Simon Warren
INTERIM 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

29 September 2016

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 7 OCTOBER 2016

A meeting of the Health & Wellbeing Board will be held on **Friday 7 October 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 MEETINGS HELD ON 14 JUNE & 15 JULY 2016**	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.	-
5.	**BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) NHS SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE** A verbal update on the latest situation with the development of the NHS Sustainability and Transformation Plan (STP) for Buckinghamshire,	verbal report

../Cont

Oxfordshire and Berkshire West (BOB), following the confidential briefing given to members of the Board on 13 September 2016 on the STP.

6. HEALTH AND WELLBEING BOARD POST-LGA PEER REVIEW STOCKTAKE - UPDATE verbal report

A verbal update on the results of a Stocktake which will be undertaken by the Health and Wellbeing Board on 3 October 2016 to consider the feedback and recommendations from the LGA Peer Review of the Reading and West of Berkshire Health and Wellbeing Boards and look at what changes are needed to the Reading Health and Wellbeing Board.

7. READING'S SECOND HEALTH & WELLBEING STRATEGY 25

A report setting out progress in developing Reading's second Health and Wellbeing Strategy since the Health and Wellbeing Board in July 2016, and seeking authority to launch a formal consultation on the draft.

8. A WEEK IN A&E: FINDINGS OF A HEALTHWATCH READING PROJECT TO COLLECT PATIENT VIEWS 56

A report by Healthwatch Reading on a project carried out in May 2016 collecting patient views in the Royal Berkshire Hospital Accident & Emergency department.

9. PUBLIC HEALTH BUDGET 2016/17 105

A report setting out the current position of the Public Health budget for 2016/17 and detailing the programmes of work being funded by the grant.

10. UPDATE ON TACKLING FEMALE GENITAL MUTILATION (FGM) 113

A report providing a summary of work planned and undertaken in relation to tackling Female Genital Mutilation since January 2016, when a previous report was presented to the Health and Wellbeing Board.

11. BERKSHIRE TRANSFORMING CARE PARTNERSHIP – UPDATE 118

A presentation giving an update on the work of the Berkshire Transforming Care Partnership on the Berkshire Transforming Care Plan.

Cont/..

../Cont

12. INTEGRATION AND BETTER CARE FUND 129

A report setting out the Better Care Fund (BCF) integration performance within Reading at the end of quarter one, the BCF reporting and monitoring requirements and the findings from the Joint Commissioning workshop held in September 2016.

13. DATE OF NEXT MEETING -

Friday 27 January 2017 at 2pm

READING HEALTH & WELLBEING BOARD MINUTES – 14 JUNE 2016

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Andy Ciecerski	Chair, North & West Reading Clinical Commissioning Group (CCG)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Ishak Nadeem	Chair, South Reading CCG
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Jo Hawthorne	Head of Wellbeing, RBC
Kevin Johnson	Integration Programme Manager, RBC
Tom Lake	South Reading Patient Voice
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Sarita Rakhra	Carers/Voluntary Sector/Mental Health and Learning Disability Commissioning Manager, Berkshire West CCGs
Nicky Simpson	Committee Services, RBC
Catherine Williams	Healthwatch Officer, Healthwatch Reading
Councillor Stanford-Beale	RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

Apologies:

Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Lise Llewellyn	Director of Public Health for Berkshire
Councillor Lovelock	Leader of the Council, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Ian Wardle	Managing Director, RBC

The Chair welcomed those present and thanked them for attending the extra meeting of the Board, called at short notice.

1. BETTER CARE FUND 2016/17 FINAL SUBMISSION

Further to Minute 10 of the meeting held on 18 March 2016, Wendy Fabbro and Kevin Johnson submitted a report on the 2016/17 Better Care Fund (BCF) submission. The BCF Vision from the submission "Our Vision: A Healthier Reading – Better Care Fund Plan 2016/17" was attached at Appendix 1.

The report explained that, at the Board meeting held on 18 March 2016, authority had been given to the Director of Adult Care & Health Services to formally sign the agreement for the 2016/17 BCF submission for Reading, in consultation with the Chair and members of the Board, in order to meet the April 2016 submission deadline (Minute 10 refers). The BCF submission had been submitted and was now awaiting full assurance from NHS England, which was expected in the next few weeks.

The report set out the following seven key areas of challenge outlined in the BCF submission, which were the main drivers for change in the local economy, and gave further details of these challenges:

1. An increasing population, particularly in those over the age of 65
2. Increasing growth in non-elective admissions
3. Increasing A& E attendances, and pressure on urgent and emergency capacity
4. Delayed transfers of care, and subsequent bed days lost
5. Increasing pressures on adult social care for community packages and care homes
6. Increasing demand for planned (elective) care
7. Improving but remaining inequality of access to services across the "whole system: the whole week"

The report gave summary details of the following BCF commissioned programmes for 2016/17:

- Connected Care
- Community Re-ablement Team
- Discharge to Assess
- NHS Commissioned Out of Hospital Services:
- Adult Speech & Language
- Community Geriatricians
- Intermediate Care
- Health Hub

The report also addressed the need to improve engagement and co-production approaches with patients and service users in relation to the BCF, and gave financial details of the final submission.

It was reported at the meeting that there had been significant system pressures in recent weeks, including in Delayed Transfers of Care, and that partners were working together on these. It was also noted that the BCF was just one part of integration; not all elements of integration were included in the BCF (for example other initiatives such as the Frail Elderly Pathway) and the pressures and issues in all areas needed attention to ensure that health and social care services were able to support Reading residents.

The meeting discussed the information available on hospital admissions and accident and emergency (A&E) attendances and it was noted that historic Hospital Episodes Statistics (HES) data on patients admitted to NHS hospitals was being analysed by the Shared Public Health team, and that the CCGs had commissioned the Commissioning Support Unit to look at live data on non-elective admissions. However, this data was from the health side, the HES data only covered the presenting condition and the work was focused on preventing unnecessary and often expensive hospital admissions. It was also noted that Healthwatch was currently carrying out a project looking at the reasons why patients attended A&E, information from which could help provide information on people's behaviour and why and how they changed it, from a social perspective, not just the health aspect. David Shepherd reported that the project had another month or so to go, but that 45% of the 260 people interviewed so far had contacted their GP surgery before attending A&E, and the project would identify how the patients had arrived at A&E.

It was reported at the meeting that officers would be meeting with Healthwatch to discuss commissioning some work to support the BCF in community engagement.

Resolved - That the submission of the 2016/17 BCF be noted and acknowledged.

2. BERKSHIRE TRANSFORMING CARE PLAN

Sarita Rakhra submitted a report presenting the Berkshire Transforming Care Joint Health and Social Care Plan (TCP), which was appended to the report.

The report explained that NHS England had set up a series of boards across the country to oversee the reforms required by the post-'Winterbourne View' National Review "Transforming Care for People with Learning Disabilities and/or ASD and/or Mental Health problems whose behaviour challenges others and services". The Berkshire Transforming Care Board consisted of all the CCGs and Local Authorities in Berkshire and it had drafted the Berkshire TCP which had been submitted by the CCGs to NHS England on 16 May 2016, but the TCP also needed to be agreed for each local authority area through its Health and Wellbeing Board.

The plan outlined a proposal to reduce the number of inpatient Assessment and Treatment Unit beds for this cohort of people with challenging behaviour, and to use the resulting resource to provide an intensive intervention service to support this cohort to live safely in the community and reduce admissions to Assessment & Treatment Units. This change would require better specialised care provision in the community and affordable accommodation for a small increase of very high needs individuals.

The Berkshire TCP had been jointly developed by key stakeholders including the six local authorities and the seven CCGs and showed how services would be transformed for people of all ages with a learning disability and/or autism who displayed challenging behaviour, including those with a mental health condition. It was aligned to the national plan 'Building the Right Support – to develop community services and close 50% of the inpatient facilities by March 2019'. The vision was to improve the pathway for people with learning disabilities and challenging behaviour by reducing reliance on inpatient beds and increasing access to intensive specialist community services.

Some inpatient beds would be retained to provide therapeutic inpatient support for planned and emergency day and overnight services to individuals for whom it was clinically indicated. A specialist multi-disciplinary team would assess needs and design and implement therapeutic programmes of care that required the physical environment a building-based unit could offer. A therapeutic inpatient unit would also act as a resource hub for the intensive intervention service and sessional activity, such as Sensory Integration, could be provided. This cohort of people usually required intensive support in the community and high cost packages of care. There was a high risk of breakdown of care package and it was difficult for this cohort to acquire and maintain housing tenancies.

The Plan aimed to close 50% of the inpatient beds by March 2019 and use the same staff resource to provide an intensive support service in the community to prevent further admissions and support on discharge. Therefore, suitable affordable accommodation in the community would need to be identified and either specialist care providers brought into the area or existing providers would need specialist

training to be able to meet the needs of these people. The specialist providers could be third sector or commercial. A public request for Expressions of Interest would be published which it was hoped would attract a good range of providers to work with to develop the specification.

Sarita reported that the Berkshire TCP submission had been rated green by NHS England and would be published on 11 July 2016. An easy-read version and a summary would need to be produced and there was further work to be done, including aligning financial processes, exploring joint commissioning across Berkshire for complex needs, and working out how to co-produce an implementation plan.

It was noted that, whilst everyone supported the principle behind the vision, as the affected individuals desperately needed better pathways, there was a national discussion and debate about the funding for achieving the aims of the TCP, as there would be a significant increase in costs to local authorities, both in social care and in housing, and there were already significant pressures on local authority budgets. Previously, when long-stay hospitals had been dismantled, the individuals who had moved to being cared for in the community had come with funding to support them, but no money had yet been identified to ensure that the new community provision was in place prior to the closure of the beds.

Resolved -

(1) That the Berkshire Transforming Care Board's vision to close down 50% of the inpatient service and develop an intensive intervention service in the community, thus reducing the reliance on Assessment and Treatment units to support people with a learning disability and/or autism and mental health conditions, be supported;

(2) That the Board work with the West Berkshire and Wokingham Health and Well Being Boards to identify resource and budget to ensure the transformation took place by March 2019.

3. WEST OF BERKSHIRE, OXFORDSHIRE AND BUCKINGHAMSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN

Further to Minute 5 of the previous meeting, Wendy Fabbro submitted a report on the development of the five year Sustainability and Transformation Plan (STP) for BOB (West of Berkshire, Oxfordshire and Buckinghamshire) for submission at the end of June 2016. The report had appended:

- Appendix 1 - Motion on Local NHS Reorganisation agreed at Council on 22 March 2016
- Appendix 2 – BOB STP Submission to NHS England – 15 April 2016

The report explained that the NHS England Planning Guidance in December 2015 had asked all health and care systems to develop a five year Sustainability and Transformation Plan (STP) for submission at the end of June 2016. Over the following months a footprint had emerged which comprised the West of Berkshire, Oxfordshire and Buckinghamshire (BOB). The footprint did not include the East Berkshire area. The BOB STP footprint would encompass a population of 1.8m people, with a £2.5bn 'place-based' budget for spending on local services. Within the footprint there were the following organisations:

- 7 NHS Clinical Commissioning Groups
- 6 NHS Hospital Provider Trusts
- 14 Local Authorities

The Council meeting on 22 March 2016 had debated the NHS England decision to define the footprint in this manner and had relayed concerns about the proposals to decision makers in the Department of Health, NHS England, the Local Government Association and local MPs and CCGs (Minute 60 refers). The Council motion which had been agreed was attached at Appendix 1.

An STP Plan had been submitted to NHS England by BOB at the end of April 2016 and a copy of the submission was attached at Appendix 2. This had the following emerging priorities:

- Tackling inefficiencies and reducing variation between organisations and geographical areas
- Urgent and emergency care
- Mental health
- Improving outcomes in cancer and maternity services
- Focus on developing the workforce, particularly with regard to General Practice

It had been communicated from NHSE that the BOB April 2016 submission was low risk within the overall national context. However, it was also clear that all organisations were facing significant budget deficit and financial challenge (£150m for Berkshire West, £511m for BOB). It was anticipated that there could be opportunities for financial reconciliation across the BOB health community footprint, ie any underspends could be contributed to tackle overspends elsewhere, although this did not have a direct impact on Local Authorities.

A further submission containing a revised draft of the STP was due to be submitted to NHS England at the end of June 2016, and work was ongoing on producing this, which would then be submitted to the next Board meeting.

In early June 2016, Sustainability and Transformation Plan (STP) leads had received further guidance on what to include in their 30 June 2016 submissions, which included a template that asked how each footprint would achieve financial balance by 2020/21. The template covered most CCG and NHS England commissioning activity, as well as Better Care Fund income and expenditure and asked for voluntary information on additional impacts arising from social care or non-NHS providers where it had been modelled.

For the end of June 2016, the submission was to cover:

- Three to five critical decisions which would be required to implement the strategic priorities identified
- An explanation of the anticipated benefits, with a focus on specific outcomes against health, quality and finance (Five Year Forward View triple aim)
- The proposed activities to be undertaken by specific geographic/organisational members
- Detailed modelling of the local activity, workforce and finance

- An early calculation of how the 2021 funding allocation would be spent within the footprint

The report gave further details of the current position, listing the following issues:

- The East of Berkshire did not reside within the footprint of the BOB STP and it was not yet understood what challenges this might present to the West of Berkshire, particularly in respect of Berkshire-wide services.
- The impact on emerging models of shared financial governance for the acute, community and primary care in West of Berkshire through an Accountable Care System (ACS) and how this was presented within the STP was not yet clear.
- Changes in the organisation of acute services with respect to operational and financial sustainability, improvements in outcome, networks, outreach etc could potentially impact on Reading residents.
- Any changes to the provision of Specialised Services (which were commissioned by NHS England rather than local CCGs) hade not yet been fully scoped and might operate over an even larger footprint.
- Mental health had a significant spend (over £100m) out of area, and several Trusts operated within BOB, which would require further work to understand.
- Although in principle all areas' integration plans included stimulating and facilitating more individual accountability for health and sustainable resilient communities, it was currently unclear what the full extent of these initiatives might be. However, driving change via prevention services at the scale of BOB might not facilitate a community co-production model.
- Releasing the level of financial savings required for all organisations with the footprint would continue to be extremely challenging, and could well include organisational change.
- There was an ongoing requirement to ensure that the governance of the STP took into account the statutory functions of all member organisations; with particular reference to democratic accountability and compliance with the Health and Social Care Act 2012. It was not yet clear how Health and Wellbeing Boards would be engaged in forming plan and polices, approving, and monitoring progress.

The report also proposed that:

- All the stakeholders in the system needed to have a clear understanding of the drivers for new care models that had the potential to deliver a better user experience, higher quality and the potential to lower costs.
- All partner organisations needed to support the vision and direction of travel.
- Consideration was needed of each member organisation's statutory functions and the role of its local residents.
- Partner organisations should consider how services could be delivered closer to home and community.
- There was a greater understanding and clarity around the resourcing and funding implications for each organisation of the STP process.

The report provided an opportunity for the Board to discuss the potential impact of the STP in Reading and asked it to consider what criteria it wished to be used to evaluate, approve or challenge the STP submission due by the end of June 2016 and to delegate authority to the Director of Adult Care and Health Services and the Chief Officer of the Berkshire West CCGs, in consultation with the Chair of the Health and

Wellbeing Board, to provide any approval or challenge on behalf of the Board. It also asked the Board to consider how it wished to be engaged in the future governance of the STP implementation.

Wendy Fabbro gave an update at the meeting on the latest position on the development of the STP, noting that the challenge was to focus on the activities in the Plan where there was an advantage in working at the BOB scale, as there were many other areas where it would be better to operate within communities within the primary care structure and to the existing Berkshire West Better Care Fund plans; the STP seemed to be creating a very complicated organisation. She said that the latest draft had just been produced, and explained that the three key themes were prevention, urgent care and workforce development, but there was still work to be done to finalise the STP.

In accordance with Standing Order 36B, Tom Lake, from South Reading Patient Voice, addressed the Committee on this item, including expressing concerns about the BOB area not being a good basis for place-based care as there were few natural affinities, and about the lack of publicity to and consultation and dialogue with patients and public on the STP proposals. He expressed support for the plans for the ACS and the opportunities for working together, noting that the ACS had quoted transparency as a criterion for success and that David Smith, Chief Executive of Oxfordshire CCG and lead for the BOB STP, had said that consultation would continue locally, even on issues decided at the BOB level.

The meeting discussed the issues raised in the report and the points made included:

- Although there could be benefits of organisation of Prevention at scale, it would be better if this could be consistent at an even greater scale than BOB, such as Public Health England being responsible. It was also not yet clear how some of the BCF projects would connect to the STP prevention work.

- For urgent care, Reading people should be able to look to the acute sector for help within the Borough boundary and there should be good standards across the region and services available in Reading.

- Although Frimley was in the East of Berkshire, provision would be on a Berkshire-wide footprint and so it was not expected that the West of Berkshire would be adversely affected.

- It was explained that NHS England was clear that Berkshire West was one of the economies within the BOB footprint and that the Berkshire West 10 plans for an Accountable Care System should be pursued.

- The commissioning of specialised services by NHS England was currently across the Thames Valley and Wessex and it was not proposed to change this, although it was expected that gradually some specialised commissioning might come back to the CCGs.

- With regard to Mental Health, there were currently two providers within BOB, and a bigger footprint could be considered to provide more local services in BOB at a reduced cost.

- In response to a query about a potential £9M loss to the CCGs budget it was explained that the CCGs already knew their indicative allocation to 2021 and would not lose funding from their allocation to the STP.

- The South Reading CCG had the lowest funding allocation in the country due to the National Allocation Formula and it was not expected that the STP would change this, although it was noted that, as there was differential growth year on year, the four CCGs in the Berkshire West Federation shared risk, so the Reading CCGs had benefited from this.

- For urgent care, there were a few major emergency centres with all specialist expertise and lower tier centres with less specialist services but other additional services because of quality or locality, and the important thing was to ensure that the right specialists were in the right places.

- The Board was being asked to make a decision without knowing the full details of the proposal and there should be a formal public meeting about the proposal. The way the STP proposal was being handled by NHS England did not seem to be in line with the spirit of the NHS constitution in terms of engagement with the public. Currently members of the public had no idea what the STP was or what its implications would be and big changes were being planned to the health system out of sight.

- Once the priorities within the June 2016 submission had been agreed by NHS England in July 2016, there would be public consultation on the STP proposal.

- The way the STP was being developed by imposition did not imply any real intention of partnership and the development of priorities across the BOB could lose the emphasis needed in Reading on health inequalities due to its different population profile. There were no links with Buckinghamshire currently and this linking did not seem logical.

- It was not clear how the development of the STP would be of benefit to Reading residents, as it did not seem to represent local interests and it was being developed without the desire or knowledge of the people of Reading. The Council was not happy about the way the STP had been developed but it seemed to have very little control or input.

- It was suggested that the Sustainable Transformation Plan should be evaluated against the following criteria:

    - Democratic accountability and transparency;
    - A focus on a neighbourhood place-based and person-centred approach rather than on pathways and processes;
    - The language used within the submission;
    - Reflection of local priorities, especially in relation to the health inequalities in Reading and protection of the interests of Reading residents.

- Members of the Board said that they would like to be engaged in the development of the STP as much as possible.

- Berkshire Healthcare NHS Trust, which provided mental health services, was expecting to provide services on a Berkshire-wide basis, but this could be more difficult as East Berkshire was not part of the BOB. It was noted, however, that the STP geographical area was for planning, not for providers.

- The BOB STP should only be planning services to serve the large 1.8m population and should not be involved in neighbourhood working – the local work should continue and it was not intended that the STP would take this over. The three key priorities had been discussed at a high level, but there would be opportunities for the local needs of the seven Health and Wellbeing Boards involved to be reflected, as it was understood that there would be different answers for each area.

- In terms of governance arrangements, there was a BOB STP Leadership Group which was open to all members in the STP, including the Council, and was the method for influencing. This Group had met once and would be meeting again on 20 June 2016, and a programme of meetings for the year had been requested.

Resolved -

(1) That the progress made in the development of the BOB STP for submission by 30 June 2016 be noted;

(2) That the criteria set out above be used to evaluate the BOB STP submission;

(3) That the Director of Adult Care and Health Services and the Chief Officer of the Berkshire West CCGs, in consultation with the Chair of the Health and Wellbeing Board, be authorised to provide any approval or challenge on the BOB STP submission on behalf of the Board;

(4) That, if necessary, a small group of members of the Board be convened after 30 June 2016 to further discuss plans for the BOB STP, and the latest STP submission be presented to the 15 July 2016 Board meeting.

(The meeting started at 6.00pm and closed at 7.45pm)

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Councillor Lovelock	Leader of the Council, RBC
Ishak Nadeem	Chair, South Reading CCG
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Jo Hawthorne	Head of Wellbeing, RBC
Kevin Johnson	Integration Programme Manager, RBC
Lois Lere	Operations Director, Wokingham CCG
Jill Marston	Senior Policy Officer, RBC
Kim McCall	Performance & Data Analyist, Wellbeing Team, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Janette Searle	Preventative Services Manager, RBC
Jenny Scott	Senior Policy Officer, RBC
Nicky Simpson	Committee Services, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Councillor Stanford-Beale	RBC
Kim Wilkins	Senior Programme Manager, Public Health, RBC

Apologies:

Andy Ciecerski	Chair, North & West Reading Clinical Commissioning Group (CCG)
Andy Fitton	Acting Head of Early Help and Family Intervention, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Helen McMullen	Director of Children, Education & Early Help Services, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

The Chair referred to a terrorist attack carried out in Nice, France on 14 July 2016, which had resulted in a large number of deaths and injuries. The meeting stood in silence as a sign of respect.

1. MINUTES & MATTERS ARISING

The Minutes of the meeting held on 18 March 2016 were confirmed as a correct record and signed by the Chair.

a) Youth Cabinet Campaigns

Further to Minute 2 (2), regarding the Youth Cabinet campaigns, it was reported that members of the Youth Cabinet had been invited to present their campaigns to the Special Educational Needs Coordinator and Head Teacher meetings as proposed and that, although attending the recent meetings had not been practical because of exams, the Youth Cabinet members hoped to attend at a future opportunity. Cllr

Hoskin also reported that he would be meeting with the Youth Cabinet about their campaigns.

b) Sustainable Transformation Plan (STP)

Further to Minute 5, regarding the Sustainable Transformation Plan (STP), and following the discussion at the extra Board meeting on 14 June 2016 (Minute 3 refers), Wendy Fabbro gave a verbal update on the latest situation. She reported that a draft STP submission for the West of Berkshire, Oxfordshire and Buckinghamshire (BOB) region had been submitted by 30 June 2016, but this was still considered a work in progress and would not be released for the public until the early autumn and there might still be some amendments. She said that she was about to go to a meeting with Simon Stevens, Chief Executive of NHS England, to discuss this first stage of the STP screening.

She explained that the following major themes within the STP had been developed, but there was still a great deal of detail to come:

- Prevention – child & adult obesity
- Urgent Care
- Acute Services
- Mental Health, with the aim to eliminate suicide
- Workforce
- Enabling Digital Interoperability

She said that it was being suggested that there could be a closed session consulting with stakeholders on the STP over the summer, but not in public, and that further work was being done by the leadership group about the ongoing governance of the STP and, in particular, the role of local democracy.

Councillor Hoskin reported that the Adult Social Care, Children's Services and Education (ACE) Committee, at its meeting on 4 July 2016 (Minute 15 refers), had also received a verbal update on the latest situation with the STP and had registered its concerns about the failure of the BOB STP to meet the following four criteria, against which Sustainable Transformation Plans should be judged:

(a) Are they transparent?
(b) Are they democratically accountable?
(c) Are they person-centred?
(d) Do they reflect local priorities?

He proposed that the offer of a closed session to discuss, be briefed on and input to the STP be taken up, but expressed concern about not being able to do this in public.

It was reported that there would be extensive public consultation on the STP after the main themes had been firmed up, but it was queried who would be organising and carrying out the consultation and it was also suggested that, once the key areas had been set, the consultation might be of limited use.

The meeting also discussed the governance of the STP, querying where the final decision would be made after the public consultation, whether this would be in public, and what was happening in the meantime to ensure that the governance arrangements were fit for purpose and ready to operate as soon as possible. It was

reported that Simon Stevens wanted to make sure that each of the STP submissions demonstrated achievement of local goals as well as the five year forward goals. The plans would go to the Minister and then back down for approval.

Resolved -

(1) That the positions be noted;

(2) That the offer of a closed session for members of the Board to be briefed on and discuss the development of the STP be taken up;

(3) That Wendy Fabbro take back to NHS England the comments of the Board about the consultation on and governance of the STP.

2. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

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

(a) Reconfiguration of Stroke & Cardiac Services

Since the last attempt at reconfiguration of cardiac emergency services in the South Central region, the RBH and SCAS have established a nationally leading system of prompt treatment for cardiac emergencies and a similar achievement for stroke.

National thinking on these services seems based on metropolitan experience exclusively.

Has reconfiguration of stroke and cardiac services been discussed in the Urgent and Emergency Care Network? What proposals are being considered?

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

Prior to the development of the Sustainability & Transformation Plan, there was a review of urgent and emergency care and, as stroke and cardiac services are providing successful outcomes and there is no desire to unpick these, it concluded that there was no need to change the current situation. There has been no discussion at the Urgent Care Board about any destabilisation of stroke services, the Urgent Care Board has Health and Wellbeing Board and Patient representatives on it, and it reports to public board meetings.

(b) Major A&E Departments

National policy on A&E departments is to establish 40-70 major centres. How many major centres will there be in the COBWeB/BOB/WeBOB area and where will they be?

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

Each major emergency centre has expertise; some centres, such as Oxford and Southampton, have all the specialisms and then the tier below are less specialist, but have particular specialisms as add-ons because of their quality, or because they are needed in the region – the key is getting the right specialists in the right place. We are not expecting changes in current service configuration for Reading residents.

(c) Registering of Carers

GP practices can improve the position of carers by registering them as such. Although the duties under the recent Care Act devolve onto the local authority, this practice is helpful to carers to whom we are all deeply indebted.

I understand that the registering of carers is universal at practices in North and West Reading but not so in South Reading.

Isn't it time that South Reading practices made this small change to help the carers that contribute so much to our society?

REPLY by the Chair of South Reading CCG (Dr Ishak Nadeem), on behalf of the Chair of the Health & Wellbeing Board (Councillor Hoskin):

Thank you Mr Lake for raising this issue which we have briefly answered at our engagement event at the St Lawrence Church on June 7th as well as when I visited the South Reading Patient Voice Group meeting. I have asked all the surgeries in South Reading subsequent to your query being raised at the Health & Wellbeing Board to ascertain what arrangements they have for registering carers in the surgeries. A majority of surgeries have responded with the statement that they publicise this in the form of posters and leaflets and have arrangements for registering carers as part of their registration process. They are well aware of this requirement as it forms part of their assessment under the CQC visits.

In fact not just registering carers, but offering them advice and support and help is considered as important for the CCG and towards this we have had a presentation from the Berkshire Carers Network at our Practice Managers monthly meetings to inform them of the Berkshire Carers Network offer.

However if there are shortcomings we will be happy to highlight this issue at our next Council of practices meeting and in our annual practice visits which are being planned to start from September.

3. NHS BERKSHIRE WEST CCGS OPERATIONAL PLAN 2016-17

Further to Minute 5 of the meeting held on 18 March 2016, Eleanor Mitchell submitted a report presenting the final Operational Plan 2016/17 for the four Berkshire West Clinical Commissioning Groups (CCGs) which had been submitted to NHS England in April 2016 and contributed to year one of the emerging Sustainability and Transformation Plan (STP). A copy of the final Operational Plan 2016/17 was attached at Appendix 1.

Eleanor Mitchell explained that the Plan had not yet had final approval, but the CCGs were not aware of any concerns from NHS England. She noted, however, that, as set out in the covering report, the year ahead would reflect a dramatically increased set of challenges, including delivering higher levels of savings than ever before, whilst also implementing the New Model of Care through the Accountable Care System. The size and scale of the challenge was reflected in the 'high' risk rating for delivery of a 1% surplus and over £17m savings. The senior management team was holding weekly voluntary finance turnaround meetings to address the issues.

The report explained that Berkshire West CCGs were collectively recognised as high-performing and benchmarked well nationally on a number of key performance measures, including non-elective admission rates and prescribing. For the previous two full years, Berkshire West CCGs had been in the top 4% of CCGs for non-elective admission rates and were also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience eg Diabetes Care, Stroke Care, and Improving Access to Psychological Therapy services.

However, in line with other health and care systems, the CCGs were facing increasing operational and financial challenges. Both elective and non-elective activity had increased significantly in recent months with significant spikes in emergency admissions. The plan was focussed on addressing this pattern of activity in what could be a fragmented system experienced by patients, resulting in people being driven into treatment in hospital with higher and more costly levels of care than their needs determined. This fragmentation of care could impact on both the citizen's experience and outcomes, and was a poor use of public money.

Health and social care partners in Berkshire West were therefore committed to developing, testing and implementing innovative approaches to new ways of working and in delivering a shared vision for the system as a key foundation on which to build. By 2020/21, the vision was that enhanced primary, community and social care services in Berkshire West would have a developed service model which prevented ill-health within local populations and supported people with much more complex needs to receive the care they needed in their community. People would be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers would share information, and use this to co-ordinate care in a way that was person centred, and reduced duplication and hand-offs between agencies. This vision was underpinned by the principle that people would only be admitted into hospital, nursing or residential homes when the services they required could not be delivered elsewhere. All the services that responded to people with an urgent need for care would operate together as a single system, ensuring that people with urgent but not life-threatening conditions would receive responsive and effective care outside hospital.

It was reported that, following a "deep dive" through the data about non-elective admissions, more information was available about where they were coming from and the CCGs were looking at the data with the relevant GP practices. A key issue for the Reading Integration Board (RIB) would be to come up with action plans for key conditions, and a further discussion was needed at the RIB about what else could be done, for example working with Public Health.

Wendy Fabbro said that she welcomed the commitment to rolling out Personal Health Budgets set out in the Plan and that the Council was keen to work with the CCGs to achieve this.

David Shepherd said that he welcomed the comments on patient engagement set out in the Plan and requested information on the patient representatives in the patient groups for Healthwatch.

Resolved -

(1) That the content of the final Berkshire West CCGs' Operating Plan for 2016/17 be noted;

(2) That partners continue to work together to deliver shared objectives;

(3) That the CCGs send information on the patient representatives in the patient groups to David Shepherd at Healthwatch.

4. OUTCOMES AND RESPONSE TO LGA PEER REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARDS

Jenny Scott submitted a report presenting the outcome of the LGA Peer Review/Challenge of the Reading and West of Berkshire Health and Wellbeing Boards. The report outlined the headline messages, key findings and recommendations contained in the review letter and proposed a draft framework to address the recommendations. The full review letter received from the LGA was attached at Appendix 1 and the draft framework in response to the recommendations was attached at Appendix 2.

The report explained that, on 9 October 2015, the Health and Wellbeing Board had approved a review of the Board's effectiveness and efficiency by LGA Peer Challenge (Minute 11 refers). This review had been undertaken collaboratively with Wokingham and West Berkshire Health and Wellbeing Boards, in order to identify any potential opportunities for future synergies or integrated working, with the LGA conducting 'on-site' visits from 1 to 4 March 2016. The LGA Review Team had produced a feedback letter, providing a summary of the Review Team's findings specific to Reading and including the collective feedback given to all three areas and the review letter had been circulated to Board Members for comments.

The report noted that an update report on the Health and Wellbeing Strategy refresh was also being considered at the meeting. The refreshed Health and Wellbeing Strategy would represent – in part - the Board's response to the recommendations of the Review, and would offer an outcome-focused framework to drive the future agenda of the Health and Wellbeing Board. The report recommended that the Board hold a stocktaking event and set up Task and Finish Groups to consider how to address the recommendations of the Review, which were set out in paragraph 4.13 of the report.

Eleanor Mitchell noted that one of the recommendations was that a vice-chairing arrangement with the CCGs be considered, and suggested that one of the GPs on the Board should be the Vice-Chair. The members of the Board expressed support for this change. It was also noted that, whilst a good informal relationship had been built up between the partners on the Board, it would be useful to have more regular informal meetings of members of the Board to strengthen the partnership and in order to come to a better shared understanding on key issues. The Board would also continue to meet in public and make its decisions at the public meetings.

Resolved -

(1) That the observations and findings from the LGA Peer Review/Challenge be noted;

(2) That the recommendations of the LGA Peer Review, as set out in paragraph 4.13 of the report, be endorsed;

(3) That the suggested initial framework to develop a response to the recommendations, as set out in Appendix 2, be agreed;

(4) That a Health and Wellbeing Board member stocktaking event be organised and Task and Finish Groups be established to look at the framework and address the recommendations;

(5) That the principle of one of the CCG GP members of the Board being the Vice-Chair of the Board be agreed.

5. ALIGNING COMMISSIONING INTENTIONS WORKSHOP

Jo Hawthorne submitted a report on plans to run a workshop with partners to share the critical themes to be built into organisations' commissioning intentions.

The report explained that, at its meeting on 22 January 2016, the Board had agreed to convene a workshop to ensure co-creation of commissioning intentions based on Health and Wellbeing Board strategic aims and priorities (Minute 6 (2) refers).

A workshop had been arranged to be held on 2 September 2016 in the Council Chamber at the Civic Offices, to which Commissioning leads from Reading Integration Board, partner authorities in the West of Berkshire and Health and Wellbeing Board members would be invited. The day would aim to receive succinct presentations on the Joint Strategic Needs Assessment and strategic intentions, partner imperatives and expectations (such as NHSE and regulator requirements (eg CQC/Monitor/Ofsted), in order to spend the majority of time discussing and evaluating priorities. It was planned to have a "beauty parade" of the options at the end of the day for the workshop to vote on priorities they would like to ask commissioners to consider as they formulated the detail in plans.

The workshop would share the critical themes to be built into organisations' commissioning intentions plans so that:

- The Health and Wellbeing Board could see the 'golden thread' from the JSNA and the Health and Wellbeing Strategy to commissioning for solutions
- Plans could be worked up to build synergy and alignment without fear of potential conflict

Feedback from the day would be reported to the 7 October 2016 Board meeting and could be used to evaluate the final submissions in January 2017.

Councillors Lovelock and Eden said that they would not be available on 2 September 2016 and requested that the date be reconsidered.

Resolved -

That, subject to reviewing the date, the plans for the workshop be endorsed and feedback be received at the 7 October 2016 Board meeting.

6. HEALTHWATCH READING ANNUAL REPORT 2015/16

David Shepherd and Mandeep Sira submitted the 2015/16 Annual Report for Healthwatch Reading, which gave details of the work carried out by Healthwatch Reading in 2015/16.

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

The report explained that, due to an increasing number of calls about local GP services, Healthwatch Reading had decided to focus the year's activities on primary care, and had carried out Enter & View visits to GP surgeries and spoken to patients, and the report on the findings of this work would go to inform the design and commissioning of primary care services. Reports had also been produced from an Enter & View visit to the Royal Berkshire Hospital Eye Clinic and on projects on the experiences of the ex-Gurkha community in accessing health and social care and the experiences of women diverted from giving birth at their preferred place. Summary details of the report findings were set out in the annual report, which stated that the recommendations had been acted on by the providers and commissioners of the services.

The report also gave details of the information, advice and advocacy work carried out by Healthwatch Reading, including holding a local event in July 2015 bringing together NHS and Council complaints staff to compare and discuss complaint handling, to help them learn from complaints. It stated that, since April 2015, Healthwatch Reading had also been delivering a contract to co-ordinate Care Act advocacy, in partnership with other voluntary sector organisations in an arrangement called Reading Voice, and gave further details. The report also gave details of further working with other organisations and of how Healthwatch Reading involved local people in its work.

The report explained that Healthwatch Reading faced challenges entering its third year, including a 15% budget cut, but planned to build on its previous work and gave details of the planned focus on work in the following areas:

- GP services
- End of Life Care
- Homeless people
- Electronic Prescriptions
- Health and Social Care Integration
- NHS Sustainable Transformation Plans

Resolved -

(1) That the report be noted;

(2) That the Health and Wellbeing Board's thanks to the Healthwatch Reading team, for their good work and patient-focused approach, be recorded and passed to the team.

7. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT – THE HEALTH OF CHILDREN & YOUNG PEOPLE

Jo Hawthorne submitted a report presenting the Berkshire Strategic Director of Public Health's draft Annual Report for Reading, focusing on the health of children and young people, which was attached at Appendix A to the report.

The report explained that the Director of Public Health had a duty to write an annual report on the health of the local population and the local authority had to publish it, in accordance with Section 31 of the Health & Social Care Act 2012.

The draft Annual Report pulled together a snapshot of some of the key challenges and inequalities that existed within children and young people in the local population. It described the impact of these inequalities in later life and current service provision and concluded that the evidence showed that children should be a key focus for attention to address inequalities.

The report also highlighted some of the issues that challenged Reading's children and the inequalities that existed within this group. It highlighted that services could be too focused on clinical conditions and not recognise the huge impact that other issues contributed to outcomes. It also noted that education and health were interlinked and, whilst Reading performed well to improve overall educational attainment in secondary schools and supported children who were eligible for free school meals, there was still a wide gap in attainment between this group and other pupils, and this group's attainment in Reading was lower than in some neighbouring authorities.

Resolved - That the report be noted and used to influence the work to reduce health inequalities.

8. DEVELOPMENT OF WELLBEING DASHBOARD

Kim McCall and Jo Hawthorne submitted a report giving an update on progress of the development of a Wellbeing Dashboard. The latest draft of the Wellbeing Dashboard was attached at Appendix 1, as well as an example of the more detailed information on each indicator available in the full spreadsheet version of the Dashboard. It had been intended to show this information further in a demonstration at the meeting, but, due to a failure in the technology, this was not possible.

The report explained that the development of a dashboard had been agreed in principle at the meeting held on 18 March 2016 (Minute 7 refers) and, following a meeting of the Task and Finish group with key stakeholders, the model for the dashboard had been developed further. Key issues discussed by the group had been goals, indicators, targets, format, updates and presentation to the Board, details of which were set out in the report.

The report stated that any further recommendations from the Board for development would be taken into account and the model refined further, including developing mechanisms for ensuring sufficient background information was available to Board members on request to inform a practical oversight and understanding of

performance and decision-making. The most up-to-date version of the Dashboard would be presented at the next Health and Wellbeing Board meeting for discussion and action and would be a standing item for future meetings. The report proposed that a lead would be identified for each indicator, who would be able to provide background information when requested and raise any performance concerns with Board members through the normal reporting channels. Where concerns were consistently highlighted, a Task & Finish Group could be convened to investigate.

It was noted that some of the indicators were still indicative and that work on the new Health and Wellbeing Strategy would also impact the Dashboard. Further work needed to be done to populate information in the Dashboard on the indicators where no performance data was currently available, and in some areas, more up-to-date data needed to be obtained. It was reported that the CCGs had more up-to-date data, for example on Delayed Transfers of Care and dementia diagnosis, which could be provided. The final indicators to be included in the Dashboard would be agreed in partnership with the stakeholders, once the final Health and Wellbeing Strategy had been agreed.

Resolved -

(1) That the Wellbeing Dashboard and the initial indicator sets be endorsed and further work be carried out to refine and present the Dashboard;

(2) That the spreadsheet containing full details of the current draft Dashboard be circulated to members of the Board after the meeting;

(3) That, where partners had more up-to-date data available, this be provided to the Public Health team;

(4) That the Dashboard be presented as a standing item at each Health and Wellbeing Board meeting.

9. JOINT HEALTH & WELLBEING STRATEGY REFRESH – UPDATE

Kim Wilkins submitted a report on progress to date in developing a second Joint Health and Wellbeing Strategy for Reading. The report had appended:

- Appendix 1 – Analysis of Reading 2016 JSNA – May 2016
- Appendix 2 – Adult Wellbeing Position Statement Consultation Report - May 2016

The report explained that members of the Health and Wellbeing Board had worked with stakeholders to review Reading's first Joint Health and Wellbeing Strategy against the following, details of which were set out in the report:

- the 2016 Joint Strategic Needs Assessment (JSNA)
- performance against the 2013-16 Health and Wellbeing Action Plan
- Reading's programme for health and social care integration, including the Berkshire West 10 Integration Programme and the 2016 Better Care Fund plan
- the priorities identified in Reading's Adult Wellbeing Position Statement for meeting the Care Act wellbeing duty

An independent analysis of the 2016 JSNA key findings against the first Joint Health Wellbeing Strategy for Reading had also been carried out and the report gave details of the areas highlighted for review in the development of the second Strategy. The full analysis was attached at Appendix 1.

The report also stated that there had already been a consultation on the Council's Adult Wellbeing Position Statement, the report from which was attached at Appendix 2, and this feedback would inform the development of the new Health and Wellbeing Strategy, in terms of meeting the wellbeing duties detailed in the Care Act and relating to adults with current or emerging care needs.

The report explained that stakeholders had welcomed the opportunity to be involved in the development of the strategy as members of the Involvement Group and that, in the future, the Involvement Group would like to see:

- a clear plan to shift the emphasis onto prevention rather than care;
- an approach which took a holistic view of people rather than looking at health conditions in isolation;
- stronger collaboration around providing people with the information they needed to take charge of improving their own health;
- recognition that different approaches were needed to reach different communities;
- better use of technology to empower people, support independence and make the most efficient use of limited resources;
- a strategy which focused the collective effort on fewer priorities, and so targeted the biggest risks for Reading.

There would be further involvement with partners and communities to develop proposed priorities for the new strategy which would then go through a period of formal consultation in autumn 2016. The new strategy would reflect Board members' agreed priorities for health and social care integration, and the need to develop a framework to drive co-commissioning across the Board's membership. The 2017-20 strategy would incorporate wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

The report stated that the refreshed Health and Wellbeing Strategy would also represent – in part - the Board's response to the recommendations of the Health and Wellbeing Peer Review carried out in March 2016, and offer an outcome-focused framework to drive the future agenda of the Health and Wellbeing Board.

Resolved -

That the proposals for development of Reading's 2017-20 Health and Wellbeing Strategy be endorsed, and a further report be submitted to the next meeting on the commencement of a formal consultation.

10. BERKSHIRE WEST 10 LOCAL DIGITAL ROADMAP SUBMISSION

Lois Lere submitted a report presenting the Local Digital Roadmap for Berkshire West, which was attached at Appendix 1 to the report.

The report explained that, in September 2015, NHS England had begun a three-step process to enable local health and care systems to produce Local Digital Roadmaps (LDRs), setting out how they would achieve the ambition of 'Paper-free at the Point of Care' by 2020. The first step had been the organisation of local commissioners, providers and social care partners into LDR footprints, in Reading's case across the 'Berkshire West 10'. The second step had been for NHS providers within LDR footprints to complete a Digital Maturity Self-Assessment. Both of these steps had now been completed. Each LDR footprint had been asked to develop and submit an LDR by 30 June 2016, which would be reviewed in July 2016 within the broader context of Sustainability and Transformation Plans (STPs). A signed-off LDR would be a condition for accessing central investment for technology-enabled transformation.

An LDR was expected to include the following elements:

- A five-year vision for digitally-enabled transformation
- A capability deployment schedule and trajectory, outlining how, through driving digital maturity, professionals would increasingly operate 'paper-free at the point of care' over the next three years
- A delivery plan for a set of universal capabilities, detailing how progress would be made in fully exploiting the existing national digital assets
- An information sharing approach

The report had attached the final LDR submission which had been sent to NHS England on 30 June 2016, and it stated that there was the opportunity to refine the submission before it was published on NHS England's public facing internet site in September 2016.

The Board discussed the importance of public accountability and appropriate governance and of the involvement of professionals to ensure that the public were engaged and genuinely consulted on this project. It was reported that there was an Information Governance Reference Group, which would be considering how best to get explicit consent from patients in order to be able to make the change to 'paper-free', and what the relevant system might look like.

It was reported that the Reading Local Strategic Partnership was carrying out a piece of work on information sharing and working more smartly, and it was suggested that Lois Lere should be put in touch with those working on this project, so that health partners could be involved in that project.

Resolved -

(1) That the current content of the Local Digital Roadmap, and the collaborative effort that would be required to deliver the 'paper-free at the point of care' requirements, be noted;

(2) That Lois Lere be put in touch with the Council officers working on the Reading Local Strategic Partnership project on information sharing and working more smartly.

11. QUALITY ACCOUNTS: REVISED SCRUTINY ARRANGEMENTS

Further to Minute 8 of the previous meeting, Jo Hawthorne submitted a report on plans for future scrutiny of Quality Accounts (QAs) presented by healthcare providers, giving the Health and Wellbeing Board a clear overview and scrutiny lead in this area

via a delegation from the Adult Social Care, Children's Services and Education (ACE) Committee.

The report explained that a QA was a report about the quality of services delivered by an NHS healthcare provider. The reports were published annually by each provider and were available to the public. The quality of the service was measured in the QA by looking at patient safety, the effectiveness of treatments that patients had received and patient feedback about the care that had been provided.

The recent Peer Review of the Health and Wellbeing Board had observed that the Board's role to date had been primarily to receive information about decisions made elsewhere in the Council and CCGs. Therefore giving the Board a clear lead in receiving and responding to QAs would help to consolidate its leadership role in relation to local healthcare.

The report explained that provider trusts were only required by regulation to share their QAs with NHS England or relevant Clinical Commissioning Groups, Local Healthwatch organisations and Overview and Scrutiny Committees (and have their reports audited). There was no regulatory requirement for provider trusts to share their QAs with Health and Wellbeing Boards unless the Health and Wellbeing Board was fulfilling a scrutiny function. Therefore ACE Committee had agreed (Minute 16 of the meeting on 4 July 2016 refers) to delegate its health scrutiny function in relation to QAs to the Health and Wellbeing Board, which could bring together representatives of all bodies required to comment on QAs and allow responses to be prepared collaboratively across the local authority, CCGs and Healthwatch.

It was proposed that, in future, all QAs received for local healthcare providers would be received and responded to by the Health and Wellbeing Board. As the Board ordinarily met four times a year, which might not be sufficiently frequent to facilitate discussion of each QA response by the full Board, the report proposed that the Board establish a QA Task and Finish Group, to include representatives of:

- Director of Adult Care & Health Services
- Director of Children, Education & Early Help Services
- Healthwatch Reading
- North and West Reading CCG
- South Reading CCG

This group would prepare and submit QA responses on behalf of the Board. The CCGs, as commissioners of the services concerned, would continue to engage their Quality Committee in the QA Task & Finish Group in order to agree the form of response from the partnership, and the ACE Committee would receive QAs to scrutinise as necessary, if required.

It was suggested that a letter should be sent by the Chair to the providers, asking them to send their QAs to the Health and Wellbeing Board.

Resolved –

(1) That a Quality Accounts Task and Finish Group be set up to evaluate local NHS Healthcare provider Quality Accounts against strategic intentions and JSNA priorities, with the membership to include Debbie

Simmonds from the CCGs, David Shepherd or Mandeep Sira from Healthwatch and Councillor Hoskin from the Council;

(2) That the Chair send a letter to the relevant healthcare providers asking them to send their Quality Accounts to the Health and Wellbeing Board.

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

Jill Marston submitted a report giving a six-monthly update on 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 latest version of the Action Plan was attached at Appendix A.

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 report gave details of the aims of the Armed Forces Community Covenant and it explained 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 included further progress on the outstanding actions relating to health and wellbeing since the last report, and the report highlighted some key successes to date, including the award of funding from the Community Covenant fund for two Nepalese community development workers and the translation of a leaflet on accessing health services into Nepalese, which was being used to run classes.

The report also gave details of the latest Community Covenant grant fund which had recently been launched, with £10m of funding available each year. The following priorities for 2016/17 and 2017/18 had been set:

1. Veterans' Gateway
2. Families in Stress
3. Improving Local Covenant Delivery (clusters of authorities only)
4. Community Integration/Local Service Delivery

The report gave details of the deadlines for applications under priority 4 for funding for projects of up to £20,000 and stated that the Community Covenant Working Group would discuss any potential bids in September 2016 for the 2 November 2016 deadline.

The report proposed that future reporting to the Board be done on an annual basis, rather than six-monthly, and it was explained that this change was also being proposed to the Policy Committee which received similar regular reports on progress on the Action Plan.

Councillor Lovelock reported that the leaflet translator had some concerns about the community workers who had been appointed not being able to do their work at the Royal Berkshire Hospital and that they also needed support in printing more leaflets and it was agreed that they should be put in touch with Jill Marston for her to look at the issues and concerns.

Resolved -

(1) That the progress against the actions set out in the Armed Forces Community Covenant Action Plan be noted;

(2) That, in future, update reports on the Action Plan be submitted to the Board annually, rather than six-monthly;

(3) That Councillor Lovelock ask the leaflet translator to make contact with Jill Marston, for her to look at their issues and concerns.

13. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 7 October 2016.

(The meeting started at 2.05pm and closed at 4.00pm)

READING BOROUGH COUNCIL
REPORT BY THE DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**7 OCTOBER 2016**	**AGENDA ITEM:**	**7**
TITLE:	**READING's 2nd HEALTH & WELLBEING STRATEGY**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN / COUNCILOR GAVIN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE / CHILDREN'S SERVICES**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JANETTE SEARLE / KIM WILKINS**	**TEL:**	**0118 937 3753 / 3624**
JOB TITLE:	**PREVENTATIVE SERVICES MANAGER / SENIOR PROGRAMME MANAGER**	**E-MAIL:**	**Janette.Searle@reading.gov.uk / Kim.Wilkins@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out progress in developing Reading's 2nd Health and Wellbeing Strategy since the Health and Wellbeing Board in July 2016, and seeks authority to launch a formal consultation on the draft.

1.2 At its July meeting, the Health and Wellbeing Board agreed to a set of proposals for developing Reading's 2017-20 Health and Wellbeing Strategy, and requested a further report to the Board's October meeting on the commencement of a formal consultation. The Chair of the Health and Wellbeing Board requested a period of stakeholder engagement prior to the formal consultation so that the draft strategy could be co-produced with local partners, particularly voluntary and community sector partners who will be key to developing a strong community infrastructure to support wellbeing.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board:
(a) agrees to the launch of a formal consultation on the draft Health and Wellbeing Strategy 2017-20 which appears at Appendix 1; and
(b) requests a progress report to its January 2017 meeting presenting a final version of the Strategy including a supporting Action Plan developed with stakeholders as part of the consultation process.

3. POLICY CONTEXT

3.1 The primary responsibility of Health and Wellbeing Boards, as set out in the Health and Social Care Act 2012, is to produce a Joint Strategic Needs Assessment (JSNA) to identify the current and future health and social care needs of the local community, which will feed into a Joint Health and Wellbeing Strategy (JHWS) setting out joint priorities for local commissioning. Through these key tools, the Health and Wellbeing Board will develop plans to:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and
- promote the integration of services.

Local authority and CCG commissioning plans should then be informed by the JSNA and the Joint Health and Wellbeing Strategy.

3.2 The Care Act in 2014 created a new statutory duty for local authorities to promote the wellbeing of individuals. This duty – also referred to as 'the wellbeing 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, however, but includes all assessment functions, the provision of information & advice, and the local offer of 'preventative' services. The Care Act 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 needs to be considered alongside the general duty of co-operation (with partners outside the local authority).

3.3 The Care Act requires councils to have a strategy for meeting their wellbeing responsibilities under the Act. In January 2016, Reading Borough Council launched a draft Adult Wellbeing Position Statement intended to cover this responsibility whilst a revised JSNA and then updated Health and Wellbeing Strategy were in preparation. Feedback from a public consultation on the Adult Wellbeing Position Statement is being used to inform the development of Reading's 2017-20 Health and Wellbeing Strategy.

3.4 Over the coming months, the Health and Wellbeing Board will be reflecting on the findings of a Health and Wellbeing Peer Review, and considering how to align Commissioning Intentions across members of the Board more closely in future. Throughout these discussions, the Board will consider how the new Health & Wellbeing Strategy can steer the Board in the direction it needs to take, including providing the best foundation for health and social care integration.

4. READING'S 2nd JOINT HEALTH AND WELLBEING STRATEGY

4.1 There have now been two workshops bringing together members of the Health and Wellbeing Board and other key stakeholders representing public services, local providers and Reading's voluntary sector (the Health & Wellbeing Involvement Group) to refresh Reading's Health and Wellbeing Strategy. This

stakeholder group has brought a range of knowledge and expertise into a collaborative review of local need – based on the Joint Strategic Needs Assessment - and of past performance against the goals of the 2013-16 Health & Wellbeing Strategy. In addition, the emerging priorities of the new strategy have been discussed at Reading Voluntary Action's Wellbeing Forum for the third sector.

4.2 The Joint Strategic Needs Assessment is now updated through a rolling programme. The latest published data is therefore available through the JSNA to underpin discussions about the development of the new Health and Wellbeing Strategy. The JSNA will also continue to be a tool to assist the Health and Wellbeing Board in reviewing progress against the new strategy based on latest intelligence about Reading's health and wellbeing.

4.3 Members of the Involvement Group have welcomed the opportunity to be involved in the development of the 2017-20 strategy at an early stage and so shape a draft strategy prior to a formal consultation period. Key messages from the Involvement Group were that the refreshed strategy should represent and include:

- a clear plan to shift our emphasis onto prevention rather than care;
- an approach which takes a holistic view of people rather than looking at health conditions in isolation;
- stronger collaboration around providing people with the information they need to take charge of improving their own health;
- recognition that different approaches are needed to reach different communities;
- better use of technology to empower people, support independence and make the most efficient use of limited resources; and
- a focus of partners' collective effort on fewer priorities, so as to target the biggest health and wellbeing risks for Reading.

4.4 The Health & Wellbeing Involvement Group felt that the 2013-16 Health & wellbeing Vision – now widely cited across other local strategies and plans – was still valid, and recommended that this be carried forward as the 2017-20 vision:

Vision: *A healthier Reading*

The Group also liked the idea of adopting the Public Health England mission statement, and suggested adding a Reading Mission Statement:

Mission Statement: *to improve and protect Reading's health and wellbeing – improving the health of the poorest, fastest*

4.5 A number of issues were then identified to make up a 'priorities shortlist' for the new strategy using the following criteria.

- Reading's performance in this area is significantly below average (for England / for the region / by reference to statistical neighbours).
- This is something which stakeholders feel confident is under local control and influence, and can therefore be changed through a local strategy.

- Reading's performance over time indicates a need to focus on this issue, e.g. Reading is now performing in line with or better than national averages, but this reflects a focus given to a 'hot topic' which needs to be sustained.
- The issue either isn't already included in / monitored via other strategic plans, or there would otherwise be clear added value in making this a HWB priority, e.g. this is something which stakeholders believe Reading would be best placed to address by working together across the membership of the HWB Board.
- The expected return on investment in this area is significant if the issue is made a priority across the HWB partnership.

4.6 The priorities shortlist was then developed, ranked and annotated by the Health & Wellbeing Involvement Group through a second workshop. As a result of this process, three 'building blocks' have been identified to underpin the refreshed Health and Wellbeing Strategy.

- Developing an integrated approach to recognising and supporting all carers
- High quality co-ordinated information to support wellbeing
- Safeguarding vulnerable adults and children

4.7 From this base, the draft Strategy proposes seven priorities for the next three years:

- Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity and physical activity)
- Reducing loneliness and social isolation
- Reducing the amount of alcohol people drink to safe levels
- Promoting positive mental health and wellbeing in children and young people
- Making Reading a place where people can live well with dementia
- Increasing breast and bowel screening and prevention services
- Reducing the number of people with tuberculosis

4.8 There were a number of issues which the Involvement Group considered were best owned by partnerships other than the Health and Wellbeing Board. All were seen as being relevant to achieving the Health and Wellbeing vision, and the Group suggested that they should be recorded as issues in which the Health and Wellbeing Board would maintain an interest and a dialogue with other appropriate local partnerships. These issues are:

- Increasing the number of young people in employment, education or training (not NEET)
- Ensuring more people plan for end of life and have a positive experience of end of life care
- Supporting vulnerable groups to be warm and well.
- Reducing the number of people using opiates
- Protecting Reading residents from crime and the fear of crime
- Narrowing the gap between the educational attainment of children who are eligible for free school meals and those who are not eligible.
- Tackling poverty

- Reducing the number of people and families living in temporary accommodation

The Involvement Group's recommendation is that future information sharing with the Health and Wellbeing Board should be purposeful, with clear requests or recommendations to the Board as part of any reports submitted to it.

4.9 A dashboard of key performance indicators has now been developed to increase the accountability and transparency of the Health and Wellbeing Board's future progress against stated aims and objectives. This dashboard will be used to track performance against the Action Plan which will be developed in support of the 2017-20 Health and Wellbeing Strategy. It will identify performance in those areas ultimately selected as the priorities for the new Health and Wellbeing Strategy, as well as performance in the wider 'business as usual' across the health and wellbeing landscape.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Members of the Health and Wellbeing Board have worked with key stakeholders to review the 2016 Joint Strategic Needs Assessment (JSNA) and performance against the 2013-16 Health and Wellbeing Action Plan. In light of these reviews, a draft strategy has been prepared which includes shared priorities for realising the vision of 'a healthier Reading'. The draft also reflects priorities for health and social care integration, and the need to develop a framework to drive co-commissioning across the Health and Wellbeing Board's membership. The 2017-20 strategy will incorporate wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

5.2 The refreshed Health and Wellbeing Strategy will also represent – in part - the Board's response to the recommendations of a health and wellbeing peer review carried out in March 2016, by offering an outcome focused framework to drive the future agenda of the Health and Wellbeing Board.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 There have been two stakeholder workshops to date to review Reading's first Health & Wellbeing Strategy and start to outline the issues for inclusion in the second strategy. There was a third opportunity to work with representatives of the local voluntary and community sector on the development of the strategy prior to a formal consultation at Reading Voluntary Action's Wellbeing Forum on 9th September.

6.2 There has already been a 12 week consultation on the Council's Adult Wellbeing Position Statement, and this feedback has informed the development of the new Health and Wellbeing Strategy. This will ensure that the new strategy includes Reading's approach to meeting the specific wellbeing duties detailed in the Care Act and relating to adults with current or emerging care needs.

6.3 Subject to the Health and Wellbeing Board's approval, there will be a 9 week formal consultation on the draft strategy, commencing immediately. This will include an online questionnaire alongside presentations to a series of resident / patient / service user forums to give people the opportunity to take part in a dialogue about proposed priorities and the development of an Action Plan to achieve these. A report on that consultation and engagement exercise will be taken to the January meeting of the Health and Wellbeing Board along with an updated draft of the Strategy and a proposed Action Plan for adoption.

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. In addition, the Council has a duty under the Care Act (2014) to develop a clear framework for ensuring it is meeting its wellbeing and prevention obligations under the Care Act.

7.2 Members of the Health and Wellbeing Board 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 draft Health and Wellbeing Strategy will be in possession of 'protected characteristics' as set out in the Equality Act, and the Strategy 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 draft Strategy might impact differently on protected groups, and will also highlight any concerns or impacts any changes may have. As a vehicle for addressing health inequalities, it is expected that any such differential impact would be positive. However, an equality impact assessment will be prepared to accompany the final strategy presented to the Board for approval.

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 Health and Wellbeing Action Plan, at which point the financial implications of adopting the Strategy will be presented to the Health and Wellbeing Board. It will be an imperative that the Strategy drives the efficient use of resources and identifies clear health benefits on investment so as to protect a sustainable local health and care system.

10. APPENDICES

Appendix 1 – Draft Health and Wellbeing Strategy 2017-20

Consultation Draft

Reading Borough Council
Working better with you

Reading's Health and Wellbeing Strategy

2016 - 2019

NHS
South Reading
Clinical Commissioning Group

NHS
North and West Reading
Clinical Commissioning Group

Foreword

This draft of Reading's second Joint Health & Wellbeing Strategy sets out the work done so far by the Health and Wellbeing Board to develop our plans for the next three years. Our final strategy will set out the areas we will focus on from 2017 to 2020 to improve and protect Reading's health and wellbeing, including our plans to meet our Care Act obligations to prevent, reduce and delay care and support needs.

Our mission for the next few years is:

to improve and protect Reading's health and wellbeing

- ***improving the health of the poorest, fastest***

Individual wellbeing is affected by many things, and our approach recognises the importance of the places where we live, work and play as well as our health and social care services.

Reading offers its residents support in many ways to enjoy a healthy, independent and fulfilled life. 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 Health and Wellbeing Strategy needs to give us a framework for supporting all residents, including people of all ages, people from our diverse communities, those who have current or emerging care needs, and the unpaid or family carers who are helping to keep people well and independent.

However, the financial settlements we have received from central government make it impossible for us to invest as widely in Reading's health and wellbeing as we would like. Health inequalities are real and widening, and this is a particular concern for us.

The gap in healthy life expectancy (the number of years people are expected to live in 'good' health and are disability-free) between people living in the most deprived and in the most affluent areas of Reading now stands at 10 years for men and 5 years for women.

Our poorest communities have suffered the consequences of reductions in the value of welfare benefits, restrictions on entitlements to support, as well as rising costs of food and fuel. At the same time, members of the Health and Wellbeing Board have had to make service cuts to meet centrally imposed budget cuts.

Policies of austerity increase inequities in our society - with those in the poorest communities paying the very highest price of all in terms of early ill health. Our response to centrally imposed

budget cuts is to take a more targeted approach locally to make sure those who most need additional support to stay well can receive it in Reading. We will also continue to look for ways to work more efficiently, including making better use of technology.

Across the Health and Wellbeing Board, we are committed to working together and with our partners to develop our plans. The people of Reading's different communities, the providers of local services, and our various faith and community groups hold the detailed knowledge we need to draw on in order to build on Reading's assets and meet the challenges ahead. We look forward to hearing people's thoughts on our draft plan so we can develop it, and agree the detailed actions we need to take in order to make a difference over the next three years.

Councillor Graeme Hoskin
Chair, Reading Health & Wellbeing Board

Contents

Vision: a healthier Reading

Our mission: to improve and protect Reading's health and wellbeing, improving the health of the poorest fastest

Our priorities

Supporting people to make healthy lifestyle choices - dental care, reducing obesity, increasing physical activity, reducing smoking
Reducing loneliness and social isolation
Reducing the amount of alcohol people drink to safe levels
Promoting positive mental health and wellbeing in children and young people
Making Reading a place where people can live well with dementia
Increasing breast and bowel screening and prevention services
Reducing the number of people with tuberculosis

Safeguarding vulnerable adults and children	**Recognising and supporting all carers**	**High quality coordinated information to support wellbeing**

Our vision and purpose

The Health & Wellbeing Board's vision is the same as it was in 2013:

A healthier Reading

And, in order to get us there, our mission is:

to improve and protect Reading's health and wellbeing -
improving the health of the poorest, fastest

What we want this strategy to achieve

This is the second Joint Health and Wellbeing Strategy for Reading. It builds on our first (2013-16) strategy, and takes into account national and local developments over the past three years.

We want this strategy to provide a solid foundation for health and wellbeing in Reading over the next three years, setting priorities which are reflected in local authority and clinical commissioning group commissioning plans.

A shared view of health and wellbeing

Health and wellbeing is about the whole person – giving physical, emotional and social aspects equal attention. It is about improving people's chances of living well for longer into the future, as well as about how they feel and function today.

People also need to feel safe to enjoy full wellbeing, which is why making sure we are safeguarding vulnerable adults and children in Reading is one of the building blocks of our Health & Wellbeing Strategy.

Preventable ill health represents human misery which could be avoided, and a demand on care services which could be reduced. We want to increase our focus on keeping people well, so that there is less need for support to help people get better or cope with long term conditions.

There are many factors which can improve health and wellbeing, and a wide range of activities which the Health and Wellbeing Board could support.

Working together, we need to focus our efforts on those areas where the evidence tells us we can

have the greatest impact on health and wellbeing in Reading. This involves reviewing the evidence, looking at the cost effectiveness of different interventions, and considering the likely scale of impact of the different areas we could concentrate on.

Setting a framework for prevention

The Care Act in 2014 created a new statutory duty for local authorities to promote the wellbeing of individuals in delivering their care and support functions.

This includes:

- delivering social care services
- assessing people's needs with wellbeing at the core of that assessment
- providing information & advice and
- developing services locally which reduce people's needs for care and support.

The Care Act also introduces a duty of co-operation between all bodies involved in public care.

Early in 2016, the local authority published a draft Adult Wellbeing Position Statement setting out its approach to meeting Care Act wellbeing responsibilities. People's comments on that document have helped us to come to a view about our future priorities.

Our second health and wellbeing strategy will include our plans to meet Care Act obligations in Reading as well as our health protection and promotion duties under the Health and Social Care Act.

Recognising and supporting carers

An estimated 12,000 people in Reading provide unpaid care to family members or friends.

National studies have valued carer support as the equivalent of a 2nd NHS. However, this huge resource to support people's health and wellbeing is also a very fragile one, and supporting carers is key to a successful approach to preventing care needs from increasing across the local population.

Carers face high risks of poor health and wellbeing themselves because of the strains of caring, and a tendency to put the needs of the person they care for first.

We want to see clear plans to recognise and support carers included in all of the initiatives we

prioritise and monitor going forward – including parent carers and young carers as well as adult carers of other adults.

Supporting health and social care integration

Reading's plans for health and social care integration have progressed significantly over the lifetime of our first Health and Wellbeing Strategy.

The Health and Wellbeing Board has overseen the development of Reading's Better Care Fund plans - now in their second phase - to use pooled health and social care budgets in ways which improve people's lives by designing care around individuals.

Reading also continues to be part of the wider 'Berkshire West 10' integration programme which is developing integrated care projects in partnership with our neighbours in Wokingham and West Berkshire.

Our second Health and Wellbeing Strategy complements these integration plans so as to promote seamless care by the right agency at the right time and in the right place.

How we are developing this strategy

This draft Strategy represents the views of a range of local partners, including members of members of the Health and Wellbeing Board and representatives of the local voluntary sector.

People have come together to review the last strategy and to consider updated evidence about local needs, and then think about what our priorities should be for the next three years to build on our performance so far.

We have also taken into account the feedback we received on the Council's Adult Wellbeing Position Statement, focusing on how we prevent adult care and support needs from increasing.

The involvement of partners so far gives us a good starting point, but we now need to hear the views of many more partners, especially local residents. Improving and protecting health and wellbeing in Reading will be most effective if everyone works together. This includes individuals, communities, employers and public services.

By consulting on our draft strategy, we want to bring more people into the conversation about health and wellbeing. We want our Second Health and Wellbeing Strategy to describe our shared goals for Reading, and to include an Action Plan which has been developed with the people who will experience and deliver it.

Joint Strategic Needs Assessment (JSNA)

The Reading JSNA presents national data alongside local information - telling 'the Reading story' and giving the Health and Wellbeing Board robust intelligence about the needs and strengths of the local population.

The JSNA is the cornerstone of local needs assessments and commissioning, and it will continue to underpin our Health and Wellbeing Strategy. See: http://www.reading.gov.uk/jsna

Our population – Reading at a glance

Census data from 2011 gives a total population figure for Reading of 155,700 – an increase of 11,300 people over the previous decade. The population is expected to continue to increase.

Reading has and benefits from a strong labour market, a high rate of employment and higher than average earnings. However, there are some areas in the borough that are experiencing high and rising levels of deprivation.

Between the 2001 Census and the most recent Census in 2011, two areas in South Reading - the far south of Whitley ward and to the south of Northumberland Avenue in Church ward - fell into the category of the 10% most deprived areas in England.

In areas outside of the town centre, deprivation appears to be driven by low income, low employment and lack of education and skills, while in town centre areas deprivation appears to be more closely linked to high levels of crime and poor living environment.

Although there are some exceptions, most areas with high levels of overall deprivation also have a high level of health deprivation – meaning a high risk of premature death or reduced quality of life through poor physical or mental health.

Reading is ethnically and culturally rich and diverse. In 2011 the largest proportion of the population (66.9%) identified themselves as 'White British'. This proportion had decreased from 86.8% in the previous census and was considerably lower than the national figure of 80.9%. This tells us Reading has a more diverse population than in other local authority areas, and is becoming more diverse.

People who identify themselves as 'Other White' (covering a number of nationalities, including Polish) account for 7.9% of the population - an increase from 4.2% in the previous Census. South

Asian groups (Indian, Pakistani and Other Asian) accounted for 12.6% of all residents in 2011, an increase from 5.2% in 2001. The proportion of people identifying themselves as Black African increased from 1.6% to 4.9% over the same decade. In the 2011 Census, Reading residents born outside of the UK mostly reported they were born in India, Poland or Pakistan.

As well as a relatively high BME and migrant population, the JSNA identifies other ways in which the Reading population is made up differently from national averages.

The population of Reading is a younger one relative to the whole of Berkshire, the South East, and England and Wales populations. There were 67.0 live births per 1,000 women aged 15-44 living in Reading in 2014. This gives Reading a general fertility rate that is much higher than the national (62.1) and South East regional (61.4) averages.

Specific groups of children are more likely to have particular health and wellbeing needs as described in the JSNA:

- children looked after by the Local Authority
- children subject to a child protection plan
- children and young people not in education, employment or training
- children with disabilities and
- children living in poverty.

The number of older people in Reading is smaller than in other areas of Berkshire. However, whilst Reading expects to see a relatively small increase in the total number of older people compared to other areas, by 2037 Reading is predicted to have a 65+ population of around 31,300.

Successes and challenges

A significant amount of work has been undertaken across the local Health and Wellbeing partnership to support the delivery of the local vision for health and wellbeing since 2013, and much good progress has been made.

- Sexual health services are performing well in general and an information website has been developed.
- The Drug and Alcohol Treatment service has re-launched as the 'Reading IRiS Phased and Layered Treatment Model'. More people are completing treatment with the service.
- We have good and improving services for the care and education of young children (early years settings).
- More newborn babies in Reading are breastfed than the averages for the region or nationally.
- A Reading Domestic Abuse Strategy has been agreed and put in place.
- Support for people with a range of long term conditions is being managed by multiple support activities and relevant boards across the borough.
- A new Carers Information and Advice service is in place, commissioning jointly by the local authority and the clinical commissioning groups.
- Opportunities for active travel have increased through a range of schemes to encourage more cycling and walking.
- National Child Measurement Programme (NCMP) 3 year aggregated data is now available to help target future weight management offers to local school children.
- The number of people smoking across Reading is just below national averages.

However, Reading has some key health and wellbeing needs identified through the JSNA.

- Life expectancy for men is poor, with significantly worse early death rates from cardiovascular disease, and a 10.2 year difference in life expectancy between our least and most deprived wards. Reading has high levels of preventable premature mortality and low uptake of screening programmes in key areas e.g. breast and bowel screening.
- Reading has higher levels of some infectious diseases, particularly sexually transmitted infections and TB.

- Reading has higher levels of homelessness, including families, and higher rates of unemployment. Crime rates are also higher than expected
- Reading has a largely young population (25% of the population are under 20) and we see a significant impact of mental illness on our children's health.
- During primary school we see a doubling of rates of obesity, and significant numbers of children have tooth decay.
- Reading has low levels of school readiness, and in older children educational attainment in children who are eligible for free school meals is less than 50% of that seen in children not eligible. We also have higher than expected numbers of young people not in education, employment or training.
- Reading males show significantly higher rates of death as a direct result of alcohol, mainly alcohol associated cancers and chronic liver disease. The prevalence of opiate users is also higher than seen in similar populations.

Financial context

Organisations are facing challenging budget pressures and 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. Responsibility for meeting the local challenges will be shared between individuals, families, communities, local government, business and the NHS.

Empowering people to take charge of their care and support

Across the Health and Wellbeing Board, we believe that individuals should feel that they are in the driving seat for all aspects of their and their family's health, wellbeing and care. This applies to people maintaining their wellbeing and preventing ill health, as well as people living with a long-term condition who want to keep as well as possible and manage the condition to avoid it getting worse. People should be true partners in their care so that decisions are shared as far as possible, based on the right information and genuine dialogue with health professionals.

Many teams across different sectors 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. Every contact we have

with individuals is potentially an opportunity to encourage someone to make a positive lifestyle change. Through MECC training, 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.

Delivering this strategy

Our 2nd Health and Wellbeing strategy has been developed after a review of Reading's Health and Wellbeing Board by a group of our peers from Health and Wellbeing Boards in other areas. We are responding to their finding that our strategy should be used to drive the agenda of the Board, and have identified key priorities which we will use in future to do this.

It is important to identify core members of the Health and Wellbeing Board who will commit to working together throughout the life of the strategy. However, we will use our monitoring and review of agreed actions as opportunities to bring more people into health and wellbeing conversations. We particularly want the voice of local residents, and those who use health or care services, to be strong in our future discussions.

As well as checking on progress on our Health and Wellbeing priorities, the Health & Wellbeing Board will maintain close links with other local partnerships which are taking the lead on actions which have an impact on wellbeing. The Health and Wellbeing Board wants to work with these partners, and we will invite groups to report to us on their progress as well as presenting their requests or recommendations to us.

We have a responsibility under the Care Act to make sure our residents have a good range of wellbeing services to choose from. Our aim is to continue to have a vibrant local market, which is resilient to funding challenges. The third sector is key part of this. We also need a co-ordinated approach to working with the business sector – as service providers, as employers, as a source of expertise, and as part of Reading.

Going forward, we will work together on developing our information resources so as to connect people to the right health and wellbeing support at the right time, making the most of new technology. We want people to be more in control of their health, care and wellbeing and there is huge potential to support this through co-ordinated digital solutions.

How we will measure success

We have established a robust and proportionate performance management framework so that we can measure progress and better understand where we may need to divert additional resources as we tackle the various challenges we face in terms of promoting health and wellbeing in Reading in the future.

A dashboard of key performance indicators has now been developed to enable clear and transparent progress monitoring. This will cover the commitments and actions set out in a Health and Wellbeing Action Plan to accompany this strategy.

The dashboard will also support the Health and Wellbeing Board to track progress against the various other aspects of health and wellbeing which partners are addressing as part of their core business alongside working towards the goals of the Health and Wellbeing Strategy.

Our priorities

Priority 1: Supporting people to make healthy lifestyle choices focused on:

- dental care
- reducing obesity
- increasing physical activity
- reducing smoking

By 5 years of age, children in Reading are assessed as having more Decayed, Missing and Filled (DMF) teeth than the average for England as a whole. Reading's rates of DMF teeth in children at ages 3 and 12 are also above England averages, and for children up to the age of 2, service uptake is very low.

Obesity significantly increases the risk of numerous long term conditions including type 2 diabetes, cardiovascular disease and high blood pressure.

Obesity is also known to impact negatively on educational attainment, mental health, respiratory and musculoskeletal disorders.

For those with a Body Mass Index over 40, excess weight can shorten a person's lifespan by an average of 8-10 years. 61% of adults in Reading are overweight or obese. Although this is lower

than the England average rate of 64.6% and compares favourably with similarly deprived local authority areas, the absolute figures are significant and, without action, this will have a huge impact on our residents' health and quality of life.

Data from the National Child Measuring Programme (NCMP) shows that the levels of childhood obesity in Reading in Reception Year children and Year 6 children have consistently remained above the South East average.

The Active People Survey 2014 shows that in Reading, 50.4-59.5% of residents achieved the Chief Medical Officer targets for physical activity. This is lower than the average in the South East region, but similar to the England average. However, the figures indicate that 40.5-49.6% of local residents still aren't doing enough physical activity to protect their health. Physical activity can help to prevent and improve the management of a range of long term conditions, and help people to enjoy a healthier and more independent life. It is a part of various local initiatives already, but needs to become a more explicit priority.

Estimated smoking prevalence in 2014 in Reading was 17.0% - similar to the national average. This equates to just over 21,000 people (adults) in Reading. It is estimated that smoking costs society approximately £1,700 per smoker. The total annual cost to NHS trusts in Reading as result of smoking-related ill health (including passive smoking) is approximately £4.4m

Reading has a higher rate than average of premature death, with a particularly high rate of deaths from heart attack and stroke and cancer. Smoking-attributable morbidity and mortality is preventable and a significant number of lives could be saved if we are able to prevent uptake and reduce prevalence both nationally and locally. The most significant thing that a smoker can do to improve their health is to quit smoking.

Smoking increases the risks of ill health, including infections in children, and in the long term it causes conditions that significantly affect people's everyday lives, putting them at considerable increased risk of serious illness and early death. This risk applies to children and young people who are exposed involuntarily to second hand smoke, including babies born to smoking parents, both during pregnancy and after.

We want to see that healthy lifestyles are promoted vigorously in a variety of settings so that every Reading resident has a chance to maximize their health and quality of life.

In particular, we will work to deliver priorities identified within the Healthy Weight Strategy for Reading, which sets out how children and adults in Reading will have the opportunity to achieve and maintain a healthy weight by supporting them to make healthy dietary choices and choose a physically active lifestyle.

We want to see improved provision and sharing of information about lifestyle and weight management services and promotion of walking and cycling, both for leisure and active travel purposes.

The focus for smoking across Reading remains on prevention of uptake - whilst we have seen a consistent decline in the estimated prevalence locally, we want to see continued action targeted on stopping people from starting smoking and - via local stop services and promoting smoke-free communities - helping those who want to stop to quit and remaining quit in the long term.

Priority 2: Reducing loneliness and social isolation

A wealth of evidence has emerged in the last few years about the significant negative impact of loneliness on physical and emotional health – now seen as on a par with smoking for the elderly.

Studies have shown that services that reduce loneliness have resulted in:

- fewer GP visits,
- lower use of medication,
- lower incidence of falls,
- reduced risk factors for long term care,
- fewer days in hospital,
- fewer physician visits and outpatient appointments, and
- fewer – or later - admissions to nursing homes.

National data indicates that 10% of people aged 65+ are 'chronically lonely' which would translate to 1,720 chronically lonely older people in Reading.

Most research in this area has focused on the elderly population. However, loneliness can be a health risk at any age. 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 without public toilets or benches;
- lower income;
- fear of crime;
- high population turnover;
- becoming a carer.

Many of these risk factors are associated with advancing years, but not exclusively.

Mental health problems during pregnancy and the first year after birth are often under-reported, under-diagnosed and under-treated. Up to one in five women and one in ten men are affected by mental health problems in the perinatal period. Unfortunately, only 50% of these are diagnosed.

Tackling social isolation during this period has the potential to impact positively on mild and moderate depression at this time and on parents' ability to relate to their child and the child's development.

Our aim is to develop our understanding of who in our community is most at risk from loneliness, and develop a co-ordinated all-age approach to reach those most in need of support to connect or re-connect with their community.

Our approach will include direct support to improve the quality of people's community connections as well as the wider services which help these relationships to flourish – such as access to transport and digital inclusion.

Priority 3: Reducing the amount of alcohol people drink to safer levels

The Reading Drug and Alcohol Misuse Needs Assessment highlights that alcohol, mainly in the adult population, is a far greater problem than drug use in Reading. This is the same in other areas of the country.

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 as research shows that people tend to under-report their drinking quite significantly, we can infer that people's true drinking levels are even higher than this.

Reading has high rates of alcohol-specific mortality and morbidity from chronic liver disease in both men and women. These rates indicate a significant number of people who have been drinking heavily and persistently over the past 10-30 years. There are very many more people in Reading who could benefit from specialist treatment than are currently able to receive it.

As well as increasing the risk of certain diseases and health problems, the use of alcohol affects behaviour and risks in the short term and can have a negative effect on relationships, work and personal safety.

Alcohol use is sometimes classified as:

- 'risky' (drinking at a level that may cause physical or emotional harm, or cause problems in a person's life in some other way);
- 'harmful' (drinking at a level that has already led to harm) or
- 'dependent' (heavy drinking where the person has become physically dependent on alcohol and will require detoxification to stop using safely).

Our work will focus greater emphasis on the problems of alcohol misuse at all ages. We want to see greater emphasis on prevention, particularly targeting under 18 year olds, with specialist family support in place for children at risk.

We want to enable and encourage frontline staff in all sectors to do more to identify people at risk of harm from alcohol use, and to provide a brief intervention or refer people for specialist treatment where appropriate.

Priority 4: Promoting positive mental health and wellbeing in children and young people

Children's social and emotional wellbeing is important not only in its own right, but also a contributor to good physical health and as a factor in determining how well children do at school.

In 2013, 1,902 children aged 5-16 living in Reading (9.1% of the total) were estimated to have a mental health disorder. Children and young people who are living in more deprived areas, are disadvantaged, have vulnerable backgrounds or may be living a chaotic lifestyle are more likely to have mental health issues.

National policy as set out in *Future in Mind* (Department of Health, 2015) is to improve mental health service provision for young people by delivering on 5 key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support - a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Whilst Reading has a range of projects in place to promote and address children and young people's mental health, surveys, workshops and reports undertaken by Reading Children's Trust, Healthwatch and Reading Youth Cabinet have highlighted recommendations for improvements in local services and support for children and young people with mental health conditions.

The earlier interventions happen the more likely it is that children and young people can be resilient at difficult points in their lives. Early Intervention services should equip children and young people to cope more effectively, and provide timely support.

We will drive forward improvement and change through a local *Future in Mind* process. We want to promote greater awareness around understanding, identifying and talking about emotional health and well-being issues, covering areas such as attachment difficulties, bullying and self-harm.

We want to promote the inclusion of families in the support process as well as including peers and friends, particularly to help young people feel and think differently about mental health issues with less fear, stigma or discrimination.

Priority 5: Making Reading a place where people can live well with dementia

Dementia can have a huge impact on individuals and families, and when communities aren't dementia-aware and dementia-friendly, the condition can severely curtail people's ability to live independently.

Family carers - so often the key to people being able to live within their communities with a long term condition - face particular challenges when caring for someone with dementia. Those carers often feel they are 'on duty' 24 hours a day, and their previous relationship with the person cared for changes more dramatically than it does for carers of people with other long term conditions.

As well as the personal cost, dementia costs the UK economy an estimated £26billion per year.

Dementia is more common in older people, with a particularly marked increase from age 80,

although those with early onset dementia face particular challenges. Rates of dementia can be brought down through lifestyle improvements, e.g. programmes aimed at reducing blood pressure and cholesterol levels. However, dementia is still a major health and social care challenge because of the anticipated growth in the number of people who are living for longer.

Reading currently has an estimated 1,500 people aged 65+ living with dementia. This figure is expected to increase by 50% over the next 15 years.

Reading has had a Dementia Action Alliance in place since 2013, bringing partners together with the aim of improving the lives of people with dementia and their carers.

Although dementia diagnosis rates are improving, they are still quite low in some communities. Over the next three years, we want to improve awareness and understanding of dementia in Reading, giving people the information they need to reduce the risk of developing dementia as well as to live well with dementia.

People with dementia should have equal access to the health and wellbeing support which is available to everyone. Enabling more people to live well in their community with dementia involves bringing a range of agencies together and raising awareness on a large scale.

Priority 6: Increasing breast and bowel screening and prevention services

While the chances of being diagnosed with cancer or dying from cancer in Reading are similar to elsewhere in England, cancers are still the most common cause of premature deaths in Reading. Cancers are responsible for 142 deaths in every 100,000 people aged under 75 in Reading.

Rates of incidences of cancers and mortality from cancers are increasing. Cancer incidence increases with age and is more likely in people who come from more deprived socio-economic groups.

Reading's cancer rates are highest in three of the wards that include very high areas of deprivation – Abbey, Norcot and Whitley.

The number of people who take part in screening for breast, bowel and cervical cancers in Reading is lower than the national average. This tells us that more could be done locally to prevent harm from cancer if we understand and then overcome the barriers which stop people from taking part in screening. We want to:

- increase awareness of early cancer symptoms and of the screening programmes available, with the aim of increasing screening uptake and improving early diagnosis.
- support people in their understanding of cancer, and enable people to make healthy lifestyle choices.
- concentrate our efforts especially in areas with high deprivation and where smoking and alcohol use are known to be higher.

Priority 7: Reducing the number of people with tuberculosis (TB)

In Reading, we have rates of TB that are significantly higher than the national average. In 2014 there were 65 new cases of TB, with an incidence rate (number of new cases) of 40.8 per 100,000 population. The three year incidence of TB in Reading has remained higher than the England rate since 2000. The number of new TB diagnoses over a three-year average was 36.3 per 100,000 people living in Reading each year from 2012 to 2014.

Although rates of TB in Reading are among the highest in England outside London, TB services are good, as evidenced by high TB service completion rates at 12 months. The proportion of people completing treatment for TB within 12 months of diagnosis for Reading was 90.0%, compared to the all England figure of 84.8%.

We want to focus efforts locally on promoting awareness of the symptoms of the disease, and encouraging people to seek advice and receive treatment as soon as possible.

We also want to make our approaches more localised to reach effectively into the different communities of Reading at greater risk of having the disease or of failing to take up treatment.

A week in A&E: findings of a Healthwatch Reading project to collect patient views

Where: The Emergency Department, Royal Berkshire Hospital, Craven Road, Reading, RG1 5AN

When: Monday 16 to Sunday 22 May 2016, for 2 to 4 hours each day, making a total of 10 visit sessions

Who: 249 people (238 adults and 10 young people) in either the adults or children's waiting areas, shared their views.

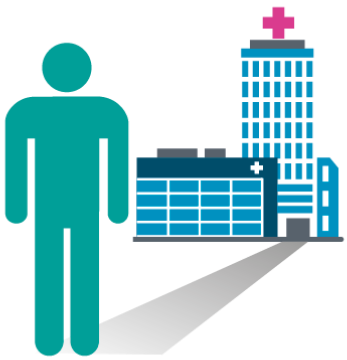
Why: To collect people's experiences about what services, if any, they contact before coming to the ED and what factors influence their decision to go to A&E, in order to inform commissioners as they plan and make changes or improvements to urgent care and other services

How: People filled in an anonymous 2-page survey handed out by a Healthwatch Reading staff member or volunteer; Healthwatch Reading also spoke in-depth with some people who wanted to share more details. The visits were agreed in advance with the hospital. The findings have been independently produced by Healthwatch Reading, under its statutory Enter and View function.

Main findings

The most common health problem leading to a person's visit to the emergency department was:

- an accident (39%, 93 out of 239);
- a new symptom/problem (14%, 33 out of 239); or
- a change or worsening of a long term condition (10%, 25/239)



25% **of people also described 'other' issues** - ranging from a bee sting, to lump in the head, eye or dental problems, swollen tongue, back pain or chest pain.

Nearly half of people (48%, 113 out of 236) had experienced their health problem for a duration of 1-7 days beforehand

More than half of people (55%, 127 out of 232) had tried to seek help from other services before going to the emergency department.

Turn over for more survey findings

Most of these people sought help from:

- their GP (73%, 93 out of 127)
- the NHS 111 telephone helpline (33%, 42 out of 127)
- an NHS Walk-In Centre (15%, made up of 13 people who visited Reading Walk-In Centre; and 6 who went to one outside Reading)
- their GP out-of-hours service (12%, 15 out of 127)

Only 4% of people had contacted a pharmacist

Only 1 person said they had sought advice from the NHS Choices website

79% of people (99 out of 140) said the service they had contacted beforehand, advised them to go to the emergency department:

'The walk-in centre wrote a letter for me for A&E.'

'111 called an ambulance for me. After 1 hour, an ambulance 'nurse' called and said that they had no spare ambulances and after discussing symptoms she advised I went to casualty myself rather than wait for an ambulance to become available.'

'GP said it would be 'safer' to go to A&E.'

'Yes, told me to go to A&E next day if still bad.'

'GP said come to A&E if still feeling pain after a few days.'

The 83 people who did not contact a service before they came to the emergency department, selected these main reasons:

- **they believed A&E had machines, technology, or medicines that were not available anywhere else (28%, or 23 out of 83)**
- **they believed their problem was very serious (27%, 22 out of 83)**
- **they believed A&E had staff/experts they would not find anywhere else (23%, 19 out of 83)**

One-quarter of people (20 out of 83) gave a variety of 'other' reasons, including:

- 4 who mentioned suspected broken limbs
- 3 who said another service would not be open
- 3 who raised concerns about how another service would handle their problem

'Sunday – GP not open.'

'19.30 on Friday ruled out GP.'

'Experience of other services are they are not very responsive. Felt it was too late to go elsewhere.'

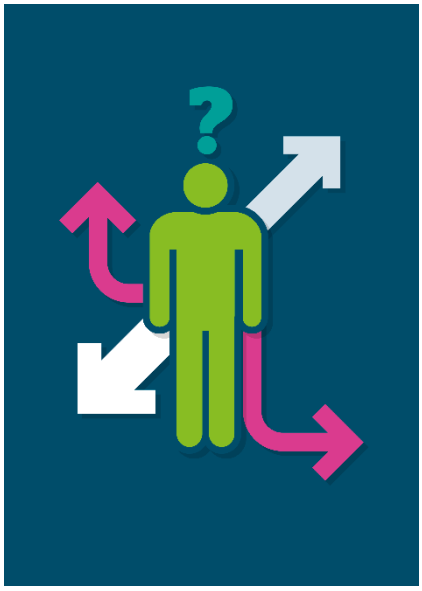
'Would've been sent for X-ray.'

'I have broken enough bones to know how one feels different to a muscle injury.'

'Spent 40 mins on phone whilst in a lot of pain. Told Dr may call, waited 30 mins, didn't call, so called 999, didn't know how long ambulance would be, so brought in by car.'

People who did not contact a service before they came to the emergency department, said they would consider doing so in the future, if:

- they had more information about alternative services in their area (48%, 34 out of 71 people)
- they had more information about what health issues/symptoms/injuries, other services can see or treat (32%, 23 out of 77)
- other services had extended opening hours (28%, 20 out of 77)



Of the 14 people who volunteered extra feedback on this question, 6 mentioned the need for a service offering X-ray:

'Anywhere with an X-ray unit.'

Other feedback volunteered by respondents

'A&E is very helpful and quick most of time, all staff polite and very clean.'

'Surprised how well A&E works. Do need to wait but service good.'

'Long waiting time, especially with a baby.'

'Went to my GP this morning to have the dressing changed before an appointment as advised. The GP told me to go to A&E as the wound is quite complex and they are better placed to re-dress it.' (Wokingham person)

'The lab contacted GP, who called me at 5pm and advised to go to A&E for re-test as may require Vitamin K.'

'Called doctor's surgery twice and they failed to return our calls, very disappointed, very poor service from our surgery, this left no alternative but to come to A&E.' (Wokingham person)

'Surgery advises attend A&E as no appointment in morning - could only see child later that afternoon.' (South Oxfordshire person)

'There was different advice at different services. 111 said to go to walk-in centre for minor injuries, but walk-in centre can't do X-rays so advised to go to A&E, rang 111 to check this was okay, 111 said no food or drink, water or pain relief. A&E said always okay to give pain relief.'

'If you ring 111 they cannot answer many of the questions.'

'I think he needs an X-ray so presumed we could only get in A&E.'

'Accident required stitching.'

'GP surgery said [I] would get a call back but didn't say when.'

Other feedback continued…

'I hope GPs can have more time with patients and listen carefully and watch their patient for possible illnesses. Left unrecognised, things get worse…GPs should not be thinking of profit, should think of the patient's health.'

'GP unable to see an acutely unwell child and advised 999. I did not feel this was necessary and so went to urgent care centre and they advised making my own way to A&E.' (outside of Reading)

'First aider suggested going to A&E. Have used walk-in centre before and think it is good. Wouldn't want to wait twice - walk-in centre limited to what they can do with breaks.'

'Think it needs a butterfly stitch.'

'I am away from home yet I would still have gone to A&E as I have [a] heart condition - I do not know what other services can offer for example ECHO, ECG, X-ray.'

'I do not think online services are the answer, the 'Dr Google' concept is causing more unproved diagnosis and hypochondriacs as opposed to expert advice.'

'I am worried about wasting time here….there have been delays in getting appointment at surgery.'

'Came to A&E as require an X-ray which is not available elsewhere to my knowledge.'

'I had seen my GP x2 time in the period of 2 weeks. I was left with just some pain relief. I also called ambulance as I was unable to mobilise at all but they never seemed concerned.'

'Doctor not listening to patient who is in pain and feet swollen. Hoping for an X-ray or scan.'

'The consultant [oncologist] told me to go to A&E if I had any problems.' [Elderly, post-operative, cancer patient]

Turn over for more survey findings

Observations about the ED department

During each of the 10 visits over the week, four different Healthwatch staff members, assisted by a pool of six volunteers (members of North & West Reading Patient Voice, and South Reading Patient Voice), made observations about the ED reception and waiting areas.

Overview: The adults waiting area is through two double sliding doors. In between these doors is a lobby area with food and coffee vending machines, plus toilets. The reception staff are situated in an enclosed admin unit behind glass windows and the check in windows are straight ahead as people enter through the second set of doors. The waiting area is an L-shape which means that some patients are out of sight. There are approximately **30 check** hard seats bolted to the floor. There is a television on one wall showing programmes but it is not visible to everyone in the waiting room. There is also another monitor attached to another wall showing information about the hospital. There is an electronic display showing approximate waiting times.
There are some posters up, including one about healthy eating. There is a free water dispenser.

Specific observations:

- During all 10 sessions it was observed that some patients appeared confused about the function of, or did not notice, a taped red line on the floor, meant to indicate the place to wait until you were called to the reception window in the adult's ED department
- During all sessions we noticed some patients waiting for some time to be called to a reception window, because the reception staff member was talking to another staff member, or staff did not look up from paperwork or did not make eye contact with arriving patients
- Sometimes a person was sat at each of the two reception windows in the adults ED department, but only one person was greeting patients and the other was doing other work – some people commented that it looked as if the second person was ignoring patients as there was no sign to indicate that they were not carrying out duties to check in patients

Case study: Friday night in A&E

A Healthwatch staff member and volunteer from South Reading Patient Voice visited the emergency department from 8pm-10pm on Friday 20 May 2016.

When they arrived it was very busy. All the seats were taken and people were standing in the main waiting area, the lobby area and outside the main doors. It was unclear where the reception queue was due to the amount of people congregating and by 9pm there were also four people waiting in wheelchairs which added to the cramped feel of the small waiting area.

The water in the free dispenser was tepid and the automatic doors made an almost continuous squeaking noise opening and shutting.

A number of people appeared to be in distress and in pain. Patients could not always hear the names of people that clinicians were calling to come in to be seen.

At around 9.45pm, an A&E consultant came out and stated that due to severe pressures, and the number of ambulance cases, that the wait time would be at least four hours and that if there was anyone who could return tomorrow, or go to a pharmacist, then they should.

Nobody appeared to leave as a result of this statement.

The next patient who was checked in was asked by Healthwatch if she had been told by receptionist that the waiting time was four hours - she said no she was not told.

Despite the long waits, patients appeared to be generally good natured and resigned to sitting it out to be seen.

Observations continued…

- We observed one reception staff member help to defuse a situation where an adult patient had become agitated about the length of their wait – the staff member came out to the waiting area to sit and talk to a patient and advised them that it was nearly their turn to be seen
- A notice taped to the adult ED reception window glass advising patients to ask for interpreters if needed, was in English and not translated into other languages
- The automatic doors into the adult ED reception area often slid open and shut constantly because of proximity to the queue of people waiting to be checked in or when people were standing because all seats were full, and was very squeaky, meaning that people often could not hear their name being called out

Turn over for more survey findings

- Adult patients were called in to the clinical area in a variety of ways: some nurses or doctors stood at the doorway of the clinical area and shouted in clear voices, some spoke quietly and could not be heard in the part of the waiting room out of view, and some staff walked right out into the waiting room and walked around and repeated names until they found the patient
- We observed multiple occasions of clinicians calling for patients who had already been called previously into the clinical area
- We spoke to one woman who had been told by reception that she would not be seen for at least three hours, so she decided to go to another part of the hospital for food; her name was called out almost immediately after she left (we advised the patient on her return and she contacted receptionist and was seen shortly after)
- The sign advising people how long they might have to wait is not visible when first entering ED reception area (we have seen this at other services and it can deter people who would prefer not to wait for long)

- The waiting times shown did not always correlate with actual times people waited, especially when it when people appeared to be seen quicker during quieter times
- The waiting time sign was sometimes switched off
- One TV monitor on a wall in adult ED waiting room showed a range of very useful information on a slide-show basis, of various hospital topics (such as a picture of all the different colour uniforms clinical staff wear, and what they mean), but the slides changed too quickly, giving patients only three seconds to read an entire screen. One of the slides asked patients to inform reception if they left the waiting area – this information was not on a static notice elsewhere in the waiting room
- There are not enough seats for all waiting people at busy times
- We observed one group of people go into the clinical area unchallenged, at the same time a clinician was holding the door open and calling out for a different person; these people returned shortly after with a different staff member to direct them to another part of the hospital

- Police were observed bringing in a young woman who appeared very upset to main reception to ask for mental health assessment – she was called through relatively quickly but it raised questions about whether it would have been more appropriate to bring her to 'back door' of A&E to help maintain her dignity
- Police were observed bringing in a bleeding man who had been arrested; again he was called in quite quickly, but is there a policy of taking such patients through the back?
- One adult who attended during a quieter session told Healthwatch he had just popped in to see a clinician friend of his to get his blood pressure checked
- There were no magazines or newspapers provided in the waiting area
- The TV information monitor states there is a Freephone to call a taxi in reception – this no longer exists – although there is a notice about this behind the vending machine in lobby area
- A receptionist did offer to call a taxi for a person who needed one
- The water in the free dispenser was often tepid and sometimes cups were not available
- Many patients asked us where the toilets were (in the lobby area) as there was no signage to the toilets from the main waiting area and they had not noticed them on first entering, as they were preoccupied with getting checked in at reception
- On some days there were no sandwiches in the vending machine in lobby area (run by external company) or the coffee machine was occasionally broken
- Sometimes the toilets were messy and in need of more frequent cleaning
- Because some of the waiting area is out of sight of reception, staff did not notice a situation that could have needed diffusing (person shouting and swearing loudly and another person objecting to this)
- A poster aimed at helping patients choose the right service for their urgent care needs was beside the triage room door where it did not seem to be noticed or read by patients
- Some patients said the drop-off area outside the ED department is not well signed and difficult to access
- Many people complained about lack of on-site parking

Turn over for more survey findings

Observations about the children's department

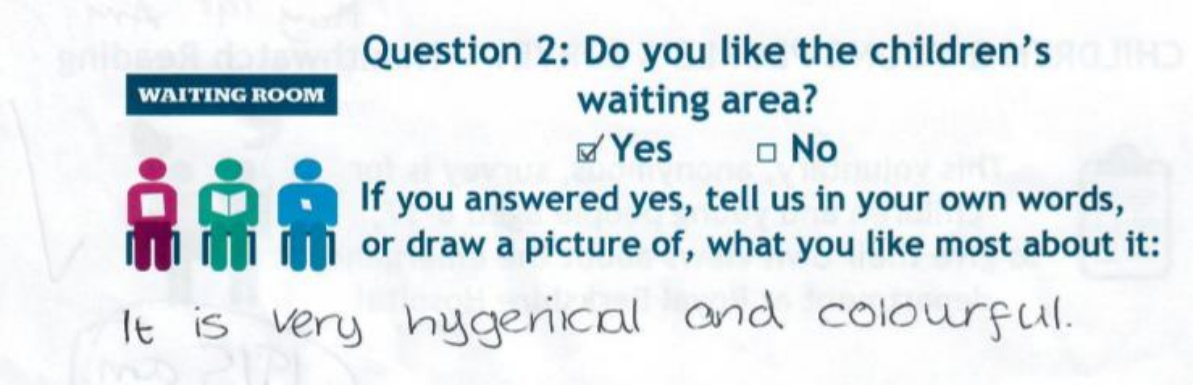
- Brightly coloured walls
- Toys and books provided that appeared to be aimed at toddlers, helped to keep very young patients occupied; not much material for older children
- We witnessed and stopped a child who had run out of the child's waiting area, down the ramp and towards the road outside the department, because the adult they were with was preoccupied
- We observed one child being triaged with the triage room door open – although we could not hear what was said and an adult with the child was stood just outside.
- We noticed a useful poster explaining that even if it seemed quiet, it did not mean that the ED clinical area was not busy – could this also be displayed in adult's waiting room?
- Very cramped when busy

Separate Young person's survey

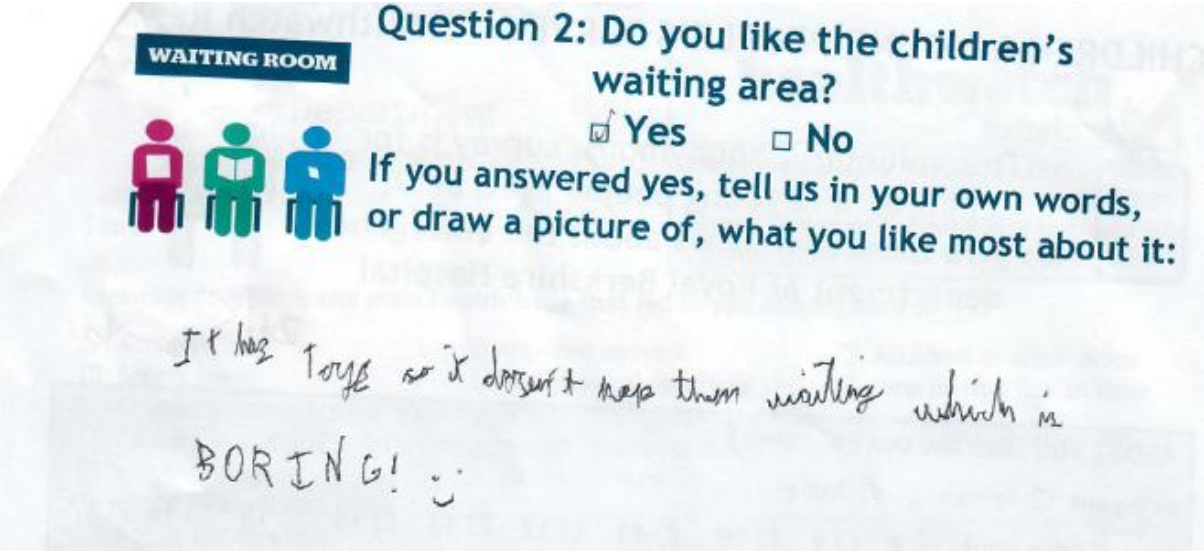
10 children aged 8 to 16 answered a separate, short survey we handed out with their adult's permission, to fill in themselves:

- **All 10 said they liked the children's waiting area**
- **Of the 7 who had been in to see a triage nurse, all 7 said the nurse spoke to them or asked questions in a way they could understand**
- **All 7 who had seen the nurse, said the nurse had been friendly**
- **5 of the 7 young people said the nurse had told them the nurse's name**

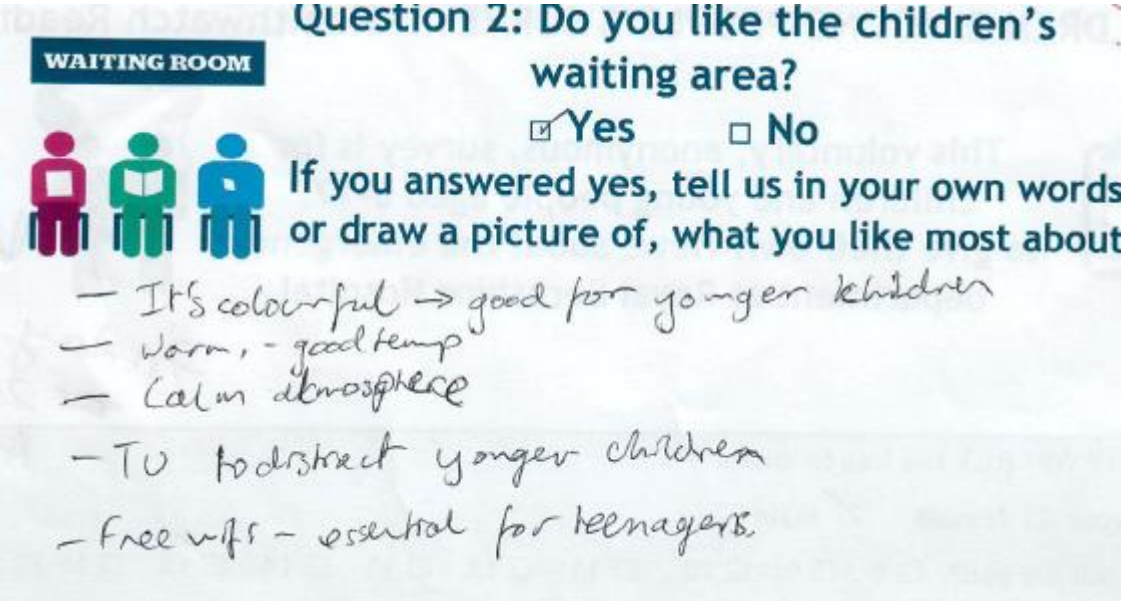
Young people also gave feedback about the children's waiting area:



Comment from 11-year-old girl about the clean and colourful environment



Comment from 8-year-old boy about toys preventing boredom while waiting



Comments from 15-year-old male, including positive feedback about the free Wi-Fi in the waiting area, which is 'essential for teenagers'

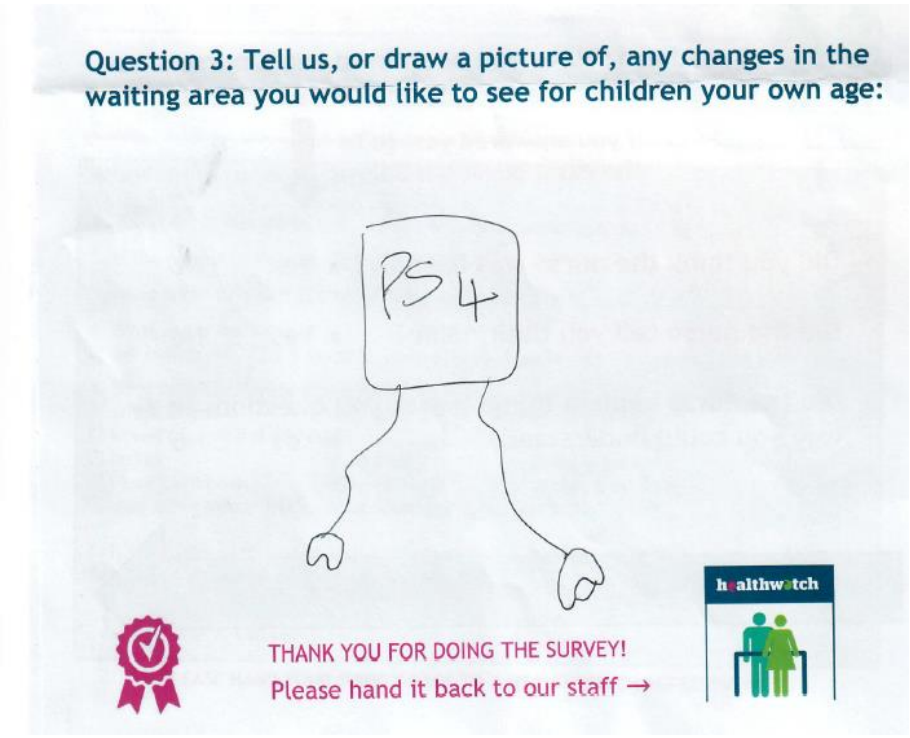
Other comments:

'The painting on the wall.' (9-year-old girl)

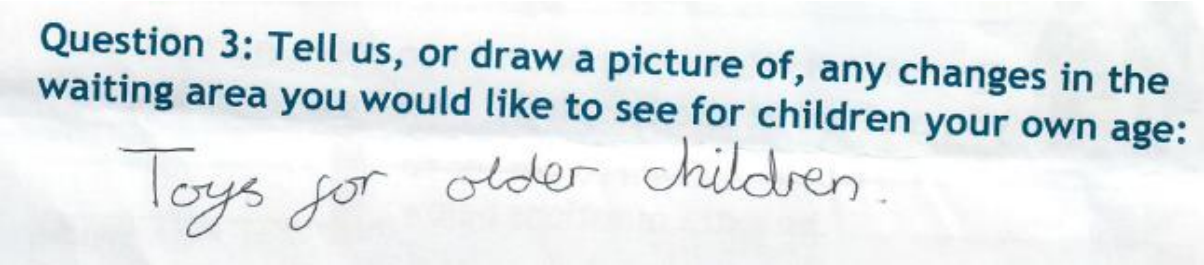
'I liked the walls.' (12-year-old boy)

'Yes it is a good place for children.' (16-year-old male)

Young people's suggestions about the children's waiting area:



A 10-year-old suggested having a Playstation in the waiting area



A 9-year-old girl suggested toys suitable for her age group

Other comments:

'Magazines, newspapers.' (16-year-old male)

'There should be more toys to play with.' (9-year-old boy)

'Bigger space for kid's area.' (12-year-old boy)

'Chairs are flexible, may be more comfortable if they are a bit harder/supportive. Books for teenagers e.g. about tech, science, sport, entertainment magazines.' (15-year-old male)

Turn over for more survey findings

Discussion

We believe our findings raise a number of questions that we urge the Urgent Care Programme Board to consider and report on:

1. **Are common triage pathways/ED referral criteria used by various clinicians and services - including GPs, 111, walk-in centres, urgent care centres, ambulance services and hospital specialists caring for end-of-life patients, when seeking help for problems they believe are urgent? Do people of Reading (and the rest of Berkshire West) get consistent advice about when it is appropriate to go to A&E?**

   Our findings showed that more than half of people contact another service before going to A&E. Some people were told to go 'if your pain gets worse' – leaving a patient to make the decision to attend ED, rather than encourage them to seek a re-assessment.

   We also spoke with cancer patients who had been told by their specialist nurses or consultants previously, to go to ED should their condition worsen – could these cases be better managed in the community?

   Similarly, a 'complex' wound was sent to be re-dressed in ED – could this be managed in the community by nurses with appropriate training?

   A national report published last May also showed 'a *substantial proportion*' [nearly 40%] of the 924 people surveyed, '*attended because they had been advised to do so by other healthcare providers*'. The joint findings from The Royal College of Emergency Medicine and the Patients' Association, adds that '*this suggests, that like patients, many healthcare providers behave and give advice based on a lack of confidence in viable alternatives to the A&E service*'. (See http://www.patients-association.org.uk/wp-content/uploads/2015/06/rcem-pa-report-time-to-act.pdf)

2. **Are clinical quality audits regularly carried out of referrals made to A&E by other healthcare services to assess their appropriateness?**

   We noted that when people were being checked in at ED, they were asked which GP practice they were registered with. We are unsure if the hospital also routinely asks and records if people contacted services beforehand and if so, who advised them to go to A&E? Such information, if audited over a longer period of time and with more people, could establish trends about current advice given and where any improvements could be made.

   We also query whether various front-line professionals meet to jointly carry out an in-depth examination of retrospective ED attendances, to share learning about how cases could have been handled differently.

3. **Do we need to consider restructuring local urgent and emergency care services?**

   An NHSE report on transforming urgent care published in August 2015, suggests that '*the co-location of primary care out of hours' services with emergency departments provides opportunities for collaboration, routine two-way transfer of appropriate patients and can help decongest emergency departments (see: http://tinyurl.com/og9qv7t for further guidance on primary care supporting emergency departments).*' See https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

   We also note that a large number of people in our survey said they had attended ED seeking an X-ray as they were unaware of any other alternative sites that offered this. The raises issues about how well alternatives such as the minor injury unit at West Berkshire Community Hospital in Thatcham or the minor injury unit at Townlands Hospital in Henley. And is there a case for X-ray facilities to be situated within Reading's walk-in centre, or within a new site altogether within Reading?

Turn over for more survey findings

4. **How can we improve the information given to the public about using the right service at the right time?**

   Nearly half of all people in our survey who didn't seek help beforehand, said they could be persuaded to do next time if they had more information about alternative services. Some people had made assumptions that only A&E had equipment to undertake certain procedures or they felt that a visit to a WIC would be a doubling up of their time because it would send them to A&E anyway. Some people also automatically assumed they could not access any GP service after hours.

   This raises the need for more detailed information listing what procedures or treatment, various urgent care services can provide. The Reading Walk-in Centre website and patient leaflet for example, states it can treat 'minor injuries and minor illnesses' but does not define what these are. Would a worried parent suspecting their child needed a stitch for a cut to the head know whether the WIC could treat this, or would they head straight to A&E? In contrast, and by example, the West Berkshire Minor Injury Unit includes a long list of the type of thins it can treat, for patients' information (http://www.berkshirehealthcare.nhs.uk/ServiceCatInfo.asp?id=62).

   The NHS has run previous advice campaigns, including 'Choose Well' and Know Who To Turn To and various local evaluations have been published, suggesting flyers, posters or booklets are most remembered by the public.

   The Know Who To Turn To guide in Scotland included examples of the types of symptoms people could self-manage or could be assessed by various professionals. The guide included a listing of local minor injury units and their opening hours. http://www.know-who-to-turn-to.scot.nhs.uk/pdf/21396_UnscheduledCare_WEB_1707.pdf

   A 2012 discussion paper by the Primary Care Foundation (whose directors include the GP author of Carson Report commissioned by the DH) found that '*information for the public about opening hours and the range of available services is incomplete and*

unreliable. In too many centres, services vary depending on which members of staff are on duty.' The foundation's report Urgent Care Centres: What works best, also recommended *'that at least for NHS Choices, a consistent structure is used that makes plain what conditions can be treated and whether there are limitations on prescribing, for example because the service is staffed only by nurses.' It also said 'commissioners should also make sure that the advertised services are available consistently over time and not subject to variation depending on who is on duty. Finally, we urge commissioners to review the multiplicity of names for urgent care services in their locality and look to simplify these in the interests of clarity for users.' One suggestion in the report was to call urgent care centres 'Local A&E'.*

Healthwatch England (HWE) has raised similar concerns. In a 2014 poll of 1,762 people that HWE commissioned from YouGov, around a third of those who responded said that they didn't know where their nearest minor injuries unit or NHS walk-in centre was or the services it provides. The survey showed while 4 out 5 people said they were aware of NHS 111 just 1 in 5 reported having used it, or its predecessor NHS Direct, when in need of urgent care. HWE said *'blaming people for going to the 'wrong place' when we need care and support is the wrong way of looking at the problem…until the health and care sector offers a more consumer-friendly experience, things are unlikely to improve'.*

Healthwatch Reading believes that the need for information raised about alternatives to A&E by our survey respondents, and national findings, make a strong case for a more detailed, bespoke urgent care 'map' or guide be produced for people in Reading and the rest of west Berkshire. In particular, people need examples of types of symptoms, injuries or illnesses can be treated by various services and when.

What would be the impact, for example, of creating a leaflet of all the conditions/injuries that the Reading walk-in centre can (and cannot) treat or assess, and leaving it on every waiting room seat in every GP surgery in Reading? Would it lead to more appropriate use of A&E and the centre?

Turn over for more survey findings

We would recommend that any new guide on choosing an urgent care service is translated into most common languages other than English, spoken in Reading, and that pictorial, or Easy Read guides are produced to recognise low literacy levels or learning disabilities.

Healthwatch Reading is willing to work in in partnership with commissioners and/or providers to co-produce or road-test with members of the public, draft guides and other information.

5. **What can be done to prevent ED attendances prompted by dissatisfaction with other services?**

   A small number of respondents mentioned they had chosen to got to A&E because of dissatisfaction with how unexplained symptoms had been managed in primary care. We spoke with one woman who said she had come following three previous visits to her GP, which had left her pain issues unresolved and she felt she needed tests or investigations. This raises issues about the time GPs have to spend with patients to discuss symptoms in more detail and explain why tests may or may not be suitable to carry out.

   Some people also mentioned not getting called back by their GP surgery about their urgent problem, which indicates ongoing pressures on GP surgeries to cope with patient queries or issues with administration.

The following questions for discussion relate to the observations we made and patient feedback about the environment of the ED waiting rooms.

6. **What can be done to improve the 'check-in' experience of people arriving at A&E?**

   During peak times, patients often are unsure where to queue, as there is only a taped red line on the floor, which may be obscured by crowds of people waiting to be called in. Patients may also be unsure which of the admin staff that they can see through the glass windows is checking people in, as there may be a slight delay in being noticed by a receptionist. Have other

check-in ideas been explored to improve this experience – such as:

- a physical stand as used in banks or department stores for queuing
- a 'window closed' sign on the reception window not checking patients in, so people do not think the staff member is ignoring them while they carry out other admin duties in sight of arriving patients
- a 'greeter' standing in the hospital waiting area, in a similar way to how Reading Borough Council offices have a receptionist to meet arriving people to give them initial information and a 'customer-friendly' experience.

Is it also possible to add a second electronic sign displaying the wait times, very near reception windows, to give people immediate information on how long they will have to wait?

We would also like to clarify if there is a hospital policy of which entrance police should use to bring people needing medical attention, particularly those needing mental health assessments as a result of threatened suicides, in order to protect the dignity of these patients.

7. Could changes be made to improve the overall experience for patients and relatives/friends, while they are waiting to be seen?

The inadequate size of the ED department has already been acknowledged by the hospital at a time when demand is growing to sometimes more than 300 patients per day.

However, we still believe there are some improvements that could be made within the department, including:

- signage to the toilets from the waiting area
- more posters translated into other languages, especially the poster informing people about requesting an interpreter if needed
- alterations to the TV information screen so people have more time to read each topic
- fixing the squeak in the automatic doors
- more frequent restocking of cups for water

- providing chilled free water
- reviewing the frequency of how often vending machines are filled
- suppling reading material like newspapers
- supplying reading material for older children in the children's ED
- ensuring the waiting times displayed electronic are accurate.

8. **Could changes be made to the way patients are called through to the ED clinical area?**

   We observed that the system to call patients in to the clinical area is inadequate because patients cannot always hear their name being called.

   Have other systems been considered – such as electronic signs as used in GP surgeries, or ticket/number calling? We also query what systems are used in the clinical area to show clinicians which patients have gone through, given the amount of times we witnessed patients being called to go in when they had already gone through some time previously?

9. **Can more in-depth research be commissioned in the future on the patient's journey, before, during and after ED?**

   Our survey focused on getting a good sample size, which meant we had less time to focus on getting in-depth patient stories about their journey before, during and after the ED. An interview with a person, and subsequent transcribing and analysing takes approximately one hour per person. We recommend that future retrospective audits be commissioned to examine the appropriateness of the advice given to patients seeking urgent care, factors influencing patients' own decisions to go to A&E, and any factors influencing subsequent repeat visits.

Conclusion

In conclusion we request that the Urgent Care Board uses this report to discuss and debate the points raised by the findings and our own suggestions.

We appreciate that there may be no immediate solutions to the questions we have raised in the report. However, we would request that the Urgent Care Board provide written feedback to Healthwatch Reading by the end of September 2016, detailing their reaction to the findings, and how any of the findings or questions posed will be considered and incorporated into future local work on urgent care services. We also ask the hospital to provide a specific response on suggestions we have made about improving the ED waiting room experience for patients.

We plan to publish an abridged version of this report for the public in September, which will explain that we have sent the findings to the board for consideration. We can update this with the Urgent Care Programme Board's response as we receive it.

Appendix 1: About the people who answered our survey

- 68% (156 out of 230) said they were the patient
- 29% (67 out of 230) were a relative or friend of the patient
- 3% (7 people) had 'other' roles, such as being a care worker

- 57% of the people who took part (131 out of 230) were female; 43% (99 out of 230) were male; no-one said they transgender

- Working-age adults made up most respondents:
  - 25-34 years (15%, 34 out of 223 people)
  - 35-44 years (14%, 32 out of 223)
  - 45-54 years (10%, 22 out of 223)
  - 55-64 years (9%, 19 out of 223)

- Of patients aged under 18, the biggest groups were:
  - 6 months-4 year-olds (9%, 19 out of 44 patients)
  - 5-10 year-olds (6%, 13 out of 44)
  - 11-17 year olds (4%, 9 out of 44)

- White British people were the biggest ethnic group in the respondents (68%, 154 out of 226 people), followed by:
  - Any Other White (11%, 25 people out of 226)
  - Indian (5%, 11 people out of 226)
  - Mixed (4%, 10 people out of 226)

- Most people (95%, 214 out of 226) said they were registered with a GP surgery; 5%, 12 people out of 226, said they were not

- Most respondents said they lived in the postcode area of:
  RG1 (13%, 28 put of 220)
  RG30 (also 13%, 28 out of 220)
  RG2 (9%, 20 out of 220)
  RG4 (8%, 17 out of 220)

- 15 people said they lived outside of Reading, including 2 from Maidenhead, 2 from Surrey, and 1 from Ascot; only 1 said they were from overseas

Appendix 2: How we carried out the visits

- Each visit was undertaken by two people – a Healthwatch staff member and a volunteer, or two Healthwatch staff members

- We visited the ED department before the survey with the RBH's Urgent Care Group Director of Nursing, and the ED reception manager, to see how the emergency department operates in the clinical area and to discuss the logistics of our visit.

- We carried out our visits at the following times:
  - Monday 16 May: 11am-1pm & 2-4pm
  - Tuesday 17 May: 11am-1pm
  - Wednesday 18 May: 12.30-2.30pm
  - Thurs 19 May: 11am-1pm & 5-7pm
  - Fri 20 May: 11am-1pm & 8pm-10pm
  - Saturday 21 May: 4pm-6pm
  - Sunday 22 May: 4pm-6pm

- We handed out a 2-page survey to all people after they had checked in at reception and offered help to fill it in if they were unable to do so themselves. We also sat and talked with people who wanted to share more in-depth details about their experience. We explained the survey was anonymous. We had a Healthwatch Reading-branded mobile stand on wheels where people could drop off completed surveys, and take any leaflets and pens, or colouring sheets and pencils for children.

- The survey sample represents 11% of the total number (2,117) of people who attended the ED during that week, according to figures supplied by Royal Berkshire Hospital

- The survey respondents were 'walk-ins', not people brought in by emergency ambulance through the rear entrance of A&E. We did not follow people through to the clinical areas to find out the outcome of their visit. We did not survey any clinicians about the appropriateness of ED attendances during the week.

Turn over for more survey findings

Appendix 3: Detailed data breakdown

Q1 What is the main health issue that led to you coming here today? Answered: 239 Skipped: 0

Answer Choices	Responses	
Accident at home	19.67%	47
Accident at work	6.69%	16
Accident at other place	12.55%	30
Sports injury	5.44%	13
New physical symptom	13.81%	33
New mental health issue	0.00%	0
Change/worsening of an existing long-term physical condition	10.46%	25
Change/worsening of an existing mental health condition	1.67%	4
Alcohol/drug use	0.00%	0
Victim of crime	0.42%	1
Other (state below if you wish)	0.00%	0
Prefer not to say	1.26%	3
Accident at school	2.93%	7
Breathing problems (child)	1.67%	4
Fever (child)	0.42%	1
Rash (child)	0.84%	2
Cough (child)	1.26%	3
Fit/seizure (child)	0.00%	0
Diarrhoea (child)	0.00%	0
Stomach/abdominal pain (child)	1.67%	4
Swallowing item/poisonous substance/liquid (child)	0.00%	0
Mental health/emotional (child)	0.00%	0
Other (state if you wish)	24.69%	59
Total Respondents: 239		

Other responses:

Sore willy
Something in eye
Not feeding properly
Swollen eye
Post op infection
Picked up tick bite from park
Accident at nursey
Cycle accident Sat 8am
Eye problem
worsening of infection
Allergies
Collapsing
Cancer operation on May 3rd TWOC
last week , now not able to pass urine
Eye problem
Injection after operation on knee

Cancer patient
Blood transfusion -emergency
High potassium level in his blood
GP referral for back issues
severe back pain and struggling to walk
blood in stools
?Infection
Reaction to medication GP requested urgent blood test
INR up 13.7 earlier in day
Kidney pains
emergency heard problems
lump behind the ear
Heart Attack
swollen face after tooth abscess emergency
nothing stated
nothing stated
ear pain
foreign body in ear
Sudden chest pain
Ongoing stomach pain
Severe dental pain
bee sting
(may also be a mental health issue - form unclear)
fell out of bed last Sunday, visited A&E had POP, now back to have removed
n/a
A injury to knee last year and now other problems in leg.
Bladder infection & breathing problems
Kidney problem
suspected DVT
Worsening of swollen tongue preventing eating and drinking
Referred by doctor
Burn
n/a
collecting results from emergency
Heartache
Finger infection

Q2 How long have you been experiencing the problem that led you here today?
Answered: 236 Skipped: 3

Answer Choices	Responses	
Immediately before coming here	30.51%	72
Up to 24 hours ago	21.61%	51
Between 1 and 7 days ago	30.51%	72
Longer than a week	17.37%	41
Total		236

Q3 Have you been discharged from hospital about this problem in the past 30 days?
Answered: 217 Skipped: 22

Yes	9.22%	20
No	90.78%	197
Total		217

Q4 Did you try to seek help from any other services before coming here today?
Answered: 232 Skipped: 7

Yes, go to Question 4a (list below)	54.74%	127
No, go to Question 5	36.21%	84

Q4a: Tell us which service you contacted:

Healthwatch Reading analysis of selected options from list in survey plus addition of any free text answers given in 'other' option which clearly stated which service they had contacted. People could select more than one option, bringing the total to more than the 127 people who had contacted a service.

GP surgery	73%	93
111	33%	42
Reading or other Walk in Centre	15%	19
Out of Hours GP service	12%	15
999	7%	9
Pharmacist	4%	5
Dentist	4%	5
Optician	2%	3
Palliative care		1
NHS Choices		1
Mental health crisis service		0
Community midwife		0
Sexual health clinic		0
Social worker		0
Charity/voluntary sector		0
Other (see below)	9%	12
Total		**205**

Other:
Physiotherapist
Medical staff at a horse show
Dietician
X-ray [unclear where]
Self-diagnosis I am a doctor
Internet
Bracknell Health Space
Came by ambulance [unknown if emergency or patient transport]
Cancer nurse
District nurse
I waited until my symptoms were severe to act, someone insisted I act

Spoke to charity organiser and nurse advised to go to A&E

Question 4b: Were you able to speak to a person who could give you advice?
Answered: 133 Skipped 106

Yes, now go to Q.4c	91.73%	122
No, their phone line was engaged	0.75%	1
No, I only got a recorded message	0.00%	0
No, they did not return my call	0.75%	1
No, the service said no-one was available to talk to or see me as quickly as I wanted	6.77%	9
al		133

Question 4c: Did the service advise you to go to A&E?
Answered: 141 Skipped 98

Healthwatch Reading analysis from selected options plus free text in 'Other' option which clearly indicated they had been advised by a service to go to A%E:

Yes: 119 (84% of 141 people)

No: 11 (8%)

Other: 10 (7%)

141 responses from 119 people

GP	75	53%
Reading Walk in Centre	8	6%
111	27	19%
999	5	4%
Out of Hours GP service	8	6%
St Marks urgent care centre	2	1%
Branks Bridge urgent care centre	4	3%
Minor Accident – Henley	1	0.7%
Dentist	3	2%
Pharmacist	2	1%
Palliative Care	1	0.7%
HOLT nurse	1	0.7%
Medic at an event	1	0.7%
Optician	1	0.7%
District nurse	1	0.7%
Hospital	1	0.7%
Total	**141**	

Turn over for more survey findings

22 people contacted more than one service = 18%

These were:

GP + WIC +111	2	9%
111+Out of hours GP	1	4.5%
Dentist + 111	2	9%
GP + Optician	1	4.5%
111+WIC	2	9%
GP+Branks Bridge	1	4.5%
GP + District Nurse	1	4.5%
GP + Pharmacist	1	4.5%
GP + Out of Hours + Pharmacist	1	4.5%
GP + 111	4	18%
GP + St Marks	1	4.5%
WIC + Out of hours + 111+999	1	4.5%
WIC+Out of Hours+111+GP	1	4.5%
GP + Out of hours	1	4.5%
GP + WIC + 999	1	4.5%
GP+WIC	1	4.5%
Total	**22**	

GP surgeries that advised patient to go to A&E

GP Surgery	No.
Balmore Park Surgery RG4	1
Brookside Surgery	1
Burghfield Health Centre RG7*	1
Burma Hill surgery	1
Chalfont surgery	1
Chatham Street Surgery RG1	1
Chancellor House Surgery RG2*	1
Circuit Lane Surgery RG30	3
Downland practise	1
Emmer Green RG4	1
Finchampstead surgery	1
Grovelands Medical Centre RG30	2
Holywell surgery, Watford	1
Lodden Vale surgery	2
London Street Surgery (Drs Essa & Harrold) RG1	1
Melrose Surgery RG1	4
Milman Road - unspecified	2
Newbury Street Practise	1
Pangbourne Boathouse Surgery RG8	1
Parkside family practise	2
Reading Walk-In Centre RG1	1
Ringmead medical practise	1

Shinfield Medical Practice RG2*	1
Sonning Common Health Centre	1
South Reading Surgery RG2*	1
Swallowfield Surgery	3
Theale Medical Centre	3
The Hart surgery	2
Tlehurst Surgery Practice (Pottery Road) RG30	2
Tilehurst Village Surgery (Westwood Road) Surgery RG31*	1
Tilehurst - unspecified	1
University Medical Centre RG2*	3
Western Elms Surgery RG30	2
Westfield Road surgery	2
Wokingham medical centre	5
Woodcote surgery	1
Woosehill medical centre	1
Prefer not to say	15

Question 5: If you did not contact another service before coming to A&E, why not?
Answered: 83

Answer Choices	Responses	
My problem is very serious	26.51%	22
I believe A&E has staff/experts I would not find anywhere else	22.89%	19
I believe A&E has machines, technology or medicines that are not available anywhere else	27.71%	23
I can get help quicker at A&E	24.10%	20
Another service/professional that I wanted to contact was closed	10.84%	9
I did not know about any other service I could go to instead of A&E	14.46%	12
A&E is closer than other services	7.23%	6
I trust A&E from past experience	19.28%	16
A&E is more anonymous	2.41%	2

Other service/s have let me down	1.20%	1
I wanted a second opinion	3.61%	3
Other (please state if you wish)	24.10%	20
Total Respondents: 83		

Turn over for more survey findings

Other responses:

would have been sent for XRay

WIC is terrible

Sunday-GP not open

A lot of pain-parental judgement

19.30 on Friday ruled out GP

It was a small head wound, needed cleaning and closing, a simple job for A&E. I'd do it at home for myself but kids need extra care

Experience of other services are they are not very responsive Felt it was too late to go elsewhere

Probably need X ray

Daughter has broken finger

Ambulance

referred by ex-nurse

paramedics made the decision to come to A&E

Feeling really sick. Had tried to get GP apt in previous days

Long waiting time especially with a baby

Child has been given a medication mother & siblings allergic to. Don't know if this child is too. Been 2x to GP so far. Keeps saying illness viral. Now rash all over and [other serious signs] - worried because of serious illness with another child.

Family history of health problems worrying

I have broken enough bones to know how one feels different to a muscle injury. I am pretty sure I have a cracked rib.

Doc is useless

Not registered with a GP

Did not seek any help from other service I am not the patient

Question 5a: What changes would help you consider trying to contact an alternative service about an urgent problem in future, instead of going straight to A&E?
Answered: 71

More information about what alternative services are in my area	47.89%	34
More information about what health issues/symptoms/injuries other services can see or treat	32.39%	23
Extended opening hours at other services	28.17%	20
More urgent appointments available at other services	22.54%	16
More information online about other services	12.68%	9
Other, state if you wish	19.72%	14
Total Respondents: 71		

Other responses:

Because serious, otherwise would not come

Probably need X-ray so came straight to A&E

Not sure there is anything else as ? has suspected broken arm

GP

nothing stated

somewhere with X Ray needed

exhausted all alternatives

none in this instance

Doctor not listening to patient who is in pain and feet swollen. is hoping for an X ray or scan

Anywhere with an x ray unit

Needed to come to A&E

Just need to register with GP, have not had time

no requirements other than an x ray required

Postcode breakdown of respondents: Answered 220

RG1	13%	28 people
RG2	9%	20
RG3	1%	3
RG4	8%	17
RG5	7%	15
RG6	4%	9
RG7	4%	8
RG8	3%	6
RG9	2%	5
RG10	2%	5
RG11	0	0
RG12	1%	2
RG13	0	0
RG14	3%	6
RG15	0.45%	1
RG16	0.45%	1
RG17	0	0
RG19	1%	2
RG20	1%	2
RG21	0	0
RG22	0	0
RG23	0	0
RG24	0	0
RG25	0	0
RG26	0	0
RG27	0	0
RG28	0	0
RG29	0	0
RG30	13%	28
RG31	5%	12
RG40	4%	9
RG41	5%	10
RG42	1%	2
RG45	1%	3
Prefer not to say	5%	11
Other:	7%	15

E17		
KT10		
OX12		
Overseas visitor		
SL5		
WD18		
SL6		
SL6		
HR1		
BN2		
BH4		
S16		
B55		
SK6		
RH1		

Age breakdown of respondents: Answered: 223

Answer Choices	Responses	
0-1 month old	0.90%	2
2-5 months	0.45%	1
6 months - 4 years	8.52%	19
5-10 years	5.83%	13
11-17 years	4.04%	9
18-24	13.45%	30
25-34	15.25%	34
35-44	14.35%	32
45-54	9.87%	22
55-64	8.52%	19
65-74	8.52%	19
75-84	8.07%	18
85+	2.24%	5
Total		223

Ethnicity breakdown of respondents

Answer Choices	Responses	
White British	68.14%	154
Any other white (describe below if you wish)	11.06%	25
Mixed (describe below if you wish)	4.42%	10
Indian	4.87%	11
Pakistani	0.88%	2
Bangladeshi	1.33%	3
Black Caribbean	2.21%	5
Black African	1.77%	4
Chinese	0.88%	2
Any other ethnic background (describe below if you wish)	3.10%	7
Prefer not to say	1.33%	3
Total		226

Which GP surgeries respondents are registered with

Answer Choices	Responses	
Prefer not to say	13.81%	29
Not a N&W Reading or South Reading Practice (please enter details in comment box below)	0.48%	1
Abbey Medical Centre RG1	0.00%	0
Balmore Park Surgery RG4	2.86%	6
Burghfield Health Centre RG7*	0.48%	1
Boathouse Surgery Pangbourne RG9	0.00%	0
Chatham Street Surgery RG1	0.48%	1
Chancellor House Surgery RG2*	0.48%	1
Circuit Lane Surgery RG30	2.86%	6
Eldon Road Surgery RG1	0.00%	0
Emmer Green RG4	1.90%	4
Grovelands Medical Centre RG30	2.38%	5
Kennet Surgery RG1	0.48%	1
London Road Surgery (the New Surgery) RG1	0.48%	1
London Street Surgery (Drs Essa & Harrold) RG1	0.95%	2
Longbarn Lane Surgery RG2	0.00%	0
Melrose Surgery RG1	2.86%	6
Milman Road Dr Kumar & Partners RG2*	0.95%	2
Milman Road Dr Mittal & Partners G2	0.00%	0
Mortimer Surgery RG7	0.00%	0
Overdown Surgery RG31*	0.00%	0
Pangbourne Boathouse Surgery RG8	0.48%	1
Pembroke Surgery RG1	1.43%	3
Peppard Road Surgery RG4	0.00%	0
Priory Avenue Surgery RG4	0.48%	1
Reading Walk-In Centre RG1	1.90%	4
Russell Street Surgery RG1* (also Coley Park Surgery RG1)	0.00%	0
Shinfield Medical Practice RG2*	0.48%	1
South Reading Surgery RG2*	1.90%	4
Tilehurst Medical Centre RG30*	0.00%	0
Tilehurst Surgery Practice (Pottery Road) RG30	4.29%	9
Tilehurst Village Surgery (Westwood Road) Surgery RG31*	0.95%	2
University Medical Centre RG2*	2.38%	5
Western Elms Surgery RG30	3.81%	8
Westwood Road Surgery RG31*	0.48%	1
Whitley Villa Surgery RG2	0.95%	2
Whitley Wood Lane Surgery RG2*	0.00%	0
Name of Practice & area/first half of postcode (Healthwatch look up) and Not a N&W Reading or South Reading Practice (please enter details in comment box below)	49.05%	103

Turn over for more survey findings

Other GP practices respondents are registered with:

Swallowfield

Sonning Common

Theale Med centre

Brookside
6/16/2016 12:28 PM View respondent's answers

Tilehurst?Dr

St James Med centre E17

Claygate Surgery

Strawberry Hill Newbury

Swallowfield

Twyford

Newbury Street practice

Milman Road ?Dr

Parkside

Westfield Road Winnersh

Crosby House

Loddon Vale

Loddon Vale

Wokingham Medical Centre

Woodland Park Surgery

Hart Surgery

Dr Zylstar Finchampstead

Milman Road

Loddon Vale Woodley
Woodcote Medical Practice

Wokingham Rose Street Medical Centre

Binfield Surgery

Dr W HChing Burma Hill Surgery

Goring and Woodcote

Dr Dagenham Eastwood House Newbury

Tilehurst

Loddon Vale Woodley

Holywell GP

Dr Caewasat Brookside Lower Earley

Finchampstead surgery

Hart Surgery RG9

Ringmead Medical Practice RG12

Rose Street Wokingham RG40

Swallowfield Surgery RG7

Sarum House HR1

Green Road Parkside RG6

Chalfont Surgery Lower Earley RG6

Hart Surgery RG9

Swallowfield Medical Practice RG7

Swallowfield Medical Practice RG7

Wokingham Medical Centre RG40

Woosehill Surgery RG41

Turn over for more survey findings

Melbourne Winnersh

Hart surgery Henley

Theale

Dr Brobaker Swallowfield

Westfield Road Surgery

Mortimer

Sonning Common

Loddon Vale

Parkside Surgery

Ardingley Brighton

college road surgery

Theale

Swallowfield

Sonning Common Health Centre, Oxfordshire, RG4 9SW

Downland Practise, Newbury, RG20 8UY

Finchampstead Surgery, Wokingham, RG40 3RG

Parkside Surgery, Woodley, RG5 4JA

Ringmead Medical Practise, Bracknell, RG12 7WW

Twyford Surgery, Wokingham, RG10 9JA

Brookside Surgery, Wokingham, RG6 7HG

Wilderness Road Surgery, Wokingham, RG6 7RU

name of practice illegible, but is in Woodley, Wokingham

Wokingham Medical Centre, RG40 1XS

Parkside Family Practise, Green Road Surgery, RG61JS

The Wargrave Surgery, West Berkshire RG10 8BP

Parkside Surgery, Woodley, RG5 4JA

Wokingham Medical Centre

Eastfield House, Newbury, RG14 7LW

Redwood House Maidenhead

Marlow

Parkside practice Woodley

Milman Road

Sonning Common

Theale Medical

Burma Hill Surgery

Woosehill Medical centre

Dr Mellors Finchampstead

Easthampstead

Woosehill Medical Wokingham

Victoria Rd Wargrave

I don’t know

Loddon Vale

Well Spring Bristol BS5

Parkside Practice RG6

Dr Ali Wokingham

Heath Hill Surgery RG45

Chapel Row Bucklebury

Downland Surgery RG20

Marple Road Medical Practice SK6

Binfield Surgery RG42
Westfield Road Surgery Winnersh RG41

Easthampstead Park RG12

Brookside Surgery RG6

Chapel Row RG19

END OF APPENDICES

READING BOROUGH COUNCIL

DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**7 OCTOBER 2016**	**AGENDA ITEM:**	**9**
TITLE:	**PUBLIC HEALTH BUDGET 2016/17**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICERS:	**WENDY FABBRO JO HAWTHORNE**	**TEL:**	**ext 73623**
JOB TITLE:	**HEAD OF WELLBEING**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the current position of the public health budget for 16/17 and details the programmes of work being funded by the grant.

1.2 The breakdown of spend and savings measures is attached in appendix 1. The final budget position for 16/17 is attached in appendix 2.

1.3 In addition it details the further grant cut of 2.7% (£253k) in 17/18.

2. RECOMMENDED ACTION

2.1 That the board note the current budget position for 2016/17.

2.2 That the board note the budget pressures faced in 2017/18 as a result of further grant reductions.

3. FINANCIAL/POLICY CONTEXT

3.1 The Government announced that the 15/16 public health grant reduction will be recurrent and confirmed further overall reductions to the Councils public health grant. Table 1 below provides a breakdown of the grant reduction.

Table 1 – Grant reduction

15/16 baseline	£11,104,085
DH Funding reductions	

LA share of the £200m savings (15/16)	£597,795
Allocation reduction	£237,289
Total funding reduction	£835,085
2016-17 allocation	**£10,269,000**

3.2 The Chancellor's Autumn Statement confirmed that public health funding will continue to be reduced annually until 2020. The Autumn Statement also confirmed that the ring-fenced conditions for use on public health grant would continue for at least two more years.

3.4 In addition the drug and alcohol treatment service currently receives a £284,635 grant from the Police and Crime Commissioner. This grant is being reviewed, should the grant reduce or be cut in full for 17/18 this will create an additional pressure.

3.5 Table 2 shows the likely position for 2017/18.

Funding reductions	
Non recurrent savings (16/17)	£144,274
Allocation reduction	£253,000
PCC grant	£284,635
Total funding reduction	**£681,909**
2017-18 allocation	£10,016,000

4.0 OPTIONS

Budget Position 2016/2017

4.1 All public health grant spend across the council, both for services commissioned directly by public health locally and through the shared team, as well as all additionally funded services provided across the council have been reviewed.

4.2 Officers across the council have worked together to identified ways to manage the impact to services through better use of resources or reducing activity within contract limits. The rationale for spending reductions or reducing services is included in appendix 1.

4.3 Additional savings on top of those initially identified are listed in the table below. The final budget position and savings made for 16/17 is attached at appendix 2 and reports a breakeven positon.

Additional Savings	**Value**
Team re-structure (recurrent)	£105,000
Training and development (Non recurrent)	£2,000
Health Checks (Non recurrent)	£13,500

Implementation of Healthy Weight Strategy (Non recurrent)	£30,000
Weight Management - Additional Eat 4 Health(Non recurrent)	£39,000
15/16 Accrual underspend[1](Non recurrent)	£59,774
Total	**£249,274**
Predicted overspend	-£249,081
Forecast Surplus	**£193**

Budget Position 2017/2018

4.4 To address the ongoing grant reductions up to and including 2019/20, officers will be reviewing all spend against the public health grant. Longer term planning will ensure that all expenditure is informed by local health priorities and local population health needs.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The approach taken to dealing with the Department for Health's Public Health Grant reduction should still enable the Council, within available resources, to meet Corporate Plan priorities where there is a significant public health aspect, such as:

i. Safeguarding and protecting those that are most vulnerable;
ii. Providing the best start in life through education, early help and healthy living; and
iii. Keeping the town clean, safe, green and active.

5.2 The proposal will contribute to the Council's strategic aim to promote equality, social inclusion and a safe and healthy environment for all.

6. LEGAL IMPLICATIONS

6.1 The grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 ("the 2006 Act").

6.2 The functions mentioned in that subsection are:

- functions under section 2B, 111 or 249 of, or Schedule 1 to, the 2006 Act
- functions by virtue of section 6C of the 2006 Act

[1] At year end a prediction was made for demand led primary care services. The actual level of the work undertaken was lower than anticipated and the 16/17 budget has been adjusted.

- the Secretary of State's public health functions exercised by local authorities in pursuance of arrangements under section 7A of the 2006 Act,
- the functions of a local authority under section 325 of the Criminal Justice Act 2003 (local authority duty to co-operate with the prison service with a view to improving the exercise of functions in relation to securing and maintaining the health of prisoners)

7. EQUALITY IMPACT ASSESSMENT

7.1 Where service delivery will be impacted or decommissioned an EIA will be competed.

8. FINANCIAL IMPLICATIONS

8.1 Revenue Implications
The report sets out that the councils public health grant has been reduced by 7.52% in 16/17 and a further 2.7% in 17/18. The report goes on to detail where the grant will be spent.

8.2 Value for Money
There is a requirement to ensure that public health service expenditure delivers value for money and this has been considered when identifying Public Health commissioned projects/services to deliver.

8.3 Risks
Any unexpected costs will create a budget pressure in year. There are a number of demand lead services funded by the public health grant, any significant increase in demand will create an overspend in 2016/17.

Services	Projected Budget Build for 16/17(£ '000s)	Proposed target reduction in 2016/17 (£)	Budget After Reduction 2016/17 (£)	RAG	Rationale	Impact to Service & Health / Missed Opportunity
Balance of PH Funding cover 15/16 Council savings target not allocated	300,000	0	300,000	GREEN		
Local Team restructure	£650,482	63,565	586,917	AMBER	The Wellbeing Department is a new structure and has given the opportunity to revise staffing levels. Reduced by: 1 x FTE programme manager, 1 x FTE admin, 0.5 x training budget. Additional staffing underspend of £105k also required to balance the budget.	No budget for us to buy in PH consultant costs when we need dedicated support.
Mental health - first aid	7000	0	7000	GREEN	Budget to stay the same. Training has been delivered.	No change to service
CALM	1700	0	1700	GREEN	This service has been paid for and is currently being delivered.	No change to service
Beat the street	64000	10500	53500	GREEN	Renegotiated with provider to create a £10.5k saving.	No change to service.
Preventative element of care act and making every contact count MECC	25000	10,000	15000	GREEN	The project was due to start in 2015/16 but there was reduced resource to start the project. The roll out is part of the work programme of the team and we believe it can be reduced by £10k in year by working across departments in the Council, including National Management Trainee. £20k requirement is assumed for 2017/18.	Corporate impact. Programme has started but could be reduce. Minimal impact, primarily scale and pace.
NTG - Reducing the risk of loneliness - people whose first language is British Sign Language and people with an acquired Hearing Impairment (from 01.06.2016)	18,333	0	18,333	GREEN	Contracted service commenced 1st June 2016.	No change to service
NTG - Reducing the risk of loneliness - people with a Learning Disability or who are on the Autistic Spectrum (from 01.06.2016)	14,167	0	14,167	GREEN	Contracted service commenced 1st June 2016.	No change to service
NTG - Reducing the risk of loneliness - people with a Physical Disability (from 01.06.2016)	12,500	0	12,500	GREEN	No bids to deliver this contract under NTG Framework. Resources have been highlighted as Transformational savings for 16-17.	n/a
NTG - Reducing the risk of loneliness - people with a Visual Impairment (from 01.06.2016)	18,333	0	18,333	GREEN	Contracted service commenced 1st June 2016.	No change to service

NTG - Reducing the risk of loneliness - isolated members of minority ethnic communities (from 01.06.2016)	30,833	0	30,833	GREEN	Contracted service commenced 1st June 2016.	No change to service
NTG - Reducing the risk of loneliness - people who are becoming frail or isolated through old age or the effect of long term health conditions (from 01.06.2016)	60000	0	60000	GREEN	Contracted service commenced 1st June 2016.	No change to service
NTG - Handyperson service (from 01.06.2016)	16,660	0	16,660	GREEN	Contracted service commenced 1st June 2016.	No change to service
NTG - VCS grants for 15/16 extended up until May 2016 (April cost)	17646	0	17646	GREEN	Funding spent, agreement now terminated	Not feasible
NTG - VCS grants for 15/16 extended up until May 2016 (May cost)	17646	0	17646	GREEN	Funding spent, agreement now terminated	Not feasible
NTG - Reading Samaritans – full year funding	2,000	0	2,000	GREEN	Funding agreement from April 16 to March 17 (3 months notice required)	Corporate reputation impact.
Floating support	319300	0	319300	GREEN	The floating support service is delivered under a contract let in 2015 for an initial period of 3 years. The saving proposed as part of the 10/20/40 exercise is badged against 18/19. Risk - this would have a direct effect on costs pressures to Housing and may result in failing contractual obligations.	No change to service
Free Swim for Children	93200	0	93,200	GREEN	This service has not to date been targeted to focus on the most vulnerable children a review of this service will take place in 16/17. Risk - this will be a cost pressure on leisure services and the total impact will be unknown.	No change to service
Reducing falls in the private sector housing by enforcement interventions	43000	43,000	0	GREEN	Funding removed but service can still be provided within existing resources by a vacancy in the Regulatory Services team.	No impact to service delivery.
Reducing particulate air pollution through implementation of the Air Quality Management Plan	17200	17,200	0	GREEN	Funding removed but service can still be provided within existing resources by a vacancy in the Regulatory Services team.	No impact to service delivery.
Children Services (Teenage Parent Support)	45000	0	45000	GREEN	High Risk - There will be no resources to fund new and improved public health work in Reading during 2016/17 and beyond. Potential reduced support for teenage parents in Reading. Increased cost pressures on Children's Services.	No change to service

Children's Services (Health Sex & relationship Education [SRE] Coordinator)	54000	0	54000	GREEN	High Risk - There will be no resources to fund new and improved public health work in Reading during 2016/17 and beyond. Potential SRE co-ordination across schools in Reading becomes less effective and school children not receiving the related advice and support. Increased cost pressures on Children's Services. The SRE Co-ordinator is ideally placed to support delivery of the C-Card scheme.	No change to service
Children's Services (Primary Mental Health Worker)	60000	0	60000	GREEN	High Risk - There will be no resources to fund new and improved public health work in Reading during 2016/17 and beyond. Increased cost pressures on Children's Services. Potential for CAMHS resource to be reduced across Reading, support for children and young people reduced.	No change to service
Children's Services (children's centres)	102500	0	102500	GREEN	High Risk - There will be no resources to fund new and improved public health work in Reading during 2016/17 and beyond. Potential for services provided from Children's Centres to be reduced impacting on young children and their families. Increased cost pressures on Children's Services.	No change to service
Anti-social behaviour sex workers and street smoking	12000	0	12000	GREEN	A full review needs to be completed in 2016/17 for VFM.	No change to service
SOURCE YOT Team	85000	0	85000	GREEN	Risk - There will be no resources to fund new and improved public health work in Reading during 2016/17 and beyond. Potential for services provided from DAAT YOT Team to be reduced impacting on service users. Increased cost pressures on Children's Services.	No change to service
Early help services/universal services for children reorganisation and landing of the new responsibilities for health visiting and Family Nurse Partnership	50000	25,000	25000	AMBER	High Risk - this resource is for staff costs and will transfer the cost pressure to Children Services.	Alternative options considered no impact to the service delivery for Health Visitors or Family Nurse Partnership.
Health walks	8000	0	8000	GREEN	Encouraging people to walk has wider benefits for reducing congestion and improving air quality.	No change to service
Winterwatch	91000	16,000	75000	GREEN	£91k figure is incorrect (funding for this scheme was cut to £75k during 15-16). Reducing this funding by £45k is not sustainable therefore and officers advice is that the service could not continue on this basis.	No impact to service delivery. The £91,000 has been checked and was allocation therefore the amount is reduced to £75,000.

Community Alcohol Partnership	34000	0	34000	GREEN	Risk - recommendation would be that these need to be reviewed in 2016/17 against the JSNA priorities and PH Outcomes. This is currently funding a 2 year post.	No change to service
Drink Aware (Alcohol Kits)	1000	0	1000	GREEN	During 2015/16 the Policy decision was not to reduce these budget lines beyond these amounts. Our recommendation would be that these need to be reviewed in 2016/17 against the JSNA priorities and PH Outcomes.	No change to service
Tobacco Control Alliance (3rd of a post with West Berks LA)	9500	0	9500	GREEN	High Risk - this will have an organisational and reputation impact with other Councils. The post may no longer be viable despite delivering Public Health Outcomes which may result in the post being removed. It will also impact on key stakeholders i.e. Police and Education as post holder provides integrated programmes.	No change to service
Flu vouchers for frontline staff	5000	0	5000	GREEN	Risk - Any reduction could impact on front line staff sickness level and their health and wellbeing.	No change to service
C card Condom Distribution (Children and young people)	10000	0	10000	GREEN	Risk - Potential increase in teenage pregnancies and STIs rates, including HIV.	No change to service
Condom Distribution TVPS	10000	0	10000	GREEN	Risk of potential increase in rates HIV, and STIs including HIV, and unwanted pregnancy.	No change to service
Implementation of Healthy Weight Strategy	30000	0	30000	AMBER	We will be unable to act to resource meeting identified needs and gaps highlighted in the local or forthcoming national childhood obesity Strategy.	Non recurrent saving made for this year. Assumed that full budget will be needed for 17/18.
Breast Feeding Peer Support	40000	0	40000	GREEN	Risk - Potential to reverse the current good breastfeeding rates across Reading and not been able to target low uptake areas/wards in the town. This is in the procurement stage and has been halted..	No change to service
IRIS - Domestic Violence	40000	0	40000	GREEN	Currently funds a GP training project which has increased DV referrals.	No change to service
HIV (ASC budget)	42000	0	42000	GREEN	Medium Risk - Contract review during 2016/17. Impact on corporate reputation with vol. orgs.	No change to service
HIV Testing	750	0	750	GREEN	Risk of reducing of testing for HIV, which could increase late diagnoses	No change to service

Alcohol Screening (contract to be reviewed)	40000	0	40000	GREEN	GP alcohol screening service. Service to be reviewed in 2016/17.	No change to service
Health Checks (PCC)	82000	2,000	80000	AMBER	The proposal to cut £2k, represents the monies historically allocated to Pharmacies, however there is no contract or programme in place to deliver these. £13.5k non recurrent savings were we annually report an underspend against actuals V budget. Contract to be renegotiate for April 2017, hence non recurrent saving.	No impact to service delivery.
Drug Misuse	30000	15000	15000	GREEN	The budget has been reduced based on annual usage.	No impact to service delivery if demand stays the same.
IUCD	90,000	0	90,000	GREEN	Demand led mandated service. This is the best forecast of in terms of usage and therefore reducing the budget would be ill advised.	No impact to service delivery if demand stays the same.
Nexplanon (long-acting reversible contraception)	80,000	0	80,000	GREEN	Demand led mandated service. This is the best forecast of in terms of usage and therefore reducing the budget would be ill advised. A full review needs to be completed in 2016/17 for VfM.	No impact to service delivery if demand stays the same.
Contraception (EHC)	10000	5000	5000	GREEN	Demand led mandated service. The budget has been reduced based on annual usage.	No impact to service delivery if demand stays the same.
Sexual health Out of Area	90,000	0	90,000	GREEN	This is the best forecast on a demand lead services in terms of usage and therefore reducing the budget would be ill advised. This is a mandated service and we are required to pay for out of area sexual health activity.	No impact to service delivery if demand stays the same.
Joint Team and Informatics Support	156,000	0	156,000	GREEN	High Risk – if reduced or removed will impact on the SDPH, Health Protection Cover, informatics/JSNA Data provision and large scale contract management e.g GMS & PMS contracts, Sexual health contract along with contract support.	There is likely to be an increase in cost.
Smoking Cessation	355,000	0	355,000	GREEN	High risk – this is mandated service and under contract. The contract has just been awarded and this budget has already had a 15% reduction for 2016 in the financial envelope for the new services. Stopping smoking is the single most effective lifestyle change that people can make to improve their health.	No change to service

WM - Let's Get Going	22000	0	22000	GREEN	This service targets childhood obesity through an evidence-based approach to family lifestyle change (healthy eating, physical activity and behaviour change). The courses are targeted in the areas of Reading where we have the highest prevalence of obesity.	No change to service
WM - Eat 4 Health	85203	0	85203	AMBER	This successful, evidence-based service targets adult obesity through healthy eating, physical activity and behaviour change. The programme is already over-subscribed as demand is high. Non recurrent saving from budget to reduce waiting list (£39k).	No change to service (under contract). Any additional classes will be on hold for 16/17.
School Nursing (Children (5-19) - National Child Measurement Programme)	642,222	0	642,222	GREEN	The NCMP element, delivered by School Nurses, is a mandated service and therefore should remain in place. The service delivers a range of interventions that support working to achieve many PHOF measures for children and young people.	No change to service
GUM – out of area block payments	7000	0	7000	GREEN	Demand led/mandated service. This is our best forecast of spend based on historical activity data.	No change to service
GUM – out of area block payments.	13500	0	13500	GREEN	Demand led/mandated service. This is our best forecast of spend based on historical activity data.	No change to service
GUM – Out of Area block payments.	3000	0	3000	GREEN	Demand led/mandated service. This is our best forecast of spend based on historical activity data.	No change to service
Sexual Health	1410540	6172	1404368	GREEN	Small saving against actual contract spend to cap limit. The money is tied up in a contract and we have already achieved significant savings through the retender process to achieve best value for money. This is a mandated service.	No impact to service delivery.
GUM and FP West	47520	0	47520	GREEN	High Risk- as demand led and is mandated service. This allocation is to fund Reading people accessing a Slough facility. This is within a block contract.	No change to service
IT Platform for GUM Services	3000	0	3000	GREEN	High Risk – Mandated service. The aim of this service is to be a one-stop shop for all sexual health advice and services in Berkshire. To improve access to information and advice about sexual health; which will help people to avoid or access treatment for STIs, access contraception and reduce the risk of unwanted pregnancy.	No change to service

Children's Death Overview Panel Berkshire	7590	0	7590	GREEN	High risk as it is a mandated function of the SDPH across Berkshire. Funds a post to sit on the panel.	No change to service.
Library	1000	0	1000	GREEN	Risk that staff cannot access appropriate research material to support their continual and professional development. This is needed so staff can continue to maintain professional access to library services and to ensure Public Health Practitioners are supported in their work.	No change to service
GP data collection system (CSU)	14,000	0	14,000	GREEN	GP Data is accessed bespoke for Reading and is used to validate activity for GP contracts. Risk Contracted for 2016/17. Potential to reduce in 2017/18.	No change to service
Web system for Pharmacy contracts	3193	0	3193	GREEN	This system is supports the validation of activity in Pharmacies. Risk to data collection and is part of a pan Berkshire Contract.	No change to service
Health Visitors and FNP	2,892,000	29,000	2,863,000	GREEN	This is under current contract delivering mandated services for Health Visitors. Slight reduction based on the actual contract amount. FNP is under current contract for Berkshire West, including Reading. The service delivers a range of interventions that support working to achieve many PHOF measures for young children and their families.	No change to service
Oral Health Survey	10,000	0	10,000	GREEN	Oral Health Survey shared across Berkshire, required to undertake once every 2 years.	No change to service.
DAAT	2262000	55000	2207000	GREEN	High Risk – Reading has the highest rates of drug related deaths and to reduce the budgets to DAAT may increase risk. £55k reduction identified, however, cuts in Police Crime and Commissioner planned for 2017 may impact on this service.	No change to service if demand stays the same.
Southcote	10000	10000	0	GREEN	Entire budget removed, we are not contracted to deliver a service, no work has begun on this project.	Officer time will be made available if required.
Chlamydia Screening (West)	50000	50,000	0	GREEN	In 15/16 the budget was reduced following the service being decommissioned. At the time it was felt the money would be better invested in condom distribution as there was a view that chlamydia screening wasn't effective.	This money has not yet been reinvested and has been removed to elevate budget pressures.

School-based Nutrition Programme/ healthy weight programme outcome from the strategy. (Obesity and Physical activity commissioning)	30000	30,000	0	GREEN	There is no impact as there is currently no service however this is considered a missed opportunity to improve health outcomes in school age children by addressing a gap in provision.	No further development of services.
Brushing for Life	3000	3,000	0	GREEN	There is limited evidence of this type of intervention improving oral health and reducing prevalence of tooth decay in young children, along with concerns about product suitability.	Potential parental dissatisfaction that they can no longer access free oral health packs. May have a reputational impact.
	10,908,518	390,437	10,518,081			

Services	Projected Budget Build for 16/17(£ '000s)	Proposed target reduction in 2016/17 (£)	Budget After Reduction 2016/17 (£)
Balance of PH Funding cover 15/16 Council savings target not allocated	300,000	0	300,000
Local Team	£650,482	63,565	586,917
Mental health - first aid	7000	0	7000
CALM	1700	0	1700
Beat the street	64000	10500	53500
Preventative element of care act and making every contact count MECC	25000	10,000	15000
NTG - Reducing the risk of loneliness - people whose first language is British Sign Language and people with an acquired Hearing Impairment (from 01.06.2016)	18,333	0	18,333
NTG - Reducing the risk of loneliness - people with a Learning Disability or who are on the Autistic Spectrum (from 01.06.2016)	14,167	0	14,167
NTG - Reducing the risk of loneliness - people with a Physical Disability (from 01.06.2016)	12,500	0	12,500
NTG - Reducing the risk of loneliness - people with a Visual Impairment (from 01.06.2016)	18,333	0	18,333
NTG - Reducing the risk of loneliness - isolated members of minority ethnic communities (from 01.06.2016)	30,833	0	30,833

NTG - Reducing the risk of loneliness - people who are becoming frail or isolated through old age or the effect of long term health conditions (from 01.06.2016)	60000	0	60000
NTG - Handyperson service (from 01.06.2016)	16,660	0	16,660
NTG - VCS grants for 15/16 extended up until May 2016 (April cost)	17646	0	17646
NTG - VCS grants for 15/16 extended up until May 2016 (May cost)	17646	0	17646
NTG - Reading Samaritans – full year funding	2,000	0	2,000
Floating support	319300	0	319300
Free Swim for Children	93200	0	93,200
Reducing falls in the private sector housing by enforcement interventions	43000	43,000	0
Reducing particulate air pollution through implementation of the Air Quality Management Plan	17200	17,200	0
Children Services (Teenage Parent Support)	45000	0	45000
Children's Services (Health Sex & relationship Education [SRE] Coordinator)	54000	0	54000
Children's Services (Primary Mental Health Worker)	60000	0	60000
Children's Services (children's centres)	102500	0	102500
Anti-social behaviour sex workers and street smoking	12000	0	12000
SOURCE YOT Team	85000	0	85000
Early help services/universal services for children reorganisation and landing of the new responsibilities for health visiting and Family Nurse Partnership	50000	25,000	25000
Health walks	8000	0	8000

Winterwatch	91000	16,000	75000
Community Alcohol Partnership	34000	0	34000
Drink Aware (Alcohol Kits)	1000	0	1000
Tobacco Control Alliance (3rd of a post with West Berks LA)	9500	0	9500
Flu vouchers for frontline staff	5000	0	5000
C card Condom Distribution (Children and young people)	10000	0	10000
Condom Distribution TVPS	10000	0	10000
Implementation of Healthy Weight Strategy	30000	0	30000
Breast Feeding Peer Support	40000	0	40000
IRIS - Domestic Violence	40000	0	40000
HIV (ASC budget)	42000	0	42000
HIV Testing	750	0	750
Alcohol Screening (contract to be reviewed)	40000	0	40000
Health Checks (PCC)	82000	2,000	80000
Drug Misuse	30000	15000	15000
IUCD	90,000	0	90,000
Nexplanon (long-acting reversible contraception)	80,000	0	80,000
Contraception (EHC)	10000	5000	5000
Sexual health Out of Area	90,000	0	90,000
Joint Team and Informatics Support	156,000	0	156,000
Smoking Cessation	355,000	0	355,000
WM - Let's Get Going	22000	0	22000

WM - Eat 4 Health	85203	0	85203
School Nursing (Children (5-19) - National Child Measurement Programme)	642,222	0	642,222
GUM – out of area block payments	7000	0	7000
GUM – out of area block payments.	13500	0	13500
GUM – Out of Area block payments.	3000	0	3000
Sexual Health	1410540	6172	1404368
GUM and FP West	47520	0	47520
IT Platform for GUM Services	3000	0	3000
Children's Death Overview Panel Berkshire	7590	0	7590
Library	1000	0	1000
GP data collection system (CSU)	14,000	0	14,000
Web system for Pharmacy contracts	3193	0	3193
Health Visitors and FNP	2,892,000	29,000	2,863,000
Oral Health Survey	10,000	0	10,000
DAAT	2262000	55000	2207000
Southcote	10000	10000	0
Chlamydia Screening (West)	50000	50,000	0
School-based Nutrition Programme/ healthy weight programme outcome from the strategy. (Obesity and Physical activity commissioning)	30000	30,000	0
Brushing for Life	3000	3,000	0
TOTAL EXPENDITURE	**10,908,518**	**390,437**	**10,518,081**
TOTAL GRANT			**10,269,000**

Shortfall			**249,081**

Additonal action to address shortfall			
Team re-structure		105,000	
Training and development (Non Recurrent)		2,000	
Health Checks (Non Recurrent)		13,500	
Implementation of Healthy Weight Strategy (Non Recurrent)		30,000	
Weight Management - Additional Eat 4 Health (Non Recurrent)		39,000	
15/16 Accrual underspend (Non Recurrent)		59,774	
Total			**249,274**
Forecast Surplus			**193**

READING BOROUGH COUNCIL

REPORT BY DIRECTORATE OF CHILDREN, EDUCATION & EARLY HELP

TO:	**Health and Wellbeing Board**		
DATE:	**7th October 2016**	**AGENDA ITEM:**	**10**
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:**	**0118 9374688**
JOB TITLE:	**Head of Early Help in Children's Services - RBC Equalities Coordinator – ACRE LSCB Business Manager - RBC**	**E-MAIL:**	**andy.fitton@reading.gov.uk**

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 2016, when a previous report was presented to the Health and Wellbeing Board

2. RECOMMENDED ACTION

2.1 That Health and Wellbeing board notes the work undertaken so far and endorses the proposed next steps.

2.2 That a report from ACRE on progress against the creation of a community based education and preventative programme of support come back to the Health and Wellbeing Board in January 2017.

2.3 That a report from Berkshire West CCG on the progress of establishing a clinical response for Adults who have suffered FGM come back to the Health and Wellbeing Board in January 2017.

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 Research has shown that 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 FGM is illegal in England and Wales under the FGM Act 2003 and is child abuse.

3.6 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.

3.7 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.

3.8 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.

3.9 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 since last report in January 2016 are:

4.3 Community engagement work has continued with focus on awareness raising, engaging community leaders and young people to affect change.

- The community working group continues to meet, and is now looking at how to increase engagement with the forthcoming specialist FGM centre.
- The men's group of 14 participants is established to discuss the importance of a male response to FGM within their communities.
- ACRE in partnership with Utulivu organised an FGM focus on Zero Tolerance Day in February 2016 to continue the awareness raising but in the wider population.

Acre presented the findings of the 6 months needs assessment and our recommendations for a specialist local FGM service and led table discussions and consultation on the benefit of a local specialist service.

- Provided an assembly at Kendrick for some young people to raise awareness of what FGM is and its prevalence in Reading
- A new community group of FGM survivors has been created called Women of Vision, led by Midwife and survivor to which Acre lends support. They are meeting monthly, with around 30 members.
- An NCS group volunteered with Acre to create a canvass for the new Reading Rose Centre. The young people took the Reading Rose logo and gave it their own personal twist. This opportunity also facilitated increasing awareness amongst young people of FGM.
- ACRE, along with community activist and survivor presented at the LSCB Pathways Launch Event.

4.4 A plan of action has been drafted on how to best engage with practising communities in the run up to the opening of the forthcoming specialist FGM centre for the West of Berkshire, the Reading Rose Centre, to secure its optimal reach and value. ACRE needs to source start-up funding, to avoid engagement coming to a standstill until the opening of the clinic. It would be a considerable obstacle as community participation in the planning of the service would be exemplary and most advantageous.

- The top priority now is to raise awareness that the Reading Rose Centre is coming, what it will offer, and to tailor this offer to what the community want and need. The optimal time to do this at the planning stage before the clinic opens, thus making the centre more efficient in the long term. A consultation strategy has been drafted, to raise awareness and promote the Reading Rose Centre.
- An information leaflet has been developed, with community input, to disseminate to GPs, practising communities, any public or community bodies with an interest/responsibility re FGM. Funding is needed to print the leaflet.
- In partnership with Utulivu, a second 'Afternoon Out' for survivors and women from affected communities has been arranged for November. This is at the behest of attendees of last year's event for a further opportunity to meet and discuss, and a testament to the success of the first.

4.5 Forward UK carried out a training session primarily for Schools on 8th March 2016. This was provided free of charge, through DFE funding. There were 20 attendees from Reading – 8 Secondary School representatives, 10 Primary School representatives and 2 members of staff from RBC. The feedback was overwhelmingly positive, with the knowledge of the trainers and how to apply it in school particularly noted.

4.6 **Strand 2** has been led by Children's Services in Reading Borough Council, with support from all 3 LSCB's across the West of Berkshire.

4.7 The action plan has 5 actions relating to protection. These actions primarily focus on:

- Improving professional knowledge and confidence in FGM
- 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

There has been good and timely progress against the action plan, of which key highlights is;

4.8 A range of tools for the workforce is now available on our LSCB website, that include:

- A FGM Fact Sheet and a link to home office FGM awareness training that aims to raise awareness for professionals
- A professional's tool kit that provides clarity on four pathways for children and adults at risk or having undergone FGM.
- A FGM risk assessment tool for professionals to use to understand and decide on the course of action required as directed by the 4 FGM pathways.

4.9 A launch event has taken place in July 2016, that was very well received. Over 65 Professionals from a range of agencies, across the 3 participating Local Authorities attended and feedback The event supported professionals to understand the scale and impact of FGM and introduced the tools, inviting them to disseminate this information to colleagues in their agencies Feedback from the event has been overwhelmingly positive, stating that the mix of detail, hearing from survivors, men from effected communities and a review of the risk assessment tool and pathways, was motivating.

4.10 An update on the safeguarding procedures has been completed in the online tool that all agencies and professionals use. This is now consistent with both national and local guidance.

4.11 An audit of prevalence based on work in the hospital with public health was completed in July 2016. The key learning and insights have been shared and discussed at the LSCB quality assurance and performance sub group. Over an 18 month period 29 cases were identified at the Royal Berkshire Hospital of which 24 were Reading residents, approximate half of what would be expected based on national estimates. The results of the audit indicate that the nationality of the women concerned and the types of FGM they have been subjected to are in line with national statistics. All cases identified were appropriately referred to the hospital safeguarding team for scrutiny and referrals to Children's Social Care for assessment were made when appropriate (i.e. the unborn child was known to be female or there were female siblings).

4.12 Going forward up till Jan 2017 the expectation is to

- To set up a West of Berkshire online training for professionals to improve use of the FGM risk assessment tool
- Explore a method of intelligence sharing between community groups/ leaders as well as key statutory reps (Police, CSC, Hospital/ Health, Education)

4.13 A significant gap in provision has been confirmed for Adults having undergone FGM. As noted in the January 2016 report on FGM to this board, Berkshire does not have a specialist clinic similar to Oxford and Bristol. In designing the four pathways and discussion with primary care colleagues it has become very clear that without a specialist clinic, such as the Oxford Rose Clinic then many women will not be able to seek the help they need.

4.14 ACRE with the support of Children's Services in RBC have written a proposal that provides an option to create a single West of Berkshire provision of a specialist clinic alongside the extension of the preventative community work that ACRE have already been providing. The Reading Rose Clinic would be the centre point for health, education and affected community activists and leaders could use to educate, enable and support girls, women, their wider families and communities to stop FGM.

4.15 This proposal was presented to Nurse director CCG Berkshire West federation and the Police and Crime Commissioner in June 16 to gain their support. Both key partners are in principle committed to establishing a specialist clinic with a level of wrap around preventative work led by ACRE.

4.16 The CCG are currently building a business case to consider funding a start medical clinic and ACRE is in discussion with the PCC office to explore potential funding options for the preventative work. The current target is to set up a clinic by April 2017.

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 continues to 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 has ended. The key risks are:

- Community engagement will effectively come to a halt, at a critical time. This creates a real barrier to functional planning, promotion and opening of the Rose Centre.
- There is the further risk of invested community members disengaging, when ACRE does, and closes the opportunity to broaden the Centre's reach, at a pivotal time for garnering support and sowing the seed of the Rose Centre in community psyche.

10 BACKGROUND PAPERS

10.1 None

NHS Newbury and District Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

NHS Bracknell and Ascot Clinical Commissioning Group

NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group

NHS Slough Clinical Commissioning Group

Bracknell Forest Council
The borough of opportunity

Reading Borough Council
Working better with you

West Berkshire Council

www.slough.gov.uk
Slough Borough Council

The Royal Borough of Windsor and Maidenhead

Wokingham Borough Council

Berkshire Transforming Care Partnership
August 2016 Update

Reading Health and Wellbeing Board

Slide deck author: Sarah Rowland
Interim Programme Manager, Berkshire TCP
sarah.rowland5@nhs.net

Contents

Introduction

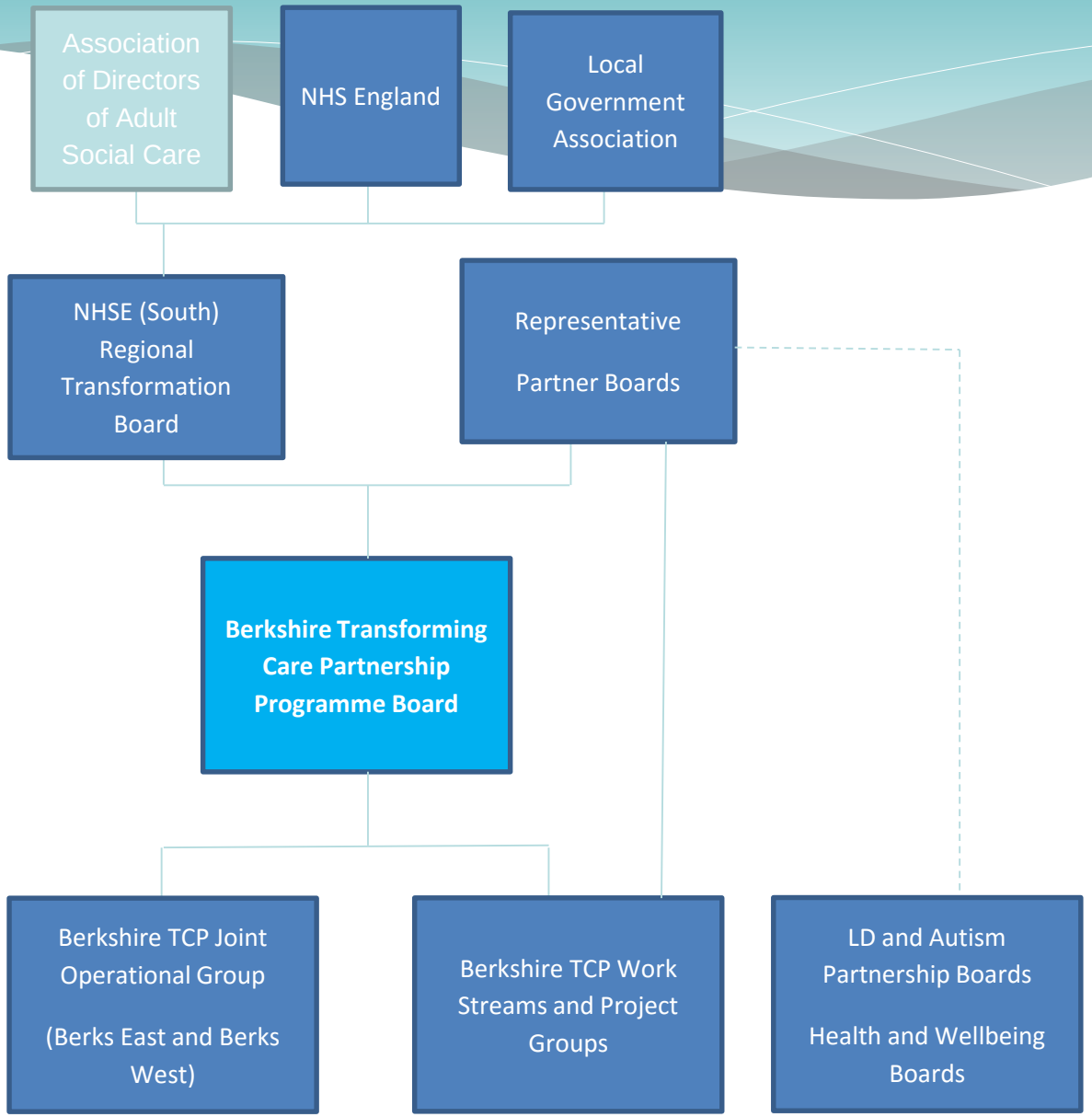
The Berkshire Transforming Care Partnership Board hold a shared vision and commitment to support the implementation of the national service model to ensure that children, young people and adults with learning disabilities, behaviour that challenges and those with mental health and autism receive services to lead meaningful lives through tailored care plans and subsequent bespoke services to meet individual needs.

Berkshire Transforming Care Plan has 4 big aims:

1. Making sure less people are in hospitals by having better services in the community.
2. Making sure people do not stay in hospitals longer than they need to
3. Making sure people get good quality care and the right support in hospital and in the community
4. Making sure everyone who comes out of hospital has a Care and Treatment Review (CTR)

Dedicated web page with links to the TCP plan and Easy Read version - http://www.wokinghamccg.nhs.uk/berkshire-transforming-care-partnership

Programme Governance Structure



Achievements

Key Programme Achievements in July and August

- Grant Application for Capital Bid Programme to NHSE for Shared Housing provision in Royal Borough of Windsor and Maidenhead for three individuals from Berkshire with complex LD and challenging behaviour

- Berkshire Healthcare NHS Foundation Trust staff and service user engagement exercise on a proposal to suspend the provision of inpatient services at Little House, Bracknell and relocate the service to a single location at the Campion Unit from September 2016

- Published communications brief to partners on changes to inpatient bed capacity and Little House and first edition of monthly 'TCP Briefing to Partners'

- Merged Berks East and West TCP Operational groups to create efficiencies

- Engaged interim Programme Manager and co-opted Carer Expert by Experience onto TCP Programme Board

Next Steps

Key Focus Areas for the Next Month:

- Refresh the Programmes Risk Register to reflect the risk identified through the scoping work undertaken by the Programme Manager with Local Authority colleagues
- Start recruitment drive for additional Experts by Experience to join project groups, supported by NHS England and Patient Public Voice (national) Team
- As part of shaping the market, work with South Central Provider Forum and ADASS South LD Network to review specialist commissioning inpatient providers and housing and accommodation providers
- Finalise the appointment of the Chairs and terms of reference for the Activity and Finance, Workforce and Autism work streams
- Working with Health Education England and Skills for Care to plan a pilot of the new Intensive Intervention Service Workforce Toolkit
- Monitor the safe transition of clients from Little House to appropriate sustainable community placements during September and October

TCP - Communications and Engagement

- Communications and Engagement Messaging Document in place to guide stakeholders when communicating around the programme
- Engagement Plan currently being drafted and discussed at Programme Board level
- Continued coordination between partner organisation's communications and engagement teams, with October Event Planned to support local communication channels
- Monthly Update Newsletter

TCP – Activity and Finance Workstream

Jointly chaired by a CCG and a Local Authority Finance Director - Key deliverables:

- Develop a range of pooled budget ‘arrangement’ options for the financial management and risk sharing of aggregate budgets - to be considered by internal Partner Boards
- Ensure arrangements are set on the principle that expenditure is based on the needs of the service users and not the level of contribution
- Develop a clear strategy for the creation and deployment of the arrangements
- Establish an understanding between partner agencies around the opportunities to deploy resources more effectively to achieve shared outcomes
- Reduce the number of separate funding streams that users have to access
- Identify new joint commissioning and integrate decision making opportunities that reduce bureaucracy, reduce transactional costs and overheads, and secure better outcomes for service users
- Undertake, on behalf of the TCP Programme Board, a quarterly stocktake of activity across the system; to include the cost of current and new service models

Update on Dowries

It has been decided that some funding for individuals will be through what is called a ‘dowry’

How do they work?

Available to patients

- discharged on or after 1 April 2016
- Five years or more inpatient stay as of 1 April 2016
- Dowry calculated at discharge.

£’s

released annually as a result of no longer buying inpatient beds

Minus

£’s

Required annually for new services in the community to support the wider population

=

Total remaining funds from which the NHS funds:

1. NHS contributions to the cost of health and social care packages (Continuing Healthcare or NHS S117 contributions)
2. Transfers to local authorities towards social care costs (dowries)

A - B = C

126

Reduction in inpatient capacity

- National transforming care mandate to reduce 50% inpatient capacity by March 2019
- Care Quality Commission rated Berkshire Healthcare NHS Foundation Trusts learning disability inpatient services as 'Requiring Improvement'
- 1st August 2016 the Trust started its staff consultation on the suspension of beds at Little House during September and October 2016
- Safety and quality is imperative for all inpatients Little House
- Assessment and treatment inpatient care will remain at Campion Unit, Prospect Park
- In the future the new Intensive Intervention Service will facilitate timely discharge with support plans coordinated with the local CTPLD's
- Engagement with patients and carers at Little House is a priority and plans are being put in place and monitored on a weekly basis by the TCP Programme Board

- The changes will:
  - Improve the quality and safety of the overall service,
  - Eliminate the risks associated with Little House providing 24/7 services from a standalone building.
  - Improve rapid access to a wider range of support and care on site, a nicer more modern, calmer and suitable environment inside and outdoors, and improvements to health, wellbeing and recovery.
  - Enable resources to be directed to being trained and skilled to become the new Intensive Intervention Service - working with CPTLD prevent admissions and support timely discharge

Any Questions?

READING BOROUGH COUNCIL
REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**7th October 2016**	**AGENDA ITEM:**	**12**
TITLE:	**INTEGRATION AND BETTER CARE FUND**		
LEAD COUNCILLOR:	**CLLR HOSKIN / CLLR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	**ALL**
LEAD OFFICER:	**KEVIN JOHNSON**	**TEL:**	**0118 937 4807**
JOB TITLE:	**INTEGRATION MANAGER**	**E-MAIL:**	**kevin.johnson@reading.gov.uk**

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care services. It requires Clinical Commissioning Groups (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. Reading has an allocation of £10.4m within 2016/17.

1.2 This report sets out:
1. The BCF integration performance at the end of quarter one within Reading
2. The BCF reporting and monitoring requirements
3. The findings from the Joint Commissioning workshop held September 2016

2 RECOMMENDED ACTION

2.1 The Health and Wellbeing Board is asked to delegate approval to the Director of Adult Care and Health Services and the Chief Officer of Reading South and Reading North & West CCG's, in consultation with Reading Integration Board, for the quarterly report to NHS England. Acknowledge position of Integration and Reading Better Care Fund as of end of quarter 1.

3 POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care services. It requires Clinical Commissioning (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation.

4 CURRENT POSITION

4.1 The BCF Reading gained a fully approved assurance by NHS England on 8th July 2016. Letters confirming this approval were sent to Cllr. Graeme Hoskin, Dr. Cathy Winfield and Ian Wardle. Copy attached appendix 1. To understand the 2016/17 submission a Better Care Fund on a Plan on a Page has been produced. Appendix 2.

4.2 The Reading BCF for 2016/17 totals £10.4m and funds a range of integration initiatives intended to promote more seamless care and support services, deliver improved outcomes to patients and service users and protect key front line services that deliver value to both the NHS and the Local Authority. As in previous years, the BCF has a particular focus on initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care as well as a number of national conditions that partners must adhered to. If any of these conditions are not met the Care Act 2014 enables NHS England to withhold, recover or direct how the money is used. Summary of key BCF National Conditions:

- Maintaining the provision of social care services
- Contributing to the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Delivering better data sharing between health and social care;
- Delivering a joint approach to assessments and care planning and ensuring that, where funding is used for integrated packages of care, there will be an accountable professional;
- An investment in NHS commissioned out-of-hospital services

4.3 The BCF Policy Framework establishes national metrics for measuring progress of integration through the BCF and partners must report progress against them each quarter to NHS England. Summary of Key BCF Metrics

- Improving People's experiences of care
- Avoiding unnecessary non-elective admissions
- Reducing inappropriate admissions of older people (65+) in to residential care
- Increase in the effectiveness of reablement services
- Reducing delayed transfers of care (DToC) from hospital

4.4 The funding that comes directly to the Council for the Disabled Facilities Grant of £815k also included in the BCF is not subject to these conditions.

Performance to date

4.5 To date, Reading has seen some positive local BCF scheme performance, such as an increase in the number of patients / service users successfully reabled via the Discharge To Assess / CRT services, fewer admissions to residential care and reduced admissions to hospital from care homes supported by the rapid response and assessment team (RRaT). As at the end of Q1, however, this has not translated into clear system wide benefits or a positive impact on the key BCF metrics, namely NEA and DTOC.

Delayed transfers of care

4.6 As a key requirement of the 16/17 BCF, the Reading CCGs and the council have agreed a local action plan to reduce DTOCs and improve patient flow. The target is to have no more than 2960 bed days lost per 100,000 population in 16/17. This equates to no more than 3703 actual bed days lost.

		2016/17			
		Q1	Q2	Q3	Q4
Metric Actual number of days delayed	Plan	980	956	914	953
	Actual	2038			

4.7 As demonstrated above, quarter one shows a dramatic increase in delayed transfers of care from RBH. The top three reasons for these delays are access to further non acute NHS services, disputes and the commissioning of home care packages. There has been a 20% increase in patient admissions within the acute trust this is impacting on the capacity of health and social care within Reading. These delays have been escalated to Reading Integration Board with outcomes to be recommended. These will include; greater emphasis on the Choice Policy, further analysis on delays within community reablement team and reason of delays caused by assessment processes.

Non Elective Admissions

		2016/17			
		Q1	Q2	Q3	Q4
Total non-elective admissions in to hospital (general & acute), all-ages.	Plan	3514	3561	3915	3804
	Actual	3690			

4.8 The level of non-elective admissions is also above target and planned reductions are not being realised. It is anticipated, however, that performance may improve in subsequent quarters now that the Care Home project is fully implemented (see 4.11).
There are a number of other initiatives being pursued by the CCGs and the local authority in order to reduce NELs. In addition data shows that there are a significant number of NEL admissions in specific wards in Reading and Dr Lise Llewelyn, Director Public Health, is arranging for this data to be overlaid with deprivation and prevalence of smoking, physical activity data etc. to see what the correlation is and what actions are required to support prevention.

Residential and Nursing Admissions

		2016/17			
		Q1	Q2	Q3	Q4
Total admissions to residential and Nursing homes (over 65 years)	Plan	24	24	24	24
	Actual	17			

4.9 The table above demonstrates residential and nursing home admissions within quarter one are within target. Reading Borough Council had made significant progress against this target in 15/16 (31% reduction from 151 to 104). Continued focus is needed to ensure only those who need intensive support, live in residential care settings.

Local Project Performance Update

4.10 **Connected Care**

The Connected Care project will deliver a solution that will enable data sharing between the fourteen health and social care organisations in Berkshire. Provide a single point of access for patients wanting to view their care information. The project will support delivery of the 10 universal capabilities as defined in the Berkshire West LDR and enable service transformation as specified in the BCF and Digital Roadmap. The projects primary objectives are to:

Enable information exchange between health and social care professionals.

- Support self-care by providing a person held (health and social care) record (PHR) for the citizens of Berkshire.
- Enable population health management by providing a health and social care dataset suitable for risk stratification analysis.

Position as at end Q1

- System/portal supplier selected via competitive tender. Programme on track with first interfaces and data sharing (between Berkshire Health Trusts and GPs) scheduled for quarter 3 with the council scheduled for access to data sharing portal May 2017.
- The information governance subgroup continues to revise policy and data sharing agreements, as required, to ensure lawful handling and sharing of data.

4.11 Care Homes

The Enhanced Support to Care Homes project implements improvements to the quality of care and provision of service to and within care homes for residents, in collaboration with all Health and Social Care providers across Berkshire West, to improve people's experience of care and avoid unnecessary non-elective admissions.

The primary objective is to improve resident outcomes and support care homes in providing high quality health and social care, by:

- Establishing a consistent and co-ordinated health and social care MDT (the rapid response and treatment team) across Berkshire West
- Establishing a consistent and co-ordinated approach to monitoring performance
- Preventing avoidable admissions or attendance to hospital
- Reducing delay discharges of care back into care homes
- Reducing length of stay for care homes residents during an acute illness

Position as at end Q1

- Rapid response and treatment team (RRaT) - Q1 performance demonstrates management of non-elective admissions demand from care homes but minimal reduction, compared to 15/16 activity. Quarter 1 (Apr – Jun) is not a true reflection of the impact of RRaT on non-electives admission from care homes,

however, as not all of the target care homes were fully signed up to and accessing the support. Quarter 2 (Jul – Sept) onwards expected to reflect the true impact of the investment made in the service to further reduce non-elective admission from care homes.

- Unified admissions and discharge process drafted and due for pilot in quarter 2
- Staff recruited and care home resident mediation reviews underway
- Continuing to scope national examples of effective GP support for care homes
- Supported 176 residents within quarter one

4.12 Community Reablement Team (CRT)

CRT provides a short term flexible service for up to 6 weeks, for customers who have been assessed as being able to benefit from a re-ablement program. The service is delivered in the clients own home. CRT is available 7 days a week, 24 hours a day. CRT milestone status within quarter 1 was reported as amber. The financial budget status was reported as green, online and within target

4.13 Key Achievements (CRT)

- Residential and nursing home admissions reduced by 48% on target
- Record number of hospital avoidances. 92% of annual target achieved
- Finance reported on line with targets
- 295 users 21% above target
- Average length of stay within the service 17 days
- CRT staffing structure proposals complete and consultation commenced. This will allocated a greater amount of care hours supplied by the service this is estimated to increase care capacity from 700 hours per week to 900 hours per week
- Integration Performance Analyst appointed
- Section 75 signed and sealed by CCG's and RBC

4.14 Key Challenges

- DTOC a national challenge and further local measure need to be identified
- Reading wide approach to performance needs to be individualised to programme performance measures e.g. CRT and DTA

4.15 **Discharge to Assess (DTA)**

4.16 The DTA service is part of the Willows residential care complex operated by the Council. The home consists of both residential units and self-contained assessment flats with 14 units appointed as Discharge to Assess units.

DTA is a 'step up step down' rehab and reablement service with the primary aims being:

- To reduce the number of patients on the fit to go list
- To reduce the length of stay for individuals who are fit to leave acute hospital care
- To reduce permanent admission to residential and nursing care

4.17 Key Achievements

- Record number of hospital avoidances. 66% of annual target achieved
- 90% of patients returned home
- Finance reported on line with targets
- Integration Performance Analyst recruited
- Newly appointed team members
- 90% bed utilisation
- Key objectives and KPI's set for health and therapy staff to increase customer contact
- Section 75 signed and given corporate seal by all parties

4.18 Key Challenges

- DTOC a national and local challenge that is being reviewed taking a system approach
- Reading system approach to performance needs to be aligned to programme performance measures

4.19 Performance Table

Performance Measure	Q1		Q2		Q3		Q4	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Non-elective admission avoidance (no less than) CRT and DTA figure	15	52						
*Delayed transfer of Care (no more than)	980	2038						
*Residential admissions (no more than)	24	17						
Customer satisfaction score	90%	88%						
Number of users	242	295						
Length of stay within CRT	21 days	17						

*Reading system figure not totally attributable to the scheme. Scheme figures to be presented in second quarter.

4.20 Engagement with Patients and Service Users

It is recognised that we need to improve our engagement and co-production approaches in relation to the BCF. In 2016/17 we will work with Reading Integration Board to ensure we gain a meaningful understanding of the personal impact of each scheme. We will also utilise a range of engagement techniques to ensure patients and users can shape our BCF programme, via dedicated task/finish

user forums through to direct communications with key groups via existing private and voluntary sector partners.

Additionally, individual BCF schemes have established user feedback mechanisms to gather regular input from patients/service users in relation to their satisfaction with, and ultimate success of, the services. This feedback will be used on an on-going basis to develop individual services and the BCF programme throughout 2016/17.

5. REPORTING AND MONITORING REQUIREMENTS

5.1 There is a requirement set by NHS England to report on BCF metrics on a quarterly basis. The reports aim to fulfil both the quarterly reporting and annual reporting requirements to monitor the totality of the BCF at Health and Wellbeing Board level. The template return requires sign off by the Health and Wellbeing Board. The Health and Wellbeing Board will need to submit a written narrative with the quarterly report to explain any changes to plan and any material variances against plan.

5.3 The high level timetable for this process in 2016-17 is set out in the below table:

Quarter	Period	Activity	Date
1	April to June 2016	Template released	22nd July 2016
		Template submission deadline	26th August 2016
		Data Collection and Performance Report published	7th October 2016
2	July to September 2016	Template released	21st October 2016
		Template submission deadline	25th November 2016
		Data Collection and Performance Report published	6th January 2017
3	October to December 2016	Template released	20th January 2017
		Template submission deadline	24th February 2017
		Data Collection and Performance Report published	14th April 2017
4	January to March 2017	Template released	21st April 2017
		Template submission deadline	24th May 2017
		Data Collection and Performance Report published	21st July 2017

5.4 The submission dates do not coincide in a timely way with the Health and Wellbeing Board meetings. This results in the recommendation for delegated approval for the Director of Adult Care and Health Services and the Chief Officer of Reading two CCGs to sign off the reporting templates to ensure the deadlines set by NHS England are adhered to.

6 CONTRIBUTION TO STRATEGIC AIMS

6.1 The decision contributes to the following Council's strategic aims:

- To promote equality, social inclusion and a safe and healthy environment for all
- To remain financially sustainable to deliver our priorities

6.2 Reading Borough Council is committed to:

- Ensuring that all vulnerable residents are protected and cared for;
- Enabling people to live independently, and also providing support when needed to families;
- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the council is financially sustainable and can continue to deliver services across the town;

6.3 The decision also contributes to the following:

- Equal Opportunities
- Health equality

7 RISKS

7.1 Both the CCGs and the Council are faced with significant funding issues going into 2016/17 and beyond. Section 12 sets out that there is current £3.611m of BCF funds supporting Council frontline services. Without this funding the Council could not support these services and these would have to cease, with the resulting impact on Council and NHS services.

8 LEGAL IMPLICATIONS

8.1 As per 2016/17, the requirement to formally pool budgets, established under section 75 of the NHS Act 2006, with South Reading CCG and North & West Reading CCG remains.

8.2 The Director of Adult Care and Health Services submitted a report on the Better Care Fund Section 75 to ACE Committee on 4th July 2016. It was agreed on section 17 that the Director of Adult Care and Health Services be granted delegated authority, in consultation with the Chair of the Adult Social Care, Children's Services and Education Committee and the Chair of the Health and Wellbeing Board, to agree joint commissioning arrangements under the new 2016/17 Better Care Fund Section 75 Agreement with the two Reading Clinical Commissioning Groups.

9 FINANCIAL IMPLICATIONS

9.1 Old Section S256 and Protection of Social Care
All the services funded under the old Section 256 funding and the new protection of social care is on plan to achieve a breakeven position.

Community reablement team and the Willows (DTA)

A review has been undertaken on both of these schemes as they are critical to the success of supporting individuals on discharge from hospital and also in some instances preventing admissions. Both schemes have been reviewed in terms of how these have actually operated during the first quarter. It has been identified that due to changes in delivery and efficiency measures that £94k of the original allocation is unlikely to be required. The intention, subject to RIB approval (through demonstration of the benefits and performance) is that this funding would be used for an additional bed at the Willows. (This will be in addition to those already identified in the PID and will be used to increase the performance with no additional overall, investment in the service).

Local Project Office

The performance analyst is currently out to advert and there will only be a part year impact of this post. There is currently a review of the support needed, but there maybe a small understand to report in coming months.

Local Contingency
At this stage no further pressures have been identified however it is assumed that this will be required and therefore this is not being shown as an underspend due to the current high demands on services across the system.

Disability Facility Grants

At the end of quarter 1 a full review has been undertaken on the Disability Facility Grant. The current position is:

- total spend on DFG's (major adaptations) as at the end of July was £141k
- The approved commitment at the end of July (this is where a grant has been approved and is either at pre-site or on site stage) was £219k

Based on the current forecast is unlikely that the full grant of £815k will be required in 16/17, however there are a number of areas where it has been identified where current DGF processes can slow down discharges. Therefore a business case is currently being developed (with input from the OTs at RBH) to use some of these funding to support:

- Obtaining (procurement exercise) a framework for providers or Stair lifts and ramps (currently each time a stair lift or ramp is required a mini tender for the work has to be run slowing the whole process down)
- How telecare/ telehealth care can be improved
- Review of equipment and minor adaptions

9.2 Performance Fund

As part of the BCF plan, there is a payment for performance target relating to the reduction in non-elective admissions specifically within the Care Home, Community Reablement and Discharge to Assess Programmes. In the Reading BCF plan, the CCG target is set at no more than 2.2% increase.

If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand.

Table 9.3

Scheme	Hospital Avoidances	Savings £
Care Homes	148	408,480
Discharge to Assess	12	26,700
Community Reablement	48	106,800

10. BACKGROUND PAPERS

10.1 Better Care Fund on a page**,** NHS England Assurance approval letter, Commissioning workshop outcomes

11 NEXT STEPS

11.1 Key next steps for Quarter 2

- Staff restructure in process for CRT
- Development of an integrated seven day hospital team
- Choice policy implementation
- Further investment into business analysis
- Development of assistive technology strategy with implementation plan to enhance prevention
- Increased efficiency of patient flow
- Implementation of key themes (see appendix 3) and synergies of commissioning workshop held in September and the promotion of the commissioning intentions across the three localities within Berkshire West

The BCF is a standing item on the HWB agenda. The BCF programme manager will update the Board on progress to date and performance measures at the next meeting.

NHS England
Skipton House
80 London Road
London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*
Councillor Graeme Hoskin, Chair of Reading Health & Wellbeing Board
Ian Wardle, Managing Director, Reading Council
Dr Cathy Winfield, Chief Officer, Reading Clinical Commissioning Group

8 July 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support

and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

NHS England

Copy (by email) to:

Anthony Kealy, Programme Director, Better Care Support Team

Reading Better Care Fund - Integrating health and social care

Unified prevention offer for Reading communities

- A clear, consistent menu of services that are on offer in each community for a range of social, emotional and practical help with third sector engagement.
- Connecting communities and supporting vulnerable people to access information, help and advice to avoid escalating health and care needs.
- Greater use of assistive technology to keep people independent for longer.
- A range of improved support to carers.
- A one-stop shop for housing support to help maintain people's independence in their own home including the use of the Disabled Facilities Grant.

Integrated, proactive care for those with long term conditions

- Improve the identification of people with long term conditions.
- Improved care planning from health and social care for those with complex conditions and/or the over 75s.
- Integration with the Frail and Elderly pathway
- Evidence based collaboration with Reading JSNA
- To enhance Readings digital pathway
- Integrated Commissioning
-

Integrated urgent response

- Work with the ambulance service to prevent unnecessary hospital admissions at home, a care home or in the community.
- A community based assessment service for frail older people.
- New seven day services across the system.
- Improved rapid response to prevent admissions.
- Greater focus on health and social care working within the emergency department
- To support people at the end of life

Hospital discharge and reablement

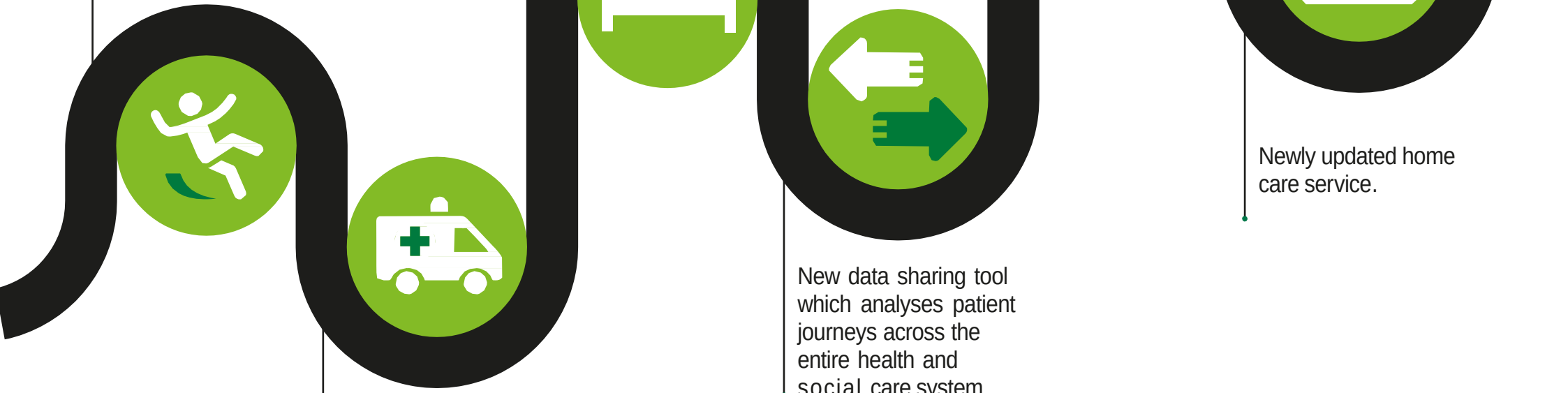
- Work across health and social care to maintain good performance in reducing the amount of time people have to wait in hospital whilst home care support is set up.
- Review service for those in receipt of care packages two weeks after discharge from hospital.
- Home first aims to work with people to make sure they feel confident, independent, and supported in their own home following a discharge from hospital

What improvements will we see?

- Reduce the number of permanent admissions to residential and nursing homes supporting people to stay in their homes for longer.
- Increase the number of service users still at home 91 days after reablement.
- Reduce the number of bed days people have to wait in hospital once medically fit to go home.
- To have no more than an increase of 2.2% in non-elective admissions.
- Increase the percentage of patients with long term conditions who feel their care meets or exceeds their expectations.
- Reduce the number of emergency admissions from care homes.

Better Care Fund - Our journey so far

An improved prevention offer for Reading's communities, featuring neighborhood support, care support and Local Area Co-ordination.



Emergency admissions avoidance schemes.

Major improvements in hospital discharges.

New data sharing tool which analyses patient journeys across the entire health and social care system.

Development of integrated health and social care teams working in partnership with GP practices and the acute trust.

Newly updated home care service.

Appendix 3 - Commissioning Intentions – Themes and synergies to explore – from September Workshop

- Further and faster exploration of options for combining back office and uniform functions across partners, where it can generate demonstrable process and or finance efficiencies
- Set up process to ensure new initiatives are not commissioned without first identifying where similar existing capacity could be re-configured/reduced to release/ensure best use of resources
- Further exploration of pooled funds with appraisal of current set ups and options for more/less in:
    - Residential & nursing care placements
    - CHC
    - Reablement
    - Discharge processes
    - Personal budgets/personal health budgets
- Improving the discharge processes and experience
    - Promote consistent practice and processes across partners
    - Implement trusted assessors
    - Earlier involvement of private/vol. sector providers to promote more timely transfer to long term care, where required
    - Better analysis and understating of current options for discharge (i.e. community hospital bed use, nursing care etc.) to be clear on capacity, suitability and identify any gaps in provision
- Review current community hospital bed use across BW10 – is it utilised effectively and consistently?
- Explore options to incentivise providers to safely promote timely move on and/or avoid higher intensity services, where appropriate (i.e. further exploration of capitated contracts, commissioning by outcome/need not service type)
- Better patient/service user segmentation to deliver more targeted services that have the greatest impact on key HWBB measures/outcomes
- Develop a better understanding of savings/efficiencies of current and future service models (e.g. quantifying the benefits of investing in step down/reablement which can delay need for residential/more intense dom care)
- Prevention and community/patient/user engagement
    - Promoting community ownership of their HWBB and building stronger links (multiple work streams in this area that need coordinating)
    - Review initiatives that can make our workforce champions of public health and lead by example
    - Invest in broader use of technology (AT, more on-line services, improved data sharing)
- Making better use of local/national enterprise and businesses –
    - Can we tap into local business to deliver joint initiatives (i.e. local tech business and research/academic institutions) for patient/user benefit?
    - To make bids attractive will need to be of scale and likely pan west Berkshire
    - Set up of dedicated role to explore and maximise funding opportunities via grants and challenge funds etc. to deliver change projects/pilots
- Firmer agreement on what 7-day services means and what should be provided / what do we want to achieve? Analysis of current provision against agreed parameters, identify any gaps. Promote 7 day access/service equity across partners
- Promote crossover and consistency between partner commissioning strategies to highlight joint working and communication. Localities to agree on common section/text, as appropriate.