnership arrangements, and make sure that the services we support and commission through the sector are efficient, effective and delivered to meet the needs of citizens.

[13] *Cinnamon Faith Action Audit (Reading)* – Cinnamon Network (2015)

4. achieving our aims

Our seven key aims map onto our prevention objectives as illustrated below.

Wellbeing Aim	PREVENT	REDUCE	DELAY
Embed the wellbeing principle throughout the Council's functions			
Ensure Reading homes support wellbeing			
Harness the assets Reading has to prevent care and support needs from increasing			
Empower people with care needs to self care and make positive lifestyle choices			
Support people to prevent their care and support needs from increasing			
Promote a re-abling approach across care services			
Ensure people with care needs and unpaid carers can access services that work well together to support people's independence			

4.1 Embed the wellbeing principle throughout the Council's functions

Creating a new focus on wellbeing

We will establish a **Wellbeing and Prevention Delivery Group** to oversee the achievement of our agreed aims, to champion wellbeing across the authority, and to bring initiatives together in a cohesive way. The Delivery Group will be accountable to the Transformation Programme Board within the Directorate of Adult Care and Health Services, and will present progress reports to the Health and Wellbeing Board alongside proposing refreshes to the action plan.

Wellbeing interventions to prevent recourse to formal care will not achieve an instant impact. It is therefore essential that we see this Position Statement and its accompanying Action Plan as part of a long-term process, and refresh it as other strategic documents are updated, in particular the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, both of which are due to be updated in 2016.

The Adult Wellbeing Position Statement is currently part of existing budget plans. This includes drawing on funding allocated by the Department of Health to support Care Act implementation and the pooled Better Care Fund budgets which support health and social care integration plans.

We have developed a set of **principles to underpin our commissioning activity** so that promoting wellbeing and preventing the escalation of care needs is embedded in service provision across the borough. We will incentivise and reward support for wellbeing, and support the development of a network of enabling services that will:

- Help people to help themselves, make informed choices and decisions about their own
- lives, and be in control of their health and care
- Be tailored to people's individual needs and preferences
- Value and support the contribution of carers
- Harness and strengthen the contribution of local people in local communities
- Be responsive and make things happen for people in a timely way
- Reach people, including those in marginalised groups or who are isolated
- Be delivered in ways that make best possible use of health and social care resources
- Be sustained if they are shown to be achieving positive prevention outcomes

Developing a workforce for wellbeing

Many teams within the Council support people to make positive lifestyle choices and to maintain their commitment to their own wellbeing. Our ambition is to involve many more frontline staff in promoting people's wellbeing through our **Making Every Contact Count**

(MECC) programme. MECC is about building a culture of health improvement through the range of contacts the Council has with Reading residents. Every contact we have with individuals is potentially an opportunity to encourage someone to make a positive lifestyle change. Through MECC training, our staff will be equipped with the skills to seize these opportunities – asking questions about possible lifestyle changes at appropriate opportunities; responding appropriately when these issues are raised; and then taking action to signpost or refer people to the support they need.

In the first phase of our MECC programme, we will train frontline staff working across Adult Social Care and our Customer Call Centre. An evaluation of the first phase will inform the development of Phase Two, including the training methodology as well as how to target our next training round, reaching out to partner agencies as well as Council teams. Typically, MECC interventions encourage people to stop smoking, eat a healthy diet, maintain a healthy weight, keep alcohol consumption within safe limits, take more exercise or take care of their emotional wellbeing. Support with these issues can benefit any resident, but we are committed to ensuring that people with emerging care needs are reached through this programme.

Using a risk matrix approach, a cross agency Steering Group of Reading's Local Strategic Partnership will identify priority groups who could benefit from the Partnership's **Joined Up Front Line Delivery** project. Key partners from the police, the health service, the fire and rescue service, higher education, business and the voluntary, community and faith sectors are working with the Council to improve our ability to connect people to the right services at the right time. The Partnership has committed to developing a toolkit to enable effective cross-sector working, including information-sharing protocols; an evaluation of brief interventions based on local experience; and the development of a culture of advocating for customers across services.

4.2 Ensure Reading homes support wellbeing

Where people live can have a significant impact on their wellbeing, and poor housing can lead to a decline in both physical and mental health and so lead to the escalation of care needs. Accommodation costs in Reading are amongst the highest in the country and the provision of affordable housing continues to be the key strategic concern.

Housing Renewal Policy (Private Sector)

Within the boundaries of Reading Borough Council, the private sector represents 83.1% of households. The Private Sector Stock Condition Survey carried out in 2006 showed that the number of non-decent dwellings in the private sector is 20,500, consisting of 40% of the stock, of which 3,460 are occupied by vulnerable households. The Council uses the Housing, Health & Safety Rating System (HHSRS) hazard assessment tool to prioritise action, make homes safer and reduce accidents and in this way achieving the Decent Home Standard. The authority has adopted a **Housing Renewal Policy** that ensures funds are targeted to those residents in the private sector that are in the greatest need - older people, those on a low income or who are disabled.

Although it is primarily the responsibility of private sector owners to maintain their own property, some owners - particularly the elderly and most vulnerable - do not have the necessary resources to repair or improve their homes. Local authorities therefore have an important role to play in providing assistance in these cases. Reading's Housing Renewal Policy (Private Sector) sets out the criteria for accessing financial assistance through several schemes targeted at people who are older or in poor health, including the **Grant for Hospital Discharge** - for homeowners or private tenants to fund small adaptations to facilitate hospital discharge, and the **Flexible Home Improvement Loans** – for home owners aged 60 or over.

Home adaptations

Reading Borough Council works in partnership with a **Home Improvement Agency** which provides support and guidance to help people with adaptations, repairs or improvements to their home from grant applications through to completion of the work. If someone has limited mobility, they may need to adapt their home to make it easier to get in and around. A **Disabled Facilities Grant (DFG)** may help to pay for these adaptations – including things like wheelchair ramps, stairlifts or hoists or installing a downstairs bathroom. The Home Improvement Agency can assist people to apply for the means-tested DFG. We will be re-commissioning our Home Improvement Agency from June 2016 with clear targets to improve the customer journey and promote independent living for residents in need of support.

Through the Narrowing the Gap Bidding Framework, the Council is also re-commissioning a **handyperson service** to resolve hospital discharge-related work and emergency household repairs within 2 working days. This service will support older people and people with a long

term health condition. The currently commissioned handyperson service is well used and deals with 100-150 emergency service requests p.a. In addition to emergency repairs, however, there also appears to be an unmet need for non urgent repair work. We need to understand this better, and if necessary develop the local market to ensure that people who feel vulnerable on account of their age or state of health are able to access affordable small repairs services from trusted providers.

Tackling fuel poverty

Cold housing has a known detrimental impact on health - for example, circulatory diseases, respiratory problems and mental health are all affected by cold housing. In Reading the seasonal increase in the death rate has been rising for several years and we are committed to targeting support to keep warm and well more effectively on those who need it most. **Winter Watch** is an annual campaign administered by Reading Borough Council designed to provide support to fuel poor households and those at risk of the negative health effects associated with cold weather. In 2014-15, 177 residents were visited in their homes and 64% of people assisted had a long term heath condition. 55 homes were draught proofed and 17 applications were submitted for replacement boilers under the Government's ECO scheme. The 2015-16 campaign offers:

- A home energy check
- Referral to a draught proofing/ handyman service
- Information and help accessing energy efficiency grants
- Help to access an emergency payment where there is severe hardship associated with energy purchase
- Emergency measures/equipment – such as heaters and bedding
- Advice on how to switch energy supplier or change payment tariff

Winter Watch is being actively promoted through forums for older people, people with disabilities and carers to ensure those with care and support needs can benefit from the scheme.

Home safety

We work with the Royal Berkshire Fire and Rescue Service (RBFRS) to offer vulnerable adults a **home fire safety check**. People are more at risk from fire if they:

- are over 65 years of age
- live alone
- have mental health issues (including dementia or memory loss)
- have mobility difficulties
- suffer from hearing loss or are visually impaired
- abuse alcohol or drugs
- smoke heavily
- have a learning disability; or
- are hoarders

Under the scheme, an RBFRS representative will visit someone at home to assess the home for fire risk, with a view to fitting free smoke detector alarms if required. The representative will also discuss home escape plans and provide education advice to lower fire risk. The home fire safety checks provide a good opportunity not only to reduce fire risk but also to connect vulnerable adults to other services to improve their wellbeing. We are keen to improve our information sharing across agencies to make this scheme more effective and better targeted.

Citizens Advice estimates that around 4 million people a year are "scammed" in Great Britain, i.e. tricked into parting with money for things they don't really want or need. Research in 2006 by the Office of Fair Trading (OFT) found that while older people were no more likely to be scammed than other age groups, their financial losses were often greater. The Alzheimer's Society calculates that 15% of individuals with dementia (an estimated 112,500 people) have been victims of cold-calling, scam mail or mis-selling. Scams can have a devastating impact, including mental illness and the physical manifestations of long-term stress, as well as reducing people's confidence and skills to maintain independent living. Reading's **Trading Standards** service works with people identified as having been, or at risk of being, scammed or pressurised through doorstop selling and helps equip people to avoid future financial abuse. Our outreach programme includes talks to groups, to raise awareness of the issues as well as individual visits. We will build on this by with partners to explore how we can develop a more co-ordinated and proactive response.

An important part of maintaining independent living is being able to keep a home clean and clear of waste. The Council offers an **Assisted Collection** service as part of its Refuge & Recycling provision. This is for Reading residents who are unable to move their bins on account of their age, illness or disability and have no one at their property to help them with this task. Residents who have joined the Assisted Collection scheme are a priority group to reach with other wellbeing services given the majority are managing a long term health condition alone. We will develop this within the Council next year, and explore options for information sharing protocols with partner agencies to make the most of this targeted approach.

Homelessness

For some of the Reading population, the priority need is to get into a home and away from rough sleeping. Rough sleeping has a marked detrimental effect on both physical and mental health and, nationally, the average age of death of someone sleeping rough is 47 years for men and 43 for women. Many rough sleepers have complex needs across mental health, physical health and drug and alcohol misuse issues. They also may not have the skills to manage a tenancy or live independently. Those who are homeless also face significant barriers to access health services, being unable to register with regular services due to being unable to provide details of a residential address. The **Homelessness Pathway** is funded by Reading Borough Council and is designed to help people develop the skills and confidence they need to move from being homeless. The Pathway offers three stages of accommodation with different types of support.

Stage	Example of Support Offered	Support Goals
One	24-hour, intensive support	Opening a bank account; applying for benefits and learning to budget; registering with a GP to deal with any drug or alcohol problems
Two	Support during the day time	Registering to vote; developing hobbies; dealing with debts
Three	A minimum of one hour's support every fortnight	Opening a Credit Union account; saving towards a deposit; working towards training or employment

Housing options for people with care needs

The Council is developing an **Accommodation with Care Strategy** to bring together a number of initiatives to assist older and disabled people to maintain their ability to live independently in their own home for longer, including our Extra Care development programme and the Supported Living Accredited Select List.

The Council also offers assistance to older people through the **Should I Stay or Should I Go** scheme. When an older person is identified who is having difficulty in maintaining a safe and habitable home, Council officers will help that person explore their options around housing assistance and different types of accommodation. Going forward, we will explore how we can reach more people in need of this type of support, including developing referral protocols with partner agencies.

4.3 Harness the assets Reading has to prevent care and support needs from increasing

Reading Sports & Leisure

Over 750,000 people use the Council's sports and leisure facilities across the town each year. This includes gyms, pools, exercise classes for all abilities at studios across Reading, and a wide range of outdoor venues for ball or racquet games, and skateboarding. A key driver for the provision of high quality leisure facilities is to promote the health and well-being of the population. Taking part in sports and leisure activities is a good way to build social networks, self esteem, physical and emotional resilience, and the Council offers opportunities for all residents to enjoy these benefits. Staff are trained to assist people with additional needs, and where people need extra one-to-one support to take part in activities they are welcome to attend facilities with a carer or Personal Assistant. There are adapted classes for people with mobility or other health issues, and discounted activities for people who are aged over 60 or have a disability.

Following a review in 2015, the Council has committed to a modernisation programme which will ensure that leisure and recreation services can remain open whilst the Council invests in facilities, undertakes feasibility work and secures additional funds and support to undertake improvements and provide new leisure facilities within the town. New facilities generally result in increased level of use and participation in the communities where they are located. In turn this provides more opportunities to target specific initiatives to increase engagement and participation from those who have various health conditions that can be ameliorated through exercise and well-being programmes.

The **Pathway Exercise Referral Scheme** is aimed at patients with specific medical conditions (e.g. obesity, cardiovascular disease, asthma, diabetes, depression and stress, arthritis, COPD, stroke, MS) who require a referral from their doctor to take part in supervised activities, or for those who are at risk of developing coronary heart disease. People on the Pathway scheme are supported by specially trained coaches and instructors to take part in activities such as swimming, health walks, cycling, circuit training, chair based exercises and aqua mobility. A scheme co-ordinator works with health professionals and doctors surgeries across Reading to refer patients with existing health conditions to supervised activities.

People who need support and encouragement to take part in exercise pre-treatment, undergoing or post treatment for cancer can join the **Cancer Wellbeing exercise programme**. This is made up of exercise classes designed specifically for people who have been affected by cancer, and whose quality of life can be maintained or improved through taking part in regular, supervised activity. Classes are taken by a cancer rehabilitation qualified instructor. RSL also offers a **Cardiac Rehabilitation programme** as a follow on from a hospital based physical activity rehabilitation programme. This is specifically for people with Coronary Heart Disease, who are recovering from a heart attack or heart surgery.

The **Stay Active programme** is aimed at the over 50s and runs one morning a week at Meadway Sports Centre. Older people are assisted to enjoy activities such as badminton, table tennis, exercise classes, walking, basketball, swimming and gym use. The sessions are very popular, and the Council is looking to expand the programme over more days and possibly additional venues.

The **Reading Walks** programme includes a series of weekly walks and seasonal walk trips lead by qualified walk leaders. The programme objectives are: engaging with older and isolated people in the community; increasing people's physical activity levels; increasing people's independence and discovery of their local community and green space; and decreasing social isolation. Although any adult can join the Reading Walks programme, activities are promoted to residents at greater risk of developing health problems so that the programme contributes to reducing health inequalities across the town. The Reading Walks co-ordinator post is funded for a fixed term, and plans will be developed to exit from or to develop the programme following a review in 2016.

Partnership working with other sports and leisure providers

Sport in Mind is a mental health charity founded to provide people experiencing mental health problems with the opportunity to play sport and physical activity in a supported environment. Reading Borough Council, in collaboration with neighbouring authorities, is funding a Sport in Mind co-ordinator to work across Berkshire promoting sport and physical activity to promote mental well-being, help aid recovery, improve physical health, encourage social inclusion and empower people experiencing mental health problems to build a positive future for themselves. This is a new post which will be monitored closely to ensure we learn from better-than-expected outcomes and can correct poorer ones quickly.

Rivermead Leisure Centre is situated just north of the town centre and is managed by a social enterprise partner, GLL. The centre includes a pool, several gym areas and ball courts, a café and rooms of various sizes which can be hired out on a regular basis or for events. As Reading has a number of town centre gyms which are popular with working age adults, GLL has taken the decision to focus on a different target market for Rivermead – older people and young families. GLL is creating an older people's lounge at the Rivermead site to encourage more older people to use the Centre's facilities, and is keen to work with the Council and local voluntary sector providers to offer a wider range of services from the Rivermead site for people of all abilities. The Council will be re-locating its day activities with care service to Rivermead in autumn 2016 after re-developing an unused wing of the Centre. The aim is that this partnership will widen the range of activities available to people with complex needs and also encourage more family carers to access fitness and wellbeing services whilst those they care for are receiving respite care within the Centre.

Reading Museum

Reading Museum is open Tuesdays to Saturdays and entry is free of charge. The Museum is relaxed and informal, and staff are very happy to help those with additional needs to

discover more about the displays. This includes organising **special tours for adults with learning disabilities and/or autism** which are arranged in partnership with local colleges. **Magnifying glasses and torches** are available for loan, and **large print** information sheets are available. There are also a number of **tactile displays**, including raised images of the Bayeux Tapestry which can be accompanied by an **audio guide**. The Museum also has a community engagement programme to take projects out to groups who might find it harder to engage with resources at the Museum premises.

The Museum operates a **Memory Box** scheme, and has over 40 collections designed to spark recollections amongst older residents. Original objects, photographs, documents, smells and sounds draw the user back in time and place and help to stimulate conversations. The boxes are delivered in partnership with Reading Mobile Library Service. Many older people enjoy reminiscence as a way of affirming their identity and personal history. For people with dementia, reminiscing is a way of conversing more easily than trying to engage about recent topics. Having the opportunity to reminisce therefore maintains skills and confidence in social interaction for longer. Alongside the Memory Box scheme, the Museum offers **Reminiscence Training** to help care workers and others make best use of the boxes. Reminiscence Therapy has been shown to be helpful in reducing depression and anxiety, helping individuals come to terms with growing older, and encouraging older people to regain interest in past hobbies and pastimes, especially people who are confused or disoriented. The Memory Boxes were loaned out for 12,600 user sessions last year, and most care homes in the area now have a member of staff who havebeen on the Reminiscence Training course. A future area for development is to raise awareness of the scheme and resources with other care providers.

Library services

As well as being a place to borrow books, CDs and DVDs, Reading libraries also offer **free internet access** for members for up to two hours a day. Staff and volunteers can assist people to make use of online facilities. The libraries also host several book clubs and writing groups, as well as offering book collections to support external book clubs. These resources can help develop social contacts. There is a **reading group for visually impaired people** at Central Library: members listen to books on MP3 discs rather than reading the printed version. In addition, there is no charge to people who are blind or visually impaired for audio book loans.

All of Reading's libraries are fully accessible to wheelchair users. However, Reading residents who have difficulty visiting their library can request the **Home Visiting Service**. The mobile library van takes 2,200 books to care homes, sheltered housing, day centres and other establishments around Reading and is fully accessible. People registered to use the service normally receive a visit once every three weeks. Volunteers often stay for a drink and a chat while dropping off books, and in this way the service includes an element of befriending. These regular visits by volunteers to people who find it hard to leave the house also provide an opportunity to offer other wellbeing services / checks, and we will consider how to make best use of the service within our Joined Up Front Line Delivery project (see above).

4.4 Empower people with care needs to self care and make positive lifestyle choices

Improve access to preventative health services

The **NHS Health Check** programme systematically targets the top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. It is primarily a health improvement programme offering an opportunity to engage people aged 40-74 in discussions about healthy lifestyles before they get sick and goes on to help them to take control of their health and take action to avoid, reduce or manage their risk of developing future health problems.

The majority of Reading GPs have accepted contracts to deliver the Health Check programme and eligible patients registered with these practices will be invited for a health check once every five years. The Council's Public Health team manages the programme, including raising awareness of the entitlement to a health check and its value. The Health Check programme targets the age range in question because evidence shows that this group face the highest risk of developing cardio vascular problems if they make poor lifestyle choices. People with various pre-existing conditions are excluded from the programme, and there is currently no mechanism for adding other 'at risk' groups, e.g. people with care needs or carers. Working in partnerships with the CCGs, we will explore options for developing the Healthcheck programme to increase its preventative impact.

Residents over the age of 75 have a **named accountable GP**. One of the responsibilities of the accountable GP is to provide a health check on request where an examination hasn't been performed in the preceding 12 months. There is a local commitment to develop care plans following a face to face consultation for 50% of over 75 year olds who are also in the top 2% risk category for hospital admission. The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP).

The Council's Public Health Team has supported the **national flu campaign** to encourage those in vulnerable groups to take up the offer of a free flu vaccine, ie. pregnant women, those aged 65 or over, those aged under 65 with long-term conditions, and unpaid or family carers. An annual flu jab is the most effective way to reduce the likelihood of developing pneumonia or other severe chest infections by preventing flu. The adult flu vaccine is available from GPs and pharmacies to those in groups at particular risk of infection and complications from flu.

Putting emotional wellbeing on an equal footing with physical wellbeing

Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012. However, people with mental health problems have a significantly different level of contact with health services compared with other patients. In 2011/12:

- 78% of mental health service users accessed hospital services compared with 48% of non-mental health service users; and
- 71% of mental health service users admitted to hospital were classified as an emergency compared with 40% of non-mental health service users.

In an attempt to address this discrepancy, a group of national mental health organisations have issued the **Local Authority Mental Health Challenge** to support and encourage councils to take a proactive approach to mental health. Reading Borough Council has signed up to the Challenge and nominated a member 'champion' to lead this locally.

The Council continues to provide funding support for **Reading Samaritans** who offer a 7 day phoneline and drop in service to provide listening support to people who are in distress. This includes, but is not confined to, people who are feeling suicidal. There has been a recent increase in the suicide rate in Reading, and the Council is funding various initiatives to raise awareness of support for those who may be severely depressed and considering this course of action. Funding has been put into the **CALM (Campaign Against Living Miserably)** programme to raise awareness of mental health support for middle aged men, who are particularly at risk.

The Council also provides funding support to the **Mothertongue** multi ethnic counselling and listening service. The charity offers holistic support to people who are heard with respect in their chosen language. Mothertongue also offers professional development to staff and volunteers from other agencies, and helps to bridge language gaps to help people overcome barriers to accessing the support they need. In partIcular, there is a strong working relationship with Berkshire's IAPT[14] service, Talking Therapies. In 2014-15 Mothertongue delivered 1,476 hours of counselling to 46 clients per month (on average). They saw clients from over 39 different ethnicities and delivered counselling in 12 different languages. The Mental Health Interpreting Service provided 682 hours of interpreting in nine languages.

We are currently developing our **Mental Health Commissioning Strategy** for Reading, and will ensure this reflects the need for preventative services to promote emotional wellbeing as well as support to manage mental ill health.

Promoting self care,

Reading's **Better Care Fund plan**, endorsed by the Health and Wellbeing Board in 2014, sets out a joint commitment from the local authority and the Clinical Commissioning Groups to

[14] Improving Access to Psychological Therapies

promote self-care, support people to take more responsibility for their health and wellbeing and make decisions about their own care. A web based tool has been deployed in Reading to promote joint care planning between individuals and doctors and will be built on to deliver further self-care initiatives.

The Council works with Reading's various condition specific support groups within the voluntary and community sector to enhance opportunities for peer support and learning from others' experiences. Through the Narrowing the Gap Bidding Framework, the Council is commissioning services to **facilitate peer support and/or enablement training** for adults affected by long term health conditions (and their families where relevant). Specific services are being commissioned to support those affected by dementia, visual impairment, hearing impairment, autism, physical disability, Multiple Sclerosis and Parkinson's Disease. In each case, providers will have clear targets to deliver services which enhance people's resilience. Service users will be supported to establish contact with others affected by similar long-term health conditions; to share and benefit from one another's knowledge; where relevant, take part in social skills training; and learn the basic skills of self-management. A **self advocacy** service is being commissioned for adults with a learning disability so they are supported to have a voice in their community, choose their support, and shape the services they use. Through this self advocacy provision, we will give service users the tools to take better charge of their own wellbeing.

New Directions

New Directions is Reading Borough Council's Adult Learning Service. It provides a wide range of part-time courses for adults in the Reading area. New Directions has 3 main centres - in Caversham, Reading Central Library and South Reading - and also runs courses at the Avenue in Tilehurst, from Children's Centres and from a number of local community venues. Each main New Directions centre has free job searching facilities. New Directions was rated 'Good' in an Ofsted report published on January 5th 2012.

Lifelong learning can yield significant health and wellbeing benefits for individuals. Keeping mentally active can reduce and delay the risk of certain long term health conditions, e.g. dementia in older adults. Learning a skill such as a language or a handicraft can promote general well-being and mental health. Moreover, attending classes gives people social contact, with the opportunity to make new friends, and so reduce loneliness and isolation.

New Directions offers a range of courses for the whole community which promote wellbeing. These include the free **Eat for Health** and **Kids Cooking for Health** cookery courses; plus a range of arts, crafts and complementary therapy courses, IT and language courses, including English as a Second or Other Language (ESOL). There is already some targeted marketing of these courses to reach people with greater needs, such as a free ESOL course for expectant mothers and waiving the fee for IT confidence building courses for people receiving Job Seekers Allowance. There is scope to do more to encourage take up of these courses by people with long term health conditions, however.

In addition, New Directions has a suite of courses for adults with **Supported Learning** needs. This includes cookery, IT, pottery, photography. There is a **Confidence Building** class for people with low self esteem or mental health needs, and an **Adults with Dyslexia** awareness course. These courses are already marketed to target audiences, but could attract a wider learner group through the development of key partnerships and exploring other options for delivery in the community.

In the last academic year, 552 people aged 55 or over took a New Directions course, and 113 of these were over 70 years of age. 666 learners disclosed a disability or long term health condition as set out in the table below.

Long term health condition	No. of learners
Visual impairment	16
Hearing impairment	32
Disability affecting mobility	30
Other physical disability	14
Other medical condition	81
Emotional / behavioural issues	14
Mental health issues	69
Learning difficulty or disability	265
Temporary disability after illness	9
Asperger's Syndrome	14
Multiple disabilities	114
Other	8
TOTAL	666

Reducing loneliness

Ensuring people with care needs have opportunities to enjoy social contact is a key component of our approach to wellbeing. There are clear links between loneliness – which is subjective and relates to individual levels of need for social contact - and depression, hypertension, and cognitive decline. The known risk factors for loneliness are: living alone, not being in work, poor health, loss of mobility, sensory impairment, language barriers, communication barriers, bereavement, lack of transport, living in an area with poor access to public toilets or benches, lower income, fear of crime, and living in an area with high population turnover. Some of these factors are directly linked to disability or long term health conditions, whilst others will tend to correlate – e.g. older people are more likely to experience bereavement, disabled adults are less likely to be in work.

In 2013, the Council launched a **Neighbourhood Day Opportunities for Older People** initiative to facilitate the engagement of socially isolated older people, and older people at risk of isolation and loneliness in social and peer groups. A full-time Neighbourhood Coordinator was appointed in November 2013 and joined by a full time assistant in

November 2014. The Neighbourhood Team has supported the development of a wide range of community activities, principally for older people, but meeting the needs of adults with a range of long term health conditions or vulnerabilities, including mental health needs. The team's work has included establishing four thriving **Over 50s clubs** in Caversham, Southcote and Whitley and a town centre afternoon tea and dance session, all of which are run by volunteers and located in community buildings.

The Neighbourhood Team works to increase older people's involvement in activities which promote physical, mental & emotional wellbeing. Their aim is to build older people's personal resilience to mitigate against the risks of loneliness in older age. By identifying gaps in service provision, and developing solutions in partnership with other agencies, the team develops **volunteering opportunities** as well as 'services', and whilst these opportunities are open to all, they are typically filled by older people or people with long term conditions. Our upcoming commissioning strategies for older people, mental health and learning disabilities will address the need to build community capacity to offer strong social connections for people with various health needs, and how best to develop the Neighbourhood Team.

There is a wide range of social opportunities in Reading for older people and people with long term health conditions. Voluntary and community groups offer in excess of 40 lunch clubs (e.g. Age UK, the Pakistani Community Centre, the Indian Community Association) and over 20 befriending services (e.g. Age UK, Engage Befriending, ENRYCH Berkshire). Retirement clubs such as Firtree offer activities such as dancing, singing, talks and games, and there is a varied programme within Age UK's Active Living scheme. There are also approximately 60 faith-based services aimed at reducing social isolation.[15] The level of support and care available within these services varies, but people who are eligible for Adult Social Care would, subject to a personal needs assessment, have the option of engaging a Personal Assistant to help them access these community services.

Through our Narrowing the Gap Bidding Framework we are commissioning six new services to **connect people and communities to reduce loneliness**. These services will give people opportunities to take part in one to one or larger group leisure activities that promote physical & emotional wellbeing, promote independence, and develop people's skills and personal resilience. The services will include some outreach provision for people who find it hard to engage with services. Services will be commissioned to support:

- People whose first language is British Sign Language and people with an acquired Hearing Impairment
- People with a Learning Disability or who are on the Autistic Spectrum
- People with a Physical Disability
- People with a Visual Impairment
- Isolated members of minority ethnic communities
- People who are becoming frail or isolated through old age or the effect of long term health conditions

[15] Cinnamon Faith Action Audit (Reading) - 2015

Transport

Good transport planning can have a strong influence on promoting healthy lifestyle choices. Enabling people to incorporate walking and cycling into their daily routine helps to raise levels of physical and emotional wellbeing, whether people take these journeys alone or in groups, although in the latter case there is often the added benefit of developing social networks. Keeping vehicle usage down contributes to air quality which benefits all residents, but vehicular transport still has an important role to play, particularly for people with care needs. Accessible transport services help people with care needs to have greater choice and control over making use of other community facilities.

Our **Highways Maintenance** service, which includes street lighting, and our **Street Cleansing** service both work to develop the 'walkability' of Reading and to reduce actual and perceived risk so as to encourage vulnerable groups to use pedestrian routes. We adopted a new **Cycling Strategy** in 2014 incorporating commitments to a new and improved cycle infrastructure; a cycle hire scheme; increased cycle parking facilities; and positively promoting the benefits of cycling in a compact urban area such as Reading.

When people with care or support needs do need to use vehicular transport, there are accessible options to choose from in Reading. The award winning **Reading Buses** is a wholly owned arms length trading company, which uses a low-floor, wheelchair-accessible fleet. All buses have an entrance ramp and many can be lowered to the kerb to allow easier access. Wheelchair users have priority over all other passengers in using the dedicated wheelchair space inside each bus. Vehicles on frequently used routes are colour coded, making it easier for people with limited visual or cognitive ability to find the bus they need.

For people who cannot use the public bus service, there is the **Readibus** Dial-a-Ride door to door bus service for people with restricted mobility. Specially trained Readibus drivers are able to meet the additional support needs which some people have to be able to use their buses. The Readibus service is funded by Reading Borough Council and operates 7 days a week up to 11pm. A programme of scheduled trips to shopping centres and excursions wider afield operates alongside the on-demand service. In 2013-14, Readibus supported 3,500 people to take 169,000 journeys. That represented a 3.1% increase (an extra 5,000 journeys) compared to the previous year, and 643 new users registered with the service in that year.

The Council also operates an in-house assisted transport service for people who need assistance to get to and from day activities. The Council plans to re-commission all its assisted transport in 2016-17 to put in place a service which offers fair access and gives priority to those in greatest need.

Reading Borough residents over 60 years of age are entitled to a pass allowing free travel on all local buses between 9am and 11pm Monday to Friday and at any time on weekends and bank holidays. The **Reading concessionary pass scheme** allows older people free travel from earlier in the day than the national scheme requires. The Reading pass can also be used for concessionary travel outside Reading but only after 9:30 am. Anytime concessionary travel passes are available to residents who cannot hold a driver's license on medical grounds or

who suffer from certain disabilities which seriously impair their ability to walk. **Companion passes** extend the concession to carers travelling with someone who has an eligible disability.

The **Blue Badge** Scheme gives people with severe mobility problems better access to goods and services by allowing them to park closer to their destination. The scheme is open to eligible disabled people whether they are a driver or passenger. There are currently 5,503 Blue Badges in circulation in Reading, and 1,725 applications were processed last year. There is scope to streamline the application process and reduce the size of the Reading application in line with the Council's digital strategy and bench marking against other local authorities.

4.5 Support people to prevent their care and support needs from increasing

Information & Advice Services

Ensuring that people with care and support needs can access reliable high quality information about local services is a priority. This empowers people to make good choices about maintaining their independence, and the Council is developing a separate Information and Advice Strategy to take this forward.

In the 2014-15 Adult Social Care Outcomes Framework return, 77% of people who used services[16] in Reading reported they found it easy to find information about services. This is slightly higher than the average for similar local authorities and the England average (both 75%), but a fall of two percentage points compared to survey results for Reading the previous year. A new measure of carer satisfaction with information provision was introduced in 2014-15. Only 63% of Reading carers surveyed reported they found it easy to find information about services, which is lower than the results for similar local authorities (65%) and the England average (66%).

The Council established **ReACT (Reading Adult Contact Team)** in 2010 as a single point of access for Adult Social Care. ReACT consists of a team based in the Council's Call Centre to help callers identify and access low-level services, and a team that supports professionals and residents by co-ordinating referrals for Adult Social Care support. ReAct takes calls Monday to Friday from 9:00am to 5:00pm. Mystery shopping exercises were used to identify strengths and weaknesses of the ReAct service in its early days and help to develop the service. Further mystery shopping exercises will be used in future to gauge how well the service has adapted to the new Care Act provisions, particularly adopting the wellbeing principle as a foundation.

The Council also produces a range of leaflets about its Adult Social Care services. These are available as downloads from our website or in printed form. We will be re-formatting the Adult Social Care leaflets into factsheet form to make them more accessible electronically in line with our Digital by Design policy. We are also working with care partners including our User Reference Group to rationalise the **Adult Social Care factsheets** into a more focused set of resources based on "trigger points" when information and advice about care and support are most relevant to people. We recognise that people's needs for information and advice change over time, and too much information can be as unhelpful as too little when people need to make important decisions about care, often at a stressful time.

The **Reading Services Guide (RSG)** is the Council's online directory of local services. It was launched in 2014 as a more user-friendly and accessible tool than the Council's previous

[16] Adult Social Care services

online directory of services. The RSG is wide-ranging, and entries are organised under the following categories:

- I am looking for information, advice and support
- I am looking for things to do
- I am looking for work or training
- I look after someone (carer)
- I need help to live at home
- I need information about housing options and care homes
- I want to get out and around
- I want to stay healthy and well

The number of unique visits to the RSG continues to grow. From April to September 2015 the average number of visits per month to the RSG was 43,428 compared with 36,367 from the same period in 2014. 92% of users surveyed in 2015 thought that the information contained in the Reading Services Guide was easy to understand, accurate and up to date, useful and appropriate. Officers continue to improve the RSG by enhancing the existing information – including adding information sheets based on relevant 'life episodes' - and increasing the number of entries. The Council also works closely with providers to support them to maintain their entries and so promote their services to new users. However, there is scope to increase awareness and usage of the RSG, and in particular to promote its functionality, such as the translate, print and text options for personalised shortlists. The Council is also keen to explore options for the ongoing maintenance of RSG, including closer working with partners to harmonise processes and drive out greater efficiencies.

Throughout 2015, there was extensive consultation with the public and community providers about a refreshed approach to commissioning community services, including services to promote and support wellbeing. Through the Narrowing the Gap Bidding Framework, the Council will commission a new service to provide **targeted information and advice for people with current or emerging care and support needs**. This service will be in place from June 2016 and will provide support for people who are unable or unwilling to use the RSG unaided, and will help people to understand:

- the care and support system
- the types of care and support, and the choice of care providers available in the Reading area
- how to access the care & support services available locally
- how to access independent financial advice on matters relating to care and support
- how to raise concerns about the safety or wellbeing of an adult with care and support needs
- how to access other services to promote physical and emotional wellbeing
- how to give feedback to help improve and develop the Reading Services Guide and other information sources.

The new service will encourage people to make future enquiries more independently where this is realistic, but will also assist those people who may need more support to make use of the information in the RSG. This may include, for example, assistance with form-filling or home visiting.

The Council has also worked with its neighbouring authority in West Berkshire and with the local Clinical Commissioning Groups to re-commission carers information advice and support services. A new Reading-specific service will be in place from April 2016 to provide a **targeted information and advice service for carers.** This service will:

- provide carers with information and advice to support their physical and emotional wellbeing, and support carers to navigate other information resources;
- offer advice and support on carer specific issues and entitlements, including financial entitlements and rights in employment, and signposting to other relevant services.
- support carers to access breaks via awareness raising and signposting.
- support more accurate referrals of carers into key support services, including raising awareness of:
  - The right to a carer's assessment delivered by or on behalf of the local authority
  - Carers' entitlements to personal budgets
  - Access to health-checks
  - Support for carers to develop emergency /contingency plans

The Council's information and advice responsibilities under the Care Act cover everyone with care and support needs. In particular, the Care Act widens the Council's responsibility to ensure people who fund their own care and support can access information and advice.
The Council has entered into a partnership arrangement with **My Care My Home** in order to meet its statutory duty to ensure that people are supported to get access to financial information and advice to help them plan for paying for their care. From April to September 2015, 36 referrals were made to the service. From these referrals, 6 people chose to go on to access specialist independent financial advice which they paid for themselves. Feedback from users of the service has been very positive, but we need to increase the referral rate to ensure Reading residents understand their financial entitlements and options in time to plan effectively for meeting their needs.

Assistive technology

Assistive technology refers to devices or systems that support a person to maintain or improve their independence, safety and wellbeing. Using new technology can enable more people to take responsibility for their health and manage their conditions. Devices such as smartphones and tablets, coupled with widespread internet coverage, are making technology ever more accessible. However, while many assistive technology devices are electronic, the term does not just refer to high-tech devices.

Telecare is equipment and services that support someone's safety and independence in their own home. The equipment can sense risks such as smoke, floods and gas, can remind someone to take pills and even call for help if the user falls. A help centre can be contacted automatically if any of these problems occur in the home. If needed, the help centre can arrange for someone to come into the home or can contact the user's family, doctor or emergency services. The system can also warn users of problems by sounding an alarm, flashing lights or vibrating a box which can be kept in a pocket or under a pillow.

Environmental Control Systems can enable people to operate everyday domestic appliances and mechanisms by remote control from a display panel. Mechanisms that can be operated include door and window openers, electronic curtain rails and blinds. Appliances that can be operated include lamps and lighting, televisions, telephones and heating. Environmental control systems vary considerably in their capabilities. Some only turn one or two devices on and off while others control a range of settings for several devices.

If we are to make best use of assistive technology, however, then we need to develop understanding of how this technology can be used - amongst our workforce and our local residents. The Council has created a new **Assistive Technology Lead** post to progress this. This officer will be:

- working with stakeholders to develop Reading's vision for assistive technology
- scoping and clarifying Reading's requirements for the Berkshire Wide Equipment contract to feed into the upcoming tendering process
- preparing an action plan to further embed and maximise opportunities posed by Assistive Technology, including telecare, into personalised support packages.
- Developing an options paper on increasing equipment recycling rates both in the short and long term, and implement short term actions to improve recycling rates and generate savings/offset overspends
- Reviewing the role of Occupational Therapists and the assistive technology/minor adaptations pathway, and identifying opportunities to refocus expertise away from issuing small pieces of equipment towards more specialist solutions
- Developing options for an equipment self serve offer

<u>Supporting carers</u>

Reading Borough Council recognises the vital role carers have played and will play in supporting adults with disabilities, frailties or long term health conditions. There is a clear need to invest in sustaining caring relationships which enable many people with support needs to live as independently as possible. Carers are also an 'at risk' group in terms of wellbeing because of the strains caring can place on physical and emotional health. It is important we secure maximum value and impact from the services we commission to provide carers with assistance in areas such as health and wellbeing, and access to a life outside caring.

In addition to ensuring carers have access to information and advice services as described above, the Council's offer to unpaid/family carers also includes the offer of a **Carer's Assessment** - to all carers on the appearance of need. The Care Act requires us to be more proactive in identifying carers and offering carers' assessments. This continues to be taken forward operationally and through wider public and partnership work, including publicity and events at Carers Week and Carers Rights Day in 2015. Awareness of the entitlement is increasing, and in the first 6m of 2015-16 the number of Carer Assessments carried out was double the number completed for the same period in the previous year.

The Care Act also sets out national eligibility standards for carers for the first time and gives carers the right to services in their own right – a **Carer's Personal Budget** - if they meet the national criteria. Prior to April 2015, Reading already offered direct support to carers in the form of a Direct Payment scheme based on 'banding' the impact of caring. A similar approach has been retained as one of the ways in which eligible carers can have their support needs met now. The Council continues to offer a range of services to promote carer wellbeing, keeping processes proportionate from very light touch through to more detailed support planning for carers with more complex needs.

Together with the Reading Clinical Commissioning Groups, the Council is commissioning a new service from April 2016 to **support carers to manage caring**. This service will:

- Support carers to prepare for a Carer's Assessment or to complete a self-assessment.
- Support carers to take best care of their own physical, mental and emotional wellbeing, including responding to the findings of a health-check assessment.
- Support carers to develop emergency contingency plans.
- Support carers with end of life care planning in a timely and co-ordinated manner alongside other necessary organisations.
- Identify training needs of carers and developing access to appropriate provision.
- Reduce, prevent or delay carers' need for more intensive support or active referrals to services.

Again working with the local Clinical Commissioning Groups and also with our neighbour authority in West Berkshire, the Council is also re-commissioning services to **support, enable and empower carers to enjoy a life outside of caring**. New services for Reading and for West Berkshire will be in place from April 2016 to:

- Facilitate and develop mechanisms and opportunities for carers to offer and benefit from peer support.
- Support carers to access work, remain in work, or access community/voluntary activities by encouragement and signposting.
- Identify and enable socialisation opportunities for carers.

Through the Narrowing the Gap Bidding Framework, the Council has re-commissioned community services which **support carers to take breaks**. New services will be in place from June 2016 for adults who rely on unpaid carers and their carers, including families unable to access these services via Personal Budgets. Services will enable carers to:

- Take planned breaks from caring
- Maintain wider social contacts
- Access peer support
- Take part in social activities with the person they care for

We will be re-commissioning **Short Breaks for Disabled Children** after completing our new Short Breaks Strategy, which will include our priorities for ensuring carers of disabled children can get breaks from caring.

Another way that carers can get a break from caring is by the person who normally relies on that carer using their Personal Budget to purchase **respite care.** We encourage carers to take part in the Needs Assessment or Review of the person they care for so that the carer's input can be properly understood and taken into account. This can be through having a joint

Needs Assessment and Carers Assessment if everyone agrees to this, or we can carry out separate assessments and then talk through with everyone how we can take a whole family approach to Support Planning. Respite care can take many forms – from short stays in a residential setting through to care at home or support to take part in a community or social activity.

A Berkshire West Carers Commissioning Forum (BWCCF) has been formed to oversee the future commissioning and development of carer support across Berkshire West. This is one of the enabling work streams within the local health and social care Integration Programme, and the aim is to move towards single pot funding for all carer support across the West of Berkshire and to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries. The BWCCF leads on the development of strategic plans and commissioning arrangements for supporting carers, and also informs the development of other plans and arrangements which have the potential to improve outcomes for carers. The BWCCF is developing a **Berkshire West Carers Commissioning Strategy** which will be published next year, supported by local Action Plans for carers.

4.6 Promote a re-abling approach across care services

The Council has committed to helping people continue to live in their neighbourhood and community where this is feasible and affordable. We will seek to reduce admissions of people to residential care where we can safely meet their assessed needs in a community based setting. We will no longer admit any older person direct from a hospital bed to a residential care home unless there is a longer term social care assessment in place that shows this is the right setting for that individual. We will always ensure that the assessment is offering more than just a response to a current crisis and that each person is getting the right health, housing and other support alongside their social care. If a person is now in residential care and an assessment indicates that they may be able to live in the community we will give them the opportunity to try that option.

All of the care services the Council commissions will be based on the principles of re-ablement, meaning providers will be expected to work with people to assist them in doing more for themselves. Over time, this should mean that some packages of care will decrease as people meet their own defined outcomes in achieving greater independence.

Changing the conversations we have with people who approach us

Making wellbeing the basis of our conversations with people who approach Adult Social Care represents a significant change in the way we work. We need to shift away from professionals identifying needs which can be met by services and start by empowering people to make best use of their personal, family and neighbourhood strengths to enjoy a better life.

We are trialling a new way of working called '**Right for You'** to embed this cultural change. Under the Right for You model, we aim to connect people to their local community and resources and so support them to help themselves. At times when people are in crisis or need short term help, we will offer an immediate 'emergency plan' and work closely with people to see this through. We will not attempt to make long term plans with people while they are in crisis, but if they need ongoing support then when the time is right we will support them to make use of a Personal Budget to take control of getting the life they want. The Right for You teams are capturing a wealth of data about community assets which is being used to develop our preventative information offer to all residents via the Reading Services Guide, and inform our future commissioning and community development work.

Outside of the Right for You pilots, our Social Care assessment tools have been revised to meet Care Act requirements, including recording **impacts on a person's wellbeing** as part of determining eligibility for services based on the national criteria. People making contact with Adult Social Care for the first time are offered a self-assessment option or the opportunity to be put through to an advisor to discuss their situation straight away. If people are shown to be ineligible for Adult Social Care support at this stage they are provided with information and advice about services available in the community that could support them, including information on accessing the Reading Services Guide so they are equipped to make their own future enquiries. Equally, if someone is eligible for support,

preventative or wellbeing services are still considered as part of the whole package of care. We undertake regular file audits to ensure wellbeing is being properly considered within assessments and reviews.

Re-ablement service

This specialist service offers up to six weeks of intensive therapy, care and support designed to help someone regain their independence. Re-ablement is offered to people who:

- have been inactive for a while following an illness, injury or surgery;
- are finding it increasingly difficult to cope without help from others because of a general deterioration in health; or
- have been dependent on care and support services for a while and would like the opportunity to see if they can regain all or some of their independence.

Re-ablement support is based on very individualised plans to promote wellbeing which can include:

- physiotherapy to help improve strength and mobility
- Occupational therapy to help people relearn skills or find new ways of doing things using equipment, gadgets or adaptations to the home
- Support to help someone manage personal care (washing, dressing etc) and day-to-day tasks (like shopping and cooking)
- Health care and advice
- Any other therapies and help which are identified

Re-ablement services are always provided in a home based setting. This is usually someone's own home or, if appropriate, we may offer a short stay in a residential intermediate care centre. Progress is reviewed regularly and the personal plan is adjusted as people achieve their agreed goals. Most people do not need any ongoing support once their re-ablement service ends. Others only require a small amount of ongoing support.

Home from hospital service

Through our Narrowing the Gap Bidding Framework, we will commission a service to support people to **re-settle at home following a period of hospitalisation**. The service will support adults who are aged 65 or over and/or adults with a diagnosed long term health condition. When someone who has been admitted to hospital as an in-patient is being discharged home, the 'Home from Hospital' service will be contacted to support those who live alone or rely on an unpaid carer. The service will support people in their re-enablement at home and reduce the risk of re-admission to hospital.

End of Life Care

End of life care (EOLC) is the care experienced by people who have an incurable illness and are approaching death (likely to die in the next 12 months). Good EOLC enables people to live in as much comfort as possible until they die, and to make choices about their care. It is about providing support that meets the needs of both the person who is dying and the people close to them, and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support.

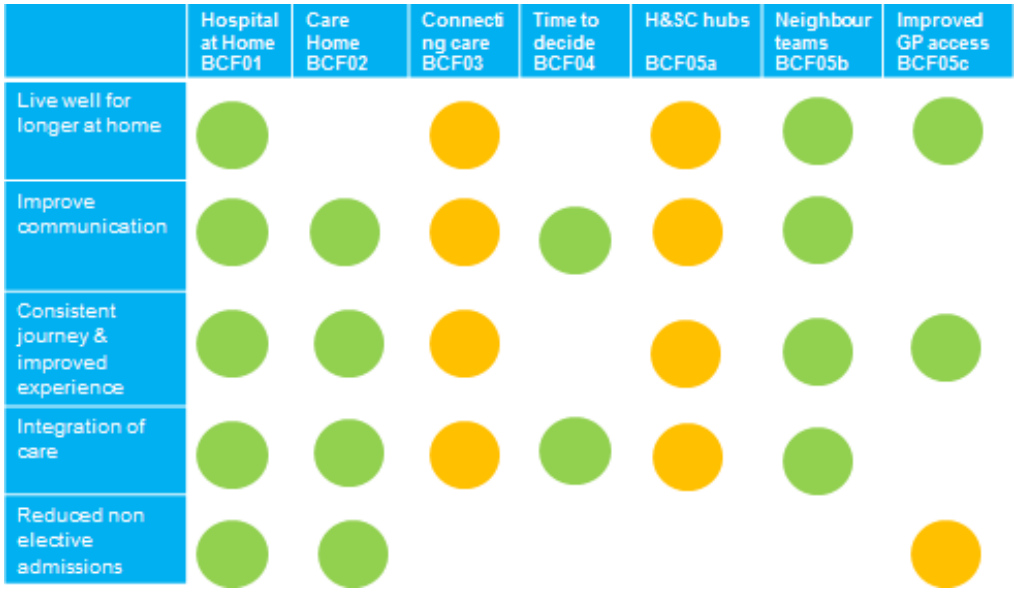
The Reading Health & Wellbeing Board has agreed for a Reading **End of Life Steering Group** to be established, looking at how end of life care can be communicated. The group will map local services and develop services within nationally recognised frameworks, particularly 'Gold Standard Framework - Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'. The group will work towards a "Call to Action" event to coincide with national **End of Life Care Week** (June 2016). This will be based on the following ambitions:

- Each person is seen as an individual
- Each person gets full access to care
- Maximising comfort and well-being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

4.7 Ensure people with care needs and unpaid carers can access services that work well together to support people's independence

Through the Integration of health and social care services in Reading, our **Better Care Fund** (BCF) programme aims to:
· Ensure that Reading residents feel empowered and supported to live well for longer in their own home
· Improve communication between the individual, their family, carers and health and social care professionals
· Provide a positive patient/service user journey and experience of care which is consistent and efficient, through the whole system throughout the whole week
· Provide easily accessible care, seamlessly across health and social care
· Reduce avoidable unplanned admissions to hospital

Reading's BCF plan is designed to target key pressure areas and populations in Reading, and focuses on areas where it has been identified that care can most be improved by integration, based on local experiences and the wider evidence base. The programme is intended to shift more care back into the community and people's own homes, and away from acute settings where people are less likely to be re-abled to maximise their independence.



The diagram above shows how the various Better Care Fund schemes are intended to impact on programme aims. (Direct impacts are shown in green and indirect impacts in gold.)

The **Hospital@Home** service will be developed to support patients that require initial intensive 24-hour support and treatment but can then continue to be managed at home by being discharged after a few days into traditional community care provision.

The **Care Home** scheme will enhance the capacity of care home staff to support people with multiple health conditions and complex needs. Taken together, the various elements of the scheme will promote a shift towards more planned and less reactive care, the latter being notoriously more resource intensive.

The **Connected Care** project seeks to ensure health and social care professionals have access to accurate and timely information regarding patients by facilitating the sharing of information. IT interoperability is critical to improving the quality and experience of care that patients receive, removing silos to ensure that health professionals have access to comprehensive records, and that patients only have to tell their story once.

The **Time to Decide** (also known as **Discharge to Assess**) service will afford patients coming out of hospital a better opportunity to evaluate long term care options. This is expected to reduce the number of permanent admissions to residential care, which are more costly care options than discharge back to a home setting.

Health & Social Care Hubs are intended to offer a single point of access into local care services for health and social care professionals initially, and eventually patients, to help ensure everyone receives the right care at the right time and is not cared for in ways which promote dependency when they should be being enabled to regain skills and strengths.

Neighbourhood Cluster Teams (NCTs) are multidisciplinary teams of health and social care professionals who will be allied to GP clusters or hubs across Reading. The Neighbourhood Cluster Teams NCTs) will integrate health and social care teams across the week to respond to local patient/service user need providing early interventions through care planning to reduce the need for admission to hospital and facilitate discharge. Community services are being reconfigured to support the Neighbourhood Cluster approach with both a **Social Prescribing** and a **Living Well Co-ordinator** scheme being piloted in Reading currently. Both schemes are designed to connect people attending GP surgeries to a wider range of facilities to support their overall wellbeing and moving away from a purely clinical response.

The **Improved GP access** scheme will expand the availability of GP services in the evenings and at weekends. Pilots have commenced, focussing initially on Saturday mornings, and this service will ultimately include both routine and urgent appointments. It is expected that the urgent appointments will alleviate the pressure on urgent care and prevent avoidable admissions. In addition, the availability of GPs at weekends should also facilitate more timely patient discharge.

We are about to embark on the second phase of our Better Care Fund plan.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**13**
TITLE:	**ADULT WELLBEING POSITION STATEMENT**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JANETTE SEARLE**	**TEL:**	**0118 937 3753**
JOB TITLE:	**PREVENTATIVE SERVICES DEVELOPMENT MANAGER**	**E-MAIL:**	**Janette.Searle@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Care Act (2014) creates a new statutory duty for local authorities to promote the well-being of individuals. This duty – also referred to as 'the well-being principle' - is a guiding principle for the way in which local authorities should perform their care and support functions. It is not confined to the Council's role in supporting those who are eligible for Adult Social Care, but includes all assessment functions, the provision of information & advice, and the local offer of 'preventative' services.

1.2 The Care Act requires councils to have a well-being strategy. The 'position statement' that we have prepared is intended to cover this responsibility whilst we prepare an updated version of the health and well-being strategy for 2016-2019 which will be based on the revised JSNA (due to presented to the Health & Well-being Board in March). Our Care Act 'well-being principle' responsibilities will be incorporated in this new health and well-being strategy. The revised JSNA will emphasise the importance of prevention, that is, reducing the risk of avoidable disease and disability, and thus will provide a good basis for a comprehensive, Care Act-compliant, health and well-being strategy.

1.3 The Care Act also gives the local authority a responsibility to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area, and contribute towards preventing or

delaying the development of such needs. This is a corporate responsibility, and not one which rests entirely with the Adult Social Care service.

1.4 This report presents Reading's local approach to prevention, as stipulated in the Care Act regulations, in the form of a draft Adult Wellbeing Position Statement. The proposal is that the Council's approach to promoting adult wellbeing is developed through public consultation on the draft Position Statement, to include the addition of an Action Plan based on priorities agreed with stakeholders.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board agrees to the launch of a public consultation on Reading's approach to promoting adult wellbeing, based on the draft 2016 Adult Wellbeing Position Statement which appears at Appendix 1.

3. POLICY CONTEXT

3.1 Reading's current 2013/15 Health and Wellbeing Strategy and identifies four goals to achieve the vision of a healthier Reading.
Goal 1: Promote and protect the health of all communities particularly those disadvantaged
Goal 2: Increase the focus on early years and the whole family to help reduce health inequalities
Goal 3: Reduce the impact of long term conditions with approaches focused on specific groups
Goal 4: Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

3.2 The Care Act in 2014 triggered a refreshed approach to adult wellbeing with significant reforms to the care and support system and a strong emphasis on improving independence and wellbeing. In the same year, the NHS Five Year Forward View set out a new vision for health care, bringing the prevention of illness to the fore. Both documents highlighted the importance of developing integrated models of care to achieve the changes needed for our care system to be sustainable into the future.

3.3 Locally, in 2014 the Council articulated a new way of working with local people and across agencies in 'Capable Communites: a framework for change'. This sets out a commitment to achieving cultural change so that we can invest in tackling the causes of inequality, based on the premise that neither public services nor citizens have – on their own - access to all the resources necessary to deliver public goods. Social support within and between communities is recognised as being critical to physical and emotional wellbeing.

3.4 Also in 2014, the Council adopted a 3-5 Year Plan for Adult Social Care which:

- Puts Adult Social Care services within the context of the community and neighbourhood that the person who requires care lives within

- Sees service users who require support as being people who still contribute to their family and community
- Is centred on the person – not the convenience of service providers
- Promotes independence and focuses on what people can achieve
- Values and recognises the central part that carers play
- Safeguards people
- Promotes a good life and a good death

This set out a strategic direction for care in Reading which has, at its heart, practice that highlights re-ablement, recovery and rehabilitation and reduces dependency. Promoting wellbeing becomes key to managing demand under this model. The Council has committed to the effective development of universal services to include provision for people whose needs do not meet the threshold for specialist care services, drawing on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living at home safely.

3.5 This drive towards more integrated care is taken forward through the Better Care Fund (BCF) initiative with local BCF plans in place from April 2015. The BCF transfers significant portions of NHS and social care funding (£3.8bn nationally for 2015-16) into pooled budget arrangements between local authorities and Clinical Commissioning Groups. The BCF includes a 'payment for performance' framework based on reducing emergency admissions to hospital. In addition, local BCF plans must set targets to reduce admissions to residential and care homes, demonstrate the effectiveness of re-ablement services, reduce delayed transfers of care, and show patient / service user satisfaction with care services.

3.6 Reading Borough Council's Corporate Plan for 2015-18 sets the following priorities for the local authority:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Providing homes for those in most need
- Keeping the town clean, safe, green and active
- Providing infrastructure to support the economy
- Remaining financially sustainable to deliver these service priorities

4. READING'S APPROACH TO ADULT WELLBEING

4.1 Wellbeing as described in the Care Act is a broad concept. There are nine areas to consider, and each is of equal importance:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal;

- suitability of living accommodation;
- the individual's contribution to society.

A holistic approach is necessary to understand individual wellbeing, drawing on the expertise which sits across Council services – and beyond.

4.2 The Council provides a great many services which support healthy independent living. These benefit the 'well' population as well as those who are at risk of needing care or who are living with established long term health conditions. Our Joint Strategic Needs Assessment and our Health and Wellbeing Strategy set out our local priorities. The draft Adult Wellbeing Position Statement develops our approach to supporting those residents who have current or emerging care needs, and supporting the unpaid or family carers who are helping to keep people well and independent.

4.3 The need to invest in preventative services to delay people's need for social care and health services is widely recognised as key to ensuring that care services are to be sustainable into the future. The challenge of reduced budgets alongside population growth means we need to achieve a significant shift in emphasis across parts of our service offer, and develop our understanding so that we can target our approaches ever more effectively. A major focus now is to identify, at the earliest possible stage, the most vulnerable people in our communities – those who are at risk of poor health and likely to require social care. Reaching these residents must be a priority within programmes that promote people's capacity to maintain an independent lifestyle.

4.4 Our vision is to narrow the wellbeing gaps in Reading so that adults affected by care and support needs can access early help and enjoy healthy and fulfilling lives.

4.5 In order to realise our vision for adult wellbeing as defined in the Care Act, our proposed key aims are to:

- Embed the wellbeing principle throughout the Council's functions
- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

4.6 Our key objectives are in three inter-related categories, often referred to as the 'prevention continuum'.
Prevent (primary prevention) – i.e. avoiding poor health and the development of care and support needs
Reduce (secondary prevention) – i.e. limit the deterioration in individual wellbeing as a result of illness, disability or frailty

Delay (tertiary prevention) – i.e. avoid, or at least delay, the need for intensive support for as long as is safe and appropriate

4.7 The evidence base on the outcomes of early intervention, prevention and enablement activities is relatively new and many of the research findings are largely indicative rather than conclusive. Establishing a clear causal link between targeted wellbeing interventions and improved health/care outcomes is a challenge. Developing local schemes against clear criteria will enable us to evaluate these and so develop our understanding of what works and where the benefits clearly outweigh the costs.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The draft Adult Wellbeing Position Statement builds on and complements several existing strategies, particularly:

- Reading Health and Wellbeing Strategy 2013-16
- Reading Borough Council Plan for Adult Social Care 2014
- Reading Borough Council Corporate Plan 2015-18

The Adult Wellbeing Position Statement does not set out to replace these. Rather, the Adult Wellbeing Position Statement is intended to promote a more cohesive approach to adult wellbeing across the local authority by bringing existing strands of activity together and identifying priorities to ensure we are as effective as we can be.

6. COMMUNITY ENGAGEMENT

6.1 Reading's vision has been developed with our customers and their families and carers so as to offer people a range of options that aim to maximise independence, strengthen people's connections and enjoyment of their communities and networks of support, and so to defer the need for statutory care.

6.2 The Council is committed to working better with residents, and will invite stakeholders to engage with us in developing our approach to adult wellbeing Strategy and an Action Plan to deliver on agreed priorities. This will take the form of an 8 week public consultation. People will have the option of engaging online, through a survey or by taking part in discussion groups. We will focus on engaging people who are likely to be affected by adult care and support needs, i.e. older residents, people with long term health conditions, unpaid/family carers, and care partners across the private, voluntary, independent and statutory sectors.

7. LEGAL IMPLICATIONS

7.1 Producing an Adult Wellbeing Position Statement will provide the Council with a clear framework for ensuring it is meeting its obligations under the Care Act, i.e. to promote the well-being of individuals, and to provide or arrange services that reduce needs for support from people with care needs and their informal carers, and contribute towards preventing or delaying the development of such needs. The services which the local authority is under a

duty to provide or arrange under the Care Act are broadly defined, as wellbeing will mean different things to different people.

7.2 Members are under a legal duty to comply with the public sector equality duties set out in Section 149 of the Equality Act 2010. In order to comply with this duty Members must positively seek to prevent discrimination, and protect and promote the interests of vulnerable groups. Many of those intended to benefit from the priorities set out in the Adult Wellbeing Position Statement will be in possession of 'protected characteristics' as set out in the Equality Act, and the Position Statement therefore has the potential to be a vehicle for promoting equality of opportunity.

8. EQUALITY IMPACT ASSESSMENT

8.1 The consultation will provide an opportunity to develop an understanding of how the proposed Adult Wellbeing Position Statement might impact differently on protected groups, and will also highlight any concerns or impacts any changes may have. This will help to inform any future equality impact assessment which may be required as part of future proposals.

9. FINANCIAL IMPLICATIONS

9.1 This engagement exercise will be met using existing resource and will not in itself require additional capital or revenue investment.

9.2 Consultation feedback will inform the development of the Adult Wellbeing Position Statement to include an Action Plan, at which point the financial implications of the Position Statement will be presented to the Heath ad Wellbeing Board.

10. SUPPORTING PAPERS

Appendix 1 – Adult Wellbeing Position Statement 2016: consultation draft

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**14**
TITLE:	**MENTAL HEALTH CHALLENGE PROPOSAL**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**MELANIE O'ROURKE**	**TEL:**	**0118 937 4053**
JOB TITLE:	**HEAD OF ADULT SOCIAL CARE**	**E-MAIL:**	**MELANIE.O'ROURKE@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Mental Health Challenge is a national initiative and was set up by a group of key mental health (MH) organisations. It is funded by the Department of Health, Public Health England and NHS England, through the 'Voluntary Sector Strategic Partnership Programme'. The initiative is asking all local authorities to undertake this important function through the Mental Health Champion role.

1.2 This report aims to outline the benefits to the Reading area of the lead councillor for health becoming a MH Champion.

1.3 Participation in the challenge is timely given the recent work of Cllrs Hoskin, Eden and Stanford-Beale in the scrutiny of the number of absconders from prospect park hospital which was presented to ACE in November 2015.

2. RECOMMENDED ACTION

2.1 For the council to take up the Mental Health Challenge programme led by the lead councillor for Health; Cllr Graeme Hoskin.

2.2 Agree the identification of a lead officer as described in the initiative.

2.3 For the council to agree to identify a person with experience of using mental health services to form part of the 'challenge group'.

2.4 Work with existing strategies and initiatives across the system, Such as CAMHs Transformation and future strategies in development to promote Mental Health issues.

3. POLICY CONTEXT

3.1 The initiative highlights the need for Local Authorities to have a key role in implementing the mental health strategy and improving mental health in their communities. It supports and encourages local authorities to take a proactive approach to this crucial issue.

4. THE PROPOSAL

4.1 The challenge provides a vehicle to promote awareness and create challenge for issues related to Mental Health.

The initiative provides helpful information to aid the authority to understand the context and impact of mental illness on its community, as well as the roles and responsibilities individual members and officers across the council. These are described below:

- 1 in 4 people will experience a mental health problem in a given year
- The World Health Organisation predicts that depression will be the second most common health condition world wide by 2020
- Mental ill health costs some £105 billion each year in England alone
- People with a severe mental illness die up to 20 years younger than their peers in the UK
- There is often a circular relationship between mental health and issues such as housing, employment, family problems and debt

4.2 The role of the council should be:

- As a local authority we have a crucial role to play in improving the mental health of everyone in our community and tackling some of the widest and most entrenched inequalities in health
- Mental health should be a priority across all the local authority's areas of responsibility, including housing, community safety and planning.
- All councillors, whether members of the Executive or Scrutiny and within community and casework roles, can play a positive role in championing mental health on an individual and strategic basis

4.3 It suggests that the council should resolve to:

- To sign the Local Authorities Mental Health Challenge run by Centre for Mental Health, Mental Health Foundation, Mental Health Providers Forum, Mind, Rethink Mental Illness, Royal College of Psychiatrists and YoungMinds.
- Commit to appoint an elected member as "mental health champion" across the council
- Seek to identify a member of staff within the council to act as 'lead officer' for mental health.

And that the council should also;

- Support positive mental health in our community, including local schools, neighbourhoods and workplaces

- Work to reduce inequalities in mental health in our community

- Work with local partners to offer effective support for people with mental health needs.

- Tackle discrimination on the grounds of mental health in our community

- Proactively listen to people of all ages and backgrounds about what they need for better mental health

5. BENEFITS OF BECOMING A CHAMPION

5.1 The council will have access to a number of tools including a checklist to review Public Health impact on mental health as well as guidance tools for councillors and officers.

5.2 In the South East of England there are few councillors who have become champions. However, it is anticipated that this number will rise, particularly give the spot light that mental health services now have nationally.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 The Mental Health Champion role will promote out key corporate and strategic aims of:

- Safeguarding and protecting those that are most vulnerable

- Providing the best life through education, early help and health living

- Remaining financially sustainable to deliver these service priorities

7. COMMUNITY ENGAGEMENT

7.1 Limited community engagement has been apparent to date. However this will increase through the development of the champion role.

7.2 There is a strategic commissioning group lead by the Head of Adult Social Care who can raise the profile of mental health needs and services across the Reading locality.

8. LEGAL IMPLICATIONS

8.1 None identified at this stage

9. EQUALITY IMPACT ASSESSMENT

9.1 To be developed as the role becomes established.

10. FINANCIAL IMPLICATIONS

10.1 There are no costs associated to becoming a Mental Health Champion, however it should be noted that neither is there any allocated investment as a result of becoming a champion.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**15**
TITLE:	**READING DRUG & ALCOHOL MISUSE NEEDS ASSESSMENT**		
LEAD COUNCILLOR:	**GRAEME HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**SUZIE WATT**	**TEL:**	**0118 937 4806**
JOB TITLE:	**PROGRAMME OFFICER**	**E-MAIL:**	**susan.watt@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Reading Borough Council (RBC) drug and alcohol misuse needs assessment quantifies the extent of misuse of alcohol and drugs in Reading; the effect this is likely to have on people and thus on health and social care and other services, and on prevention and early interventions and, the nature of current services and treatment demand for substance misuse; and what might be done to better meet identified needs.

1.2 This needs assessment is a precursor to a revised strategy for drug and alcohol services in Reading which will be developed in the near future.

1.3 Contributors to the report include key stakeholders and partners for example, Clinical Commission Group's, Source (RBC's Young Persons Drug & Alcohol Treatment Service), IRiS (Adults Drug & Alcohol Treatment service provider), RBC's Parental Substance Misuse Service, Thames Valley Police and RBC Licensing/Trading Standards Team. Client feedback and/or experience is **not** reflected within the paper because this is a needs assessment and not a details proposal for how service might be changed in the light of a needs assessment.

1.4 In Reading, as in many other places, there has been a greater emphasis put on the treatment of drug misuse rather than alcohol misuse. Whilst drug-related deaths rates in the local population are higher than the England average, and in comparison to other Berkshire local authorities, the numbers remain small. In contrast, the figures in the needs assessment show that the health and social care and the wider societal effects of alcohol misuse are substantially greater than those of drug misuse.

1.5 Appendix A – Reading Drugs & Alcohol Misuse Needs Assessment

2. RECOMMENDED ACTION

That Health and Wellbeing Board endorse the Reading Borough Council's Drug & Alcohol Needs Assessment and recommendations.

3. POLICY CONTEXT

The recommendations in this paper will help the Council meet obligations including:

3.1 National Policy & legislation:

- National Health Service Act (2006)[1] and Health & Social Care Act (2012)[2] – mandates local authorities to improve life expectancy and reduce health inequalities.

3.2 Reading's Health & Wellbeing Strategy:

- Promote and protect the health of all communities, particularly those disadvantaged
- Reduce the impact of long term conditions with approaches focused on specific groups
- Promote health-enabling behaviours & lifestyles tailored to the differing needs of communities.
- Joint Strategic Needs Assessment

3.3 Public Health Outcomes Framework [PHOF], which councils are required 'to have regard to:

- Hospital admission episodes for alcohol-related AND alcohol-specific conditions
- Alcohol-specific mortality AND alcohol-related mortality
- Mortality from chronic liver disease
- Number in treatment at specialist alcohol misuse services
- People entering prison with substance dependence issues who are previously not known to community treatment
- Successful completion of treatment for alcohol
- Proportion waiting more than 3 weeks for alcohol treatment
- Claimants of benefits due to alcoholism

4. THE PROPOSAL

4.1 Current Position:

Please see Appendix A.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Prevention, intervention and treatment of drug and alcohol misuse contribute to Corporate Priority 2: *Providing the best life through education, early help and healthy living*.

5.2 The drugs and alcohol treatment services allows the council to significantly contribute to other strategic aims and corporate priorities. It contributes to

[1] *National Health Service Act 2006*. London, HMSO. Available at: http://www.legislation.gov.uk/ukpga/2006/41/contents (Accessed 22 July 2015)
[2] *Health and Social Care Act 2012, c.7*. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 22 July 2015).

the protection of vulnerable children, families and adults. It supports the prevention of alcohol and drug misuse and, uses harm reduction as a way of reducing risks to clients.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Community engagement and consultation will be actioned in the follow up stages, once the needs assessment has been approved.

7. EQUALITY IMPACT ASSESSMENT

7.2 An Equality Impact Assessment (EIA) is not relevant at this stage.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications at this stage.

9. FINANCIAL IMPLICATIONS

9.1 Not applicable at this stage.

Reading drug and alcohol misuse needs assessment

7 January 2016

Suzie Watt
Public Health Programme Officer

Kim McCall
Drugs and Alcohol Contract Performance Analyst

Sally Anderson
Drugs and Alcohol Contract Manager

Dr Andrew Burnett
Interim Consultant in Public Health Medicine

CONTENTS

Summary 1

1 Introduction 3

2 Context 3

2.1 Population – age, ethnicity and socioeconomic deprivation 3

2.2 Drugs & Alcohol 6

2.3 Commonly-used illicit drugs 6

2.4 Alcohol 8

3 The impact of drugs 10

3.1 Hospital admissions 10

3.2 Overdose 12

3.3 Drug Misuse Deaths 12

3.4 Injecting Drugs and Blood Borne Virus 14

3.5 Other harms 14

4 The health impact of alcohol 15

4.1 Hospital admission 15

4.2 Mortality and alcohol 20

4.3 Other harms 22

4.4 Economics, accidents and injuries 23

5 The impact of drug and alcohol misuse on other aspects of community life 25

5.1 Police and judicial systems 25

5.2 Domestic violence and parental substance misuse 30

5.3 Local authority housing 33

6 How big is the problem of drug and alcohol misuse in Reading? 34

6.1 Drugs 34

6.2 Alcohol 39

6.3 Dual diagnosis – mental illness combined with drug or alcohol use 41

7 What works and what is available in Reading for people who misuse drugs and/or alcohol? 42

7.1 Prevention and early interventions to reduce long term dependence on drugs and/or alcohol 42

7.2 Drug and alcohol treatment services in Reading 46

7.3 Needle Exchange 48

8 How are services currently being used in Reading? 49

8.1 All in treatment population 50

8.2 Opiate and crack users in treatment 52

8.3 Users of other drugs in treatment 55

8.4 Residential rehabilitation 55

8.5 Alcohol users in treatment 56

8.6 Drug treatment completion rates 57

8.7 Alcohol completion treatment rate 60

8.8 Complexity 61

8.9 Young people and treatment 63

9 Discussion 65

10 Conclusion 68

11 Recommendations 69

12 References

SUMMARY

The misuse of both drugs and alcohol is a problem in Reading, as elsewhere, and is growing for alcohol; locally, we are not doing all that we can to prevent misuse and the provision of interventions are not to be addressing the need of local Reading residents.

Alcohol misuse, mainly in the adult population, is a far greater problem than drug use in Reading, as elsewhere. Principally this is because of the sheer number of people who drink alcohol in our society (a very large majority) and the increasing proportion who do so in ways that risk injuring their health: based on current guidelines, we estimate that at least some 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels. As these figures are based on national self-reported drinking levels, and research shows that people significantly under-report their drinking, we can infer that people's true drinking levels are even higher than this. It is noteworthy that Reading has high rates of alcohol-specific mortality and mortality from chronic liver disease in both men and women. These rates indicate a significant population who have been drinking heavily and persistently over the past 10-30 years. Liver disease is one of the major causes of mortality and morbidity which increasing in England with deaths reaching record levels having risen by 20% in the last decade.

Whilst locally the numbers of drug-related admissions and drug-related deaths are proportionally smaller, what is clear is that drug misuse, particularly of opiates and crack cocaine, places an enormous strain on the families of drug users, including their children; can have a serious negative impact on the long-term health and well-being of family members; and that many drug misusers have a myriad of health and social problems which require interventions from a range of providers.

The most commonly used drugs, such as cannabis, opiates and crack cocaine, are illegal, uncontrolled novel psychoactive substances (also known as 'legal highs' and 'club drugs') are relatively easily available.

Drug and, especially, alcohol misuse is a significant cause of both violent crime and acquisitive crime. Whilst we know that acquisitive crime, mainly associated with drug use, is declining, violent crimes and assaults (including domestic abuse) are increasing and are a significant factor in personal and family problems, often placing children at especial risk.

Many young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often report being victims of domestic violence; having contracted a sexually transmitted infection; experiencing sexual exploitation; being more likely not to be in education, employment or training; and being increasingly likely to be in contact with the youth justice systems.

More needs to be done to encourage and enable front-line personnel in education, health and social care, and across other relevant sectors, to sustainably raise awareness of the risks of drug and alcohol misuse and how to avoid it.

Education, health and social care front-line personnel also need to be enabled and encouraged to do more to identify people at risk of misusing drugs and/or alcohol, to provide brief interventions, and to refer to appropriate services. It would be appropriate to extend this to other services too, which may come into contact with vulnerable adults and young people, such as housing and the police.

A review of current specialist service provision for drug and alcohol misuse against current resource allocation in Reading is required. It may be appropriate to change the way current services are delivered, with the current resources allocated, in order to meet the needs of an ageing, dependent, opiate using population and increase the access to specialist alcohol misuse services and youth services. Specifically, Reading needs a revised approach to its drug and alcohol services that:

- puts a much greater emphasis on the problems of alcohol misuse at all ages (that is, younger people and older ones), and for people with different problems causing them to use drugs and/or to misuse alcohol;
- puts a much greater emphasis on prevention, particularly targeting 0-18 year-olds, with specialist family support for children at risk, but also helping to address the issue that both young and older adults face;
- ensures that all health and social care services, and those of the police and judicial system, work together more effectively so that people do not fall into gaps between services and so that it is simple to provide care between different agencies without the service user having to try to negotiate their way from one to another;
- provides services of all types in different locations to improve engagement and thus outcomes;
- enables and encourages front-line staff in all sectors, to do much more to identify people at risk of misusing drugs and/or alcohol and to provide brief interventions, and refer to appropriate services; and
- enables different policies and services and the enforcement of regulations, to take account of the cumulative impact of drug and alcohol misuse to enable greater benefit to people's health and to the community more widely.

IMPORTANT NOTE

At the time of writing this report it was announced that the Department of Health was expected to publish new guidelines on alcohol consumption including that the recommended weekly upper limits for drinking were to be reduced and made the same for men and women. In addition, it was expected that the Department of Health would add that there was actually no real safe lower limit for alcohol consumption.

This report was completed before the publication of these revised guidelines and the calculations in it in relation to the number of people in Reading drinking alcohol at hazardous and at harmful levels are likely to be underestimates in the light of this expected revised guidance.

Reading drug and alcohol misuse needs assessment 2015/16

1 Introduction

The Reading Borough Council (RBC) drug and alcohol misuse needs assessment quantifies the extent of misuse of alcohol and drugs in Reading; the effect this is likely to have on people and thus on health and social care and other services, and on prevention and early interventions and, the nature of current services and treatment demand for substance misuse; and what might be done to better meet identified needs.

This needs assessment will enable the development of a Reading drug and alcohol strategy and action plan. We have sought contributions from key stakeholders and partners, particularly those who have direct involvement in drug and alcohol treatment services.

The most significant drug of addiction in England,[i] nicotine – most commonly inhaled in tobacco smoke – is not considered in this report; this is a sufficiently large topic to merit dealing with separately, and references here to the use of 'substances' should be read as being 'he most likely after tobacco in terms of having a deleterious effect on health.

2 Context

2.1 Population – age, ethnicity and socioeconomic deprivation

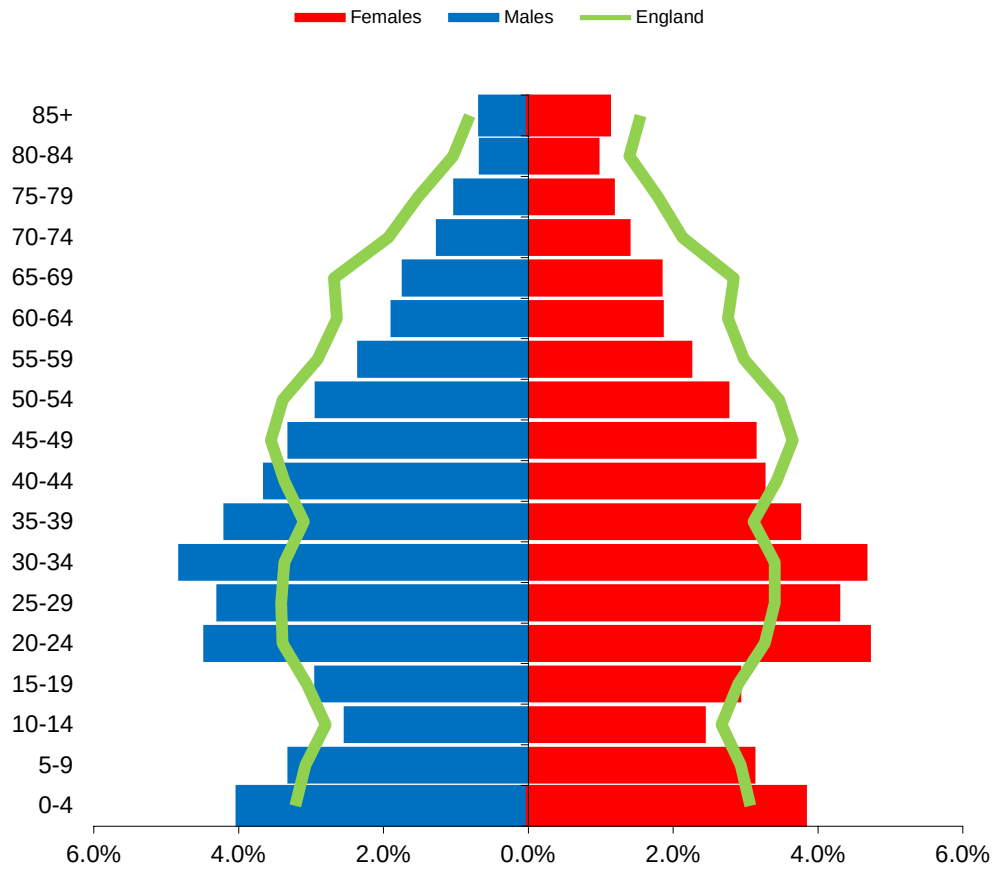
The structure of a population can have an impact on how we apply and model evidence about local drugs and alcohol misuse and more importantly, how we plan prevention, intervention and treatment services. There is good evidence that different populations have different relationships with drugs and alcohol, this includes age, sex and ethnicity. Socioeconomic deprivation is linked with health inequalities and with a higher incidence of substance misuse.[1]

The Office for National Statistics (ONS) mid-year 2014 population estimates 124,171 people aged 18+ as living in Reading [2] and, as seen in Figure 1, Reading has a greater proportion of younger residents aged 18-27 years in comparison to the England average and other local authorities in Berkshire. The difference between the Berkshire local authorities could be partially be explained by the number of students attending Reading University and Reading College and the number of large business that provide employment opportunities.

The majority of people from Black and ethnic minorities (BME) in Berkshire come from the Asian/Asian British community (Figure 2), making up approximately 12.6% of the population in Reading. In total, people from BME backgrounds make up approximately 20% of the total Berkshire population and 22.2% of the Reading population (Figure 3).

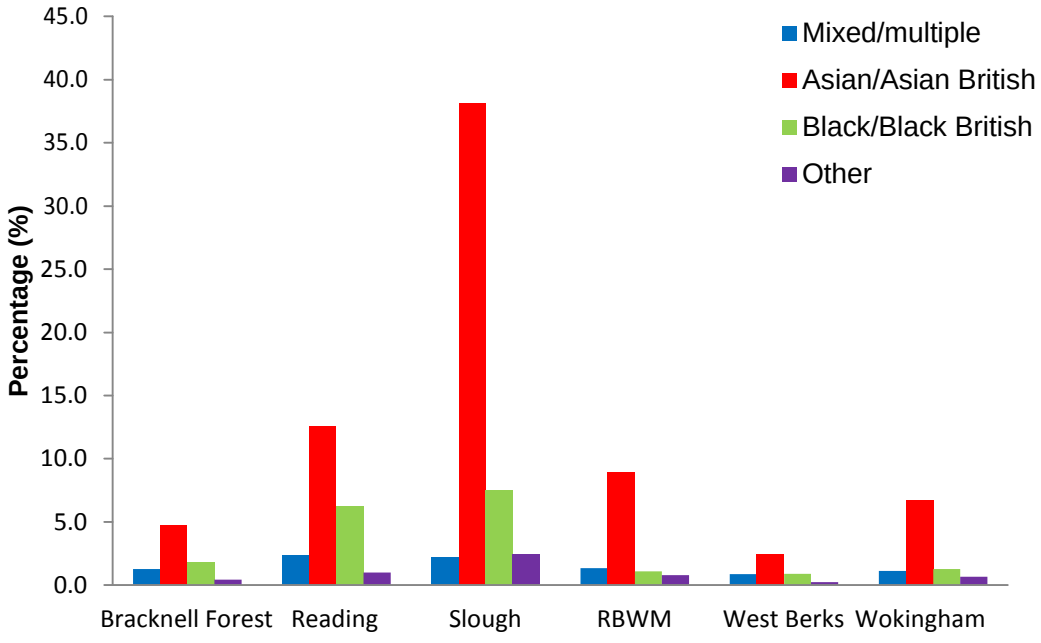
i Addiction, increasingly referred to as 'dependence', is characterised by various features, including a compulsion to take a substance; tolerance (a need to take increasingly larger amounts to get the same effect); and physical and psychological withdrawal symptoms when unable to do so. (World Health Organisation. *Management of substance abuse. Dependence Syndrome*. See http://www.who.int/substance_abuse/terminology/definition1/en/ (accessed 26 October 2015))

Figure 1. Reading population structure 2014 compare to England



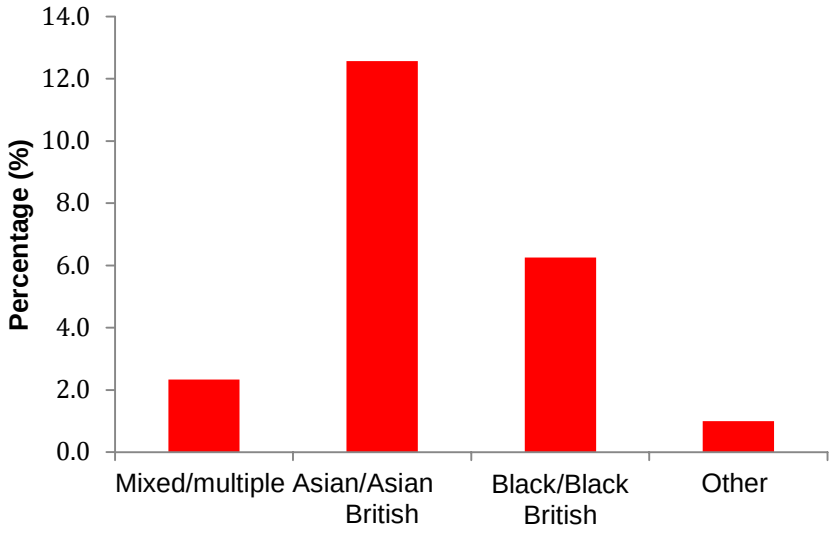
Source: ONS Mid-year population Estimates, 2014.

Figure 2. BME ethnicity in Berkshire as % of population, by Berkshire local authority, 2013



Source: ONS Mid-year population Estimates, 2013.

Figure 3. Proportion of people in the population from BME groups in Reading



Source: Ce

Social and economic inequalities in society are reflected in, and can help to determine, our health outcomes. [3] In 2011, Lower Super Output Areas (LSOA) [ii] boundaries were revised, taking changes into account, Public Health England (PHE) have used a formulation, applying a score and ranking system. LSOAs are ranked using adjusted scores and are aggregated into ten groups, or 'deprivation deciles' based on their ranking. The most deprived tenth were allocated to decile one and the least deprived to decile ten. [4] Depending on the year of the data source, Reading falls predominantly within the fifth decile.

Reading has over half of the LSOAs in Berkshire that fall within the 20% most deprived areas, a significant higher proportion that most other Berkshire local authorities (as shown in Table 1). Current evidence shows, for example, that a boy born to parents living in Minster ward, is expected to live 11 years longer than one born at the same time to parents in Whitley ward. Some sources of evidence usefully allow us to compare Reading outcomes against areas that are estimated to have similar levels of deprivation. Where comparators are available, we have used these throughout the report.

Table 1. Number of LSOAs by Berkshire Local Authority that fall in the 20% most deprived nationally:

Local Authority	Number
Reading	12
Slough	10
West Berkshire	1
Wokingham	0
Bracknell	0
Royal Borough of Windsor & Maidenhead	0

Source: Department for Communities and Local Government 2011

ii Lower super output areas (LSOAs) are subdivisions of electoral wards for data analysis purposes that are defined by aggregating individual household data collected at the decennial census into larger groups. The importance of analysing data at LSOA level is that electoral wards are not homogenous: most wards are patchworks of, for example, small areas of different levels of deprivation and different proportions of people from Black and minority ethnic groups. These differences affect local need and how services can be targeted effectively

Whilst health outcomes are determined by a number of different factors, understanding local inequalities is useful in us being able to determine what the local needs are in relation to drugs and alcohol misuse, particularly where vulnerabilities are socioeconomically factors. Identifying what the alcohol and drug misuse issues are in Reading is also reliant on data such as hospital admissions, treatment services and crime statistics, being recorded in such way that we can confidently draw conclusions from them. Where local data and intelligence is available and relevant, it is presented and discussed, and, where appropriate, we have extrapolated national and international evidence and applied this to our local population in order to estimate the impacts of drug and alcohol misuse in our community.

2.2 Drugs & Alcohol

Alcohol, within certain limits, is legal to purchase and use in this country, however the situation with drugs is different. Drugs can be obtained on prescription, some of them can be sold and bought legally, and some are illegal.

Unlike alcohol, it is also less clear whether the use of some drugs can be associated with reasonably safe relaxation and pleasure. Legal and illegal drug use is less obvious to the public. This may be that many people use certain drugs without significant harm being apparent (as is the case with moderate use of alcohol) and thus do not come to the attention of the health, social care or police or judicial systems. [5]

It is also noteworthy that there anecdotal reports from children and young people in Reading that it is far easier to obtain drugs than it is alcohol. This phenomenon is likely to be found elsewhere too with the increasingly effective enforcement of age restrictions on the selling of alcohol to minors. Whilst there are number of factors that influence a person's alcohol and drug use behaviour, we know that young people's attitude and behaviours are heavily influenced by people they live with.[1,6]

What is clear is that drug misuse, particularly of opiates and crack cocaine, can place an enormous strain on the families of drug users, including their children; can have a serious negative impact on the long-term health and well-being of family members; and that many drug misusers have a myriad of health and social problems which require interventions from a range of providers.[1]

The use of alcohol, to an extent, is largely socially acceptable, not only because of its legal status but also because drinking is a well-established part of our culture. We know that chronic heaving drinking, hazardous and harmful drinking (to a lesser degree) also pose threats to the health and wellbeing of the drinker, their family, and friends as well as to the community and has wide health and social care costs. [7]

2.3 Commonly-used illicit drugs

The illicit drug most likely to be used in the United Kingdom (UK) is cannabis, followed by cocaine, and then other stimulants such as amphetamine and similar drugs such as the extremely addictive crystal methamphetamine. Opioids (such as heroin), lead to the most significant health problems, are used less commonly,[8] and, as will be seen later, are more commonly used by an ageing cohort who took up the habit in the 1980s and 1990s. Opioids are now much less commonly being taken up by younger people. Novel psychoactive substances (NPSs) are an emerging issue and are commonly advertised and sold as 'legal highs' and 'club drugs' and are often cheaper than illicit drugs. [9] The impact of illicit drug use is discussed in further detail in section 3.0 of this report.

Cannabis is mainly consumed as marijuana (which essentially is the dried flowering tops of plant Cannabis sativa), as hashish (resin, commonly referred to as 'hash'), or as an oil extracted from the resin. Cannabis is commonly mixed with tobacco and smoked in a cigarette or 'joint', but can also be swallowed. It contains a psychoactive ingredient, delta-9-tetrahydrocannabinol (also known as THC) and levels of this vary in different strains of plant. Cannabis remains in the body for up to a month; when smoked it is rapidly absorbed by the bloodstream and reaches the brain within seconds. Health impacts are dependent on quantity consumed and frequency of consumption: cannabis impairs both short and long-term cognitive functioning, including being able to organise and integrate complex information, and impairs recall of previously-learned tasks for up to 24 hours after consumption.[10,11]

Opiates is the generic term used to describe the group of drugs which are derived from the opium poppy (Papaver somniferum). Naturally-occurring drugs in this group include opium, morphine and codeine, whilst substances such as heroin are classified as semi-synthetic. Opioids, or 'opiate-like' substances such as methadone, pethidine and fentanyl, are wholly synthetic products. Opiates depress the central nervous system and are used therapeutically in many commonly-used and prescribed medications.[10, iii]

Because of its ability to penetrate the blood-brain barrier, heroin produces a quicker 'high' in comparison to other opiates, making it the drug of choice for many opiate users. The euphoriant effects of heroin, often results in the reduction of anxiety, boredom, physical and emotional pain. Heroin can be snorted, smoked or inhaled (a method known as 'chasing the dragon' whereby it is heated on foil and the fumes inhaled). In addition to the features of dependence, its use, especially if injected intravenously, is associated with a number of harms. [10,12]

Cocaine acts a stimulant to the central nervous system. Some naturally occurring plants which act in a similar way include khat and betel nuts (not currently under international control). Crack-cocaine and cocaine hydrochloride are products which are extracted from the leaf of the coca bush. Similar to opiates, there are therapeutic uses for cocaine, for example being used a local anesthetic and, synthetic stimulants, which are similar in chemical structure and effects, are used in treatment for narcolepsy and of children suffering from attention deficit disorder.[10, 13]

Drugs which act as a central nervous system stimulant are often used to elevate mood, to overcome fatigue and to improve performance. The effects vary depending on the drug of choice. Effects from cocaine can last from a few minutes to less than an hour, whereas the effects of amphetamine-type stimulants (ATS) may last several hours. Cocaine hydrochloride is most commonly snorted, but can also be injected. Crack cocaine is usually smoked and ATS can be taken orally, injected, smoked or snorted. [5, 10,13]

NPSs are drugs that affect brain function (hence the term 'psychoactive'). They are 'novel' because many are relatively new and/or variants of other drugs and chemicals which are not currently prohibited substances under the United Nations (UN) Single Convention on Narcotic Drugs or by the Misuse of Drugs Act 1971. They are predominately used for their intoxicating and stimulating properties. NPSs began to appear in the UK drug scene around 2008/09.[9,14]

The fact that most NPSs are not currently prohibited does not mean that they are

iii Opiates are powerful pain killers, the best known being morphine. Heroin is manufactured from morphine and has been used with great benefit in medical practice, albeit much less commonly since Harold Shipman was convicted of multiple murders using excessive doses of this drug.

harmless. Heavily marketed as 'legal highs' (and tagged with various trade names), in most cases they only remain lawful because there has been no scientific testing and advice leading to a ban. They are usually sold with no indication of active ingredients or dosage, while others are sold as 'research chemicals' with chemical names, but both are often of unreliable quality and analysis shows that the contents can change substantially between batches.[9, 10]

NPSs fall into four main categories:[9]

- Synthetic cannabinoids – these mimic cannabis and bear no relation to the plant other than to act on the brain in a similar way. Current trade names include Clockwork Orange and Black Mamba.
- Stimulant-type drugs – these drugs are structured to mimic amphetamines, cocaine and ecstasy and include mephedrone, ethylphenidate, benzylpiperazine (BZP), methylenedioxypyrovalenrone (MPDV), Naphyrone (NRG -1), Benzo Fury, 5,6-Methylenedioxy-2-aminoindane (MDAI).
- 'Downer'/tranquiliser-type drugs – structured to mimic anti-anxiety or tranquiliser drugs, particularly from the benzodiazepines family, and include Etizolam, Pyrazolam and Flubromazepam.
- Hallucinogenic drugs – these drugs mimic substances like LSD and include 25i-NBOMe, Bromo-Dragonfly and the more ketamine-like methoxetamine.

In recent years, the UK has seen an increase in the number and range of new NPSs. Health care professionals have reported dealing with patients under the influence of substances that they have not heard of. In part, this is because chemists involved are dynamic, responding quickly to changes in the law, easily creating new substances to replace newly-banned ones repacking substances as a different (and allegedly legal) product. [9,10]

2.4 Alcohol

Alcohol is a psychoactive substance made from a chemical called ethanol, produced by putting either grains, fruits or vegetables through a fermentation process. The length of fermentation determines the drink's alcohol content. Whilst our bodies, mainly the liver, can generally process one unit of alcohol per hour (although this is dependent on a number of factors), the fact is that ethanol is a poison which sometimes has lethal consequences.[15,16]

Most people who drink alcohol reportedly do so in moderation, its use is widely associated with relaxation and pleasure, and is a well-established part of culture in the UK. It is the *misuse* of alcohol that leads to problems, with 'binge drinking' accounting for half of all alcohol consumed in the UK.[17]

Whilst excessive alcohol intake does not always lead to harm, alcohol consumption is the primary causal factors in more than 200 different diseases and injury conditions.[15] It also increases the risk of social, physical and mental harm to the drinker and to others. For example, it is well known that driving under the influence of alcohol substantially increases the risk of having a serious accident, with fatal injuries occurring especially in relatively younger age groups.[15] Excessive alcohol intake is also associated with antisocial behaviour, street violence, domestic violence and suicide; it also affects people's ability to work and, when it becomes a significant problem, this can often lead to job loss. [15,18] An estimated 7.5m people in England are unaware of the damage their drinking could be causing. [19]

A variety of factors have been identified at individual and societal levels, which

affects the levels and patterns of alcohol consumption. For example, culture, availability of alcohol, enforcement of alcohol policies, family history; psychological factors such as anxiety or depression; the addictive nature of alcohol itself, and the environment in which people live.[20]

Whilst alcohol consumption in the UK has nearly doubled since the 1950s,[21] official data available shows that in the UK, between 2005 and 2012 the proportion of adult men who self-reported drinking in the week preceding the surveys fell from 72% to 67% and the proportion of adult women fell from 57% to 53%.[6] As 40-60% of alcoholic drinks sold in this country are unaccounted for based on self-reported consumption, it is reasonable to assume that these statistics are not a wholly reflective of alcohol consumption in the population, and it is likely to be significantly higher.[22]

Statistics also show that between 2009 and 2012, household spending on alcoholic drinks increased by 1.3%, whilst alcohol brought outside the home decreased 9.8%, but more importantly, alcohol was 53.8% more affordable in 2014 than it was in 1980. This is based on a 'basket of alcohol' rather than cheapest, or that with the highest purity. [22]

Over one third of adults are apparently drinking above weekly guidelines and more than three-quarters are drinking above daily limits on their heaviest drinking day each week, with women as likely as men to be binge drinking and more likely to exceed daily limits.[23] It is important to note that binge drinking is not limited to the media image of young people consuming excessive amounts of alcoholic drinks in public places but includes people of all ages often binge drinking in the privacy of their own homes. Adults living in household in the highest income quintile are twice as likely to drink heavily than adults in the lowest income quintiles – 22% compared to 10% and whilst older people tend to drink more frequently, younger people tend to drink more heavily on a single occasion. [24]

The current recommended limits to alcohol drinking are that:

- men should not regularly drink more that 3-4 units[iv] of alcohol each day;
- women should not regularly drink more than 2-3 units of alcohol each day; and
- anyone who has had a heavy drinking session should refrain from drinking alcohol for the next 48 hours.[25, v]

iv In the UK, consumption of an alcohol drink is measure in units. Units are a simple way of expressing the quantity of pure alcohol in a drink by offering a standardised comparison of the volume of pure alcohol between alcohol beverages, that is 1 unit is equal to 8 grams of pure alcohol, which is equivalent to 10 millilitres of pure ethanol (alcohol).

v There are two important aspects to these recommended limits: (1) the recommended maximum intake for women is lower because the relative amount of fat and muscle is different in women's and men's bodies. This leads to alcohol being distributed in the body differently and metabolised at different rates, and (2) many alcoholic drinks are now stronger than when these recommended drinking limits were defined. For example, the average strength of wine is now 12.5% whilst alcohol units are based on wine of 9% strength, and a unit of beer was based on an alcoholic strength of 3.5%, whilst the strength of most modern lagers is 4%. In addition, wine is normally now sold in pubs and bars in 175ml or 250ml glasses whilst a unit of wine is based on a 125ml measure. Most alcoholic drinks are now labeled with definitions of their alcohol contents and show, for example, that whilst a 70cl bottle of wine used to contain six units of alcohol most now contain 9-10 units

It is also noteworthy that some authorities now recommend that people who drink on most days of the week should refrain from drinking on two days of every week.[vi]

The *Smoking, Drinking and Drugs Use Amongst Young People in England* survey contains information on drinking in children aged 11 to 15 years in secondary schools. In 2013, there was a decrease in the national trend of pupils reporting drinking alcohol as well as the proportion of pupils who drank alcohol in the week preceding the survey. Pupils were more likely to drink if they lived with someone who did and/or if they felt their families would not mind them drinking, as long as it was to excess. [26] Despite this, alcohol misuse remains a problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009 and, the secondary school survey would not account for our most vulnerable children who may not be in long term education or training.[27]

3 The impact of drugs

Individuals who take illicit drugs face risk of being poisoned, overdosing and other potential health risks. [1] This section presents a range of national and local information about the impact of drugs, including hospital admissions and health and social care impacts.

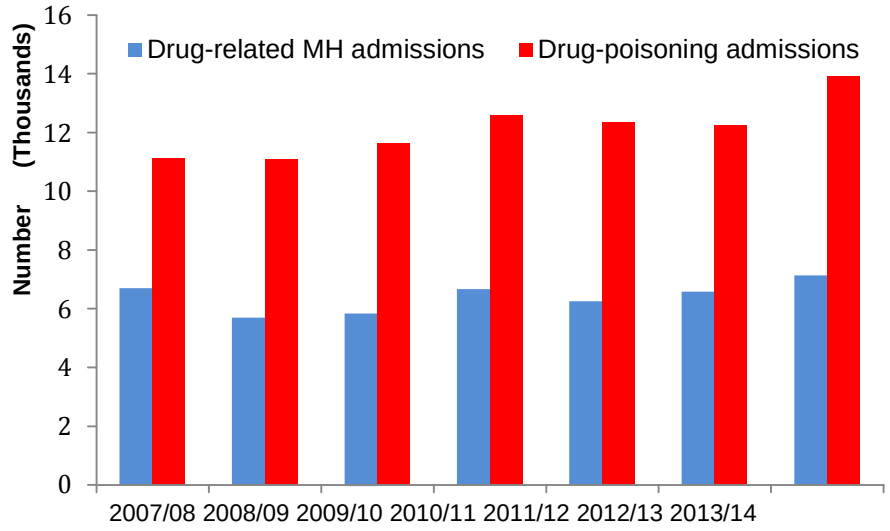
3.1 Hospital admissions

Nationally there has been a marginal increase since 2011/12 in the number of people being admitted to hospital because of an illicit drug-related mental health and behavioural disorder, with the greatest increase being in people aged 16 to 24 years. Despite this, the overall numbers have still not returned to the higher levels seen in the early 2000s. The same cannot be said for the number of NHS hospital admission in England with a primary diagnosis of poisoning by illicit drugs; this has been on the increase since 2003/04 (see Figure 4). This is true of all age groups, with the exception of those under the aged of 16 where nationally there has been a marginal decrease. The largest increase in admissions was seen in those aged between 45 and 54 years. [28,29]

The numbers for such admissions for 2013/14 were relatively small for Reading, there being fewer than five admissions recorded for drug-related mental health or behavioural disorders and 32 for poisoning by illicit drugs. Both have declined since 2010/11, down from 21 and 45 respectively. We unable to confidently compare figures to previous years as 2013/14 was the first year admissions were reported by local authorities, prior to which admissions were reported by primary care trusts (PCTs).[28]

vi Some academics consider that there is no safe lower limit for alcohol consumption and that there is no 'moderate' intake of alcohol that actually improves health. See http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf (accessed 1 November 2015). Certainly, there have been no good-quality randomised controlled trials comparing the long-term effects of alcohol against a placebo. And observational studies that were thought to show a so-called J-shaped mortality curve (implying that people who totally abstained from alcohol had higher death rates than those imbibing 'moderate' amounts, whilst those consuming much larger quantities had much higher death rates) are now thought to have suffered from confounding with a high proportion of subjects refraining from taking alcohol because they were already in poor health and thus at a higher risk of dying

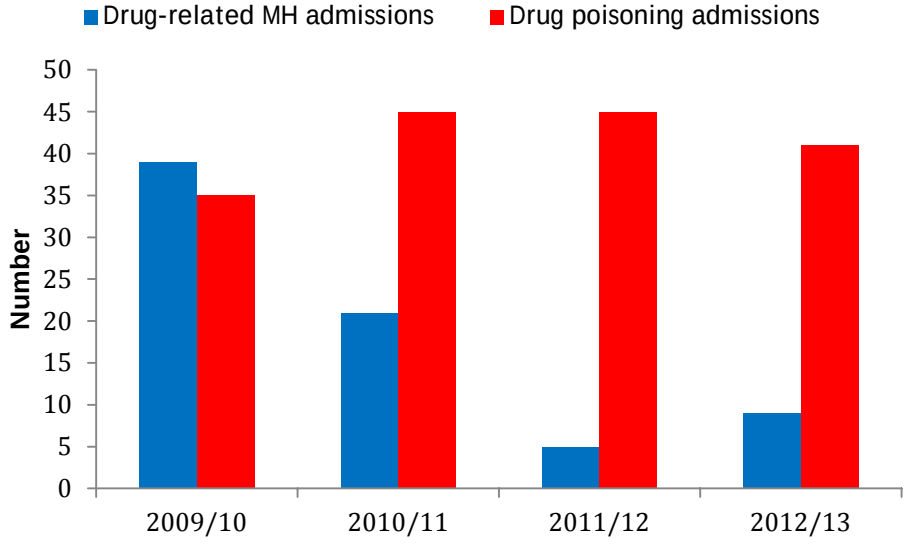
Figure 4. The number of NHS hospital admissions in England by primary diagnosis of drug-related mental health or behavioural disorder, or primary diagnosis of poisoning by illicit drugs, 2007/08 – 2013/14.



Source: Hospital Episode Statistics (HES). The Health and Social Care Information Centre 2014.

Figure 5 below shows the number of NHS hospital admissions for Berkshire West PCT[vii] for both drug related mental health conditions and drug poisonings, 2009/10 to 2012/13. It is difficult to confidently draw conclusions on what the true numbers are for Reading, but what we can say is that drug-related mental health admissions showed a decreasing trend until 2012/13, whilst drug poisoning admissions remain fairly consistent.[25]

Figure 5. The number of NHS hospital admissions in Berkshire West PCT where there was a primary diagnosis of drug-related mental health (or behavioural disorder) and of poisoning by illicit drugs 2009/10 to 2012/13



Source: Hospital Episode Statistics (HES). The Health and Social Care Information Centre 2014.

vii Under the historical structure of PCTs, the patient population for Berkshire West PCT was made up of residents from Reading, West Berkshire and Wokingham.

3.2 Overdose

A drug 'overdose' is the usually inadvertent consumption of an excessive and amount of a substance leading to harm. The main causes of overdose include:[30]

- low tolerance/using too much – users' bodies develop tolerance to repeated presence of drugs. Tolerance is reduced if there is a break or reduction in drug use for a period. Higher doses are often needed to achieve the same effect, increasing the risk of overdose;
- mixing drugs (including alcohol) – combining drugs often results in unintentional physical effects, especially when depressants are used as they slow down a user's breathing and heart rate. The top four drugs involved in overdoses are depressants such as heroin, diazepam, alcohol and methadone; and
- variable purity levels – illicit drugs vary in strength and unknown purity levels have implications for users when deciding how much to take.

Additional substances may be added to bulk, dilute, complement and enhance the effects of drugs, however stories of illicit drugs being frequently cut with household cleaning products are often inaccurate. Poisonings commonly occur through the use of adulterants[viii] such as lead, quinine and clenbuterol, to name but a few. Toxicity is also a risk when adulterants such as paracetamol and procaine are used.[31]

The rate of drug misuse death is relatively high in Reading, but the numbers are low (see section 3.3). [32] Drug misuse deaths in Reading are mostly associated with overdoses from heroin. In terms of harm, long-term follow-up of heroin addicts show they have a mortality risk nearly 12 times greater than the general population.[33]

It is difficult to report the true number of drug-related overdoses, however local usage of naloxone is one source of information we can consider. Naloxone provision is a safe, efficacious drug administered to reverse the effects of opioid overdoses and it is used both nationally and in Reading as an intervention to reduce the risk of a drug-related death.[34] Of course, it has to be given in sufficient time following an overdose.

Between April 2014 and June 2015 naloxone was administered by South Centre Ambulance Service (SCAS) paramedics 149 times in Berkshire clinical commissioning group (CCG) areas. Of these, the drug was administered 48 times to residents in South Reading CCG and five times to residents in North and West Reading CCG. [35] This represents over a third of all naloxone used by SCAS in Berkshire, suggesting a higher need for use in Reading in comparison to other areas in Berkshire. It was mostly administered to those aged 26-34 (16 individuals) and 35-49 (13 individuals) and to men (37). This correlates to the higher prevalence of drug use, drug-related deaths and injecting-use in Reading in comparison the other Berkshire local authorities.

3.3 Drug Misuse Deaths [ix]

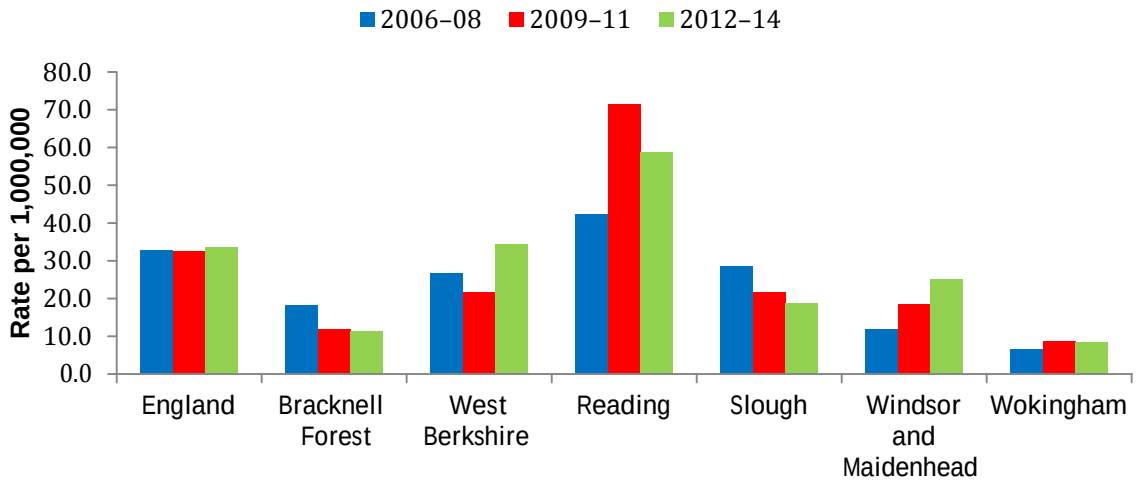
In 2012-2014, Reading had a drug-misuse death (also referred to as drug-related death (DRD)) rate of 58.7 per 1,000,000 population, much higher than the England

viii Adulterants refer to pharmacologically active ingredients added to give either a synergistic or antagonistic effects.

ix Drug Misuse deaths are defined by ONS as deaths where a) *the underlying cause is drug abuse or drug dependence* or b*) where the underlying cause is drug poisoning AND where any of the substances controlled under the Misuse of Drugs Act 1971 are involved*. This definition has been adopted across the UK.

average of 33.5 per 1,000,000, and the highest rate in Berkshire (see Figure 6). Although the rate is high, the number of deaths that occurred is relatively small. Local information suggests that deaths correspond to patterns seen nationally.[36,37]

Figure 6. DRD rate per million by Berkshire local authority, 2006-2014



Source: Office for National Statistics 2014

In 2014/15, ten people in Reading died as a direct result of their drug use (two are still awaiting inquest, however a verdict [x] of DRD is anticipated in both). Heroin was implicated in eight of the deaths (alone or in combination), one involved amphetamines and MDMA, and there is one case where information about the substances involved is unavailable.

So far in 2015/16, nine people In Reading have apparently died of drug-related causes. A verdict of DRD has been recorded in four of the Reading cases, and five are awaiting inquest. Two out of the four cases deaths where verdicts have been made involved heroin, the other two involved a combination of (primarily) prescribed drugs and, in one of the cases, alcohol.

Of the 19 deaths recorded in Reading (in 2014/15 and in 2015/16 to date) seven of those who died were in their 40s, six in their 30s, three in their 20s, two in their 50s and one in their 60s. Eighteen were male and one female. Five of those who died were engaged with local treatment services and one was in residential rehabilitation; the others were not known to the drug and alcohol services. It seems that in most years, only about half of those suffering a drug-related death are known to the local drug and alcohol services.

There is an apparently greater risk of death from overdose in Reading compared to other areas in Berkshire, and in comparison to the England average, but care must be taken in interpreting these statistics as the numbers are very small. The risk is apparently greater for heroin users, which is unsurprising given the evidence of risks associated with heroin use, particularly when injecting. The risk of drug-related deaths is greater in men who are in their late 30s and 40s living alone and this is also seen locally. [36, 37]

x Verdicts are determined by the local Coroner and it is important to note that whilst drug use may be factor in a person's death, a DRD verdict may not necessarily be returned in all cases.

3.4 Injecting Drugs and Blood Borne Virus

Whilst non-injecting and injecting drugs users face similar harms from the drugs themselves, injecting drug users are also vulnerable to contracting and to spreading blood-borne viruses such as hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV). They are also at an increased risk of endocarditis (inflammation/infection of the heart); liver disease; kidney disease; thrombosis, abscesses; pneumonia; and death.[38, 39] A study of injecting drug users also showed that they were 22 times more likely to die prematurely than their non-injecting peers.[40]

Injecting drug users also have a:

- 10-fold greater risk of community-acquired pneumonia;
- increased risk of general infection due to poor nutrition;
- increased risk of contracting tuberculosis; and
- increased risk of experience psychiatric and other psychological problems, that is major depression, anxiety and withdrawal syndromes. [27]

RBC commissions a needle and syringe exchange service in order to reduce the blood-borne virus risks associated with injecting drug use. Whilst there is good evidence of this as a harm-reduction strategy, we are unable to determine the true impact of this service on the health outcomes of injecting drug users, but based on national evidence, where it is utilised, it is likely to be positive.

3.5 Other harms

Drug users tend to have worse physical and mental health than the general population, and as well as symptoms of physical dependence and withdrawal; there are often factors involved which lead to other adverse outcomes such as offending or risky sexual behaviour.[41]

Long-term effects of cocaine use include internal damage to the nasal passages if it is inhaled (because of its strong blood vessel constrictor action), upper respiratory tract infections, heart attack, stroke and sudden death.[42] Injecting cocaine and crack cocaine[xi] is associated with the highest health risks.[43]

Drug users who also inhale (for example, cannabis, cocaine, ATS) have a high frequency of upper respiratory tract infections.[10] Probably the greatest health risk associated with cannabis use is from the tobacco which it is commonly mixed with, and whilst this needs assessment is not focused on tobacco, it is important to note indisputable evidence of the burden tobacco in terms of lives prematurely lost, reduced quality of life (principally through smoking-related illness) and the high health and social care costs.[44]

There is growing evidence that regular use of cannabis, particularly from adolescence, doubles the risk of developing an acute psychotic episode or developing chronic schizophrenia in the longer term. [45] As well as impairing new learning, cannabis use impairs motor co-ordination and increases the risk of motor vehicle accidents; and its use in pregnancy can impair fetal development and lead to low birth-weight.[46]

People using NPSs are exposed to a number of similar risks to those using illicit

xi Crack cocaine is a form of the drug that can be smoked rather than snorted as a powder. It is considered to be much more addictive.

drugs, but the variable potency and variation in effect mean that it is difficult to determine or compare the level of risk. A 2013 survey carried out by *The Scottish Drug Forum* summarized the short and long term harms of NPSs as:[47]

- overdose and temporary psychotic states and unpredictable behaviours;
- attendance at A&E, some resulting some hospital admission;
- sudden increase in body temperature, heart rate, coma and risk to internal organs;
- hallucination and vomiting;
- confusion leading to aggression and violence;
- intense 'comedown' that cause users to feel suicidal;
- increase mental health issues e.g. psychosis, paranoia, anxiety, depression; and
- physical and psychological dependency.

'Chemsex' is also an emerging issue. Surveys indicate that a higher than average proportion of men who have sex with men (MSM)[xii] drink alcohol and use drugs to enhance the effect[48] making them an especially high-risk population. To a lesser extent the risk also applies to the wider community including the lesbian, gay, bisexual and transgender (LGBT) population.[49]

Illicit drugs such as crystal methamphetamine, GHB/GBL and mephedrone are commonly used for chemsex, and there is evidence that these drugs are sometime injected (also known as 'slamming'). National data from the National Drug Treatment Monitoring System (NDTMS) shows that self-reported gay or bisexual men who started drug treatment in 2013/14 accounted for three percent of all men starting treatment in that year. In comparison to heterosexual men, this group presented with problematic amphetamine use (32% compared to 7%), and GBL use (16% compared to 0.1%), whereas problematic heroin and crack cocaine use is more prevalent amongst heterosexual men. Gay or bisexual men in treatment for non-opiate drugs were more likely to inject (16% compared to heterosexual (3%), however injecting rates for opiates were practically the same.[45] Further assessment of the of the Reading MSM population and associated patterns of drug use is required in order to understand the local impact of this emerging issues.

4 The health impact of alcohol

The national situation with alcohol has shown a similar trend except that the problem is much bigger, in that the numbers are greater. Alcohol misuse is estimated to cost the NHS about £3.5bn per year and society a whole £21bn annually (see section 4.4 for more information on economic cost). This does not include any estimate for the economic costs of alcohol misuse to families and the community.[17, 50]

4.1 Hospital admission

Hospital admission episodes are coded as being 'alcohol-related' that is, partially attributable to alcohol or alcohol-specific, where they are wholly attributable to alcohol. [6]

xii MSM: 'men who have sexual contact with other men' is the term use most often to describe a population by sexual behaviour rather than sexual identity. Public Health England acknowledges that 'it is not a term appropriate to use more broadly when discussing issues of diversity relating to male gay community or to the lesbian, bisexual and trans communities. PHE feel it helpful in the context of discussing specific topics such as chemsex.

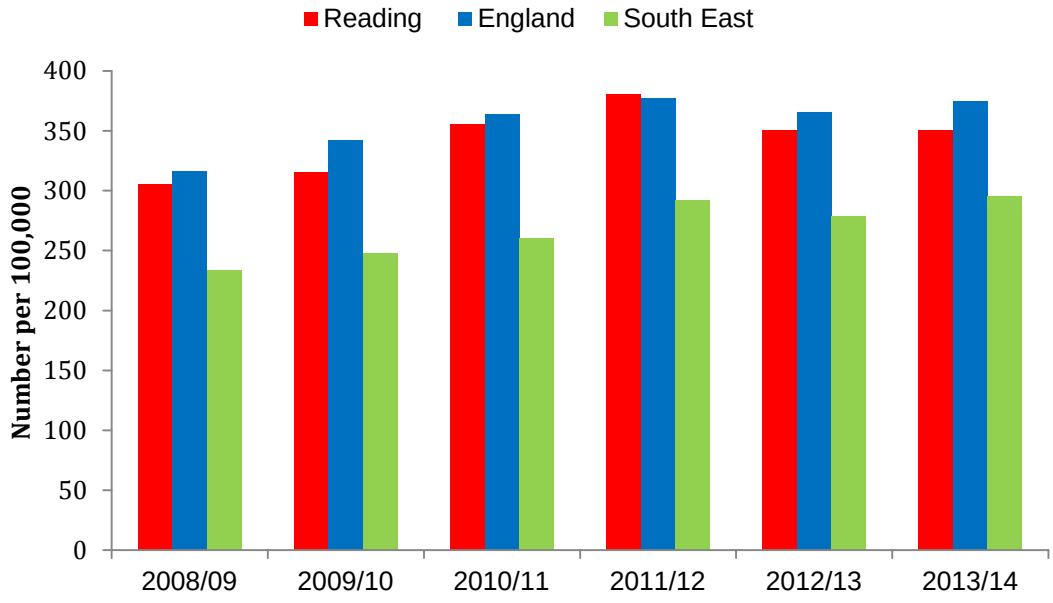
There are two different measures for alcohol-related hospital admissions:

- *broad* – which is an indication of the totality of alcohol-related health harm (primary or secondary diagnosis); and
- *narrow* – which is an indication of admission where alcohol was the primary reason for admission, or was identified as an external cause.

The broad measure is a comprehensive indicator of the total burden that alcohol has on health services because it includes all alcohol-related harms. The narrow measure more precise focus makes it easier to see changes over time. [6]

As shown in Figure 7, there seems to be little difference between alcohol-specific hospital admissions for Reading in comparison to England, but there are more admissions in comparison to the South East England average. The total burden on health services is greater in Reading than the average burden to others in the South East England region. More analysis would be required in order to understand what makes Reading different to others in the South East England, which might include, for example, there being higher levels of deprivation, a generally younger population and the proximity to London.[51]

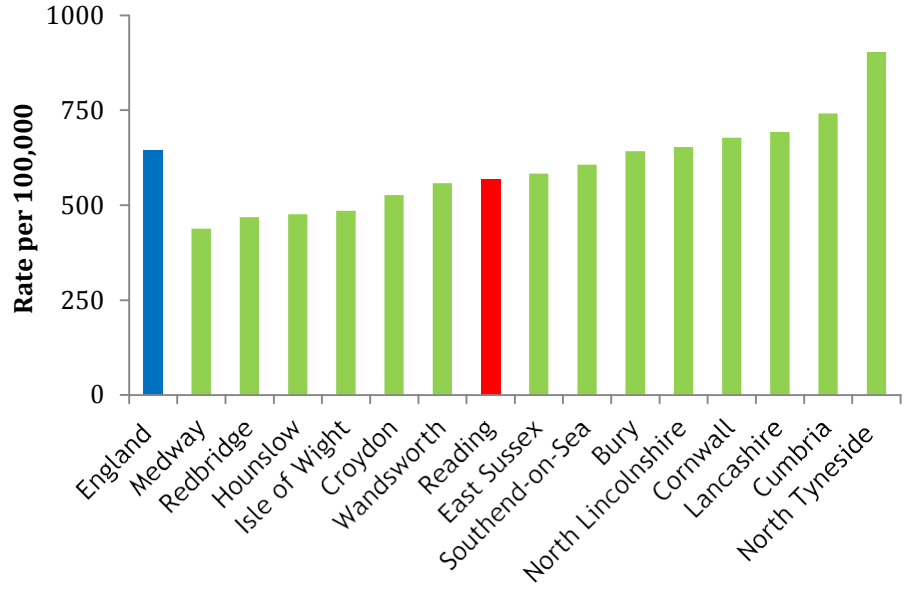
Figure 7. Reading Alcohol-specific hospital admissions (Persons) (Broad) 2008/9 to 2013/14



Source: Public Health England, Local Alcohol Profile England 2015

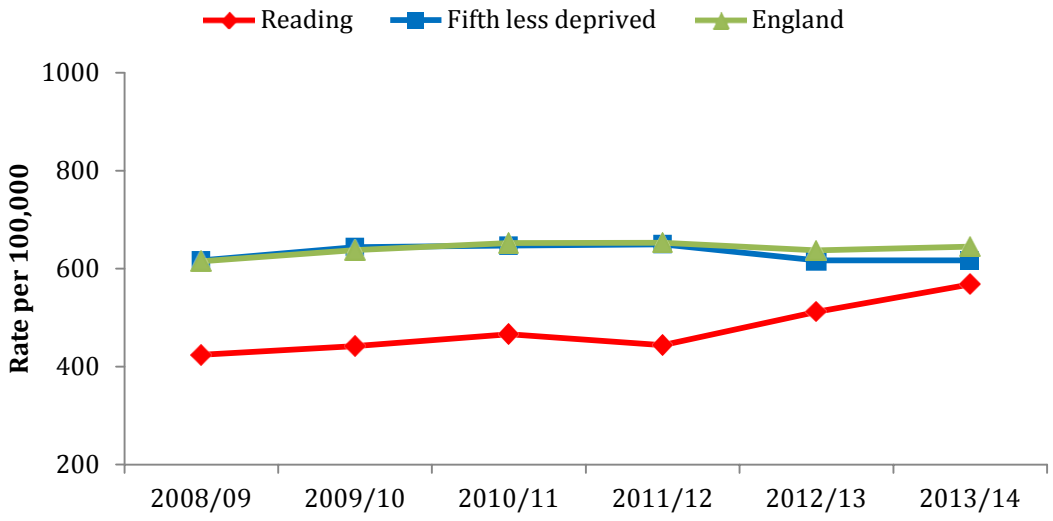
As shown in Figure 8 and Figure 9, hospital admissions for alcohol-related conditions puts Reading as seventh out of the 15 comparator sites (all in the filth less-deprivation decile) and lower than the England average. Whilst this suggests a comparatively modest rate of alcohol-related admissions, it is worth noting that since 2011/12 there has been a greater increase in comparison to previous years and has significantly narrowed the gap making Reading similar to the England and the average of those in the fifth less deprivation decile. [51, 52]

Figure 8: Admission episodes for alcohol-related conditions, for Reading, England and comparator local authorities (all in fifth less deprivation decile),[xiii] 2013/14



Source: Public Health Outcomes Framework, 2015

Figure 9: Admission episodes for alcohol-related conditions (narrow), for Reading, England and all in fifth less deprivation decile, 2008/09 – 2013/14



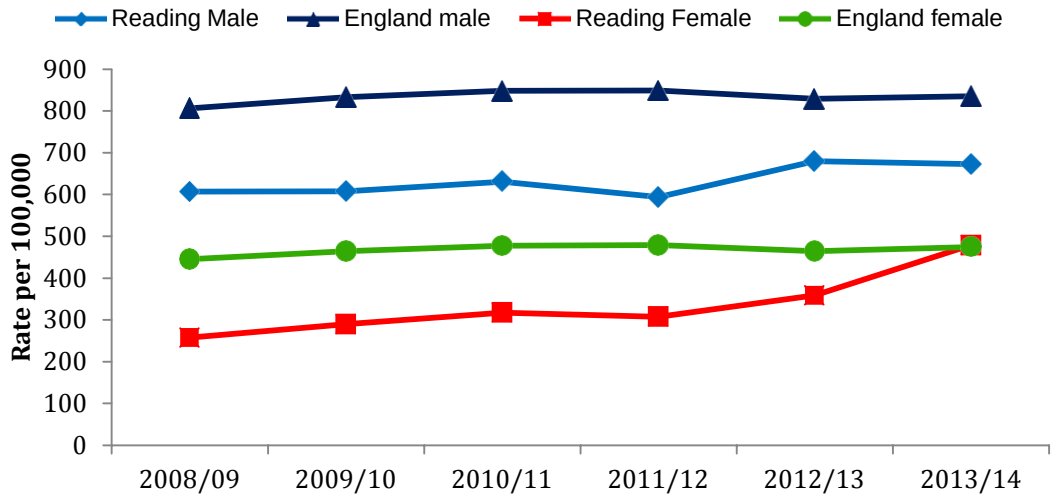
Source: Public Health Outcomes Framework, 2015

xiii As referred to in section 2.1, local authority areas can be compared by looking at levels of deprivation in 'lower layer output areas' (LSOAs), which are subdivisions of electoral wards based on decennial census data. LSOAs are ranked using adjusted scores and aggregated into ten groups (deprivation deciles). The most deprived tenth are allocated to decile one and the least deprived to decile ten. xiii Depending on the year of the data source, Reading falls predominantly within the fifth decile. Comparator local authorities used in this needs assessment, unless otherwise stated, are those in the same decile as the borough of Reading in the relevant year

The total number of admission per 100,000 were greatest in 2013/14 in all persons and in males aged 65 to 74 years, however for females it was greatest in those aged 55 to 64. There could be number of reasons for this, for example, females being more likely to access health services. In England there has been a steady decline in admissions for all persons aged under 16, whilst all other ages groups show an increasing trend since 2003/04. Females aged under 16 are still more likely to be admitted than males. [52]

Whilst males in Reading had a far greater number of admission episodes for alcohol-related conditions than females, 673 versus 479 respectively, (see Figure 10), and are lower than the England average, the number of Reading female admission episodes showed a sharp increase between 2011/12 and 2013/14, narrowing that gap with Reading males. This does not necessarily mean that more local women started drinking alcohol at harmful levels during this year, rather, it could be similar number to previous years, but the number of women diagnosed and/or being admitted to hospital with alcohol-related conditions during this year increased.[52]

Figure 10. Admissions episodes for alcohol-related conditions (narrow), Reading and England, 2008/09 – 2013/14

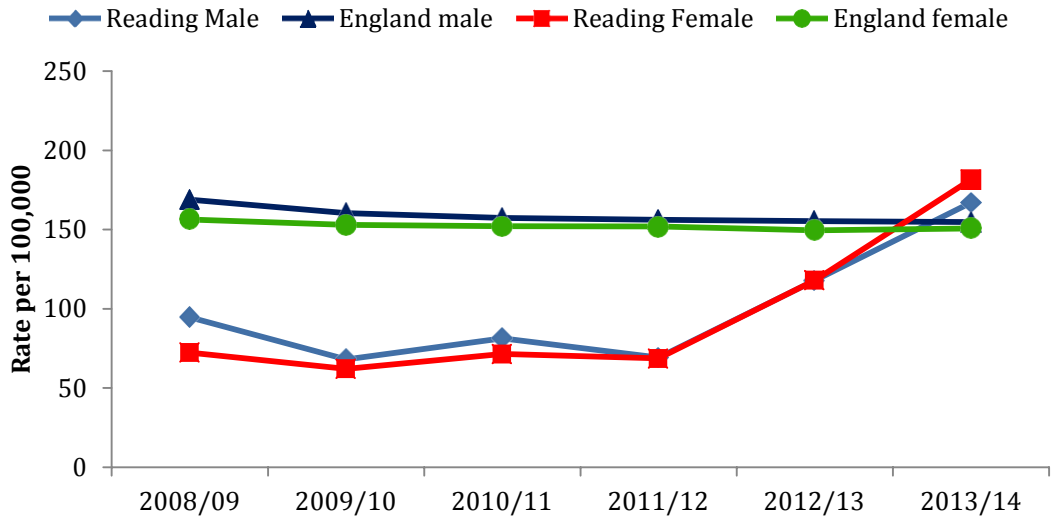


Source: Public Health Outcomes Framework, 2015

Further analysis of the data for alcohol-related conditions (as shown in Figures 11 - 13), reveals that hospital admissions for alcohol-related cancers in Reading residents increased substantially from 2011/12. By 2013/14, females in Reading were more likely to be admitted for this than Reading males. This would go some way to explaining the increase in the overall alcohol-related admissions figures in Reading as shown in Figure 10. At this stage, we cannot be sure what this increase might be attributed to.[52]

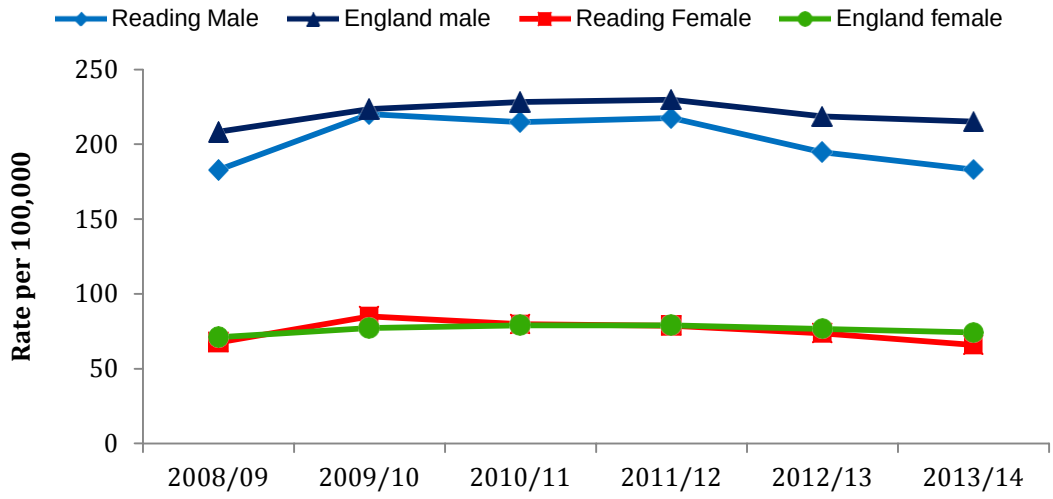
Males in both Reading and England are almost three times more likely to be admitted to hospital for alcohol-related unintentional injuries in comparison to females. This is unsurprising considering the evidence clearly showing that, nationally, males drink more frequently, particularly at harmful levels, and we also know that there is an increased risk of injury when excessive alcohol is consumed. [6. 52]

Figure 11. Admission for alcohol-related malignant neoplasm conditions (narrow), all ages, directly age standardised (males and females), Reading and England, 2008-09 – 2013/14.



Source: Public Health England, Local Alcohol Profile England, 2015

Figure 12. Admission episodes for alcohol-related unintentional injuries (Narrow) all ages, directly age standardised (Males and Females), 2008/09 – 2013/14.

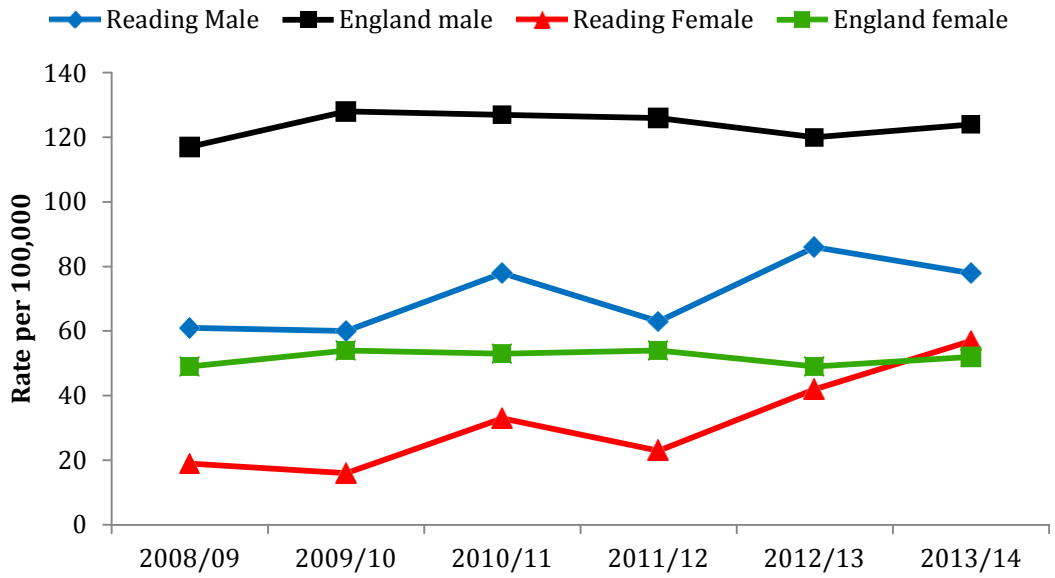


Source: Public Health England, Local Alcohol Profile England, 2015

Nationally, males are one-and-a-half times more likely to be admitted with alcohol-related mental and behavioural problems than females, however for Reading males this does not appear to be the case as rates are significantly lower than the England average (as shown in Figure 13). Since 2011/12, there has been a significant increase in Reading female admissions for alcohol-related mental and behavioural problems due to use of alcohol. [52] There could several reasons for this, including improved diagnosis of conditions that require hospital treatment, rather than it being a real increase in number of women affected. Regardless of what this can be attributed too, we can be confident that in Reading we are seeing a change in alcohol-related admission trends, particularly in the female population and the risks to males remains higher. In the short term, this has an immediate impact on health

costs and in the long term there is an increased likelihood of increasing costs for social care as well.

Figure 13. Admission episodes for alcohol-related mental and behavioural due to use of alcohol condition (Narrow) all ages, directly age standardised (Males and Females), Reading and England, 2008/09 – 2013/14.

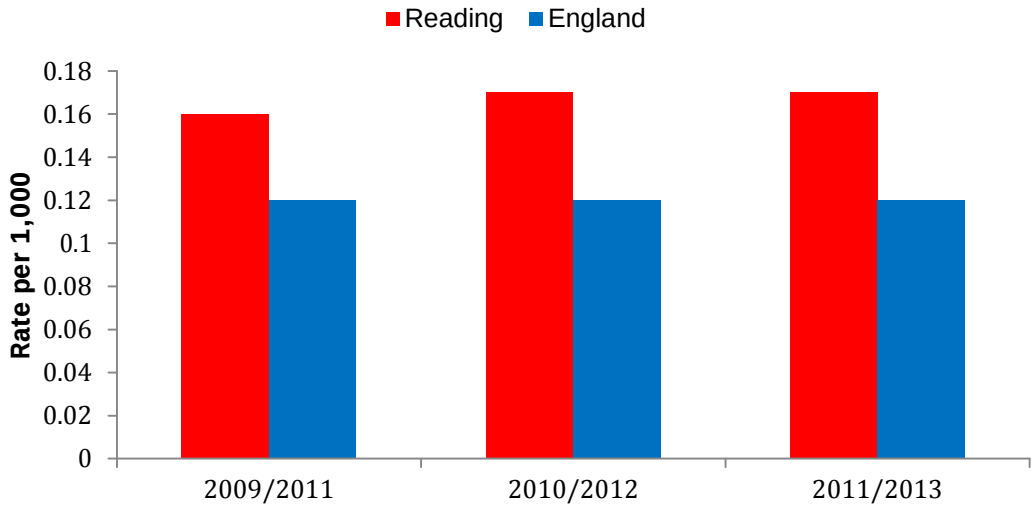


Source: Public Health England, Local Alcohol Profile England, 2015

4.2 Mortality and alcohol

Mortality resulting from alcohol misuse is consistently higher in Reading in comparison to the national average, with around 3% of all deaths in Reading being linked to alcohol use. Of these, about a third are alcohol-specific, as shown in Figure 14, that is conditions that are directly caused by alcohol use such as poisoning, alcoholic liver disease, and alcoholic pancreatitis.[52,53]

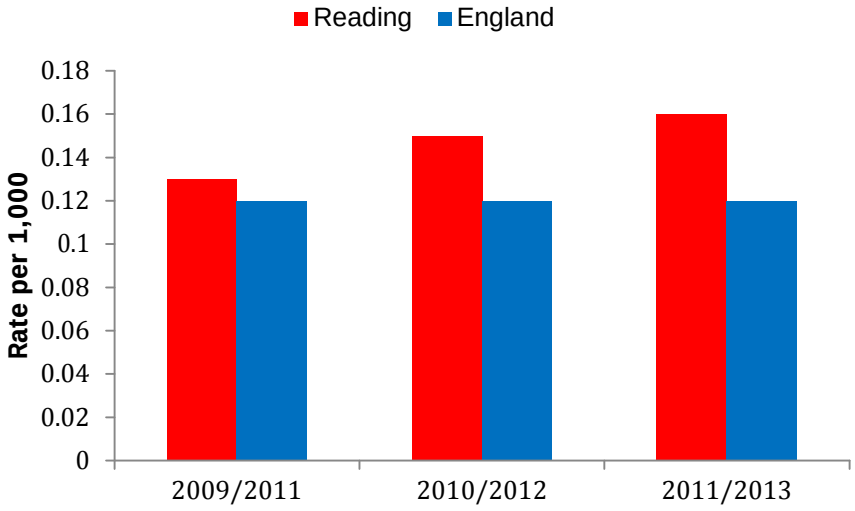
Figure 14. Alcohol-specific mortality 2011-2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

High rates of alcohol-specific mortality, as shown above, and mortality from chronic liver disease (shown in Figure 15) are likely to indicate a significant population who have been drinking heavily and persistently over the past 10-30 years. [53]

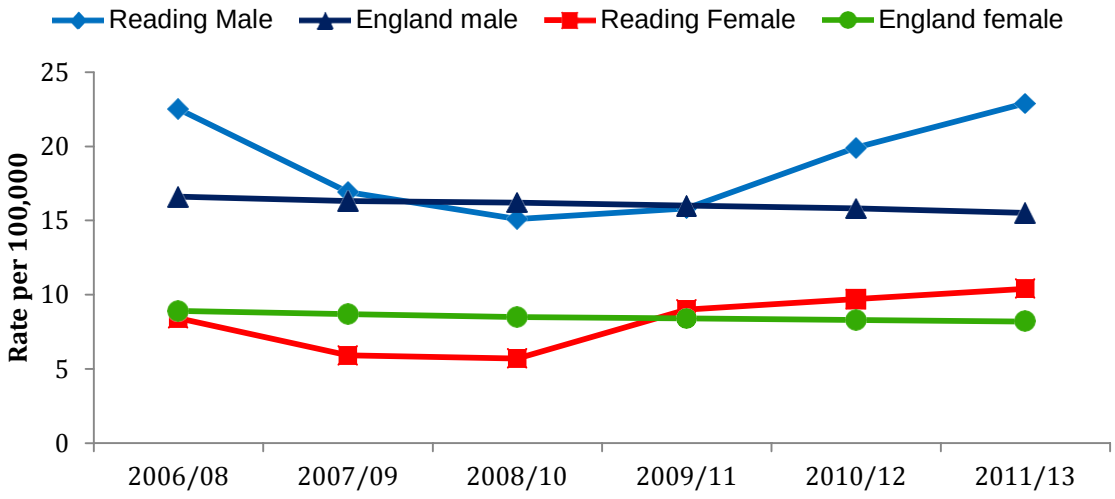
Figure 15. Mortality from chronic liver disease 2011-2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

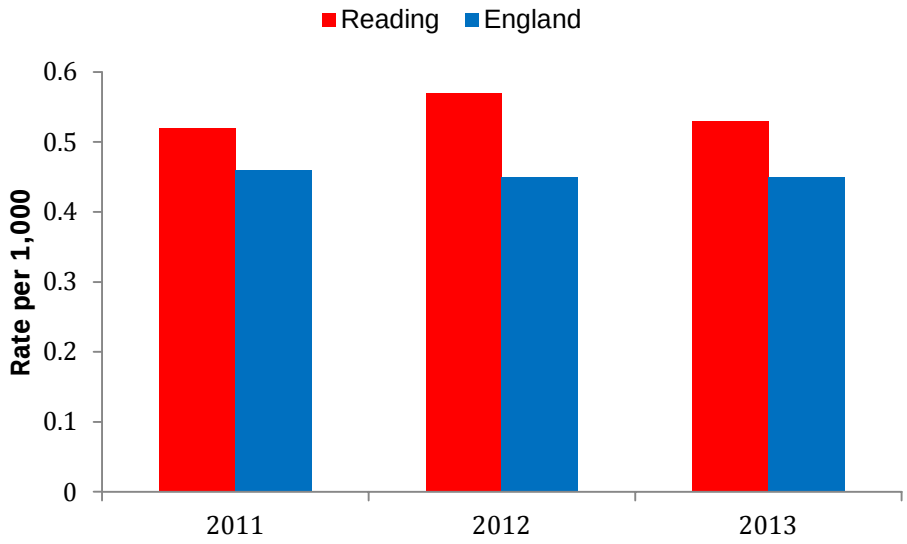
Figure 16 shows that mortality from chronic liver disease in Reading is greater than England averages for both males and females, and, significantly greater in Reading males. This indicates that chronic drinking is significantly prevalent in Reading male population. Liver disease is one of the major causes of mortality and morbidity which is increasing in England, whilst decreasing in other European countries, with deaths reaching record levels, having risen by 20% in a decade. [54, 55]

Figure 16. Mortality from chronic liver disease, Reading and England, 2006/08 – 2011/13 (male and females)



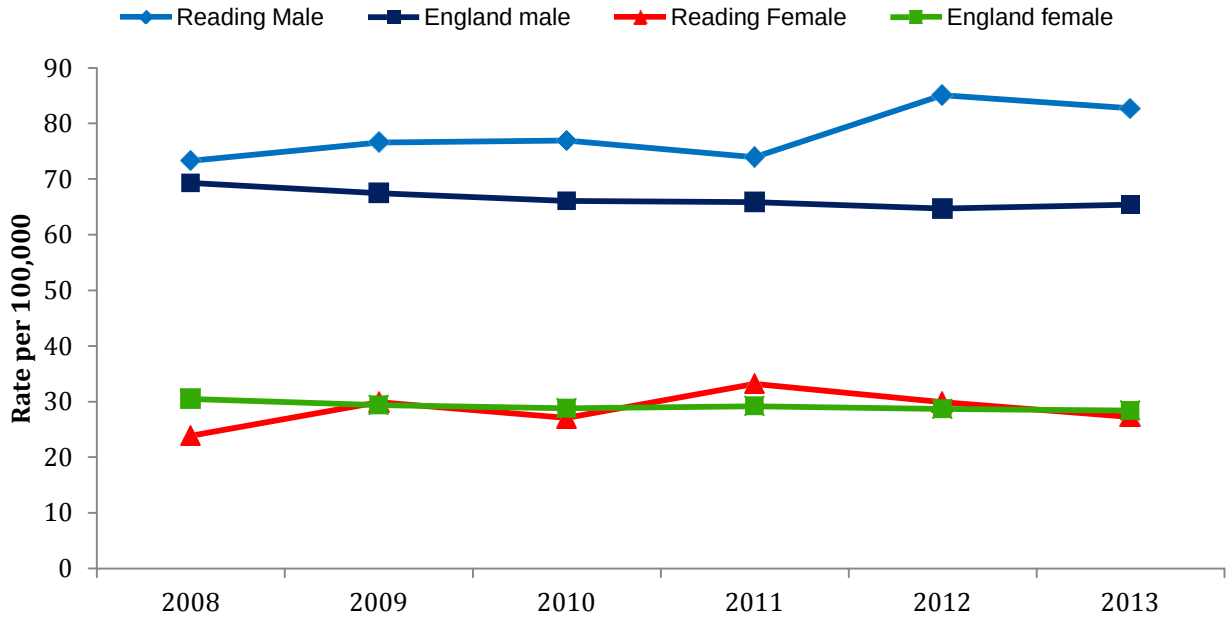
The remaining two thirds are alcohol-related deaths that is, conditions that are frequently, but not always, related to alcohol, such as haemorrhagic stroke, cardiac arrhythmias, cancer of the oesophagus, road traffic collisions or intentional self-harm (see Figure 17). Males in Reading are also more likely die due to alcohol-related conditions in comparison to the England average and, females in Reading (see Figure 18).

Figure 17. Alcohol-related mortality, Reading and England, 2011 - 2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

Figure 18. Alcohol-related mortality, Reading and England (males and females)

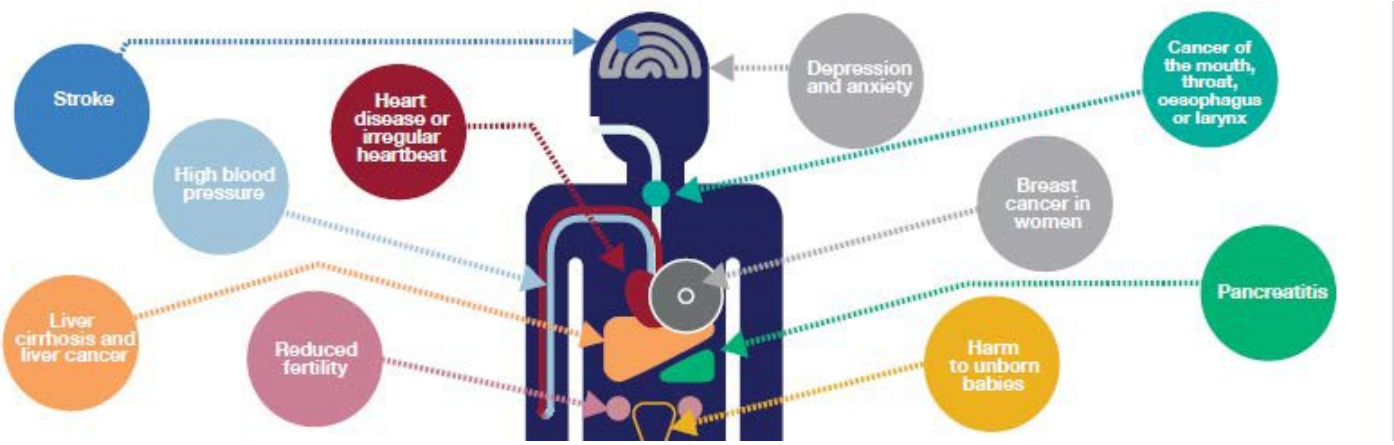


Source: Alcohol Data: JSNA support Pack, Public Health England 2015

4.3 Other harms

Despite the fact that alcohol is legal to buy (for some), and to drink, in the UK, we cannot avoid the fact that alcohol is an addictive drug as well as a toxic substance. As depicted in Figure 19, excessive use is causally related to more than 60 different medical conditions, including cancer of the mouth, pharynx, oesophagus, liver and breast; depression; epilepsy; diabetes; heart attack and stroke; cirrhosis of the liver; and foetal alcohol spectrum disorder (including mental and physical birth defects) in the babies of mothers who drink heavily when pregnant. [56]

Figure 19. ***Infographic depicting alcohol misuse damages to health***



Source: Based on Lisa Jones & Mark A Bellis (2013), Updating England-Specific Alcohol-Attributable Fractions. Alcohol-Attributable Fractions Report, Liverpool John Moores University.

Hazardous drinking is a pattern of alcohol consumption which carries risks of physical and psychological harm. Harmful drinking denotes the most hazardous use of alcohol; this is the level at which damage to health is likely, and carries a risk of alcohol dependence. Alcohol dependence is often a combination of behavioural, cognitive and physiological factors that typically manifests in a person have an overwhelming desire to consume alcohol and difficulties in controlling their drinking.[57] Dependent drinking is a complex issue and can have many causes, including family history; psychological factors such as anxiety or depression; the addictive nature of alcohol itself; and the environment in which people live and socialise. [58]

Alcohol is an addictive substance in the same way as tobacco and opiates; people can both physically and emotionally depend upon it and become habituated. Dependent drinkers are much more likely to be consuming physically-damaging quantities of alcohol and are thus at greater risk of developing significant ill health as a consequence. [59] Furthermore, if we consider hospital admissions and death attributable to alcohol, the burden associated with drinking alcohol at harmful levels is generally increasing in Reading. This is likely to increase the burden on the health and social care services as well as having wider impacts. Crucially, these problems are avoidable.

4.3.1 Economics, accidents and injuries

As well as the health impacts, there are also economic implications, for example, revenues generated from local sales, which is taxed by the government, and jobs which are created through alcohol production and distribution. [22] It is estimated that the UK alcohol industry directly employs more than 650,000 people and supports a further 1.1 million jobs in the wider economy. [60] Duty on spirit, wine, beer and cider in 2012/13 raised £10.1b for the Exchequer. It is difficult to be precise about the local economic benefits of alcohol but it is reasonable to assume that it contributes significantly to local economy.

In contrast, the government's alcohol strategy estimated that alcohol-related harm costs England society £21b annually (this excludes estimates for economic cost of alcohol misuse to families and social networks).[17] This is broken down as:

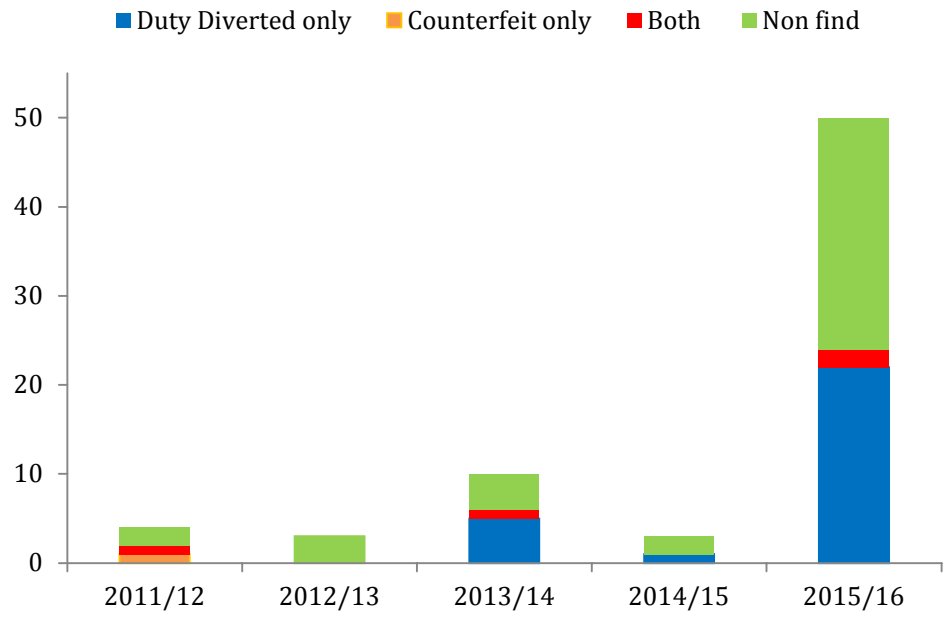
- £3.5b per year NHS costs (at 2009-10 costs);
- £11b per year alcohol-related crime (at 2010-11 costs); and

- £7.3b per year lost productivity due to alcohol (at 2009-2010 costs, UK estimate).

HM Customs and Revenue estimates that fraudulent alcohol supply costs the UK around £1.3bn a year in lost venue, also having an adverse effect on the drinks industry. [61] Results from the work carried out by the local RBC trading standards and licensing teams shows that this year, nearly half the inspections has resulted in seizures for alcohol where duty was diverted (see Figure 20). During one inspection, where both counterfeit and duty diverted alcohol was found, a total of 103 bottles were seized. Year to date, five licenses have been revoked as a result of the work.

Inspections in 2011-13 were primarily reactive to consumer complaints, with some support from the International Federation of Spirit Producers and HM Revenue and Customs. In 2015, the RBC Trading Standards team had a small increase in capacity which has allowed them to carry out proactive visits.

Figure 20. Trading Standards inspection results, Reading, 2011/12 – 2015/16 (YTD)



Source: RBC Trading Standard Performance Monitoring Report, 2015.

Drink driving is also a significant source of pressure for police, fire, paramedical and hospital emergency services as well as its impact on the victims and their families. Since 1979 there has been an almost six-fold reduction in the number of people killed in the UK in drink-drive accidents and a similar drop in seriously injured casualties. Despite this, in 2013 there were 5,690 road traffic collisions caused by alcohol resulting in an estimated 8,270 casualties. In the same year, 240 people were killed in the UK in accidents attributed to drink-driving, which is more than four deaths per week.

Binge drinking has been calculated to increase road traffic collisions by 17%, costing an estimated £2bn (2014 prices), this cost being spread across emergency services and the wider public sector. Local data on road traffic collisions directly attributed to alcohol is unavailable, but we know that between 2012-14 the rate of people killed and seriously injured on roads in Reading was lower than the England average being 28.3 compared to 39.3 per 100,000. [62]

In addition to road traffic collisions, we can also measure the burden using local data and intelligence such as that gathered through Reading's First Stop Bus (FSB) project. The service is delivered on an appropriately resourced bus, including medical staff and first-aiders trained to treat minor injuries, and the aim is to ease the burden on the A&E department at the Royal Berkshire Hospital.

Information collected by FSB staff indicates that between December 2013 and October 2015 some 800 people have been seen. South Central Ambulance Service estimates that during this period, 662 people would have either had an ambulance called and/or been taken to A&E. Conservative estimates on the total amount money that was saved through avoidance of ambulance calls for the full period is £46,340 and the total save preventing treatment at A&E was £51,636.[xiv]

Of those people presenting, mostly as a result of an accident or alcohol intoxication, 685 (87%), had consumed alcohol and 73 (9%) had used other substances. Almost two-thirds were males (62%) and over half (55.4%) were aged between 18-24 years, 18.7% were aged 25-30 years and 14.5% were aged 31-40 years.

5 The impact of drug and alcohol misuse on other aspects of community life

5.1 Police and judicial systems

Drug and alcohol use are both associated with crime. Alcohol is estimated to be implicated in 40% of violent crime and 78% of assaults, including domestic violence, and 88% of criminal damage cases are committed while the offender is under the influence of alcohol.[63] Some research studies have found that a lot of acquisitive crime is committed by dependent users of heroin and crack cocaine trying to pay for their drugs. Some show a high proportion of people arrested for a range of offenses testing positive for drug use. It has been suggested that one third to over a half of all acquisitive crime is related to illegal drug use [64] although acquisitive crime rates have dropped substantially since the mid-1990s [65] and it is noteworthy, as referred to elsewhere in this paper, that overall opiate and crack cocaine use is less common now.

Categorising crimes as drug-related and alcohol-related is methodologically complex. For example, categorisation would require that relationships between the behaviours of drug-using and offending be established as causal, rather than coincidental, and that records of when offenders have used drugs or are dependent are kept. This is rarely done. As a result, it is not possible to ascertain the true extent to which crime in Reading is related to drug or to alcohol use.[66]

Drugs and alcohol use appear to impact on crime rates in different ways. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identifies four categories of drug-related crime:

- psychopharmacological - while under the influence of a substance;
- economic compulsive - to obtain money to purchase drugs;
- systemic - drug market activities; and

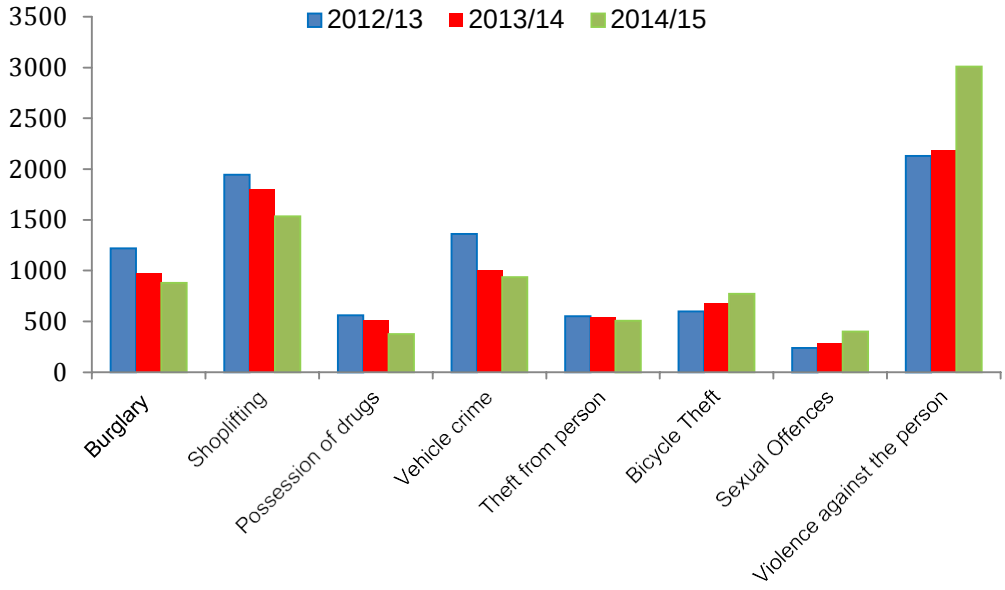
xiv Ambulance call savings are based upon the cost of mobilising an emergency vehicle (£70 per call). This does not take account of the time and treatment that would follow. Total savings for preventing treatment at A&E has been calculated by taking Tier 1 and Tier 2 2014 cost of treatment at an A&E for treatment, which equates to £78 per patient. Higher tiers are not included as most patients treated by FSB would generally not trigger in higher tier costs.

- drug law - in violation of legislation e.g. possession.

The EMCDDA report goes on to associate psychopharmacological crime mainly with alcohol use but also with some illicit stimulant use. Economically-motivated crimes (principally acquisitive crime, sex working and drug selling) are associated with drug dependence.[43] Other surveys and reports also link drug use, particularly opiate use and injecting, with shoplifting and other acquisitive crime.[67]

Despite the absence of specific information on drug-related crimes in Reading, reviewing all notifiable offences in Reading, as shown in Figure 21, may help in understanding trends. From October 2014 to September 2015, there was a 2.5% increase in recorded crime[xv] overall, with a total of 12,853 crimes committed in the period in Reading. While most of these were acquisitive the numbers of most acquisitive crimes have decreased year on year since 2012/13 (with the exception of theft of vehicles and bicycle theft, which are, perhaps, less likely to be related to trying to raise money to buy drugs). The crime types with the largest increases in the same period were violent offences and sexual offences, which are more likely to be related to alcohol use. [68] Whilst acquisitive crime remains dominant, the figures suggest a growing volume of alcohol-related crime, and a diminishing amount of drug-related acquisitive crime.

Figure 21. Summary of notifiable offenses for Reading, October 2012/13 – September 2014/15



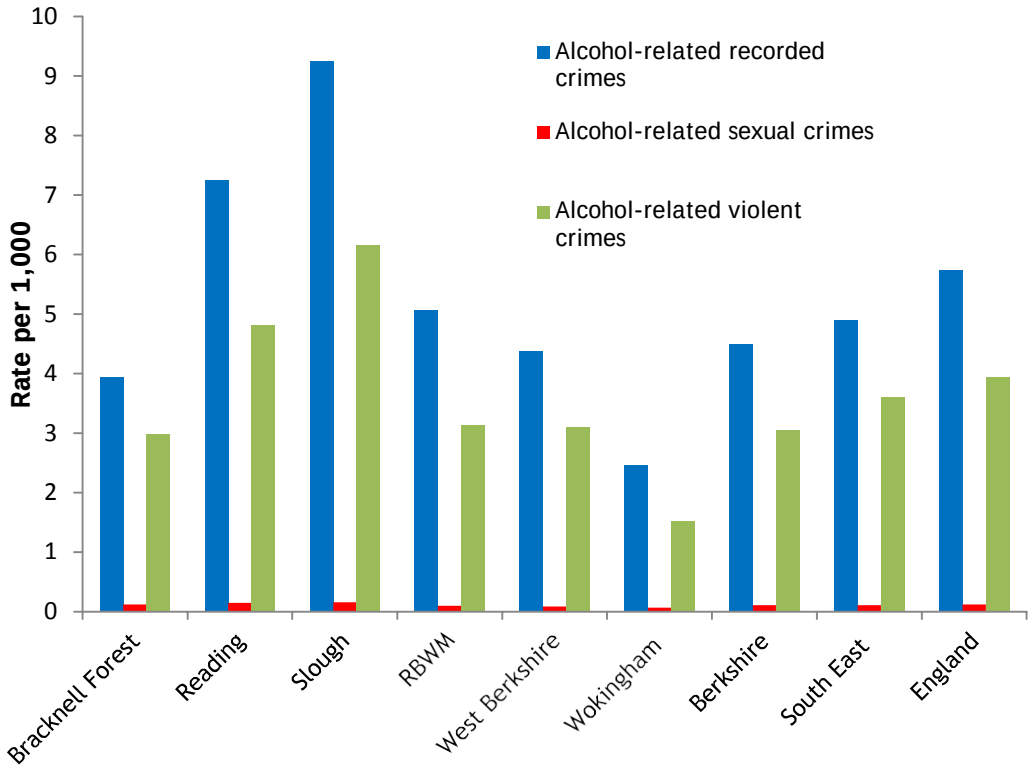
Source: Thames Valley Police, Summary of notifiable offence report, 2015

Three indicators of alcohol-related crimes (all alcohol-related recorded crimes, sexual crimes and violent crimes) have been used to measure alcohol-related crime. These measures are estimates based on the Home Office's former key offence categories

xv Crime is recorded for the year in which it was reported, not necessarily allegedly committed. For example, the increase in reported sexual offences in recent years is, in part, attributable to people reporting alleged historical assaults. The rise in violence against the person has been driven by increases in 'violence without injury' and may, in part, reflect changes in recording practice {see http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/year-ending-june-2015/stb-crime--ye-june-2015.html (accessed 6 January 2016)]

and include a proportion of all violent offences, domestic violence and visible anti-social behaviour and damage related to the night time economy. [69] Reading was similar to the national average except for alcohol-related recorded crimes where it has a higher rate of alcohol-related crime than average. Reading also recorded the second highest crime rates relating to alcohol in Berkshire, with Slough recording the highest (see Figure 22). Local crime rates suggest an increasing level of violent crime, but more work is needed to determine the precise nature of this.

Figure 22. Alcohol-related crime[xvi] rate per 1,000 population by Berkshire local authority and England, 2012/13



Source: Public Health England, Local Alcohol Profiles England, 2015

5.1.1 Treatment for the prevention of offending

There is evidence to suggest that pharmacological treatment interventions for the management of opiate dependence can help to reduce re-offending, especially where dose is high enough, the time in treatment is sufficient, and where psychological support is also provided. Treatment often takes the form of long-term prescribing of an opioid substitute such as methadone or buprenorphine. The aim is for people who are dependent to progress from maintenance to detoxification and then abstinence. However, depending on the individual, it can be associated with longer periods in treatment, sometimes for many years with some clients seeming to have little or no motivation to stop using substances.[xvii] It is therefore reasonable to

xvi Six offences: violence against a person, sexual offenses, robbery, burglary dwelling, theft of a motor vehicle and theft from a motor vehicle. Alcohol related sexual crimes are therefore included in the alcohol-related recorded crime rates

xvii There are anecdotal reports of some such people being referred to as 'Giro Junkies', that is, when they receive a state benefit payment they buy illicit opioids or other substances and when their money runs out they use methadone or buprenorphine prescribed by drug and alcohol services or by their GP

conclude that this kind of treatment will have little effect on the numbers of people leaving treatment in the short-term or on the average length of time in treatment.[70, 71, 72, 73, 74]

Reading's Integrated Offender Management (IOM) programme targets the most prolific acquisitive offenders in the area. A recent analysis showed that 58% of those on the scheme were also in drug treatment at the time (which has to raise questions about the effectiveness of treatment and crime reduction, especially as perhaps only half of the opiate and crack cocaine users in Reading are known to the drug and alcohol service) and a further 17% had been referred for treatment or been in treatment at another time. Some 95% of those who had been in treatment while on the programme identified heroin as their main substance of use. No information is available to show what effect opioid substitute prescribing had on their offending. In light of this, while we can say that a high proportion of prolific offenders in Reading engage with substitute prescribing treatment, and that drug-related offending appears to have declined in recent years, it is not possible to conclude that this treatment had a mitigating effect on the offending rates of these local prolific offenders.

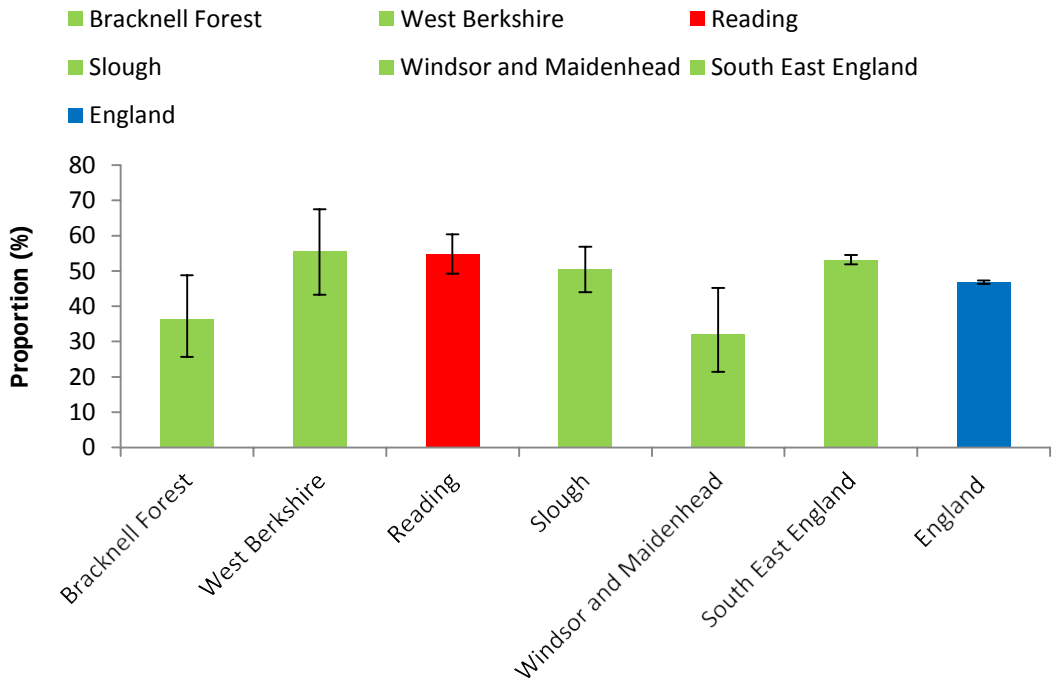
The Public Health Outcomes Framework measures the proportion of those who are assessed for drug and alcohol treatment in prison, who have been engaged with treatment in the community. In the context of the outcomes framework, this is because treatment is considered to be one way of helping to reduce offending and this serves as a measure of prevention work on substance dependence among vulnerable groups.[75]

In 2012/13 Reading had a statistically significantly higher proportion of drug or alcohol users who had not engaged with treatment in the community before entering treatment in prison than the England average. Figure 23 shows the percentage of people entering prison with substance misuse issues who were not previously known to community treatment services in comparison with England and the other areas of Berkshire.

The data indicate that a lower proportion of offenders in Reading have used community treatment services than offenders elsewhere, suggesting that less preventative work is done locally to reduce drug and alcohol-related offending than in the rest of England. Confidence intervals for local authority level data are wide, so it is not possible to conclude that this is significantly worse in Reading than in the rest of Berkshire, We can say, however, that Reading is the only local authority in Berkshire that is significantly worse than the England average.

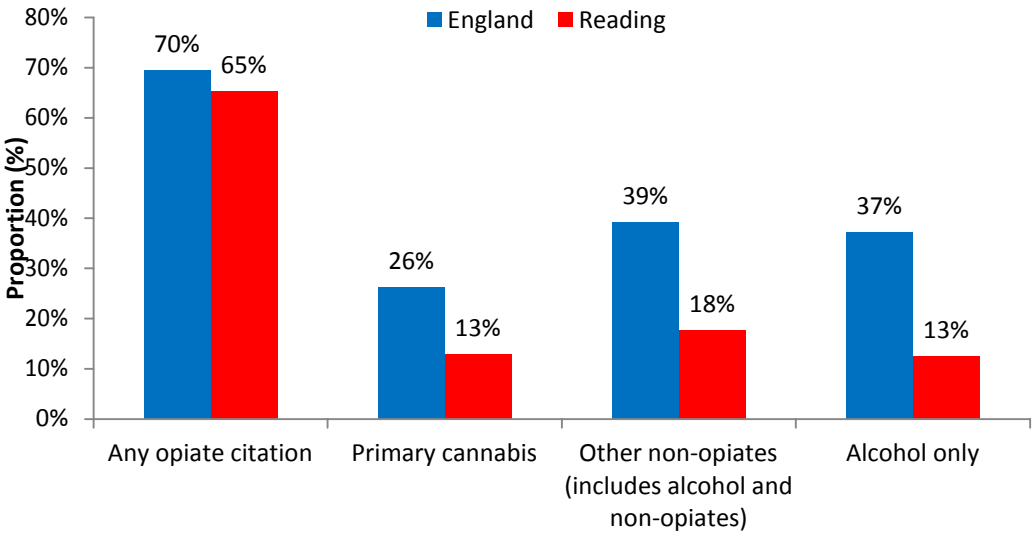
Further analysis shows that 65% of opiate users from Reading who started treatment in prison had been in treatment in the community. This is close to the England average of 70%. The proportions of alcohol, cannabis and other non-opiate are much lower in Reading and the rest of England, but the differences between Reading and the England averages are much greater for alcohol and non-opiate substances (see Figure 24). This suggests a low proportion of offenders and those at risk of offending who use alcohol and non-opiate drugs receive treatment in Reading. Confidence intervals are not provided for this further breakdown, and the numbers at local authority level are small, so these analyses need to be considered with caution.

Figure 23. Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community, 2012/13.



Source: Public Health Outcomes Framework, 2015

Figure 24. Proportion of users in treatment in the community in Reading, 2013/14, by substance



Source: Public Health Outcomes Framework (PHOF) Indicator 2.16 Supporting Data 2013/14

So, while opiate users in Reading are almost as likely as opiate users elsewhere to have received treatment in the community prior to entering treatment in prison, users of other substances appear to be less likely to have received treatment. This may indicate that more preventative work could be done, particularly with alcohol users, to reduce local levels of crime.

5.1.2 Obtaining novel psychoactive substances

Because of the legal status of NPSs, they are currently easily obtainable with open sales occurring in offline retail outlets, including being available on most high streets, sometimes being sold in 'headshops' (shops which sell drug paraphernalia), market stalls, takeaways, convenience stores, newsagents or petrol stations. The three main sources which users obtain NPSs from are online retailers, high-street retailers and non-retail vendors (family, friends, and street level dealers).[9, 76]

Anecdotally it is suggested that transactions with high-street and non-retail vendors could be seen an easier source for young people to acquire NPSs as they will invariable involve untraceable, cash transactions. Whilst the virtual marketplace is popular and provides anonymity to website owners and buyers because of the sophisticated technical concealment of web market places, for younger people, it requires them to have access to a bankcard, which could make it harder for them to purchase via this source. The clever concealment of these virtual markets makes it increasingly difficult for law enforcement authorities to understand the true scale of the drug trade and therefore drug-related crimes, but is fair to say that there will be a local impact.[9,10]

The UK Government proposes to introduce legislation that will seek to eradicate the NPSs market, but there is debate that *The Psychoactive Substance Bill (HL) 2015-16* [77] does not address the key problems of NPSs and there are concerns it will merely serve to move NPSs into the illicit market, possible at street level and online.[78] If this happens there is a possibility that it will impact on drug-related crimes but how is unknown. There are no precise numbers of offline or online retail outlets in the UK selling illicit drugs or NPS, however there are reports of there being more than 250 headshops selling non-controlled NPSs and, the National Crime Agency (NCA) estimates there to be between 100 and 150 UK-based 'clearnet' sites, who primarily sell non-controlled NPSs.[9,10]

5.2 Domestic violence and parental substance misuse

Domestic violence and abuse is frequently associated with alcohol use.[79] In 2013/14, 36% of victims of domestic abuse reported in face-to-face interviews that the offender was under the influence of alcohol [80] and around 20% of high-risk victims of abuse report using drugs and/or alcohol. [81] Unfortunately, there are no local data for the numbers of women or men accessing domestic abuse services, or coming into contact with police for domestic abuse issues, where alcohol or drug misuse is a contributory factor.

In addition to the harm the adult victim of domestic abuse faces, children in families where there is parental alcohol or drug misuse, including babies in the womb, face an increased risk of significant harm. Parental substance misuse is a major risk factor for harm to children and may expose them to physical abuse or neglect, dangerously inadequate supervision, intermittent or permanent separation or changes in residence, toxic substances in the home, interrupted education, criminal or other inappropriate adult behaviour and social isolation. [82,83]

An analysis of child deaths and serious injuries in England (2003-2005) found that in well over half of cases (57%), there was evidence of substance misuse, furthermore, over half of children were living with domestic violence, or parental mental ill health, or parental substance misuse (with these three problems often co-existing). There are serious concerns that this is likely to be underestimated as there is no routine screening by children and family services for parental alcohol misuse. [84]

An inquiry by the Advisory Council on the Misuse of Drugs in 2003 estimated that 2-3% of children aged under 16 were likely to be affected by parental substance misuse. Recent estimates of the number of children affected based on UK household surveys suggest that the number of children in the UK living with a parent misusing drugs or alcohol is likely to be higher than previously thought, with an estimated 22% (over 2.6 million children) living with a parent with a drinking pattern that is hazardous and 705,000 living with dependent drinkers.[74,85,86,87,88]

In Reading, this equates to some around 600 children aged under 16 likely to be affected by parental substance misuse and 6,000 children likely to be living with a parent misusing drugs or alcohol.

An evaluation of Family Drug and Alcohol Courts highlighted both supportive work to enable children to return to their families where possible and swift action to find an alternative home where it was not. The evaluation also reports more positive attitudes amongst parents and savings to local authorities.[74]

RBC has a Parental Substance Misuse Service (PSMS) which was developed to help to address concerns about the needs of parents in drug and alcohol treatment. The team work with any family where a child's needs are affected by their parents' misuse of drugs or alcohol. Children are usually identified by family workers, through children's centres or drug and alcohol treatment services, or, sometimes when child is put on a child protection plan. The service offers a holistic response to each family's needs, helping them to access both drug and alcohol treatment and provides parenting support. The service continues to work with the family until parents are established in recovery or the children have been permanently removed. While families may be required to work with a social worker, engagement with the PSMS is voluntary. Social workers can choose to make a referral but are not required to do so in all cases where substance misuse is identified.

Reading's PSMS currently provides one-to-one support to 22 parents/pregnant women who are experiencing problems with drug and alcohol use; group work programmes called *Just What You Need* and *Family Time* programmes, which are used by a further 17 parents; and they also support three people who are caring for children of drug or alcohol using parents (within their extended family).

Most of those receiving one-to-one support are users of alcohol (15), four primarily use heroin and two cannabis. As shown in Table 2 below, eight have children on child protection plans,[xviii] nine have children monitored under *Child In Need* [xix] (three have been de-escalated from child protection plans), two are being assessed after contact with police or identification by the Early Help hub, one parent has a child who is classified as a *looked after child* [xx] as they are in residential rehabilitation with their child, one is abstinent and receiving support to maintain recovery, and one is currently pregnant. Most of those using the group work programme are currently abstinent from substances and working with the service to maintain their recovery.

xviii A CPP is a plan drawn up by the local authority. It sets out how a child can be kept safe, how things can be made better for the family and what support they will need. Parents should be told the reason for the plan.

xix Section 17 of the Children Act 1989 has defined criteria for when a child is considered as being in need, for more information, please see http://protectingchildren.org.uk/cp-system/child-in-need/

xx A *looked after child* may either be accommodated (which means the local council is looking after them with the agreement, at the request or in the absence of their parents) or subject to Care Order by the Family Courts.

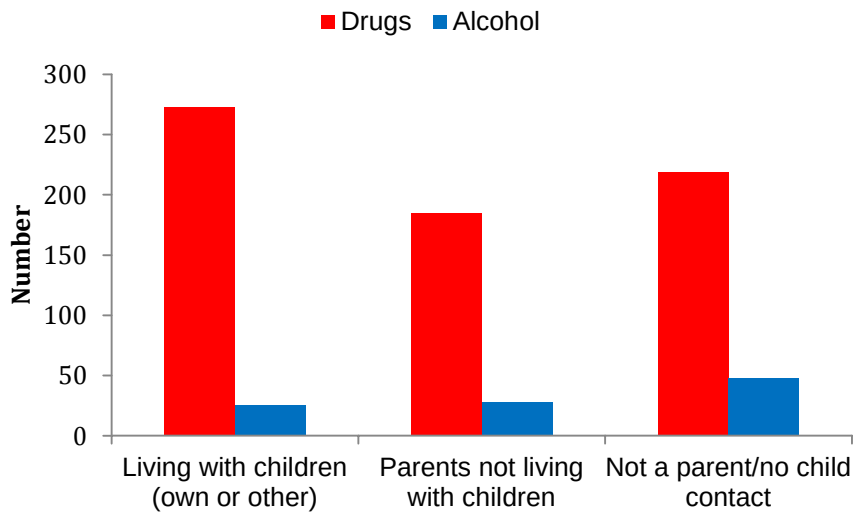
Table 2. Current case analysis (snapshot) of parents supported by RBC PSMS, as of November 2015

Status	Number
Child Protection	8
Child in Need	9
Assessment	2
Looked after child (residential rehabilitation)	1
Abstinent - recovery support only	1
Pregnant	1

Source: RBC Parental Substance Misuse Service, 2015

Data from local treatment services can also be used to illustrate the number of drug and alcohol users in Reading in treatment who: live with children; are parents but do not live with children; and do not have children. This is shown in Figure 25 (incomplete data have been removed). However, it is important to recognise that this is a reflection of the balance of drug and alcohol users in treatment in Reading and not of the actual number of misusers of drugs and, especially, alcohol in the borough.

Figure 25. The parental status number of drug and alcohol treatment-users in Reading



Source: Drug Data: JSNA support Pack, Public Health England 2015

Based on estimates of local alcohol misuse, there is likely to be a significant number of children in Reading whose parents require interventions or treatment for alcohol misuse who are not engaged with treatment services. Furthermore, the number of parents' engagement with the PSMS is relatively low in comparison to the number of children we know to be living with drug users in Reading. It is important to note that these users are engaged with treatment services and referrals to the PSMS may not be necessary if it has been determined that their drug and/or alcohol misuse does not affect their ability to meet their child's needs.

Despite this, the Office of the Children's Commissioner has highlighted the large and increasing prevalence of parental alcohol use and recommends a greater policy focus within the wider scope of all parental substance use.[55] Several sources

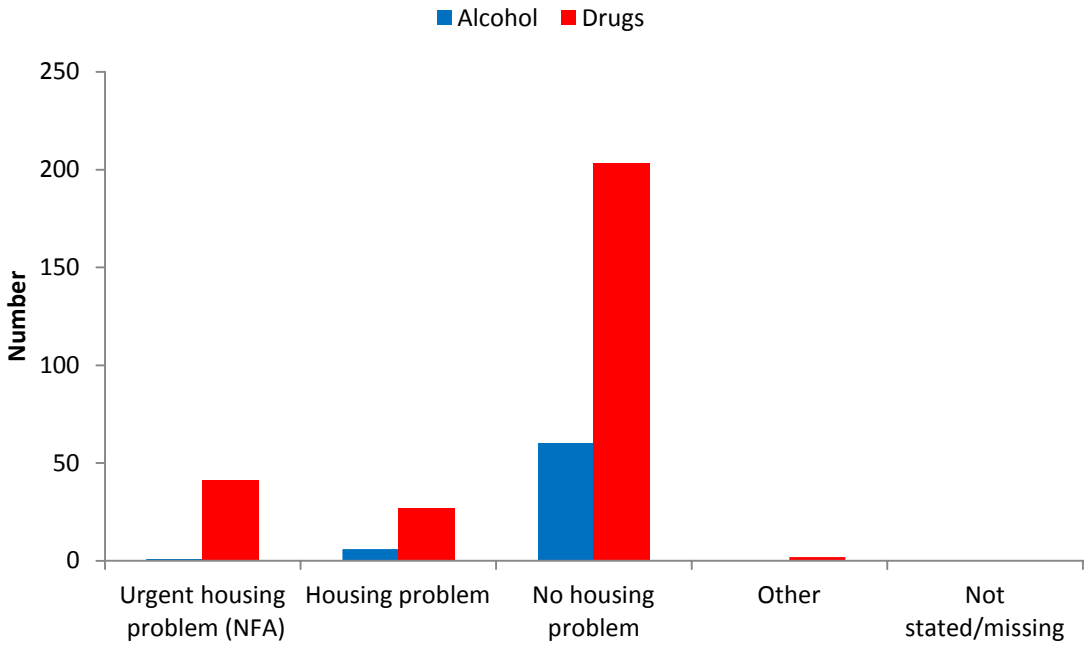
highlight connections between parental drug and alcohol use, inadequate parenting, domestic violence, poor mental health and housing and social problems and recommend 'whole family' approaches focussed on creating a stable environment for the child or children. This in turn, is likely to have a positive impact on the future behaviours of children, particularly in relation to drug and alcohol use, which could reduce the burden of health and social care costs.[52, 53, 89]

5.3 Local authority housing

Local authorities are obliged to give re-housing priority to people who are vulnerable and homeless. For drug and/or alcohol misusers, a safe, stable home environment better enables them to sustain their recovery whilst insecure housing or homelessness threatens it. RBC does not give re-housing priority to people simply because they misuse drugs and/or alcohol.

The overall number of decisions on homelessness applications taken by RBC in 2014/15 was 737. Figure 26 shows the self-reported housing status of adults when they started treatment for drugs and/or alcohol misuse in the same period. Based on self-reported housing status, we can see that urgent housing problems are more prevalent in drug users at the start of treatment, in comparison to alcohol users in treatment, which is unsurprising considering we know locally more people access treatment services for drug misuse rather than alcohol misuse, but that the prevalence of misuse is higher for alcohol than drugs. These data could also mean that people who misuse alcohol in Reading do so without causing significant risk to their housing status and thus do not come to the attention of the council. Based on data in Figure 26, 10% of the applications considered involved someone who commenced treatment for drug or alcohol misuse.

Figure 26. Self-reported housing status of adults at start of treatment (by drugs and alcohol) Reading, 2014/15



Source: Drug & Alcohol Data: JSNA support Pack, Public Health England 2015

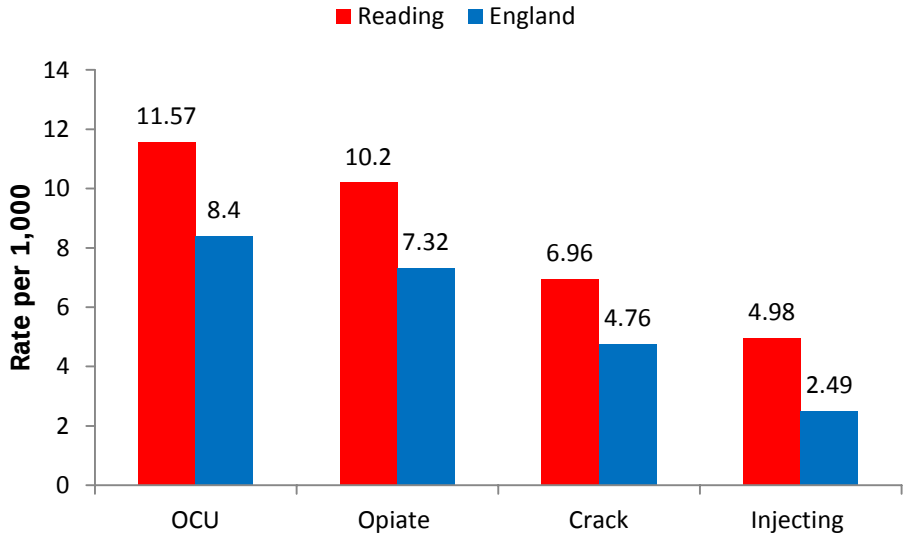
6 How big is the problem of drug and alcohol misuse in Reading?

6.1 Drugs

The estimated prevalence of opiate and crack cocaine use was carried out in eight 'sweeps' by independent researchers commissioned by the Home Office.[90, 91, 92, 93, 94] The estimates use numbers of known opiate and/or crack users recorded by different sources and other indicators, such as levels of drug-related crime.

The most recent estimate indicates a higher rate of opiate and/or crack cocaine users (OCU) per 1,000 population in Reading than the England average: 11.7 and 8.4, respectively. The rate of injecting drugs in Reading is twice as high as the England average: 4.98 in Reading compared to 2.49 England average (see Figure 27).

Figure 27. Prevalence estimates of drug users, Reading and England

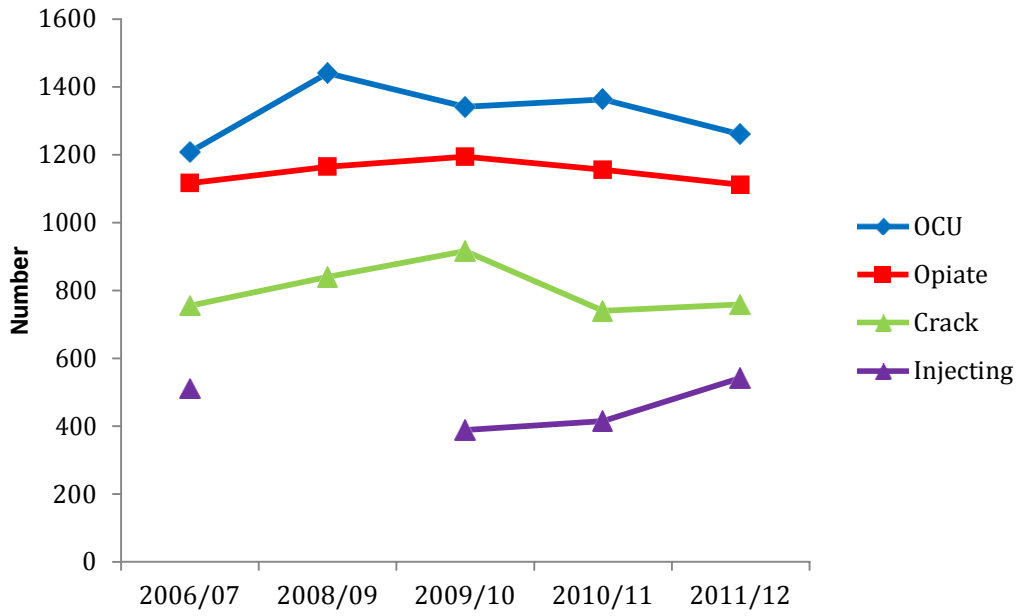


Source: Drug Data: JSNA support Pack, Public Health England 2015

Opiate and crack cocaine use prevalence trends, by drug-use category, are shown in Figure 28. The numbers suggest little change since 2006/07. This is consistent with the overall national picture, which saw a slight decrease in OCU prevalence, but not a significantly significant one. Prevalence estimates also report a national decrease in drug injecting between 2010/11 and 2011/12, but point to an increasing trend in Reading. Although prevalence estimates were carried out prior to 2006/07, these data are no longer publicly available. No local authority-level data for prevalence of injecting is available for 2008/09.

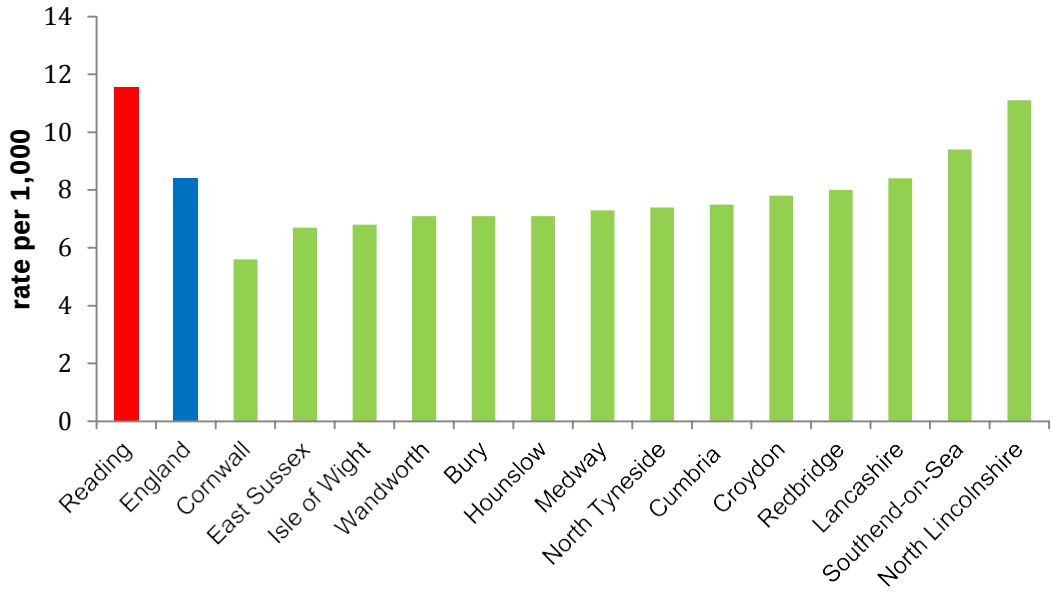
When compared to areas with similar levels of socioeconomic deprivation, Reading's estimated rates of OCU and injecting drug users per 1,000 population are higher than similar local authorities, suggesting that local high rates of opiate and crack cocaine use and drug injecting may not be linked simply to relative deprivation (Figures 29 and 30).

Figure 28. ***Estimated number of drug users, by drug use, Reading, 2006/07 to 2011/12***



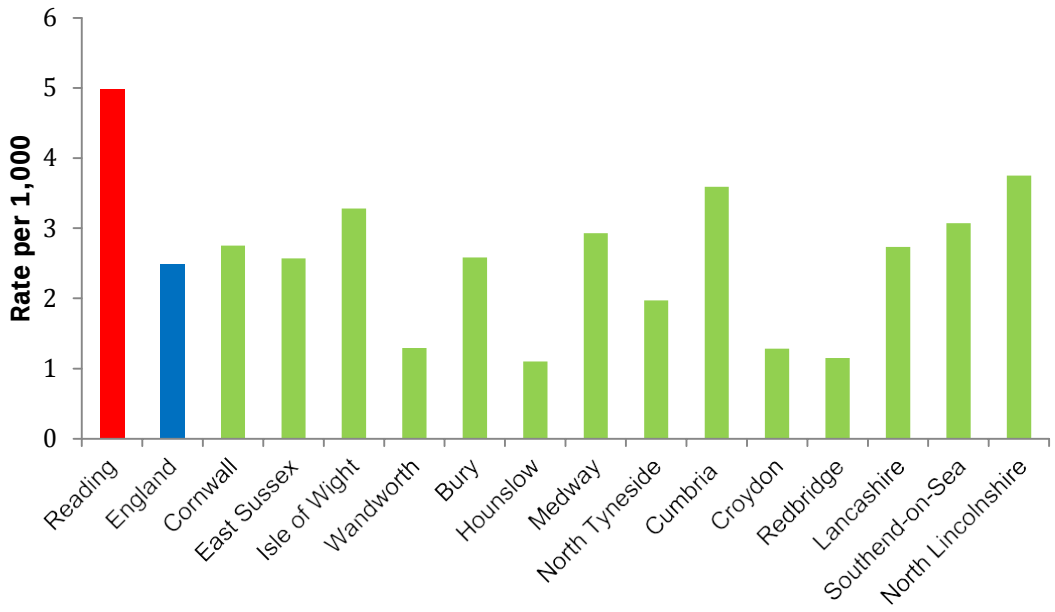
Source: Healthier Lives, Public Health England 2015

Figure 29. Prevalence estimates of OCU per 1,000 population by comparator local authorities (Socioeconomic decile 6)



Source: Healthier Lives, Public Health England 2015

Figure 30. Rate of injecting OCU users per 1,000 population by comparator local authorities (Socioeconomic decile 6)



Source: Healthier Lives, Public Health England 2015

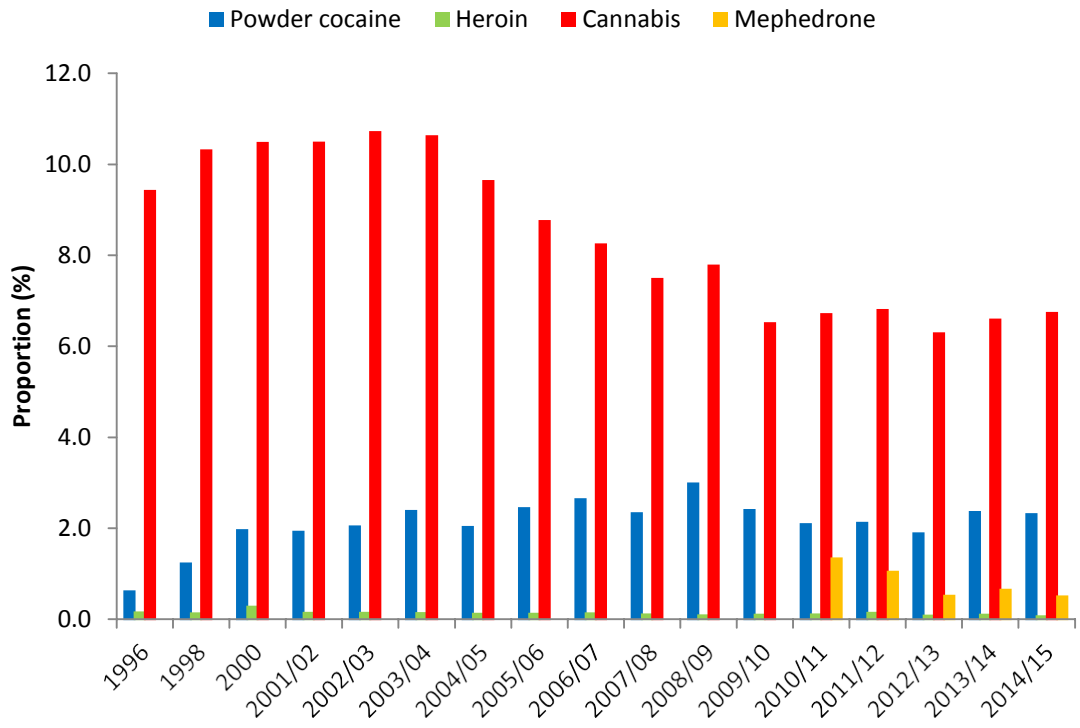
While there are no estimates on the prevalence of cannabis and other drug use by local authority area, the Crime Survey for England and Wales produces statistics on self-reported drug use amongst respondents, most recently, as shown in Figure 31, the evidence suggests that 6.7% of 16-59 year olds used cannabis in the last year and 2.3% used powder cocaine and 0.5% mephedrone (included in the survey since 2011).

Applied crudely to the 2014 mid-year population estimate for 16-59 year olds for Reading,[xxi] this equates to nearly 6,000 people having used cannabis, some 2,000 having used cocaine, 445 having used mephedrone and about 90 having used heroin in the year 2014/15. We should note that there is likely to be a discrepancy between self-reported drug use and actual drug use, and that this may be greater where there is greater stigma, (for example, more than 500 people from Reading presented to drug treatment services with problematic heroin use in the same period) so we need to consider the implications of using the survey method for collecting information about drug use prevalence. Nevertheless, the survey data suggests much wider use of cannabis, powder cocaine and NPS than class A drugs such as heroin and crack cocaine.

Reliable data on the number of people using NPS are impossible to obtain. The data in Figure 32 cover the main NPSs reported by new entrants into specialist drug and alcohol treatment England. While the majority of opiate and crack users can be expected to develop significant health and/or social care service needs in time, the long-term health impact of NPS use is not yet known. Non-opiate using adult NPS users typically have good personal resources – such as jobs, relationships, accommodation – and this may mean that they are less likely to need treatment or, if they do, that they will be more likely to make the most of it.[95]

xxi The borough's estimated adult population in mid-2014, produced by ONS, is 124,975 people aged 18+ years.

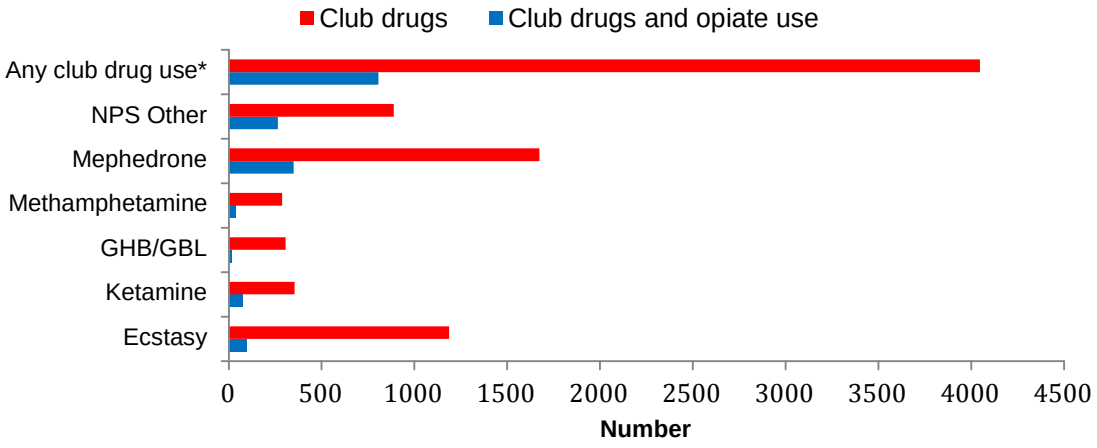
Figure 31. Self-reported drug use in the last year, 16-59 year olds, England, 1996 – 2014/15



Source: Home Office (2015). Drug Misuse: Findings from the 2014-2015 CSEW.

The majority of opiate and crack users can be expected to develop significant health and/or social care service needs in time, whereas possibly a majority of NPS users will not, unless they go on to use opiates and/or crack (although there is no inevitable pathway from one to the other). A very high proportion of opiate and crack users will also use tobacco and alcohol.

Figure 32. The number of new treatment entrants in England citing club drug use or club drug use and opiate



Source: Drug Data: JSNA support Pack, Public Health England 2015

Surveys of young people suggest that 20-40% will have tried an NPS at some time and that, before it was banned, some 34% had tried mephedrone, but these data may be derived from heavily biased samples and give an inaccurate picture. [96] Despite these limitations, it is probably reasonable to assume that a sizeable minority of young people in Reading have used an NPS at least once.

NPSs are relatively new in the UK and it is difficult to meaningfully determine the profile of people using them; patterns of use vary enormously across the UK. Much of the data are collected from self-reporting or from surveys of self-selecting participants, often carried out amongst those with a higher level of drug use than the general population. So far, relatively few people accessing treatment service cite NPS as their primary drug problem. There could a number of reasons for this, for example, it could reflect that people are able to use NPSs without harm being apparent or without dependency forming, or it this could reflect treatment set-up, including access to specialist club drug services;[97] there would appear to be only two specialist NPS clinic in England at present, one in London and the other in Brighton. In 2014/15, barely a handful of people accessing drug treatment services cited NPSs as problematic substance during an assessment with the Reading drug treatment service.

Source (Young People's Drug & Alcohol Service in Reading) reports that the majority of young people that they come into contact with are aware of NPSs and some have experimented/used them for a period of time. Based on ONS mid-year data, Reading had over 33,000 young people (aged 15 to 27 years). Using the lower end of the survey's results referred to earlier, this means we can estimate that over 6,500 people aged 15-27 years in Reading will have used NPSs at some time.

With regard to young people and drugs, the key findings from the *Smoking, drinking and drug use amongst young people in England 2014* report, which surveys pupils in secondary school aged between 11 to 15 years in England, included that :[98]

- there is a continuing decline in the prevalence of drug use amongst pupils aged 11 to 15 years in England, however the decline has slowed since 2010;
- almost 15% of pupils have ever taken drugs and 10% have taken drugs in the last year and 6% in the last month;
- drug use prevalence increased with age, 6% of 11 year olds compared to 24% of 15 year olds reported trying drugs at least once;
- 2% of pupils said that they usually took drugs once a month or more often;
- cannabis was the drug most likely to have been taken in the last year by pupils (6.7%), with 2.7% reporting inhaling glue, gas, aerosols or solvents. Very few reported use of other types of drugs;
- 2.5% reported having taken NPSs, including 2% having taken them in the last year and less than one percent taken them in the last month; and
- pupils who smoked, drank alcohol, truanted from school or had been excluded from school were more likely to have taken drugs in the last year. Ethnicity and region were also associated with reported drug use.

The relationship between drug use and mental health problems amongst young people is of particular concern and over time, regular users run the risk of developing dependence. Drug use is more prevalent in young people with multiple vulnerabilities including truanting, exclusion from school, homelessness, time in care or serious/frequent offending. Addressing the issues of drug use amongst young people should aim to change their attitudes and behaviours, as well as providing

information and advice to parents and communities in order to prevent uptake.[99, 100]

6.2 Alcohol

Obtaining reliable information about drinking behaviour is difficult, however results from the 2013 Health Survey for England[101] show that most adults in England who drink alcohol do so in moderation, with 63% of men and 64% of women reporting drinking at levels indicating lower risk of harm, that is, their average weekly consumption is at or under the currently recommended weekly limits. Applying this to the Reading mid-year population data for 2014[2] we can infer that some 40,000 adult male and 32,400 adult female residents drink alcohol at levels which are consider a low harm risk.[102] Surveys consistently record lower levels of consumption that would be expected from data on alcohol sales with some 40-60% of alcohol sales are unaccounted for[103] so actual consumption I – and thus the number of people at risk – is likely to be much higher.

Whilst there is no reliable national model that estimates prevalence of alcohol dependence at a local level, the latest the *Statistics on Alcohol* produced by HSCIC cites national estimates for hazardous and harmful drinking and alcohol dependence in the general adult population in England.[6,7,74] In 2007, HSCIC estimated that some 24% of adults in England (33.2% of men and 15.7% of women), were drinking at hazardous levels. Of these, 3.8% (5.8% of men and 1.9% of women) were drinking at levels which were classified as harmful. In men, both hazardous and harmful drinking was most prevalent in 25-34 year-olds, for women it was in those aged 16-24 years, and, as mentioned earlier, females under 16 years are more likely to be admitted to hospital for alcohol-related conditions (broad) that males.[52] Based on these overall estimates, we can surmise that nearly 30,000 Reading residents could be drinking at hazardous levels and over 4,500 residents drinking at harmful levels. It is also reasonable to assume that the prevalence of alcohol misuse in Reading may be greater that the national estimates because Reading has a younger population in comparison to England.

Alcohol dependence is also more common in white males and females than in those from BME groups. Males are also at risk of cumulative health harms in that they are more likely to drive under the influence of alcohol, commit domestic violence and experience martial breakdown; there is also evidence that heavy drinkers have poorer mental health.[74]

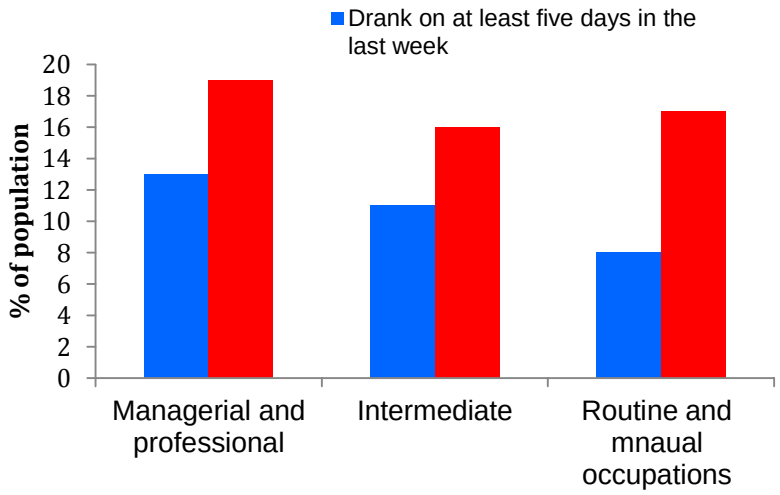
Alcohol consumption is also influenced by availability and affordability, and evidence shows variations in consumption by economic status and other socio-economic variables. Between 1980 and 2014, the price of alcohol increased by 23.2%, however, relatively speaking, it was 53.8% more affordable than in 1980. This is relevant in that affordability is an influencing factor in an individual's choice of whether to purchase alcohol.[74]

It is also fair to surmise the pattern of drinking amongst drinkers in Reading is likely to be widening health inequalities. Whilst data from the General Household Survey[104] (shown in Figure 33) shows that nationally, men and women who are more affluent tend to drink more alcohol than those who are more deprived, people in more deprived areas are: [105,106]

- 2-3 times as likely to die of causes influenced by, in part, alcohol;
- 3-5 times more likely to die of an alcohol-specific cause; and
- 2-5 times more likely to be admitted to hospital because of an alcohol-related condition.

This differential effect is likely to be related to the generally poorer health experienced by people living in more deprived areas, thus have a negative effect on health inequalities. This is significant for Reading as it has over half the LSOAs in Berkshire that fall within the 20% most deprived areas nationally.

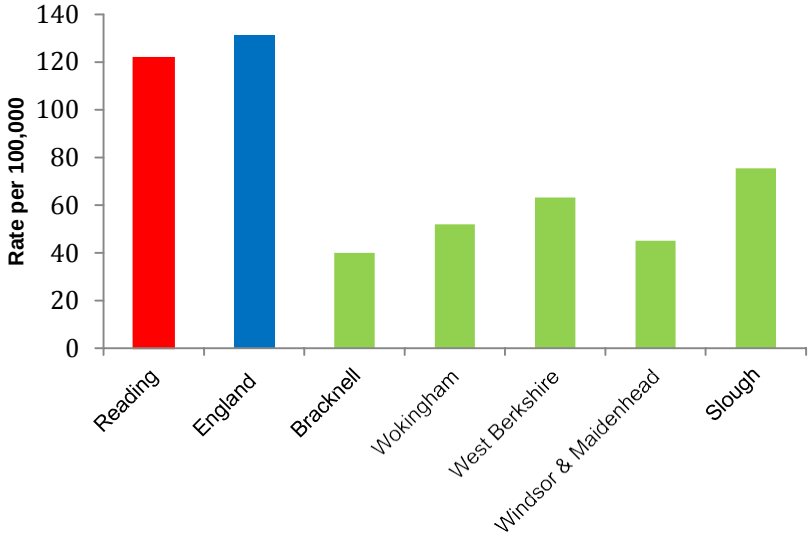
Figure 33: The proportion of adults, by economic class, reporting drinking alcohol in the preceding week



*6 units for women and 8 units for men Source: ONS 2015, General Household Survey 2013

In 2014, Public Health England calculated a crude rate per 100,000 of claimants of Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance who cited alcohol misuse as their main disabling condition. As shown in Figure 34, whilst the number of claimants in Reading is similar to the England average, it is double that in comparison to most other Berkshire local authorities (with the exception of Slough).

Figure 34. Claimants of Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance who cite alcohol misuses as the main disabling condition, 2014.



Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using bespoke request data from Department for Work and Pensions and ONS mid-year population estimates 2014.

The drinking prevalence amongst young people in England has continued on a downward drink since 1998 [107] (when measurement first began), when 61% of pupils aged 11-15 years in secondary school reporting having drunk alcohol at least one, in comparison to 38% in 2014. Other key findings of the *Smoking, drinking and drug use amongst young people in England 2014* report in relation to alcohol were that:

- the proportion of pupils having drunk in the week preceding the survey was 8% in 2014, this has continued on a downward trend since 2003 when it was 25%;
- about half (48%) of pupils thought it was acceptable for someone of their age to try drinking alcohol, and 24% thought it was ok to drink once a week. Some 18% thought it was acceptable for someone their aged to try getting drunk to see what it was like and 7% thought it was acceptable to get drunk once a week;
- the proportion of pupils who have ever drunk alcohol increased with aged, from 8% of 11 year olds to 69% of 15 year olds, as well as those who drank alcohol in the last week, increasing from 1% of 11 year olds to 18% of 15 year olds;
- most pupils who drank alcohol in the last week had consumed more than one type of alcoholic drink;
- males and females were equally likely to have reported drinking alcohol and to drink similar amounts. Most were likely to have drunk beer, larger or cider (72%), followed by spirits (59%), alcopops (40%) or wine, martini and sherry (38%). Preferences differ between the sexes, with females more likely to consume spirits, alcopops or wine;
- pupils were more likely to drink alcohol if they lived with someone who did, and 86% of pupils whose households did not include anyone who drank had not themselves drunk alcohol, but 40% of pupils who lived with three or more drinkers had; and
- pupils who thought their families did not like them drinking were less likely to have drunk alcohol in the last with only 2% reported drinking, compared to 16 percent of pupils who said their parents would not mind as long as they did not 'drink too much'.

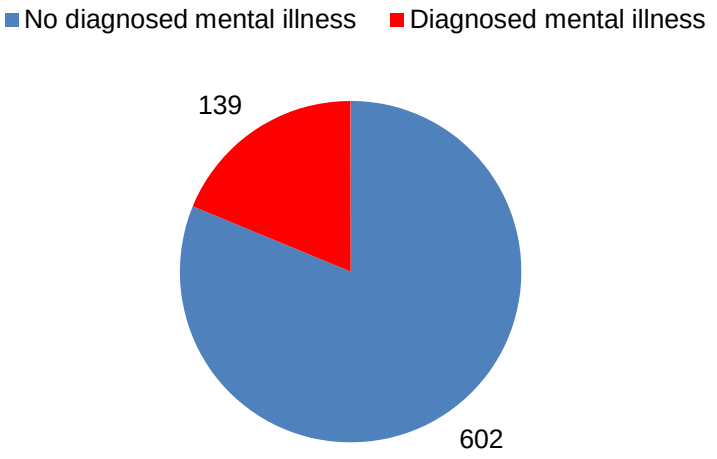
The burden of alcohol on Reading's health care system, and by implication also its social care system (and, probably also its policing and other judicial systems), is likely to be worsening and yet to be under-reported. Whilst the national trend of both young people and adults drinking alcohol has shown a decline, under-reporting means we have more people drinking at harmful and possibly hazardous levels, and they will remain undetected until health and social issues arise.[17] Whilst alcohol-specific and alcohol-related hospital admission in Reading indicate that Reading has similar numbers to the England average, some alcohol-related conditions, alcohol-specific mortality and months of life lost reflects a level of chronic heavy drinking in a proportion of the Reading population, which is not reflected in number of clients in treatment services.[108]

6.3 Dual diagnosis – mental illness combined with drug or alcohol use

In the context of this needs assessment, the term *dual diagnosis* refers to a diagnosis of a mental illness alongside a drug and/or alcohol problem. (Some sources use the term to refer to any mental illness, while others restrict the definition to severe illness.) Prevalence estimates range from 20% to 37% of mental health patients and 6-15% of those in addiction treatment having a dual diagnosis.[109]

Local treatment data (as shown in Figure 35) shows that 19% of those in drug and alcohol treatment (139 people) in 2014-15 in Reading reported a dual diagnosis at the time of starting their treatment.

Figure 35. Number of people in drug and/or alcohol treatment with dual diagnosis, Reading, 2014-15.



Source: Local drug and alcohol treatment data

Just over 1,000 people registered with GPs in the South Reading CCG and some 770 registered with GPs in North and West Reading CCG have been diagnosed with a serious mental health problem (including schizophrenia, bipolar affective disorder and other psychoses). [110] Applying the prevalence estimates above suggests that between 360 and 670 of these people may have a dual diagnosis across North and West Reading CCG and South Reading CCG areas, respectively. These estimates do not include personality disorder, which is likely to be more prevalent amongst those misusing drugs and alcohol.[111] It should be noted that a small number of the people registered with GPs in these two CCGs may be resident in neighbouring boroughs.

7 What works and what is available in Reading for people who misuse drugs and/or alcohol?

There is significant evidence of the benefit of primary prevention and early intervention of drug and alcohol misuse and of the types of activities that can have a positive impact on behaviour. There are a number of commissioned services in Reading whose primary focus is drug and alcohol misuse, but we know there are whole range of other services, that are not necessarily commissioned or funded directly by RBC, which have either a direct or indirect impact on people misusing drugs and alcohol. These include, but are not limited to, services provided by voluntary and community sector, planning and licensing, housing and domestic abuse services. This section is not intended to be a comprehensive list of all prevention and intervention services.

7.1 Prevention and early interventions to reduce long term dependence on drugs and/or alcohol

Primary prevention is designed to prevent misuse of drugs and alcohol occurring in the first place; this is a particularly important activity to be targeted at children and young people before they start using substances. Young people are particularly

vulnerable because they are at an age when behavioural patterns are being formed and they are particularly influenced by peers and role models. [112] At a time when budgets are being significantly reduced, investing in prevention can only benefit Reading residents in both the short and long term; a cost-benefit analysis found that every £1 invested in specialist interventions for young people's substance misuse saved £1.93 within two years and, up to £8.38 in the long term.[55]

Evidence shows that a normative pattern for drug use initiation, beginning with tobacco and alcohol use, moving into cannabis use and then harder illicit drugs, can occur.[113,114] There is evidence to suggest that progression to illicit drugs is dependent on prior use of alcohol in males, but in females, the use of *either* cigarettes or alcohol is sufficient to led to the use of cannabis. [115] There is continuing debate about whether there is a predictive association between these factors or whether they reflect confounding environmental factors such as socioeconomic deprivation or availability of substances.[116, 117] Put another way, not all young people who drink alcohol or who smoke will go on to use cannabis or other drugs or to misuse alcohol but all those who misuse substances started with smoking and/or using alcohol. Importantly, the use of cannabis is associated with a doubling of the risk of developing schizophrenia and this risk could be reduced by discouraging its use amongst vulnerable young people; [118] and, significantly, American studies have shown that the median age at onset of drug abuse or dependence is 19 years.[119] Doing something early in someone's life to prevent progression to substance misuse is therefore important.

School-based approaches that help pupils to develop coping skills and examine motivation for risky behaviour [120 , 121] family-based programmes addressing parenting,[87,122,123] group-based therapy for children entering secondary school who are persistently aggressive,[89] and motivational interviewing for under 25s who are already using drugs[88,89] are recommended evidence-based interventions to prevent the onset of problematic drug and alcohol use.

There is also strong, high quality evidence that community-based multi-component models (that is, mass media as well as local community and school-based approaches) that enable the creation of partnerships are effective in preventing drug and alcohol misuse, bringing together different groups in a community. Whilst there is marginally less strong evidence on multi-component workplace prevention programmes, these too can enable employers to maintain safe and healthy workplaces.[124]

Whilst prevention is often focused primarily on the younger population, it is important to note the steady increase in the amount of alcohol consumed by older people in recent years [125] and a sizable cohort of people now aged 46-65 years consume more alcohol every day than any previous generation. [126] It is also likely that there are differences in the reasons that younger and older people drink more heavily, for example because of bereavement, job loss, reduced self-esteem because of major life changes (such as job loss, reduced independence, long-term medical conditions). Perhaps a third of older drinkers are 'late onset' drinkers[127,128,129] and the remainder, 'early onset' drinkers started before the age of 40 years.[127] Specialist services for older drinkers are scarce in the UK but there is evidence that not only are specialist services for older people linked to better results but that they offer additional treatment benefits to current mainstream services.[130]

It is also important to recognise that a quarter to a third of drug misusers also misuse alcohol and these people need to be offered treatment for both drug and alcohol

misuse.[131] (It is noteworthy that informal reports from Reading's drug and alcohol services suggest that at least 50% of drug users also misuse alcohol.)

There is also evidence that interventions for people with moderate or harmful dependence on alcohol are cost effective. For example, in the context of the provision of psychotherapy and other interventions for such people it has been found that:[132]

- social behaviour and network therapy is equally cost effective as motivational enhancement therapy, each saving about five times as much in costs on health, social care and criminal justice services;
- stepped-care interventions (single session of behavioural change counselling by a GP practice nurse, four 50-minute sessions of motivational enhancement therapy delivered by a trained alcohol counselor, and referral to a community alcohol treatment agency) can lead to greater cost savings and more motivation to change compared with minimal interventions (such as 5-minute directive advice);
- extended case monitoring (low intensity, long-term interaction with an alcohol case worker) was both clinically and cost-effective in preventing lapses in those who had previously misused alcohol;
- coping and social skills, behavioural self-control, motivational enhancement therapy, and family therapy were all cost-effective and reduced relapse rates;
- psychosocial/family therapies produced cost savings to the NHS; and
- two-week in and day-patient regimes were as clinically effective as five-week in-patient regimes but had significantly lower costs.

Local primary prevention activity targeting young people in Reading is mainly delivered through Personal Social Health & Economic (PSHE) Education in local schools, RBC's local young person's substance misuse service, *Source*, and initiatives such as the Community Alcohol Partnership (CAP). The collective aim is develop a culture where both young people and adults, are aware of the risks related to alcohol and, are able to drink responsibly; young people under the age of 18 are only able to access alcohol under responsible and informed supervision, and, safe consumption limits are understood.

Source is a small team of drug and alcohol workers who support young people up to the age of 18 years (or 25 years if a young person has a learning disability). Their service is also extended to parents and carers who are affected by a young person's drug use. Source can also refer the families and carers of young people with drug and alcohol issues to an independently-funded provider that works across different Berkshire locations, *DrugFAM*, which provide free support and delivers weekly support groups, one-to-one sessions with families, and telephone support.

The Reading CAP initiative aims to raise awareness of substance misuse through the provision of free resources which are made available to schools across the Reading borough; Resources from the Alcohol Education Trust have been independently evaluated and are aimed at those aged between 11–18 years. Using these resources alcohol awareness lessons are delivered by the Reading CAP, teachers and professionals working within the schools. Professionals are trained to deliver these lessons and support is ongoing to ensure this resource will be used consistently for years to come.

The Reading CAP will also be piloting the *Royal Society of Public Health Youth Health Champions Qualification* in some schools in Reading during 2016. The scheme aims to provide knowledge and vital practical skill sets, and harness young people's natural energy and enthusiasm to facilitate peer to peer education and mentoring about lifestyle related risks to health, to effect real and lasting change in the wider community. These Youth Health Champions will be a valuable resource to the community and the school in which they are situated.

Another essential part of the Reading CAP involves enforcement of the laws relating to young people and alcohol including purchase of alcohol by under-18s, sale to under-18s, drinking by under-18s in public places, and proxy or agent purchase. Compliance testing is an integral part of any CAP and usually takes place several times in the life of a CAP to provide benchmarking activity and monitor the success, or otherwise, of retailer training.

Alcohol retailers in Reading are encouraged to use Challenge 25 [xxii] as an age verification policy. RBC funds training for all retailers on this, as well as on how to identify fake identification, to ensure that this policy is applied in practice locally by all authorised staff. All of this training and intervention contributes towards reducing the risk of young people purchasing alcohol in Reading. (It is interesting to note that anecdotal reports from young people in Reading indicate that it is easier to obtain drugs than it is alcohol for this reason.)

The Reading CAP also supports and aims to ensure that local youth diversionary activities are in place and highlights any community where there may be gaps. Diversionary activities have included provision of sports (using local Reading leisure and sports facilities, youth clubs or 'youth buses' and local cafes) and it provides opportunities for young people to drop in and meet in a supervised, safe environment. Youth workers also have access to the alcohol education resources and offer alcohol awareness activities at youth clubs across Reading.

Parental education is also a key part of the CAP. National studies have shown consistently that only a small proportion of under-18s buy alcohol themselves and that it is mainly adults – usually parents, but also older friends or strangers – who purchase alcohol on behalf of young people. The Reading CAP encourages communications targeted at parents and other adults about the importance of not giving children and younger teenagers alcohol and highlighting the offence of proxy purchase (buying alcohol for or on behalf of an under 18 year-old).

There is also a Cumulative Impact Policy (CIP) that applies to all premises in a designated zone in the centre of Reading. To date, the policy has been effective in restricting new premise license application for late night venues that wish to sell alcohol past midnight and takeaways, which are both becoming a focus for disorder at night in Reading town centre. A combination of CIP and partnership working between RBCs licensing team and Thames Valley Police has been key in providing a local focus on restricting extended licenses to applicants that can robustly demonstrate they can meet the conditions of the license, and, to raise standards with existing licensees. This work could be enhanced with the further evidence and support from other key partners, as improved evidence and intelligence creates better opportunities to reduce the burden of anti-social behaviour fuelled by alcohol

xxii Challenge 25 is a scheme that encourages anyone who is over 18 but looks under 25 to carry acceptable ID when they want to buy alcohol. Challenge 25 builds on the Challenge 21 campaign introduced by the British Beer and Pub Association, who represent the beer and pub sector, in 2005. It's now run by the Retail of Alcohol Standards Group, which represents alcohol retailers.

misuse. One way of achieving this may be taking a coordinated response from all responsible authorities in relation to new license applications, or applications to extend alcohol hours, which could make the CIP more robust. Also, there is currently no body within Reading that can bring together the licensees. Previously there were schemes such as *Pubwatch* and *Best Bar None* which helped to give RBC and traders a forum to meet and to raise standards but these no longer exist.

7.2 Drug and alcohol treatment services in Reading

In 2013, RBC adult services responded to a national drug strategy[133] and alcohol strategy[134] by restructuring existing drug and alcohol misuse service provision being delivered through five separate service providers into a single contract, with a greater focus on recovery from addiction. Previously, in line with national policy, investment was concentrated on a service providing pharmacological harm reduction treatment. Local and national strategy aimed to attract those likely to be engaged in risky behaviour and drug-related crime into a substitute prescribing programme intended to minimise risks. Changes in national policy to focus on supporting drug and alcohol users to achieve recovery made this harm reduction model outdated. Amalgamating these contracts appeared to offer an opportunity for investment to be shifted.

The resulting contract was awarded to Integrated Recovery in Services (*IRiS) Partnership*, [135] a consortium led by *Cranstoun* and including *Inclusion*, both well-established third sector providers of drug and alcohol treatment services. The service is structured into three tranches offering:

- *Health and Engagement:* needle exchange, harm minimisation advice, drop-in services;
- *Change and Recovery:* structured pharmacological and psychosocial interventions, e.g. alcohol detoxification, opiate substitute prescribing, keywork and group work utilising motivational interventions and cognitive behavioural approaches to relapse prevention; and
- *Recovery and Reintegration:* offering peer support, access to community activities and mutual aid.

In 2014/15, 85% of all people in treatment with IRiS in Reading received motivational interventions and 37% received cognitive behavioural therapy. [136] Residential rehabilitation is also funded by RBC in exceptional cases. Applicants must demonstrate commitment to their own recovery and that they have made use of community treatment to progress as far as they are able. Typically, a keyworker may suggest residential rehabilitation as a treatment option and help their client to prepare an application, including looking at which establishment is likely to offer the most appropriate treatment.

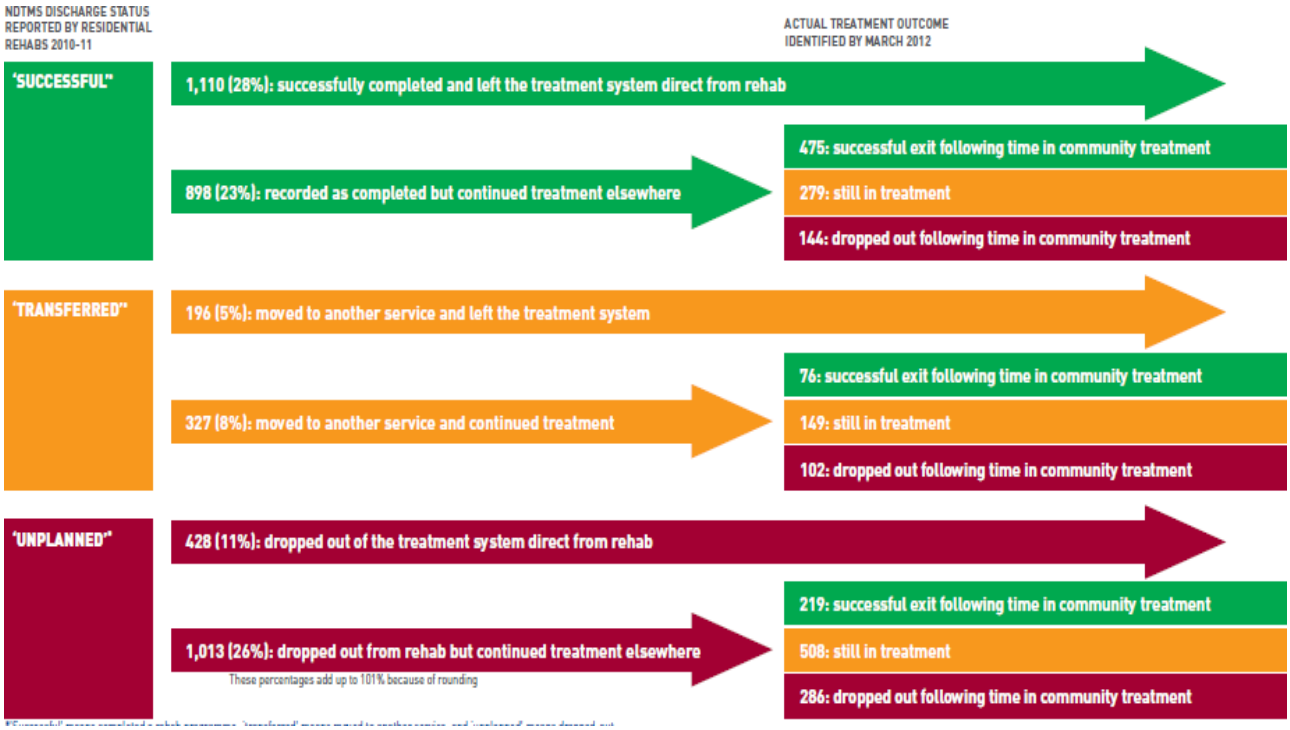
Residential drug or alcohol treatment is perceived as a very powerful treatment option in comparison with equivalent, community-based treatment programmes. There is good evidence to support the effectiveness of residential rehabilitation in helping some people to overcome drug or alcohol addiction.[137, 138, 139, 140] Residential rehabilitation is particularly recommended for those with complex social and health factors for example, homelessness, significant physical health conditions or severe mental health problems.[65, 66, 141]

Residential rehabilitation is an expensive provision; each client would be expected to stay for a minimum of 12 weeks at a cost of around £600 per week.[108] Many would be expected to continue to a second stage of a further 12 weeks, sometimes at a slightly reduced weekly cost. Treatment of one client at a residential rehabilitation establishment can therefore be expected to cost between £7,000 and £12,000. Research by the Department of Work and Pensions concludes that, despite good

outcomes, these costs of residential rehabilitation for opiate users are not fully offset by savings from housing benefit, offending, health, and employment.

Evidence published in 2012 by the National Treatment Agency for Substance Misuse (NTA) demonstrates some of the methodological difficulties in understanding effectiveness of residential rehabilitation treatment. The NTA report tracked the treatment journeys of nearly 4,000 residential treatment residents during 2010-12 (see Figure 33) and showed that although half left residential rehabilitation before completion, only 22% of these left treatment altogether. The remainder returned to community treatment and 15% of them ultimately left community treatment free of addiction. Of those who completed their residential rehabilitation treatment, 23% also returned to community treatment (see Figure 36).

Figure 36. The treatment journey of 3,972 residential rehabs residents, 2010 -12



*'Successful' means completed a rehab programme; 'transferred' means moved to another service; and 'unplanned' means dropped-out.

Source: Public Health England (PHE) 2014. *Residential Rehabilitation, pg. 7.*

Through primary care contracts, RBC currently commissions alcohol screening and brief motivation interventions from 27 GP practices across South Reading CCG and North & West Reading CCG. Practices are required to screen both newly-registered and existing patients aged 16 years and older using the AUDIT C tool. AUDIT C is a shortened version of the Alcohol Use Disorders Identification Test, a validated tool developed by the World Health Organisation and used for identifying problematic alcohol use.[142] Where problematic alcohol use is identified, GP practices should offer a brief intervention in line with the 'FRAMES' model described by the National Institute for Care and Excellence,[143] which includes:

- **F**eedback: identify personal risk or impairment, such as alcohol as a cause of gastritis;
- **R**esponsibility: emphasis on personal responsibility to change;

- **A**dvice: discuss ways to cut down or abstain in the context of lifestyle choices;
- **M**enu: provide a range of alternative options for changing drinking patterns and setting targets;
- **E**mpathic interviewing: listening reflectively without cajoling or confronting; and
- **S**elf-efficacy: an interviewing style which enhances people's belief in their ability to change.

Opportunistic brief interventions (also called 'Identification and Brief Advice' (IBA)) are recommended for people drinking above sensible limits who may or may not be experiencing problems which may be related to their alcohol use and, these can be delivered through primary care and other health and social care settings. [76, 144, 145, 146]

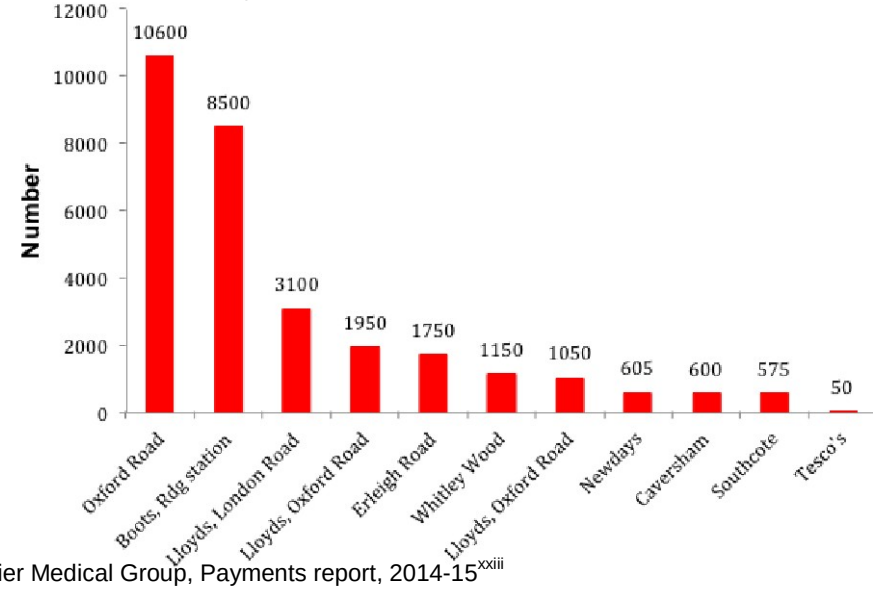
Software used by GP practices uses an automated version of AUDIT C and prompts users to complete assessments. In the first quarter of 2015-16, 812 AUDIT C results were recorded but this does not coincide with modelled estimates of need, or with the number of brief interventions delivered or referrals to structured alcohol treatment. More work is needed to understand how consistently brief interventions are being offered in primary care.

7.3 Needle Exchange

There is good evidence that needle and syringe programmes (NSPs) are an effective way to reduce risks of blood-borne virus transmission associated with injecting drug use, especially where coverage (the proportion of injections for which sterile equipment was used) is high. [147] In Reading, NSPs are provided through nine community pharmacies and at one site provided by IRiS, the specialist drug and alcohol treatment service.

Activity as shown in Figure 37, suggest that the most frequently used pharmacy-based needle exchanges are in Reading station (town centre) and the Oxford Road area (west of town centre).

Figure 37. Reading pharmacy needle exchange transactions, 2014-15



Source: Frontier Medical Group, Payments report, 2014-15[xxiii]

xxiii Pharmacists are required to record transactions using the Pharmoutcomes system, but many Pharmacies do not do so and reports are therefore unreliable. The system has capacity to prompt users to ask questions and to link to printable information sheets).

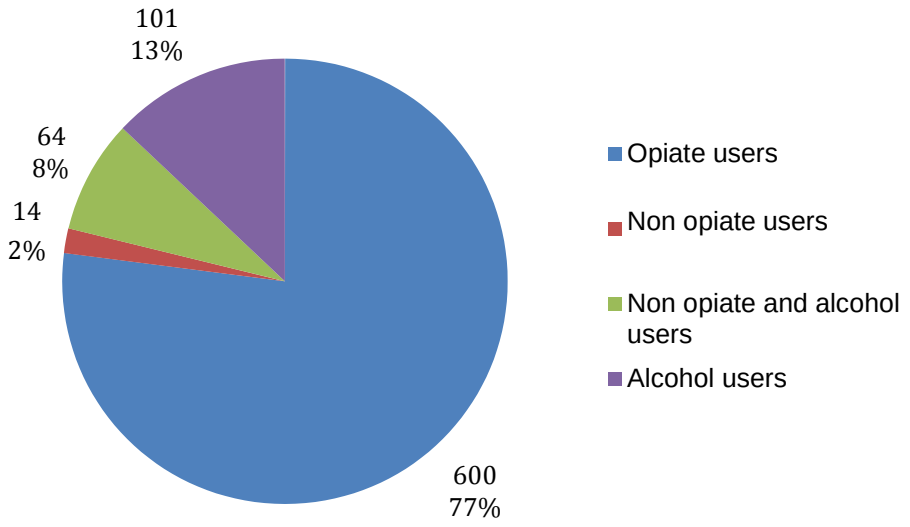
In April 2015, IRiS conducted a survey with pharmacies providing NSPs. The results indicated that pharmacists and pharmacy workers felt that they had gaps in their knowledge about drug use and that they did not always feel confident to provide verbal harm reduction advice to those using needle exchange services, respondents also felt they did not know how to access written information to be taken away. [148] Further analysis of this would be required in order to fully understand the implications of this, for both pharmacy staff and patients.

8 How are services currently being used in Reading?

The following section looks at how local adults and young people's drug and alcohol treatment services are being used and, at a high level, the outcomes of treatment. The information reported on nationally for adults and young people differs, for example, treatment completion rates for young people are generally measure on planned and unplanned exits rather than successful completions (see section 8.9 for more information).

As shown in Figure 38, three quarters of receiving adults-only care are primarily in treatment for opiate use, followed by alcohol use. These proportions are very similar to those seen in treatment prior to the start of the IRiS contract but does not reflect the need for alcohol misuse identified in this needs assessment. It is important to note that these data do not necessarily include all opiate users in treatment in Reading as some may be prescribed an opiate substitute by their GP without involvement of specialist services.

Figure 38. Substance use profiles of adults in Reading receiving treatment from IRiS, 2014/15

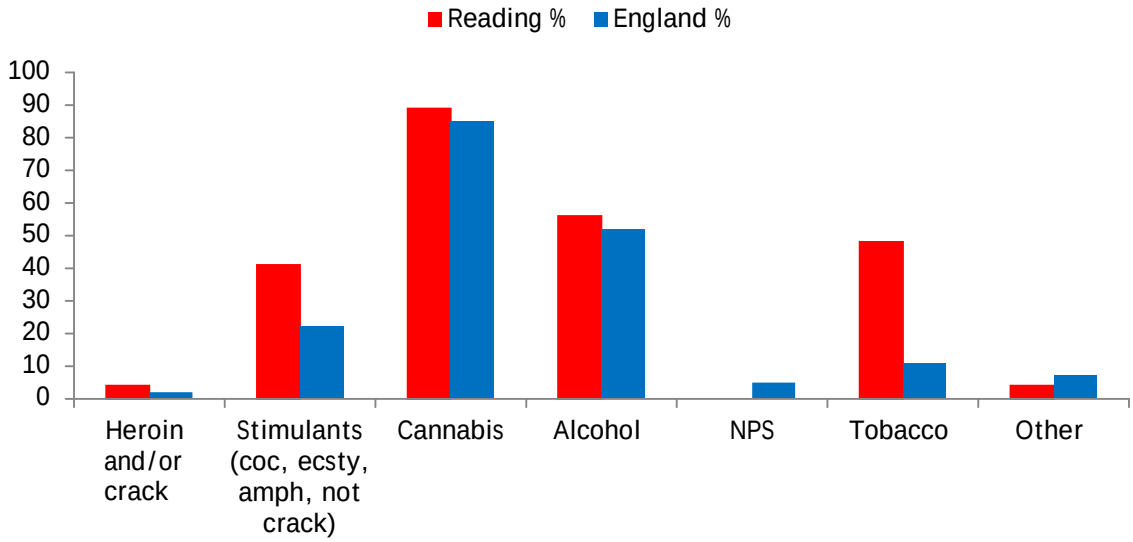


Source: Drug and Alcohol JSNA Support Packs, Public Health England 2015

Cannabis was the main substance used by young people accessing specialist misuses services in Reading during 2014-15 (as shown in Figure 39 below). This includes those aged 18 years and over accessing 'young people only' services. Whilst the numbers in Reading are small, 27 in total across all in the service, the percentage comparison against England (substance of use) is similar for all substances except tobacco and stimulants, which were higher in Reading. This

suggests multiple drug use amongst the young people in Reading who are accessing the service.

Figure 39. Substance use in young people* in specialist substance misuse services, Reading and England, 2014-15.

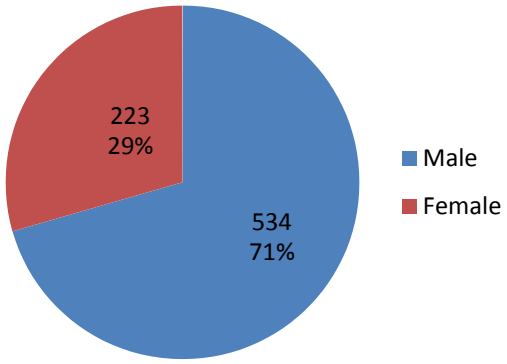


Source: Young People's substance misuse data: JSNA Support Packs, Public Health England 2015.

8.1 All in treatment population

Over two-thirds of those in drug and alcohol treatment (adults only) in Reading during 2014/15 were male (Figure 40), a similar proportion to that seen nationally (69.9%). While almost half of all referrals into drug and alcohol treatment are self-referrals, fewer women self-refer. Most women are referred to drug and alcohol services through the criminal justice system (35%) or 'other' (31%).[149]

Figure 40. Reading adult client treatment profile by gender, 2014/15.



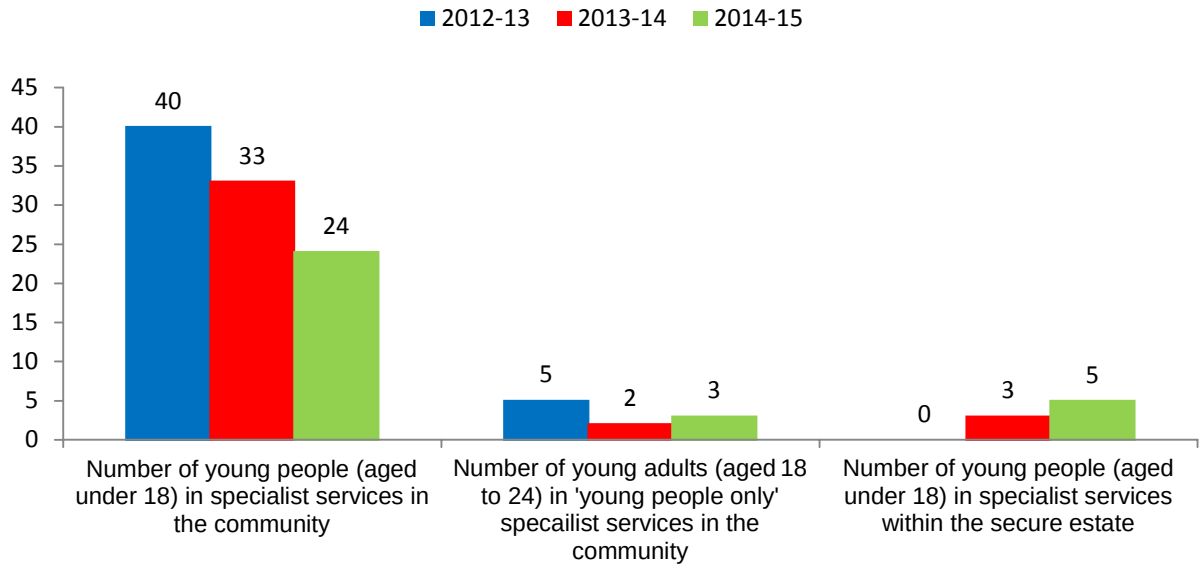
Source: National Drug Treatment Monitoring System, 2015

This was similar for young people in specialist substance misuse services in Reading during 2014/15, where over two thirds (71%) were male. Nationally, the proportion of

females citing alcohol a problematic substance is higher than males, the opposite being the case for cannabis. In Reading, the proportions and numbers are similar.

In Reading, we have also seen a decline in the numbers of young people (aged under 18) in specialist services in the community since 2012-13 (as shown in Figure 41), however we have seen a marginal increase in the number of those in specialist services within the secure estate[xxiv].

Figure 41. ***Numbers in service, Reading, 2012-13 to 2014-15.***



Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

The number of adults in Reading treatment services from Black and minority ethnic groups is small, as shown in Table 3, and, with the exception of African and Asian populations, roughly corresponding to their proportion in Reading's population. Relationships between drug use and ethnicity are various and complex.

A series of reviews of Department of Health data on drug misuse and different Black and minority ethnic groups discusses the impact of cultural identities on stigma attached to drug use. For example, Black Caribbean participants reported concern about the negative effects of drug use and dealing on their localities and the reputation of their community, leading to increased stigma for users.

The National Treatment Agency for Substance Misuse has concluded that various ethnic groups require more and better-targeted information which not only enables community members to understand the impact of drugs, but also helps them to access and to trust drug services when needed.[150]

xxiv Reporting into NDTMS is now done by secure estates such as young offender institutions (YOIs), secure training centres and secure children's homes.

Table 3: Reading users in treatment by ethnic group, 2014/15

Ethnic group		Number in treatment	Proportion in treatment (%)	Proportion in local population (%)
White	White British	586	77.4	65.3
	White Irish	7	0.7	1.5
	Other White	38	5.0	7.9
Mixed	White & Black	22	2.9	1.7
	White & Black African	0	0	0.5
	White & Asian	2	0.3	0.9
	Other Mixed	6	0.8	0.8
Asian or Asian British	Indian	4	0.5	4.2
	Pakistani	27	3.6	4.5
	Bangladeshi	1	0.1	0.4
	Other Asian	20	2.6	3.5
Black or Black British	Caribbean	15	2	2.1
	African	5	0.7	3.9
	Other Black	4	0.5	0.7
Chinese/ Other	Chinese	0	0.0	1.0
	Other	3	0.4	0.5
	Not stated/missing code	19	2.5	0
	Total	757	100	99.4

Source: National Drug Treatment Monitoring System (NMDTS) & Census 2011

Table 4: Patterns of drug use in various Black and minority ethnic groups

Ethnicity	Patterns of Use
Chinese and Vietnamese	Smaller population available for study, difficult to make comments on prevalence. Cannabis and ecstasy most commonly used, especially among young people. Heroin and cocaine powder are also used, but by far fewer than cannabis and ecstasy. Other use of illicit drug is low.
South Asian	Patterns are little different to general population. May be less amongst women, but this may be greater under-reporting.
Black African	Lower prevalence than amongst general population. Cannabis is most used. Khat amongst Somalis and Ethiopians.
Black Caribbean	Large majority exposed to illicit drug use. Cannabis is most used. Crack cocaine more widely used than heroin. Early onset drug use.

Source: Fountain, J (2009).[151]

8.2 Opiate and crack users in treatment

Reading has an estimated 1,260 opiate and crack users (OCUs).[78] During 2014/15, 561 opiate or opiate and crack adult users were 'effectively' engaged [xxv] with treatment services in Reading, equivalent to 44.5% of the estimated number of users

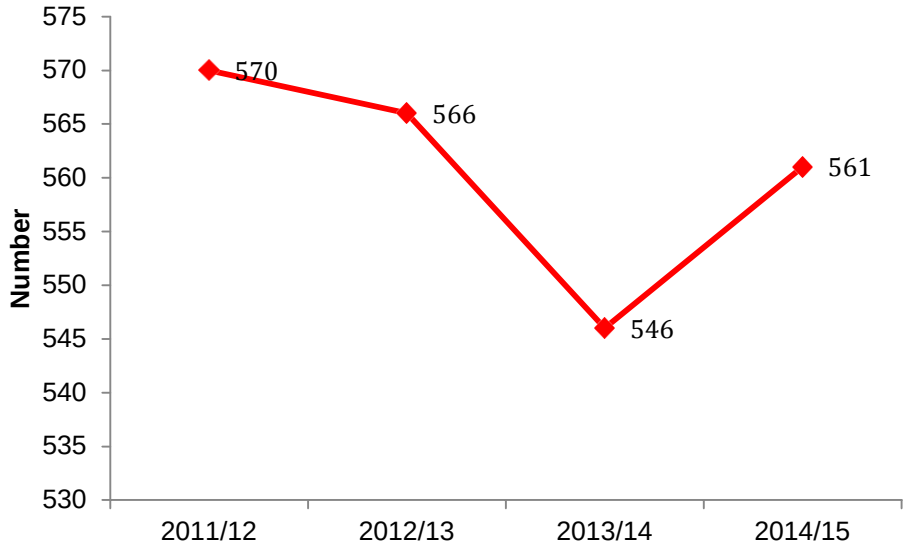
xxv When engaged with treatment, people use fewer illegal drugs. A measure for effective treatment is when people have been in treatment for three months or more and are using fewer or no illegal drugs

in the borough. This is slightly lower than the national rate of 49.6% drug users in treatment of (estimated 293,879 OCUs in England, 145,875 in treatment during 2014/15).

Nearly 80% (589) of those individuals using drug and alcohol treatment services in 2014/15 reported problematic heroin or other opiate use at the point when they entered treatment in Reading. Of these, most (59% or 347 individuals) reported using both opiates and crack cocaine. The remainder used opiates only (23% or 139 individuals) or opiates and other drugs (17% or 103 individuals).

The total number of opiate users 'effectively' engaged in treatment declined from 2011/12 to 2013/14, where we can see the number has increase in 2014/15 (Figure 42).

Figure 42. Number of opiate users effectively engaged in treatment, Reading 2011/12 – 2014/15



Source: Public Health England, JSNA Support Pack, Drug Data 2011/12 – 2015/16.

The total number of opiate users 'effectively' engaged in treatment declined from 2011/12 to 2013/14, where we can see the number has increase in 2014/15 (Figure 43).

It is also noteworthy is that a recent statistical analysis by Public Health England and partners of NDTMS data[152, 153] has drawn attention to the decline in the number of heroin users in treatment in England and highlighted that many now in treatment are older and likely to have additional health needs. The number of opiate users in treatment has fallen from over 170,000 in 2009-10 to less than 155,000 in 2014-15. In 2014-15 nearly half (48%) were aged over 40, compared to just over a third (34%) in 2012-13.

The national report also highlighted a decline in the number of young people accessing drug and alcohol services, which supports the earlier local evidence shown in Figure 44. A large majority of young people in treatment both nationally and in Reading are users of cannabis and alcohol. The total number of young people in treatment peaked in 2009-10 at 23,356, and has since declined, reaching 18,334 in 2014-15. The decline has mostly been seen amongst young alcohol users engaging in treatment, with numbers of cannabis users remaining more consistent. The

number of young people using opiates is consistently low, accounting for not more than 2% of those in treatment in any year since 2005-06. [138]

Figure 43. Trends in opiate users in treatment in England, 2009/10 – 2014/15

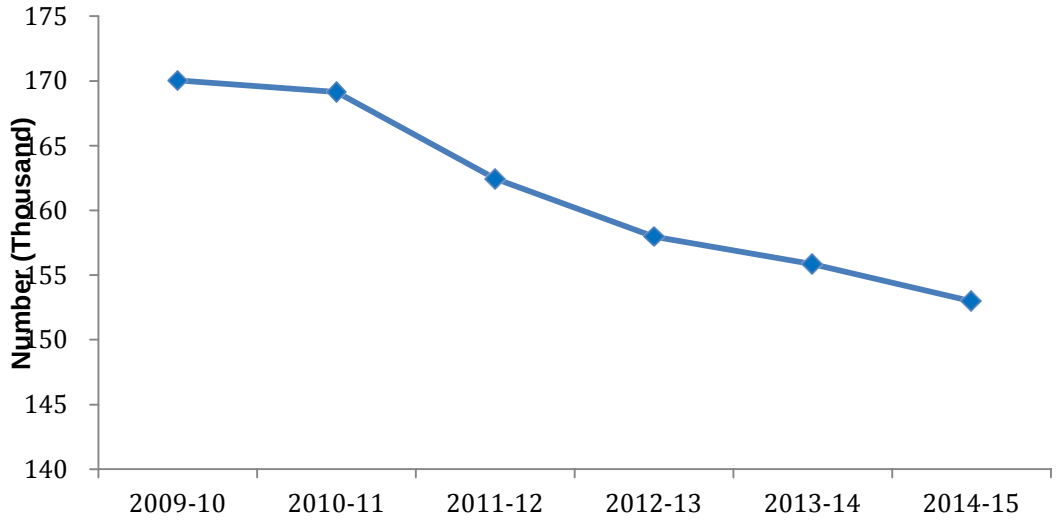
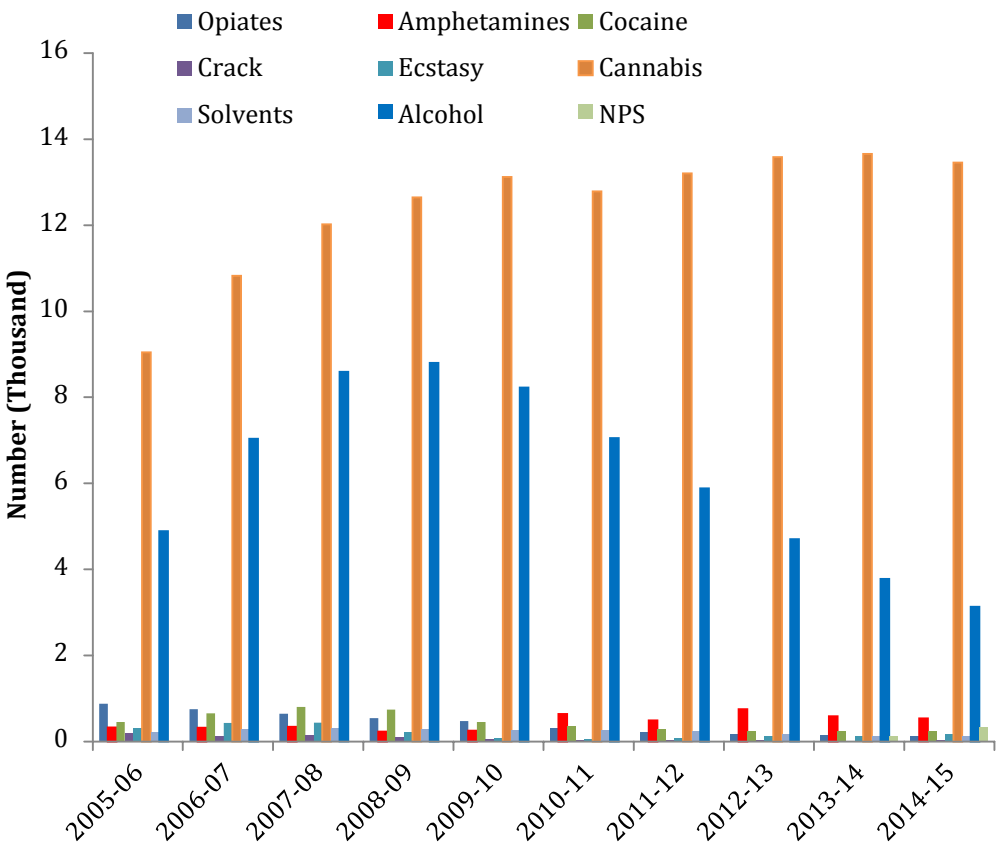


Figure 44. Number of young people in treatment by substance

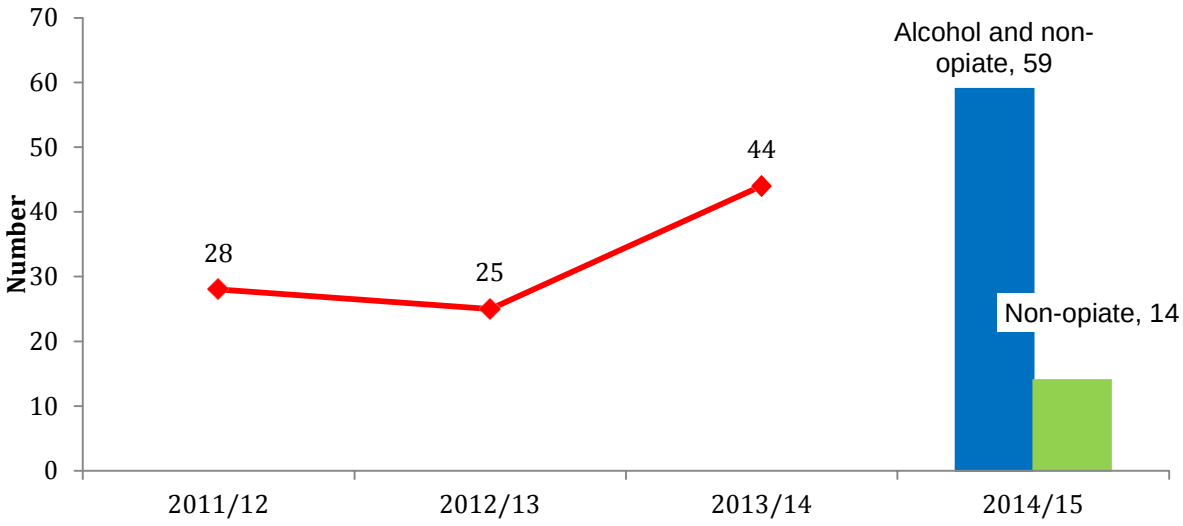


While local data in Reading seem suggest an increasing number of opiate users in treatment, they nevertheless support the finding that opiate users tend to be older, to have been accessing treatment services for their dependence for many years and to have complex needs that are difficult to meet (see section 8.2 for information on complexity)

8.3 Users of other drugs in treatment

Figure 45 shows for the general non-opiate using population, there appears to have been a peak in engagement in 2013/14, which may be related to increased focus on increasing number of successful completions, which tends to be easier to achieve for this cohort. In 2014/15, there was a change in the way substance user profiles were categorised, therefore these numbers have been include in the new categories of 'alcohol and non-opiate' and, 'non-opiate only'.

Figure 45. Non-opiate users in effective treatment, Reading, 2012/13 – 2014/15



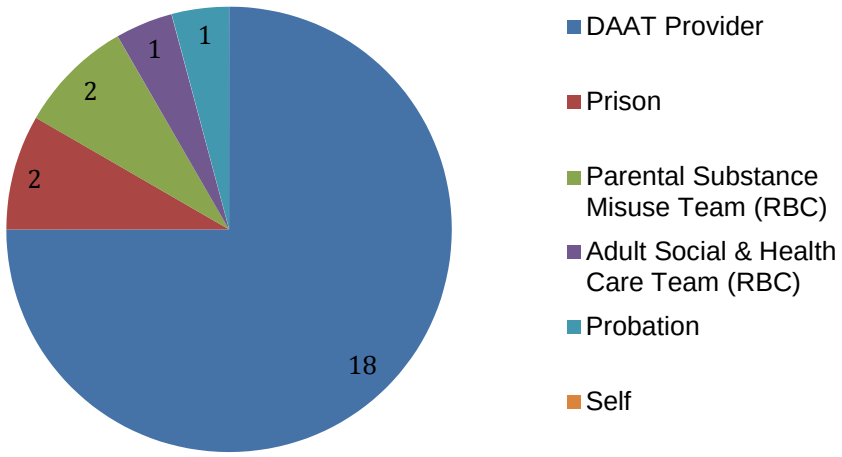
Source: Public Health England, JSNA Support Pack, Drug Data 2011/12 – 2015/16

8.4 Residential rehabilitation

Residential rehabilitation can be very effective but is an expensive treatment option. A local report into outcomes from locally funded residential rehabilitation treatment was made at the end of 2013-14. Applications for funding are made to a panel and reviewed against criteria requiring the applicant to demonstrate their commitment and preparation for residential treatment. During the year, 26 applications for funding were received, with over two thirds being put forward by the drug and alcohol treatment providers (figure 46). Funding was agreed for 17 applicants, the remainder either withdrew applications or were not considered to have met the criteria.

At the end of 2013-14, six of the 17 applicants had completed successfully. Only two successfully completed before the standard 12 weeks of treatment; two completed at 24 weeks of treatment and two after completing more than 24 weeks of treatment. Nearly half have gone beyond the standard 12 weeks of rehabilitation. Using the average weekly costings outlined in section 6 of this report, for the person engaged for 42 weeks, the estimated cost of treatment is in excess of £25,000.

Figure 46. Number of Reading residential rehabilitation applications by referral source 2013/14

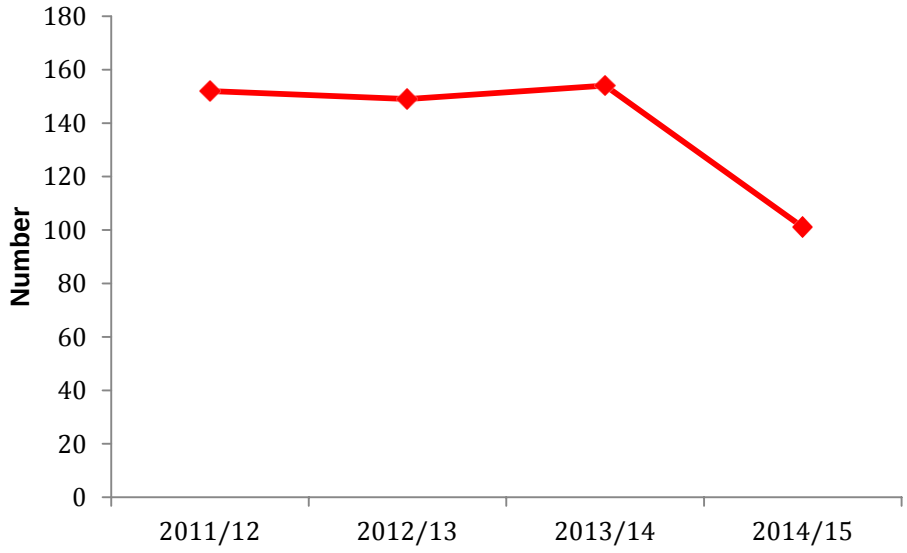


Source: RBC, Integrated Review Panel case records, 2014

8.5 Alcohol users in treatment

The number of adults engaged in treatment who use alcohol and no illicit drugs is much smaller than the proportion of opiate users in treatment and represents only a tiny proportion of those estimated in Reading's population to have problematic drinking. As shown in Figure 47, there were 53 fewer people in alcohol treatment between 2013-14 and 2014-15, representing a very small proportion of the estimated 4,500 adults in Reading drinking at harmful levels.

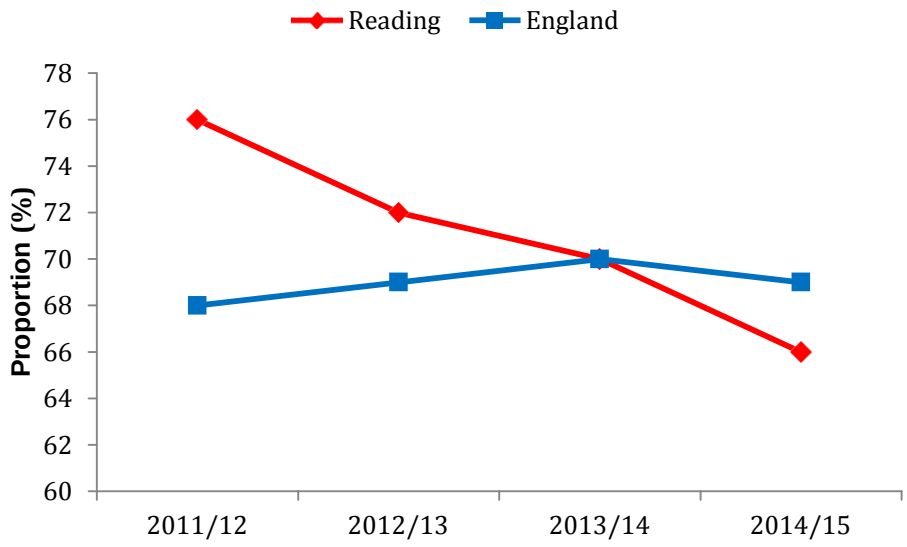
Figure 47. Number of alcohol users in treatment, Reading, 2011/12 – 2014/15.



Source: Public Health England, JSNA Support Pack, Alcohol Data 2011/12 – 2015/16

The proportion of adults starting new treatment in the year as a percentage of all in treatment in Reading has also seen a decline (Figure 48). This suggests that, in contrast to the rest of England, the amount of treatment being provided to alcohol misusers in Reading is decreasing and that the number of alcohol misusers in the area receiving treatment may fall even further the current low number.

Figure 48. The proportion (%) of adults starting new treatment, Reading and England, 2011/12 – 2014/15.



Source: Public Health England, JSNA Support Pack, Alcohol Data 2011/12 – 2015/16

8.6 Drug treatment completion rates

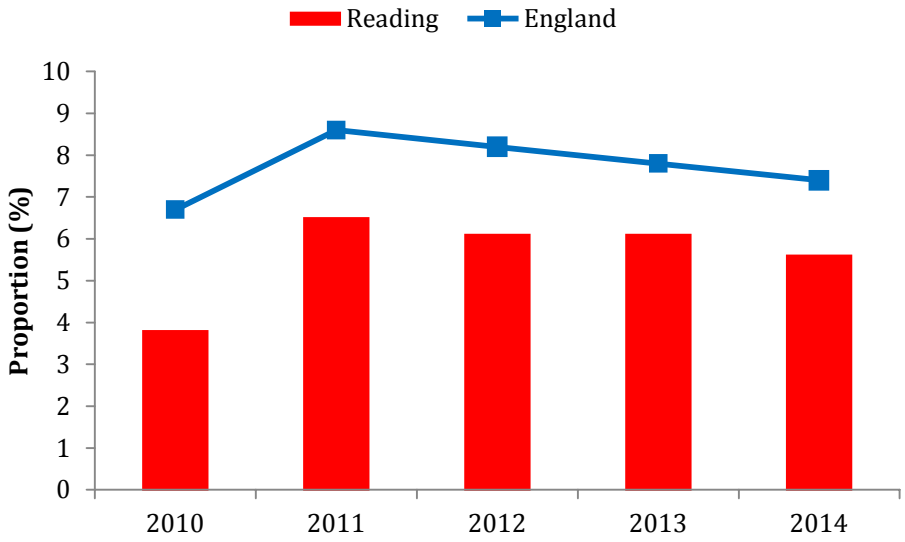
The Public Health Outcomes Framework indicators 2.15 (i), *opiate using* and 2.15(ii), *non-opiate using*, report the proportion of adults in the treatment population who are discharged with completed treatment. Successful drug treatment completion can be defined as people who have used drugs being free of drugs on leaving treatment and not presenting for treatment again for at least six months. To be effective, such treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.[154] .

8.6.1 Drug treatment completion – opiate users

The proportion of opiate users who leave treatment drug-free is low in Reading: 5.6% left drug-free in 2014, compared to an England average of 7.4% (Figure 49). There has been little change in Reading in performance on this indicator since 2011. The proportion completing treatment has remained consistently below the England average and compares poorly with comparable areas (see Figure 50).[xxvi]

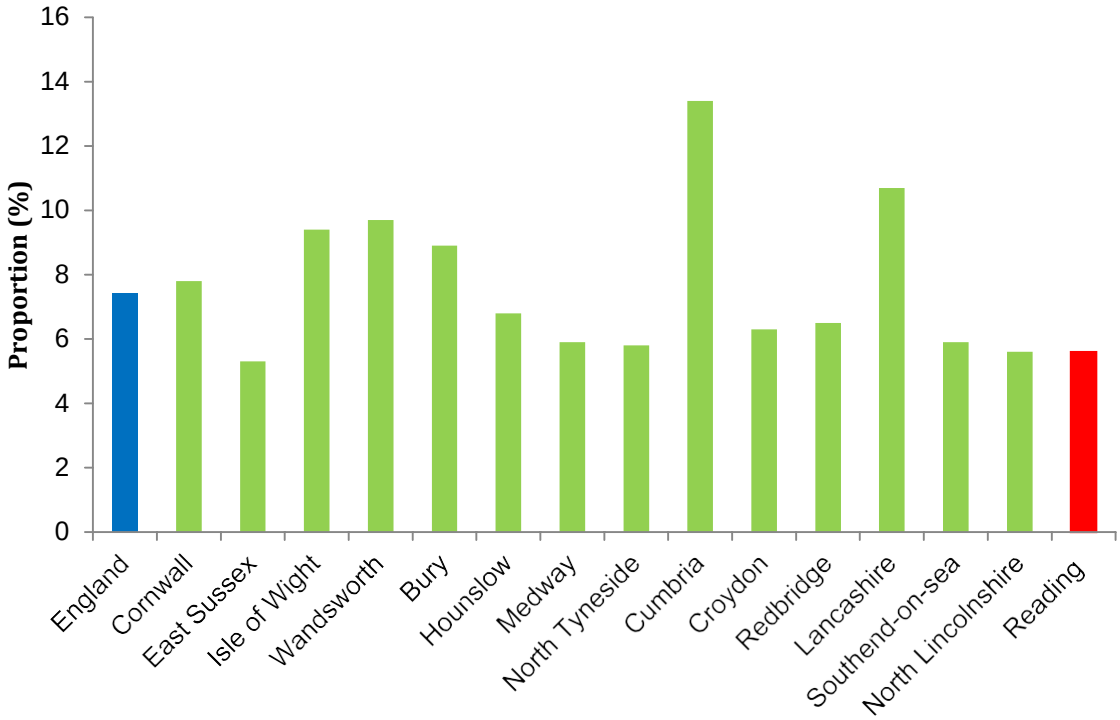
xxvi In 2014/15 a new method of comparators was devised by Public Health England which aimed to improve comparisons between local performance and that of other areas. Local outcome comparators are based specifically on the complexity of the populations in substance misuse treatment and not on broader similarity between the general population of each local authority.

Figure 49 – PHOF 2.15i Proportion (%) of successful completion of drug treatment – opiate users, Reading and England 2012-2015



Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS

Figure 50 – PHOF 2.15i Proportion (%) of successful completion of drug treatment – opiate users, by comparator authorities, 2014

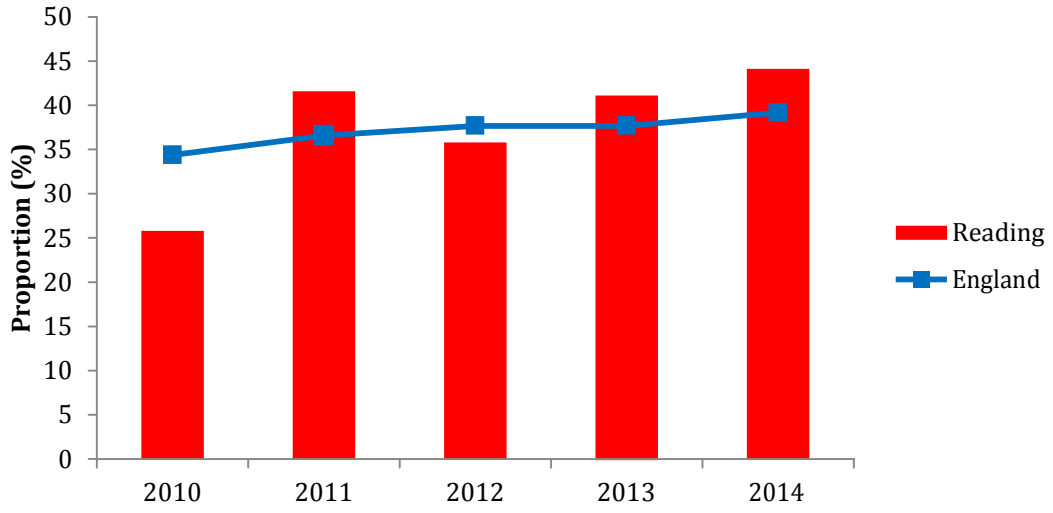


Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

8.6.2 *Drug treatment completion – non-opiate users*

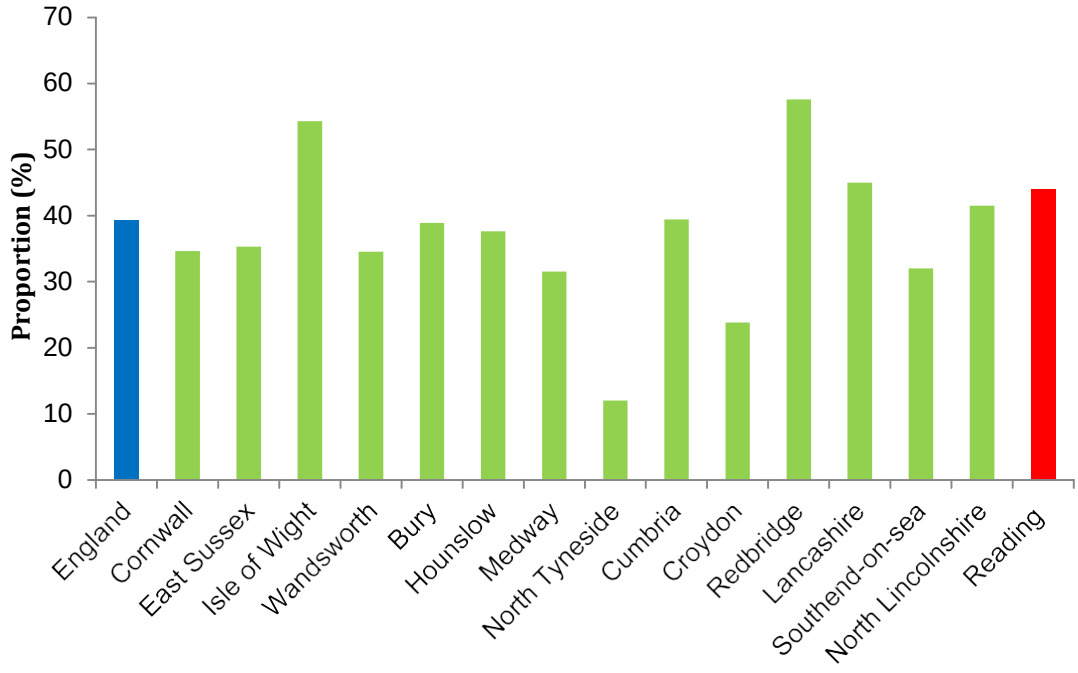
The proportion of adult non-opiate users in Reading who leave treatment drug-free is much larger and, at 44% at the end of 2014, was higher than the England average of 39.2%. Reading performs well against local authority areas with similar deprivation levels (see Figure 51 and Figure 52). It should be remembered, however, that this represents a small proportion of the treatment population so differences may not be statistically significant.

Figure 51 – PHOF 2.15ii Proportion (%) of successful completion of drug treatment – non-opiate user, Reading and England, 2010 - 2014



Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

Figure 52 – PHOF 2.15ii Successful completion of drug treatment – non-opiate user, 2014

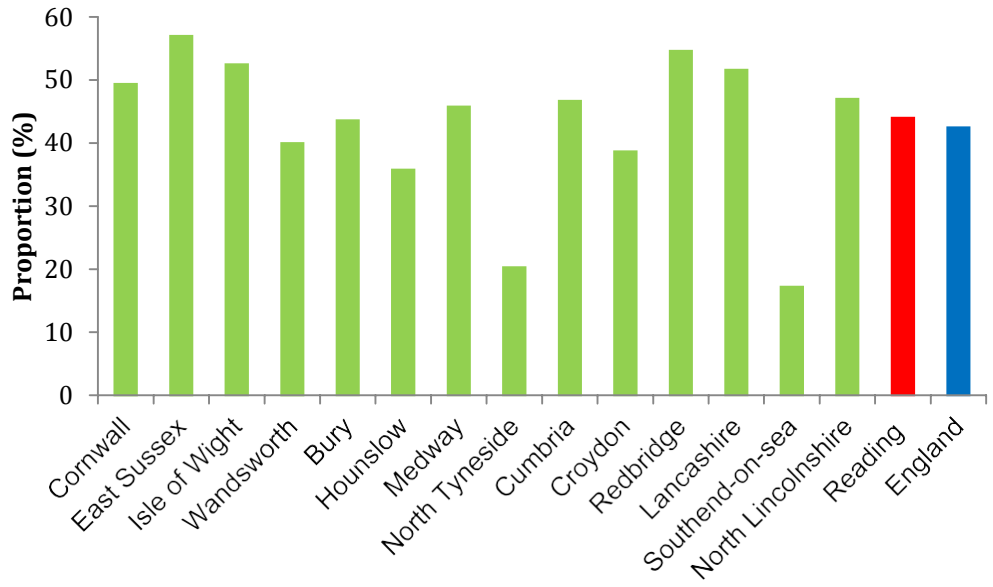


Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

8.7 Alcohol completion treatment rate

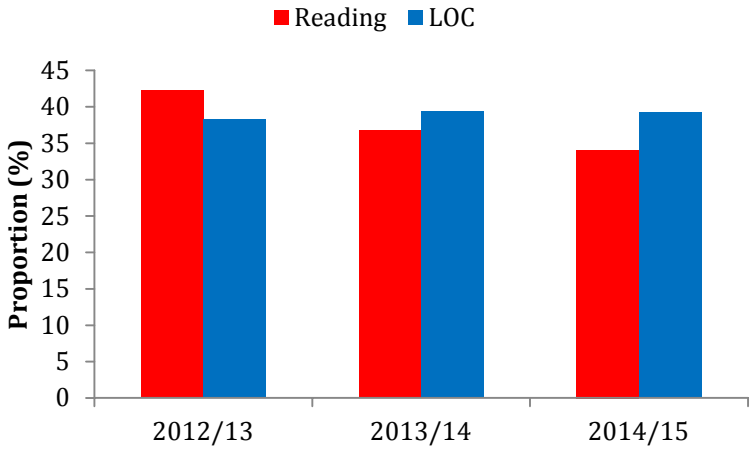
The proportion of clients completing treatment alcohol-free is much the same as the national average (see Figure 53). Again, it should be remembered that this represents only a small proportion of the total alcohol misusing population as the number of alcohol users receiving treatment is very small. As the completion of alcohol treatment is not measured by PHOF, using the data from NDTMS (figure 54), we can see this shows a similar trend.

Figure 53. Successful completion of treatment for alcohol 2013 (in comparison with areas with similar level of deprivation)



Source: Healthier Lives, Public Health England 2015

Figure 54 – Successful completion of alcohol treatment, Reading and LOC[xxvii] 2012/13-2014/15 – non-opiate users



Source: NDTMS, Recovery Diagnostic Tool, 2014/15

xxvii Reading's 'Local Outcome Comparators' are the 32 areas considered most similar to Reading based on measures of treatment population complexity, determined by NDTMS and PHE.

8.8 Complexity

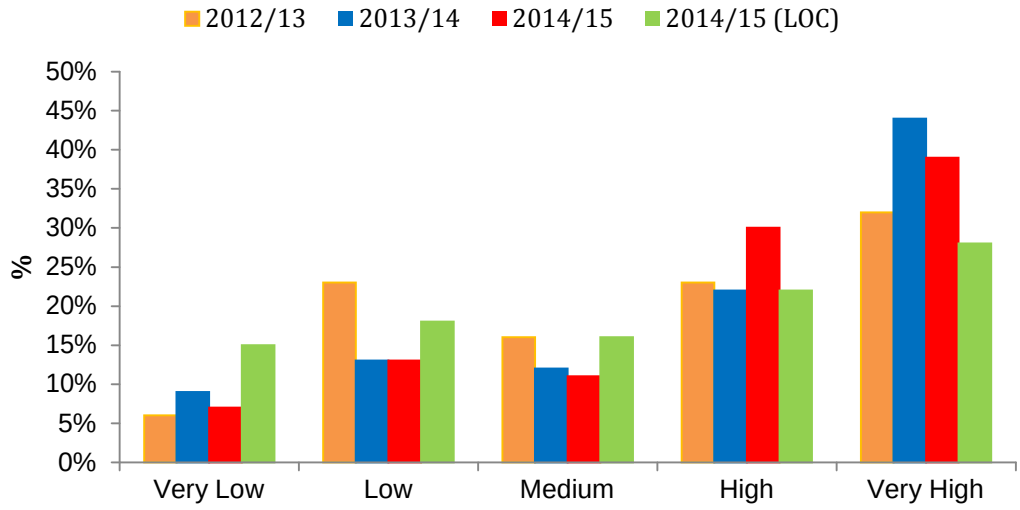
One of the difficulties in comparing treatment engagement and outcomes for drug and alcohol treatment in different localities is the diversity in populations and differences in the needs of those seeking treatment. A small population of individuals with needs that are difficult to meet may require more resources than a larger population whose needs could be considered straightforward.

Public Health England assigns a complexity score to individuals in drug and alcohol treatment that enables the characteristics of treatment populations in different areas to be compared. Complexity scores are based on:

- whether they use heroin, methadone or other opiates;
- the frequency of heroin use;
- the frequency of injecting;
- the frequency of crack use;
- the frequency of amphetamine use;
- the frequency of alcohol use;
- whether they use benzodiazepines; and
- the number of previous unsuccessful episode of treatment.

As shown in Figure 55, of the 669 individuals in treatment in drug and alcohol treatment in Reading in 2014/15, 258 (39%) scored 'very high' for complexity. This indicates that, based on criteria developed by Public Health England and measured through NDTMS, Reading's treatment population appears to have very complex needs that require more resources to meet. This is higher than the national average of 28% 'very complex' individuals.

Figure 55 – Complexity scores for all in drug and alcohol treatment in Reading

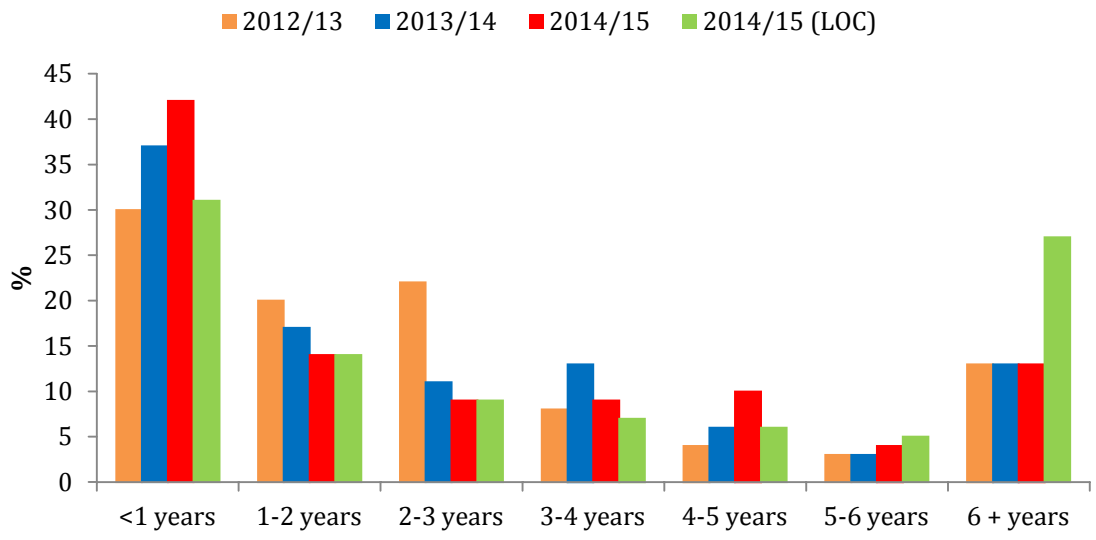


Source: NDTMS, Recovery Diagnostic Tool, 2014/15

In part, it is likely that this reflects the high proportion of heroin and other opiate users in Reading's treatment population. It may also be a reflection of the long-term heroin use amongst this growing cohort. As shown in Figure 56, the proportion of those in treatment in Reading for opiate use who have remained in treatment for four years or more increased from 20% to 27% between 2012-13 and 2014-15 (112 individuals in

2012-13, 127 in 2013-14 and 161 in 2014-15). The proportion of the population with four or more previous episodes of treatment has also increased from 21% to 30% in the same period and in 2014/15 was higher than in Reading's comparable local authority areas (LOC) (figure 56). This suggests a growing proportion in treatment who have been in treatment for a long time or have moved in and out of treatment over a number of years.

Figure 56 – Length of time in treatment opiate users in treatment in Reading compared to areas with similar treatment populations



.Source: NDTMS, Recovery Diagnostic Tool, 2014/15

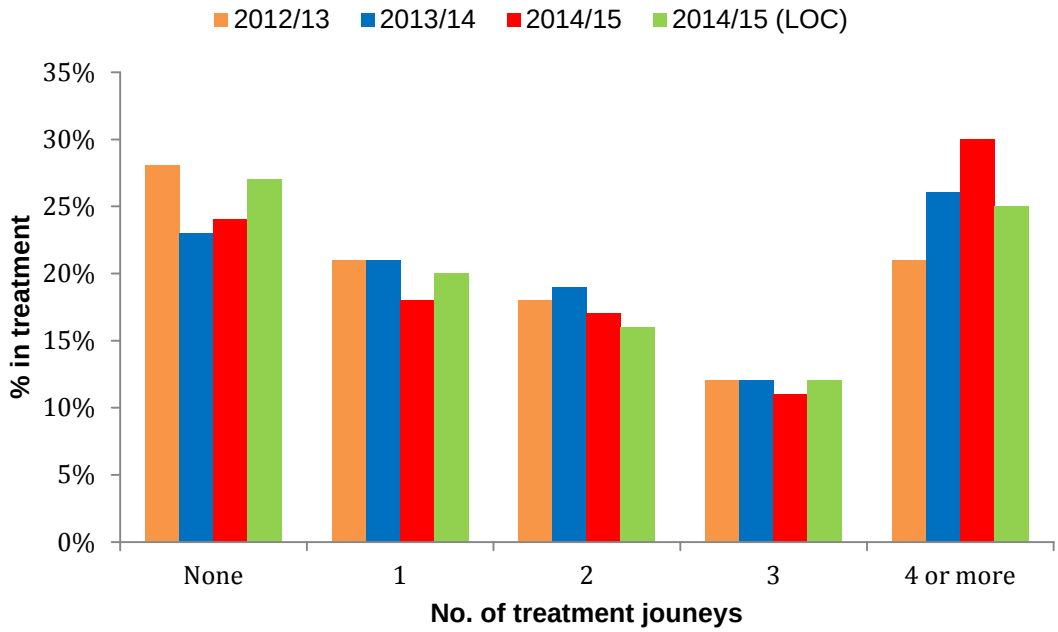
Figure 56 shows how long opiate users in treatment in Reading have been in treatment. The proportion in each 'treatment length' category for Reading is shown for each year alongside the percentage in comparison with areas with treatment populations of similar complexity (shown in green).

The chart demonstrates a large and increasing proportion in treatment for less than one year (most of these are unsuccessful). For the last three years around 13% of those in treatment have been in treatment for 6 years or more.

Figure 57 shows how many previous episodes of treatment opiate users in Reading have had. The proportion in each 'number of previous episodes' category for Reading is shown for each year alongside the percentage in comparison with areas with treatment populations of similar complexity (shown in green).

The chart indicates that the largest proportion (30%) have had four or more treatment journeys, suggesting that most people in treatment in Reading have moved in and out of treatment several times without successfully addressing their opiate use. The proportion of those in treatment in this category is higher than the average amongst comparable areas and is on an upward trend.

Figure 57 – Number of previous treatment journeys of opiate users in treatment in Reading compared to areas with similar treatment populations



Source: NDTMS, Recovery Diagnostic Tool, 2014/15

By comparison, alcohol users and non-opiate users in treatment in Reading are less likely to have had multiple previous treatment episodes and more likely to have a successful outcome from treatment. (In 2013/14, no non-opiate users and 7% of alcohol users had four or more treatment journeys, 86% of non-opiate users and 43% of alcohol users had never entered treatment before). This suggests that non-opiate and alcohol users are more likely to have a single episode of successful treatment, while opiate users are more likely to move in and out of treatment for a number of years and not to leave treatment free of addiction.

8.9 Young people and treatment

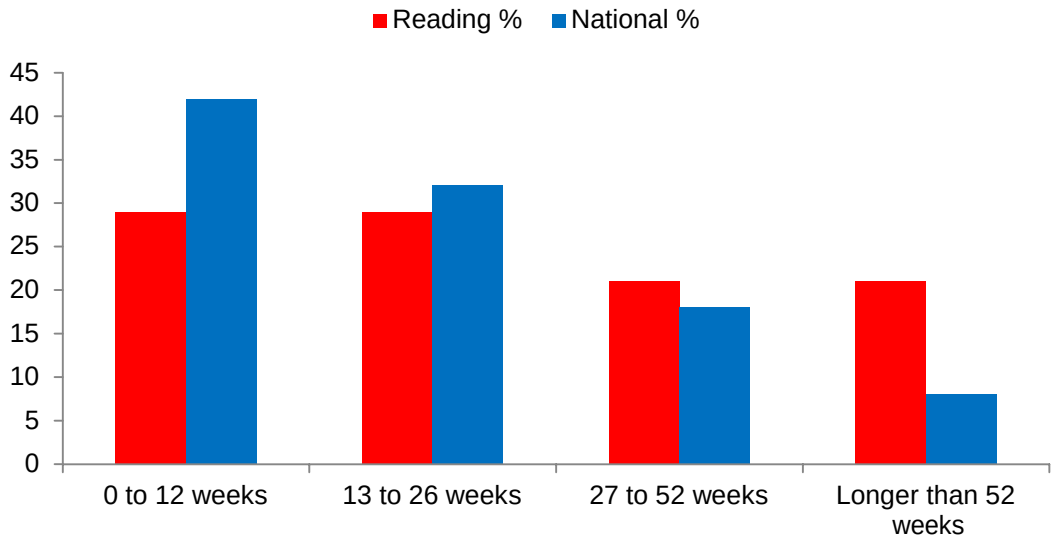
This section describes the length of time, interventions delivered and planned exit of young people who accessed specialist substance misuse treatment services in Reading. Whilst young people with complex needs often require extended support, for the most part, it is expected that young people will spend less time in specialist interventions.

Figure 58 shows that the proportion of young people in specialist services is similar to the national figure, except for those that in services between 0-12 weeks and, longer than 52 weeks. Whilst the numbers are very small, having more young people in treatment longer than 52 weeks could indicate Reading has more complex cases, or younger people with wider vulnerabilities that need ongoing support.

Having available a wide range of interventions which can be delivered to meet the specific needs of a young person will often result in better outcomes, particularly

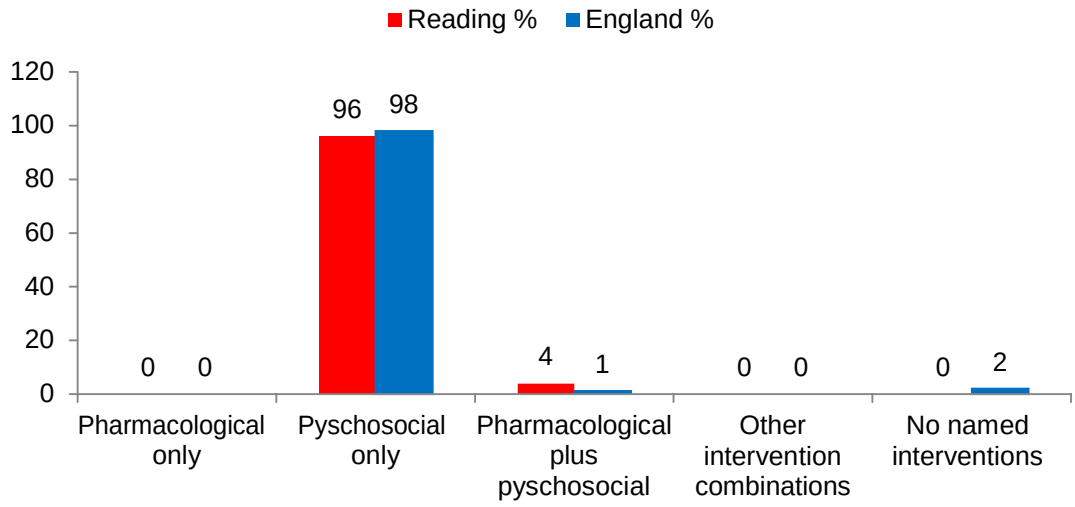
when supported by care. As shown in Figure 59, the most common intervention is psychosocial[xxviii] which is designed to encourage behaviour change.

Figure 58 Young people length of time in specialist substance misuse services, Reading, 2014-15.



Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

Figure 59. Interventions offered to young people in treatment services, Reading and England, 2014-15.



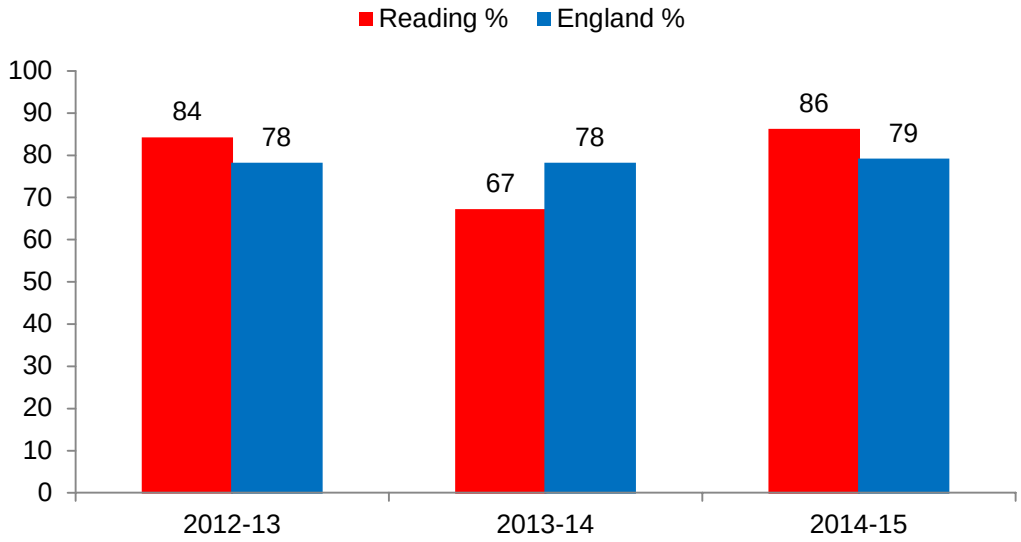
Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

Leaving specialist interventions in a planned way is the measure of success for young people, however if they re-present to treatment, this is not necessarily considered a failure. Re-presentations may occur if a young person's circumstances change and, this creates an opportunity for reassessment and a personalised plan

xxviii Psychosocial interventions are a range of talking therapies designed to encourage behaviour change. Data produced and published by Public Health England includes family interventions and harm reduction as well as other specific psychosocial interventions types.

that can support them to address the challenges they face. Figure 60 shows that the proportion of young people leaving substance misuse services in Reading in a planned is similar to the England for 2014-15, having seen an increase between 2013-14 and 2014-15. There were no planned exits with re-presentation in Reading between 1 January 2014 and 31 December 2014.

Figure 60. Proportion of those leaving young persons treatment in a planned way as a percentage of all exits, Reading and England, 2012-13 to 2014-15.



Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

Commissioning of local specialist services for young people enables us to engage quickly and effectively with young people and the Department of Education cost-analysis estimates that for every £1 invested, savings of between £1.93 (within 2 years) and £8.38 (long term) could be achieved.

9 Discussion

In Reading, understandably, there has perhaps been a greater emphasis put on the treatment of drug misuse rather than alcohol misuse. Whilst drug-related deaths rates in the local population are higher than the England average, and in comparison with the other Berkshire local authorities, the numbers remain small. In contrast, the figures in this report show that the health and social care and the wider societal effects of alcohol misuse are substantially greater than those of drug misuse. This may be in part because, with the possible exception of cannabis and NPSs, only a relatively small number of people use drugs (principally opiates, cocaine, and their derivatives, all of which are illegal), the use of almost all of which leads to a variety of significant and very complex problems. In contrast, a very large number of people use alcohol (which is a legal substance that is a significant part of the culture in the UK) and which has a proportionately smaller risk of significant problems. But, because the number of alcohol users is so large, the number of people who develop health and social problems is very much higher and the wider societal issues associated with it are very much more extensive.

Next to tobacco, alcohol is the most commonly used substance in Reading that leads to significant health problems. We know that nationally there has been a decrease in the estimated numbers of people drinking alcohol; but there is still a sizable proportion of people drinking at hazardous and at harmful levels. Modelled estimates

for Reading suggest that there are likely to be a large number of people (almost 30,000) drinking in excess of current recommended weekly amounts, with nearly 4,500 residents drinking to harmful levels. Taking into consideration that surveys on which national and local estimates are based consistently reported lower levels of consumption that would be expected using data on alcohol sales, we can conclude that the modelled estimates for Reading are likely to substantially underestimate the alcohol consumption in our community, perhaps by about a half.

More adult males than females drink alcohol at high risk levels, however alcohol misuse is increasingly more common amongst young females. There is also evidence of higher than average rates of alcohol-related ill health and mortality in adults in Reading, which reflects a cohort of people who have been drinking chronically (probably for between 10 and 30 years), and reported admissions to hospital are increasing (possibly because detection of previously undiagnosed alcohol related conditions has improved, particularly notable in some conditions in females) but mostly because more alcohol is being consumed. We also know that alcohol misuse is not confined to young people but to people of all ages and that a sizable cohort of people now aged 46-65 years consume more alcohol every day than any previous generation. It is also noteworthy that alcohol consumption is generally greater amongst people in higher socio-economic groups.

Alcohol is estimated to be implicated in 40% of violent crimes and 78% of assaults (such as domestic violence) and 88% of criminal damage cases, and figures suggest there is a growing number of alcohol-related crimes in Reading. Reading also has a statistically significant higher proportion of alcohol misusers who had not engaged with treatment in the community before entering prison.

In addition to low engagement of treatment by offenders entering prison in Reading, in comparison to the estimated number of people drinking to harmful levels, there are low numbers of people in the general community in Reading engaged with adult treatment services citing alcohol as their primary substances of misuse. It is unclear if this is due to lack of awareness, low screening rates of patients in Reading of their alcohol use, and/or referrals into treatment services. Furthermore, we know that there are different reasons that younger and older populations drink alcohol and, perhaps, a greater availability of specialist services, particularly for older people, may result in better engagement.

By comparison, Reading has an estimated population of between 600 and 1,300 opiate and/or crack cocaine users, and drug use incurs physical dependence, unpleasant symptoms of withdrawal and a risky, volatile lifestyle that exposes users to potential overdose, blood borne viruses (for those injecting drugs), and involvement in crime (particularly acquisitive crime). Reading has a statistically significant higher proportion of injecting drug users in comparison to other similar local authorities and, a higher rate of drug-related deaths.

Specialist drug treatment services in Reading engage with around 500-600 opiate users each year, which means that we are potentially only reaching half the drug-using population over a year. (The number is probably lower as many of these 500-600 clients stay in treatment for several years or leave and return to treatment.) Only a very small proportion of these clients (and smaller than other areas with similarly complex treatment populations) leave treatment drug-free.

Finally, while there good evidence from household surveys that suggests that, nationally, cannabis is the most widely used illegal drug, followed by cocaine, and that there is an emerging issue relating to novel psychoactive substances, there are

only a small number of people, particularly young people, in treatment in Reading who cite these drugs as being problematic for them and even fewer citing these as the drugs that they are primarily dependent upon. This could be because, for the most part, people believe they are able to use these drugs recreationally or with seemingly little effect on their lives (and this may be true to a large extent, although there is an increase risk, certainly of health harms, associated with their use).

So what else can be done to identify and help people who misuse drugs and/or alcohol? One simple thing is improving the local provision of 'brief advice' by health services (and, by implication, also by social and community care) professionals; brief advice for hazardous and harmful drinking is effective in reducing harm, but it is important to recognise that people with alcohol dependence and some harmful drinkers will require more specialist alcohol services.[155] This certainly applies in a primary care setting, where there is consistent evidence from a large number of studies of the effectiveness of brief interventions in reducing total alcohol consumption and episodes of binge drinking in hazardous drinkers for periods lasting up to a year.[156] A brief intervention is effective at the point when the hazardous or harmful drinker is newly identified[157] and may occur during attendance for a related or unrelated illness or injury, at health screening for employment or for insurance purposes. With appropriate training, it should be possible to provide such brief interventions in social care and other council service settings as well, especially as alcohol misuse is a common but often unrecognised problem in older people.[158]

A particularly authoritative source of evidence for various different approaches to the management of alcohol misuse has been produced by the National Institute for Health and Care Excellence[159] together with a recent update.[160] The key points of these, all of which are based on evidence of effectiveness, are that:

- a combination of approaches is required to manage alcohol misuse at both a population-level and an individual one;
- making alcohol less affordable is the most effective way of reducing alcohol-related harm (all major medical bodies, such as medical royal colleges, advocate a national minimum price policy for alcoholic drinks based on the number of alcohol units contained);
- reducing the availability of alcohol, for example, by limiting the number of outlets selling alcohol in an area, and the number of days and hours when it can be sold: in Scotland, protection of the public's health is part of the licensing objectives;
- reducing the exposure of young people to alcohol advertising;
- using local crime and related trauma data to map alcohol-related problems as part of a review of licensing policy;
- adequately resourcing enforcement services to prevent under-age sales;
- supporting children and young people who are thought to be at risk because of their use of alcohol;
- supporting the use of screening and brief interventions (which applies in both health and social care and voluntary sector settings);
- supporting the use of extended brief interventions, for example, using motivational interviewing, (which applies in both health and social care and voluntary sector settings); and
- referring people to services, as relevant (which requires adequate resourcing of those services).

There is also a role for voluntary organisations (for example Alcoholics' Anonymous) in helping people with drinking problems (and the related organisations, Al-Anon for the significant others of alcoholics, and Al-Ateen for their children). A review of a number of studies of Alcoholics Anonymous (AA) and other self-help 'twelve-step facilitation' (TSF) programmes versus other psychological interventions in reducing alcohol intake, obtaining and maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol-related accidents and health problems found no experimental studies unequivocally proving the effectiveness of AA or TSF for reducing drinking problems, but attending AA meetings was shown to help people to accept treatment and to stay in treatment, and both AA and TSF helped people to reduce drinking, but not necessarily to achieve complete abstinence, in comparison with other psychological programmes.[161]

Helping people with drug problems, and – especially – helping them to avoid starting misuse in the first place, is more difficult. Not only do many drug misusers have a myriad of health and social problems which require interventions from a range of providers (who ideally should work in an integrated way), drug misuse can also place an enormous strain on families, including children, and can have a serious negative impact on the long-term health and wellbeing of family members: protecting children from the potential impact of drug misuse is thus also an important issue. [162] Specialist-provider involvement is especially important for drug misusers, as injecting drug users especially, which is a particularly issue in Reading, are particularly vulnerable to contracting and spreading blood-borne viruses such as hepatitis B, hepatitis C and HIV. For example, a long-term follow-up of heroin addicts showed they had a mortality risk nearly 12 times greater than the general population,[163] and another study of injecting drug users showed that they were 22 times more likely to die than their non-injecting peers.[164]

A large proportion of people who misuse drugs do not limit their use to any particular one and a very high proportion also misuse alcohol and also smoke tobacco. Pharmacological approaches are the primary treatment option for opioid misuse, with psychosocial interventions providing an important element of the overall treatment package. Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange service and in primary care settings) if the service user or staff member identifies concerns about drug misuse. These interventions should:

- normally consist of two sessions each lasting 10–45 minutes; and
- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgmental feedback.[165]

Addressing broad social problems, improving levels of educational attainment and opportunities for work, in common with reducing health inequalities and improving people's health, are also relevant to helping people to avoid getting drawn in to the downward spiral that usually accompanies drug use.

Whilst helping to address drug misuse issues in Reading is important, the sheer size of the alcohol misuse problem should make this a much greater priority.

10 Conclusion

Alcohol misuse is a much bigger issue in Reading than drug misuse: it affects far more people individually and has much wider societal impacts. Significant problems

are related to both, but especially to alcohol misuse, are getting bigger year-on-year in Reading, as elsewhere.

The lives of most drug users and of a sizeable group of alcohol misusers are complex and often chaotic. A multidisciplinary approach that truly joins up the various different services provided (for example, general practice, A&E, other hospital services, community services, specialist drug and alcohol services, social services and voluntary and community services) will enable benefit for them and their families and for society more generally.

Our current service has been commissioned to concentrate mainly on people with significant opioid drug dependency (with, recently, a slight increase in the number of people with severe alcohol dependency being treated) with many having been in 'treatment' for many years: we currently have a cohort of between 500-600 opiate users many of whom have multiple occasions of engagement with specialist services, but with only a very small proportion leaving treatment drug-free each year. This begs the question: are they content with their current lifestyle and have no real motivation to change? Whatever the reasons, within the current allocation of resources for drug and alcohol services, there are very many people who would benefit from short-term, semi or high intensity interventions that would have a high likelihood of preventing them from developing significant drug or alcohol-related problems but whose needs are not being addressed. We thus need to consider providing a different type of specialist service to the one currently being provided so that many more people with alcohol misuse problems, and those with early drug use problems, who can benefit from specialist intervention and be much more likely to avoid long-term misuse and dependency, can benefit from specialist interventions.

There is also a need to develop services for people who use NSPs. Currently, there are only one or two specialist units in the country yet this is becoming an increasing problem. The scale of physical and mental health risk in using NSPs is not clear, and, for many, it may be that 'recreational use' of these substances, and cannabis, is no more an issue that the 'recreational use' of alcohol. However, it is important that, for 'recreational' users of both drugs (such as cannabis and NSPs) and alcohol, there are services available to help those at risk of dependency and significant harm.

It is clear that current drug and alcohol services are not meeting local needs. Principally the needs of people that are not being met are:

- alcohol misuse – there are very many more people in Reading who could benefit from specialist treatment than are able to receive it under current arrangements; and
- prevention – there are many people in Reading with either (or both) 'early' misuse of alcohol and drugs who could benefit from specialist intervention to help them avoid a decent into more damaging use of substances.

11 Recommendations

Reading needs a revised approach to its drug and alcohol services that:

- puts a much greater emphasis on the problems of alcohol misuse at all ages (that is, younger people and older ones), and for people with different problems causing them to use drugs and/or to misuse alcohol;
- puts a much greater emphasis on prevention, particularly targeting 0-18 year-olds, with specialist family support for children at risk, but also helping to address the issue that both young and older adults face;

- ensures that all health and social care services, and those of the police and judicial system, work together more effectively so that people do not fall into gaps between services and so that it is simple to provide care between different agencies without the service user having to try to negotiate their way from one to another;
- provides services of all types in different locations to improve engagement and thus outcomes;
- enables and encourages front-line staff in all sectors, to do much more to identify people at risk of misusing drugs and/or alcohol and to provide brief interventions, and refer to appropriate services; and
- enables different policies and services and the enforcement of regulations, to take account of the cumulative impact of drug and alcohol misuse to enable greater benefit to people's health and to the community more widely.

12 References

1 The Health and Social Care Information Centre 2014. *Statistics on Drug Misuse England, 2014*. The NHS Information Centre for Health and Social Care. 2014. see http://www.hscic.gov.uk/catalogue/PUB12994/drug-misu-eng-2013-rep.pdf (Accessed 2 October 2015)

2 Office for National Statistics 2014, *Annual Mid-year Population Estimates, 2014,* Statistical bulletin: ONS.

3 The Royal College of Nursing 2012, *Health inequalities and the social determinants of health,* Royal College of nursing Policy & International Department. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/438838/01.12_Health_inequalities_and_the_social_determinants_of_health.pdf (Accessed 24th November 2015).

4 Office for National Statistics 2014. *Inequality in Healthy Life Expectancy at Birth by National Deciles of Area Deprivation: England, 2009-11.* ONS.

5 Department of Health (England) and the devolved administrations. *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. 2007

6 Health & Social Care Information Centre 2015, *Statistics on Alcohol, England, 2015,* Lifestyles Statistics Team, June 2015.

7 Faculty of Public Health 2008, *Alcohol & Public Health,* FPH May 2008. Available at: http://www.fph.org.uk/uploads/ps_alcohol.pdf (Accessed 10th November 2015

8 National Institute for Health and Clinical Excellence. *Drug misuse in over 16s: psychosocial interventions.* NICE Guidelines (CG51). London. 2007

9 The Government Home Office 2014, *The New Psychoactive Substance Review Expert Panel,* Drugs & Alcohol Support Unit, The Home Officer, United Kingdom. September 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368583/NPSexpertReviewPanelReport.pdf (Accessed 2 October 2015).

10 United Nations Office on Drugs and Crime 2015, *Information about drugs,* UNODC. Available at: http://www.unodc.org/unodc/en/illicit-drugs/definitions/ (Accessed 1st November 2015).

11 World Health Organisation. *Management of substance abuse: cannabis*. http://www.who.int/substance_abuse/facts/cannabis/en/ (accessed 1 October 2015)

12 National Institute on Drug Abuse. *The Science of Drug Abuse & Addiction. Drug Facts: heroin.* National Institute on Drug Abuse. Bethesda, Maryland (See http://www.drugabuse.gov/publications/drugfacts/heroin accessed 1 October 2015))

13 National Institute on Drug Abuse. *Drug facts: cocaine*. http://www.drugabuse.gov/publications/drugfacts/cocaine (accessed 1 November 2015).

14 DrugScope 2015, *New psychoactive substances,* DrugScope. Available at: http://drugscope.org.uk/new-pyschoactive-substances/ (Accessed: 30th October 2015).

15 World Health Organisation, 2015. *Alcohol: Fact sheet.* WHO. Updated January 2015. Available at: http://www.who.int/mediacentre/factsheets/fs349/en/ (Accessed 24th November 2011).

16 DrinkAware 2015. *What is alcohol: alcohol's ingredients and chemicals.* Available at: https://www.drinkaware.co.uk/check-the-facts/what-is-alcohol/alcohol-ingredients-and-chemicals. (Accessed 24th November 2011)

17 The Government Home Office 2012, *The Governments alcohol strategy,* Home Office, March 2012. Available at: https://www.gov.uk/government/publications/alcohol-strategy (Accessed: 30th October 2015).

18 DrinkAware 2013, *The facts about Alcohol and accidents,* DrinkAware. Available at: http://eb6eac5692db912ed5d9-411b8674dd3ca0f7d171c621142907c5.r53.cf1.rackcdn.com/Alcohol%20and%20accidents.pdf (Accessed 30th October 2015).

19 NHS, 2012. *Social Drinking: The Hidden Risks.* NHS England.

20 National Audit Office. *Reducing Alcohol Harm: health services in England for alcohol misuse.* The Stationery Office. London. 2008

21 Institute of Alcohol Studies 2013, *Alcohol consumption Factsheet,* IAS, Updated August 2013. Available at: http://www.ias.org.uk/uploads/pdf/Consumption%20docs/Alcohol%20consumption%20factsheet%20August%202013.pdf (Accessed: 30th October 2015).

22 Institute of Alcohol Studies 2013, *Economic impacts of alcohol: Factsheet,* IAS, Economic Impact Update August 2013. Available at: http://www.ias.org.uk/uploads/pdf/Factsheets/Economic%20impacts%20of%20alcohol%20factsheet%20August%202013.pdf (Accessed 30th October 2015).

23 Boniface S, Shelton N. How is alcohol consumption affected if we account for under-reporting? A hypothetical scenario. The *European Journal of Public Health*. 2013 doi: http://dx.doi.org/10.1093/eurpub/ckt016

24 Office for National Statistics (ONS), March 2012. *General Lifestyle Survey Overview Report 2010.* ONS.

25 NHS Choices Information, *Alcohol Units,* NHS England 2015. Available at: http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx (Accessed 30 October 2015).

26 Health and Social Care Information Centre 2014. *Smoking, drinking and drug use among young people in England 2013.* HSCIC. Available at http://www.hscic.gov.uk/pubs/sdd13 (Accessed 24th November 2015).

27 National Institute for Health and Care Excellence. *Alcohol dependence and harmful alcohol use quality standard. NICE quality standard 11.* National Institute for Health and Care Excellence. London. 2011

28 The Health and Social Care Information Centre, 2014. *Hospital Episode Statistics (HES*). HSCIC 2014.

29 Health & Social Care Information Centre 2015. *Statistics on Drugs Misuse 2004/05 to 2014/15.* HSCIC.

30 Scottish Drugs Forum, 2013. *Drug-related deaths: What you should know*. Safer Scotland, Scottish Government. Available at: www.sdf.org.uk (Accessed 25th November 2015).

31 Cole et al, 2010. *CUT: A guide to Adulterants, Bulking agents and other Contaminants found in illicit drugs.* Centre for Public Health, Faculty of Health and Applied Social Sciences, Liverpool John Moores University. Available at: http://www.cph.org.uk/wp-content/uploads/2012/08/cut-a-guide-to-the-adulterants-bulking-agents-and-other-contaminants-found-in-illicit-drugs.pdf (Accessed 25th November 2015).

32 Office for National Statistics 2015, *Deaths related to drug poisoning in England and Wales, 2014 registrations.* ONS Statistical Bulletin, 3 September 2015.

33 Oppenheimer E, Tobutt C, Taylor C and Andrew T. Death and Survival in a Cohort of Heroin Addicts from London Clinics: A 22-Year, Follow-Up Study. *Addiction* 1994; 89: 1299– 1308

34 Advisory Council on the Misuse of Drugs 2012, *Consideration of naloxone,* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/119120/consideration-of-naloxone.pdf (Accessed 24th November 2015).

35 South Central Ambulance Service (SCAS), 2015. Local data collected by South Central Ambulance Service 1st April to 30th June 2015.

36 National Programme on Substance Abuse Deaths (NPSAD), 2013. Drug-related deaths in the UK: January- December 2012.

37 Office for National Statistics (ONS) 2015. Deaths related to drug poisoning in England and Wales.

38 National Institute on Drug Abuse. *The Science of Drug Abuse & Addiction. Drug Facts: heroin.* National Institute on Drug Abuse. Bethesda, Maryland (See http://www.drugabuse.gov/publications/drugfacts/heroin accessed 1 October 2015))

39 World Health Organisation, 2009. *Management of common heath problems of drug users.* World Health Organisation, Regional Officer for South-East Asia, Publication Series No. 56.

40 Frischer M, Goldberg D, Rahman M and Berney L. Mortality and Survival Amongst a Cohort of Drug Injectors in Glasgow 1982–1994. *Addiction* 1997; 92: 419–427

41 Public Health England 2015. *The international evidence on the prevention of drug and alcohol use: Summary and examples of implementation in England.* PHE, June 2015.

42 National Institute on Drug Abuse. *Drug facts: cocaine*. http://www.drugabuse.gov/publications/drugfacts/cocaine (accessed 1 October 2015)

43 European Monitoring Centre for Drugs and Drug Addiction. *Cocaine and crack cocaine*. http://www.emcdda.europa.eu/online/annual-report/2010/cocaine/4 (accessed 1 October 2015)

44 Action on Smoking and Health (ASH) (2014). ASH Ready Reckoner. ASH and LeLan Solutions, September 2014. Available at: http://www.ash.org.uk/localtoolkit/R8-SE.html. (Accessed 20 July 2015).

45 Royal College of Psychiatrists. *Improving the lives of people with mental illness*. http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx (accessed 26 October 2015)

46 World Health Organisation. *Management of substance abuse: cannabis*. http://www.who.int/substance_abuse/facts/cannabis/en/ (accessed 1 October 2015)

47 Scottish Drugs Forum. The shape of drug problems to come: the results of the 2013 drug trends in Scotland survey, p.11

48 The Government Home Office. *Drug Misuse; findings from the 2013 to 2014 CSEW (2015)* London: Home Office. Available at: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2013-to-2014-csew (Accessed 21st November 2015).

49 Public Health England, 2015. *Substance misuse services for men who have sex with men involved in chemsex.* Produced by the Health & Wellbeing Directorate, PHE.

50 Institute of Alcohol Studies 2013, *Economic impacts of alcohol: Factsheet,* IAS, Economic Impact Update August 2013. Available at: http://www.ias.org.uk/uploads/pdf/Factsheets/Economic%20impacts%20of%20alcohol%20factsheet%20August%202013.pdf (Accessed 30th October 2015).

51 Public Health England 2015, *Local Alcohol Profiles for England.* PHE Knowledge & Intelligence Team. June 2015.

52 Health & Social Care Information Centre 2015. *Alcohol-related NHS hospital admissions in England, based on primary and secondary diagnoses (broad measure) by gender and age group 2003/04 to 2013/14.* Available at: http://www.hscic.gov.uk/article/2021/Website-Search?productid=18118&q=%22Statistics+on+Alcohol%22&sort=Relevance&size=10&page=1&area=both#top (Accessed 23rd December 2015).

53 Public Health England 2015. Alcohol Data: JSNA support Pack (Reading), Public Health England 2015.

54 Davies, S.C. 2012. *Annual Report of the Chief Medical Officer,* Vol. 1, 2011. On the State of the Public's Health London, Department of Health.

55 Public Health England 2015. *Alcohol Data: JSNA Support Pack, Reading.* PHE South East Intelligence Team.

56 BMA Board of Science. *Alcohol misuse: tackling the UK epidemic.* British Medical Association. London. 2008.

57 Health and Social Care Information Centre, 2009. *Adult Psychiatric Morbidity Survey, 2007.* HSCIC.

58 National Audit Office. *Reducing Alcohol Harm: health services in England for alcohol misuse.* The Stationery Office. London. 2008

59 World Health Organisation 2007. *International statistical classification of diseases and related health problems – 10th revision.* (ICD-10). WHO.

60 The Wine & Spirit Trade Association, 2015. *Facts & Figures.* Available at: http://www.wsta.co.uk/resources/facts-figures (Accessed 11th December 2015)

61 HM Revenue & Customs, 2014. *Measuring tax gaps 2014 edition.* Available at: http://webarchive.nationalarchives.gov.uk/20150612044958/https:/www.gov.uk/government/uploads/system/uploads/attachment_data/file/364009/4382_Measuring_Tax_Gaps_2014_IW_v4B_accessible_20141014.pdf

62 Department for Transport Statistics, 2015. *Table RAS510001:Estimated number ofreported drink drive accidents and casualties in Great Britain:* 1979-2014,

63 Alcohol-related crime: the National Archives. See http://webarchive.nationalarchives.gov.uk/20100413151441/http:/crimereduction.homeoffice.gov.uk/toolkits/ar020101.htm (Accessed 28 October 2013).

64 Drugscope 2015. *How much crime is drug related?* Available at: http://drugscope.org.uk/how-much-crime-is-drug-related/ (Accessed 26th November 2015).

65 See http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-property-crime--2013-14/sty-patterns-and-trends-in-property-crime.html (accessed 4 December 2015)

66 EMCDDA (2007) Drugs in Focus Briefing 2nd Issue.http://www.emcdda.europa.eu/attachements.cfm/att_44774_EN_Dif16EN.pdf (Accessed 3rd November 2015).

67 Bryan, M, Del Bono, E and Pudney, S. (2013). Drug-Related Crime. Institute for Social and Economic Research. ISER Working Paper Series.

68 Thames Valley Police. Summary of notifiable offences in Reading 1 October 2014 – 30 September 2015 http://www.thamesvalley.police.uk/yournh/yournh-tvp-pol-area/yournh-tvp-pol-area-berksw-reading/yournh-tvp-pol-area-berksw-read-figs.htm (Accessed 3rd November 2015)

69 Public Health England 2013, *Local Alcohol Profile for England, 2013.* PHE Knowledge & Intelligence Team (North West).

70 Gossop M, Marsden J, Stewart D, Rolfe A (2000). Reductions in Acquisitive Crime and Drug Use After Treatment of Addiction Problems: 1-Year Follow-Up Outcomes. *Drug and Alcohol Dependence*; 58(1-2):165-72.

71 Stewart D, Gossop M, Marsden J, Rolfe A (2000). Drug Misuse and Acquisitive Crime Among Clients Recruited to the National Treatment Outcome Research.

72 Gossup M, Marsden J, Stewart D, and Kidd T. (2003). The National Treatment Outcome Research Study (NTORS): 4-5 years follow-up results. *Addiction*, 98, 3, 291-303.

73 NICE (2007). *Substance Misuse Interventions for Vulnerable Under 25s*. PH4. London, NICE.

74 ACMD (2014). *Prevention of drug and alcohol dependence*. ACMD.

75 Public Health England 2015. *Public Health Outcomes Framework*. Available at http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000042/pat/6/par/E12000008/ati/102/are/E06000038/iid/91189/age/168/sex/4 [Accessed 30 November 2015].

76 Smith, S.W. and Garlich, F.M. (2013) Availability and Supply of Novel Psychoactive Substances In: Dargan, P.I. and Wood, D.M. (Eds) (2013) *Novel Pyschoactive Substances: Classification, Pharmacology and Toxicology* London: Academic Press pp.55-77.

77 The UK Government 2015, *Psychoactive Substances Bill (HL) 2015-16,* The UK Government 2015. Available at: http://www.publications.parliament.uk/pa/bills/cbill/2015-2016/0063/16063.pdf (Accessed 29 October 2015).

78 Beckley Foundation 2015, *Written evidence submitted by the Beckley Foundation (PSB 25) in response to the Pyschoactive Substances Bill,* October 2015. Available at: http://www.publications.parliament.uk/pa/cm201516/cmpublic/psychoactive/memo/psb25.htm (Accessed 30th October 2015).

79 Galvani, S. *Grasping the nettle: alcohol and domestic violence. 2nd Edition*. Alcohol Concern. London. 2010

80 Office of National Statistics (ONS). 2015. *Violent Crime and Sexual Offences – Alcohol Related Violence*. London, ONS.

81 SafeLives (2015), Getting it right first time: policy report. Bristol: SafeLives. Available at: http://www.safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf (Accessed: 1st November 2015).

82 Cleaver H, Nicholson D, Tarr S, Cleaver D. *Child protection, domestic violence and parental substance misuse: family experiences and effective practice.* Department for Children, Schol and Families. London. 2008. See http://dera.ioe.ac.uk/8820/1/child-protection-domesticviolence-parentalsubstance-misuse-2.pdf (Accessed 27 November 2013)

83 Advisory Council on the Misuse of Drugs (ACMD). 2003. Hidden Harm: Responding to the Needs of Children of Drug Users. Report of an Inquiry by the ACMD. London, Home Office.

84 DCSF, 2008. *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.* DSCF Research Report RR023. London, DCSF Publications.

85 Manning V, Best D, Faulkner N, and Titherington E. 2009. New estimates on the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health*, 9, 377.

86 The Office of the Children's Commissioner. 2012. *Silent Voices: Supporting children and young people affected by parental alcohol misuse.*

87 Harwin J, Ryan M, Tunnard J, Pokhrel S, Alrouh B, Matias C and Momenian-Scheider. 2011. *The Family Drug and Alcohol Court (FDAC) Evaluation Project: Final Report (Executive Summary).* Nuffield Foundation and Brunel University, London.

88 Alcohol Concern 2010, *Swept under the carpet: Children affected by parental alcohol misuse.* Alcohol Concern & The Children's Society. Available at: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Swept-under-the-carpet.pdf (Accessed 11th December 2015).

89 The Scottish Government. 2013. *Getting our Priorities Right*. Edinburgh, The Scottish Government.

90 Hay, G., Dos Santos, R., Worsley, J. (2014). *Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2011/12: Sweep 8 Report*. London: Home Office.

91 Hay, G., Dos Santos, R, Millar, T. (2012). *Estimates of the Prevalence of Opiate and/or Crack Cocaine Use, 2010/11: Sweep 7 Report*. London: Home Office.

92 Hay, G., Gannon, M., Casey, J., Millar, T. (2011). *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2009-10: A Summary of Key Findings.* London: Home Office.

93 Hay, G., Gannon, M., Casey, J., Millar, T. (2010). *Estimates of the Prevalence of Opiate and/or Crack Cocaine Use, 2008/09: Sweep 5 Report.* London: Home Office.

94 Hay, G., Gannon, M., MacDougall, J., Millar, T., Eastwood, C. and McKeganey, N (2008) *National and regional estimates of the prevalence of opiate use and/ or crack cocaine use 2006/07: a summary of key findings. Home Office Research Report 9.* London: Home Office).

95 British Medical Association. *Drugs of dependence: the role of medical professionals.* British Medical Association. London. 2013

96 Advisory Council on Misuse of Drugs. *Consideration of the novel psychoactive substances ('legal highs')*. Advisory Council on Misuse of Drugs. London. 2001. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/119139/acmd nps2011.pdf (Accessed 4 November 2013)

97 DrugScope 2015, *Not for human consumption: An updated and amended status report on new psychoactive substances (NPA) and 'club drugs' in the UK.* DrugScope, 2015. Available at: https://drugscopelegacysite.files.wordpress.com/2015/07/not-for-human-consumption.pdf (Accessed: 30th October 2015)

98 Health & Social Care Information Centre, 2015. *Smoking, drinking and drug use among young people in England in 2014.* HSCIC. Available at: http://www.hscic.gov.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf (Accessed 20th December 2015).

99 Patton G et al. 2002. *Cannabis use and mental health in young people: cohort study.* British Medical Journal. 2002. November 23; 325 (7374): 1195 – 1198.

100 Becker J and Roe S 2005. *Drug use among young people: findings from the 2003 Crime and Justice Survey.*

101 Health and Social Care Information Centre, 2013. *Health Survey for England, 2013 – Trend Tables.* HSCIC.

102 Health and Social Care Information Centre, 2015. *Statistics on Alcohol, England 2015.* HSCIC.

103 Office for National Statistics (ONS), March 2012. *General Lifestyle Survey Overview Report 2010.* ONS.

104 Office for National Statistics 2015. Adult drinking habits in Great Britian, 2013. ONS. Available at: http://www.ons.gov.uk/ons/dcp171778_395191.pdf (Accessed 30th November 2015).

105 North West Public Health Observatory. *Indications of public health in the English Regions 8: alcohol.* Association of Public Health Observatories. Liverpool. 2007

106 Association of Public Health Observatories. *Estimates of Adults' Health and Lifestyles.* See http://www.apho.org.uk/resource/view.aspx?RID=97287 (accessed 25 November 2013)

107 Health & Social Care Information Centre, 2015. *Smoking, drinking and drug use among young people in England in 2014.* HSCIC. Available at: http://www.hscic.gov.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf (Accessed 20th December 2015).

108 Public Health England 2015, *Local Alcohol Profiles for England,* PHE. Available at: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/6/gid/1938132832/pat/6/par/E12000004/ati/102/are/E06000015. (Accessed 20 October 2015).

109 National Institute for Health and Care Excellence (NICE) 2014. *Dual Diagnosis: community-based services to meet people's wider health and social care need when they have a severe mental illness and misuse substances*. Guideline Scope.

110 Public Health England 2014. *Community Mental Health Profiles*. June 2014. Available at: http://fingertips.phe.org.uk/ *(Accessed 10th November 2015).*

111 Verheul, R. (2001). Co-morbidity of personality disorders in individuals with substance misuse disorders. *European Psychiatry*, 16 (5), 274-82.

112 United Nations Office on Drugs and Crime 2015, International Standards on Drug Use Prevention. Vienna. United Nations.

113 Kandel, D. (1975) Stages in adolescent involvement in drug use. *Science*, 190 (4217); 912-4.

114 Kandel D, Faust R. (1975) Sequence and stages in patterns of adolescent drug use. *Archives of General Psychiatry*. 32:923–932.

115 Kandel DB, Yamaguchi K, Chen K. Stages of progression in drug involvement from adolescence to adulthood: further evidence for the gateway theory. *J Studies on Alcohol* 1992; 53: 447-57

116 Degenhardt, L, Dierker, L, Chiu, WT, Medina-Mora, ME, Neumark, Y, Sampson, N, Alonso, J, Angermeyer, M, Anthony, JC, Bruffaerts, R, de Girolamo, G, de Graaf, R, Gureje, O, Karam, AN, Kostyuchenko, S, Lee, S, Lepine, JP, Levinson, D, Nakamura, Y, Posada-Villa, J, Stein, D, Wells, JE, Kessler, RC. (2010). Evaluating the drug use "gateway" theory using cross-national data: consistency and associations of the order of drug use among participants in the WHO World Mental Health Surveys. *Drug and Alcohol Dependence*, 108 (1-2), 84-97.

117 MacCoun R. (2006) Competing accounts of the gateway effect: the field thins, but still no clear winner. *Addiction*. 101:473–474.

118 Arseneault L, Cannon M, Witton J, Muray RM. Causal association between cannabis and psychosis: examination of the evidence. *Br J Psych* 2004; 184: 110-17

119 Christie KA. Epidemiologic evidence for early onset of mental health disorders and higher risk of drug abuse in young adults. *Am J Psych* 1988; 145: 971-5

120 Faggiano, F, Minozzi, S, Versino, E, and Buscemi, D. (2014). Universal school-based prevention for illicit drug use. *Cochrane Database of Systematic Reviews*.

121 ACMD (2015). *Prevention of drug and alcohol dependence*. ACMD.

122 Gates, S, McCambridge, J, Smith, LA, and Foxcroft, D. (2006). Interventions for the prevention of drug use by young people. *Cochrane Database of Systematic Reviews*.

123 NICE (2007). *Substance Misuse Interventions for Vulnerable Under 25s*. PH4. London, NICE.

124 Public Health England. *The international evidence on the prevention of drug and alcohol use: summary and examples of implementation in England.* Public Health England. London. 2015

125 Smith L, Foxcroft D. *Drinking in the UK: an exploration of trends.* Joseph Rowntree Foundation, York. 2009

126 NHS Health Scotland. *Alcohol and ageing: is alcohol a major threat to healthy ageing for the baby boomers?* NHS Health Scotland. Edinburgh. 2006

127 Widner S, Zeichner. Alcohol abuse in the elderly: review of epidemiology research and treatment. *Clinical Gerontologist: the Journal of Ageing and Mental Health*. 1991; 11:3-18

128 Dufour M, Fuller RK. Alcohol and the elderly. *Ann Rev Med* 1995; 46: 123-32

129 Mellor MJ, Garcia A, Kenny E, Lazerus J. Alcohol and Ageing. *J Geront Social Work* 1996; 25: 71-89

130 Wadd S, Lapworth K, Sullivan M, Forrester D, Galvani S. *Working with older drinkers.* Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire. Bedford. 2011

131 Public Health England. *The international evidence on the prevention of drug and alcohol use Summary and examples of implementation in England.* Public Health England. London. 2015

132 Ubido J, Lewis C, Holford R, Scott-Samuel A. *Prevention programmes cost-effectiveness review; alcohol*. Liverpool Public Health Observatory. Liverpool. 2010

133 The UK Government Home Office 2010, *Drug Strategy 2010,* Policy Paper, Drug misuse and dependency December 2010.

134 The UK Government Home Office 2012, *Alcohol Strategy 2012,* Policy Paper, March 2012.

135 Integrated Recovery in Services (IRiS) 2015, Available at: http://www.irispartnership.org/services/reading/ (Accessed 10th November 2015).

136 National Drug Treatment Monitoring System, 2015, NTMS Adult Partnership Activity Report, Q4 2014/15.

137 Gossup M, Marsden J, Stewart D, and Kidd T. (2003). The National Treatment Outcome Research Study (NTORS): 4-5 years follow-up results. *Addiction*, 98, 3, 291-303.

138 McKeganey N, Bloor M, Robertson M, Neale J, and MacDougall J. (2006). Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. *Drugs: Education, Prevention and Policy*, 13 (6), 537-550.

139 National Treatment Agency for Substance Misuse (NTA). 2012. *The Role of Residential Rehab: An integrated treatment system*. http://www.nta.nhs.uk/uploads/roleofresi-rehab.pdf (Accessed 16 November 2015).

140 NICE. 2007. *Drug Misuse Psychosocial Interventions.* NICE Clinical Guidelines 51. London, NICE.

141 Department for Work and Pensions (2015). *Understanding the Costs and Savings to Public Services of Different Treatment Pathways for Clients Dependent on Opiates.* London, DWP.

142 Babor TF ; de la Fuente JR ; Saunders J ; Grant M. AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care. Geneva : World Health Organization, 1992.

143 NICE, 2011. *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.* Clinical Guidance 115 (CG115). London, NICE.

144 NICE, 2010. *Alcohol-Use Disorders: Preventing harmful drinking.* NICE Public Health Guidance 24 (PH24). London, NICE.

145 Department of Health (DH)/National Treatment Agency for Substance Misuse (NTA). 2006. *Models of Care for Alcohol Misusers*. London, DH.

146 Department of Health (DH). 2010. *Signs for Improvement – commissioning interventions to reduce alcohol related harm.* London, DH.

147 NICE (2014). NICE Guidelines PH52: Needle and Syringe Programmes. http://www.nice.org.uk/guidance/ph52 (Accessed 12th November 2015).

148 Clarke, L for IRIS Reading. (2015). Reading Needle Exchange Report.

149 Public Health England, 2015, *Drug Data: JSNA support pack, Reading,* PHE.

150 NHS National Treatment Agency for Substance Misuse. *Issues surrounding drug use and drug services among Black African communities in England. 2.* University of Central Lancashire. Preston. See http://www.nta.nhs.uk/uploads/2_black_african_final.pdf (Accessed 11 November 2013)

151 Fountain, J. (2009). A series of reports on issues surrounding drug use and drug services among various Black and minority ethnic groups in England. *Drugs and Alcohol Today*, 9, 4, 41-42.

152 Public Health England, 2015. *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1st April 2014 – 31st March 2015.* PHE, Department of Health, National Drug Evidence Centre & The University of Manchester.

153 Public Health England, 2015. *Young people's statistics from the National Drug Treatment Monitoring System (NDTMS) 1st April 2014 – 31st March 2015.* PHE, Department of Health, National Drug Evidence Centre & The University of Manchester.

154 See http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment (accessed 25 November 2013)

155 World Health Organisation. *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm.* WHO Regional Office for Europe. Copenhagen. 2009

156 Moyer A, Finney JW, Swearingen CE, Vergun P. Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment- seeking and non-treatment-seeking populations. Addiction 2002;97(3):279-92.

157 Ockene JK, Adams A, Hurley TG, Wheeler EV, Hebert JR. Brief physician- and nurse practitioner-delivered counseling for high-risk drinkers: does it work? Arch Intern Med 1999;159(18):2198-205.

158 Dar K. Alcohol use disorders in elderly people: fact or fiction? *Adv Psych Treat*. 2006;12: 173-181

159 National Institute for Health and Clinical Excellence. *Alcohol-use disorders: preventing harmful drinking*. National Institute for Health and Clinical Excellence. London. 2010

160 NHS Evidence. *Alcohol use disorders: harmful drinking and alcohol dependence. Evidence Update January 2013*. National Institute for Health and Clinical Excellence. London. 2013

161 Foxcroft DR. *Evidence for Drugs and Alcohol Policy (EDAP): Cochrane Systematic Reviews.* Oxford Brookes University. Oxford. 2005

162 Department of Health (England) and the devolved administrations. *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. 2007

163 Oppenheimer E, Tobutt C, Taylor C and Andrew T. Death and Survival in a Cohort of Heroin Addicts from London Clinics: A 22-Year, Follow-Up Study. *Addiction* 1994; 89: 1299– 1308.

164 Frischer M, Goldberg D, Rahman M and Berney L. Mortality and Survival Amongst a Cohort of Drug Injectors in Glasgow 1982–1994. *Addiction* 1997; 92: 419–427.

165 National Institute for Health and Clinical Excellence. *Drug misuse: psychosocial interventions.* National Institute for Health and Clinical Excellence. London. 2007

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**16**
TITLE:	**SMOKING CESSATION SERVICE RE-PROCUREMENT**		
LEAD COUNCILLOR:	**GRAEME HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**SUZIE WATT**	**TEL:**	**0118 937 4806**
JOB TITLE:	**PROGRAMME OFFICER**	**E-MAIL:**	**Suzie.Watt@reading.gov.uk**

PURPOSE OF REPORT: TO CONFIRM THE CONTRACT AWARD FOR SMOKING CESSATION SERVICE CONTRACT TO SOLUTIONS 4 HEALTH.

CURRENT POSITION:

1. The Council participated in a joint tendering exercise with all other Berkshire unitary authorities (except Royal Borough Windsor and Maidenhead) to commission an evidence-based smoking cessation services aimed to help smokers quit.

2. The contract has been awarded to 'Solutions 4 Health' for a period of three times one years plus options to extend for up to a further two years. The investment required by Reading is up to £355,000 per annum.

3. The contract start date is 1st April 2016.

BACKGROUND TO THE DECISION:

- A competitive tender process was led by the Bracknell Forest Public Health Consultant, on behalf of Reading, Bracknell Forest, Slough, Wokingham and West Berkshire and therefore jointly undertaken by the shared Public Health team in Bracknell Forest and carried out in accordance with the Public Contracts Regulations 2015.

- A Business Manager (Bracknell Forest Council) and Programme Officers from each of the participating unitary authorities evaluated the eligible tender submissions. The financial elements of the bids have been reviewed independently by the finance lead at Bracknell Forest.

OUTCOME:

- A unanimous decision to award the contract to **Solutions 4 Health** was reached.

- Authority to award the contract was delegated to the Consultant in Public Health in consultation with the Lead Member for Health and the Head of Finance and Head of Legal and Democratic Services.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**17**
TITLE:	**UPDATE –CHILD HEALTHY LIFESTYLE AND WEIGHT MANAGEMENT CONTRACT AWARD.**		
LEAD COUNCILLOR:	**GRAEME HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**PUBLIC HEALTH**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**MELISSA ARKINSTALL**	**TEL:**	**0118 937 4805**
JOB TITLE:	**PROGRAMME OFFICER**	**E-MAIL:**	**MELISSA.ARKINSTALL@READING.GOV.UK**

PURPOSE OF REPORT: TO CONFIRM THE CONTRACT AWARD FOR THE CHILD HEALTHY LIFESTYLE AND WEIGHT MANAGEMENT PROGRAMME TO SOLUTIONS 4 HEALTH.

CURRENT POSITION:

1. The Council participated in a joint tendering exercise with West Berkshire Wokingham and Slough to commission an evidence-based children's healthy lifestyle and weight management programme to help families with overweight or obese children in Reading.

2. The contract has been awarded to 'Solutions 4 Health' for a period of three years plus options to extend for up to a further two years. The investment required by Reading is up to £25,700 per annum.

3. The contract start date is January 1st 2016.

BACKGROUND TO THE DECISION:

- A competitive tender process was been led by the West Berkshire Public Health Consultant on behalf of Reading, Slough, Wokingham and West Berkshire and therefore jointly undertaken by the shared Public Health team in Bracknell and carried out in accordance with the Public Contracts Regulations 2015.

- A Business Manager (Bracknell Forest Council) and Programme Officers from each of the participating unitary authorities evaluated the eligible tender submissions. The financial elements of the bids have been reviewed independently by the finance lead at Bracknell Forest.

OUTCOME:

- A unanimous decision to award the contract to **Solutions 4 Health** was reached.

- Authority to award the contract was delegated to the Consultant in Public Health in consultation with the Lead Member for Health and the Head of Finance and Head of Legal and Democratic Services.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**22 JANUARY 2016**	**AGENDA ITEM:**	**18**
TITLE:	**REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARD**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**ALL**
LEAD OFFICER:	**WENDY FABBRO**	**TEL:**	**0118 937 2072**
JOB TITLE:	**DIRECTOR OF ADULT SOCIAL CARE**	**E-MAIL:**	**WENDY.FABBRO@READING.GOV.UK**

1. **PURPOSE OF REPORT AND EXECUTIVE SUMMARY**

1.1 This paper takes stock of the current governance arrangements and suggests issues for consideration by the Health and Wellbeing Board.

2. **RECOMMENDED ACTION**

2.1 That HWB establish a small task and finish group to review then consider the key measures to be prioritised for monitoring achievement of strategic outcomes.

2.2 That HWB establish a small task and finish group to review the relationships between key bodies involved in Health and Wellbeing, and propose protocols for reporting and sharing information.

2.3 That HWB consider establishing a sub group to continue development of the Board once feedback from the LGA Peer Review has been delivered

3. POLICY CONTEXT

3.1 The Health and Wellbeing Board is a sub-committee of Reading Borough Council, but its terms of reference describe ambitions to oversee the efficient and effective commissioning and delivery of integrated Health and Social care.

3.2 The Board includes voting members, non-voting members whose inclusion is defined in regulation relating to the establishment of the Board, and a number of key observers, whose participation is deemed to be critically important such as major Health provider organisations and representatives of the Voluntary sector. These are set out in Appendix A.

3.3 The Board negotiates a careful position in relation to decision making. Constitutional authority to make decisions relating to the commissioning of health services sit with the CCGs, and decisions relating to the remit of the Local Authority will be made by the Council, both directly and via its key Committees (Policy, Adult/Childrens and Education Services Committee (ACE- which is established to make policy and strategic direction decisions, and deliver a scrutiny function). The decisions made directly by the HWB relate to arrangements for the delivery of services within the 'Better Care Fund', and agreeing the Health and Wellbeing Strategy but there is a growing reliance throughout the UK on the HWB function of influencing statutory organisations and promoting integration.

3.4 There is therefore an opportunity to review, and potentially to establish ways of improving joint working between key stakeholder organisations to break down silo working within the respective constraints of budget management and good use of resources and statutory accountabilities. This review may also be able to identify different ways of commissioning together that would deliver simpler and better connected pathways for achieving outcomes for our patients/customers. This could be managed by a sub group of the Board to include development issues arising from the LGA Peer Review.

3.5 As the strategic owner of the Health and Wellbeing Strategy, the board has governance of the monitoring of achievement of strategic outcomes. The line between monitoring of key performance indicators and outputs, and the monitoring of achievement of strategic outcomes is a rich source of debate, and this paper seeks to be a catalyst to reviewing the current positions.

3.6 Appendix A illustrates the current alignment of bodies overseeing health and wellbeing. The 'wiring diagram' describes relationships between groups in terms of authority and decision making, periodic information sharing, and joint membership (suggesting potential for alignment).

4. CURRENT POSITION

4.1 The draft JSNA for 2016-2019 has been taken to a wide range of groups in an initial consultation stage, and the proposed JSNA will be received by the HWB at its March 2016 meeting. The metadata has been carefully developed to align across other Berkshire LA and key partners, and the conclusions for the JSNA will underpin the new edition of the HW Strategy.

4.2 The HWB Strategy is also to be received by HWB at its March meeting, and if agreed as an appropriate draft for consultation will be taken to a wide range of commissioner, provider and VCS organisations and Patient and Service User/Carer representative bodies.

5. THE PROPOSAL

5.1 The Health and Wellbeing Strategy's vision for a healthy Reading is underpinned by 4 key goals:

- Goal One: Promote and protect the health of all communities particularly those disadvantaged: communicable diseases, immunisations and screening, BME groups
- Goal Two: Increase the focus on early years and the whole family to help reduce health inequalities: maternity, family support, emotional heath, domestic violence
- Goal Three: Reduce the impact of long term conditions with approaches focused on specific groups: self-care, carers, learning disability
- Goal Four: Promote health-enabling behaviours and lifestyle tailored to the differing needs of communities: tobacco, drugs and alcohol, obesity

Associated with each goal is a set of objectives (sub-goals) which are shorter-term measurable steps that will move us towards achieving the longer-term goals and a supporting action plan. These were reported to the Board in September 2015 as actions completed or underway.

5.2 The Board may wish to establish a task and finish group, to complete the work on recommending the protocol to guide which outcome measures and performance indicators will enable the Board to best monitor its strategic aims, and which measures and concerns are more appropriately directed to Healthwatch or to Health scrutiny (delivered via Adult, Childrens, Education Committee). A suggestion to start the task group work is attached at appendix B.

5.3 Appendix A sets out a summarised diagrammatic representation of the current dynamic relationships of the Board, and the information flows associated with each body. The board may wish to set up a small group to consider if the required information is available to enable the Board to focus on its core purpose.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 The Health and Wellbeing strategy is being refreshed but will be built upon the evidence and intelligence contained in the JSNA.

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 There is a good opportunity to set the terms of reference for the task and finish group to ensure that stakeholder consultation is robust.

8. EQUALITY IMPACT ASSESSMENT

8.1 This report focuses on the business processes that will support delivering improved health and wellbeing equalities.

9. LEGAL IMPLICATIONS

9.1 The terms of reference for the HWB require the board to

- Set out a strategy to achieve improvement in Health and Wellbeing based on the JSNA agreed by DAS, DCS, and DPH
- To *oversee the delivery of the Better Care Fund Programme of activities and to approve plans to deliver specified aims and targets.*

This paper proposes development to enhance the governance of these functions.

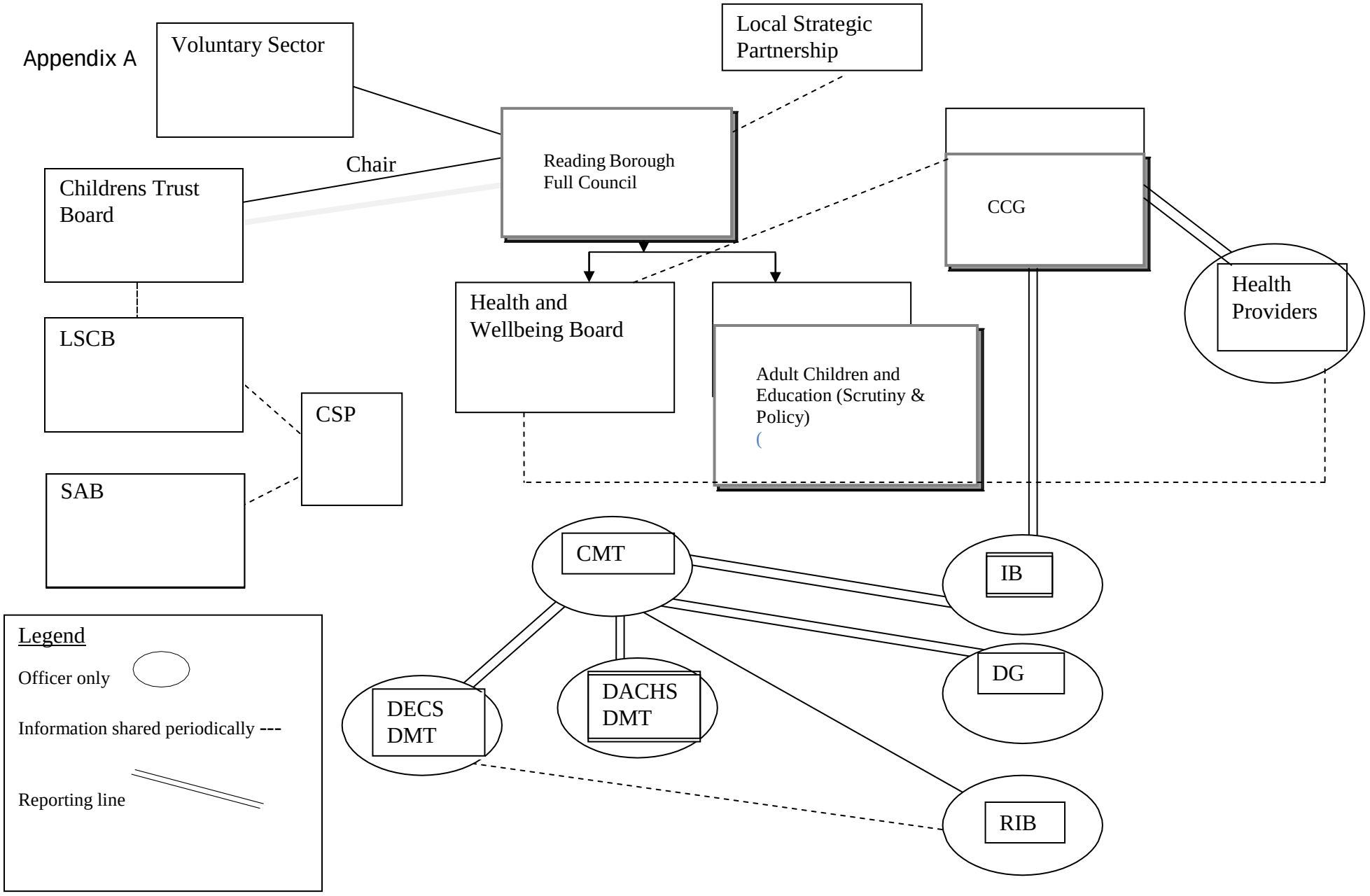
10. FINANCIAL IMPLICATIONS

10.1 The funding for delivery of core services is decided by each Commissioning Authority. The funding for the BCF is the subject of a separate report.

11. BACKGROUND PAPERS

11.1 None

Appendix A


Voluntary Sector
Local Strategic Partnership
Chair
Childrens Trust Board
Reading Borough Full Council
CCG
Health Providers
LSCB
Health and Wellbeing Board
Adult Children and Education (Scrutiny & Policy)
CSP
SAB
CMT
IB
DG
DECS DMT
DACHS DMT
RIB
Legend
Officer only
Information shared periodically ---
Reporting line

Appendix b

Performance indicators for consideration

(PH team delivering)

Source document	Topic	Measure (eg- to be prioritised by task and finish group)
JSNA	Avoidable death rates	Mortality rate from causes considered preventable
	Prevalence of obesity Prevalence of diabetes	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds Excess weight in 4-5 and 10-11 year olds - 10-11 year olds Excess Weight in Adults Recorded diabetes
	Rate of Substance misuse	Under 75 mortality rate from liver disease (Persons) Successful completion of drug treatment - opiate users Successful completion of drug treatment - non-opiate users. People entering prison with substance dependence issues who are previously not known to community treatment Admission episodes for alcohol-related conditions – narrow definition (Persons)
	Life expectancy	Life Expectancy at birth (Male) Life Expectancy at birth (Female)
	Activity to support carers	Social Isolation: % of adult social care users who have as much social contact as they would like. Social Isolation: % of adult carers who have as much social contact as they would like.
Strategy	Prevalence of long term conditions, and co morbidities	Estimated diagnosis rate for people with dementia Recorded diabetes
	Rate of use of leisure services and participation in active lifestyles	Utilisation of outdoor space for exercise/health reasons (For use of leisure services - Grant Thornton. Percentage of physically active and inactive adults – active adults Percentage of physically active and inactive adults – inactive adults

	Wellbeing issues included in all policy decisions	As a suggestion: all papers submitted to CMT, H&WB and policy require the author to describe the impact of proposals on wellbeing.
	Ensuring effective use of local resources	
	Community engagement and use of community social capital	Social Isolation: % of adult social care users who have as much social contact as they would like. Social Isolation: % of adult carers who have as much social contact as they would like Older people's perception of community safety - safe in local area during the day Older people's perception of community safety - safe in local area after dark Older people's perception of community safety - safe in own home at night
Public Health Outcome Framework	Wider determinants of health- Housing in Decent Homes standard Homelessness Educational attainment and NEET Planning and Licensing using wellbeing advice Environment- pollution levels	25% of Homes should meet Decent Homes standards. Focus on category 1 safety measures Homelessness - Statutory homelessness - homelessness acceptances Statutory homelessness - households in temporary accommodation Educational attainment and NEET - 16-18 year olds not in education employment or training Environment- pollution levels - Fraction of mortality attributable to particulate air pollution
	Domestic violence	Domestic Abuse
Health protection	Immunisation rates	Population vaccination coverage - Hepatitis B (1 year old) Population vaccination coverage - Hepatitis B (2 years old) Population vaccination coverage - Dtap / IPV / Hib (1 year old) Population vaccination coverage - Dtap / IPV / Hib (2 years old) Population vaccination coverage – MenC Population vaccination coverage – PCV Population vaccination coverage - Hib / MenC booster (2 years old Population vaccination coverage - Hib / Men C booster (5 years old Population vaccination coverage - PCV booster Population vaccination coverage - MMR for one dose (2 years old) Population vaccination coverage - MMR for one dose (5 years old) Population vaccination coverage - MMR for two doses (5 years old) Population vaccination coverage – HPV

		Population vaccination coverage – PPV Population vaccination coverage - Flu (aged 65+) Population vaccination coverage - Flu (at risk individuals)
	Sexual health reported issues and activity	Chlamydia detection rate (15-24 year olds) HIV late diagnosis Teenage conception rates
	Lead role in developing Support to women and prevention of FGM	Breastfeeding - Breastfeeding initiation Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth
	Rate of take up of Breastfeeding advice and support	
	Reduction of smoking levels	Smoking status at time of delivery Smoking Prevalence