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To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

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19 January 2017

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NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 27 JANUARY 2017

A meeting of the Health & Wellbeing Board will be held on **Friday 27 January 2017 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

		PAGE NO
1.	**DECLARATIONS OF INTEREST**	-
2.	**MINUTES OF THE HEALTH & WELLBEING BOARD MEETING HELD ON 7 OCTOBER 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.	-

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5. END OF LIFE CARE BRIEFING 16

A report giving an update from the previous report presented on 9 October 2015, including an overview of End of Life Care locally, to aid discussion on how the Reading locality can now further develop our care and support for those at the end of life.

6. BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) NHS SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE 21 & verbal report

A letter about and a document summarising the NHS Sustainability and Transformation Plan (STP) for Buckinghamshire, Oxfordshire and Berkshire West (BOB), sent in December 2016. A verbal update on the latest situation with the development of the BOB STP will be given at the meeting.

7. READING'S SECOND HEALTH & WELLBEING STRATEGY 32

A report presenting Reading's second Health and Wellbeing Strategy for adoption by the Health and Wellbeing Board and an Action Plan for approval.

8. BERKSHIRE WEST CLINICAL COMMISSIONING GROUPS (CCGs) OPERATIONAL PLAN 2017/19 & READING ADULT SOCIAL CARE COMMISSIONING INTENTIONS 2017/18 151

A report presenting the Berkshire West CCGs Operational Plan 2017/19 and the Reading Borough Council Adult Social Care Commissioning Intentions 2017/18.

9. HOW IS ELECTRONIC PRESCRIBING WORKING FOR READING PEOPLE? - FINDINGS OF A HEALTHWATCH READING PROJECT 210

A report by Healthwatch Reading on a project carried out in September & October 2016 to find out Reading people's experiences of the NHS electronic prescribing service (EPS), which allows a patient prescription to get from a GP's computer to a patient's pharmacy computer, so people don't have to take a paper copy.

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10. UPDATE REPORT: ACRE'S FEMALE GENITAL MUTILATION (FGM) COMMUNITY ENGAGEMENT WORK & PROGRESS TOWARDS CREATION OF THE ROSE CENTRE, READING 236

A report from ACRE (Alliance for Cohesion & Racial Equality) providing a summary of developments in relation to tackling Female Genital Mutilation by prevention and education since October 2016, when a previous report was presented to the Health and Wellbeing Board.

11. ESTABLISHING CLINICAL RESPONSE FOR ADULTS WHO HAVE SUFFERED FEMALE GENITAL MUTILATION (FGM) 238

A report from Berkshire West CCGs giving an overview of the current arrangements for physical and/or psychological support for survivors of FGM and outlining the proposed plan for the development of services in this area.

12. A&E DELIVERY BOARD & IMPROVEMENT PLAN 251

A report giving an update on:

- The role of the system-wide Berkshire West Accident & Emergency (A&E) Delivery Board in ensuring delivery of the NHS constitutional standard that no patient should spend more than 4 hours in an A&E department from arrival to admission, transfer or discharge
- Progress on delivery of the local A&E Improvement Plan which is designed to support recovery of the standard at the Royal Berkshire Hospital.

13. INTEGRATION AND BETTER CARE FUND 268

A report providing an update on the progress of the Integration programme, including Better Care Fund Performance (BCF).

14. A HEALTHY WEIGHT STATEMENT FOR READING – PROGRESS UPDATE 277

A report presenting a Healthy Weight Position Statement for Reading and reporting on progress on the development of a Healthy Weight Strategy and action plan.

15. BERKSHIRE TRANSFORMING CARE PARTNERSHIP – UPDATE 322

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

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16. WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16 332

A report presenting the 2015/16 annual report of the West of Berkshire Safeguarding Adults Board (SAB).

17. READING LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16 454

A report presenting the 2015/16 annual report of the Reading Local Safeguarding Children Board.

18. READING AUTISM STRATEGY AND ACTION PLAN 514

A report setting progress on the delivery of the Reading Autism Strategy's key objectives, and a proposed revised action plan for 2017/18.

19. ANTIMICROBIAL RESISTANCE 559

A report providing an information briefing on Antimicrobial Resistance (AMR).

20. DATE OF NEXT MEETING -

Friday 24 March 2017 at 2pm

READING HEALTH & WELLBEING BOARD MINUTES – 7 OCTOBER 2016

Present:

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

Also in attendance:

Andy Fitton	Head of Early Help and Family Intervention, RBC
Jo Hawthorne	Head of Wellbeing, RBC
Kevin Johnson	Integration Programme Manager, RBC
Tom Lake	South Reading Patient Voice
Lise Llewellyn	Strategic Director of Public Health for Berkshire
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Councillor Stanford-Beale	RBC
Libby Stroud	South Reading Patient Voice
Cathy Winfield	Chief Officer, Berkshire West CCGs

Apologies:

Councillor Eden	Lead Councillor for Adult Social Care, RBC
Simon Warren	Interim Managing Director, RBC

1. MINUTES

The Minutes of the meetings held on 14 June and 15 July 2016 were confirmed as a correct record and signed by the Chair, subject to the amendment that Frimley Park Hospital was actually in Surrey, not in the East of Berkshire.

2. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

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

(a) Health and Wellbeing Dashboard – Mortality Rates

"The Health and Wellbeing Board is having a dashboard of local Health and Wellbeing designed. Standardised mortality rates assess the ultimate outcome of health evolution and interventions. Indeed it has been reported that mortality rates for older women have increased in the last year in Reading. Will the Health and Wellbeing Board's dashboard include mortality rates?"

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

"As discussed by the Health and Wellbeing Board, the final indicators that will be included in the Health and Wellbeing Dashboard will be selected by a dedicated group of stakeholders and partners when the partnership Health and Wellbeing Strategy has been finalised. We want to make sure that the indicators we select give a full and accurate picture of how Reading's services are working towards the specific issues and priorities identified. Comparing mortality rates with areas with similar populations is a very useful way of giving an indication of the relative health of people in a given area and may well be considered an appropriate indicator to include. However, there are a great many indicators available to the group, including those focusing on particular health conditions and important social care processes, and it is difficult to say at this time which will be considered most beneficial to the Board.

Benchmarked mortality rates for Reading and all other Local Authority areas are publicly available as part of the Public Health Outcomes Framework http://www.phoutcomes.info/ and the PHE Longer Lives website (See http://healthierlives.phe.org.uk/topic/mortality/#are/E06000038/par/E92000001/ati/102/pat/)"

(b) Swimming Offer – Health Consequences

"Reading Leisure's swimming offer is shrinking and will be restricted, especially in East Reading, for several years. Have the health consequences of closures been considered? What health consequences are foreseen?"

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

"Reading's recent review of leisure facilities has indeed taken into account the health benefits of swimming and the need to modernise our facilities to improve access for our residents.

The Council proposes to build a new 25m 6 lane pool and a teaching pool at Palmer Park which will improve swimming facilities in the East Reading area. Because of the current condition of the Arthur Hill Pool, the Council is talking to user groups about adapting the programmes at other pools (Academy Sport, Meadway and Central) to accommodate swimmers in the event that the Arthur Hill Pool needs to be closed before the new Palmer Park pool is ready. A planned closure is the best way to manage the impact on user groups and to avoid the risk of an unplanned, forced closure.

The Council is also taking forward plans for a demountable pool at Rivermead, and there will be a new hourly bus service between Rivermead and the town centre from later in October making that site more accessible to more residents. Having the demountable pool in place is part of our preparations for the development of a new competition standard pool to replace Central Pool over the next few years.

Reading residents can also access public swimming sessions at the Bulmershe and Loddon Valley leisure sites to the south and east of the Borough. With the range of alternatives available, any health impact of a short term reduction in facilities in East Reading should be minimal. In the medium to longer term, facilities will be enhanced so that more people can enjoy the health benefits of swimming, which include reducing the risk of and helping delay a deterioration in a range of chronic long term conditions including cardiovascular disease, type 2 diabetes, obesity and mental

health issues. Swimming has added benefits for those who have difficulties with weight-bearing activities or disabilities that impact on mobility and is less likely to cause impact injuries than other forms of physical activity so is particularly well suited for those with mobility restrictions."

In response to a supplementary question from Tom Lake about provision of arrangements for those with mobility problems or learning difficulties to access sessions at other swimming pools, Councillor Hoskin said that he understood that discussions were currently taking place in order to make such arrangements.

(c) Health & Social Care Public Engagement – Information at Civic Offices

"Public engagement with local health and social care involves a range of events organised by various arms of the NHS, local authority and community. Could the Borough Council make available a notice board or web page in the Civic Centre main reception area to accommodate a calendar of forthcoming events and the individual event notices?"

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

"The Council is always happy to promote public engagement in developing health and social care services, and to help reach as wide a range of our residents as possible.

The Council has three screens in the foyer at the Civic Centre which are used to advertise events and services. The display revolves throughout the day and can accommodate a range of items. We would be happy to design a calendar to include on the revolving display which sets out forthcoming public engagement opportunities in health and social care, and could be refreshed on a monthly basis.

In addition, we have a consultations page on the Council's website and we are happy to include health and social care partner engagement opportunities on there alongside public engagement events being co-ordinated by the Council.

Relevant items for inclusion on the display screen or RBC website can be sent to Wellbeing.Service@reading.gov.uk."

Tom Lake noted at the meeting that the Commissioning Support Unit provided rotating notice screen arrangements for GP surgeries, which were customisable and updated periodically, and suggested that these could also be provided in non-surgery civic venues.

Councillor Hoskin said that further conversations were needed with health partners about communications and engagement opportunities.

The following question was asked by Libby Stroud in accordance with Standing Order 36:

(d) Homeless Children

"South Reading CCG is commissioning an audit of the health needs of the single homeless, which I welcome. This is expected to cover those on the streets and the much larger numbers in hostels and temporary accommodation, as well as those borrowing a sofa or bed. But why has this not been extended to the health needs of homeless children and young people under 16 (who will be in temporary

accommodation) as they are recognised as being particularly vulnerable to the effects of homelessness on their health (in the widest sense of the word)?"

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

"Reading Borough Council's Housing Needs department are currently having discussions with partner agencies and voluntary sector organisations about planning a Homeless Health Needs Audit for a month across January and February 2017. The first planning meeting was held on 7 July 2016 and the second is scheduled for 27 October 2016.

It is Homeless Link, a national membership charity for organisations working with people who become homeless in England that has developed the Homeless Health Needs Audit toolkit. Homeless Link works towards making services better and campaigning for policy changes that will help to end homelessness. The toolkit includes the resources and planning tools to conduct the Audit. After the local authority area has conducted the Audit it is Homeless Link that dedicates their resources to analysing the Audit data and producing any subsequent reports.

RBC Housing Needs department will be using the toolkit and Homeless Link's advice and guidance to conduct the Homeless Health Needs Audit. Several local authorities have conducted the Audit since its inception and the toolkit has evolved over time to ensure that it produces the most useful outcomes for the local authority area. The data collated feeds into the overall national picture and assists Homeless Link with their ongoing work around single homelessness. Therefore the toolkit we are using for the Audit has been developed for auditing single homeless individuals only.

The resource for planning, organising and following up the Audit comes from the Homelessness Pathways team within Housing Needs. The team works with those who are aged 18+, who are single and homeless. The Council's Housing Needs department commissions several services for single homeless individuals and the Audit will help to inform the development of services and future provision. The time and resources saved by using Homeless Link's Audit toolkit, as well as the guidance they are able to provide, is what is making it possible to conduct the Audit in Reading. Additionally, to create nationally comparative data and to be able to benchmark the health needs of single homeless individuals, the sample context must be the same for all local authorities that take part.

As outlined by Homeless Link, the aims of conducting a Homeless Health Needs Audit are as follows:

- To listen to, take account of and record the views of single homeless people regarding their health needs using relevant evidence gathering procedures.
- To provide an evidence base on the health needs of single homeless people by building a comprehensive dataset on the local homeless population to fill in any information or evidence gaps.
- To contribute to the local authority's Joint Strategic Needs Assessment (JSNA).
- To demonstrate the value of homelessness services in contributing to the health agenda and vice versa – identifying what we are doing well and where improvements could be made.
- To improve service access and delivery for single homeless individuals in the local authority area and ultimately improve their overall health.

- To develop a case for change by considering the development of new services; service remodelling; new or better partnerships and systems, or additional training for targeting and engaging single homeless individuals.

As a service, Housing recognises the effects that homelessness has upon the health of children and young people under the age of 16. Although the Homeless Link toolkit is not available for this group, an audit that includes children and young people under the age of 16, who may or may not be in temporary accommodation and that may be vulnerable to the effects of homelessness on their health, may be something that Children's Services, the Reading Clinical Commissioning Groups (CCGs), Public Health Reading and Housing Needs would want to commission in the future. However, in the context of the Homeless Link Homeless Health Needs Audit, the resources are not available to include this wider group."

3. BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) NHS SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE

Further to Minute 1(b) of the meeting held on 14 July 2016, regarding the draft Sustainable Transformation Plan (STP) submission for the West of Berkshire, Oxfordshire and Buckinghamshire (BOB) region, and following the closed session held on 13 September 2016 for members of the Board to be briefed on and discuss the development of the STP, Cathy Winfield gave a verbal update on the latest situation.

She reported that, following the Board's previous concerns about the STP process and the scale of the BOB region, she had been heartened that, when the latest STP planning guidance had been issued a couple of weeks previously, it seemed that there would be an opportunity for STPs operating over large areas to split into sub-divisions, each with their own governance arrangements and financial control totals. She said that the Berkshire West 10 was keen to operate as a sub-division, and that there was already governance in place.

She said that the STP submission was due in on 21 October 2016 and the Leadership Group would be meeting in the week beginning 10 October 2016 to develop a new iteration of the submission to reframe the STP in sub-divisions. Contact had been made with NHS England, who wanted to see robust plans at the local health economy level. She explained that there were some areas where partnership work at the BOB level would still be needed, including digital transformation, workforce, acute sector, mental health and prevention, but the vast majority of work would be done in local partnership, with a split of about 80:20 expected.

Wendy Fabbro said that, by the time of the next Health and Wellbeing Board meeting, the agencies involved should be in a position to explore opportunities for aligning the plans from all agencies.

The Board discussed the process of public engagement on the STP, with some members of the Board expressing concern that the public had not been involved in the development of the proposals or able to comment and influence. Cathy Winfield explained that the guidance issued had said that public engagement would not start until after the formal sign off on 21 October 2016 and she said that then further work on detail would be needed and consultation events would need to be planned up to February 2017. She noted that these might now be aligned with the CCGs' operating

plan consultations, as the timescale for the operating plans had been brought forward to 23 December 2016, rather than the usual March deadline.

Resolved - That the position be noted.

4. HEALTH AND WELLBEING BOARD POST-LGA PEER REVIEW STOCKTAKE

Further to Minute 4 (4) of the previous meeting, Jo Hawthorne gave a verbal update on the results of a stocktake undertaken by members of 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.

She said that the stocktake session had been very successful, providing an opportunity for members of the Board to have an initial look at the challenges from the Peer Review, but that the key discussions had really just been getting going by the end of the session, so some additional sessions needed to be organised in order to take the work forward further.

Members of the Board noted that the Peer Review had identified the strength of all the Board members being committed to the health and wellbeing of the people of Reading and also challenges in the different ways of working within the organisations involved and in working out how best to bring these together in partnership working. There was a lot of potential for developing relationships and integrating agendas further, including aligning strategies and workstreams to avoid duplication of effort, and further sessions would help identify what could be changed in the way the Board organised itself and its work.

It was reported that, at the session, members of the Board present had agreed that the Vice Chair of the Board should be from the CCG membership, rather than from the Councillor membership, and so this change to the operational arrangements for the Board was recommended to the Board for formal approval. It had also been agreed to mix up seating positions at the Board meetings so that health and Council partners were not sitting separately and this had been put into place for the current meeting.

Resolved -

(1) That the position be noted;

(2) That further stocktake sessions be organised to take the work further;

(3) That the operational arrangements for the Health and Wellbeing Board be amended to say "A Clinical Commissioning Group member of the Health and Wellbeing Board will be Vice-Chair." rather than "A Councillor member of the Health and Wellbeing Board will be Vice-Chair" and Andy Ciecierski be appointed as Vice-Chair of the Board.

5. READING'S SECOND HEALTH AND WELLBEING STRATEGY – 2017-20

Further to Minute 9 of the previous meeting, Janette Searle submitted a report setting out progress in developing Reading's second Health and Wellbeing Strategy for 2017-20 and seeking authority to launch a formal consultation on the draft Strategy, a copy of which was attached at Appendix 1.

The report explained that, at its 15 July 2016 meeting, the Health and Wellbeing Board had agreed to a set of proposals for developing Reading's 2017-20 Health and Wellbeing Strategy, and had requested a further report to the next meeting on the commencement of a formal consultation. The Chair of the Board had 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 would be key to developing a strong community infrastructure to support wellbeing.

The report set out the process which had been carried out to develop the new strategy, involving members of the Health and Wellbeing Board and key stakeholders in the Health and Wellbeing Involvement Group, which had developed the priorities for the Strategy.

The Health & Wellbeing Involvement Group had 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: "A Healthier Reading"

The Group had also liked the idea of adopting the Public Health England mission statement, and suggested adding a Reading Mission Statement: "To improve and protect Reading's health and wellbeing – improving the health of the poorest, fastest"

A number of issues had been identified to make up a 'priorities shortlist' for the new strategy using the following criteria:

- Reading's performance in this area was significantly below average (for England/for the region/by reference to statistical neighbours).
- This was something which stakeholders felt confident was under local control and influence, and could therefore be changed through a local strategy.
- Reading's performance over time indicated a need to focus on this issue, eg Reading was now performing in line with or better than national averages, but this reflected a focus given to a 'hot topic' which needed to be sustained.
- The issue either was not already included in/monitored via other strategic plans, or there would otherwise be clear added value in making this a HWB priority, eg this was something which stakeholders believed 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 was significant if the issue was made a priority across the HWB partnership.

Three building blocks had 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

The draft Strategy proposed the following 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 drank to safe levels
- Promoting positive mental health and wellbeing in children and young people
- Making Reading a place where people could live well with dementia
- Increasing breast and bowel screening and prevention services
- Reducing the number of people with tuberculosis

The report stated that 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 were:

- Increasing the number of young people in employment, education or training (not NEET)
- Ensuring more people planned for end of life and had 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 were eligible for free school meals and those who were not eligible
- Tackling poverty
- Reducing the number of people and families living in temporary accommodation

The Involvement Group's recommendation was 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.

A dashboard of key performance indicators had been developed, to increase the accountability and transparency of the Health and Wellbeing Board's future progress against stated aims and objectives. This dashboard would be used to track performance against the Action Plan which would be developed in support of the 2017-20 Health and Wellbeing Strategy. It would 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.

The Board noted the importance of consulting with children and young people on the strategy, presenting it in an accessible way, and co-designing solutions with young people. It was reported that plans were in place to develop a suitable presentation for consultation with young people, and for consultations with various patient groups and user forums, but that other suggestions would be welcomed.

Resolved -

(1) That a formal consultation be launched on the draft Health and Wellbeing Strategy 2017-20 set out at Appendix 1;

(2) That a progress report be submitted to the next meeting presenting a final version of the Strategy, including a supporting Action Plan developed with stakeholders as part of the consultation process;

(3) That the Board's thanks to all those involved in drawing up the draft Strategy be recorded.

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

Mandeep Sira submitted a report on a project carried out in May 2016 collecting patient views in the Royal Berkshire Hospital Accident & Emergency (A&E) department. She explained that the project had been carried out outside the Healthwatch action plan because of the recent discussions about pressure on A&E, in order to collect patient views to feed into the discussions when coming up with solutions.

The survey had been carried out at the Royal Berkshire Hospital from Monday 16 to Sunday 22 May 2016, for two to four hours each day, making a total of ten visit sessions, to collect people's experiences about what services, if any, they had contacted before coming to the emergency department (ED) and what factors had influenced their decision to go to A&E, in order to inform commissioners as they planned and made changes or improvements to urgent care and other services.

249 people (238 adults and 10 young people) in either the adults' or children's waiting areas had shared their views, by filling in an anonymous two-page survey handed out by a Healthwatch Reading staff member or volunteer; Healthwatch Reading had also spoken in-depth with some people who wanted to share more details. The visits had been agreed in advance with the hospital, and the findings had been independently produced by Healthwatch Reading, under its statutory Enter and View function.

The report set out the main findings of the project as follows:

- Most common reasons for visit:
  - Accident (39%)
  - New symptom or problem (14%)
  - Change or worsening of long term condition (10%)

- 25% described 'other' issues (eg bee sting, lumps, eye and dental problems, swollen tongue, back and chest pain)

- 48% had experienced their health problem for 1-7 days

- 55% had tried to seek help from other services before going to the ED (ie GP (73%), NHS 111 (33%), NHS Walk In Centre (15%), GP out-of-hours service (12%), pharmacist (4%) but only 1 person NHS Choices website)

- 79% said the service they had contacted beforehand had advised them to go to the ED

- The 83 patients who had not contacted a service before coming to the ED had selected these reasons:

- 28% believed they had machines, technology or medicines not available anywhere else
- 27% believed their problem was very serious
- 23% believed A&E had staff/experts they would not find anywhere else

- Patients who had not contacted a service before coming to the ED said they would consider doing so in future if they had more information about alternatives

The report also set out observations about the A&E department and detailed results from a separate young person's survey.

It stated that Healthwatch believed the findings raised a number of questions and it urged the Urgent Care Programme Board and the Hospital to consider and report on these questions. The report listed the following questions and also included further comments on each question:

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?
2. Are clinical quality audits regularly carried out of referrals made to A&E by other healthcare services to assess their appropriateness?
3. Do we need to consider restructuring local urgent and emergency care services?
4. How can we improve the information given to the public about using the right service at the right time?
5. What can be done to prevent ED attendances prompted by dissatisfaction with other services?
6. What can be done to improve the 'check-in' experience of people arriving at A&E?
7. Could changes be made to improve the overall experience for patients and relatives/friends, while they are waiting to be seen?
8. Could changes be made to the way patients are called through to the ED clinical area?
9. Can more in-depth research be commissioned in the future on the patient's journey, before, during and after ED?

Mandeep Sira explained that a thorough preliminary response had been received from the Berkshire West CCGs, including an action plan, and a fuller formal response was being prepared. She said that she was concerned about the consistency of messages across the health and social care economy and the need for local, clear and concise communications about what services were available locally.

Maureen McCartney said that the CCGs had welcomed the comprehensive report, which had been discussed at the Primary Care Commissioning Committee on 19 September 2016 and she tabled copies of the preliminary response at the meeting, which set out initial responses to the questions and initial action plans and stated that a formal written response was to be approved by the A&E Delivery Board on 27 October 2016.

It was noted that the project needed to be seen in context, as 87% of Berkshire West's residents did not attend A&E and were attending the various NHS services appropriately, but that there was a need for reinforcing communications about the purpose of A&E and where and when other services were available.

Cathy Winfield explained that the Urgent Care Programme Board was now the A&E Delivery Board, which would be taking oversight of the delivery of the agreed actions and was developing an Improvement Plan, which could be brought to the next meeting.

Resolved -

(1) That Healthwatch be thanked for their work on the project and the report be welcomed;

(2) That the Berkshire West CCGs bring back a report on progress on the A&E Delivery Board Improvement Plan to the next meeting of the Board and set out anything the Health and Wellbeing Board could do to support the solutions.

7. PUBLIC HEALTH BUDGET

Jo Hawthorne submitted a report which set out the current position of the Public Health Budget for 2016/17 and detailed the programmes of work funded by the Public Health grant. The report had appended a breakdown on spend and savings measures at Appendix 1 and the final budget position for 2016/17 at Appendix 2.

The report stated that the Government had announced that the 2015/16 public health grant reduction would be recurrent and had confirmed further overall reductions to the Council's public health grant. Details of the breakdown of the grant reduction to £10,269,000 (7.52% reduction) were set out in the report. The Chancellor's Autumn Statement had confirmed that public health funding would continue to be reduced annually until 2020 and that the ring-fenced conditions for use on public health grant would continue for at least two more years.

In addition, the drug and alcohol treatment service currently received a £284,635 grant from the Police and Crime Commissioner. This grant was being reviewed and should the grant reduce or be cut in full for 17/18 this would create an additional pressure. The report gave details of the likely position for 2017/18, involving a further 2.7% reduction in grant to £10,016,000.

The report stated that 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, had been reviewed. Officers across the Council had 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 was included in Appendix 1.

Additional savings on top of those initially identified were listed in the report. The final budget position and savings made for 2016/17 was attached at Appendix 2 and reported a breakeven position. To address the ongoing grant reductions up to and including 2019/20, officers would be reviewing all spend against the public health

grant. Longer term planning would ensure that all expenditure was informed by local health priorities and local population health needs.

Resolved -

(1) That the current budget position for 2016/17 be noted;

(2) That the budget pressures to be faced in 2017/18 as a result of further grant reductions be noted.

8. UPDATE ON TACKLING FEMALE GENITAL MUTILATION (FGM)

Further to Minute 5 of the meeting on 22 January 2016, Andy Fitton submitted a report giving an update on work undertaken since January 2016 and planned in relation to tackling Female Genital Mutilation (FGM).

The report explained that two strands had been identified to organise the response to FGM:

- Strand 1 – Prevention and Education
- Strand 2 – Protect and respond

Strand 1 had been led by the Alliance for Cohesion & Racial Equality (ACRE) with partnership support, including sponsorship from the Local Strategic Partnership (LSP) that had accepted FGM as one of its three priorities in June 2015. The report listed key achievements since January 2016 on the continuation and development of community engagement work. It stated that a plan of action had 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 Clinic, to secure its optimal reach and value, and the report gave details of further work on prevention and education. It stated that ACRE needed to source start-up funding, to avoid engagement coming to a standstill until the opening of the clinic. The report noted, however, that the funding from the LSP to ACRE had now ended and there was no short-term way of continuing the FGM community engagement work, and it set out the key risks.

Strand 2 had been led by Children's Services in Reading Borough Council, with support from the LSCBs (Local Safeguarding Children Boards). The report stated that good and timely progress had been made against the partnership action plan on protection work and gave details of key highlights, including a launch of a range of tools on FGM awareness and assessment in July 2016 and completion of an audit of prevalence in July 2016, based on work in the hospital with public health. It also listed planned work up to January 2017.

The report explained that, as previously noted in January 2016, there was a significant gap in provision for adults having undergone FGM, as Berkshire did not have a specialist clinic similar to Oxford and Bristol, without which many women would not be able to seek the help they needed. ACRE, with the support of Children's Services in the Council, had written a proposal that provided an option to create a single West of Berkshire provision of a specialist clinic alongside the extension of the preventative community work that ACRE had already been providing. This Reading Rose Clinic would be the centre point for health and education and

affected community activists and leaders could use it to educate, enable and support girls, women, their wider families and communities to stop FGM.

The proposal had been presented to the Nurse Director at the CCG Berkshire West Federation and the Police and Crime Commissioner (PCC) in June 16 to gain their support. Both key partners were in principle committed to establishing a specialist clinic with a level of wraparound preventative work led by ACRE, and the CCG were currently building a business case to consider funding a start medical clinic and ACRE was in discussion with the PCC office to explore potential funding options for the preventative work. The current target was to set up a clinic by April 2017.

Resolved -

(1) That the work undertaken so far and the proposed next steps be endorsed;

(2) That a report from ACRE on progress against the creation of a community-based education and preventative programme of support be submitted to the Health and Wellbeing Board in January 2017;

(3) That a report from Berkshire West CCG on the progress of establishing a clinical response for adults who had suffered FGM be submitted to the Health and Wellbeing Board in January 2017.

9. BERKSHIRE TRANSFORMING CARE PARTNERSHIP

Sarah Rowland, Interim Programme Manager for the Berkshire Transforming Care Partnership, who had been due to attend the Board to give a presentation giving an update on the work of the Berkshire Transforming Care Partnership on the Berkshire Transforming Care Plan, was unable to attend the meeting due to sickness. Copies of the presentation slides had been included in the agenda.

Resolved - That consideration of the item be deferred until the next meeting.

10. INTEGRATION AND BETTER CARE FUND

Kevin Johnson submitted a report setting out the Better Care Fund (BCF) integration performance within Reading at the end of Quarter 1, the BCF reporting and monitoring requirements and the findings from a Joint Commissioning Workshop held in September 2016.

The report explained that the Reading BCF had gained fully approved assurance by NHS England on 8 July 2016 and a copy of the letter was attached at Appendix 1. A BCF Plan on a Page had been produced to explain the 2016/17 submission, which was attached at Appendix 2.

The Reading BCF for 2016/17 totalled £10.4m and funded 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 delivered value to both the NHS and the Local Authority. As in previous years, the BCF had 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 to which partners must adhere.

The report stated that, to date, Reading had 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/Community Reablement Team services, fewer admissions to residential care and reduced admissions to hospital from care homes supported by the Rapid Response and Assessment Team. As at the end of Quarter 1, however, this had not translated into clear system-wide benefits or a positive impact on the key BCF metrics, namely non-elective admissions (NEA) and delayed transfers of care (DTOC).

The report gave further details of the figures for Quarter 1 on NEA, DTOC and residential and nursing home admissions and on actions being taken. It also gave details of local project performance on the Connected Care project, the Enhanced Support to Care Homes project, the Community Reablement Team and the Discharge to Assess service.

The report explained the reporting and monitoring requirements set by NHS England to report on BCF on a quarterly basis, and set out the timetable for this process in 2016/17. It explained that the template return required sign off by the Health and Wellbeing Board, but that the submission dates did not coincide with Health and Wellbeing Board meetings, and therefore recommended an officer delegation to meet the NHS England deadlines.

The report set out the key next steps to be taken in Quarter 2, including work on the Commissioning Intentions themes and synergies, which had been identified at a Joint Commissioning Workshop held in September 2016 and were set out in Appendix 3 to the report.

Kevin Johnson noted that, as set out in the report, Quarter 1 had shown an increase in DTOC from the Royal Berkshire Hospital, for a number of reasons including an increase in patient admissions within the acute trust, and the delays had been escalated to Reading Integration Board. He said that a lot of work was being carried out on this area, an analyst had recently been employed to go through the data to work out why there was such a problem, and partners would be working together to look at this issue further.

Maureen McCartney reported at the meeting on the figures for elective and non-elective hospital admissions in South and North & West Reading CCGs, noting that elective admissions had only increased by around 2-3% and that both Reading CCGs benchmarked very well nationally on NEAs. In 2015/16, South Reading CCG had been ranked fourth out of 209 CCGs and North and West Reading fifth. The latest figures for 2016/17 showed this trend continuing. She also explained that the CCGs planned to work with patients who had five or more NEAs in one year, looking at how to give better support to these patients.

Resolved -

(1) That the Board note the position on Integration and the Better Care Fund performance at the end of Quarter 1;

(2) That the Director of Adult Care and Health Services and the Chief Officer of Reading South and Reading North & West CCGs, in consultation with Reading Integration Board, be given delegated authority to sign off and submit Better Care Fund quarterly reports to NHS England.

11. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 27 January 2017.

(The meeting started at 2.05pm and closed at 4.05pm)

JOINT REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP, NORTH & WEST READING CLINICAL COMMISSIONING GROUP & READING ADULT SOCIAL CARE

TO:	**HEALTH AND WELLBEING BOARD**	
DATE:	**27TH Jan 2017**	**AGENDA ITEM: 5**
TITLE:	**End Of Life Care Briefing**	
LEADS:	**Cllr Rachel Eden**	
	Dr Andy Ciecierski	
	Dr Bu Thava	
	Dr Cathy Winfield	
	Ms Jo Hawthorne	
JOB TITLE:	**Lead Cllr for Adult Social Care**	
	Chair, North & West Reading CCG	
	Chair ,South Reading CCG	
	Chief Officer , Berkshire West CCGs	
	Head of Wellbeing, Commissioning and Improvement, Reading Borough Council	

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide an update to the Health and Wellbeing Board members following on from the previous report presented on 9.10.15. This includes an overview of End of Life Care locally and will aid discussion on how the Reading locality can now further develop our care and support for those at the end of life.

1.2 This report covers end of life care for people of all ages (from birth).

1.3 It should be recognised that End Of life care is a crosscutting theme across a wide range of conditions. For this reason, a Berkshire West wide End of Life Steering group meets quarterly and has representation for all key stakeholders. This includes representation from RBC and the Reading CCGs, with Dr Barbara Barrie (N & W Reading) as the chair. This group reports into the Long Term Conditions Programme

Board. This ensures that all the Long term Conditions work also aligns with the ambitions for End of Life as well as other programmes of care.

1.4 A Reading End of Life working group was set up following the recommendation from the Nov 2015 Health and Well Being Board. This group sponsored a local conference involving a range of stakeholders. The meeting highlighted services available locally and some of the service gaps. It is now proposed to convene a multi -agency task and finish group to develop an implementation plan for service development locally and to ask the group to report back on its work to a future Health and Well Being Board.

2. RECOMMENDED ACTION:

2.1 To note the report

2.2. To agree to setting up of an end of life task and finish group to produce an integrated implementation plan for the development of end of life care services locally.

2.3 To report back to a future Health and Well Being Board on the work of the task and finish group.

3. UPDATE REPORT

3.1 There are a number of initiatives in place across Berkshire West and within Reading, which support proactive approaches to the management of end of life care.

3.2 End of life care is locally commissioned and locally provided. A wide spectrum of care is commissioned, from generic end of life care and support such as that delivered by primary care teams, hospital teams and social services, through to hospice care and specialist palliative care services.

3.3 Reading Borough Council and the Reading CCG's are currently working together to ensure that care and health services are safe, timely, appropriately commissioned and delivered in a way that enables a personalised and proportionate approach.

3.4 Reading's Reablement and Intermediate Care teams play a role in offering high quality social care.

3.5 Continuing Healthcare is small part of wider services, including social care, which may provide care and support to people at the end of their lives. Where an individual with an end of life prognosis has been found to have a primary health need, care funding should be applied for either through a full continuing healthcare assessment or a fast track referral to ensure clinically appropriate care is offered, which is free at the point of delivery to the individual.

3.6 It is important that processes locally are robust and timely to ensure individuals are offered clinically appropriate care in their preferred choice of residence at the end of their life. This issue, and in particular planning for discharge from hospital,

has been identified locally as requiring a comprehensive joint effort and cooperation between RBC Adult Social Care and Reading CCGs.

3.7 The CCGs have recently commissioned a new 24 hour, 7 days a week Palliative care co-ordination and support service called **"PallCall."** The service, provided by Sue Ryder, through a single point of contact for patients, families and healthcare professionals, is available to anyone in their last 12 months of life with a Berkshire West GP, or to anyone who is providing support to those people. The service is designed to support End of Life patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. PallCall launched in mid-October 2016 and has in its first six weeks, dealt with 100 calls from patients, families, GPs, care homes, district and community nurses, and the ambulance service. They have prevented 19 admissions and supported 6 patients to die in their preferred place. The service is still developing and we plan to build on these early successes to deliver in home assessment directly, and to ensure GPs caring for palliative patients have considered medication well in advance of it being needed.

3.8 Relevant information at end of life is a key factor in managing care well and ensuring the needs and wishes of people are addressed. In Berkshire West we use a system known as "Adastra" to allow co-ordination of medical/clinical patient care. All GPs have access to this as do the local Accident & Emergency Departments and the ambulance service (SCAS). Work is underway as part of the Better Care Fund to develop IT integration between social care and health services. There is additionally access to specialist palliative care "Hospice" and day care facilities as well as a dedicated hospital based palliative care team.

3.9 There are a number of additional schemes which support and enable patients to remain in their preferred place of residence (including care homes) and where possible reduce the need for admission to hospital and/or A&E attendance. As well as the provision of inpatient beds people and specialist hospital palliative care , we also have access through our community teams to a Rapid Response Team (RraT) for patients in their own homes as well as those in care homes (nursing and residential).

3.10 Local GPs through an enhanced are service (CES) actively provide care planning, education in EOL for the primary care staff team , audit quality of end of life care at GP practice level and support of bereaved carers and families. A Berkshire West Anticipatory CES also further supports care planning for those individuals at highest risk of an emergency admission , putting into place arrangements in advance to support people to remain at home.

3.11 We also plan to further build on initiatives put into place in 16/17, with our community providers (Berkshire Healthcare Foundation Trust). This has improved the recognition of those patients who are entering their last year of life and are on the caseload of a community service (e.g. District Nurses, Community Nurses, Community Matrons, & community Inpatients). People once identified as entering the last year of life are then flagged to ensure the teams work effectively with GPs and the palliative care hub to support co-ordinated working for that patient.

3.12 Increasing access to healthcare education and shared learning has led to the development of a rolling programme of education across all CCGs. Practices can benefit from the local Palliative Care Consultant for case based discussion teaching. This has included managing difficult conversations and/advanced care planning, ultimately supporting the overall approach to improving patient care and outcomes. Going forward social care staff including front line carers would benefit from an education programme.

3.13 In summary, meeting the palliative and end of life (EOL) care needs of patients (and their carers) along a continuum of care, as appropriate, is critical to our overall vision and approach to integrated long term conditions management. This enables us to drive forward patient centred, holistic end of life care regardless of specific conditions, with services wrapped round the patient and where possible provided at or closer to home. It also focuses on a planned and proactive approach, minimising reactive and crisis response which often leads to hospital admission as the only option.

4. POLICY CONTEXT

The Berkshire West CCG Operational Plan 2017-2019 reflects the achievements and ambitions locally for end of life care. This was submitted on 23rd Dec 2016 as part of the NHS England planning for Clinical Commissioning Groups (CCGs).

The Reading Joint Strategic Needs Assessment highlighted national and west of Berkshire needs based on National End of Life Care Data. This identified that 48% of deaths took place in hospital and 45% of people died in their or place of residency. These figures are consistence with the national picture.

In September 2015 the National Palliative and End of Life Care: A national framework for local action 2015 – 2020, was launched.

The National Palliative and End of Life Care Partnership, is made up of statutory bodies including NHS England, the Association of Directors of Adult Social Care Services, charities and groups representing patients and professional and has developed a framework for action in making palliative and end of life care a priority at a local level.

The national framework sets out six 'ambitions' – principles for how care for those nearing death should be delivered at a local level:

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

5. CONTRIBUTION TO STRATEGIC AIMS

The importance of the delivery of high quality End Of Life Care has been identified as an area of high importance for the Reading Health & Wellbeing Board and aligns with the Health and Wellbeing Strategy.

Safeguarding and protecting those that are most vulnerable.

6. FINANCIAL IMPLICATIONS

There are many routes to receiving palliative and end of life care, and with this a range of funding streams which can prove complicated, including; Continuing Health Care funding, through national and local charities (some supported by national funding), such as MacMillan and Duchess of Kent, and through the Local Authority care provision. The importance of robust processes and access to appropriate funding is essential to the delivery of care at the end of life and to provide support to carers.

7. BACKGROUND PAPERS

7.1 Berkshire West CCGs operational Plan 2016/17 as a separate agenda item
7.2 Once chance to get it right. (Leadership alliance for the Care of Dying people).
7.3 Dying without dignity (Parliamentary and Health Service Ombudsman)
7.4 More Care, Less Pathway, A review of the Liverpool Care Pathway
7.5 Ambitions for Palliative and End of Life Care: (A national framework for local action 2015 – 2020). Association of Directors of Adult Social Care Services 2015.

Oxfordshire
Clinical Commissioning Group

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22 December 2016

Dear colleague

Buckinghamshire, Oxfordshire & Berkshire West
Sustainability and Transformation Plan

As you may be aware, proposals are being developed to improve health and care in Buckinghamshire, Oxfordshire and Berkshire West to help our communities be the healthiest they can be, while making sure that services are affordable for years to come.

The Buckinghamshire, Oxfordshire and Berkshire West five-year Sustainability and Transformation Plan (STP) will set out the challenges and opportunities facing NHS and care services across the area. It will show how we will work together to improve health and wellbeing within the funds available. Our plan is one of 44 currently being developed across the country. The Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP area includes seven Clinical Commissioning Groups (CCGs), six NHS Trusts and 14 local authorities.

Our proposals have taken into account the views people and organisations gave us during local engagement activities, such as '*Your Community, Your Care*' in Buckinghamshire, the '*Big Conversation*' in Oxfordshire and '*Call to Action'* events in Berkshire West. Similar activity will continue in communities and be led by local organisations.

To help describe our thinking about the challenges, priorities and opportunities, we have developed a summary document, which I have attached to this letter.

This document is also available online http://www.wokinghamccg.nhs.uk/publications-policies. It is still a draft and will be developed further in the New Year.

Although the STP covers a large area, the emphasis of the majority of proposals is on what can be achieved locally.

For example:

In Buckinghamshire, through plans we have been discussing with the public and partners across Buckinghamshire for some time (most recently through our 'Your Community, Your Care' engagement activities), to prevent ill health and offer people better, more joined-up care closer to home:

- trying new ways of working with people to help them stay healthy and to manage their own health conditions better
- working with our communities, public sector partners and the voluntary sector to develop 'community hubs' in each area with the right mix of services to meet local people's needs
- offering a wider range of tests and treatment locally (such as x-rays or physiotherapy), and exploring the benefits of online consultations, so people only need to travel to hospital when absolutely necessary
- joint teams of GPs, nurses and other specialists supporting frail older people, care home residents or people with complex health needs, so that fewer people end up needing emergency care in hospital, or staying in hospital for lengthy periods.

In Oxfordshire, we embarked on 'The Big Health and Care Conversation' to ask for the public's views on how the best care can be delivered in the most effective way within available resources. Our ambition is to provide high quality care, good health outcomes and value for money for people living in the county. Oxfordshire's healthcare leaders, with doctors, nurses and patients' input, have been considering this feedback when developing options for how to make care clinically and financially sustainable for the future, across the following services:

- Maternity and children's services
- Learning disability, mental health and autism services
- Specialist advice and diagnostics (outpatient services and planned operations)
- Urgent care
- Primary care

A first phase public consultation on critical care, stroke care, reducing hospital admissions, and maternity services is scheduled to begin in early 2017.

In Berkshire West, the focus continues to be on strengthening partnership working through the Berkshire West 10 Integration Programme, a project which integrates services provided by health and social care, and the Berkshire West Accountable Care System initiative, which aims to encourage closer working between CCGs and NHS Trusts to improve services for patients. Both programmes are beginning to demonstrate the possible benefits provided by greater collaboration.

Delivering on the ambitions outlined in our Sustainability and Transformation Plan cannot be done by NHS and social care organisations alone. We need everyone to get involved. Achieving real change relies on everyone taking responsibility for their own health and wellbeing - health and care professionals, individuals, voluntary and community sector, patient groups and organisations within our communities which already make a big difference to people's lives.

As the STP is developed and discussed, we will be actively seeking your views and expertise as we work together to develop and implement it.

Yours sincerely

David Smith
Sustainability and Transformation Plan Lead
Buckinghamshire, Oxfordshire and Berkshire West &
Chief Executive, Oxfordshire Clinical Commissioning Group

Att

The Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan

2016

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What is the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan?

1

The Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (STP) is one of 44 local plans being developed across England, which will set out how affordable, good quality health and social care will be provided in the future.

The vision for the NHS is clearly set out in a national document called the Five Year Forward View (www.england.nhs.uk/ourwork/futurenhs) and our STP will show how we will deliver this locally.

The Five Year Forward View vision will be achieved by everyone who has a stake in health and care adapting what they do, how they think, and how they act – at both local and national levels.

As part of this, there is a growing consensus that one of the most powerful ways to achieve change is through local health and care services working together - across entire communities and pathways of care - to find ways to close the gaps between where we are now, and where we need to be in the future.

However, this is no easy task and the Buckinghamshire, Oxfordshire and Berkshire West STP is still at the very early stages of development. We have a draft plan which we submitted to NHS England at the end of October 2016 as required, and we anticipate making significant improvements to that plan over the next couple of months.

This is a summary of the main issues we will address in our STP, which covers a population of 1.8 million and has a budget of £2.5 billion. The seven NHS clinical commissioning groups who buy and pay for NHS services, the six NHS trusts who provide health and some care services, and the 14 local authorities who buy social care services, have worked, and will continue to work together to improve people's health, provide better health and care services and improve efficiency.

Why do we need a Sustainability and Transformation Plan?

2

There are a number of challenges facing the NHS that require us to change and modernise the way in which we provide local health and care services to ensure local communities are the healthiest they can be.

There have been some big improvements in health and social care in Buckinghamshire, Oxfordshire and Berkshire West in the last ten years. People with cancer and heart conditions are experiencing better care and living longer, and people are more satisfied with their health and care services. For example, we have some of the best quality and highly regarded general practice services in the country. However, our population is growing rapidly, people's needs are changing, new treatments and technologies are being developed, the quality of care is sometimes variable, and we can do more to prevent illness. Our ambition is to be the best in everything that we do.

Over the next five years, we face the following particular challenges across our area:

- Significant increases in population due to new housing growth
- Pockets of deprivation where communities are not as healthy as they could be
- An increase in demand for services, especially for frail older people who often have more than one health and care need
- Difficulty in recruiting and retaining staff due to the high cost of living, which leads to inconsistent levels of care and unsustainable services
- Ageing NHS buildings which are not fit for modern use
- Variable access to some specialised services and other treatments
- People having to travel out of our area for specialised mental health care.

More money has been provided for the NHS, but we still estimate a gap of around £480 million in the next four years if we do nothing to help people stay healthy and modernise our services. We need to find new and better ways to meet the health and care needs of local people and do things more efficiently. This does not mean doing less for people or reducing the quality of care, but we have to provide services differently in the right place at the right time at the right cost.

How have our plans been developed?

3

We can only make improvements if we all work together. This means patients, their carers, our staff, hospitals, local councils, the NHS, universities, and a range of other organisations working in the public, private and voluntary sectors, all joining together to agree a plan to improve local health and care services in Buckinghamshire, Oxfordshire and Berkshire West.

Our plan has been developed using your feedback from local engagement activities, such as 'Your Community, Your Care' in Buckinghamshire, the 'Big Conversation' in Oxfordshire and 'Call to Action' events in Berkshire West. This engagement will continue and take place in local communities and be led by local organisations.

We have also used feedback and insights from our clinicians and staff. The Oxford Academic Health Sciences Network, which is a local partnership of NHS organisations, universities and life science companies responsible for improving health and prosperity across the region, plays an important role in helping us to work together to improve and modernise treatment and care, as well as helping our region become a better place to live and work.

What are we going to do?

4

Our ambition is to make sure that everyone in Buckinghamshire, Oxfordshire and Berkshire West has access to high quality health and care, regardless of where they live or which service they use.

Care should flow seamlessly from one service to the next so people don't have to tell their story twice to the various people caring for them, and health professionals should be working on a shared plan for each patient's care. Health and care services should also be available when people need it. We want these services to be available closer to home – a stay in hospital should be less frequent because health and care professionals are offering care and treatment at home, or in local clinics.

We have a number of priority areas where we know that by working together we can make a greater difference for patients in terms of improving their health and ensuring they have access to high quality, cost effective care. These priorities are:

- Improving the wellbeing of local people by helping them to stay healthy, manage their own care and identify health problems earlier
- Organising urgent and emergency care so that people are directed to the right services for treatment, such as the local pharmacy or a hospital accident and emergency department for more serious and life threatening illnesses
- Improving hospital services, for example making sure that maternity services can cope with the expected rise in births
- Enhancing the range of specialised services, such as cancer, and supporting Oxford University Hospitals NHS Foundation Trust as a centre of excellence to provide more expert services in the region
- Developing mental health services, including low and medium secure services, more specialised services for children and teenagers, and improving care for military veterans and services for mums and babies
- Integrating health and care services by bringing together health and social care staff in neighbourhoods to organise treatment and care for patients
- Working with general practice to make sure it is central to delivering and developing new ways of providing services in local areas
- Ensuring that the amount of money spent on management and administration is kept to a minimum so that more money can be invested in health and care services for local communities
- Developing our workforce, improving recruitment and increasing staff retention by developing new roles for proposed service models
- Using new technology so patients and their carers can access their medical record online and are supported to take greater responsibility for their health.

What does this mean for local people?

5

As we implement these plans over the next five years we aim to deliver the following benefits to our population:

- People will be able to get an appointment with their doctor at a convenient time
- Specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment and care in teams who work together in local neighbourhoods around the needs of patients
- Fewer people who need specialised mental health services will have to be cared for a long way from their home, families and friends
- Patients will only have to share their medical history, allergies and medication details once, regardless of whether they are in a hospital accident and emergency department or a GP surgery, and they will be able to access their medical record online
- For patients with diabetes, heart or breathing problems, technology will be able to monitor things, such as blood pressure, remotely, alerting the doctor to any problems
- As taxpayers, people can be assured that care is provided in an efficient and cost effective way.

How can I get involved and find out more?

6

Our STP is currently a draft plan under development and we will have an updated version to share by February 2017. Local public engagement events will continue and will be promoted via each partner organisation's website and other communication channels.

Please share your views at these events and if you have any questions or comments, please email:

Oxfordshire queries: cscsu.media-team@nhs.net
Berkshire West queries: ppiteam.berkshirewest@nhs.net
Buckinghamshire queries: ccgcomms@buckscc.gov.uk

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

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**27 JANUARY 2017**	**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 presents Reading's 2nd Health and Wellbeing Strategy for adoption by the Health and Wellbeing Board ('the Board).

1.2 As required by statute, the Strategy sets a basis for commissioning plans across both the local authority and the local clinical commissioning groups (CCGs). It is a joint strategy and its development to date has properly been driven by the Health and Wellbeing Board. As required by the constitution of Reading Borough Council (RBC), the Strategy has already been submitted to a meeting of full Council for approval.

1.3 The Board is also requested to approve an Action Plan to implement the Strategy and monitor progress towards meeting agreed priorities.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board, having considered the feedback from the formal consultation on Reading's second joint Health and Wellbeing Strategy (annexed as Appendix A) together with the Equality Impact Assessment (annexed as Appendix B),
(a) Adopts the 2017-20 Reading Health and Wellbeing Strategy as appears at Appendix C; and
(b) Approves the supporting Health and Wellbeing Action as appears at Appendix D.

3. POLICY CONTEXT

3.1 The primary responsibility of Health and Wellbeing (HWB) 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 plan 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. The intention is that publication of Reading's 2017-20 Health and Wellbeing Strategy will discharge Council duties both under the Care Act and under the Health and Social Care Act.

3.4 Reading's second Health and Wellbeing strategy has been informed by a review of Reading's Health and Wellbeing Board by a group of peers from Health and Wellbeing Boards in other areas. The new strategy responds to the peer review finding that the strategy should be used to drive the agenda of the Board, and key priorities have been identified which are properly the responsibility of the Health and Wellbeing Board in order to facilitate this link.

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

4.1 Two workshops in mid 2016 brought 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 start to refresh Reading's Health and Wellbeing Strategy. Emerging proposed priorities were discussed at Reading Voluntary Action's Wellbeing Forum for the third sector.

4.3 Members of the Health and Wellbeing Involvement Group 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 locally, 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 Health and Wellbeing Board 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

These building blocks represent issues which the Involvement Group felt both ought to underpin everything else in the strategy, and also be considered as part of the implementing plans supporting all the priorities ultimately selected.

4.7 The draft Strategy proposed 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

Following consultation, an eighth priority has been added:

- Reducing deaths by suicide

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 recommended 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 During the consultation period, health and social care integration projects were additionally identified as issues which are very much part of the health and wellbeing agenda. Addressing local performance on Delayed Transfers of Care received a specific mention. The Health and Wellbeing Board already has oversight of Reading's Better Care Fund (BCF) plans, and will continue to be part of the governance arrangements for the BCF programme, or its successors, and the wider 'Berkshire West 10' integration programme. In view of this link, and applying the criteria set out in para 4.5 (above) on how to select items for inclusion on a streamlined priorities list, the Health and Wellbeing Strategy does not, therefore, include any specific priorities which would simply replicate the BCF and/or Berkshire West 10 programme.

4.10 Following stakeholder engagement to develop a draft strategy, then, a public consultation was carried out between 10th October and 11th December 2016. This included publication of 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. This open public consultation was particularly aimed at patient and service user forums and participation groups, youth groups, parenting forums, older people's interest groups, unpaid carers (young and adult carers), staff involved in providing, commissioning or developing health and wellbeing services, and voluntary and community sector organisations.

4.11 People were invited to comment on whether the draft strategy contained the right building blocks and priorities for Reading. Respondents were asked to suggest what was needed to achieve each priority, and what they or their organisation could contribute. These answers were then used either to start to develop an action plan to support each priority, or to supplement existing action plans.

4.12 A dashboard of key performance indicators has 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 Plans which will be developed in support of the 2017-20 Health and Wellbeing Strategy. The dashboard will identify performance in those areas 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. The strategy has been prepared to include shared priorities for realising the vision of 'a healthier Reading'. The Strategy 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 also incorporates wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 A 12 week consultation on the Council's Adult Wellbeing Position Statement, informed the development of the new Health and Wellbeing Strategy. This ensured 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.

6.2 Two workshops then brought 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. In addition, the emerging priorities of the early new strategy were discussed at Reading Voluntary Action's Wellbeing Forum for the third sector.

6.3 A 9 week formal consultation on the draft strategy took place during October – December – as described above (4.10). In addition to publishing an online questionnaire to elicit feedback, representatives authorised by the Health and Wellbeing Board presented on the consultation at local forums and meetings (see below). These dates were advertised at the launch of the consultation to encourage people to take up these opportunities to give verbal feedback if that was their preferred method.

- Older People's Working Group (04.11.2016)
- Youth Cabinet (15.11.2016)
- Reading Families Forum (16.11.2016)
- Public consultation event (21.11.2016)
- Dementia Action Alliance (23.11.2016)
- Access & Disabilities Working Group (01.12.2016)
- Learning Disability Carers Forum (07.12.2016)
- Learning Disabilities Partnership Board (07.12.2016)

A workshop was hosted in November 2016 to take the consultation discussions out to a wider audience. to inform what we need to put in place to address the health and wellbeing priorities suggested for Reading.

6.4 A report on the consultation and engagement exercise is attached as Appendix A. A total of 54 questionnaires were returned. In addition, we gathered in verbal responses from 147 meeting attendances.

6.5 Key headlines from the consultation were as follows.

- Feedback was generally supportive of the three building blocks.
- Feedback was generally supportive of the seven priorities proposed in the draft Strategy.
- There were mixed reactions to plans to include safeguarding and TB reduction

- There were questions as to why breast and bowel cancer screening should be prioritised over the prevention of some other diseases.
- Many people identified a personal esteem/resilience link between several of the priorities, but felt there was a need for a more explicit reference to adult mental health and emotional wellbeing in order for the Strategy to set the basis of a properly holistic approach. In the light of this, an eighth priority is now proposed – reducing deaths by suicide – as well as making more explicit that the priority on reducing loneliness and social isolation is to incorporate developing personal resilience.

6.6 Consultation feedback has been shared with action planning leads to inform what we need to put in place to address suggested priorities. A proposed Action Plan for adoption for each of the priorities will be presented to the Health and Wellbeing Board on 27 January 2017.

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 provided an opportunity to develop an understanding of how the draft Strategy might impact differently on protected groups. As a vehicle for addressing health inequalities, it is expected that any such differential impact would be positive, and accordingly will support the discharge of Health and Wellbeing Board members' Equality Act duties. The full Equality Impact Assessment is attached at Appendix B.

9. FINANCIAL IMPLICATIONS

9.1 Consultation feedback has informed the development of the Health and Wellbeing Action Plan. This will be delivered within existing resources, realigned where necessary. It is imperative that the Strategy drives the efficient use of resources and to deliver clear health benefits on investment so as to protect a sustainable local health and care system.

10. APPENDICES

Appendix A – Reading Health and Wellbeing Strategy 2017-20: Consultation report

Appendix B - Reading Health and Wellbeing Strategy 2017-20: Equality Impact Assessment

Appendix C: Reading Health and Wellbeing Strategy 2017-20

Appendix D: Reading Health and Wellbeing Action Plan 2017-20

Reading Borough Council
Working better with you

Reading's Health and Wellbeing Strategy 2017-2020: Consultation Report

NHS
South Reading
Clinical Commissioning Group

NHS
North and West Reading
Clinical Commissioning Group

Executive Summary

Following a period of stakeholder engagement to develop a draft strategy, the Reading Health and Wellbeing Board ran a public consultation between 10th October and 11th December 2016 on a proposed Joint and Health and Wellbeing Strategy to set local priorities for the period 2017-2020.

Feedback was generally supportive of the three building blocks and seven priorities proposed in the draft Strategy. However, there were mixed reactions to plans to include safeguarding and TB reduction, as well as questions as to why breast and bowel cancer screening should be prioritised over the prevention of some other diseases. Many people identified a personal esteem/resilience link between several of the priorities, but felt there was a need for a more explicit reference to adult mental health and emotional wellbeing in order for the Strategy to set the basis of a properly holistic approach.

Background

The development of Reading's 2nd Joint Health and Wellbeing Strategy began with 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. This Health & Wellbeing Involvement Group participated in a collaborative review of local need – based on the latest iteration of Reading's Joint Strategic Needs Assessment - and of past performance against the goals of the 2013-16 Health & Wellbeing Strategy.

Members of the Involvement Group 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.

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***

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.

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)
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- 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

What we consulted on

Three cross cutting issues were identified which the Involvement Group felt ought to underpin all other actions coming out of the Strategy. These were proposed as 'building blocks' of the 2017-20 Strategy:

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

Seven strategic priorities were then proposed as the focus of health and wellbeing activity in reading 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

How we consulted

The formal consultation ran from 10.10.2016 to 11.12.2016. It was an open public consultation, but particularly aimed at patient and service user forums & participation groups, youth groups, parenting forums, older people's interest groups, unpaid carers (young and adult carers), staff involved in providing, commissioning or developing health and wellbeing services, and voluntary and community sector organisations.

People were invited to comment on whether the draft strategy contained the right building blocks and priorities for Reading. Respondents were asked to suggest what was needed to achieve each priority, and what they or their organisation could contribute. These answers were then used to develop an Action Plan to support each priority

The consultation questionnaire was available on the Council's website and in paper copy on request. People could choose which parts of the consultation they responded to. Most people commented within each section, but some focused on just a few areas.

The consultation was discussed at 7 meetings (see table below). These dates were advertised at the launch of the consultation to encourage people to take up these opportunities to give verbal feedback if that was their preferred method.

Meeting	Number of people
Older People's Working Group (04.11.2016)	54
Youth Cabinet (15.11.2016)	6
Reading Families Forum (16.11.2016)	10
Public consultation event (21.11.2016)	34
Dementia Action Alliance (23.11.2016)	16
Access & Disabilities Working Group (01.12.2016)	15
Learning Disability Carers Forum (07.12.2016)	12
TOTAL ATTENDANCES	**147**

Table 1: Health & Wellbeing Strategy 2017-20 - consultation meetings

A press release was issued at the start of the consultation. Information promoting the consultation was also published as a news item on the Reading Voluntary Action and Healthwatch Reading websites. In addition, there were short presentations during the consultation period to the Physical

Disability and Sensory Needs Network, the Reach Out youth group and the Learning Disability Partnership Board to raise awareness of the consultation and encourage people to respond.

Who responded

A total of 54 questionnaires were returned. In addition, we gathered in verbal responses from 147 meeting attendances as described above. There could be some overlap between the verbal responses and returned questionnaires. As people had the option of responding anonymously, it is not possible to say with certainty how many individuals contributed to the total of 201 responses, but this is estimated at 160-180 people.

More detailed demographic analysis is available only from those who responded to the consultation by returning a questionnaire and completing the 'about you' questions – which were optional.

55% of respondents who identified by gender were female and 45% male. Most questionnaires – 62% - were returned by people in the 45 to 64 age group. However, there were presentations taken both to youth groups and to the Older People's Working Group to capture feedback from older and younger residents. Only a small proportion of questionnaires – 11% - were completed by people who identified as having a long term health condition. Again, though, presentations were taken to forums run by and for people with disabilities or care needs.

Three quarters of questionnaires were returned by people who identified as White British. White Other was the next most frequently indicated ethnic background. 39% of respondents stated they had no religion. Most of those who identified as practising a religion – 31% - were Christian, with other religious beliefs being represented in very small numbers. 78% of respondents identified as f

24% of returned questionnaires were submitted on behalf of an organisation, and the remainder were individual responses.

Consultation feedback

Building Block A: safeguarding vulnerable and children

There were mixed views on having safeguarding as one of the building blocks of the Health and Wellbeing Strategy. Several people commented that given there are statutory frameworks for this work, and established boards to set and monitor local targets, including safeguarding within the Health and Wellbeing Strategy would be a duplication.

Some people suggested that the emphasis here should instead be on reducing people's vulnerability by promoting healthy lifestyles, healthy relationships and personal resilience. Alternatively, people suggested that if safeguarding is part on the Health and Wellbeing Strategy then this should be with a focus on addressing particular issues, such as domestic abuse or suicide prevention.

Building Block B: recognising and supporting all carers

Most people welcomed the inclusion of carer recognition and support as a building block or golden thread to apply within all priorities. However, they were keen to see this idea developed to understand how the Health and Wellbeing Board would oversee provision for different groups of carers. Mental health carers, young carers, and parent carers of disabled children were all highlighted as being in need of greater or more co-ordinated support.

Building Block C: high quality co-ordinated information to support wellbeing

Information to support wellbeing was seen as fundamental, and rightly described as a building bock on which the Strategy was based. People pointed out that the co-ordination of information should include voluntary sector partners as well as statutory sector organisations.

Feedback was that we need more concerted efforts to support informed decision making about lifestyle choices and whether to accept public health interventions. Messages need to be targeted to reflect the concerns and needs of different communities. Some commentators felt that we probably have a sufficiency of wellbeing information locally, but need to do more to make this information accessible to particular groups, such as families of children with learning disabilities, or residents whose first language is not English.

There were various suggestions made about different channels which could be used to provide wellbeing information – such as drop in sessions where people can meet providers, adding inserts to other Council mailings and roadshows in parts of the town where take up of relevant services is particularly low. Several people stressed that web-based information can only be a partial solution, and must be complemented by face-to-face engagement and encouragement.

Priority 1: supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking

> "I know from experience that cycling or walking to work or to the shops helps on so many levels. It wakes you up on the way to work, gets your blood going, keeps your body warmer and makes you feel happy through the dark winter months. It gives you an adrenaline boost."

This proposed priority attracted lots of positive comment, and practical suggestions on how to engage more people. Links were made with some of the other priorities. Lots of community groups were keen to be involved in raising awareness of these issues and supporting people to make healthy lifestyle choices. Young people made positive comments about the healthy lifestyle messages given in schools, and felt this was a very good way to reach young people, especially with workshops and drama productions tailored to different age groups. Some people pointed out that young people may also be an effective channel to other members of their family.

People pointed out that it is important to convey the message that there are many ways for people to be more active. This doesn't have to involve joining a gym, and many options are free or at low

cost. Making sure that people understand the variety of options should help people of different ages and abilities choose an activity they can enjoy. In particular, many respondents were keen to see clear plans to encourage more people to walk or cycle. Suggestions here included developing more dedicated routes and improved cycle storage/security facilities as well as thinking about pedestrian or cycle access to places like health centres. There were mixed views as to how important it is to retain the Ready Bike scheme, however.

Some were also keen to see cycling and walking promoted as group activities so as to contribute to reducing loneliness as well as encouraging physical activity. Others pointed out that encouraging people to travel in these ways would also help to improve air quality.

There was a lot of feedback about the need to modernise leisure facilities in Reading, particularly swimming pools. People also wanted leisure planning to include considerations of accessibility and affordability, including travel costs and childcare – with pay as you go options available alongside memberships. Some respondents suggested partnering with local businesses / employers to encourage people to use their lunch breaks to take more physical activity, or to take part in classes etc just at the end of the working day.

People suggested that there were ways in which better use could be made of parks to encourage physical activity, such as outdoor gyms and better lighting. There was a request that the Council try to improve the accessibility of parks for disabled children, especially in East and South Reading. Horticultural therapy was suggested as an important vehicle for supporting wellbeing across several aspects.

People noted that there are strong messages promoting unhealthy foods, and a need for equally strong messages to raise awareness of the consequences of an unhealthy diet. These probably need to be delivered in different ways to reach different groups of residents, but potentially a wide range of agencies could be involved. There were suggestions about where nutrition and cookery demonstrations could be offered in the most deprived wards, and how to include cuisine from different cultures. People also suggested that there should be more information about 'empty calories' to help people understand that they can make their grocery budget go further by making better choices.

On smoking, people asked for clearer messages about e-cigarettes. Several people commented that images and perceptions about smoking need to be tackled with young people, in particular.

On dental care, people felt clarity was needed about who can access free care, and whether there is scope to have dental staff undertake outreach visits to community groups. Cost is a worry to many. People also pointed out the importance of establishing a routine of attending regularly for dental check-ups rather than waiting for problems to start.

A number of respondents felt it is important to tackle the root causes of unhealthy lifestyles, and understand why some people have low self-respect. They wanted to see more emphasis on emotional wellbeing and helping people feel good about themselves. Some felt that more peer support groups and community role models are needed to help people make changes to their behaviour and then stay on course. This could include workshops on living with a long term condition, self managing it, and having the confidence to lead a better quality of life with that condition or disability. RVA's social prescribing service was referenced as an effective way of supporting people to make healthy lifestyle choices through a health coaching approach. A few people felt that improved access to GPs and community nurses would help to deliver on this priority. Others focused more on GP surgeries as important information points to raise awareness of local facilities for leading a healthier lifestyle. Some wanted to see tighter restrictions placed

on where people can buy cigarettes, alcohol or unhealthy food through the Council's planning and licensing powers.

Priority 2: reducing loneliness and social isolation

> "We need to focus more on local communities and local people looking out for each other. A lot of loneliness comes from people not knowing who their neighbours are."

There was a lot of feedback welcoming the inclusion of reducing loneliness as a priority, and particularly the intention to address this across all age groups. People saw scope for linking this with other priorities, e.g. strengthening community connections to support young people's emotional wellbeing and to encourage people of all ages to enjoy healthier lifestyles.

Befriending services were seen as a very important part of reducing loneliness, offering important benefits for volunteer befrienders as well as those they befriend. People felt there is a need for a wide range of volunteers/groups so as to be able to match individuals across interests and cultures. People noted that befriending goes beyond home visiting and can include accompanying someone on trips or to go shopping etc. People with dementia, for example, often become unconfident about going out and a befriender can help maintain that person's independence. Simply inviting an isolated neighbour or relative to join in with ordinary family activities can also be an important part of addressing the issue.

Peer support schemes fulfil a similar role for families / isolated parents, as can peer support groups which bring people together to support each other in managing long term health conditions or caring responsibilities. People suggested that young people need more support to understand and develop healthy relationships. They could also benefit from inter-generational befriending schemes as well as providing companionship to older people this way. Some respondents would like to see an exploration of inter-generational housing solutions.

Some people had found online forums really useful as a way of developing connections with others, and suggested that the Health and Wellbeing Action Plan could increase the visibility of these.

Identifying those most at risk of loneliness is a challenge, particularly when aiming to tackle this across all ages, but people pointed out that there are various risk factors for loneliness which are well understood and could be used to start targeting information, e.g. to those recently bereaved.

Social prescribing is one way of supporting people to find a range of community activities and services. Community noticeboards are another avenue, but groups need information on how to post information in these. Home care workers were also identified as another possible channel for informing people about local services to provide companionship. Some people pointed out that faith groups can offer a strong sense of community, although others were keen to see services run from or based in non faith settings too.

People identified language as a possible barrier to people being able to interact with their neighbours, and saw support to develop English skills as an important part of reducing loneliness. Lack of transport was identified as another possible barrier to people having the levels of social contact they would like. There is a need to find innovative ways to tackle this with communities working together. Alongside this, neighbourhood groups can provide very local solutions which reduce people's need for transport to be able to meet friends or make new ones.

Priority 2: reducing the amount of alcohol people drink to safer levels

"Continue the clear health messages about safe levels of alcohol consumption."

Many people were pleased to see the proposal to include a distinct priority on tackling excessive alcohol consumption. Better education about the harmful effects of alcohol was seen as key – starting early through programmes in schools but also reaching adults in creative ways – such as through notices at bottle recycling points - and making sure messages address Reading's sizeable student population. Many pointed out that these messages need to be complemented by positive messages about alternatives to alcohol – e.g. enticing 'mocktails' and soft drinks promotions to match special offers on alcoholic beverages, and developing the family friendly aspects of pubs. Freshers Week is an opportunity to get people off to a good start, but often has the opposite effect at the moment.

There was support for tighter licensing to reduce the availability of alcohol at particular times of the day, and to those under the legal drinking age. Several people wanted to see stronger action to stop sales to people already intoxicated. There were also several suggestions for legislative change to support this priority from a national level. These included moving towards a complete ban on driving after consuming any alcohol, and increasing the taxation on alcohol sales

The First Stop Bus is seen as a very useful service. Some respondents queried whether it is available as often as needed. Some suggested that people who need support from statutory services because of their drinking should be charged, e.g. for attendance at hospital Emergency Departments.

Excessive alcohol consumption was another issue which people felt was often a symptom of underlying distress, and so cannot be tackled without looking at root causes such as poverty, poor housing and isolation. Several people made the link between this priority and the earlier one on promoting healthy lifestyles, particularly encouraging people to be more physically active to help improve their sense of wellbeing. It was suggested that people with lived experience of self medicating with alcohol might be the best role models to reach some people currently using alcohol as a coping strategy, perhaps as part of Reading's new Recovery College. Alternative meaningful activity such as volunteering was also seen as an important component.

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

"All of us to need to see mental health as equal to physical health. We weigh and measure all our children, but where is the mental health check up to match that?"

Mental health and wellbeing for children and young people attracted a lot of comment in the consultation. People made links between this priority and others – particularly reducing both alcohol consumption and loneliness. There was positive feedback about a number of third sector groups working with young people, but a commonly held view that there is relatively low awareness of these services.

Lots of people commented on the need to improve recognition of emerging problems and how to seek help – amongst young people and the adults they come into contact with. Several people referred to the need to encourage young people to talk and be open to acknowledging pressures and stress. People wanted to see young people being supported from an early age to develop coping strategies. Schools have an important role to play, from support to manage the stresses of regular assessment through to developing peer support systems, providing guidance to parents, and supporting access to counselling via school nurses. Emotional Literacy Support – now available in some schools – was well regarded.

Some people focused on the need to support more young people to access meaningful activities which support their wellbeing – opportunities to be physically active and to interact face-to-face with others, particularly to provide an alternative to social media. Opportunities need to be available at low cost to be accessible, and in some cases young people need simple access to spaces where they can be together safely. Access to affordable travel is also significant for many young people.

Young carers were seen as a particularly vulnerable group. Local support services for them are valued but appear to be very stretched. Bullying was also recognised as a significant issue for many young people, particularly cyber bullying.

There were a number of concerns expressed about waiting lists for specialist mental health services. There were particular concerns about the lack of support for children aged under 10, and the short term nature of some of the support available.

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

"Everyone is touched by dementia in some way. We are most in need of better support for families."

A lot of respondents commented that dementia is a condition which touches whole families and not just individuals with a dementia diagnosis. Support for family carers was seen as a crucial part of ensuring more people with dementia can live in the safest places possible – usually their own homes rather than in institutional settings. This helps to preserve continuity of surroundings and

access to familiar faces. However, carers need access to information, peer support and regular breaks if they are to carry on caring in very challenging circumstances.

People also wanted to see clear plans to ensure Reading residents can access specialist dementia care when they need it. This care should be empowering and enabling, supporting people to stay active for as long as possible. Opportunities to socialise, to stay physically active and to take part in lifelong learning were all regarded as important in reducing the impact of dementia. People were keen to see our local libraries and museums involved in programmes to promote this, and also more opportunities to join singing groups.

Most people thought there was a need for more training for the very wide range of people likely to come into contact with someone who has dementia – so as to be able to recognise the condition and respond appropriately. Health and social care staff are obvious candidates for such training, but the need for better awareness is probably greater amongst the less obvious candidates. Rail staff, retail workers and front line volunteers in community groups were all suggested as people who ought to be trained to be able to offer their services as safe spaces for someone with dementia. Some people suggested a programme to target different groups based on what are common 'trigger points' for dementia being recognised, such as a bereavement or a fall. Dementia Friends training sessions are short and accessible and would probably be most appropriate way of raising awareness with most groups.

People talked about the past successes of the Reading Dementia Action Alliance (DAA), such as almost 4,000 people living or working in Reading being trained as Dementia Friends and 26 Dementia Champions trained to provide additional Dementia Friends sessions. However, although Reading still has a DAA, the pace of activity has slowed considerably since the group lost its funded co-ordinator. There is now a need for greater volunteer input to take forward the local Alliance. Several people suggested that the Alliance ought to be re-launched to remind people what it can offer and bring together a wider range of partners.

There was an enquiry as to whether Reading's recently launched Recovery College for Mental health could be developed to offer courses specific to dementia, as happens in some recovery college in other parts of the country.

Priority 6: increasing take up of breast and bowel screening and prevention services

> "We need stories of real people who have survived cancers to demonstrate positive outcomes."

Many people felt there needs to be more conversation about cancer generally – not just the screening tests – to understand people's fears and then help them start facing up to these. Some queried whether people were given enough information about the risks and side effects of screening in order to be able to make an informed choice whether to have the tests. There are some common misconceptions which mean many people don't see the value of a screening test for someone who is symptom free. It was also not clear to everyone why breast and bowel cancer

screening were proposed as priorities rather than other screening tests, suggesting more needs to be done to explain the evidence for focusing on these diseases above some others.

There were lots of suggestions as to why various groups might find screening tests off-putting. Some people may be quite fearful of what the tests entail. Reading Mencap has recognised this and starting offering escorts to breast screening for their clients. Some newly arrived communities may not appreciate that the screening tests are free at the point of delivery, in which case fear of charges may stand in the way of take-up.

It appears that many people find the bowel screening process particularly off-putting so strong and clear messages about the benefits are needed to counter people's aversion. There was a plea for 'forthright language' and a request for clearer instructions to accompany the bowel screening kits. Some suggested that the kits could include diagrams and/or cheap plastic gloves.

People asked if screening tests could be offered at different venues to reach more people, e.g. more use of mobile screening units. A range of community groups offered to carry leaflet stocks or provide a venue for awareness-raising talks. There was some positive feedback from people who have undergone the tests. Some people questioned whether the age groups targeted for screening currently ought to be reviewed.

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

> "We need to work with community leaders and give people the confidence and the trust to be able to access treatment without fear."

The inclusion of reducing numbers with tuberculosis as a priority met with mixed reactions. Many groups were surprised to learn that the number of Reading residents affected is so much higher than in other areas, or thought that TB was a public health problem which has now been eradicated. This then led a number of commentators – including the Youth Cabinet, for example - to the conclusion that it was right to prioritise an issue around which there is low awareness/understanding. However, others felt that the numbers affected were still too low to justify including this as priority for the 2017-20 strategy.

Quite a number of groups offered to help raise awareness of TB symptoms, how to access treatment and also reassure people who may worry about how a diagnosis could affect their right to remain in the UK. Some suggested targeting people via community leaders or through housing services, particularly to reach those not registered with a GP.

Additional comments

Some people felt that the strategy should include more on the expected transformation of statutory health and care services. There were questions about links between the Health and Wellbeing Strategy and Sustainability and Transformation Plans, as well as requests for greater clarity on how the new Health and Wellbeing Strategy would support integration. There was a specific suggestion that the Strategy ought to adopt Delayed Transfers of Care as an additional priority.

Some respondents queried the lack of references to certain specific groups – people with sensory impairments, or with learning disabilities. There was also a suggestion that there ought to be specific recognition of sexual violence and its impact, perhaps as part of the safeguarding building block. Some people suggested that the strategy would benefit from the inclusion of spiritual wellbeing or mindfulness to ensure a properly holistic approach. Others felt that the strategy could be improved by references to wider environmental issues, such as air quality.

There were some comments on the challenges of delivering against the Health and Wellbeing priorities with limited resources. Some people had ideas on where efficiencies could be made to free up more resources – for example, improving the recycling rate of aids and equipment,

The majority of additional comments, however, concerned adult mental health and emotional wellbeing. A wide range of stakeholders felt that this was a gap in the draft strategy. People suggested that action to promote people's personal resilience needs to underpin several of the proposed 2017-20 priorities, and that this needs to be made explicit. Although many people recognised that the proposed priority around reducing loneliness could contribute to emotional wellbeing, there was still a commonly held view that more was needed on adult mental health. The stresses of issues such as work or lack of work, poverty, poor housing or caring responsibilities are thought to be common underlying causes of unhealthy lifestyles, including excessive drinking. People also queried whether the references to postnatal depression as a contributory factor to loneliness gave the issue sufficient exposure.

A range of stakeholders suggested that the Strategy ought to include a specific reference to suicide prevention, given that this is the main killer of younger men in Reading. This was further suggested as something which merits additional focus given the rise in the Reading suicide rate as shown in the 2015-16 figures. Some local partners – such as the Berkshire Healthcare Foundation Trust – already have plans in place to reduce suicide rates, but adopting this as a priority of the Health and Wellbeing Board could help to align plans across other organisations.

People were keen to see an Action Plan which included clear plans to develop community capacity to support residents. This could include community growing schemes, community cafes and opportunities for people to get to know their neighbours better. There were some concerns as to how the proposed building blocks of the strategy – safeguarding, supporting carers and co-ordinated information to support wellbeing – would be reflected in the Action Plan. There were also requests for a clear statement from the Health and Wellbeing Board on how the Action Plan would be monitored.

Appendix B:

Equality Impact Assessment

Provide basic details

Name of proposal/activity/policy to be assessed

Adoption of a Joint Health and Wellbeing Strategy 2017-20

Directorate: Directorate of Adult Care and Health Services

Service: Wellbeing

Name and job title of person doing the assessment

Name: Janette Searle

Job Title: Preventative Services Development Manager

Date of assessment: 13th February, 2017

Scope your proposal

What is the aim of your policy or new service?

The proposal is to adopt a Health and Wellbeing (HWB) Strategy for the period 2017-20 in accordance with the duties to publish strategic plans to promote and protect health and wellbeing as set out in both the Health and Social Care Act 2012 and in the Care Act 2014.

The Reading HWB Strategy 2017-20 sets out agreed priorities across the local authority and the clinical commissioning groups which serve the Reading locality. The Strategy will underpin commissioning plans across Reading Borough Council, South Reading CCG and North & West Reading CCG (insofar as this CCG covers the Reading locality).

The 2017-20 Reading HWB Strategy is based on 3 'building blocks'. These are intended to underpin all of the strategic priorities and be considered as part of all implementation plans. The building blocks are:
- developing an integrated approach to recognising and supporting all carers;
- high quality co-ordinated information to support wellbeing; and
- safeguarding vulnerable adults and children.

The Strategy goes on to identify 8 priorities. These are:

- supporting people to make healthy lifestyle choices (with a focus on improving dental care, reducing obesity, increasing physical activity, and reducing smoking);
- reducing loneliness and social isolation;
- promoting positive mental health and wellbeing in children and young people;
- reducing deaths by suicide;
- reducing the amount of alcohol people drink to safe levels;
- making Reading a place where people can live well with dementia;
- increasing uptake of breast and bowel screening and prevention services; and
- reducing the number of people with tuberculosis.

It is intended to be an important tool in:
- Improving the health and wellbeing of Reading residents;
- Reducing health inequalities; and
- Promoting the integration of services.

Who will benefit from this proposal and how?

The Strategy is intended to be an important tool in:

- Improving the health and wellbeing of Reading residents;

- Reducing health inequalities; and

- Promoting the integration of services.

What outcomes will the change achieve and for whom?

Adopting the HWB Strategy 2017-20 will give the Health and Wellbeing Board a focus on the 8 identified priorities (see above), and set a framework for ensuring that plans to address these are based on the three underpinning issues ('building bocks') of carer recognition and support, co-ordinated information to support wellbeing, and safeguarding. In turn, the commissioning plans of individual HWB Board members over the next three years should also be driven by and reflect HWB Strategy 2017-20 priorities.

The Strategy is aimed at the entire population, and adopting it should co-ordinate efforts to improve health and wellbeing for any resident potentially affected by the priority issues.

The HWB Board will drive performance forward in its chosen priority areas as set out in the Strategy. In addition, the HWB Board will continue to receive reports and requests from other local strategic partnerships involved in promoting health and wellbeing, e.g. the Reading Integration Board, the End of Life Steering Group, the Community Safety Partnership etc.

Who are the main stakeholders and what do they want?

- Current users of care and support services

- Carers and family of people with care and support needs

- Reading residents, as potential future users of care and support services

- Staff and volunteers across care and support providers in the statutory, private and voluntary sectors

Do you have evidence or reason to believe that some (racial, disability, gender, sexuality, age and religious belief) groups may be affected differently than others?

Yes ☒ No ☐

Is there already public concern about potentially discriminatory practices/impact or could there be? Think about your complaints, consultation, feedback.

Yes ☐ No ☒

If the answer is **Yes** to any of the above you need to do an Equality Impact Assessment.

Impact of the Proposal

Consultation

How have you consulted with or do you plan to consult with relevant groups and experts?		
Relevant groups/experts	**How were/will the views of these groups be obtained**	**Date when contacted**
Reading residents, including but not confined to those with care and support needs Organisations across all sectors involving in promoting or protecting health and wellbeing	The Strategy has been informed through the engagement of stakeholders to develop an approach and a draft strategy, and then a formal 9 week public consultation. 54 consultation questionnaires were returned, and verbal feedback was obtained via 147 meeting attendances.	10th October – 9th December 2016

Describe how this proposal could impact on racial groups

No negative impact in terms of different racial groups has been identified.

Prioritising the reduction of tuberculosis is likely to involve some targeting of resources on newly arrived communities, but so as to take action to narrow the health gap

Where take up of other services is disproportionately low for some racial groups (e.g. bowel screening, befriending), which may face particular barriers to access, again there will be a focusing of resources on those communities as part of the drive to reduce health inequalities. There is an ongoing need to recognise that cultural norms and barriers such as language may impact on access to health and wellbeing support, and the Health and Wellbeing Strategy should be a tool to address this. Responses to the consultation raised the importance of ensuring that information and advice about health and wellbeing is accessible to all groups.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Describe how this proposal could impact on gender/transgender (cover pregnancy and maternity, marrieage)

No negative impact in terms of gender has been identified.

Prioritising the uptake of breast screening is an issue which only affects women. However, this has been chosen as a priority in order to redress the negative impact of breast cancer on female health and wellbeing.

There will be a focus on younger and middle aged men within the priority on suicide reduction, as well as on women who are pregnant or have given birth within the last year. A review of local data may also lead to a focus on people who are transgender. All of these are characteristics associated with a raised risk of suicide according to national evidence.

Within activities to deliver on the priorities around promoting healthy lifestyles and reducing loneliness, there will be some targeting of services on a gender-specific basis in order to promote equality of access overall.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Describe how this proposal could impact on disability

No negative impact in terms of disability has been identified.

In some areas, the strategy focuses on particular long term health conditions. For example, the priority on making Reading a place where people can live well with dementia will have a direct and immediate impact only on those with dementia and their families. These are differential but positive impacts of adopting the strategy.

There will be some targeting of resources on people living with a disability or long term health condition to help overcome barriers to accessing health and wellbeing support, e.g. screening services and support to make healthy lifestyle choices. This is expected to contribute to reducing health inequalities.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Describe how this proposal could impact on sexual orientation (cover civil partnership)

No negative impacts on the grounds of sexual orientation have been identified.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Describe how this proposal could impact on age

No negative impacts on the grounds of age have been identified.

The priority on supporting positive mental health in children and young people is age specific, as is the breast and bowel cancer screening priority in accordance with national evidence reviews of the costs and benefits of screening different age groups. These differences in likely access to support on age grounds as a result of adopting the strategy are expected to be positive.

There are some specific activities targeting older people within the priority on reducing loneliness, which are based on the evidence of how loneliness risks

correlate with advancing age. However, this priority also includes plans to develop understanding of local need across all ages.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Describe how this proposal could impact on religion or belief

No negative impact in terms of religion or belief has been identified.

Is there a negative impact? Yes ☐ No ☒ Not sure ☐

Decision

1. No negative impact identified Go to sign off ☒

2. Negative impact identified but there is a justifiable reason ☐

You must give due regard or weight but this does not necessarily mean that the equality duty overrides other clearly conflicting statutory duties that you must comply with.

Reason

3. Negative impact identified or uncertain ☐

What action will you take to eliminate or reduce the impact? Set out your actions and timescale?

How will you monitor for adverse impact in the future?

The long term impact of adopting the Reading Health and Wellbeing Strategy 2017-20 should be a reduction in health inequalities. In order to track progress towards this goal, a dashboard of key performance indicators has been developed. This, alongside regular Health and Wellbeing Action Plan progress reports to the Board, will highlight any widening of health inequalities in future.

Signed (completing officer) Janette Searle Date: 13th January, 2017

Reading Borough Council
Working better with you

Reading's Health and Wellbeing Strategy

2017 - 2020

healthwatch Reading

NHS South Reading Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

Foreword

This is Reading's second Joint Health & Wellbeing Strategy. It sets 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 three 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.

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 face the biggest challenges - with reductions in the value of welfare benefits, restrictions on entitlements to support, and rising costs of food and fuel. 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 limited financial resources 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 achieve our aims. 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. Having heard people's thoughts on our draft plan so we could develop it, and agree the detailed actions we need to take in order to make a difference over the next three years, we hope this final version will support our mission statement.

Councillor Graeme Hoskin

Chair, Reading Health & Wellbeing Board

Lead Councillor for Health, RBC

Dr Andy Ciercierski

Vice-Chair, Reading Health & Wellbeing Board

Chair, North & West Reading CCG

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Our 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 (improving dental care, reducing obesity, increasing physical activity, reducing smoking)**
- **Reducing loneliness and social isolation**
- **Promoting positive mental health and wellbeing in children and young people**
- **Reducing deaths by suicide**
- **Reducing the amount of alcohol people drink to safe levels**
- **Making Reading a place where people can live well with dementia**
- **Increasing uptake of breast and bowel screening and prevention services**
- **Reducing the number of people with tuberculosis**

We will develop plans to meet our priorities on three building blocks:

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

The aim of this strategy

Our second Health and Wellbeing Strategy for Reading builds on our previous strategy, and takes account of national and local developments over the past three years.

It provides a solid foundation for the development of local authority and clinical commissioning group commissioning plans over the next three years

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 the way people feel and function today and increasing their chances of longer and healthier lives.

People need to feel safe to enjoy full wellbeing, which is why safeguarding vulnerable adults and children is one of the building blocks of this Strategy.

Preventable ill health represents human misery which could be avoided, and a demand on care services which could be reduced. Focusing on keeping people well will reduce their need for support to 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.

We will work together to focus our efforts on areas where the evidence tells us we can have the greatest impact on health and wellbeing. 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 across the Health and Wellbeing Board.

This strategy recognises our Care Act obligations as well as our duties for health protection and promotion under the Health and Social Care Act.

Recognising and supporting carers

We estimate around 12,000 people in Reading provide unpaid care to a family member or friend. – this includes parents caring for a disabled child, young carers, and adults providing care to other adults. National studies estimate the value of carer support as the equivalent of a second NHS. However, this resource is very fragile - carers face high risks of poor health and wellbeing because of the strains of caring, and a tendency to put the needs of the person they care for first.

Supporting carers is key to a successful approach to preventing care needs from increasing across the local population.

This strategy aims to ensure that carers needs are recognised and supported in all of the initiatives we prioritise and monitor.

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 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.

This Strategy complements local integration plans and aims to promote seamless care by the right agency at the right time and in the right place.

How we developed this strategy

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

Refreshing our priorities began with a review of the previous strategy. We considered updated evidence about local needs and feedback we received on the Council's Adult Wellbeing Position Statement. We used this information to develop a draft strategy, building on our performance so far, and setting out a new set of proposed priorities to take us forward.

A public consultation on the draft strategy brought more people into the conversation about health and wellbeing priorities for 2017-2020. This was a key stage: improving and protecting health and wellbeing in Reading will be most effective if everyone (individuals, communities, employers and public services) work together.

We used the feedback we received from our consultation[1] to refine Reading's second Health and Wellbeing Strategy and develop action plans to meet our priorities - with the people who will experience the impact of our shared plans, and those tasked with achieving the desired outcomes.

[1] Visit www.reading.gov.uk/HWBStrategy to see the consultation report

Joint Strategic Needs Assessment (JSNA)

The Reading JSNA[2] presents national data alongside local information - telling 'the Reading story'. It identifies the ways that Reading's population is different from that in other areas and provides robust intelligence about the needs and strengths of the local population. It is the cornerstone of local needs assessments and commissioning and underpins our Health and Wellbeing Strategy.

Our population - Reading at a glance

The 2011 Census shows Reading's population was 155,700 people. This is an increase of 11,300 over a decade. We expect the population will continue to increase.

Employment

Reading benefits from a strong labour market, a high rate of employment and higher than average earnings.

Areas of deprivation

Some areas in the borough are experiencing high and rising levels of deprivation. Since the 2001 Census, 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 deprivation appears to be more closely linked to high levels of crime and poor living environment. Most areas with high levels of deprivation also have high level of health deprivation – meaning a high risk of premature death or reduced quality of life through poor physical or mental health.

Ethnicity

Reading has a more culturally and ethnically diverse population than other local authority areas, and is becoming more diverse. The 2011 Census showed:

- 66.9% of the population identified themselves as White British - 19.9% fewer than in 2001.
- 7.9% of the population identify themselves as Other White (covering a number of nationalities, including Polish) - 3.7% more than in 2001
- 12.6% of the population identified themselves as South Asian (Indian, Pakistani and Other Asian) – 7.4% more than in 2001.
- 4.9% of the population identified themselves as Black African – 3.3% more than in 2001
- Most residents born outside of the UK are from in India, Poland or Pakistan.

[2] See www.reading.gov.uk/jsna

Age

Reading's population is relatively younger than the average across Berkshire, the South East, and England and Wales.

- In 2014 there were 67 live births per 1,000 women aged 15 - 44 - a much higher fertility rate than the national (62.1) and South East regional (61.4) averages.
- We have fewer older people than other Berkshire authorities and expect a relatively small increase in this population compared to other areas. We predict we will have around 31,300 residents aged 65+ by 2037.

Children's health and wellbeing

According to the JSNA children who:

- are looked after by the Local Authority
- subject to a child protection plan
- have disabilities and
- live in poverty

and

- children and young people not in education, employment or training

are more likely to have particular health and wellbeing needs.

Successes and challenges

A significant amount of work has been undertaken across the local Health and Wellbeing partnership to support the delivery of our original vision for health and wellbeing. Much good progress has been made.

- Sexual health services are performing well and an information website has been developed.
- The Drug and Alcohol Treatment service was re-launched as the 'Reading IRiS Phased and Layered Treatment Model'. More people are completing treatment with this new service.
- Services for the care and education of young children (early years settings) have been rated as good and improving
- 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.
- The new Reading and West Berkshire Carers Hub[3] providing information, advice and support for carers was launched in 2016. This service was jointly commissioned by Reading and West Berkshire Councils and local clinical commissioning groups.
- A range of schemes which encourage people to walk and cycle more were introduced
- National Child Measurement Programme (NCMP) 3 year aggregated data is now being used to help target future weight management offers to local school children.
- The number of people smoking across Reading is just below national averages.

However, we also have 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.
- We have high levels of preventable premature mortality and low uptake of screening programmes in key areas e.g. breast and bowel screening.
- We have higher levels of some infectious disease, particularly sexually transmitted infections and TB.
- We have higher levels of homelessness, including families, and higher rates of unemployment. Crime rates are also higher than expected
- We have 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.
- Rates of obesity double during primary school, and significant numbers of children have tooth decay.
- We have low levels of school readiness
- Educational attainment in older children who are eligible for free school meals is less than half of that seen in other children.

[3] www.berkshirecarershub.org

- We have higher than expected numbers of young people not in education employment or training.
- Significantly higher numbers of men die as a direct result of alcohol (mainly alcohol associated cancers and chronic liver disease).
- The prevalence of opiate users is higher than in similar populations.

Financial context

Organisations are continuing to face the challenge of extreme budget pressures alongside increased demand for services. We must achieve a cultural shift to ensure our investment is increasingly directed at improving the wellbeing of Reading residents. This means helping people prevent avoidable ill-health and disability rather than just treating the effects of poor wellbeing. Responsibility for meeting the local challenges is shared between individuals, families, communities, local government, business and the NHS

Empowering people to take charge of their care and support

The Health and Wellbeing Board shares the view that people 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 to prevent ill health, as well those managing a long-term condition to stay well and prevent things from 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 can support people to make positive lifestyle choices and to maintain their commitment to their own wellbeing. We plan to involve many more frontline staff in promoting wellbeing through our Making Every Contact Count (MECC) programme. MECC is about building a culture of health improvement, equipping staff with the skills they need to seize opportunities – by asking questions about possible lifestyle changes, responding appropriately when issues are raised, and taking action to signpost or refer people to the support they need.

Delivering this strategy

Our second Health and Wellbeing Strategy has been informed by a review of Reading's Health and Wellbeing Board by a group of our peers from Health and Wellbeing Boards in other areas. We have responded 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.

The Health and Wellbeing Board members are committed to working together to:

- Monitor the progress of agreed actions to deliver our Health and Wellbeing priorities
- Use monitoring and review as an opportunity to involve more people in 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.

We will maintain close links with other relevant partnerships and invite them to:

- Report to us on the progress of any initiatives that impact on wellbeing and
- Present their ideas, requests and recommendations.

The Care Act makes it our responsibility to ensure our residents have a good range of wellbeing services. We aim to continue to encourage and support a vibrant local market, which is resilient to funding challenges to meet this need by:

- Working closely with third sector organisations
- Developing 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.

We want people to be more in control of their health, care and wellbeing. To facilitate this we will:

- Develop information resources so people can connect to the right health and wellbeing support at the right time.
- Make best use of new technologies and co-ordinated digital solutions.

How we will measure success

We have established a robust, proportionate and transparent performance management framework, which includes key performance indicators which will allow us to:

- Monitor our progress against the commitments and actions set out in the Health and Wellbeing Strategy Action Plan openly and transparently
- Understand where we may need to divert resources as we tackle the challenges we face.
- Track progress against 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.

Priority 1:

Supporting people to make healthy lifestyle choices

Focusing on improving dental care, reducing obesity, increasing physical activity and reducing smoking

Improving Dental Care

By 5 years of age, more children in Reading are assessed as having 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.

Reducing Obesity

Obesity significantly increases the risk of many long-term conditions including type 2 diabetes, cardiovascular disease and high blood pressure. It is also impacts negatively on educational attainment, mental health, respiratory and musculoskeletal disorders. A Body Mass Index over 40 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 (64.6%) and is comparable with other similar local authority areas, the absolute figures are significant and will have a huge impact on our residents' health and quality of life unless action is taken.
- Levels of childhood obesity[4] in Reading in Reception Year children and Year 6 children are consistently above the South East average.

Increasing Physical activity

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.

- 50.4 - 59.5% of residents[5] achieve the Chief Medical Officer targets for physical activity. This below the average in the South East region, but similar to the England average.
- 40.5-49.6% of residents aren't doing enough physical activity to protect their health.

Physical activity is already part of a number of local initiatives, but needs to become a more explicit priority.

[4] Data from the National Child Measuring Programme (NCMP)
[5] Active People Survey 2014

Reducing Smoking

Smoking increases the risks of ill health, including infections in children. 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 babies, children and young people who are exposed involuntarily to second hand smoke and babies whose parents smoked during pregnancy.

- Although we have seen a consistent decline in the estimated prevalence of smoking locally, in 2014 we estimated that around 21,000 (17%) Reading adults were smokers - similar to the national average.
- Smoking costs society approximately £1,700 per smoker. We estimate that smoking related ill-health cost local NHS trusts about £4.4m/year
- The number of premature deaths in Reading is above average, particularly 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 prevent uptake and reduce prevalence both nationally and locally. The most significant thing a smoker can do to improve their health is to quit.

Over the next three years

We aim to promote healthy lifestyles in a variety of settings so that every Reading resident has a chance to maximise their health and quality of life. We will focus on actions that:

- Deliver the priorities identified within the Healthy Weight Strategy (which sets out opportunities for children and adults to achieve and maintain a healthy weight by supporting them to make healthy dietary choices and choose an active lifestyle)
- Increase awareness of lifestyle and weight management services
- Promote walking and cycling both for leisure and active travel
- Prevent the uptake of smoking – by working with local stop services and promote smoke-free communities to support people to quit and remain smoke free 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.

Risk factors for loneliness include:

- living alone,
- not being in work,
- poor health, loss of mobility, sensory impairment,
- language and communication barriers,
- bereavement,
- lack of transport and local amenties (like public toilets or benches),
- lower income,
- fear of crime,
- high population turnover
- becoming a carer.

Studies show that services that reduce loneliness have resulted in:

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

National data indicates that 10% of people aged 65+ are ‘chronically lonely’ this translates to 1,720 chronically lonely older people in Reading.

Although most research in this area has focused on the elderly population, loneliness can be a health risk at any age. 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.

Over the next three years

We will focus on actions that will:

- Improve 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.
- 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:

Promoting positive mental 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.

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

In Reading:

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

  … are more likely to have mental health issues.

Whilst we have a range of projects which 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.

Over the next three years

We plan to drive forward improvement and change through a local *Future in Mind* process. We will:

- 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.
- 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 4:

Reducing deaths by suicide

Every death by suicide is an individual tragedy, and can have a devastating effect on families, on communities and others affected by how the life was lost. The World Health Organisation estimates that at least ten other people are directly affected by every suicide. In 2015:

- 18 people died by suicide in Reading
- There was a 22% increase in suicides across Berkshire compared to the previous year.

The absolute number of deaths by suicide in Reading alone is quite small but we can look at figures over time as well as across Berkshire as a whole and nationally to identify patterns which indicate which residents are more at risk. The figures tell us that:

- Men face three times the risk faced by women
- Suicide is the single biggest killer of men under 50

- It is the second most common cause of death in women who are pregnant or have given birth in the last year.

There is a strong link between suicide and self-harm as well as drug or alcohol misuse. Almost a third of people who died by suicide had contact with mental health services in their last 12 months.

Suicide risk reflects wider inequalities as people's social and economic circumstances can have a significant impact on their likelihood of taking their own lives. An effective approach to suicide prevention therefore needs to involve a range of agencies so as to tackle various factors at play.

The national suicide prevention strategy is based on two objectives:

- reducing the suicide rate, and
- providing better support for those bereaved or affected by suicide.

People bereaved by suicide face a number of risks to their wellbeing, including attempted or completed suicide, more so than people bereaved through other causes.

The national strategy identifies six areas for action, and these are reflected in the draft Berkshire Suicide Prevention Strategy, due for publication in 2017.

Over the next three years

We will:

- Develop and deliver a Suicide Prevention Action Plan for Reading to support delivery of the Berkshire Suicide Prevention Strategy
- Link to Action Plans which deliver Health and Wellbeing Priority 2:Reducing loneliness and social Isolation and Priority 3: Promoting positive mental health and wellbeing in children and young people

Priority 5:

Reducing the amount of alcohol people drink to safer levels

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

Alcohol use can be 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 is physically dependent on alcohol and needs detoxification to stop using safely.

In Reading:

- Alcohol use[6], mainly in the adult population, is a far greater problem than drug use (*this is the same in other areas of the country*).
- We estimate[7] that:
  - at least 30,000 residents are drinking to hazardous levels and
  - 4,500 are drinking to harmful levels.

  (*These figures are based on national self-reported drinking levels - research shows that people significantly under-report drinking suggesting true drinking levels are much higher)*.
- The high rates of alcohol-specific mortality and morbidity from chronic liver disease in both men and women indicates a significant number of people have been drinking heavily and persistently over the past 10-30 years.
- Very many more people could benefit from specialist treatment services than are currently able to receive them.

[6] Highlighted by the Reading Drug and Alcohol Misuse Needs Assessment

[7] Estimates based on current guidelines

Over the next three years

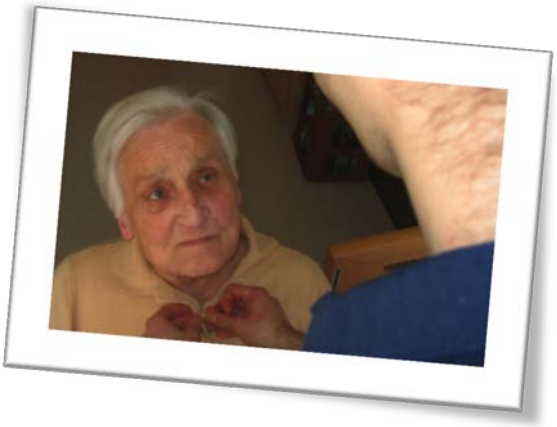
We will focus on actions that:

- focus greater emphasis on the problems of alcohol misuse at all ages, with greater emphasis on prevention, particularly targeting under 18 year olds with specialist family support in place for children at risk.
- Enable and encourage frontline staff in all sectors to do more to identify people at risk of harm from alcohol use and either provide a brief intervention or refer people for specialist treatment where appropriate.

Priority 6:

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 they care for changes more dramatically than for other carers.

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 (like 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.

- We estimate there are about 1,500 people aged 65+ living with dementia in Reading and we expect this 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

To ensure more people can live well with dementia in their communities we plan to bring a range of agencies together to:

- Significantly improve awareness and understanding of dementia so people have the information they need to reduce the risk of developing dementia as well as to live well with dementia.
- Ensure people with dementia have equal access to the health and wellbeing support which is available to everyone.

Priority 7:

Increasing uptake of breast and bowel screening and prevention

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.

While chances of being diagnosed with or dying from cancer are similar to other places in England, cancers are still the most common cause of premature deaths in Reading. Locally:

- Cancers are responsible for 142 deaths in every 100,000 people aged under 75
- Rates are highest in wards with very high areas of deprivation – Abbey, Norcot and Whitley.
- The numbers taking part in breast, bowel and cervical cancer screening is lower than the national average

Over the next three years

We will focus on actions to:

- Support people in their understanding of cancer, and enable people to make healthy lifestyle choices.
- Increase awareness of early cancer symptoms and screening programmes to improve early diagnosis
- Understand and overcome the barriers which stop people from taking part in screening
- Target areas with high levels deprivation and where smoking and alcohol use are known to be higher.

Priority 8:

Reducing the number of people with tuberculosis

Rates of TB in Reading 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, local 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%.

Over the next three years

We will focus on actions to:

- Promote awareness of the symptoms of TB, encourage people to seek advice and receive treatment as soon as possible.
- Use more targeted approaches to reach those communities at greater risk of having the disease or of failing to take up treatment more effectively

Reading Health and Wellbeing Strategy - Draft Action Plan

PRIORITY No 1	**Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking**

Note – The section below should be considered alongside the Healthy Weight Position Statement for Reading which provides an analysis of local data, scoping of current service provision and reports on the emerging priorities have been identified to help focus work on key areas of need.

Actions included below detail work in progress by the council that contribute to the healthy weight agenda. However, to tackle overweight and obesity effectively requires a multi-agency approach and as such we will invite partners, including but not limited to schools, local health services and the voluntary and community sector, private sector to join an action planning group following the January Health and Wellbeing Board to help shape a comprehensive strategy delivery plan.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Weight Management **To commission and implement an accessible tier 2 lifestyle adult weight management service that aligns with NICE guidance for overweight and obese adults aged 16 and over within the locality. This will form an integral part of the weight management service in Reading.** **To target access to the service in line**	**Wellbeing Team**	**Currently mid-contract. New contract to be procured to commence June / July 2017.**	**To contribute to halting the continued rise in unhealthy weight prevalence in adults.**	**2.21 Excess weight in adults.** **2.13i Percentage of physically active and inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.** **2.11i - Proportion of the adult**

with local Joint Strategic Needs Assessments **To monitor and evaluate the delivery and outcomes of the service to the stated objectives**				**population meeting the recommended '5-a-day' on a 'usual day' (adults).**
To commission and implement a school based Tier 2 children's healthy lifestyle and weight management programme in line with NICE guidance within the locality. This will form an integral part of the weight management service in Reading. **To target access to the service in line with local Joint Strategic Needs Assessments** **To monitor and evaluate the delivery and outcomes of the service in line with the stated objectives** **To pilot a legacy pack for schools who host our Tier 2 children's healthy lifestyle and weight management programme in order to encourage schools to continue supporting the principles of the course beyond the 10-week intervention.**	**Wellbeing Team**	**Currently mid-contract for tier 2 service.** **Legacy pack to be developed for spring 2017.**	**To contribute to halting the continued rise in unhealthy weight prevalence in children and young people.** **To promote a 'whole family approach' to healthy eating and physical activity.**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.** **2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15**
To include promotion of healthy eating	**Wellbeing**	**From October**	**Lead, co-ordinate and provide**	**2.06i - % of children aged 4-5**

and physical activity within the 0-19s service **Take proactive steps to raise awareness in schools of priority Public Health messages especially around healthy life-styles, including oral health** **To look at options for programmes that could be delivered in Early Years settings with colleagues from children's services.**	**Team/Children's Services**	**From April 2017**	**services for children and young people as set out in the Healthy Child Programme 5 – 19 years**	**classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.** **2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15** **2.11v – Average number of portions of fruit consumed daily at age 15 (WAY survey)** **2.11vi – Average number of portions of vegetables consumed daily at age 15 (WAY survey).**
To seek opportunities to promote and support local walking and cycling programmes for leisure and active travel. For example: **'Develop a Local Cycling & Walking Infrastructure Plan, as a sub-strategy to the Local Transport Plan.** **Hold a 'Walking Volunteer recruitment workshop' for voluntary and community services who work with people who have low physical activity levels**	**Transport, Leisure and Wellbeing Teams**	**From April 2017**	**Increase in the number of people walking and cycling to work** **Increase in the number of children benefitting from Bikeability** **Increase in the number of children walking or cycling to school** **Reduce congestion** **Increase the local capacity to deliver health walks to people**	**1.16 - % of people using outdoor space for exercise/health reasons.** **2.13i Percentage of physically active and inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.**

To work with partners in support of bidding for funding to develop more walking and cycling initiatives e.g. Reading Museum, transport.	**Reading Museum / Wellbeing team.**	**January 2017**	**who have low physical activity levels** **Support planned bid in development by Reading museum linking local heritage and walking.**	
To offer MECC training to the local voluntary and community sector	**Wellbeing Team**	**From January 2017**	**To increase knowledge, skills and confidence to make appropriate use of opportunities to raise the issue of healthy lifestyle choices and signpost to sources of support.**	**Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.**
To ensure delivery of the National Child Measurement Programme	**Wellbeing Team**	**Ongoing**	**Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.**
Active Nation	**Wellbeing team, Leisure and Recreation service / Transport**	**2017**	**Funding opportunities identified to help increase physical activity levels in target groups.**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or**

				obese. **2.21 Excess weight in adults.** **2.13i Percentage of physically active and inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.** **1.16 - % of people using outdoor space for exercise/health reasons.**
To Prevent Uptake of Smoking - **Education in schools** - **Health promotion** - **Quit services targeting pregnant women/families** - **Underage sales**	**Wellbeing Team; Trading Standards; CS; S4H; Youth Services; Schools;**	**From April 2017**	**Maintain/reduce the number of people >18 years who are estimated to smoke in Reading** **Improve awareness of impact of smoking on children** **Reduce the illegal sale of tobacco to >18 years** **Increase uptake of smoking cessation >18 years**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.09i – Smoking prevalence at age 15- current smokers (WAY survey)** **PHOF 2.09ii – Smoking prevalence at age 15 – regular smokers (WAY survey)** **PHOF 2.09iii – Smoking prevalence at age 15 – occasional smokers (WAY survey)** **PHOF 2.09iv – Smoking prevalence**

				at age 15 –regular smokers (SDD survey) **PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)**
To provide support to smokers to quit - **Health promotion** - **Referrals into service** - **VBA training to staff** - **Workplace and community smoking policies**	**S4H; RBC; CCGs;**	**From April 2017**	**Achieve minimum number of4 week quits - 722** **Achieve minimum number of 12 week quits** **Supporting national campaigns – 463** **Achieve minimum of 50% quitters to be from a priority group** **Increase referrals to S4H by GPs;** **Increase self-referrals to S4H**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.14 – Smoking prevalence in adults – current smokers (APS)** **PHOF 2.14 – Smoking prevalence in adults in routine and manual occupations – current smokers (APS)** **NHS OF 2.4 - Health related quality of life for carers**
To take action to tackle illegal tobacco and prevent sales to >18 - **Health promotion** - **Act on local intelligence** - **Retailer training – challenge 25** - **Test purchasing**	**CS; Trading Standards; S4H**	**From April 2017**	**Increase awareness of impact of illicit/illegal sales have on community** **Improve the no of successful completions of Retail Trainer Training (challenge 25)** **Reduce the number of retailers**	

			failing test purchasing	
Local Smoking Policy – workplace, communities - **Update workplace smoking policy (wellbeing policy)** - **Smoking ban in community (RBC sites, school grounds; RSL; Broad Street)**	**Wellbeing Team; Health & Safety; Trading Standards; Environmental health;**	**From April 2017**	**Increase referrals to S4H smoking cessation services** **Prevent harm to community through restriction of exposure to second hand smoke.**	
To collect dental epidemiology data for Reading	**Wellbeing Team**	**From January 2017**	**Reading Borough Council will have access to dental epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework indicators on oral health**	**PHOF 4.2: tooth decay in 5 year old children**

PRIORITY No 2	**Reducing Loneliness and Social Isolation**

What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**

Establish a Reducing Loneliness Steering Group	**Health & Wellbeing Board**	**February 2017**	**A cross-sector partnership is in place to oversee an all-age approach – covering prenatal, children and young people, working age adults and later life**	
Develop a reducing loneliness and social isolation module as part of the Reading Joint Strategic Needs Assessment	**Wellbeing Team, RBC**	**April 2017**	**We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**
Map community assets for building social networks (groups, agencies and services which have the potential to have a direct or an indirect impact)	**Reducing Loneliness Steering Group**	**April 2017**	**Shared understanding of existing assets to underpin better targeting of resources and development at a neighbourhood level**	

Produce a communication plan to raise awareness of community assets for building social networks, targeting potential community navigators and community champions	**Reducing Loneliness Steering Group**	**June 2017**	**Those in a position to identify and signpost individuals at risk of loneliness can access tools to help them integrate people into enabling and supportive social networks**	
Support the neighbourhood Over 50s groups to grow and be self-sustaining	**Wellbeing Team, RBC**	**Ongoing**	**Older residents are able to be part of developing opportunities for neighbours to know one another better**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**
Develop and raise the profile of community transport solutions	**Reducing Loneliness Steering Group**	**Ongoing**	**At-risk individuals know how to access transport as needed to join in social networks**	

Develop volunteering and employment opportunities for adults with care and support needs	**Wellbeing Team, RBC**	**Ongoing**	**There will be more opportunities for adults with care and support needs to enjoy supportive and enabling social connections through work**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like**
Review and promote tools to assess and evaluate services' impact on social connectivity	**Reducing Loneliness Steering Group**	**August 2017**	**Local commissioners and providers will be able to measure the contribution of a range of services to reducing loneliness, and ensure provision is sensitive to local need**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**
Prioritise local actions for reducing loneliness for 2017-19	**Reducing Loneliness Steering Group**	**October 2017**	**Activity and resources will be targeted based on local 'loneliness need'**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported**

				wellbeing

PRIORITY No 3	**Promoting positive mental health and wellbeing in children and young people** **Actions to support delivery of this priority are set out in the Reading Future In Mind Transformation plan that covers the key issues. This has been published at: http://nwreadingccg.nhs.uk/mental-health/camhs-transformation (see Appendix 1)**

PRIORITY 4	**Reducing Deaths by Suicide**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Identify local sponsors to oversee Reading's Suicide Prevention Action Plan	**Health & Wellbeing Board (Berkshire West Mental Health Strategy Group / Reading Mental Health**	**February 2017**	**Reading actions to reduce deaths by suicide will be co-ordinated across agencies / There will be consistent local representation on the Berkshire Suicide Prevention Planning Group**	

	Strategy Group)			
Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: **- the formal launch of the Berkshire Suicide Prevention Strategy** **- contributions to the 'Brighter Berkshire' Year of Mental Health 2017** **- marking World Suicide Prevention Day (10 September)**	**RBC Communications Team**	**April 2017**	**Individuals will have increased awareness of support available /** **Partners will know how to engage with and support the Reading Suicide Prevention Action Plan**	
Support the review of CALMzone and development of future commissioning plans for support services which target men - **Review local DAAT contracts to ensure suicide prevention objectives are included** - **Develop post discharge support for people who have used mental health services via the**	**Wellbeing Team, RBC**	**October 2017** **April 2017** **Ongoing**	**Suicide risk will be mitigated for higher risk groups: men, people who abuse drugs or alcohol, people who have been in contact with mental health services**	**PHOF 4.10 – suicide rates**

Reading Recovery College				
Tailor approaches to improve mental health in specific groups: - **Support delivery of the local 'Future in Mind' programme to improve mental health in children and young people** - **Recognise the mental health needs of survivors and links to suicide prevention in the refresh of the Reading Domestic Abuse Strategy** - **Raise awareness of support available to survivors of sexual abuse through Trust House Reading** - **Contribute to a Berkshire wide review of targeted community based interventions, including suicide prevention and mental health first aid training**	**Local sponsors (see above)** **DENS, RBC** **Local sponsors (see above)** **Local sponsors (see above)**	**Ongoing** **tbc** **ongoing**	**Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches** **Future commissioning of community based interventions will be informed by a review of impact**	**See Action Plan for Priority 4 for details.**

Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	**Wellbeing Team, RBC**	**ongoing**	**Access to the means of suicide will be reduced where possible**	
Review pages on the Reading Services Guide to include national resources (e.g. 'Help is at Hand' and National Suicide Prevention Alliance resources) and signposting to local services **Map local bereavement support and access to specific support for bereavement through suicide**	**Wellbeing Team, RBC**	**June 2017**	**Those bereaved or affected by suicide will have access to better information and support**	
Ensure local media and communications staff are aware of Samaritans guidance on responsible suicide reporting **Support a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting.**	**Wellbeing Team, RBC**	**February 2017** **July 2017**	**Local media will be supported to report on suicide and suicidal behaviour in a sensitive manner**	

Update Reading JSNA module on suicide and self-harm **Refresh Reading Mental Health Needs Analysis**	**Wellbeing Team, RBC** **Adults Commissioning Team, RBC**	**tbc** **May 2016**	**Local and county-wide Suicide Prevention Action will be informed by up to date research, data collection and monitoring**	

PRIORITY No 5	**Reducing the amount of alcohol people drink to safer levels**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Treatment				
Increase the number of people receiving support at the appropriate level to address risky, harmful and dependent use of alcohol. **Review current alcohol pathways to enable the specialist service to gain capacity to work with more risky, harmful and dependent drinkers.**	**All Partners required to support an alcohol pathway** **DAAT Contract Manager, CCG Leads, IRIS Reading Borough Manager, GP Lead**	**Ongoing** **April 2017**	**Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers.** **Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.**	**PHOF 2.15iii – Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**
Reinstate the Whitley project. **CAP Lead to co-ordinate a meeting with all stakeholders to kick start the**	**CAP Lead**	**April 2017**	**Encourage IBA in the community. More 'Community Alcohol Champions' to promote**	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
project.			lower drinking levels and behaviours. Alcohol Champions in the community will be able to deliver information and brief advice to members of the public.	
Promote the IRIS clinic at Longbarn Lane Surgery to all GPs for those clients whom do not wish to receive treatment at the Specialist drug and alcohol service – and future plans	IRIS Reading/ Dr. Helen George	January 2017	Clients can access treatment in the GP surgery rather than access via specialist drug and alcohol treatment service at Waylen Street. Reduce the impact on GP capacity with an additional specialist service in GP setting.	
Promote knowledge and change behaviour by promoting understanding of the risks of using alcohol and by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health contacts.	All partners	Ongoing		PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
Deliver IBA Training across all sectors – Need to encourage uptake of more Alcohol Champions	CAP Lead and Source Team Manager	Ongoing	More individuals trained to deliver an intervention – Making every contact count approach to managing alcohol issues/ signposting	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Alcohol Mapping Group to present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	Alcohol Mapping Group	April 2017		PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
First Stop Bus – in Town Centre Friday & Saturday nights Explore an option of a fixed service with TVP, to deliver an extended service in Town Centre	Licensing and TVP	Ongoing	Option for people to dry out on the First Stop Bus rather than RBH First Stop Bus can offer advice and information on alcohol use.	
Need to gain authority for Peer Mentors to be on the (selective) Wards at RBH Alcohol Peer mentors – to visit clients on hospital wards and assist in transition into community (including following detox).	DAAT Contract Manager and CCG Project Manager IRIS Peer mentors	January 2017 March 2017	Peer mentors can advise patients on specialist community services and alcohol service available locally. To prevent re-admissions to hospital.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
GP Lead to promote IBA training in primary care. Promotion of IBA training in secondary care	Dr. H George DAAT contract Manager	Ongoing	Primary and secondary care professionals have the skills to deliver IBA and knowledge to make appropriate referrals on discharge	PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
Monitor and review existing interventions and develop a robust multi agency model to reduce alcohol-	All	Ongoing		PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
related hospital admissions.				
Licensing				
A community free of alcohol related violence in homes and in public places, especially the town centre. Create responsible markets for alcohol by using existing licensing powers to limit impact of alcohol use on problem areas and by promoting industry responsibility. Address alcohol-related anti-social behaviour in the town centre and manage the evening economy Address alcohol-related anti-social Neighbourhoods	CAP Lead	Ongoing	Reduction in alcohol admissions to hospital. Responsible drinking in public spaces.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications.	Public Health/ Licensing	Ongoing	Control of licensed outlets and review of Reading's late night economy.	
Licencing to promote responsible retailing, 4 Licensing objectives. CAP to increase Test Purchasing – Challenge 25, Under 18.	CAP / Licensing	Ongoing	Stricter licensing restrictions will be in place. There is a minimum price for a unit of alcohol as a mandatory condition of a License.	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Licensed Retailer Passport to be rolled out to all retailers. **Retailer Training to commence.** **Encourage retailers to restrict the sale of higher ABV % cans**				
Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	**CAP/ licensing**	**January 2017**	**Promote healthier non-alcoholic options to customers**	
Encourage neighbourhoods to report street drinking to the Police via NAG meetings	**All**	**Ongoing**	**Reduce street drinking and ASB**	
Education				
Parent education – School age children to be set an alcohol questionnaire to complete with their parents to promote knowledge on alcohol and the health risks	**CAP lead**	**2017**		
Education if for all ages. **Alcohol awareness sessions for all.** **Comic Project to encourage alcohol awareness.** **Increase PHSE lessons in schools.** **Commence a Youth Health Champion role – encourage youngsters to be**	**CAP Lead**	**Ongoing**	**Educating everyone on the risks of alcohol and promote drinking responsibly.**	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
active in tackling alcohol and understanding the risks of drinking alcohol. Work in partnership with Colleges and University to promote alcohol awareness to students Volunteers from the Specialist Treatment Service to visit school age children to educate them about the risks of alcohol and how their lives have been affected.				
Promote diversionary activities to all – via schools, colleges, website	CAP Lead	Ongoing	Promote social activities and exercise as alternatives to drinking alcohol. Resolve the "boredom" and social issues associated with alcohol.	
Prevention				
Promotion of Dry January campaign. Promotion of January alcohol detox via IRIS Reading as part of the Dry January campaign	CAP Lead, DAAT Contract & Project Manager, IRIS Reading IRIS Reading Borough Manager & RBC Press team	December 2016 and January 2017	Encourage awareness of effects of alcohol on staff, clients and local community. Promote drinking responsibly.	
Explore with the street care team whether we can promote drinking responsibly at recycling depots.	DAAT / Street Care Team	January 2017	Encourage drinking responsibly and increase public awareness of the risks of alcohol	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Work in partnership with RVA to promote Public Health messages through their newsletter	Public Health Lead/ RVA	January 2017/ Ongoing	Encourage healthier lifestyles.	

Reading Health and Wellbeing Strategy - Draft Action Plan

PRIORITY NO 6	Making Reading a place where people can live well with dementia

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Establish a Berkshire West Dementia Steering Group to implement the Prime Ministers Dementia 2020 challenge and ensure up-to-date local information about dementia can be reflected into dementia care services and that there is an opportunity to influence and inform local practice			The Berkshire West Dementia Steering Group will report to the three Berkshire West Health and Wellbeing Boards as required from time to time, contributing updates and commentary on performance in relation to local dementia priorities and issues identified by those Boards. The Berkshire West Dementia Steering Group will also report	

			to the Berkshire West Long Term Conditions Programme Board and will in addition keep the Thames Valley Commissioning Forum updated	
Raise awareness on reducing the risk of onset and progression of dementia through building on and promoting the evidence base for dementia risk reduction (including education from early years/school age about the benefits of healthy lifestyle choices and their benefits in reducing the risk of vascular dementia) and health inequalities and enhancing the dementia component of the NHS Health Check.	**Public Health (LAs), GPs, Schools**	**May 2017**	**By 2020 people at risk of dementia and their families/ carers will have a clear idea about why they are at risk, how they can best reduce their risk of dementia and have the knowledge and know-how to get the support they need.** **This will contribute towards the national ambition of reduced prevalence and incidence of dementia amongst 65-74 year olds, along with delaying the progression of dementia amongst those that have been diagnosed.**	**PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia** **PHOF 4.13 – Health related quality of life for older people** **ASCOF 2F and NHS Outcomes Framework 2.6ii – effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia.** **ASCOF 1B – People who use services who have control over their daily life** **NHS OF 2.1 - Proportion of people feeling supported to manage their condition**

Identify patients early including those from Black, Asian and Minority Ethnic origin and other seldom heard groups enabled through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate; encourage self-referral by reducing stigma, dispelling myths and educating about benefits of obtaining a timely diagnosis	**Primary care, Social Care (LAs), Memory Clinics, Care homes**	**March 2018**	**More people diagnosed with dementia are supported to live well and manage their health**	**ASCOF 2F - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia**
Play a leading role in the development and implementation of personalised care plans including specific support working in partnership with memory assessment services and care plan design and implementation.	**Primary Care/BWCCGs/BHFT**	**March, 2018**	**GPs ensuring everyone diagnosed with dementia has a personalised care plan that covers both health and care and includes their carer. This will enable people to say "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"**	**PHOF 4.13 - Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia** **ASCOF 1B - People who use services who have control over their daily life**

				NHS OF 2.1 - Proportion of people feeling supported to manage their condition
Ensure coordination and continuity of care for people with dementia, as part of the existing commitment that everyone will have access to a named GP with overall responsibility and oversight for their care.	**BWCCGs**	**March, 2018**	**Everyone diagnosed with dementia has a named GP as well as a personalised care plan that covers both health and care and includes their carer.**	**PHOF 4.13- Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia.** **ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**

Provide high quality post-diagnosis care and support, which covers other co-morbidities and increasing frailty.	**Primary care/ Memory Clinics/ Social Care (LAs),**	**Ongoing**	**Reduced: unplanned hospital admission, unnecessary prolonged length of stay, long-term residential care**	**ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**
Target and promote support and training to all GP practices, with the aim of achieving 80% Dementia Friendly practice access to our population	**BW CCGs project Lead/ DAA co-ordinators**	**March, 2018**	**80% of practices in Berkshire West will have adopted the iSPACE and sign up to the Dementia Action Alliance to become dementia-friendly.**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii- effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **PHOF 4.13 – Health related quality of life for older people**
Work with local organisations, care homes and hospitals to support more providers to achieve Dementia Friendly status	**DAA/ LAs/ Alzheimers society/BHFT**	**Ongoing - reviewed in December 2017, 2018 and 2019**	**More services will be staffed or managed by people with an understanding of dementia and the skills to make practical changes to make their service more accessible to those with dementia**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia**

				PHOF 4.13 – Health related quality of life for older people
Maximise the use of Dementia Care Advisors & training opportunities & roll out a training package/train the trainer model for NHS & Social Care staff and other frontline workers	**BWCCGs/Alzheimers Society/ HEE/BHFT**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**
Ensure commissioned services contractually specify the minimum standards of training required for providers who care for people with dementia including residential, nursing and domiciliary care settings.	**Local authority and NHS commissioning teams**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**
Review benchmarking data, local JSNA , variation, & other models of Dementia Care to propose a new pathway for Dementia Diagnosis/Management.	**BWCCGs/ Public Health/BHFT – not clear who leads on what here**	**March, 2017**	**National dementia diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for**

			treatment and care.	**people with dementia**
Identify & map opportunities, learning from similar and neighbouring CCGs, Providers and Local Authorities, for future service delivery to meet the 2020 Challenge. e.g. annual assessment, shared care, carer identification & support	**BWCCGs/ BHFT**	**April, 2017**	**Diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia**
Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	**LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs**	**March, 2018**	**At least, 80% of people with dementia and their carers are able to access quality dementia care and support.**	**PHOF 4.13– Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for**

				people with dementia **ASCOF 1B- People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**
Provide opportunities for people with dementia and their carers to get involved in research through signposting them to register with joint dementia research (JDR)	**BHFT/Alzheimers Society /LA/BWCCGs/ University of Reading**	**March, 2018**	**More people being offered and taking up the opportunity to participate in research and to support the target that 10% of people diagnosed with dementia are registered on JDR by 2020. Future treatment and services to be based on and informed by the experiences of people living with dementia**	
Enable people to have access to high quality, relevant and appropriate information and advice, and access to independent financial advice and advocacy, which will enable access to high quality services at an early stage to aid independence for as long as possible.	**BHFT/LAs**	**March, 2018**	**People with dementia and their carers are able to access quality dementia care and support, enabling them to say "I have support that helps me live my life", "I know that services are designed around me and my needs", and "I have personal**	

			choice and control or influence over decisions about me"	
Evaluate the content and effectiveness of dementia friends and dementia friendly communities' programme.	**AS/DAA/UoR**	**March, 2018**	**More research outputs on care and services.**	

PRIORITY NO 7	**Increasing take up of breast and bowel screening and prevention services**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Identify Practices where screening uptake is low and target initiatives and practice support visits to increase uptake.	**NHSE/PHE Screening Team** **Cancer Research UK Facilitator**		**Improved Screening Coverage and detection of cancers in early stages.**	**PHOF 2.19 Cancer Diagnosed at early stage** **2.20iii Cancer Screening coverage-bowel cancer** **2.20i Cancer screening coverage-breast cancer**

				4.05i Under 75 mortality rate from cancer (persons) **4.05ii Under 75 mortality rate from cancer considered preventable (persons)**
To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and screening programmes	**Public Health Berkshire** **Cancer Research UK Facilitator Bridget England**		**Patients seek advice and support early from their GP** **Increase uptake of screening programmes**	
To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a 2WW referral and a negative result ("teachable moments")	**Public Health Berkshire** **Cancer Research UK Facilitator**		**Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their risk of developing cancer**	

PRIORITY NO 8	**Reducing the number of people with tuberculosis**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Offer training in Reading for health professionals , community leaders and other professionals who come in contact with at risk population	FHFT & RBH TB service /South Reading CCG	Jan-17	Increase awareness about TB amongst local health and social care professionals as well as third sector organisations	PHOF 3.05ii - Incidence of TB (three year average)
Develop resources / training materials for wide range of LA staff to enable them to discuss TB and signpost to local services	Berkshire shared PH team / TB Alert		Increase awareness about TB amongst local authority staff working with those at increased risk of TB	PHOF 3.05ii - Incidence of TB (three year average)
Develop and run a joint public-facing communications / social marketing campaign to raise awareness of TB, latent TB and the local New Entrant Screening Service in order to reduce stigma and encourage those invited for LTBI screening to attend	Berkshire shared PH team / CCG comms / NESS nurses	March 2017	Address social and economic risk factors related to TB	PHOF 3.05ii - Incidence of TB (three year average)
Include TB data and service information in JSNA	Reading Wellbeing team	February 2017	Address social and economic risk factors related to TB	PHOF 3.05ii - Incidence of TB (three year average)
Provide service users with a means to feed into service design discussions	PH / TB Teams	Ongoing	Future treatment and services are based on and informed by	PHOF 3.05ii - Incidence of TB (three year average)

			the experiences of people living with TB **Repeat service user survey annually**	
Continue to work closely with PHE health protection colleagues to ensure robust and effective contact tracing takes place as standard	**TB Nurses / Berkshire TB Strategy Group**		**Outcome to be added**	**PHOF 3.05ii - Incidence of TB (three year average)**
Maintain robust systems for providers to record and report BCG uptake	**NHS England**		**Monitor provision and uptake of BCG vaccination as new policies are implemented**	**PHOF 3.05ii - Incidence of TB (three year average)** **Local indicator on BCG update could be developed in partnership with NHSE**
Develop / maintain robust systems for providers to record and report uptake and to re-call parents	**Midwifery teams in FHFT and RBH**	**January 2017**	**Ensure registers of eligible infants who have missed vaccination due to shortages are kept to up to date and a mechanism exists to re-call when vaccine is available**	**PHOF 3.05ii - Incidence of TB (three year average)**

Continue to communicate clearly on BCG shortage and ordering arrangements to allow planning	**NHS England**	**Ongoing**	**Vaccinating teams have timely information on which to base decisions**	**PHOF 3.05ii - Incidence of TB (three year average)**
Ensure processes are in place to identify eligible babies, even in low-incidence areas	**Midwifery teams in FHFT and RBH**	**Ongoing**	**Outcome to be added**	**PHOF 3.05ii - Incidence of TB (three year average)**
Tackle the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases	**Reading Wellbeing Team / Reading** **Reading Housing Team / NESS nurses/CCGs**	**Jan-17**	**Work to develop the provision of appropriate and accessible information and support to under-served and high-risk populations.**	**PHOF 3.05ii - Incidence of TB (three year average)**
Ensure patients on TB treatment have suitable accommodation	**Reading Wellbeing Team / Reading** **Reading Housing Team / NESS nurses/CCGs**		**Development of robust discharge protocol**	**PHOF 3.05ii – Treatment completion for TB**
Develop and promote referral pathways from non-NHS providers	**LA public health / NESS nurses/CCGs**		**Align local service provision to these groups as per NICE recommendations**	**PHOF 3.05ii - Incidence of TB (three year average)**

Develop robust pathways to enable timely discharge of patients into appropriate accommodation	**LA public health / NESS nurses**	**Jan-17**	**Develop robust pathways to enable timely discharge of patients into appropriate accommodation**	**PHOF 3.05ii - Incidence of TB (three year average)**
Engagement with SE TB Control Board to share best practice	**DPH / PHE CCDC**		**Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved**	**PHOF 3.05ii - Incidence of TB (three year average)**
Fully implement EMIS and Vision templates in all practices in South Reading	**South Reading CCG**	**Ongoing**	**Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways**	**PHOF 3.05ii - Incidence of TB (three year average)**

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

Reading Borough Council

Local Transformation Plan for Children and Young People's Mental Health and Wellbeing-

Reading Health and Wellbeing Board and Local Authority area

Version 5 15 October 2015

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1. **High level summary of the Local Transformation Plan (Annex 1 in the guidance)**

Annex 1: West Berkshire Local Transformation Plan for Children and Young People's Mental Health

Developing your local offer to secure improvements in children and young people's mental health outcomes and release the additional funding: high level summary

Q1. Who is leading the development of this Plan? (Please identify the lead accountable commissioning body for children and young people's mental health at local level. We envisage in most cases this will be the CCG working in close collaboration with Local Authorities and other partners. Please list wider partnerships in place, including with the voluntary sector and include the name and contact details of a single senior person best able to field queries about the application.)
Lead commissioning body-NHS Berkshire West CCGs working in collaboration with Reading Borough Council, Public Health, NHS England Specialised Commissioning and Health and Justice Commissioning. Partners including the voluntary sector, NHS providers, referrers, schools, the universal and targeted children's workforce, service users and their families have shaped these plans. Implementation of the Transformation Plan will be overseen by the Berkshire West Mental Health and Wellbeing Transformation group. See section 14 Berkshire West already has a number of governance structures in place that will provide a solid foundation of support for the Transformation Plan. These include Berkshire West Integration Board Berkshire West Children's Commissioning Strategy Group Reading Children's Trust **For queries contact** Gabrielle Alford Director of Joint Commissioning Sally Murray Head of Children's Commissioning NHS Berkshire West CCGs 57- 59 Bath Road, Reading, RG30 2BA sally.murray2@nhs.net

Q2. What are you trying to do?

(Please outline your main objectives, and the principal changes you are planning to make to secure and sustain improvements in children and young people's mental health outcomes. What will the local offer look like for children and young people in your community and for your staff?). Please tell us in no more than 300 words

Our main objective is to integrate and build resources within the local community so that emotional health and wellbeing support is offered at the earliest opportunity thereby reducing the number of children and mothers at the perinatal stage whose needs escalate to require a specialist intervention, a crisis response or admission to an in-patient facility.

This means that

- Good emotional health and wellbeing is promoted from the earliest age
- Children, young people and their families are emotionally resilient
- The whole children's workforce including teachers, early years providers and GPs are able to identify issues early, enable families to find solutions, provide advice and access help
- Help is provided in a coordinated, easy to access way. All services in the local area work together so that children and young people get the best possible help at the right time and in the right place. The help provided takes account of the family's circumstances and the child or young person's views.
- Women with emerging perinatal mental health problems access help quickly and effectively
- Vulnerable children access the help that they need easily. This includes developing Liaison and Diversion services and better links with SARCs.
- Fewer children and young people escalate into crisis. Fewer children and young people require in patient admission.
- If a child or young person's needs escalate into crisis, good quality care will be available quickly and will be delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible, as close to home as possible.
- When young a person requires residential, secure or in patient care, this is provided as close to home as possible. Local services support timely transition back into the local area.
- More young people and families report a positive experience of transition.

Q3. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing your local offer in line with the national ambition set out in *Future in Mind* e.g. progress made since publication in March 2015.) Please tell us in no more than 300 words

- In 2014 a substantial engagement was undertaken with comprehensive Berkshire CAMHs service users, families, referrers, practitioners and other stakeholders led by an independent consultant.
- An initial local action plan in response to the engagement findings was developed and enacted prior to publication of Future In Mind. This includes a number of pilot projects on transition, perinatal mental health, self-care and improving care for the most vulnerable
- Reading Children's Trust Workshop July 2015. Discussion focussed on understanding and improving the range of support and interventions to help children and young people with emotional and mental health difficulties. Subsequent sessions have led to the vision outlined in section 2.
- Commissioning of Berkshire Adolescent Unit has transferred to NHS England. The unit has been re-designated as a Tier 4 24/7 resource. Bed capacity is due to increase this autumn.
- Operational resilience resources funded a trial of extended CAMHs opening times which in turn has reduced the number of children and young people whose needs have escalated into crisis. This is now being mainstreamed.
- Operational resilience resources funded an enhanced Early Intervention in Psychosis service
- Crisis Care Concordat action plan is in place and being delivered. Psychological Medicines Service, ambulance triage and street triage services are in place.
- Berkshire West CCGs have increased the investment in specialist CAMHs by £1M recurrently. The initial focus is on reducing waiting times, piloting a Short Term Care Team to follow up young people who presented with urgent care needs and delivering PPEP Care training to primary care and schools
- Redesign of the community Eating Disorders service is underway
- Young SHaRON online platform has been developed. Going live this Autumn.
- Children and Young People's Integrated Therapies toolkit is being expanded to include mental health and emotional development
- A Mental Health and Wellbeing Transformation group has being convened.

Q4. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.) Please tell us in no more than 300 words

- Reduced waiting times for specialist CAMHs
- Reduction in crisis presentations due to better risk mitigation
- Common Point of Entry will be open Monday to Friday 8am until 8pm
- Workforce development plan for emotional health and wellbeing being implemented across partners
- Joint commissioning of voluntary sector counselling where the Local Authority and CCG are currently commissioning independently
- Evaluation of the CAMHs Short Term Care team
- Launch of Young SHaRON- online platform for service users
- Increase number of in-patient beds at Berkshire Adolescent Unit

- Improved perinatal mental health service will be providing better access to advice and help for mothers
- Outcome framework developed and agreed across partners. To be implemented in all contracts from 1 April 2016.
- Neurodevelopmental pathway developed within BHFT
- Children's toolkit expanded to include mental health and wellbeing
- Enhanced Liaison Mental Health service for under 18s will have been trailed at RBFT (subject to funding through Liaison Mental Health)
- Commission enhanced Eating Disorders service. Start delivery
- Scope out the potential for a single point of access, integrated with local MASH and Early Help pathways.
- Co-design with Schools the community based approach that outlines a core intervention offer in schools and establishes a consultation service with targeted and specialist CAMHs
- Training completed on equipping Social Workers to utilise the SDQs with vulnerable children (mainly LAC) and begin to implement recommendations from project.

Q5. What do you want from a structured programme of transformation support? Please tell us in no more than 300 words

- Additional funding in order to meet the requirements of Future In Mind
- Events held in the Thames Valley to develop the workforce, commissioner and provider skills
- On line resources-e.g. concise "how to " guides linked to the evidence base
- Simple and easy to use trackers and pro-formas
- Shared comprehensive Outcome framework guidance, with particular emphasis on enabling universal and targeted providers measuring impact of their work
- Forums for CCG and partners to share and swap ideas.

2. **Self-assessment checklist for the assurance process (Annex 2 in the guidance)**

Please complete the self-assurance checklist designed to make sure that Local Transformation Plans for Children and Young People's Mental Health and Wellbeing are aligned with the national ambition and key high level principles set out in *Future in Mind* and summarised in this guidance

PLEASE NOTE: Your supporting evidence should be provided in the form of specific paragraph number references to the evidence in your Local Transformation Plans – not as free text

Theme	**Y/N**	**Evidence by reference to relevant paragraph(s) in Local Transformation Plans**
Engagement and partnership		
Please confirm that your plans are based on developing clear coordinated whole system pathways and that they:		
1. Have been designed with, and are built around the needs of, CYP and their families	Y	4.6, 4.9, 7.3 Sections 5 and 8
2. provide evidence of effective joint working both within and across all sectors including NHS, Public Health, LA, local Healthwatch, social care, Youth Justice, education and the voluntary sector	Y	Sections 4 and 6
3. include evidence that plans have been developed collaboratively with NHS E Specialist and Health and Justice Commissioning teams,	Y	4.9 Sections 10 and 11
4. promote collaborative commissioning approaches within and between sectors	Y	Sections 4,10,14
Are you part of an existing CYP IAPT collaborative?	Y	4.6, 7.1
If not, are you intending to join an existing CYP IAPT collaborative in 2015/16?	N/A	
Transparency		
Please confirm that your Local Transformation Plan includes:		
1. The mental health needs of children and young people within your local population	Y	4.9 Section 5
2. The level of investment by all local partners commissioning children and young people's mental health services	Y	Section 6
3. The plans and declaration will be	Y	4.8

published on the websites for the CCG, Local Authority and any other local partners		
Level of ambition		
Please confirm that your plans are:		
1. based on delivering evidence based practice	Y	7.1, 7.4 Sections 8 and 11
2. focused on demonstrating improved outcomes	Y	7.11 Sections 8 and 11
Equality and Health Inequalities		
Please confirm that your plans make explicit how you are promoting equality and addressing health inequalities	Y	7.4 Sections 8,9,10,11
Governance		
Please confirm that you have arrangements in place to hold multi-agency boards for delivery	Y	Section 14
Please confirm that you have set up local implementation / delivery groups to monitor progress against your plans, including risks	Y	Section 14
Measuring Outcomes (progress)		
Please confirm that you have published and included your baselines as required by this guidance and the trackers in the assurance process	Y	Section 15
Please confirm that your plans include measurable, ambitious KPIs and are linked to the trackers	Y	Sections 13 and 15
Finance		
Please confirm that:		
1. Your plans have been costed	Y	Section 15
2. that they are aligned to the funding allocation that you will receive	Y	Section 15
3. take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem)	Y	Section 15

Sylvia Chew
Director of Children, Education and Early Help Services – Reading Borough Council
Name, signature and position of person who has signed off Plan on behalf of local partners

……..
Name signature and position of person who has signed off Plan on behalf of NHS Specialised Commissioning.

3. Locality information

This local Transformation Plan relates to the Reading Borough Council Local Authority area.

Two CCGs serve the population of Reading Borough Council. These are South Reading CCG and North and West Reading CCG.

There are four CCGs in Berkshire West. The four CCGs work collaboratively with a single contract with Berkshire Healthcare Foundation Trust (BHFT) for specialist CAMHs, mental and physical health services.

Reading Borough Council commissions and provides targeted CAMHs. Health Visiting and School Nursing are also provided by BHFT.

Berkshire West CCGs and Reading Borough Council commission a range of voluntary sector organisations through grants.

Royal Berkshire Hospital Foundation Trust (RBFT) is the main acute general hospital in the area.

South Central Ambulance Service (SCAS) is the patient transport provider.

The Berkshire Adolescent Unit (BAU) is the only NHS inpatient CAMHs facility in Berkshire. It is commissioned by NHS England.

4. Engagement and partnership (groups)

4.1 The four Berkshire West CCGs work in partnership with the 3 Local Authorities (West Berkshire Council, Reading Borough Council and Wokingham Borough Council), Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital Foundation Trust and South Central Ambulance Service to form the Berkshire West Integration Board.

4.2 Implementation of the Transformation Plans will be overseen by a new Berkshire West Children and Young People's Mental Health and Wellbeing Transformation group, attended by multiagency partners (see section X) The Transformation group will report to the Berkshire West Integration Board.

4.3 Berkshire West Children's Commissioning Strategy Group meets monthly to collaboratively improve the health and wellbeing outcomes for Berkshire West Children and Young People and their families through developing and overseeing the commissioning of health, social care and education support services. Membership comprises of CCG, Public Health and Local Authority Children's commissioning leads and Local Authority Children's Services leads.

4.4 The Youth Offending Board is a multi-agency body that comprises of CCG, Public Health, Thames Valley Police, Probation service, Magistrates. This board governs the work of the youth offending team which is a multi-professional team that is tackling a range of youth offending in Reading. A critical aspect of service delivery is ensuring these vulnerable young people's emotional & mental health needs are met.

4.5 Reading's Troubled Family Programme has a partnership management board that is overseeing the phase 2 of its programme delivery. The outcome plan includes a health component to support families with a range of health related problems including meeting the emotional and mental health needs of children and young people in the household.

4.6 Berkshire CAMHs are already part of a CYP IAPT collaborative. The service has a dedicated service user engagement and participation lead. Services users, parents and carers are engaged in service development at all levels. Routine Outcome Measures are used across the service.

4.7 The Reading Health and Wellbeing Board have received updates on the status of emotional health and wellbeing services for children and young people. The latest paper was discussed at the HWB held on 17 April 2015. A further update was provided at the October HWB.


Comp CAMHs status report April 15 (2).pd


Reading HWB Oct 2015 comprehensive

4.8 Arrangements are in train for this Transformation Plan to be signed off by the HWB prior to the 16 October 2015 deadline. The Transformation Plans will be published on CCG, Local Authority and partner agency websites once the plans have been approved by NHS England.

4.9 In developing this local Transformation Plan there has been extensive engagement and joint working with service users, families, referrers, practitioners and other stakeholders to benchmark the current service across comprehensive CAMHs and to identify opportunities to develop the service to better meet local needs. In developing these plans there has been collaboration with NHS England Specialist and Health and Justice Commissioning teams.

http://www.southreadingccg.nhs.uk/mental-health/review-outcome-of-camhs

4.10 Voluntary sector youth counselling organisations across Berkshire have met together and have fed back their perspective on how they can contribute to meeting the recommendations of Future In Mind as well as their views on developing an outcomes framework.

4.11 Voluntary sector organisations were also involved in the Reading Children's Trust workshop held on the 9th July 2015. Other participants included schools, GPs, educational psychologists, police, public health, elected members, young people, CAMHs providers, University of Reading, Local Authority officers and a CCG lead. A summary of the outputs form the workshop are in this document.

Feedback from Cllr Gavin on CTB EWB wc

4.12 Voluntary sector representation is sought on the Berkshire West Mental Health and Wellbeing Transformation group.

5. Transparency- need

The Joint Strategic Needs Assessment is found here http://jsna.reading.gov.uk/

The CAMHs Needs Assessment for Reading Borough Council is found here

CCSG15-07 CAMHS_Needs_Asses

Targeted CAMHs activity from RBC primary mental health workers (PMHW)

In 2014/15 163 children and young people were assessed by the service, and 100% were seen within agreed timescales (within 10 working days of referral). 71% of these were step down cases from CPE, and only 13% of these 116 cases were taken back to CPE. 67 of these assessed children were provided an ongoing evidence based intervention from the PMHW service, with 621 successful intervention sessions provided.

In addition to direct delivery to children, the service provided 316 consultation interventions with School, GP and children's services colleagues. PMHWs also delivered a range of training (from introductory courses to specific topic based sessions e.g. anxiety, self-harm) to 82 staff from schools and 58 staff from targeted or social work teams.

Current year performance as of end of June 15, no children are waiting for a PMHW intervention.

Specialist CAMHs activity data

In 2014/15 there were 688 children and young people referred to the CAMHs Common Point of Entry from South Reading CCG and 554 referrals from North and West Reading CCGs.

During this period there were 5668 specialist CAMHs contacts with children and young people from these two CCGs.

Of the specialist CAMHS caseload, 51 children from South Reading CCG were either Looked After or subject to child protection plans and 39 were from North and West Reading CCGs.

Waiting times for Tier 3 CAMHs services in Berkshire West CCGs at the end of June 2015

- 100% of children with urgent needs were seen within 24 hours
- 53% of Tier 3 CAMHS patients (excluding ASD) waited less than 6 weeks to be seen

- 11% of Berkshire West CAMHS ASD patients waited less than 12 weeks to be seen
- Currently the longest waits continue to be in the ASD diagnostic pathway which accounts for more than 50% of current waiting list. In Berkshire West some children wait up to 2 years for an ASD diagnosis, once they have been referred to specialist CAMHs. The National Autistic Society gives an average waiting time for ASD diagnosis in children as 3.5 years.

The latest Reading JSNA estimates that 30 children and young people aged 17 years and below from the local authority area will require a Tier 4 admission per year. In 14/15 fourteen young people from Reading attended the Berkshire Adolescent Service. A further XXX children and young people from Reading were admitted to a Tier 4 facility outside Berkshire. (Data awaited from Louise Doughty- specialist commissioning). The Berkshire Adolescent Unit has 9 in-patient beds (as of autumn 2015). Scoping work that took place in 2014 estimates that Berkshire requires between 12 and 15 Tier 4 beds.

6. Transparency- resources

6.1 Reading Borough Council funding

Year	Service	Expenditure
15-16	Primary Mental Health Workers	£ 179,800
15-16	Educational Psychologists	£495,150
15-16	Youth Counselling service (Commissioned)	£75k
15-16	Short breaks (Commissioned)	£105k
15-16	Targeted family and youth support	TBC

In addition to this spend RBC spend on universal services that are applicable in this arena is

Year	Service	Expenditure
15-16	Information services for families (FIS service)	£ 100,000
15-16	Children's Centres	£1.4m

6.2 Tier 3 (specialist CAMHs) funding arrangements from Berkshire West CCGs as a whole, that is, Newbury & District, North & West Reading, South Reading, and Wokingham CCGs

	Funding allocation	Includes BAU*?	Includes YP placed out of area by NHSE at Tier 4?
2014/15	£4,649,251 plus £300K Operational Resilience funding.	yes	no
2015/16	£6,166,360 plus additional £249,535 allocated to transforming community Eating Disorder services.	no	no

	Up to £500K is available non recurrently in order to reduce waiting times through use of agency staff while new posts are recruited to.		

*In 2014/15 the Berkshire Adolescent Unit (BAU) was commissioned as a Tier 3 facility. In 2015/16 the Berkshire Adolescent Unit was re-designated as a Tier 4 facility and transferred to NHS England, Financial resources transferred with the unit to NHS England.

A CAMHs worker is employed in the Youth Offending team. Half of these sessions are provided through the CCG funded block contract with BHFT.

6.3 CCG Partnership Development Grants

A number of voluntary sector organisations are commissioned through CCG Partnership Development Grants to provide counselling, parenting support and input for children and Young People with ASD and/ or Special Educational Needs and Disabilities. In 14/15 the spend was as follows

Organisation Name	Category	% Coverage Each Area	PANEL FUNDING PROPOSAL
Berkshire Autistic Society	HWB/ Mental health/ Children and Young people/ Carers	West Berks 22.5%, Reading 42%, Wokingham 35.5%	£27,300.00
Children on the Autistic Spectrum Young People's Project (CATSYPP)	Children and Young people/Mental Health	West Berks 5%, Reading 77%, Wokingham 18%	£5,650.00
No 5 Youth Counselling	Children & Young people / Mental Health	Reading 100%	£24,572.00
Reading Mencap	Mental Health	Reading 100%	£29,592.00
Home-Start Reading	Children and Young people	Reading 100% (BME 53%)	£13,438.00
Parenting Special Children	Mental Health/ Children and Young people/Carers	West Berks 30%, Reading 35%, Wokingham 35% (BME = 45%)	£18,835.00

6 .4 NHS England funding 2014/15

Out of area spend (Young People from South Reading CCG and North and West Reading CCGs CCG who are placed out of area) £1,295,919

7. Work undertaken to date across Berkshire West

7.1 Berkshire CAMHs is already part of the Children and Young People's Improving Access to Psychological Therapies (IAPT) collaborative. As a result of the CYP IAPT training, staff within all localities across Berkshire and in Primary CAMHS where BHFT are the providers, provide evidence based CBT interventions for anxiety and depression as part of their everyday work. CYP IAPT Routine Outcome Measures are an integral part of these interventions and are being rolled out across all other clinical activity. CYP IAPT trained supervisors provide clinical supervision in all localities and clinical leads who have undertaken the CYP IAPT transformational leadership training are working with CAMH Service managers to continue to develop CAMHs. The service has a dedicated service user engagement and participation lead. Services users, parents and carers are engaged in service development at all levels.

7.2 BHFT CAMHs are currently participating in the Department for Health trial of the CAMHSWeb/ Include Me interactive shared decision making portal.

7.3 In 2014 a substantial engagement was undertaken with comprehensive Berkshire CAMHs service users, families, referrers, practitioners and other stakeholders led by an independent consultant. This was published on CCG websites along with an update in December 2014 which outlines changes planned or made to local services in response to the engagement work.

http://www.southreadingccg.nhs.uk/mental-health/review-outcome-of-camhs

In response to the engagement, local action plans were developed and implemented. This Transformation Plan builds on the original plans.

7.4 During 2014/15, a number of local pilot projects commenced. Learning from the pilot projects will be disseminated across Berkshire West CCGs and Local Authorities:

- a review of the use of nationally mandated Strengths and Difficulties Questionnaire (SDQ) assessments in Looked After Children and children at risk of exclusion. The aim of the project is to inform local policies and procedures in the improvement of screening for mental health needs in vulnerable groups of children and young people.
- a review of blockages to vulnerable women accessing perinatal mental health services. This project is also reviewing training packages for prevention, identification and intervention in perinatal mental illness across the children's workforce. A project worker has been employed to address issues
- a review of the perinatal mental health pathway led by a midwife at Royal Berkshire Hospital. A business case is currently being considered to enhance perinatal mental health support for women and their families in Berkshire West CCGs.
- a review of transition pathways into adult services. A CQIN on patient experience of transition into adult services is in the 15/16 BHFT contract
- a trial of school based ADHD clinics in Reading. Learning from this pilot is feeding into a revised neurodevelopmental pathway that is being developed across Berkshire West.

- the development and trial of PPEPCare training modules in primary care and schools. This initiative is supported by Thames Valley Strategic Clinic Network and the Charlie Waller Institute
  http://tvscn.nhs.uk/psychological-perspectives-in-education-and-primary-care-ppep-care/

7.5 Over the winter of 14/15, additional Operational Resilience funding was secured to pilot a number of initiatives which aimed to

- improve responsiveness to escalating mental health needs thereby reducing risk,
- improve early identification of psychosis
- reduce waiting times.

7.6 In March the Berkshire Crisis Care Concordat Action Plan was published. Partners meet quarterly to review progress.


Berkshire-Mental-He
alth-Crisis-Care-Conc

7.7 The CCGs increased funding to BHFT specialist CAMHs Berkshire West by £1M recurrently and up to £500K non recurrently for 15/16. The initial focus for the additional investment is building on the successful Operational Resilience projects on a more sustainable basis; reducing waiting times; reducing risk; delivering PPEP care training into selected schools and GP practices and developing sustainable care pathways.

7.8 Berkshire West CCGs have also increased funding into the all age Early Intervention in Psychosis service as part of the wider Parity of Esteem investment. BHFT are meeting the 2 week Waiting Time standards, with 85% of cases referred to EIP being allocated care co-ordinators within 2 weeks. The average time to allocation is 8 days from the point of referral.

It should be noted however the new guidance confirms that the 2 week RTT starts at referral and assessments within a dedicated EIP team, cases are allocated to an EIP care coordinator and then RTT concludes with treatments commencing using a NICE concordant package that meets the 8 quality standards. At this stage BHFT is not able to meet these standards fully but through the new Parity of Esteem investments will recruit additional staff to deliver these packages of care and the elements within the standards. An update is provided here


EIP update
commissioners Sept 2

7.9 In July and August CCG commissioners worked with BHFT, voluntary sector and Local Authority partners to identify key areas of improvement for the next 5 years, building on the intelligence gained from the local engagement initiatives as described in section 4 and service pilots described above. This included consideration of what an improved Eating Disorder service might comprise of and how physical and mental health services could become more aligned and "whole person" focussed.

7.10 In August BHFT CAMHs received a Quality Assurance visit from the CCG which demonstrated that good progress had been made in improving the patient environment, staff morale and recruitment to achieve targets against the new investment.

7.11 Discussions are currently underway between agencies to agree an outcomes reporting framework, for use in all emotional health and wellbeing contracts from April 2016.

8. Local aspiration and vision for prevention, building resilience, earlier identification, earlier intervention and better whole system working

This section provides a summary of discussions and proposals that are in development by partners in Reading.

Reading needs an alternative approach and system that enables children and young people to access support that they need quickly and easily. Ideally this new system is permeable between the processes and service offers that allows for a stepped care approach towards meeting the needs of children and young people. A key principle that should underpin an alternative system will be to work to the Recovery Model approach. Critical to this is the promotion of self-accountability within the child and parent before, during and after an intervention, which will promote owned sustained change. This is important to building resilience both in the child, family and the systems we adopt.

At this stage there are two key ideas to developing an alternative system that the Transformation Plan will support in addressing.

1. Establish a local single point of entry for targeted and specialist CAMHs support that is integrated with our current Multi Agency Safeguarding Hub (MASH) and Early Help pathways. This would enable a single screening process at the referral/ contact/ identification stage that would cover safeguarding as well as the emotional health and wellbeing needs of the child and family. This would prevent confusion in assessment & decision making as well as reducing delay in handovers. The step down or step up processes would be linked to specialist CAMHs teams and the single Early Help pathway. This Early Help pathway would include access to a range of targeted support, including Primary Mental Health workers (PMHWs) as well as voluntary sector interventions such as youth counselling.

2. Establish a community based approach, mainly in schools and local GPs, that supports universal services hold appropriate risk as well as access professional advice on when to step cases up into targeted or specialist services. To support this approach a standard/ core programme of interventions in schools would be developed that would fit with the stepped approach to care. This would need to be supported by a workforce development programme from within the Transformation Plan.

Also for inclusion in the Transformation plan for Reading are these key points:

a. A review of the behavioural pathway and linking this to the development of a trauma or attachment pathway. Similar consistent stepped care approach of evidence based interventions need to be identified and adopted, with a workforce training programme in place to keep this sustained. A similar consultation approach for Primary Schools and Early Years setting/ Children's Centres, delivered by Educational Psychology and CAMHs specialists in this field would need to be established. Tied to this point it will be important to include the current Reading perinatal mental health project recommendations that is due to conclude in March 16.

b. There should be regular reviews of the emotional and mental health needs of Looked After Children and Care leavers alongside their physical health needs. These reviews need to be supported by targeted & specialist mental health professionals using a similar consultation/ screening approach as being proposed for schools. Social Worker skills and confidence will need constant attention through workforce development. Readings SDQ project outcomes need to be included in the Transformation Plan.

c. Reading will continue to develop and strengthen its Early Help offer and this will be tied into the access approach described above. This offer will include coordinated targeted youth work, family work and parenting all of which are critical support interventions in this arena. Our PMHW role will continue to be a crucial role in supporting the practice with these services and continue to be the link between targeted and specialist services.

9. Self-assessment

NHS England requires a self-assessment to be undertaken as part of the assurance process. In light of the short timescale and availability of partners in August, CCG commissioners and BHFT undertook a self-assessment using a process provided by the Thames Valley Strategic Clinical Network. The self-assessment process took account of knowledge gained through the partnership work to develop local emotional health and wellbeing services that been undertaken in the previous 12 months.

The self-assessment identified workforce development, care for the most vulnerable and improving access as the most challenging aspects of Future In Mind for Berkshire West. It was

felt that there is a will across the system to make change happen and that Berkshire West has made much recent progress in accountability and transparency across the system.

Copy of Future in mind_ADS Self Assess

10. Overview of Local Transformation Plan priorities and outline timescales (subject to confirmation by Berkshire West Mental Health and Wellbeing Transformation group)

2015/16

- Recruit and train additional staff
- Reduce waiting times
- Reduce inappropriate/avoidable presentations to A&E – data to be collected from September 2015
- Reduction in crisis presentations due to better risk mitigation
- Common Point of Entry will be open Monday to Friday 8am until 8pm
- Workforce development plan for improving emotional health and wellbeing developed and starting to be implemented across partners
- Joint commissioning of voluntary sector counselling where the Local Authority and CCG are currently commissioning independently
- Evaluation of the CAMHs Short Term Care team
- Launch of Young SHaRON- online platform for service users
- Increase number of in-patient beds at Berkshire Adolescent Unit
- Commission improved perinatal mental health service to provide better access to advice and help for mothers
- Outcome framework developed and agreed across partners. To be implemented in all contracts from 1 April 2016.
- Neurodevelopmental pathway (ADHD and ASD) developed within BHFT
- Children's toolkit expanded to include mental health and wellbeing
- Learning from the Strengths and Difficulties pilot will be shared and will be shaping service provision
- Enhanced Liaison Mental Health service for under 18s will be trailed at RBFT (subject to funding through Liaison Mental Health)
- University of Reading study to commence
- Commission enhanced Eating Disorders service. Start service delivery
- CQIN for service user satisfaction following transition into adult services

2016/17

- Reduce waiting times

- Workforce development- develop role of schools, primary care, early year's settings, wider children's workforce
- Map collective resilience, prevention and early intervention offers. Consider how we make the system easier to navigate.
- Review current Common Point of Entry and access arrangements into CAMHs services, ensuring access for the most vulnerable (includes step down from in-patient units, links to SARCs, Looked After Children's services, emerging Liaison and Diversion services for under 18's, forensic services, provision for children and young people with LD and ASD)
- Consider whether to commission a crisis home treatment or enhanced step up/step down service following a review of the impact of the Short Term Care team and enhanced Liaison Mental Health services on reducing admissions to Tier 4.
- Enhance provision across the system for children and young people with ASD and Learning Difficulties
- Roll out of enhanced perinatal service
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.
- Implement Eating Disorders service

2017/18

- Maintain or further reduce waiting times
- Workforce development
- Implement 24/7 crisis home treatment or step up/step down service, depending on findings of the review
- Develop conduct disorder/ challenging behaviour pathway across the system. Consider implications for children and young people with LD and ASD.
- Consider availability of provision for young people stepping down from Tier 4 facilities
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.

2018/19

- Workforce development
- Implement conduct disorder/ challenging behaviour pathway across the system
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.

11. Detailed Local Transformation Plan

Key areas to be addressed in the Berkshire West Local Transformation Plans and proposal of an order in which changes might be worked through

Future In Mind (FIM) priority

R= Resilience, Prevention and early intervention for the mental well-being of children and young people (chapter 4)

A= Improving access to effective support (chapter 5)

V= Caring for the most vulnerable (chapter 6)

AT= To be accountable and transparent (chapter 7)

W= Developing the workforce (chapter 8)

Issue/ recommendation from Future In Mind	Actions/ Key Lines of Enquiry	Suggested date	FIM priority
Improving the access to help, preventing young people being lost or having to wait a long time for service delivery.	Recruit BHFT staff CPE open longer hours Technology development and roll out Introduce waiting time standards across CAMHs and Early Intervention in Psychosis services	15/16 15/16 onwards 15/16 onwards	A A A A
Reduce number of YP whose needs escalate to crisis	Trial short term care team (follow up of YP who have attended A and E in crisis) Prioritise higher risk cases, paying particular attention to Children in Care Ongoing risk review of those on waiting list Collect data from RBH on A and E attendances, wait times- identify any trends What can we learn as a system from YP who escalated into Tier 4?	15/16 15/16 15/16 From Q3 15/16 and 16/17 16/17	A A A A, AT A, V

	Those who stepped down from Tier 4? Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat is implemented. Use of on line platforms such as SHaRON and Young SHaRON	 15/16 onwards 15/16 onwards	 A, AT, V A
Reduce delays in accessing MH assessments once YP is medically fit and has presented at RBH	CPE open longer hours-staff available for longer Embed new care pathway Scope a trial of an enhanced liaison mental health service for under 18s to be trailed at RBFT	15/16 15/16 onwards Q3 and 4 15/16	A A A, V
Is there a need for a local intensive crisis home treatment team for CYP?	Evaluate learning and data from initiatives above Establish the interface with the transformed Eating Disorders service Develop options appraisal Commission and implement service	Late 16/17 17/18	A
By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.	Berkshire Adolescent Unit transfer to NHSE- MOU implemented See also “Is there a need for a local intensive crisis home treatment team for CYP?” above Consider step down arrangements for young people being discharged from in patient units- is there a case for a local facility as an alternative to out of area residential placements? Also links with Transforming Care Implement changes to community Eating Disorder services	15/16 17/18 15/16 onwards	AT V A
Enhancing existing maternal, perinatal and	Evaluate perinatal MH pilots in the community/ children’s centres.	15/16	R, W

early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE, HEE to ensure that staff are more aware of the impact that trauma has on MH and on the wider use of appropriate evidence-based interventions	Impact on take up of services for new mothers? Consider the recommendations. Commission enhanced perinatal MH service- RBH working with BHFT Participate in University of Reading clinical trial-improved treatment for severe conduct disorders in young children LAs evaluate behaviour support programmes and services to include SEN, Troubled Families, therapeutic fostering and YOS arrangements Develop conduct disorder/ behaviour pathway building on learning from trials and evidence across the system Roll out conduct disorder/ behaviour pathway Publicise and promote attendance at the Thames Valley trauma conference	 15/16 Q4 15/16 16/17 TBC 17/18 18/19 15/16	 R A, R,W, V AT, W, V A, AT, V A, W, V, R W
How far can we push integration? Enabling single points of access to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector. Move away from tiered working. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and	Review current CPE and local triage arrangements- should a single point of access/ localised triage system be developed in each LA where the family's holistic needs are considered prior to referral to CAMHs? Should this also consider physical healthcare e.g. therapies? How does this differ to existing MASH and Early Help hubs? How does the current system link to SARCs, YOS and the Troubled families programme? Consider the feasibility of changes on a Berkshire West only basis	16/17	A, V

services to prevent them falling between services. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.	How does a "Tier 2 or 3" child present? Unpick clinical thresholds and agree how cases are stepped up and down between universal, targeted, specialist and acute service providers.	15/16	A, W, AT
	Identify the skills needed in the workforce in order to respond to different levels of need/ complexity	16/17	A, V, W
	What can we learn from successful YOS and Troubled Families services re approach?	Early 16/17	A, V
	Overcome information sharing/ data collection issues between agencies	15/16	A, V
	Roll out changes	Late 16/17, early 17/18	A, V
	Is there a case to develop a regional Thames Valley service for certain groups e.g. children with sexually problematic behaviour? Services for LAC placed out of area but within the Thames Valley? YP who have been sexually exploited?	16/17	A, V, R
	Ensure all services understand and demonstrate a shared responsibility for the emotional health and well-being, and are supported with the skills and training development to fulfil those roles effectively	15/16 onwards	W, AT, V,A
	Is there a need to improve links with SARCs?	16/17	V
	Work with commissioners across the Thames Valley to maintain a Secure CAMHS Outreach service in	TBC	V,A

	the event of this moving from Specialised Commissioning across to CCGs Implement all age liaison and diversion scheme when it is developed by NHSE Improve links with SARCs	 TBC 16/17	 A, V V
Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.	Linked to CPE work above BHFT working with service users to improve communications Will schools commit to having MH lead? Agree interface between BHFT and local services- clinical supervision, training Do we as a system understand what we currently collectively offer with regard to resilience, prevention and early intervention? How do we make the offer easy to navigate?	 15/16 16/17 16/17 16/17 16/17	 A A, W A,W,V, AT AT, R AT, R, A
Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage.	CCG assurance visit Consider whether a local single point of access in each LA and having a MH link in schools where the family's holistic needs are considered might improve access for these groups.	15/16	V, A
Online support for CYP and families	Young SHaRON roll out, to include platforms for Looked After Children, carers, families	15/16	A, R, V
Strengthen links between physical health, mental health and support for children with SEN	BHFT expand children's toolkit to include Mental Health Consider whether current emotional wellbeing support for children and young people with long term conditions is sufficient	15/16 and early 16/17 16/17	A, R A, V

	BHFT to develop internal workforce	15/16 onwards	W
System wide ASD and ADHD pathway- strengthening the links between mental health, learning difficulties and services for children with Special Educational Needs and Disabilities (SEND)	ASD diagnostic waiting time standard in contract 15/16 Recruitment underway BHFT 15/16 DH guidance on LD and ASD expected. BHFT expand children's toolkit to include ASD and ADHD BHFT develop internal neurodevelopmental pathway. Link with schools, LAs, vol sector. Linkages between ASD, ADHD, SEND, behaviour? Schools role? Who does what? What do we commission from voluntary sector? Thresholds /acceptance criteria? How do agencies communicate/ key workers? Develop pathway across the system. Workforce training Link to Transforming Care initiatives to ensure that local services are available for young people with challenging behaviour and learning disabilities and or ASD	15/16 Q2 15/16 Q2 15/16 Q3 and 4 15/16 Q3 and 4 15/16 15/16/17 16/17 16/17	A A, W AT A, R, W AT, A, W, V A, AT, W W A,V
Supporting self-care	Expansion of children's toolkit to include MH Publicise Puffell apps developed in Berkshire once accredited Reading pupils given MH self-care booklets Launch Young SHaRON	15/16 and early 16/17 15/16 15/16 15/16	R, A R, A R, A R,A,V
Promoting implementation of best practice in	Transition into adult services project	15/16	A

transition, including ending arbitrary cut-off dates based on a particular age.	Consideration of access to specialist Eating Disorders services for older teenagers/ less mature older teenagers Embed changes	15/16 onwards 15/16 onwards	A A
Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	PPEPCare training to primary care and selected schools If bid successful, roll out school link pilot Reading core workforce training	15/16 15/16 15/16 onwards	W, R W, R W, R
Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	Workforce needs to be developed continuously. If current CPE arrangements change, will require extensive training and publicity Consider whether to continue PPEPCare roll out into 16/17 Local initiatives and leads???	15/16 onwards to 19/20 16/17	W W
Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.	Scope whether HVs and School Nurses could drive improvements. If this were adopted enact commissioning changes/ service changes Scope LA, school and voluntary sector issues/ workforce development	16/17 16/17	W, R, A, AT, V W, R, A, AT, V

Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.	Develop Transformation Plan, HWBs to approve plans HWBs to delegate authority to implement Transformation plans to BW CAMHs Transformation Group, Transformation Plans submitted to NHSE JSNA Eating Disorders plans developed and incorporated in Transition Plans (pan Berkshire ED plan) NHSE approve plans and release funding	Aug/ Sept 15 Sept 15 Sept 15 Q3 15/16 Aug- Oct 15 Q3 15/16	AT AT AT AT AT AT
Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.	Implement Open Rio (BHFT) Start collecting data in accordance with new CAMHs minimum data set Develop outcomes framework across all providers and commissioners Implement outcomes framework across all contracts and SLAs. Offer Open Rio access to the voluntary sector once new system is gremlin free Outcomes and progress to be reported up to HWB	15/16 From Jan 16 Q4 15/16 16/17 16/17 15/16 onwards	AT AT AT, W AT, W AT, W AT

Making the investment of those who commission children and young people's mental health services fully transparent.	How do schools spend their pupil premium? What outcomes do they achieve? Transparency of CCG financial arrangements Transparency of LA financial arrangements	16/17 15/16 15/16	AT, R AT AT
Commissioning of third sector organisations	Where LAs and CCG are commissioning the same organisations, streamline arrangements via joint commissioning Consider the support that voluntary sector organisations might require in order to successfully bid for pots of money that is not open to the statutory sector. Linked to vol sector demonstrating outcomes and being able to provide data	For 16/17 contract 16/17	AT, A A, AT
Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.	Links to Commissioning of third sector organisations section above Agree TOR for Berkshire West Mental Health and Wellbeing Transformation group JSNA	 Q2/3 15/16 Q3 15/16	 AT AT

12. Eating Disorders plan to date

CCGs in Berkshire West and Berkshire East will jointly commission a revised Eating Disorder pathway in order to meet the new access and waiting time standard. The current provider, Berkshire Healthcare Foundation Trust, has carried out some initial work to describe what a future service might look like. This document is a descriptor of the intended service to indicate how the recommendations within the Access and Waiting Time Standard for Children and Young People with Eating Disorders may be met within Berkshire. A business case has been produced for consideration.


Eating disorder descriptor document


Eating Disorders Business Case FINAL

13. Measuring outcomes (KPIs)

KPIs for Tier 2 services commissioned by Reading Borough Council

Ref	Indicator	Threshold	Method of measurement
1.	Number of assessment requests made (and % that are stepped down from CPE)	180 (65% stepped down minimum)	Reported quarterly in Early Help report
2.	% of assessment started on time (within 10 working days)	95%	Reported quarterly in Early Help report
3.	Number of Children or young people receiving a direct service or intervention	84	Reported quarterly in Early Help report
4.	Number of consultation requests	270	Reported quarterly in Early Help report
5.	Number of participants in Mental Health Training (broken in tier 1 and 2 staff groups)		Reported quarterly n Early Help report

Key Performance Indicators in the Specialist CAMHs 15/16 contract

Ref	Indicator	Threshold	Method of measurement
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS patients (excluding ASD) that are seen within 6 weeks for reporting period	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS patients (excluding ASD) that are waiting at the end of the reporting period that have waited less than 6 weeks	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West CAMHS patients (excluding ASD) waiting longer than 12 weeks as at the last day of the month	0 from October 2015	Reported within the monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS ASD patients that are seen within 12 weeks for reporting period	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS ASD patients that are waiting at the end of the reporting period that have waited less than 12 weeks	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report

Ref	Indicator	Threshold	Method of measurement
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West ASD patients waiting longer than 18 weeks as at the last day of the month	0 from December 2015	Reported within the monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West patients waiting on the total CAMHS waiting list	Q2 = Q1 minus 20% Q3 = Q2 minus 20% Q4 = Q3 minus 20%	Reported within the monthly quality schedule report
1.	Extension of CPE to 8am - 8pm model	CPE will be open 8am until 8pm on working days Monday to Friday by the end of Quarter 2.	Reported quarterly form the end of Q2
2.	Reduction in inappropriate/avoidable presentations to A&E	Baseline data to be captured from September 2015. Seasonal trends to be mapped over 15/16 and into 16/17TBC	Data to be reported monthly from September 2015 using the following methodology: 1: Numbers who present to A+E who are receiving active treatment from CAMHS 2: Numbers who present to A+E who are on a waiting list and not receiving active treatment 3: Numbers who present to A+E who are not known to BHFT CAMHS who need a CAMHs service (1+2 are the groups with potential to avoid presentations regardless of presentation or who recommends them going to A+E)
3.	Reduction in time from referral to assessment in A&E – within 4 hours.	BHFT to develop a system to collect baseline data in-year.	Data collection to start from 1 September 2015.
4.	Reduction in complaints that relate to waits longer than agreed targets for relevant team/pathway	25% reduction	To be reported quarterly from Q3
5.	Throughput measure by service line (measuring how many waiting, seen and discharged	BHFT to develop a system to collect baseline data in-year.	Tableau reporting from Q4

Ref	Indicator	Threshold	Method of measurement
6.	Implementation of Routine Outcome Measures	BHFT to continue to trial CAMHsWeb. BHFT to develop meaningful reportable outcome measures throughout 15/16 and to demonstrate how reports are being used to improve the service.  ROMS.docx	A report is to be provided in Q4 which will include narrative on how the outcome measures are in line with the CAMHs core data set requirements. For 2016/17
7.	Educational support programmes to key stakeholders – number of sessions to be agreed with commissioners	BHFT will participate in the development and implementation of a CAMHs transformation plan in line with the findings of "Future In Mind" via a partnership between commissioners and providers from the NHS, Local Authorities, schools and voluntary sector. The transformation plan will make explicit how educational support programmes to key stakeholders will be commissioned and provided. The goal is to improve the availability and effectiveness of early intervention and prevention that is being delivered by the wider children's workforce. It is anticipated that educational support to key stakeholders will build on PPEP care training that is being delivered in 15/16.	To be articulated in the CAMHS Transformation plan
8.	Evidence of the use of technological adjuncts – rollout of Young SHaRON and the Children's toolkit, and use of the NHS England		Provider to provide six-monthly updates on developments. First update required at the mental health contract meeting by the end of September 2015

Ref	Indicator	Threshold	Method of measurement
	App when available.		

14. Governance

Berkshire West Mental Health and Wellbeing Transformation group

Local Authority leads met with the CCG on 21 August and 27 August to develop plans for an oversight group. The name “Berkshire West Mental Health and Wellbeing Transformation group”is suggested.

Scope

- to monitor and facilitate implementation of the Transformation Plan
- to make recommendations- not a decision making group
- to provide different perspectives on strategy, service transformation planning and implementation i.e. this is what it feels like from a school (voluntary sector/ service user/ social care/BHFT/parent) perspective
- help to develop strategy
- promote collaboration
- task and finish groups will take on key pieces of work, pulling in additional agencies as required

Proposed membership

- Local Authority children’s services x 3 (West Berkshire Council, Reading Borough Council, Wokingham Borough Council)
- Local Authority Public Health lead
- a nominated lead from a voluntary sector counselling organisation (ARC, Number 5, Time To Talk- West Berkshire, Time to Talk- Reading, Changing Arrows). Invite specific voluntary sector representatives for specific agenda items e.g. ASD/ SEN
- University of Reading
- 4 school forum representatives drawn from Early Years, Primary, Secondary and Special Schools across Berkshire West
- Service users
- Young people who are not service users
- Parent / carer
- BHFT CAMHs service manager, clinical lead, lead for children’s integration

- RBFT- A & E and paediatrics
- Healthwatch representative
- CCG clinical lead and head of children's commissioning
- NHS England Tier 4 lead

It is envisaged that for some of the partners listed, a representative will provide an insight as to how things feel/ might feel on the ground as service transformation ideas are discussed and implemented. It is hoped that this would enable the group to be an optimal size for meaningful and timely discussion.

It is envisaged that task and finish groups will be required to undertake specific aspects of the transformation work.

Resources

The group will require resources to enable attendance. The group will require communications and secretariat support.

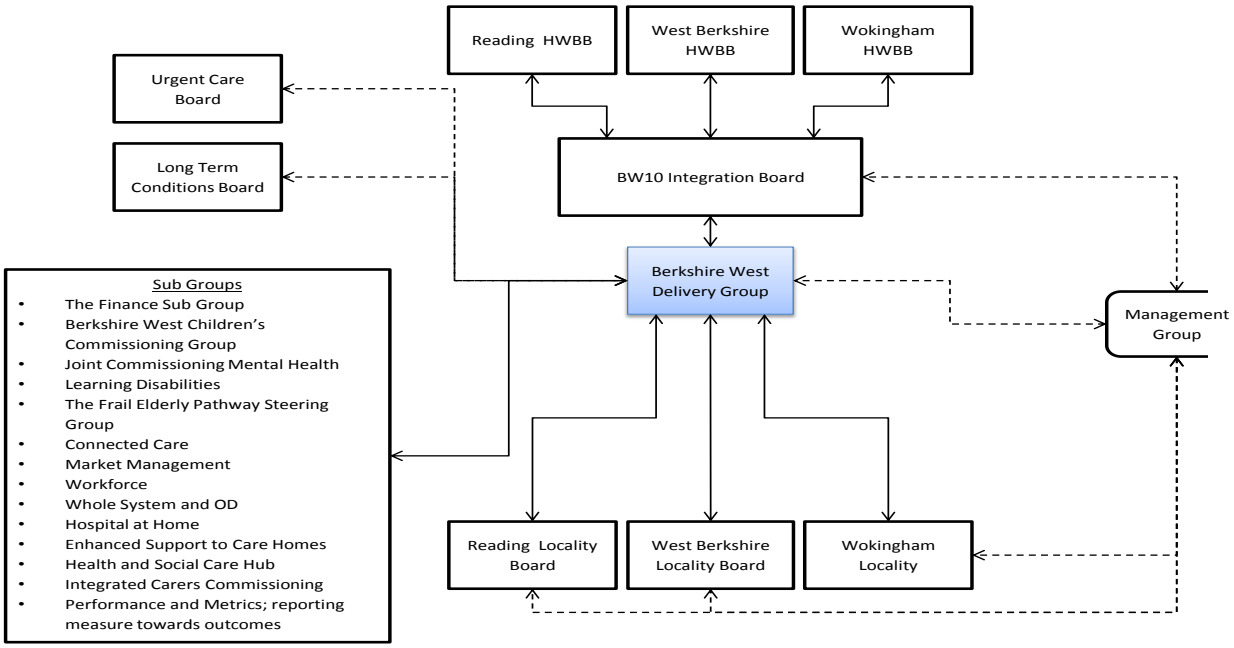
Frequency

Initially monthly, starting November 2015

Reporting arrangements

To report to the Berkshire West Integration Board (Director and Chief executive level)

Respective Health and Wellbeing Boards to delegate authority to the group.



15. Tracking template to monitor and review progress (Annex 3 in the guidance)

In Berkshire West there are four CCGs covering 3 Local Authority areas.
Berkshire West CCGs have submitted 3 Transformation Plans- one for each Local Authority area.
For the Eating Disorder investment, the 4 Berkshire West CCGs is working with the 3 Berkshire East CCGs.

Here are trackers relating to South Reading CCG and North and West Reading CCG


Tracker North and West Reading CCG 1⁴


Tracker South Reading CCG 14 Octc

BERKSHIRE WEST CLINICAL COMMISSIONING GROUPS (CCGs) OPERATIONAL PLAN 2017/19 & READING ADULT SOCIAL CARE COMMISSIONING INTENTIONS 2017/18

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**27 January 2017**	**AGENDA ITEM:**	**8**
TITLE:	**Berkshire West CCGs Operational Plan 2017/19 & Reading Adult Social Care Commissioning Intentions 2017/18**		
LEADS:	**Cllr Rachel Eden**		
	Dr Andy Ciecierski		
	Dr Bu Thava		
	Dr Cathy Winfield		
	Ms Jo Hawthorne		
JOB TITLE:	**Lead Cllr for Adult Social Care**		
	Chair, North & West Reading CCG		
	Chair ,South Reading CCG		
	Chief Officer , Berkshire West CCGs		
	Head of Wellbeing, Commissioning and Improvement, Reading Borough Council		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to present to the Health & Wellbeing board the Berkshire West CCGs Operational Plan 2017/19 and the Reading Borough Council Adult Social care Commissioning Intentions 2017/18.

1.2 These papers relate to the priorities for the council for 2017/8 and those of the Berkshire West CCGs for 2017/19.

1.3 Two separate reports have been presented as the Berkshire West CCGs are required by NHS England to submit a separate plan in line with the NHS Operational Planning Guidance issued in September 2016. A joint report has therefore not been possible.

1.4 It should be recognised however that the plans have been prepared in close collaboration between Berkshire West CCGs and Reading Borough Council Officers who have worked together in preparing the documents.

1.5 Both the Operational plan and the Commissioning Intentions refer to the need to work more closely together as well as including a range of specific objectives. During the past year close working has included development of a Reading integration Board to oversee local integration opportunities and priorities.

1.6 Both the CCGs and the Local Authority have agreed to prioritise opportunities for joint commissioning through the Integration board in the coming year.

1.7 **NHS Planning Guidance**: NHS England stipulates "nine must do" priorities. The Operational Plan must outline the CCG plans against these specified criteria. The nine must do's include:

- STP alignment;
- The plans must be delivered within the available allocated financial resources;
- Plans must demonstrate implementation of the General practice Forward View;
- Delivery of Urgent & Emergency care targets and priorities;
- Delivery of referral to treatment times in elective care;
- Implementation of the cancer taskforce report and deliver key standards;
- Delivery of transforming care plans and improved access to healthcare for people with learning disabilities;
- Improved quality of care.

1.8 These priorities do not encompass the full breadth of CCG responsibilities. In addition to the above NHS England also sets out specific areas where improvement is needed by 2020. This includes seven day services, patient experience, cancer, finance, Obesity & Diabetes, Dementia, A & E and ambulance targets, new models of care in general practice, health & Social care Integration, mental health, learning disabilities and autism, research, technology and health at work.

1.9 **Timelines:** The Berkshire West CCGs Final Operational Plans were submitted to NHS England on **23rd December 2016** and have been approved by the four CCG Governing Bodies. Initial feedback from NHS England has been positive.

1.10 All **contracts with main providers** (Royal Berkshire Hospital, Berkshire healthcare trust and South Central Ambulance Service) were required to be and have been signed by 23rd December 2016.

1.11 A "Plan on a Page" document has been produced by the CCGs to help illustrate and summarise the key elements of the plan on a single page.

Specific CCG priorities are highlighted on the reverse page of the "plan on a page".

1.12 As in previous years the Quality Premium scheme has been offered to CCGs. This now becomes a two year scheme. The two Reading CCGs have been required to choose one Quality premium target each.

North and West Reading CCG Quality Premium

Increased number of Chronic Kidney Disease (CKD) patients treated with an ACE-1 or ARB **medication** – When comparing North & West Reading CCG to the best 5 CCGs amongst a peer group of 10 CCGs in the latest RightCare pack there is an opportunity to improve quality of care of patients on CKD registers by increasing the number treated with an ACE-1 or ARB. The CCG has set a target to increase the number of CKD patients treated with an ACE-1 or ARB by 10%, 142 patients to 157.

South Reading CCG:

Increasing prevalence of hypertensive patients – If undiagnosed, hypertension can lead to a number of related conditions causing future health problems, for example, heart attack and heart failure, strokes and an increased risk of dementia, kidney disease and peripheral arterial disease. The CCG had chosen to aim to increase the number of people identified on GP Hypertension registers in South Reading from its current level of 13794 to 14288 people by 2017/18 and to increase this further to 14620 by 2018/19.

Reading Borough Council's Key Commissioning Priorities for 2017/18 are:

- Maximising Independence and recovery - we will use reablement, assistive technology, and aids for daily living as a first response.
- Personalisation - we will support personalisation through personal budgets to ensure that people requiring longer term care can take as much control over their lives as their needs allow, in line with Care Act requirements.
- Home Care - we will seek to support sustainable homecare in the borough by working proactively and building on relationships with our Home Care Framework providers (HCF).
- Reshaping Accommodation - we will continue to shift the balance of accommodation provision from residential care to extra care housing and supported living options.
- Integration with Health Partners – we will continue to build upon partnerships with our colleagues in the health service in order to work closely together to meet the needs of our population.
- Effective Commissioning and Sustainability – we will transform the way that we commission, ensuring that we have a service that is fit for purpose and able to play a key role in supporting the council to maintain a balanced budget.

2

3 RECOMMENDED ACTION:

3.1 To note the two reports: Berkshire West CCGs Operational Plan 2017/19 & Reading Social Care Commissioning Intentions 2017/18;

3.2 To note the Quality Premium Targets for the two CCGs for 2017/18 and 2018/19;

3.3 To seek approval to convene a Task & Finish Group to review joint commissioning opportunities in the form of an Implementation Plan.

4 POLICY CONTEXT

The Berkshire West CCG Operational Plan 2017-2019 reflects the priorities for 2017/19 in line with NHS guidance and NHS constitutional requirements.

The Reading Borough Council Commissioning Intentions reflect the priorities within the council's Corporate Plan, the Joint Health & Wellbeing Strategy for Reading 2017/19, the Health & Social Care Act 2012, and the Care Act 2014.

5 CONTRIBUTION TO STRATEGIC AIMS

5.1 The priorities have close synergies and align with the ambitions of the Health and Wellbeing Strategy.

6 BACKGROUND PAPERS

6.1 NHS Operational Planning and contracting Guidance 2017-19, September 2016, NHS England & NHS improvement.

Operational Plan 2017/18 – 2018/19

Wokingham, Newbury and District, South Reading and North and West Reading Clinical Commissioning Group

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1. Berkshire West Strategic Priorities

This document sets out the Berkshire West CCGs' ("Berkshire West") Operational Plan for 2017/18 and 2018/19. The plan forms part of the Berkshire (West), Oxfordshire and Buckinghamshire ("BOB") Sustainability and Transformation Plan (STP), and builds on the Berkshire West CCGs' strong track record of financial and non-financial performance. The year ahead, however, reflects an increased set of challenges which include delivering higher levels of efficiency savings than ever before whilst also implementing a new model of care through the Accountable Care System (ACS).

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

Nevertheless, in line with other health and care systems we are facing increasing operational and financial challenges. Both elective and non-elective activity has increased significantly in recent months with significant spikes in emergency admissions.

By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies.

This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

This plan has set out how the Berkshire West CCGs will deliver the NHS Five Year Forward View, working as part of the BOB STP and driving the establishment of the Berkshire West Accountable Care System. The CCGs will continue to build on strong partnership working with the three local authorities in Berkshire West to deliver the BW10 programme and maximise the impact of the Better Care Fund investment.

2. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP)

Clinical Commissioning Groups (CCGs) and providers operating in Berkshire West are members of the Berkshire (West), Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan (STP). This is a large STP with three distinct local health economies that are effectively driving place based commissioning to deliver the Five Year Forward View. The local health economies provide the best mechanism to transform primary

care, redesign the interface with local hospitals and drive integration with social care. Much of the delivery of the Five Year Forward View will take place at local health economy level with the STP ensuring the rapid adoption of innovation across BOB. Nevertheless each of the member organisations recognises the opportunities of working together with partners at this larger scale and will be progressing initiatives to improve quality and realise financial benefits for the wider system.

Across our STP we have a proven track record of implementing innovation and excellence in clinical practice to deliver high quality patient care. This has led to us being a highly cost effective system, which we will build on as part of this plan.

2.1 BOB STP wide programmes

For each of the proposed programmes where working at the STP scale adds value, we have developed Project Charters, with clear leadership, milestones and descriptions of benefits. These are reflected in each of the chapters of this plan. Through its ACS improvement schemes and local initiatives Berkshire West CCGs will contribute fully to the delivery of these STP wide programmes. Our ambition is to co-design with patients and clinicians and implement a new model of care to address the challenges facing our health and social care system.

Our proposals focus on the following priority areas:

BOB programme	**Objectives**
Prevention	• To reduce levels of adult and childhood obesity • To increase levels of physical inactivity • To reduce sedentary lifestyles
Urgent Care	• Provide an accessible and consistently high quality urgent and emergency care telephone and online advice service that promotes self-care and direct access to community based services via a single call.
Acute Services – Clinical variation	• Reduction of unwarranted variation in access to clinical care and delivery of clinical outcomes.
Acute Services - Maternity	• To ensure capacity and capability of maternity services within the Thames Valley is sufficient to respond to demand over the next 10 years.
Acute Services - Paediatrics	• To reduce unwarranted paediatric admissions within the BOB region as identified by the AHSN report. • To achieve clinical and financial sustainability for all paediatric sub-specialities across the Oxford and Southampton Children's clinical network.
Acute Services - Procurement	• Trusts work collaboratively to share procurement data and resources to improve efficiency, value and deliver cost savings.
Specialised Commissioning	• Lead, facilitate and drive integration and cross health-system redesign for specialist commissioning across STPs.
Mental Health	• Create a system for mental healthcare designed to consistently secure the best outcomes for service users and carers, building on innovation across BOB.
Workforce	• Development of a recruitment strategy • Create an education framework for the personal and professional development of health and social care support workers.

	• For Trusts within the BOB geography to achieve quality and financial improvements through the more effective utilisation and deployment of the regions healthcare workforce.
Digital Interoperability	• Delivering integrated health and care records • Empowering patient well-being and self-care through the design of personal health records

3. Local Health Economy – Accountable Care system

3.1 Delivery of the Berkshire West New Model of Care - Accountable Care System

As part of delivery of the Five Year Forward View in Berkshire West, the four CCGs which comprise 'Berkshire West'[1] are collaborating with the two local NHS providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as an 'Accountable Care System' (ACS). New governance arrangements have been put in place led by an independent Chair and the system has applied to operate a system level financial control total as a sub division of the STP. All parties are committed to developing new payment mechanisms to underpin the transformational change required.

The Berkshire West ACS is a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price.

The ACS represents an opportunity to fundamentally change how these organisations formally contract with each other in order to maximise the value for money available from the financial resources which are allocated to the local health economy each year, as well as improve patient experience. We are looking to the system regulators to keep pace with our ambition and provide the necessary support for this transformational approach.

3.2 Case for Change

As a local health system we are facing a number of significant operational, clinical and financial challenges including: providers coming under increasing financial, performance and quality pressures, demand management programmes with variable levels of success, workforce issues in recruitment across health and social care, and commissioners facing significant affordability pressures given the current configuration of services.

There are a number of barriers in the current operating environment that inhibit our ability to address these challenges. These are primarily the contracting and payment mechanisms and the different regulatory regimes under which each organisation operates. Other barriers

[1] NHS Wokingham CCG, NHS South Reading CCG, NHS North & West Reading CCG, NHS Newbury & District CCG

include the lack of a coherent approach to technology, workforce and patient engagement and empowerment.

The range of payment regimes across different providers has resulted in misaligned incentives that are preventing rapid transformation and the incentives for commissioners and providers to work collectively towards system wide sustainability. This system is determined that our current high standards will not fall and changing the existing tariff-based approach is fundamental to our progress. Our finances need to flow around the system in a way that appropriately pays providers and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system.

4. Integration – Berkshire West 10

The Berkshire West system has been working together as the Berkshire West 10 (BW10) comprising 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) since 2013 within a shared governance structure.

The Berkshire West 10 Integration Programme is an ambitious transformation programme involving fourteen projects / programmes across these ten organisations. These operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients, and achieving long term financial sustainability.

Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 focuses specifically on improvements for:

- Frail Elderly population
- Mental Health care
- Children's services

Much of our Better Care Fund investment is managed through this integration structure and as per national guidance has a focus on:

- Avoiding unnecessary non-elective admissions (NEA)
- Reducing delayed transfers of care (DTOC)

A summary of the BW10 projects is included below, mapped to the anticipated benefits of the overall programme of work.

BENEFITS – PROJECT SPECIFIC - alignment to BCF measures or national conditions

#	Project		Reduction in DTOC	Avoiding unnecessary NEA	Effective enablement	Avoiding unnecessary admissions to care homes	Improved experience	Better use of Resources / Cost reduction	Other National Conditions
1.	Care homes	Berkshire West		X			X	X	Joint assessments
2.	Connected care	Berkshire West		||			||	||	Data sharing
3.	Frail elderly pathway	Berkshire West	X	X		X		X	
4.	Getting home (Home First)	Berkshire West							
5.	Integrated carers commissioning	Berkshire West	X	X	X		X	X	
6.	Integrated H&S hub	Berkshire West					X	X	Support for carers
7.	Workforce	Berkshire West	||	||			||	||	7 day working
8.	Community reablement team	Reading	X	X	X	X	X		Maintaining ASC
9.	Discharge to assess	Reading	X	X	X	X		X	Maintaining ASC
10.	Joint care provider	West Berkshire	X		X		X	X	7 day working
11.	CHAS	Wokingham	X	X		X		X	
12.	Integrated short term H&S team (WISH)	Wokingham		X			X	X	
13.	Night responder	Wokingham	X	X		X			
14.	Step up / Step down	Wokingham	X	X		X			

KEY: X = supporting Berkshire West targets X = supporting Locality targets only || = enabling benefit Berkshire West wide

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5. Financial sustainability

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,064 compared to a national average of £1,239), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The equivalent allocation per head of a Berkshire West CCG (if it existed) would be £1,074 per person, one of the lowest in the South of England area.

Allocation growth in 2017/18 and 2018/19 averages at 2.2% and 2.1% respectively for the Berkshire West CCGs, with recurrent allocations totalling £641m and £655m in the two years. It is expected that the cost of providing the current pattern of services to our population will exceed this allocative growth during this period.

The key financial targets for the BW CCGs in 2017/19:

- Achievement of in year I&E breakeven in both years:
- Retention of 1% surplus brought forward from prior year;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2017-2018, and for half this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for the two years.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;

- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements, recognising that this is a high risk plan and have begun an internal financial turnaround process. The size and scale of the financial challenge is greater than in previous years and may yet increase. Added to this, previous financial positions have been achieved with the aid of reserves. In 2017/18 this flexibility will no longer be available.

5.1 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2016/17 outturn as the basis for 2017/19 contract negotiations.

In 2017-18 and 18-19, activity growth will be agreed with each provider based on local circumstances. Any activity savings derived from implementation of QIPP schemes will be adjusted in contracts once the detail has been agreed with the providers concerned.

5.2 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2017/18, and amounts to £23m in total (with £15m currently estimated for 2018-19). This year additional ACS schemes, that will deliver system efficiencies, will also help contribute towards this gap. See Appendix 2 for ACS schemes PIDS.

5.3 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to ensure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation. Any increased investment may be utilised in a number of organisations within the health economy including Berkshire Healthcare FT, Royal Berkshire Hospital FT, CCGs, the voluntary sector and Primary Care.

5.4 Moderating demand

Despite a number of initiatives being put in place during 2016/17 to reduce non-elective activity the system continues to see growth in non-elective activity in excess of plan, although this is below the national average in a population with high and rising numbers of the elderly. A number of schemes are being developed to mitigate this pressure in the coming two years.

5.5 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives

people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West.

This collaborative approach is exemplified by the Prevention Working Group, part of the Berkshire West 10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting organisations.

5.6 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care. In 2017/18, our system is forecasting an overall financial gap to be bridged of approx. £52m:

	2017/18 savings required (£m)
Royal Berkshire NHS FT	(23)
Berkshire Healthcare NHS FT	(6)
Berkshire West CCGs	(23)
Total	**(52)**

5.7 Primary Care

Berkshire West CCGs recognise that primary care is a key part of the system and faces significant challenge in terms of demand and workforce pressures. Ahead of the GP Forward View the CCGs have already invested £5m in primary care in each of the last two years to enhance access and maximise the impact of care planning and ensure we provide proactive support to care homes. In 2016-17 the CCGs took on fully-delegated responsibility for commissioning primary medical services bringing a strategic capability to the commissioning of primary care and supporting its integration with the wider health and social care system.

5.8 Better Care Fund (BCF)

In 16/17 the Berkshire West CCGs Minimum Contribution to the BCF was £25.7m, representing just under 84% of the total BCF funding of £30.6m. Although we do not yet have the NHS England Allocations for 17/18 and 18/19, planning is proceeding on the basis of a broadly similar level of funding to that in the current year.

For 2017-19 the intention is to build on the foundations of the integration programmes which have been successful so far, while continuing to critically evaluate all schemes and where necessary redirect investment towards reconfigured or new projects. The plans will be subject to sign off by Health and Well Being Boards by March 2017

6. Supporting Self Care and prevention

The Berkshire West CCGs measure well against national life expectancy, Newbury and Wokingham areas are both in the top decile of affluence and exceed national life expectancy, though Reading with lower affluence has lower life expectancy with men being below the national average (78.5 years). Similarly the potential years of life lost (PYLL) due to amenable causes are lower in Wokingham and West Berkshire, though similar to the national average in Reading.

The STP prevention programme and the linked local prevention programme reflect priorities that tackle the causes of inequalities in our communities. The Buckinghamshire, Oxfordshire, and Berkshire populations benchmark well against the England average for public health outcomes. However within all our areas there are pockets of our residents where outcomes are not good, and so the direction of the programmes is to address the factors that drive these inequalities, with a slight modification to include diabetes (which is linked significantly to being overweight) and physical inactivity (due to the increasing recent evidence on the separate impact of physical inactivity on health).

Prevention programmes can be delivered in a variety of settings and at different population levels. At an STP level two key enablers have been identified to drive programmes to change lifestyle behaviours:

- engaging with health and care staff to maximise the "teaching moment " of care delivery to nudge lifestyle choices "Making Every Contact Count" and
- industrialising our use of digital approaches, linking with the Connected Care programme, to improve knowledge on lifestyles, signposting to services and supporting / coaching lifestyle changes

These benefit from a STP approach and will drive delivery in two key lifestyle areas: reducing levels of obesity in adults and children and improving levels of physical activity. In addition the staff programme "Making every Contact Count" will also drive stretch improvement in NHS employee health, building on the national CQUIN initiatives, improving staff indicators and will link with an Academic Health Science Network wide programme to engage with other major employers to maximise employee health.

Locally 'Beat the Street' is a well-established programme of increasing activity and will continue in to 2017/19. Between 15th April and 27th May 2016, 6,876 people from Reading registered online to take part. Many others, including school children, took part but did not register individually. At the end of Beat the Street, 3,216 people who provided an email address and agreed to be followed up were invited to provide feedback. In total, 570 people did so (18%). The proportion of adults reportedly meeting this target increased from 36% to 53% which is statistically significant. Positive trends were also apparent for children, though the numbers were too small to draw conclusions. Importantly the proportion of people who were active on only 0 or 1 day per week reduced from 15% to 5% by the end of Beat the Street ($p<0.05$) and people with long-term conditions were just as likely to report benefits as everyone else.

6.1 Long term conditions and self-care

Our work on long term conditions (LTC) will significantly contribute to the ambition of the Five Year Forward View and our local strategic vision for 2019 which sets out an ambition for enhanced primary, community and social care services in Berkshire West to have a service model which prevents ill-health within our local populations and supports patients with much more complex needs to receive the care they need in their community.

Our vision is underpinned by the principle that patients will only be admitted into hospital when the services they require cannot be delivered elsewhere, and that when acute care is needed they will be treated in centres equipped with the appropriate facilities and clinical expertise. People with serious and life-threatening conditions will continue to be treated in acute centres that maximise their chances of survival and a good recovery.

In transforming our approach, it is recognised that there is a fundamental shift from more traditional reactive and unplanned approaches to one which is truly patient centred, proactive and anticipatory, where possible enables patients and carers to access services at or as close to home as possible and aligns specialist, primary and community care in one coherent package, and where required along a continuum of care which meets palliative and end of life care needs. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care.

The Berkshire West LTC Programme aims to identify effective and sustainable approaches to underpin the prevention of an avoidable increase in health need that may lead to a loss of independence and an increase in demand on services. Using profiling and risk stratification tools we will be able stratify populations to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. We will expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

We will move towards a model which reduces fragmentation, and is underpinned by care and support planning. This has been successfully embedded as an approach for diabetes, based on the Year of Care approach and has been partially adopted as an approach for COPD. This provides a strong foundation on which to build our new model of support to people with multiple Long Term Conditions to include respiratory disease, cardio-vascular disease, mental health and dementia. This would move from a system focused on a single condition towards a more patient centred, holistic approach improving health and wellbeing, streamlining and improving quality of care including earlier intervention and approaches which reduce the impact on specialist resource. There is real opportunity to progress this at scale.

Through our BCF initiatives, we will continue to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising opportunities for patient self-management.

6.1.1 End of Life Care

Meeting the palliative and end of life (EOL) care needs of patients (and their carers) along a continuum of care is critical to our overall vision and approach to integrated long term conditions management. This enables us to drive forward patient centred, holistic end of life care regardless of specific conditions, with services wrapped round the patient and where possible provided at or closer to home. It also focuses on a planned and proactive approach, minimising reactive and crisis response which often leads to hospital admission as the only option.

Locally, benchmarking data indicates that we are deemed to have a higher percentage of deaths in hospital at end of life. However, we know that this is higher in Newbury where there are a number of hospice style beds within the community which contributes to the overall reporting. The average however across Berkshire West is better than the national.

There are a number of initiatives in place across the area which supports proactive approaches to the management of end of life care, with the aim of enabling patients/individuals to die in their preferred place of residence. This is highly reliant on our whole system approach to reduce the impact of urgent/crisis response and ensuring that palliative and end of life care needs are considered integral to all LTC work.

The EOL Steering Group meets quarterly, with representation from all key stakeholders and reports into Long Term Conditions (LTC) Programme Board. This ensures that all the LTC work programmes align with ambitions for EOL e.g. Heart Failure/COPD/Dementia as key examples and aligns to other programme areas e.g. urgent care and cancer. This was set up is in recognition that End of Life is a crosscutting theme across a wide range of disease areas.

The Steering Group has been a key driver in progressing commissioning of a new 24 hour, 7 days a week Palliative care co-ordination and support service called “PallCall.” The service, with a single point of contact for patients, families and healthcare professionals, is available to anyone in their last 12 months of life with a Berkshire West GP, or to anyone who is providing support to those people. The service is designed to support End of Life patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. PallCall launched in mid-October 2016 and has in its first six weeks, dealt with 100 calls from patients, families, GPs, care homes, district and community nurses, and the ambulance service. They have prevented 19 admissions and supported 6 patients to die in their preferred place. The service is still developing and we will build on these early successes to deliver in home assessment directly in 2017/18, and to ensure GPs caring for palliative patients have considered anticipatory medication.

In addition Berkshire West uses Adastra to deliver the Electronic Palliative Care and Co-ordination System (EPaCCS) thereby contributing to the co-ordination of patient care through access to patient relevant information, with all GPs having access alongside A&E (a terminal in A&E) and SCAS. Additionally A&E and SCAS have GP Bypass numbers to reduce the need for conveyance and/or admission as the only option and ensures the needs and wishes of patients are addressed. There is additionally access to the hospital based palliative care team and access to the 24/7 PallCall service.

There are a number of additional schemes which support and enable patients to remain in their preferred place of residence (including care homes) and where possible reduce the need for admission to hospital and/or A&E attendance. These include the provision of inpatient beds and the West Berks Community Hospital Rainbow Rooms. Patients also have access through our community and acute services in the form of:

- The Rapid Response Team for patients in own homes (and care homes)
- Hospital based palliative care team

The Anticipatory Care Enhanced Service (CES) in addition supports both the implementation of care planning and Do Not Attempt Cardiac Pulmonary resuscitation (DNACPR) discussions for patients approaching end of life.

We will also further build upon the EOL CQUIN put into place in 16/17, with the community providers which has improved the recognition of those patients who are entering their last year of life and are on the caseload of a community service (e.g. District Nurses, Community Nurses, Community Matrons, & Inpatients). The CQUIN supports organisational development and delivery of an action plan to improve the ability of appropriate staff to identify patients who might be entering the last year of live, flag those patients on appropriate clinical systems and work effectively with GPs and the palliative care hub to support co-ordinated working for that patient.

Increasing access to healthcare education and shared learning has led to the development of a rolling programme of education across all CCGs. Practices can benefit from the local Palliative Care Consultant for case based discussion teaching. This has included managing difficult conversations and/advanced care planning, ultimately supporting the overall approach to improving patient care and outcomes.

There is also a Palliative Care Community Enhanced Service (CES) which supports one GP per Practice per year to attend a relevant EOL learning event and to subsequently evidence that this learning has been disseminated through the Practice team.

6.2 Diabetes

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading).

The House of Care and Care & Support Planning have been central to the Diabetes service re-design over recent years. Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally.

Our vision is to identify people at risk of developing Diabetes early and refer them to risk-reduction services. We will also support people with diabetes in Berkshire West, to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed, engaged patients, informed motivated Health Care

Professionals, collaboration between stakeholders and supported by the use of informatics and technology.

Across Berkshire West, we have commissioned a community enhanced service (CES) for pre-Diabetes since 2013, and have committed future funding for a three year period through to 2019. This CES has successfully identified Diabetics and Pre Diabetics as well as promoting lifestyle interventions for Diabetes prevention. This has provided us with a sound base as early adopters within the national Diabetes prevention programme, successfully participating in the first-wave as a pilot site across the whole of Berkshire (all 7 CCGs and 6 LAs). This programme is locally led by Public Health working closely with the CCGs and complements the local CES scheme. More than 30 GP Practices across Berkshire have invited 576 patients with pre-diabetes to the NHS NDPP programme. With 147 patients (26% uptake) so far being enrolled, the number of invitations and referrals each month continues to rise by the rate of additional GP surgeries being enrolled onto the programme. Across Berkshire we envisage that we will refer at least 2,300 people with pre-diabetes in first year for risk reduction, building on the early successes in the CES.

In South Reading CCG where there are higher levels of diabetes the GP practices are participating in a Prescribing Quality Scheme, which includes specific diabetes related prescribing targets aimed at optimising prescribing of medications to improve outcomes for diabetic patients. The development of prescribing formularies by the Medicines Optimisation Team supports prescribers in ensuring that the most cost effective treatments are used in line with NICE.

We will continue to commission an innovative interactive database technology "**Eclipse"**, to which all our practices have access. ECLIPSE is a software tool originally procured by Berkshire West CCG's to help support improvement in diabetes care. Use of the software has had a significant impact in improved diabetes care and now increasingly supports identification of risk in a range of other Long Term Conditions. Berkshire West have subscribed to the advanced "LIVE" version which includes true Risk Stratification, Safety Alerts, Centralised Project Management, Integrated Care and Automated Patient Care Plans. Weekly extracts allow practices to identify at-risk patients and automatically generate safety reports. In addition Berkshire West has developed an extremely effective Community Diabetes Service, led by a Community Diabetes Consultant and support network of Diabetes Specialist Nurses. This team uses Eclipses' virtual capability to identify practices needing support in the delivery of high quality diabetes care to its patients in a highly effective and cost efficient way. Eclipse has the capability of being utilised for the management of other long term conditions. We have put into place a system of remote monitoring of blood glucose in diabetic pregnancy.

South Reading CCG was one of eight CCGs in England participating in a CQC Diabetes thematic review which demonstrates and shares best practice examples across the country. South Reading has been cited in this report as demonstrating a number of areas of good practice. One such area is our comprehensive range of health care professional and patient education programmes for type 1 and Type 2 Diabetes. This is a key element of the House of Care model. Our commissioned XPERT course (type 2 Diabetes education) delivered by Berkshire Health Care Trust, recently received two national awards. Type 1 Diabetics have access to our local course "CHOICE", commissioned in 2016, which now offers greater capacity, more sustainability, greater cost-effectiveness, and for patients much more

convenience. In addition, type 1 diabetics have access to a short three-hour carbohydrate awareness course, combined with instruction on basal dose optimisation and bolus/correction dose instruction. 700 of our type 1 diabetics have been able to access this course. However we know from Eclipse, that as of October 2016, we have 2144 type 1 diabetics and 18,403 type 2, an increase on last year of 17% and 9.8% respectively. To meet this rising demand during 17/19 we will be addressing this challenge of reaching even more diabetics, and we are undertaking a review of a range of education offers and in particular options to include using online education with better use of technology. By early 2017, we will have identified and costed a range of options to better meet the future demand.

Other local initiatives to directly support and reduce the numbers of patients with very badly controlled diabetes include the insulin optimisation programme. This was set up in 2015, to provide a more focussed opportunity to work with individuals with Type 2 Diabetes who are not optimally controlled. The overall objective is to reduce individuals HbA1c levels and therefore improving their longer term health outcomes. This service has been reviewed in 2016 and we have been able to demonstrate 53% of those who attended had achieved a 10mmol/mm reduction in their HbA1c levels and of these 55% achieved changes of 20mmol/mm or more. A 10mmol/mol reduction in HbA1c levels tallies to a 17% reduction in events of non-fatal myocardial infarction and a 15% reduction in events of coronary heart disease. Throughout 17/18 and beyond we will continue to build on this success and implement further actions identified which will see improved uptake of support within the programme as well as improved data capture around insulin type associated with the courses.

Using a variety of data sources and analysis combined with our self-assessment against NICE criteria of service delivery, we have identified other inequalities and variation in Diabetes care, resulting in committed funding for 17/18 to offer a new service for the care of highly complex diabetic patients. This cohort of patients is known to have frequent associated emergency admissions. This builds on the success seen in the “virtual diabetes” clinics and will see the implementation of a community based service for this often dis-engaged patient cohort, aiming to reduce non-elective admissions and readmissions through improved Diabetic control.

These initiatives, combined with good quality education for our health care professionals, helps support and address the findings from the National Diabetic audit (100% participation rate), the recent 2016/17 CCG Improvement and Assessment Framework also tells us that more work is needed to improve coding of those attending education and to improve outcomes for diabetics locally, preventing them from developing complications and progressing to renal replacement therapy.

6.3 Obesity and Diabetes

The provision of comprehensive weight management services to our population is an important priority to help address and prevent people developing other illnesses, including Diabetes, which in turn further increases the health burden in our local area.

Weight management services are categorised into 4 tiers as outlined below. Tiers 1 and 2 are commissioned for people in Berkshire West by our three local authorities. Tier 4 (pre

surgical assessment and Bariatric surgery) is commissioned through specialised commissioning but will move to CCG responsibility on 1st April 2017.

Currently there is no provision of Tier 3 weight management service for the Berkshire West CCGs and prior to the transfer in April 2017; we plan to establish a Tier 3 services offer as the missing part of the weight management pathway. This will provide a more specialist intervention delivered by a multidisciplinary team with an aim to support and reduce the numbers of patients moving to Tier 4 (bariatric surgery) and reducing the development of other illnesses.

We have already begun discussions with our partner CCGs within the STP, BOB footprint with the aim of commissioning a service that can be provided across the geography that is consistent and supports the needs of our local populations. The aim is to provide a Tier 3 weight management intervention service as recommended by NICE guidance (CG 189). Work has taken place in 2016/17 to estimate demand for a new service and also anticipated investment costs. This business case will form a sound basis to move forward into 2017 and beyond with a comprehensive offer to our populations.

The provision of Tier 3 in Berkshire West of a Weight Management intervention service will lead to a step change within the NHS in preventing ill health and supporting people to live healthier lives, specifically addressing obesity and reducing the risk of diabetes.

7. Primary care

An effective and sustainable primary care sector will be a key element of our Accountable Care System. As fully-delegated primary care commissioners we are working with our member practices to deliver a strategic programme for primary care which will meet the following key objectives for primary care set out in the *Berkshire West Primary Care Strategy:*

- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

Delivery of these objectives is predicated on ensuring the sustainability of the primary care sector. As CCGs we have already invested £5m in primary care over the last three years and have established work streams relating to new workforce models, estates, access and IM&T. We have procured three new APMS contracts aligned to local need and have supported practice mergers and joint working, resulting in the emergence of a new GP provider organisation in South Reading CCG and shared approaches to workforce in the other CCG areas. We are currently piloting clinical pharmacist roles in two of the CCGs and have commissioned training for administrative staff to enable them to assist GPs in co-

ordinating care as well as working with the University of Reading to launch a training programme for Physicians' Associates for which many of our practices now provide placements. We have also established robust processes for undertaking the functions delegated to us by NHSE, including a quality improvement programme based around a Quality Dashboard which combines local and national data to give a 'rich picture' of local primary care provision, enabling us to work to improve the quality of care provided and address any areas of poor performance.

Under the ACS model we will look to primary care providers to offer proactive care to their registered population; supporting patients with long-term conditions in the community, working to prevent ill-health and co-ordinating robust care plans for patients most at-risk of admission. We have already invested significantly in care planning in primary care and are working to further refine our model, including enhancing links with care homes. However in order to ensure there is sufficient capacity for primary care to undertake this role, we believe that same-day demand needs to be managed differently and we are working with our practices to explore the potential for collaborative working to stream demand through Primary Care Access Hubs and other joint arrangements. These collaborative approaches will also offer opportunities to commission extended hours differently. We intend to build upon the Enhanced Access CES we have already commissioned to move towards delivering our trajectory to meet the requirement for all patients to have access to routine and booked appointments each early morning and evening and on both Saturdays and Sundays. Hubs would also align with the broader urgent care system including the re-procured NHS 111 service and it is also our intention to review the role of the Reading Walk-in Centre within this model of provision.

As this 'ask' of primary care becomes further defined, we will continue to work closely with provider leads to consider the models of care which will best deliver it for our population, recognising that the provider landscape is likely to vary somewhat across the four CCGs. We have started to discuss the potential opportunities offered by the new MCP contract with providers and will step this up once more details of the contract are released. We anticipate that a combination of federations, networks and practice mergers will move us towards the future state described in our Primary Care Strategy where at-scale providers cover at least 10,000 patients and usually 30,000 or more with increased skill-mix work in an integrated way with other ACS partners to care for patients in the community wherever possible.

Our local GP Forward View implementation will set out in more detail how we intend to realise this vision for primary care (see Appendix 4). We have already identified three key enablers; capacity for practices to consider how their future business model will make them sustainable, workforce diversification and infrastructure.

With regard to practice sustainability, we are already using Vulnerable Practice and Practice Resilience funding to support practices to plan for the future, utilising the ten High Impact Changes where appropriate. We will now support practices to access the Time to Care and General Practice Improvement Leaders' programmes, working closely with those that choose to use these processes and considering how we can make funding available as set out in the planning guidance to continue to support those for which a different approach is required.

As set out above we have already established a workforce programme for primary care and will now be linking this with the various initiatives and funding streams announced in the GPFV, for instance to roll out our clinical pharmacist programme and establish the role of mental health therapists in primary care. In addition we have submitted an application to HETV to develop a Community Provider Education Network in our area which we will act as a vehicle for supporting recruitment and retention through enhanced continued professional development and for the broader diversification of the primary care workforce.

Infrastructure development is a further key enabler and our ETTF bids reflect the CCGs' local strategic priorities for premises and IM&T investment. The proposed premises developments are required to support at-scale working and respond to significant population growth in Newbury and Wokingham in particular. Similarly, investment in IM&T will provide the early interoperability that will underpin practice collaboration and will sit alongside our broader strategy to maximise the potential of technology in meeting demand and co-ordinating care. Section 14 of this document describes our Digital Roadmap and initiatives underway to open up new ways for patients to access primary care and to ensure we make best use of existing tools such as online access, e-referrals and EPS.

8. Planned Care

Our strategy for Planned Care will deliver a step change in the productivity of elective care by redesigning planned care services to improve health outcomes for patients, reducing lengths of stay in hospital and fundamentally reviewing the delivery of outpatient services. Our vision includes the use of new technologies to enable our patients to interact with services in new ways; we will explore virtual clinics and other modalities to deliver some of the functions currently provided by outpatient departments.

To date we have been working to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access to specialist assessment and treatment and in line with national performance standards.

We are part of phase 2 of the national Right Care Programme and we already adhere to the principles outlined in this programme and utilise the tools to scope opportunities across all CCGs in Berkshire West to highlight unwarranted variation and develop solutions working with all stakeholders to redesign services. Our Integrated Pain Assessment and Spinal Service (IPASS) is an outstanding example of applying these principles and this service won an award for Emerging Best Practice from the British Society for Rheumatology. The Right Care Approach will support and underpin all delivery programmes by focussing on reducing unwarranted variation to improve people's health and outcomes, and ensure that the right person has the right care, in the right place, at the right time offering better value to patients, the population and the taxpayer.

As part of the Accountable Care System (ACS) model we are already working closely with our acute trust provider to review end to end pathways and redesign services to implement the required step change in productivity.

Our Planned Care Programme of work for 2017/2019 includes continuing work to redesign and streamline pathways and reduce clinical variation focusing on Orthopaedics and MSK

(including patient self-referral for physiotherapy), Ophthalmology, Diagnostics, efficiencies in outpatients including exploring other modalities for follow ups (e.g. virtual clinics, telephone follow ups), access to consultant advice and guidance for GPs, patient initiated clinics and Pre-op assessments.

This programme of work will become part of our ACS clinical improvement programme. Working closely with our acute trust providers we plan to take a systematic approach to the commissioning and redesign of following services:

1. MSK
2. Ophthalmology
3. New model for delivery of Outpatient appointments:
    a. ENT
    b. Audiology
    c. Pre op assessments
    d. Other modalities for follow up

Through this work we aim to apply national best practice to reduce clinical variation and ensure appropriate referrals are made to secondary care, and redesign outpatients.

8.1 Cancer

Significant improvements in cancer wait time standards have been seen during 2016/2017 at RBFT, the main acute provider for the CCGs in Berkshire West. The Trust is forecasting to achieve the 62 days target from Q3 onwards. The CCGs are expecting that this performance will be sustained during 2017/18 and beyond and is one of the best performers in RTT in the region. The CCGs will continue to focus on working with RBFT to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. In aligning our demand and capacity modelling we have factored in the capacity required to achieve the national performance standard, including diagnostic capacity.

The Berkshire West CCGs have jointly developed a cancer framework (see Appendix 5) with stakeholders from RBFT, Public Health, Thames Valley Strategic Cancer Network, Macmillan and Cancer Research UK to improve the outcomes for people affected by cancer in Berkshire West. Through this framework we will deliver the strategic priorities outlined in “Achieving World-Class Cancer Outcomes: A Strategy for England” over the next five years.

The framework includes a series of initiatives across the patient pathway emphasising the importance of earlier diagnosis and of living with and beyond cancer in delivering outcomes that matter to patients. We plan to reduce the mortality rate and increase survival rates through early diagnosis, appropriate interventions, delivering high quality care to improve patient experience, promote national and local awareness and provide care closer to home.

The Berkshire West Cancer Steering Group has been formed with all of the relevant stakeholders to lead the delivery of the prioritised strategic objectives and will work through the local Cancer Alliance.

Our overall ambition is to prevent people from dying prematurely by decreasing the potential years of life lost (PYLL) from cancer related causes and decreasing the under 75 mortality rate from associated cancers.

We also continue working with RBFT colleagues to understand and forward plan for the demand and capacity required over the coming years taking into account the impact of changes in demographics, increasing demands for diagnosis from cancer pathways, compliance with NICE Guidance on suspected cancers, GP direct access and diagnosis expected earlier in the pathway (as per the upcoming 28 day standard).

9. Urgent and emergency care

During 2017-18 and 2018-19 we will continue to work with the Berkshire West A&E Delivery Board which brings together system leaders from partner organisations to ensure delivery of:

- The NHS Constitutional Standard that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E
- The 5 national mandated actions to improve A&E Performance
- Further locally agreed priorities for the Berkshire West System arising from two "Roundtable" events held in July and September 2016

The Board will also work closely with the Thames Valley Urgent & Emergency Care Network (UECN) to further deliver the vision of the national Urgent and Emergency Care review. The TV U&ECN is focused on delivery of the 3 national strategic asks of the network:

1. Development of a roadmap for delivery of the following for 100% of the population by 2020-21:
    - All patients admitted via the urgent and emergency care pathway to have access to acute hospital services that comply with the four priority clinical standards on every day of the week
    - Access to Integrated Urgent Care, to include at a minimum Summary Care Record, clinical hub and 'bookability' for GP content; mental health crisis response in hospital; Ambulance Response Programme
    - Improved access to primary care in and out of hours
2. Carrying out further enabling activities for delivery of Keogh Review in 2017-18
3. Designate 'local' UEC services and standardise delivery e.g. Urgent Care Centres to be open 16 hours daily with x-ray and blood testing available throughout.

The Delivery Board have an agreed work plan which addresses both the 5 nationally mandated improvement actions and locally agreed priorities for the urgent & emergency care system. Berkshire West has held two Urgent Care Roundtable events in July and September 2016 which have helped to shape the strategic and operational priorities for the AEDB.

Key themes from the plan include (see Appendix 6 for full plan):

- ED streaming
- Increase in NHS 111 calls being handled by clinicians
- Delivery of the Ambulance Response programme (ARP)
- Measures to improve flow

- Improving Discharge processes/DToC performance by implementing the national Choice policy, strengthening CHC processes and the “Getting Home” project

9.1 Thames Valley Integrated Urgent Care service

Key local priorities as part of this overarching programme are the mobilisation of the Thames Valley 111 Integrated Urgent Care service from 2017/18 and a review of the contribution of Reading Walk In Centre.

The UECN is leading the Urgent Care work stream of the STP and Berkshire West CCGs are actively working to achieve the agreed deliverables, in particular Berkshire West is leading the procurement of a new Integrated Urgent Care service across Thames Valley.

Key deliverables for the workstream are:

- Regional 111 Integrated Urgent Care service, including enhanced clinical hub and enhanced Directory of Services
- Standardisation of UEC clinical pathways and designation, mapping and signposting of UEC services across the Thames Valley UEC network area
- Interoperability of UEC systems that allow the patient record to travel with the patient and be accessible to healthcare professionals across the patient pathway
- U&EC competency framework and workforce ‘passport’ arrangements across Providers
- Establishment of interface clinician roles offering portfolio employment across UEC services
- Best practice framework for 7 day access to standardised care across primary, community and secondary settings.

The Integrated Urgent Care (IUC) service, which launches in 2017/18, will offer a step change in meeting the urgent and emergency physical, mental and social care needs of patients across Thames Valley. NHS 111 will have the potential to be the single entry point to all urgent care services for the public.

The IUC service will offer improved management of patients with an increased clinical work force who can provide clinical review and early intervention for patients including vulnerable groups such as under 5s, patients at the end of life, support for self-care where clinically appropriate, and greater integration with downstream services such as community health and social care hubs. The service will provide improved transfer of patient information and access to care records.

Patients will be confident that, with one call to 111, the care that they are directed to will meet their physical, mental and social care needs in a timely and clinically safe manner. Health and Social Care professionals will be confident that the 111 Integrated Urgent Care Service has assessed and managed patients appropriately, placing them with the service that can most effectively meet their needs.

The Clinical Advice Hub is a new feature that will serve two purposes: providing enhanced clinical advice and management to patients contacting the service including generalist and specialist advice such as mental health, dentistry and pharmacy; and providing support to

clinicians (particularly ambulance staff such as paramedics and emergency technicians) via dedicated Health Care Professional (HCP) lines to ensure that no decision is made in isolation without proper clinical advice. The Hub will, in time, become the one location where a patient's physical, mental and social care needs can be co-ordinated and become, through patient's experiential learning, the choice for access to care.

9.2 Four priority standards for seven-day hospital services

As the main provider of acute services of in this area, Royal Berkshire NHS Foundation Trust are making strong progress with the implementation of the four priority standards for 7 Day Services (7DS).

As a result of this focused and targeted approach, the current position is as follows:

N	Standard	RBH Position
2	Time to first consultant review	Fully compliant
5	Access to diagnostics	Partially compliant
6	Access to Consultant-directed interventions	Fully compliant
8	On-going Review	Fully compliant

Berkshire West CCGs will continue to ensure that the provider is best placed to achieve as many of the standards (and maintain this position) as quickly as possible.

9.3 Ambulance response times

During 2015/16 and 2016/17 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards will not be met for the year. The CCGs have had a remedial action plan in place during 2016/17 that is forecasting recovery in the month of February 2017. This plan assumes activity levels are in line with agreed contractual levels; however it is worth noting that up to the end of August 2016, activity was 7.8% above plan which puts delivery against the plan at risk. A trajectory for 2017/18 is yet to be agreed with the provider.

When compared to other providers nationally, SCAS is one of the best performers against the national standards and was also the first ambulance service to receive a Good CQC inspection result. There is a national programme underway piloting various different response time options and the outcomes of these pilots are expected in early 2017 and this is likely to result in a change in targets within the 2017/19 contract.

9.4 Avoidable transportation to an A&E department

The IUC service will provide safe, effective and responsive integration with emergency ambulance services ensuring that ambulances can be dispatched without delay as clinically appropriate, for life-threatening 'Red' cases.

Patients that do not require an emergency response will be warm transferred to the IUC hub for review by a clinician and management in a more clinically appropriate community setting. 'Green' ambulance dispositions reached through NHS Pathways by 111 will be automatically transferred to a clinician for review and, where appropriate, patients will be supported to

access alternative services in the community that are appropriate to manage their level of need.

An improved, up-to-date Directory of Services (DoS) will also be central to the IUC service, including a comprehensive range of local health, community, third sector, mental health and social care service information that can provide support where appropriate. The DoS will also be made available to health professionals to search for local services to support their patients and make better decision making to manage a patient, where appropriate, in the community without recourse to attendance at an Emergency Department or admission due to lack of knowledge of local care.

SCAS are proactively seeking local opportunities to increase see and treat rates where clinically appropriate. See and treat hubs are being established to increase see and treat support through Specialist Paramedics. Five sites have been identified across the SCAS geography with a pilot currently running in Reading. The CCGs will work with SCAS in 2017-18 on delivery of the CQUIN "A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E departments". The CQUIN will act as a driver in the development of ambulance services as they become community-based providers of mobile urgent and emergency healthcare, fully integrated within Urgent and Emergency Care Networks. The CQUIN will incentivise SCAS to manage a greater proportion of care closer to home and reduce the rate of ambulance 999 calls that result in conveyance to A&E.

10. Mental health

The core objectives of the Five Year Forward View for Mental Health are to improve access to high quality care, provide early intervention and integrated services with the aim of reducing spend in acute settings and inpatient services. In Berkshire West across 2017/19 we will commission mental health services which will enable savings to be realised across the health and social care system by providing people with the most appropriate care in the right setting, this will align to the BOB STP mental health workstream objectives.

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver the two new national mental health standards.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and social care system.

In 2016/17 we have made significant investment in mental health services to support the delivery of 'Parity of Esteem' and we will continue to drive change throughout the next two years to ensure all our mental health users and carers receive a high quality, outcome focussed service comparable with physical health care. As part of the primary care five year forward view Berkshire West have invested in primary care to provide physical health checks for those patients with a severe and enduring mental health illness in the community. In

addition BHFT are committed to increasing physical health checks for patients within the community.

10.1 Crisis Care

In relation to crisis care, we have invested in expanding our Crisis Response and Home Treatment Teams (CRHTT) that will make a critical contribution to managing the pressures on acute in-patient beds that lead to increased bed occupancy and, ultimately, to people being sent out of area. The acute care pathway that we are developing during 2017/18 will incorporate demand and capacity management and will use learning from other areas where the acute care pathway has been redesigned so as to completely eliminate Out of Area placements (OAP). By redesigning our crisis care pathway into CRHTT we will see the benefit from reduced mental health in-patient admission at Prospect Park Hospital and reduce delayed transfers of care.

The Berkshire Crisis Care Concordat describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs and how different services can best work together. The Berkshire Concordat Action Plan has been informed by engagement with people who have needed to use crisis services and establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements.

Our local concordat focuses on the need for agencies to work together to deliver a high quality response when people with mental health problems need help; to establish joint intent and common purpose as to the roles and responsibilities of each service.
Berkshire Crisis Care Concordat is arranged around four key areas;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing future crises

We are working with partners to provide better access to support people before crisis point by:

- Providing a rapid response service 24/7 to all urgent and emergency mental health crisis
- Delivering an early intervention and prevention service
- Ensuring people in crisis will be kept safe, have their needs met and be helped to achieve recovery
- All staff having the right skills and training to respond to mental health crisis appropriately
- Ensuring access to our local 24 hour helpline staffed by mental health professionals for people in crisis, their carers and GPs
- Delivery of the Crisis Resolution and Home Treatment Team, available 24/7
- Delivery of a street triage service and places of safety

Both the Crisis Response Team and the Home Treatment Team will be fully operational on a 24/7 basis from 2017/18.

The effective planning and management of mental health service pathways, including the involvement of patients and their carers in the development of Berkshire West Crisis Services, will support more people to have good mental health and those people with mental health problems will recover quickly.

10.2 Improving Access to Psychological Therapy (IAPT)

The Berkshire West IAPT service has been achieving the target of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks. The Berkshire West IAPT service has been recognised nationally as a high quality service with excellent wait times and access rates. This service has received national recognition for its achievements:

- A recovery rate of more than 50%
- Wait time of 4 weeks (against a national target of 18 weeks)
- 95% patients reporting a positive experience

Our priorities for 2017/18 & 2018/19 are to ensure that current performance is maintained and that recovery rates are above 50%. This service will continue to evolve and we have secured National IAPT Expansion Site Funding from NHSE as wave 1 site to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading Children and Young People's IAPT collaborative and has been for a number of years. Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of an outcome framework in Berkshire West.

KPIs	2017/18	2018/19
Achieve a recovery rate of more than 50%	50%	53%
Waiting time of 4 weeks	75%	78%
95% patients reporting a positive experience	95%	98%

10.3 Early Intervention Psychosis (EIP)

Berkshire West Early Intervention in Psychosis service promotes early detection and engagement to reduce the duration of untreated psychosis to less than three months. BHFT employ specialist staff to provide a range of interventions, including psychosocial interventions and anti-psychotic medications, tailored to the needs of young people with a view to facilitating recovery. This service seeks to normalise experiences at a crucial developmental stage and offer therapeutic optimism, expertise and confidence in a recovery based approach. The service focuses on being person-centred, family focused, responsive and engaging.
In 2016/17 we have put in place a Service Development Plan with BHFT to implement a NICE compliant EIP service that is able to deliver the following recommended treatments to more than 50% of people within 14 days of referral:

- CBT for Psychosis (CBTP)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

This is being monitored monthly at our service and performance meeting with BHFT and we are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria in Berkshire.

In Berkshire we have set out some local outcome measures for the EIP service to deliver in 2017/18;

- Patient Reported Outcome Measures (PROMs)
- Patient Reported Experience Measures (PREMs)
- Carers Reported Outcome Measures (CROMs)
- Reduce Hospital Admission
- Improve Outcomes for BME Groups

10.4 Out of Area placements (OAP)

Berkshire patients should be treated in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment. BHFT have experienced staff as part of their placement review team to regularly review all out of area placements and provide reports to a Berkshire West funding panel, plans are in place to repatriate patients into local services. The review officers have an important role in terms of care quality, service user experience and financial management. Commissioners will monitor the progress made in reducing OAPs and report to NHSE Quarterly based on BHFT submissions.

Berkshire West CCGs are also working with our local authority partners to develop the local provider market to manage complex needs mental health patients in the area ensuring they can remain connected to their communities.

10.5 Perinatal Mental Health

Berkshire West Perinatal Mental Health Service provides a comprehensive range of community services for women requiring pre-conceptual counselling Talking Therapy or who experience mental health problems or illness during pregnancy or in the first year after birth. The service provides assessment and management of women at risk of, or suffering from mental illness that requires pre-conception advice, is pregnant or in the post-natal period. The service supports mother and infant relationship in the context of maternal mental illness and offers a service that is fully integrated in existing mental health services in Berkshire.

The following will be delivered across 2017-2019:

- Central Point of Entry (CPE) will have an identified perinatal clinical lead who will undertake the majority of the clinical work relating to new referrals into the Trust and act as a resource for referrers and the CPE team in matters relating to perinatal assessment.

- CPE perinatal lead and Manager of Trust Perinatal Mental Health Services will provide guidance to professionals within the Trust providing perinatal care including joint visit where required.

- Care Pathway/CMHT teams will have an named perinatal lead who has sufficient identified and ring fenced time to fulfil the role in order to provide care to the majority of new referrals into their team from CPE and to ensure/enable quality liaison between relevant services. They will act as resource for information and support to colleagues who have a client already open within the team and who subsequently come within the perinatal remit.

- Females who are aged 16-18 at the time of pregnancy/referral/delivery will be assessed jointly between perinatal lead at CPE adult services and CAMHS and signposted to the most appropriate service.

- Women who may require need admission to MBU will be referred to CRHTT for intensive interventions at home but where care cannot be safely managed in the community with crisis team CRHTT and with regard to risk - admission to MBU is sought from 24 weeks of pregnancy and up to one year post-partum and will be directed to MBU where at all clinically possible.

- Admission to CRHTT will also be sought to facilitate discharge from MBU.

- The named professional for the service user will attend the reviews held at MBU prior to discharge to facilitate a support plan to enable discharge.

- Advice regarding medication during pregnancy or whilst breastfeeding to be provided by pharmacy or psychiatrist as required as part of a whole assessment.

- Referrals within four weeks of birth from any source to any team within BHFT are treated as 'urgent' to commence the assessment process on the same day regardless of the information provided in order to eliminate risk of psychosis (this is the point of highest risk of psychosis).

- Women who are pregnant and come into contact with BHFT services will have a maternity planning document completed to be shared between the woman and all professionals involved with the care of the woman during pregnancy and in the early post-natal period. This document will detail information about risk in respect of medication and risk of relapse together with a plan in the event of relapse.

10.6 Suicide Prevention

The Berkshire suicide prevention strategy is being developed and is out for stakeholder's consultation, it is expected that this will be agreed by key partners by 31st January 2017. The Berkshire suicide prevention strategy commits every organisation to reduce suicide rates by 25% by 2020/21. There is a clear action plan as part of the suicide prevention strategy supported by BHFT to reduce suicide rate amongst mental health service users. The plan will:

- Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

- Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

- Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

- Ensure that local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

- A named Highways England officer is identified to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

- Ensure that local authority public health teams work with other council departments such as parking and open space services to identify local actions to prevent suicide including staff awareness training.

10.7 Dementia

Identifying those living with Dementia and the provision of high-quality post diagnosis care is a high priority for the four Berkshire West CCGs.

We have an established nationally accredited Memory Clinic service provided locally by Berkshire Healthcare Trust. In addition we have commissioned an award winning service for young people with Dementia which plays a significant role in supporting younger clients and their carers. Following the refresh of our Berkshire West Dementia Stakeholders Steering Group in late 2016, we will, in conjunction with our partners and utilising the forthcoming NHS implementation guidance, conduct a gap analysis which will allow us to update our Prime Ministers Dementia Challenge for 2020 action plan.

Currently the average Dementia diagnosis rate across all Berkshire West CCG practices at Sept 2016 is 66.9%. However, two of our CCGs currently remain below the 67% target and with support from NHSE and the SCN they are implementing CCG specific action plans to improve diagnosis rates to 67% by March 2017 (Wokingham) & April 2017 (Newbury). However, it is recognised that with changes to the denominator in April 2017, our positon may deteriorate in some CCGs further against target but with a potential for improvement in Wokingham. (Worst case scenario is for the CCG average to fall to 64.1% with all four CCGs below the 67% target). Three of our four CCGs we anticipate will therefore be in a positon to reach the 67% target by 1st April 2017 and will continue to maintain this over 2017/18 and beyond. We will continue to work closely with Newbury & District CCG to improve their positon as quickly as possible through implementation of their comprehensive action plan. For all CCGs we will continue to commission regularly updated "Dementia lists" direct to all four CCG practices from our memory clinic provider, allowing data harmonisation and registers to be kept up to date. Across all four CCGs other initiatives will include further raising awareness, on the importance of recording Dementia diagnosis, mapping and improving referral routes into the Memory Clinic and focusing on ensuring accurate and timely coding of newly identified Dementia patients from several of our newly built local Care Homes.

Building on work underway in comparable and neighbouring CCGs, we will implement a new pathway in 2017 for Mild Cognitive Impairment, led by Newbury & District CCG. This will offer us the opportunity to monitor and appropriately identify deterioration which may lead to a further improvement in Dementia diagnosis recording. A mapping exercise to identify "Dementia Friendly Practices" during late 2016 will allow us to target and promote support and training to practices, with the aim of achieving 100% Dementia Friendly practice access to our population by March 2019. To become dementia friendly, GP surgeries will sign up to the local dementia action alliance and commit to carrying actions that aim to help people living with dementia and their carers. We are adopting the iSPACE model which consists of 6 key steps to becoming a Dementia Friendly Practice:

1. **Identify** one or two Dementia Champions in the practice
2. **Staff** who are skilled and have time to care
3. **Partnership** working with carers, family and friends
4. **Assessment** and early identification of dementia
5. **Care plans** which are person centred
6. **Environments** that are dementia friendly

In line with the aspirations of the Prime Ministers Dementia Challenge 2020 to have diagnosis and treatment of Dementia within 6 weeks of referral, we will continue the work already underway with our Memory Clinic to refine patient pathways. A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6

weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices.

The integration of our Dementia Care Advisors within GP practices will further help support the identification of and provide improved ongoing support to dementia patients and their carers.

As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision using benchmarking and best practice wherever possible.

Our current established dementia stakeholders group will meet monthly and will take responsibility for the implementation of the Dementia action plan for 2017/18 and beyond. This will include ensuring robust processes are in place to provide regular reviews of Dementia Care Plans, and this will align with our plans to extend care and support planning to other Long Term Conditions, including Dementia as well as our local enhanced service for anticipatory care planning. Recent data provided by the Department of Health's Dementia Atlas will be utilised to allow us to learn and share best practice wherever possible. By refining our models of Dementia care delivery, we will be looking at the option to further integrate older people's mental health specialists within our GP practice.

Outcome measures of importance to us will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money Dementia Services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have a clearer identification of the cost of current services and the size of any need for additional investment to meet the future needs of the population.

10.8 Emotional health and wellbeing in children and young people

We published our Local Transformation Plan for child and adolescent mental health and wellbeing in 2015 in response to Future In Mind and refreshed these plans in October 2016. Our Local Transformation Plans focus on integrating and building resources within the local community, so that emotional health and wellbeing support is offered at the earliest opportunity. This will reduce the number of children, young people and mothers requiring specialist intervention, a crisis response, an in-patient admission or out of area placement. Help will be offered as soon as issues become apparent.

As well as increasing the capacity of specialist CAMHs (Tier 3), Berkshire West CCGs have commissioned partners from the voluntary sector, third sector and Local Authorities to provide emotional and mental health services in the community before needs escalate to specialist level. We anticipate that access rates will be met through a combination of specialist (Tier 3) services and services from partners.

Additional specialist CAMHs staff have been recruited and trained and waiting times for specialist CAMHs have reduced. More children and young people are having treatment. In

17/18 waiting times will reduce further and expect there to be an increase in the number of children accessing help.

We are working to reduce CAMHs crisis mental health presentations through swifter risk assessment of new referrals and better risk mitigation of new and existing cases. Referrals are being triaged faster and urgent cases access help on the same day.

The CAMHs Urgent Care Pilot operates over extended hours Monday to Friday, over bank holidays and weekends providing timely mental health assessments and care. The service is integrated with RBFT to maximise joined up working and training opportunities. Short term intensive interventions in the community are provided to young people who have experienced a mental health crisis with the aim of reducing the number of children and young people who have a second crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 in CAMHS patient bed. In 16/17 the service will be evaluated and a sustainable model will be agreed and commissioned for implementation in 17/18. We are working with neighbouring CCGs and NHSE Specialised Commissioning to ensure best use of resources and implement a care pathway that reduces the need for out of area placements. The number of in-patient beds at Berkshire Adolescent Unit has been increased. The unit is now open 7 days a week.

Our CAMHS Community Eating Disorders service has been jointly commissioned with Berkshire East CCGs. The service became operational in 2016 and is on track to meet the access targets.

School based early identification and intervention projects have been commissioned. PPEPCare emotional health and wellbeing training is being delivered across the children's workforce including school nurses, GP's, school staff, Local Authority staff. An online Young SHaRON workforce support hub has been launched to support professionals who have concerns about children. School exclusion data has been analysed with partners to identify which young people are most likely to be excluded from school and where more help in schools might make a difference. This work will be carried forward into 17/18.

In 2016 we under took an Appreciative Inquiry into services for children and young people with autism, including those who are waiting for an assessment. We are using the learning from this inquiry to work with partners to develop improved care for these children across the system and across settings. Two voluntary sector organisations have been commissioned to provide support to families whose children are waiting for autism or ADHD assessment. We have also commissioned post diagnostic support to families whose children have a diagnosis of autism and other neurodevelopmental issues. The neurodevelopmental care pathway (ADHD and ASD) is being reviewed within BHFT.

11. Learning disability

11.1 Transforming Care

The Transforming Care Projecting Adult Needs and Service Information (PANSI) projections in 2015 identified 7313 people aged 18-64 with challenging behaviours in Berkshire West with projections showing a growth of 5% year on year until 2030. Predictions suggest nearly a third have an autistic spectrum disorder.

This Berkshire Transforming Care Partnership (TCP) builds upon the lessons' learnt from learning disability and autism schemes across Berkshire West and established partner forums focused on improving people's health outcomes, to ensure parity of access and equal opportunities for people with LD and/or Autism who have health and social care needs.

The TCP Board comprises 14 Health and Social Care partners across the county who hold a shared vision and commitment to support the implementation of the national service model for children, young people and adults with learning disabilities and/or autism, who have behaviour that challenges and may or may not have mental health issues and have come into contact with the criminal justice system. The model requires integration and collaboration by commissioners, providers and other sectors to enable this cohort of people to lead meaningful lives through tailored care plans that meet individual needs.

Berkshire Transforming Care Plan has 4 key 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. To avoid admissions to and support discharge from hospital, people will receive and be involved in a Care and Treatment Review (CTR)

To achieve those aims the TCP Board has established a programme and governance structure built around a number of work streams, with children and young people and those in transition being a core component of each.

11.1.1 Priority actions for 2017 – 2019:

We know that providing suitable accommodation and appropriate and flexible support in a home environment is key to helping people with LD and/or Autism come out of hospital and stay out of hospital; whether that be in an acute or secondary care setting. This will inform the development of a programme of work for 2017/18 and 2018/19 that enables the partners to have a coherent picture of demand and supply to underpin a strategic approach to market management to ensure that people with learning disabilities are able to access services in their community.

The new Berkshire TCP service model for people with learning disabilities and autism includes an Intensive Support Team (IST) who will provide high quality functional

assessment in the person's own home, aiming to improve safety for the person and reduce reliance on hospital admission. The service will use non-aversive strategies (Positive Behaviour Support) to improve people's lives and build resilience in a constructive way by focusing on improving quality of life and the reduction of behaviours that pose a risk to self and others.

The IST will be: safe, responsive, caring, effective and well-led with health and social care staff working closely together to improve people's lives, building resilience for the individual in their own environment and their community.

The TCP Board has set a plan to reduce Berkshire East and West CCGs commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19. Working with the provider, Berkshire Heath Care NHS Foundation and NHS England Specialist Commissioning Team the plan is on track to reduce CCG and NHS England commissioned bed capacity from 44 to 28 within the time line. Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision resulting in a reduction in beds. The Berkshire West CCGs and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

To ensure plans and changes maintain safe and high quality services, responsibility for the auditing of patient outcomes during the programme will sit with the TCP Star Chamber, a group of expert clinicians and service users.

The Primary Care work stream aims to produce a collaborative health action plan in 2016/17 that over the next 2 years will support people in health, education and community settings to identify their needs, their goals, outcomes and what they want to achieve for their own health and wellbeing.

National benchmarks of physical activity rates for children and young people with learning disabilities, and adults in residential care in relation to participation in sport are poor. The health action plans will aim to foster confidence in individuals and identify where support is needed to access a range of opportunities to improve physical health and reduce obesity rates.

The CCGs will work with BHFT to review the levels of mortality in Berkshire in line with the recommendations of the Mazars report. The CCGs will ensure that there is good quality healthcare to avoid unnecessary admissions, based on an understanding of the current rate and reasons for mortality amongst people with learning disabilities. In parallel the TCP board will identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

A significant proportion of mortality rates are due to preventable illnesses or conditions (i.e. heart disease and diabetes). The action plans will improve information on good nutrition and improve access via advocates, to primary and secondary healthcare services e.g. Dental, GP, ophthalmic, occupational therapies and diagnostic services. In addition the action plans will address inequalities in the uptake of cancer screening by people with a learning disability across Berkshire West by targeting people most in need.

11.2 Special Educational Needs (SEND)

Berkshire West CCGs continue to work with local authorities, health providers, the voluntary sector, families and service users to improve collaborative working across education, health and care for children and young people with SEND aged 0 – 25 years and to give parents more control. This work is in accordance with Part 3 of the Children and Families Act 2014. A Designated Clinical Officer is in post to support to CCGs in meeting their statutory responsibilities for children and young people with SEND. “Local Offers” have been published in each area. The Local Offers provide accessible information on local services and resources for children with SEND and their families. The “Ready Steady Go” programme has been introduced in many clinical areas to improve transition into adult services and to better prepare young people and their families for adulthood. Education partners are considering how the Ready Steady Go principles can be aligned to Education Health and Care Plans to improve integrated working.

Community health services for children, young people and families (e.g. therapies, CAMHs) have integrated into a single team. The needs of children and young people referred to services are considered in a more holistic and collaborative manner with a greater emphasis on agreeing a joint care plan with meaningful outcomes with families.

12. Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC and Thames Valley Maternity Network. The broad objectives of this forum are to:

1) Review the quality of maternity services provision for women across Berkshire West in line with the agreed service specification
2) To ensure that women’s feedback is heard and contributes to strategic planning
3) To agree key initiatives to improve the quality of maternity services for women across Berkshire West, in line with national guidance and recommendations and supported by all Berkshire West CCGs
4) To monitor the implementation and achievement of key initiatives and targeted service improvements in maternity care provision

It is collectively agreed by the forum, that the above overarching objectives will enhance the patient experience and support the choice agenda, in addition to the identification of any gaps in provision to ensure that any improvements in service provision are completed with the above as a priority.

When focussing on the various deliverables in order to achieve the objectives of the forum, in collaboration with the CCGs, RBFT have chosen to;

a) Prioritise the improvement of maternal choice through increasing the percentage of midwifery led deliveries (25% in 2017/18) and continue drive to recruit to midwifery vacancies until full establishment is achieved
b) Increasing the number of home births through commissioning of a dedicated home birth service commencing 1st April 2017, aiming to achieve 3% by Q4 2017/18
c) Reducing the need for RBFT to divert women in labour
d) Improved postnatal care through the introduction of smaller community teams (4-6 midwives) and a linked consultant obstetrician, it is thought that this will be fully implemented by March 2017.

It has been identified that in order to provide benchmarking with providers and visibility of performance trends, a Thames Valley Maternity Dashboard is currently under development. This is led by the network allowing for CCGs to monitor the providers against an agreed set of key indicators, it is hoped that this will be implemented by June 2017. The CCGs will utilise these indicators during the contract period 2017/19 to monitor performance and, where required, set improvement trajectories through the provider quality schedule within the NHS contract. Challenge, scrutiny and assurance of actions regarding these indicators will continue through the maternity steering group, reporting to the CMMV Programme Board.

The CCGs are also working with the Thames valley SCN to model the future demand for maternity services in the light of an anticipated rising birth rate as a result of significant housing growth within the locality.

In addition to the specific objectives highlighted above, within 2017/19, the CCGs will ensure progress is achieved to deliver the recommendations of the National Maternity Review, Better Births (Appendix 8).

13. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2017/19. Significant progress has already been made in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure damage, reducing incidents of infection and reducing falls causing serious harm. The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers' performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fail to meet contractually obligated expectations.

The contractual individual provider quality schedules set out the expectations for quality in 2017/19. The schedules are based upon year to date performance in 2016/17, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence. The schedules are then amended to reflect local priorities with removal of indicators where consistent achievement has been noted or, the addition of new indicators based upon the collective guidance and feedback relating to services or processes.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2017/19. There is a clinical harm review process for all patients with a confirmed cancer diagnosis who have waited

longer than 104 days. The CCGs will continue monitor the outcome of these in 2017/19. In addition, the CCGs will continue to monitor cancer and RTT performance at the Royal Berkshire Hospital, ensuring progress to full compliance is sustained. All serious incidents (SI) will be monitored through our robust SI processes; ensuring learning from any lapses in care is effectively captured and embedded.

In 2017/19 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections. A number of inspections were carried out during 16/17; this is inclusive of SCAS (all areas), Spire Dunedin, Circle Reading, Ramsay BIH and Maternity and Gynae at RBFT. The new CCG in-housed Quality Team will ensure action plans are established and monitored to address and note progress regarding any areas requiring improvement.

The CCGs will continue with its programme of Quality Observational visits to our providers across 2017/19, which are now inclusive of patient pathways, gaining direct feedback from staff, patients and their families on the care they are receiving. Recommendations from the visit are then shared with the Trust and followed up within the Clinical Quality Review group.

In 2017/19 the CCGs will continue to improve the quality of primary care provided across all of our practices and will take over the full quality improvement monitoring and supportive function in 2017/18. The CCGs have developed a quality scorecard for primary care to monitor performance and support continuous improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. The scorecard will form part of a broader Primary Care Quality Report which will also incorporate information on complaints, significant events, safeguarding incidents and other information relating to managing the quality of services provided. The CCGs will be developing a quality framework for primary care to set out clearly support and intervention to be taken when individual practices are not meeting the required standards expected by the CCG. The CCG primary care team, in partnership with the quality team will continue to support those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

Part of this process will ensure there is a robust system in place for recording and monitoring any incidents which arise within the primary care setting. This process will also ensure that any learning that has arisen will be cascaded and embedded within the CCG constituent practices.

13.1 Avoidable deaths

The CCGs have a robust Serious Incident process with monthly meetings to scrutinise investigation reports into any incident which has resulted in serious harm or death of a patient. The CCGs will continue to ensure that any lessons learnt from these investigations are fully embedded within the organisation and will challenge robustly if there are any recurring themes, taking action as necessary if care falls below the quality standards we expect.

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years. Further scrutiny and assurance will also be sought in light of 'Mazars' recommendations, through the development of a Berkshire Wide mortality review of all deaths of patients with a learning disability, ensuring any learning is shared across all providers across the system, in partnership with Berkshire East CCGs.

13.2 Medicines Management

The CCGs recognise that medicines form a significant part in addressing quality of care in terms of better patient experience, improving health outcomes and reducing patient harm. Optimising the use of medicines aims to ensure that the right drug is received in the right dose in the right place; that the most cost effective choices are made in line with national and local guidance; and that only those medicines that continue to benefit a patient are continued.

Work streams carried out by the CCG Medicines Optimisation Team (MOT) to support these overarching aims include:

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.
- A joint post with the Royal Berkshire foundation trust to ensure the most cost effective drugs are used across the interface

The schemes above are delivering successfully with over £770k of efficiency savings delivered up to September 2016

The CCG MOT is strengthening the relationship with secondary care by a number of initiatives.

- Developing a cellulitis pathway in order to manage more patients in primary care and reduce the number of won-elective admissions.
- Work with the secondary care dietetics department to stop Oral Nutritional Supplements being added to Electronic Discharge Letters for low risk patients, which then lead to these products being inappropriately continued into primary care

In 2017/18, the CCGs will continue to utilise the local health economy Antimicrobial stewardship (AMS) Network which will look at all aspects of AMS, including having a joint strategy that spans primary, secondary and community care.

13.3 Safeguarding

The CCGs will continue to be active members of three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Initial Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies and procedures and to work within the framework of national guidance and legislation. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide assurance of compliance of staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

Our quality assurance reporting framework will monitor progress and contract compliance on the DH and Home Office Prevent strategy against NHS standard contract for all our providers. We will ensure quarterly reporting on training compliance and prevent referrals is submitted to our prevent lead. This training is in accordance with the NHS England prevent and training competencies Framework and as a CCG we have encouraged the use of both Home Office e-learning training and health wrap supported by the regional prevent co-ordinators forum. This is in accordance with the CCGs current status as a non-priority area.

13.5 Continuing Healthcare (CHC)

The Berkshire West CCGs are committed to ensuring their Continuing Healthcare processes are compliant with national guidance and delivered in a person centred way with the involvement of all key stakeholders.

To meet those aims Berkshire West have engaged with its local authority partners in a review of CHC processes, facilitated by the CHC Lead for NHS England South and the Lead for the CHC National Performance Advisory group. There are a number of agreed actions and these will be taken forward in 2016/2017 in an Action Plan with agreed timescales for implementation. This will improve the CCGs' processes for receiving referrals for CHC, undertaking multi-disciplinary assessments and supporting people who disagree with their assessment to appeal.

In addition the CCGs have signed up to the NHS England "CHAT" tool which enables CHC Services to evidence their compliance with the Quality Assurance Framework for CHC. We have completed the first upload of data in line with the timescales set by NHS England and plans are in place for the next phase.

14. Digital Transformation

14.1 The case for change

The Berkshire West Local Digital Roadmap forms part of the BOB STP digital work stream. The priorities described in the BOB STP are reliant on the development and utilisation of a number of technological innovations to enable improvement in outcomes, support of self-care and provision of a greater proportion of care in a community setting. The Berkshire West Local Digital Roadmap is aligned to the BOB Sustainability and Transformation Plan and includes a roadmap to achieve:

- Paper-free at the point of care.
- Digitally enabled self-care.

- Real-time data analytics at the point of care.
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

14.2 Digital technology as change enabler

It is recognised locally and nationally that the kinds of transformative change set out in the STP cannot be achieved without realising many of the opportunities afforded through extensive deployment of digital technology.

More recently the General Practice Forward View emphasises the importance of greater use of technology to connect primary care with others, for the sharing of best practice, for greater online access for patients and to deliver new modalities for provision of advice and support for patients and the public.

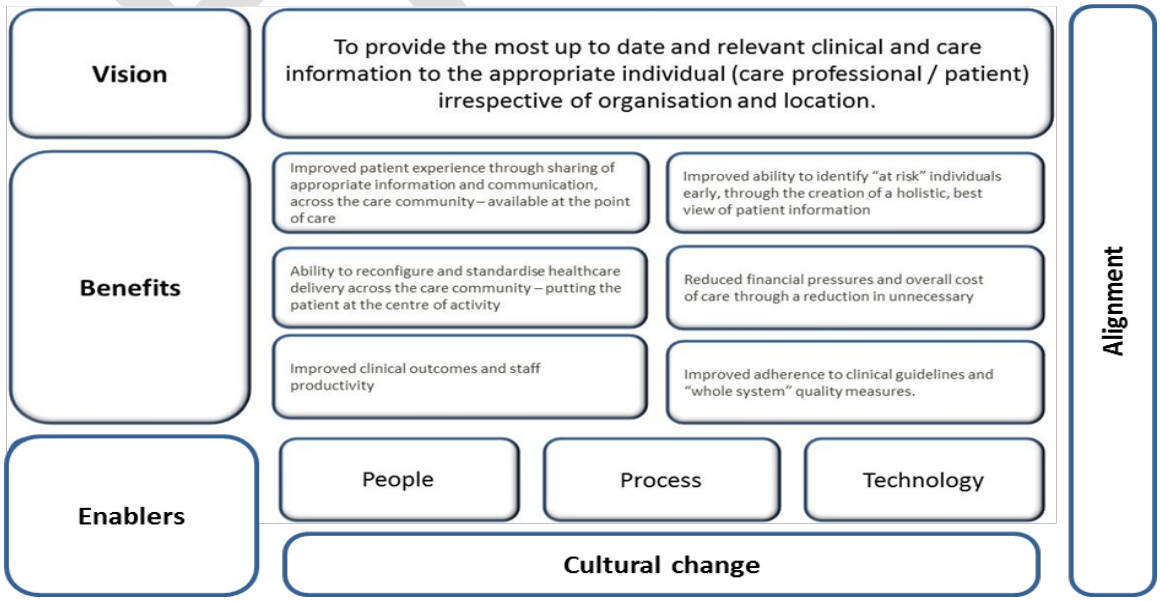
Initial benefits will relate to improvements in patient experience and patient outcomes, but with moves to more integrated care, further efficiencies will be realised by ensuring that patients can access the right care services to meet their needs, while clinicians can make better informed decisions and reduce duplication of tests and imaging.

14.3 Vision for digitally enabled transformation

Digitally enabled transformation is an essential component for addressing the challenges faced by the local health system. Berkshire West have been very clear that "digitally enabled transformation" should not focus on the technology alone but must be driven by the end-users, i.e. those at the front line of delivering care. Often the level of transformation of business processes is significantly under estimated.

Our vision is summarised in Figure 1 with investment in technology to support self-care through digital tools and enablers, data and information sharing across organisations and the development of a predictive urgent care model across the footprint.

Figure 1 - Berkshire West vision



The alignment of the local LDR into an integrated BOB STP LDR provides an aligned approach that has the commitment of provider, commissioner and local authority partners to realise the vision for health delivery for those we serve, and the ability to ensure that developments in digital maturity reflect the priorities of our future care models and services

The technology enablers of our digital vision need to meet a broad set of requirements across a number of care settings, however collectively, they need address three high level objectives:

- Improve the overall digital maturity of our providers
- Interoperability and information exchange between health and social care organisations
- Having a person / patient held record (PHR) for health and social care for the citizens
- Whole systems intelligence.

Engagement with both clinical staff and patients has been a cornerstone of our delivery approach to ensure that quality of care and patient experience are enhanced by our digital priorities.

Year one (June 2016 to June 2017) of Connected Care focusses on wide-spread deployment of the integrated digital care record platform (IDCR), making this accessible from Berkshire's main strategic health and social care systems. This will cover three phases, moving from 500 users in phase 1 to 3000 users by phase 3.

Based on the 10 universal capabilities and the work to improve digital maturity in providers, the Berkshire West Digital Transformation Board has agreed a set of work streams, which will be mirrored by work streams in the other economies of the STP. Work streams may cover a set of systems rather than a single deliverable – for example the record sharing work stream will not only deliver Connected Care, but will also deliver the federated architecture to support Primary Care at Scale, and e-Prescribing will look at delivering these systems in the acute sector, but also look at ePS incentives for dispensing practices. The work streams are supported by an STP wide professional reference group, information governance group and patient panel.

The focus on collaboration across the STP allows shared learning across the 3 health economies. Berkshire West intends to learn from work currently underway in Buckinghamshire on digital consultation, particularly in relation to urgent on the day Primary Care and remote services to Care Home residents. The Digital Centre of Excellence in Oxford University Hospitals will support improved digital maturity in our acute provider, and the pan Berkshire Work on personal health records and our healthy workforce pilot provide innovative approaches that can be shared.

We will monitor improvement in outcomes delivered through the clinical change programmes that Connected Care and our broader digital agenda enable. We intend to work with partners to develop a benefits model for enabling technology, which will help us to identify process benefits directly attributable to deploying technology but also quantify the extent of outcome improvement that could not have been achieved without our digital transformation programme.

14.4 E-referrals

The CCG is forecasting to meet the national targets in relation to e-referral utilisation and is working with providers and GP practices to support delivery of these trajectories. There are some risks associated with achievement of this indicator though, especially at 100%. There is an issue specifically for 2 week wait referrals for RBFT where we have a very good clinical triage process that is initiated on e-referrals by GPs. However these 2 week wait clinics do not count towards utilisation for the national definition even though the referrals are taking place on the e-referrals system. The CCGs are working to try and overcome this issue locally without altering the excellent clinical pathway.

There are also some technical issues with the metric which will mean 100% is very difficult to achieve, even if GPs make all referrals on the e-referrals system. This is mainly because the numerator and denominator come from different data sources nationally and therefore the numerator is not necessarily a subset of the denominator.

15. Appendix

1. Delivery of the Nine Must Dos
2. Accountable Care System - PIDS
3. Berkshire West CCGs – Operating Plans on a page
4. Berkshire West CCGs – Primary Care GPFV plan
5. Berkshire West CCGs – Cancer Framework
6. Berkshire West CCGs – A&E delivery plan
7. Berkshire West CCGs – Dementia plan on a page
8. Berkshire West CCGs – Better births implementation plan
9. Berkshire West CCGs – Local Digital Roadmap
10. Berkshire West CCGs – Communication and Engagement strategy

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

2017/19 Plan on a Page

Ensuring high quality patient care is delivered by our commissioned services through the delivery of our Quality Improvement Strategy 2017-20, including:

- Implement 'Better Births' action plan
- Develop a quality framework for primary care
- Develop a strategy for antimicrobial stewardship that spans primary, secondary and community care

Work with partners in Berkshire West, Oxfordshire & Buckinghamshire to achieve a high quality sustainable NHS by preventing ill health, improving access to urgent care, hospital services, mental health and working with NHS England to improve specialist commissioning.

Improving Quality of Care

Sustainability & Transformation Plan

Financial Sustainability

Primary Care

Urgent & Emergency Care

Planned Care & Referral to Treatment Times

Cancer

Learning Disabilities & Special Educational Needs (all ages)

Mental Health

Transform mental health services in line with the Five Year Forward View and national standards, ensuring "parity of esteem" by improving access, providing early intervention and integrating services.

- Maintain performance of psychological therapies and expand into managing LTCs
- Review Out of Area Placements
- 50% of adults with 1st psychosis episode start treatment in 2 weeks
- 10% reduction in suicide rates
- Further reduction in CAMHs waiting times
- Commission new urgent care service for CAMHs following evaluation of pilot
- Improve collaborative working for people with Special Education Needs and Disabilities
- Achieve/maintain 67% dementia diagnosis

Achieve financial targets which are dependent on delivery of the QIPP programme.
Create efficiencies by working with our providers in new ways as an Accountable Care System.

Deliver the GP Forward View through our Primary Care Strategy, to ensure effective and sustainable general practice through new workforce models, estates, access and technology
Deliver a patient centred, integrated approach in primary and community settings for people with multiple long-term conditions through to end of life care.
Specific focus on Diabetes, through better use of technology and enhanced access to education and improved care for Diabetics with the most complex needs.

Implement Berkshire Transforming Care Plan which includes:

- Improving quality of care and ensuring community services for people with learning disabilities, including children, are available
- 75% of people with learning disabilities have access to NHS Health Check by 2020

The local cancer framework will deliver the strategic priorities outlined in "Achieving World-Class Cancer Outcomes: A Strategy for England" and work streams have been developed to:

- improve early diagnosis, increase screening rates and prevention, improve 1 year survival rate and access to recovery packages and enhanced end of life care
- Achieving and maintaining constitution waiting time standards of 62 days for cancer

Redesign pathways, and reduce clinical variation working with our providers in orthopaedics, musculoskeletal, ophthalmology and develop a new model of delivering out patients.

- Meet national targets by ensuring that no fewer than 92% of patients are seen within 18 weeks from referral
- 100% use of e-referral system by March 2018

Work with other health and social care organisations to:

- Deliver an agreed A&E improvement plan and achieve the 4 hour constitutional target
- Provide new integrated 24 hour urgent clinical assessment and treatment service bringing together NHS 111, GP out of hours and other clinical advice, such as dental, medicines and mental health
- Reduce Delayed Transfers of Care
- Reduce Non Elective Admissions for our most vulnerable patients of all ages
- Meet 7 day hospital service standards

2017/19 Plan On A Page

Local Plans

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

Newbury & District CCG

- Promote healthy lifestyles in partnership with Public Health colleagues with a particular focus on:
  - Referring individuals into the National Diabetes Prevention Programme
  - Tackling childhood obesity
  - Falls prevention
  - Alcohol misuse
  - Targeting specific wards that have high levels of Non-elective admissions to hospital
  - Working together to do joint communication and engagement events.
- Establish integrated community teams which wrap around a GP practice population. Work with our providers and social care teams to streamline services so that patients get timely and co-ordinated care.
- Implement the Delayed Transfers of Care local action plan and work with the Local Authority through the Better Care Fund to increase capacity in the community by commissioning additional 'step down' beds.
- Continue to be system leaders working through the Health & Wellbeing Board and to deliver the two objectives identified for 2017-2018 which are alcohol harm reduction and building community resilience.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care. Integrate and build on the schemes piloted in 2016-2017 such as utilising Pharmacists in General Practice, providing enhanced medical administration training and expanding the comprehensive digital 'front door' to practices which aims to boost productivity by encouraging patients to do more online.
- Improve the uptake of diabetic patients who have received structured education. Increase the number of patients to 15%.

North & West Reading CCG

- Promote healthy lifestyles/services, particularly decreasing inactivity and smoking rates.
- Improve prevention of diabetes & care of pts. with diabetes by practices participating in NHS Diabetes Prevention Programme and reducing no. of diabetes pts. with HbA1c>75.
- Improve care of pts. with hypertension by continuing to increase no. of known hypertensives & increase % of patients with BP <150/90.
- 75% of high risk Atrial Fibrillation pts. to be on anticoagulation, reducing stroke emergency admissions .
- Increase breast screening rates to over 80%, maintain bowel cancer screening rates & non-attendance/completion flagged on clinical systems supporting opportunistic screening conversations.
- Support practices to become 'dementia friendly.'
- Increase CKD pts. treated with ACE-I or ARB
- Provide referral support by improved GP & Consultant engagement at point of referral.
- Support emotional resilience in children & young people through promotion of MindEd, School Link & Emotional Health Academy.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care.

South Reading CCG

- Work with Reading Borough Council to promote healthy lifestyles/services particularly decreasing inactivity and smoking rates.
- Continue to support the collaboration of GP practices through the South Reading Alliance and University practices cluster, to redesign the workforce, ensure sustainability and improve access.
- Participate in diabetes related prescribing targets to optimise medications to improve outcomes for diabetic patients.
- Improve outcomes for cancer patients by working in partnership with Macmillan and Rushmoor Healthy Living to raise awareness of the symptoms of cancer in the seldom heard population and introduce a 'Teachable Moment' programme to encourage lifestyle changes in people with negative cancer diagnoses.
- Increase number of known hypertensives to 14,288 by March 2018.
- Reduce rates of active Tuberculosis by promoting the New Entrant Screening Service and raising awareness of Tuberculosis with target populations.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Review the alcohol pathway locally to increase screening opportunities and reduce acute presentations for alcohol related conditions.

Wokingham CCG

- Work with Wokingham Borough Council to promote healthy lifestyles/services.
- Implement Community Health and Social Care (CHASC) integrated model of care by September 2017.
- Support the development of collaborative working between Wokingham CCG practices with the development of an "alliance" by June 2017, to support workforce redesign improve access, and ensure sustainability.
- Increase the number of patients with diabetes (diagnosed for less than a year) who attended a structured education course (from 5.86% to 15%).
- Through CHASC, reduce non-elective admissions amongst the top 10% at risk patients by 7.5%.
- Increase referrals to Community Navigators by 25%. supporting people to stay well by linking them to sources of support in the community.
- Work with general practice and Wokingham Borough Council to ensure there is sufficient built capacity of primary care for the borough's growing population.

Adult Social Care

Commissioning Intentions 2017-18

Draft Report – Pending Alignment to Separately Produced NHS Commissioning Intentions

February 2017

Commissioning Intentions Key Messages

These Commissioning Intentions form part of Reading Borough Council's suite of documents which outline the approach and activities we expect to take to review, improve and commission services for Reading citizens during the next financial year, and to demonstrate compliance with the market management duties as set out in the Care Act 2014.

The document is a high level indicator of our key commissioning priorities and of the strategic direction that our commissioning activities will take over the coming year.

Our Key Priorities for 2017/18 are:

1. ***Maximising Independence and recovery*** - we will use reablement, assistive technology, and aids for daily living as a first response.
2. ***Personalisation*** - *w*e will support personalisation through personal budgets to ensure that people requiring longer term care can take as much control over their lives as their needs allow, in line with Care Act requirements.
3. ***Home Care*** - we will seek to support sustainable homecare in the borough by working proactively and building on relationships with our Home Care Framework providers (HCF).
4. ***Reshaping Accommodation*** - we will continue to shift the balance of accommodation provision from residential care to extra care housing and supported living options.
5. ***Integration with Health Partners*** – we will continue to build upon partnerships with our colleagues in the health service in order to work closely together to meet the needs of our population.
6. **Effective Commissioning and Sustainability** – we will transform the way that we commission, ensuring that we have a service that is fit for purpose and able to play a key role in supporting the council to maintain a balanced budget.

1) Strategic Priorities

The commissioning ambitions described in this document are aligned with the new priorities outlined in our Corporate Plan for 2016-19, in particular:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Remaining financially sustainable to deliver these service priorities

Adult Social Care in Reading is transforming the way we commission and provide social care services over the next few years. This work will be informed by the Reading Adult Social Care Vision:

- Our purpose is to **support**, care and help people to stay safe and well, and **recover independence** so that they can live their lives with purpose and meaning.
- We do this **collaboratively** with customers, carers, communities and partners; **tailoring** a response to meet needs and to **effectively** deliver targets and outcomes.
- In delivering these services we will be **fair**, **efficient** and **proportionate** in allocating our resources.

The **key drivers** under-pinning this transformation are:

The Care Act	**Integration**	**Savings and Finance**
• National eligibility criteria • New rights for carers • Legal right to a personal budget and direct payment • Introduction of the 'wellbeing duty' • Lifetime cap on care costs (deferred to 2020) • Responsibilities for councils to develop and manage the local market for services under the market management duty • Expectation that services will be co-produced with providers and customers in strategy development, contract awards and quality assurance	• Better Care Fund – pooled budgets to support local health and social care integration • Berkshire West 10 Integration Board • Reading Integration Board • Reablement and recovery focus • Delivering key performance indicators which are relevant to the whole system (e.g. Delayed Transfers of Care, 'Discharge to Assess', 'Fit List')	• Adult Social Care requirement to support the council to achieve a balanced budget • Fair Price for Care • National Living Wage

2) Our Commissioning Priorities

2.1 Maximising Independence and recovery

We will use reablement, assistive technology, and aids for daily living as a first response. In this way our aim will be to provide a short-term intervention which supports people to be independent for longer.

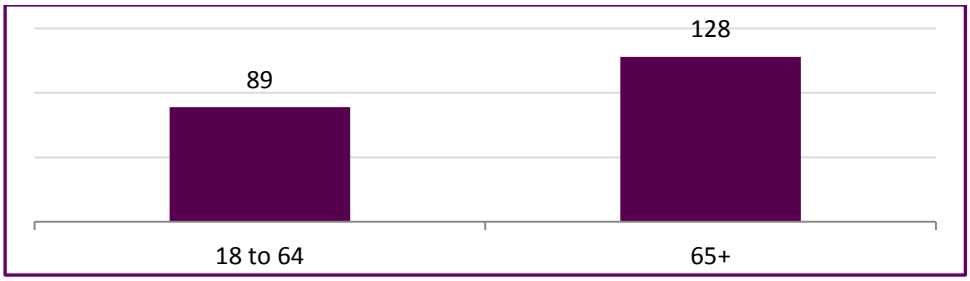
Progress to date:

- Discharge to Assess (Willows) – we have commissioned a number of 'step down' beds in one of our residential homes that enable more timely discharge for those residents that no longer need acute care and support but would benefit from a period of reablement and time to assess the most beneficial long term support.
- Rapid Response and Treatment to care homes – with our Berkshire Local authority and CCG colleagues, established a rapid response service to support local care homes to support residents to remain in their home, rather than needing hospital treatment, and enable a more timely return home following an episode in hospital.

Objectives for the year ahead:

- We will develop an assistive technology strategy – exploring opportunities to enhance our approach and including supporting people to make use of existing technology within the home.
- We will build upon our community based reablement service to develop bed based reablement, supporting people at an earlier stage in their recovery
- We will increase the use of assistive technology in people's care, ensuring their independence and dignity are promoted and preserved.
- We will review the effectiveness and efficiency/unit costs of our current 'Discharge to Assess' provision to determine whether additional or alternative capacity will support more effective discharge from hospital and sustainable care in community settings.

Chart Showing the Number People using Assistive Technology in 2016



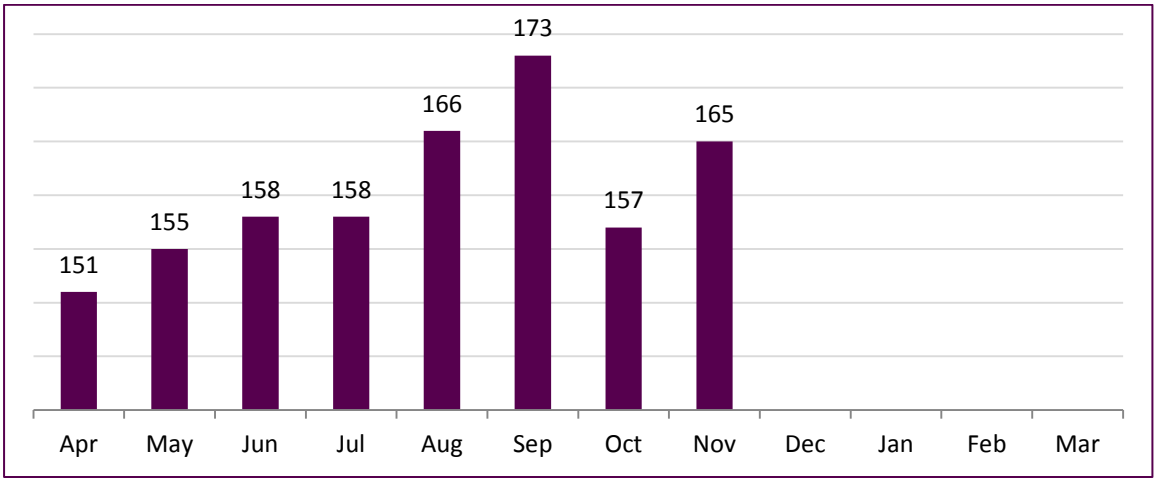
2.2 Personalisation and Independence

We will support personalisation through personal budgets to ensure that people requiring longer term care can take as much control over their lives as their needs allow, in line with Care Act requirements. We continue to review our approach to Direct Payments to increase take-up, including assessing the provision of a pre-paid card option and review of the related support services.

Progress to date:

- We have introduced prepaid cards for direct payments users, which will make the process of managing a direct payment simpler and easier. The first users go live in January, and we will gradually introduce further existing and new service users across a range of need over the coming months.
- We are currently re-commissioning a new Direct Payments Support Service, which will aim to offer direct payment users a range of choice in selecting organisations to assist them in employment of personal assistants and managing the financial elements of their direct payment.
- Our rate of direct payments has increased to 12% in the past year, and we have plans to increase this in line with national average over the next 12 months.

Chart Showing the Number of Service Users Receiving Direct Payments in 2016



Objectives for the year ahead:

- We will further develop the Reading Services Guide, whilst also reviewing the overall design, content and functionality with a view to including a broader range of providers and supporting the move towards self-directed support and an e-marketplace. This project will include evaluating the potential for supporting access to assessments for small packages of care, facilitating networks, provision of mentors and opportunities to connect with others.
- We will support younger adults with a learning disability who have sufficient ability to maximise their independence by moving into work environments
- We will review advocacy provision across all our adult social care services in order to be able to offer a more cohesive and efficient service from 2017
- We will review the Narrowing the Gap process for voluntary sector preventative support, following which there will be a revised process.

2.3 Home Care

We will seek to support sustainable homecare in the borough by working proactively and building on relationships with our Home Care Framework providers (HCF). Our aim will be to ensure availability of high quality, flexible home care services to vulnerable people in Reading. We will seek to integrate with other services, including health services to provide seamless services.

Progress to date:

- We have a responsive home care market that has avoided impacting on delayed discharges from hospitals.
- We have entered into an agreement with CM2000 for Electronic Time Recording and will develop and embed this with all of our Home Care Framework providers this year.
- We have re-procured equipment services across Berkshire and will review the new contract in 2020. We will continue to explore how new technological solutions can give residents better care, ensure their safety and enable us to deliver services more efficiently. This will prioritise the use of telecare, and other services and equipment to reduce the need for multiple carers.
- The Council wish to ensure that the workforce is valued and respected and in receipt of fair wages and decent conditions of employment and have adopted the Unison Ethical Care Charter. Providers have committed to the principles of the Charter and have achieved stage one.

Objectives for the year ahead:

- We will undertake more detailed work to better understand future demand on the local market in line with the requirements of the care Act, and in particular assessing the financial sustainability of the market as a whole.
- We will continue to build on relationships with providers on the homecare framework, supporting them to develop sustainability resilience. This will include supporting recruitment and workforce strategy (including recruitment and capacity building).
- Following on from the review and transfer of the Maples Day Service[1] for older people, we will expand this work to include learning disability, physical disability and mental health day services. The new model will provide professional care to those who need it.
- We will re-commission our support for mental health peer support aligned to the Recovery College and on a Recovery approach.
- We will develop Outcome based commissioning of individual packages. Providers will be presented with the outcomes an individual needs to achieve and tender

[1] Improving Day Opportunities in Reading (Adults, Children's and Education Committee 5th November 2015)

how they will work with the individual to achieve these outcomes within a pre-allocated budget.

- We will be exploring the possibility of Council Support Plans and Provider Support Plans within a single shared plan. The Council will give an indication of support needed (Council Support Assessment) and Providers will create a detailed Support plan which will need to be agreed with care management. Responsibility of the standard, management and updating of the Support Plan will lie with the Provider.
- We will continue to work with providers on the Home Care Framework to implement further stages of the Ethical Care Charter. This includes providing occupational sick pay and guaranteed hours to employees.

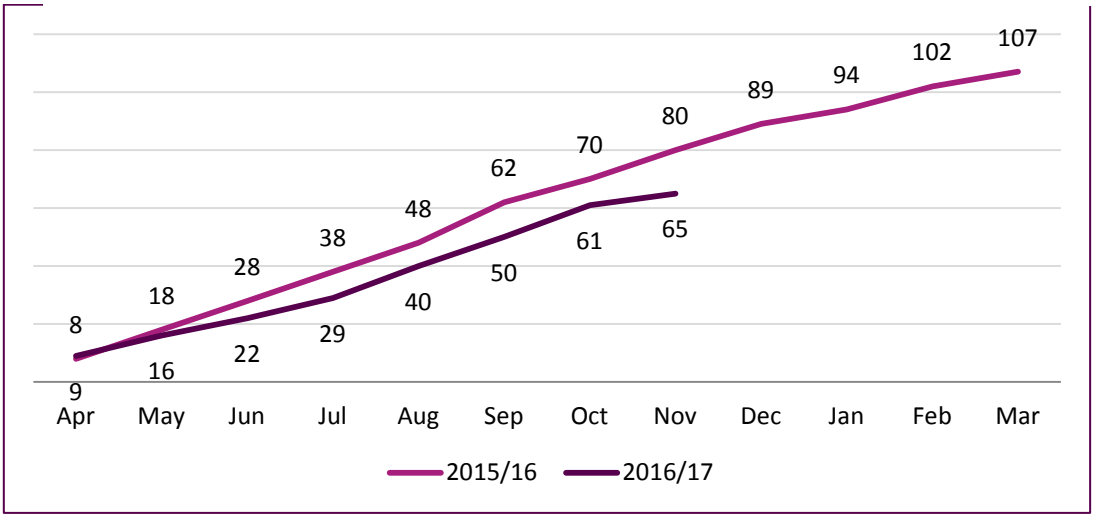
2.4 Reshaping Accommodation

In order to support the vision of cohesive, attractive and vibrant neighbourhoods, we will continue to shift the balance of accommodation provision from residential care to extra care housing and supported living options. We will continue to reduce the number of residential beds, with specific focus on learning disability.

Progress to date:

- In 16/17 we successfully developed and fully populated two new supported living residences for residents with learning disabilities. This has enabled our clients to live more independent and socially connected lives, away from traditional residential provision. We will continue to find more opportunities to develop supported living and' shared lives' for people with learning disabilities within the Reading area during 17/18.
- In the last year we have reduced the number of younger adults admitted to residential units by half, and the number of older people admitted to residential units by over two thirds. We expect to maintain this low level of admittance to residential units, and continue to work on moving existing residential placements out to the community wherever this would benefit the person.
- We have purchased new nursing provision in Dwyer Road, which enables additional capacity and opportunity for competition within this previously limited market in the borough.

Chart a reduction in the number of older people admitted into residential care



Objectives for the year ahead:

- We have re-procured the care element of our Extra Care Housing provision across all sites during 2016-17, with the exception of our in-house provision, Charles Clore Court. We expect to tender for this within the next year. The new Extra Care contracts will next be reviewed in 2020.
- We will re-procure catering provision across all our Extra Care Housing provision during 2017, and will confirm the terms of this after a consultation ending in early 2017.
- We will expand our Shared Lives model of care to offer support to a wider range of people, including Mental Health clients. This will involve further developing models to support people living in the community under their own tenancies wherever possible.
- We will review and re-commission our suite of services relating to domestic abuse, to include refuge provision.

2.5 Integration with Health Partners

We will continue to build upon partnerships with our colleagues in the health service in order to work closely together to meet the needs of our population. This will include range of projects which are designed to align services, pathways and the processes behind them.

Progress to date:

- In partnership we have developed a new Integration Board that will oversee the operation and impact of the local Integration programme, including the Better Care Fund

- We have embedded and refined our Better Care Fund, which has a particular focus on integrated / joint initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care. Key BCF developments:
    - **Connected Care** – Our West of Berkshire Interoperability Project, which enables professionals to share case information and planning intelligence has been establishes across key health partners (GPs and Acute) with Reading social services due to join in 2017.
    - **Multi-disciplinary discharge forum** - established a weekly multi-disciplinary forum to address all delayed patients / users individually and assign clear leads and actions to promote timely move on

Objectives for the year ahead:

- We will continue to develop our range of Wellbeing Services (which includes Public Health) in alignment with our duties under the Care Act and with the principles of the national Living Well Pioneer Programme.
- We will participate fully with Health partners in the delivery of the West of Berkshire Interoperability Project (Connected Care), to enable professionals to share case information and planning intelligence.
- We will ensure that the Transforming Care initiative is fully embedded within our Learning Disability Services Transformation project and will apply relentless focus to moving remaining clients out of long term assessment facilities and into real homes.
- We will provide the AMHPS service within an integrated crisis and home treatment team, providing as part of the psychiatric liaison service providing in early intervention into acute hospitals as part of our prevention strategy
- We led on the re-commissioning of a revised Carers Information and Advice service across Reading and West Berkshire Local Authorities and the associated CCGs for a 2 year period from April 2016. The revised service is designed to accommodate new requirements relating to carers under The Care Act. We will continue to evolve carers services.

2.6 Effective Commissioning and Sustainability

We will transform the way that we commission, ensuring that we have a service that is fit for purpose and able to play a key role in supporting the council to maintain a balanced budget. We have a range of pre-agreed projects underway to deliver savings in the council's Medium Term Financial Plan, and will work to ensure these are delivered effectively, whilst identifying opportunities to achieve further efficiencies.

Progress to date:

- We have a range of projects within the Adult Social Care Transformation programme which are contributing savings to achieve a balance budget.
- We have a successful track record of providing quality services which keep people safe, prevent or delay escalation of needs and allow people to be in control of their lives.
- We have improved the quality and rigour of commissioning process and practice in the past year through two commissioning improvement projects. This included assessing our commissioning functions against the standards outlined in 'Commissioning For Better Outcomes'[2].

Objectives for the year ahead:

- We will undertake a thorough Assessment of the current commissioning approach, leading to a Design of a new and transformed approach.
- We will explore opportunities to integrate commissioning functions with partners in health and other local authorities.
- We will review and develop our Market Failure Protocol[3] in collaboration with partners and providers so that we have sound monitoring and early warning of changes requiring action.
- We will make changes to our contracting approach to develop clearer expectations from providers in relation to quality, performance, use of technology, and reporting expectations.
- All of our commissioning decisions will be in alignment with savings targets previously published for Adult Social Care which will enable us to deliver a balanced budget for the year.
- As we develop our commissioning approach we will ensure that the principles of co-production, and the development of community capacity are a core aspect of all areas of our work.

3) Working with Health Partners

We will wherever relevant align our commissioning priorities and activity with health partners, having particular focus on supporting the following taken from the West Berkshire CCGs Operating Plan:

- Better Care Fund
- Frail Elderly Population

[2] A template for good practice devised jointly by Department of Health, Local Government Association, Think Local Act Personal, Association for Directors of Adult Social Services and University of Birmingham

[3] The Care Act 2014 places new duties on Councils relating to market oversight, response to provider closures (planned and emergency) and a 'temporary duty' to ensure that needs are met in the event of provider failure. The Market Failure Protocol is a key tool in the contingency planning process.

- Long-term conditions and self-care
- Urgent and Emergency Care
- Mental Health
- Support for Carers
- Transforming Care
- Transition

4) Principles – how we will support delivery of our Commissioning Intentions

The following principles underpin our commissioning approach. As we work to further develop the effectiveness of commissioning we will review these and establish effective means to ensure our principles are implemented through the way that we work.

- **Asset-based approach**. With specific focus on our 'Right for You' model of care, we pay particular attention to the resources and support that people already have around them, within their family, community, universal and preventative services.
- **Measured risk model**. We continue to review our packages of care to ensure that we are not over-providing and creating unnecessary dependence.
- **Co-production**. We will strive to enable service users and their carers / families to co-produce services directly with us, and to participate in monitoring and evaluation.
- **Intelligence / performance management**. We will aim to become an intelligence rich commissioner, so that we have reliable and relevant knowledge on which to base our commissioning decisions.
- We will work closely with providers to improve or maintain good quality services that demonstrate **value for money**.
- We will focus our efforts on supporting more service users through the use of providers on our **approved frameworks.**
- We will apply a model of **full cost recovery** in line with the national eligibility criteria, ensuring that those who can afford to pay for their care do so.
- Any service changes resulting from delivery of the Commissioning Intentions will be undertaken with **sensitivity and consideration** of the impact on individual service users and their carers / families.
- We will undertake commissioning and re-commissioning exercises with **improved timeliness**, with specific focus on reducing instances of contract extensions
- We will actively review and **consider de-commissioning** services that do not meet required expectations relating to quality and performance

healthwatch Reading

How is electronic prescribing working for Reading people?

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Section 1

PROJECT SUMMARY

What

A project to find out eading people's experiences of the NHS electronic prescribing service (EPS), which allows a patient prescription to get from a GP's computer to a patient's pharmacy computer, so people don't have to take a paper copy.

Why

Healthwatch Reading had been given evidence of some local problems with EPS. We also wanted to understand more generally: whether people knew about the service; what it is like to use the service; and if people don't use; why not? We hoped our findings would help influence any future local improvements to the EPS.

Who

217 people completed our survey; 183 filled in a paper version, while 34 answered it online. We also spoke to pharmacists, a GP, and local NHS staff to gather information.

How

We visited six GP surgeries of various sizes across Reading to ask patients to fill in the surve . We also visited two pharmacies to speak to people collecting medications. Surveys were also available: at the reception desk on the 3rd floo , Reading Central Library (where our office is based); on our stand at the Reading Older People's Day; via our monthly newsletter; and from staff carrying out general engagement work. The survey was also promoted with the help of the North and West Reading, and South Reading, Patient Voice Groups.

When

September and October, 2016

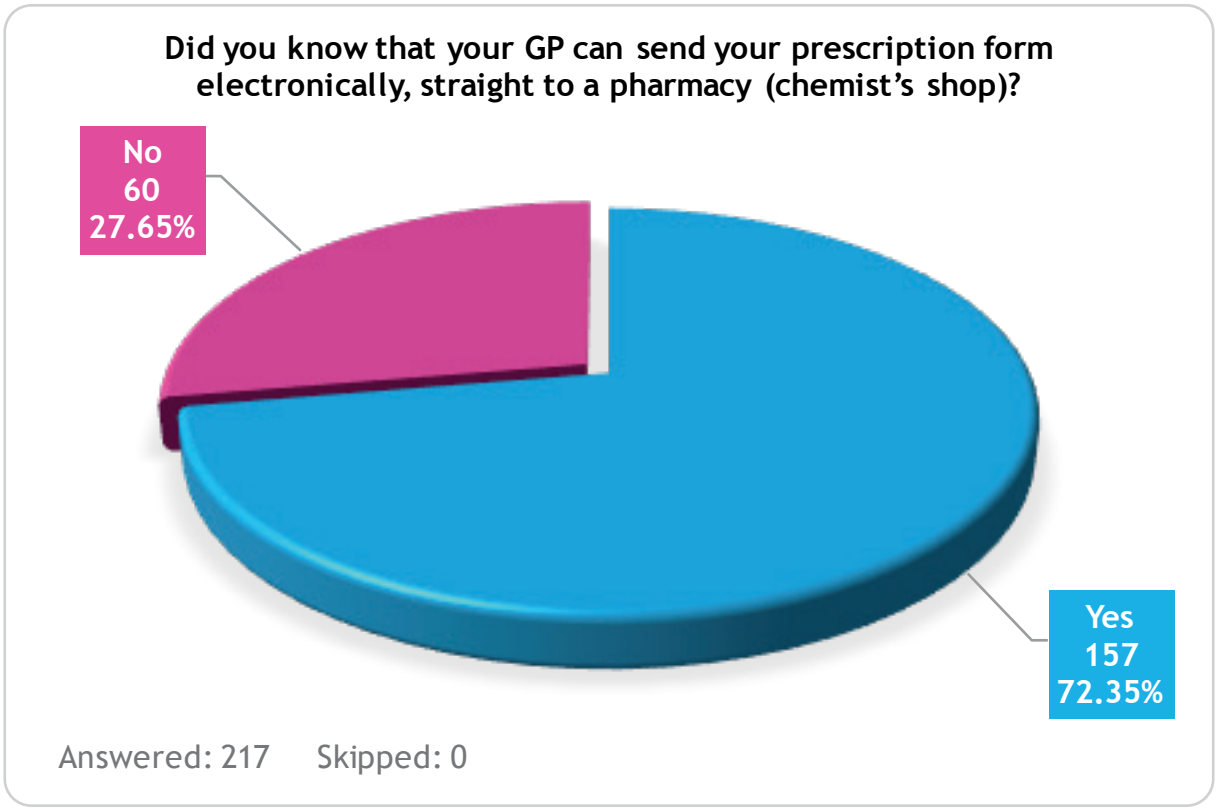
Key Highlights

- Nearly three-quarters (72%) of people said they were aware of electronic prescribing, but only 48% said they had used the service. When we spoke with people, it was clear that some people confused EPS with the online service to request repeat medications
- 60% of people had found out about EPS from their GP or surgery staff; only 23% had from their pharmacy
- Most people who used EPS said its main benefit was convenience, as it saved an extra trip going to the surgery to collect their repeat prescription
- Half of the people using the EPS said their GP had indicated when their medicines would be ready, ranging from 'within the hour' to a few days
- Half of people using the service said their medicine was not ready when they arrived at the pharmacy to collect it
- People suggested the service could be improved if: pharmacies sent patients a 'ready-to-collect' message; pharmacy staff were better trained; and patients could more easily change their nominated pharmacy on a one-off basis
- The most common reason people gave for not using the EPS, was not having heard it about it before, or not being asked by their GP; a small number said it was because something had gone wrong on a previous occasion, or not being computer literate themselves (showing misunderstanding of the service)
- People who are on more than one medication would like their prescribing synchronised to the same monthly date to avoid multiple pharmacy visits
- Overall, the system appears to mostly benefit the NHS and pharmacies, by helping to prevent lost prescriptions and improving stock ordering of medicines.
- Healthwatch Reading is challenging the local NHS to develop EPS to its full potential. We make a series of recommendations on page 19.

Section 2:

PATIENT VIEWS IN DETAIL

Awareness of the electronic prescribing service (EPS)

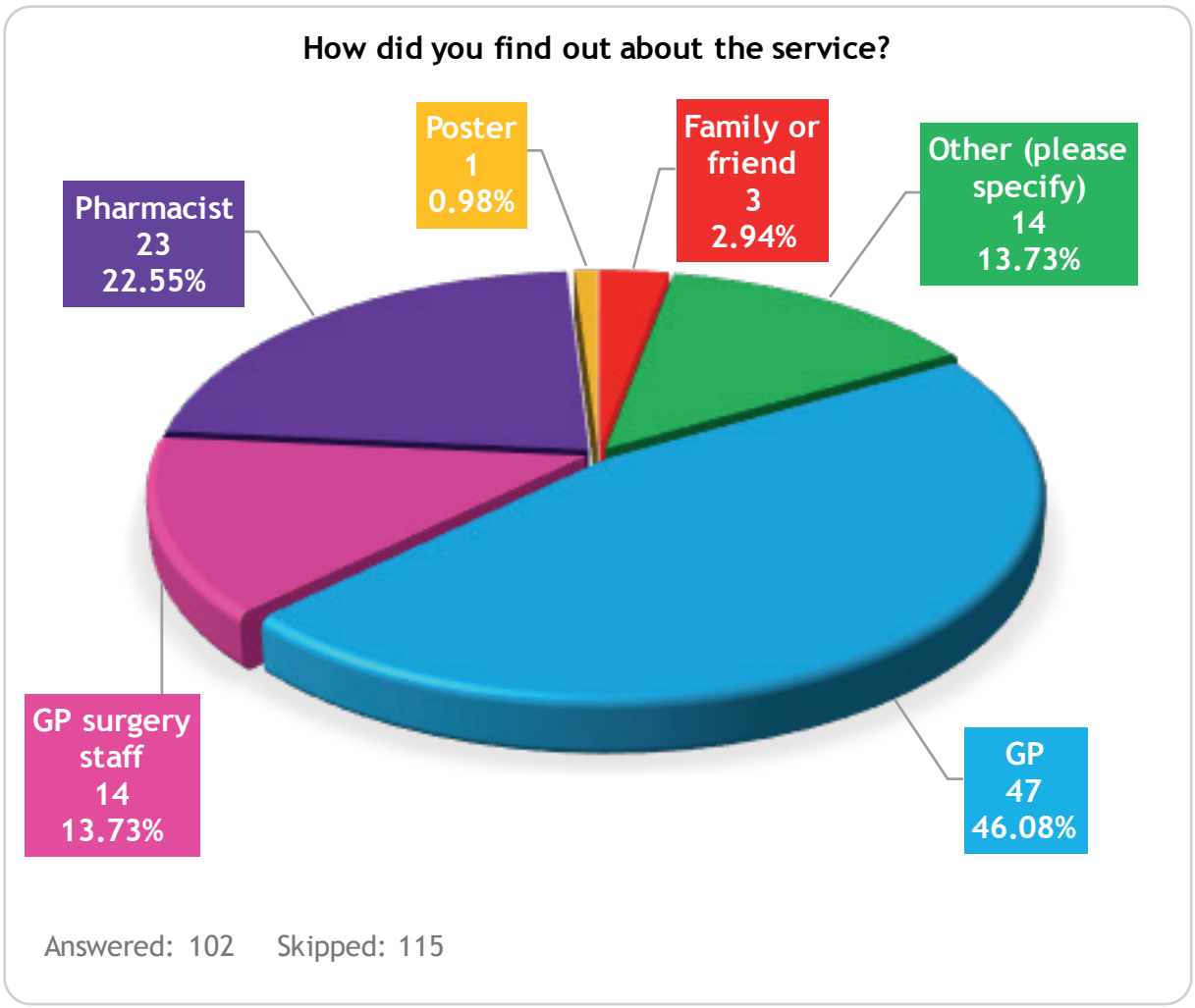


The survey responses appear to show a high level of awareness of the service, although it was clear when we were explaining to the public what the survey was about, that some respondents thought that the service was the same thing as being able to log in to their GP surgery website and order repeat prescriptions online.

The most common way people said they had heard about the EPS, as the next pie-chart shows, was from their GP or surgery staff (60%), compared with less than one-quarter saying they had heard it about from a pharmacist or pharmacy staff.

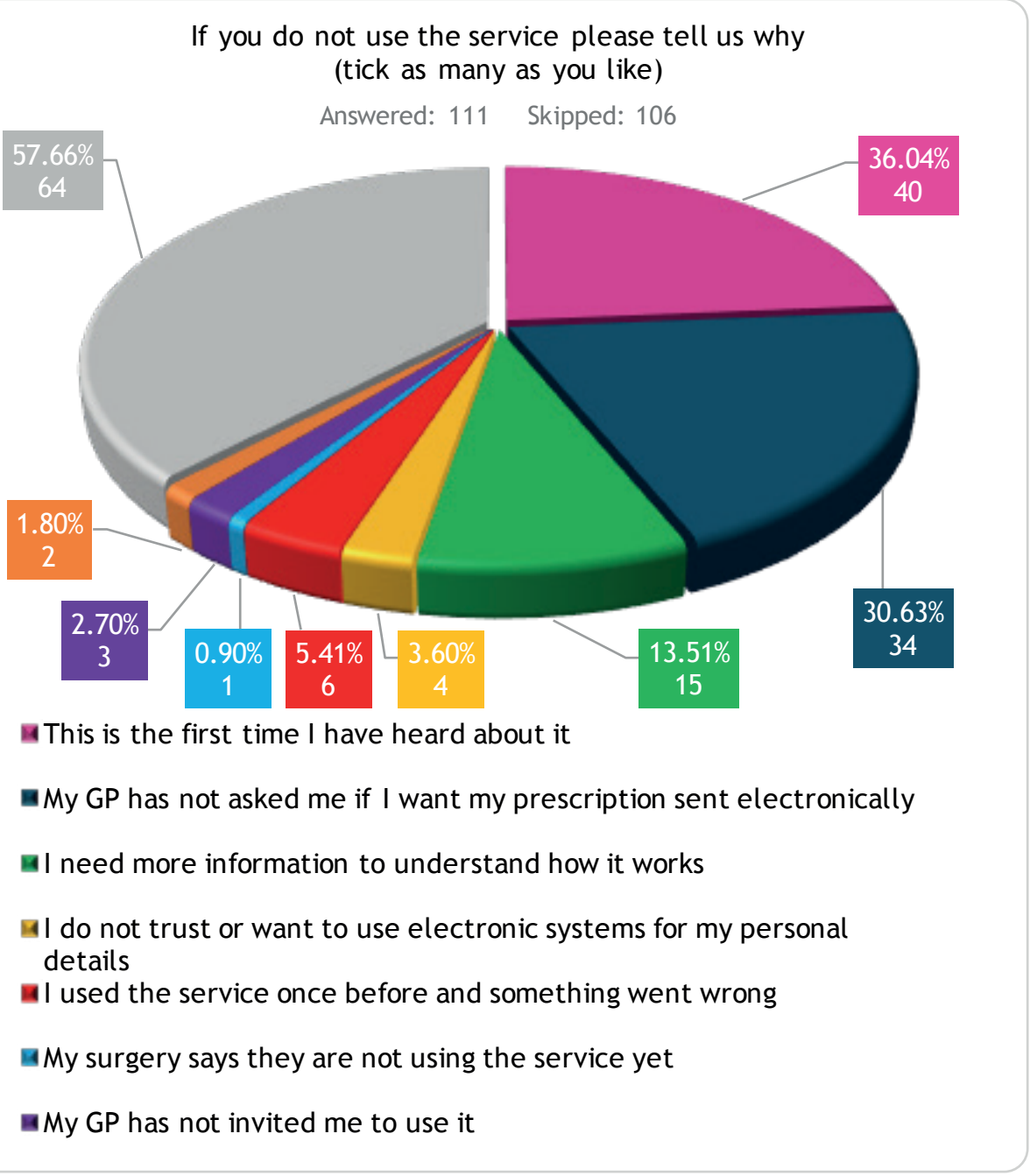
The number of people who said they used the service (52%) was less than those who said they knew about it, and again, we believe some respondents were thinking about online prescription requests, rather than the EPS.

More than one-third of respondents who said they did not use the EPS, said our survey was “the first time I have heard about it”. Other notable reasons, included ‘not having a computer’, mentioned by mostly older people, demonstrating a misunderstanding about the EPS. Some people mentioned that they liked to use more than one pharmacy, while two people commented that the EPS either could not be used by, or was not suitable for people needing more than four medicines at a time per description.



Section 2:

PATIENT VIEWS IN DETAIL



WHAT PEOPLE SAY...

"I hand in my request and collect prescription later in day because I am not computer literate."

"I wish my elderly parents could use it but they don't have a computer and are not very techie."

People's experiences of using the electronic prescribing service

We asked people to describe any good points about the service. We received 94 separate comments, mainly focusing on the convenience of EPS for people who are on regular repeat medications, because they don't have to make a trip to the surgery to collect a paper prescription and bring to the pharmacy.

WHAT PEOPLE SAY...

"It makes it quicker to collect prescriptions and avoids extra journey to the surgery."

"Saves a long drive to surgery and getting in and out of wheelchair if I am just going for prescription."

"The pharmacy makes the request and I don't have to go to the surgery. I go straight to the pharmacy to pick up my EPS prescriptions."

"Quick."

"Saves a lot of walking, not having to come into surgery, everything is delivered at home."

"I am vulnerable to infection, so welcome not having to be in contact with germs in the waiting area."

"Go directly to chemist, it saves hanging around at surgery and taking up time. Just very good."

"No risk of losing prescription."

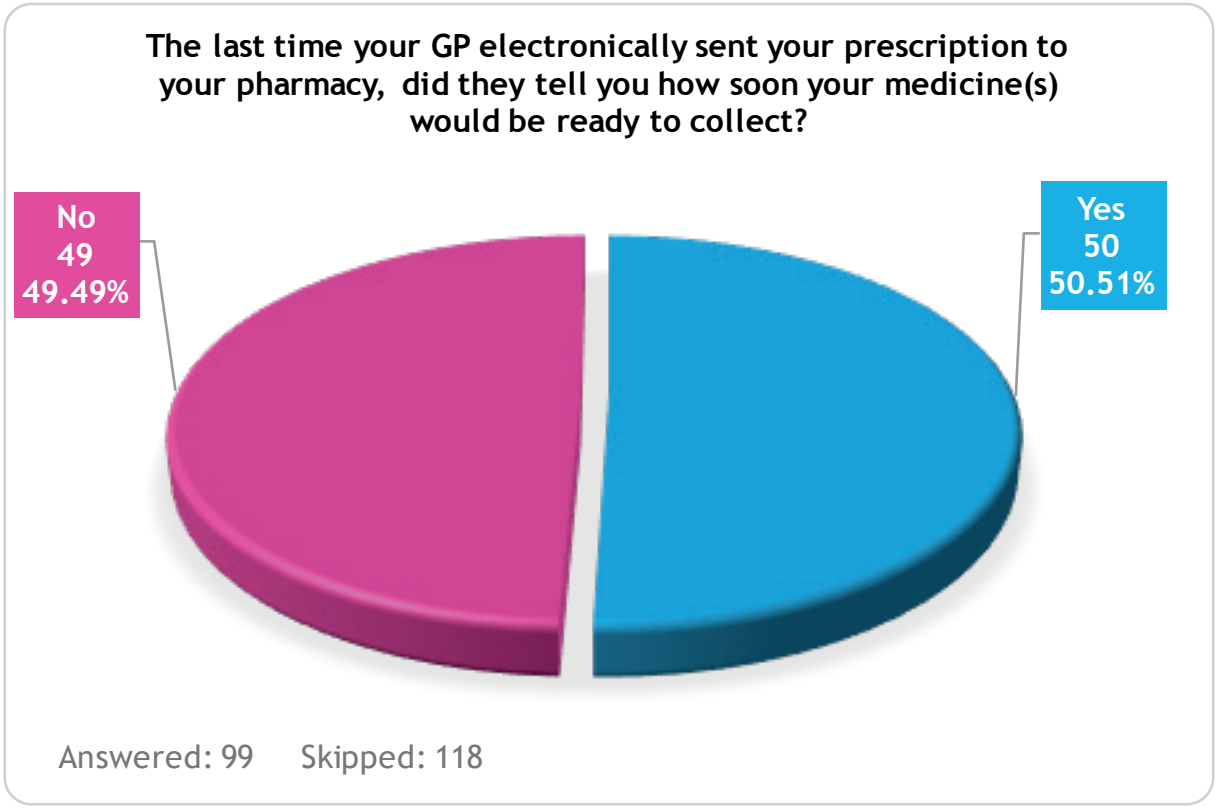
"I am very happy with it. If the medicine is not in stock, the pharmacist can place the order, avoiding extra visits [by patient] to the pharmacy. It has done away with hanging about waiting at the pharmacy."

"It is much more time efficient and easier than going to the surgery."

Section 2:

PATIENT VIEWS IN DETAIL

We also asked questions in our survey about whether patients were given any expectations about how soon their medicines would be ready to collect after their GPs electronically sent their prescriptions.



Half of the survey respondents said their GP had said something about how soon their prescription would be ready. This was mostly 'within 48 hours' or 'the next day', while eight people said they had been told that the prescription would be ready sooner – ranging from 'within the hour' through to 'this morning' or 'today'.

However just over half of people told us that their medicine had not been ready when they arrived to collect it, and this was a source of frustration for people who thought EPS was supposed to make the process smoother.

WHAT PEOPLE SAY...

"Frequently told [prescription] not received or not sent, both parties blame other."

"Had to wait for it to arrive and be processed - about four hours - went home in meantime."

"They were waiting to receive [prescription] from GP and [I] was given time to collect later."

"They usually don't get it ready before you ask for it."

"It was a right fiasco. I know the request was sent as my GP sent it to [pharmacy] whilst I was in my appointment. I went a couple of days later to collect it and they spent ages looking for it on the 'system'. After some time, about 20 mins, they said they had received it but didn't know where it was. They looked for it in the box on the counter where they are printed out but to no avail and seemingly they think it was printed out and prepared but had been lost. After about 30-45 mins and several discussions, they decided they would need to print it out again and re-issue the medication."

Section 2:

PATIENT VIEWS IN DETAIL

WHAT PEOPLE SAY...

"Usually ready and pharmacy texts [to inform patient that medicines are ready]."

"I don't see how this system saves me any time as each time I have gone to collect my prescription it has taken at least 15 minutes to find it on the system and then they still have to prepare the medication whilst I wait. I could save time by simply handing over a printed prescription to the pharmacy and them prepare it. I am also concerned that prescriptions are printed out and are in a box on top of the counter. Often staff are very busy and the counter is left unmanned and therefore confidential details are left unattended."

"It's the same performance if you take your prescription in by hand."

"The medicine was never there, I had to call ahead to ask for the items I wanted and the staff at the pharmacy just didn't know how to use the system except one person and if he wasn't in no one else understood. The problem is my surgery is in Reading but I use a pharmacy in Woodley where the doctor they mostly serve, doesn't use electronic prescribing."

"Works well for simple scripts but I also have a large amount of monthly repeats which they still do by paper. Not sure why this is, pharmacy said it did not work so well for them."

"I was not sure when it would be ready to collect so I went in on the off-chance to ask, and the pharmacist explained that it can take more than 24 hours to receive the request and process it. It impacted as I was waiting to start the medication."

Suggestions from the public on how to improve the electronic prescription service

We received 49 comments when we asked for any suggestions on improving the service, or any other feedback. People mostly wanted pharmacies to inform them when their medication was ready to pick up. People also wanted better training for pharmacy staff or GPs on using the system, and clearer explanation to the public on how EPS works, including how people can sign up to it. The responses also included 21 comments praising the service.

WHAT PEOPLE SAY...

"It [my medication] should be ready to pick up, or there's no point in the service."

"It is good when the pharmacist texts you to tell you your prescription is ready to pick up."

"Want it to be ready when I go to collect."

"If [the pharmacy] could notify me electronically it would reduce my contact with unwell individuals in the waiting area."

"Efficiency or training issues, or IT compatibility, need investigating. Can take days before prescription ready and end up returning to GP for paper copy."

"It would be good not only to have an 'accepted' or 'issued' message from the GP [to a patient's online request for a medication], but also a 'received' message from the pharmacy [and], wishful thinking, a 'ready for collection' message from the pharmacy."

"I'm not always clear about if I need to visit the pharmacy to acknowledge my prescription - sometimes I have to do that before items are ordered."

"If they could let me know an approx time when [medication] ready [to be picked up]."

"It may be useful to show a flowchart of how EPS works and the timings of each stage."

Section 3:

VIEWS AND INFORMATION FROM THE NHS

We heard from patients when we handed the questionnaire to them in person that they think of the service as being an immediate 'computer to computer' transfer of their prescription – from the GP surgery prescriber's screen direct to the pharmacy dispensary screen.

The conversations we had with NHS staff and pharmacists about EPS, revealed a more complicated reality, and we outline what we heard, in this section of our report.

Summary

The main points we heard:

- There is a lack of physical space in pharmacies, or enough staff, to prepare prescriptions in advance
- EPS training is not mandatory for NHS staff
- Locum pharmacists might not always have the 'smart card' they need to use EPS
- More awareness is needed that pharmacists can register patients to EPS, not just GPs
- Pharmacists are not allowed to alter prescriptions to synchronise start dates
- Some pharmacy computer systems are not set up to accept electronic prescriptions for controlled drugs
- There is a wide variation across Reading GP practices in the number of electronic prescriptions sent.

EPS: The national vision

Electronic prescribing has been rolled out in phases since 2005. Benefits for patients are set out by NHS England (on the web page https://digital.nhs.uk/eps):

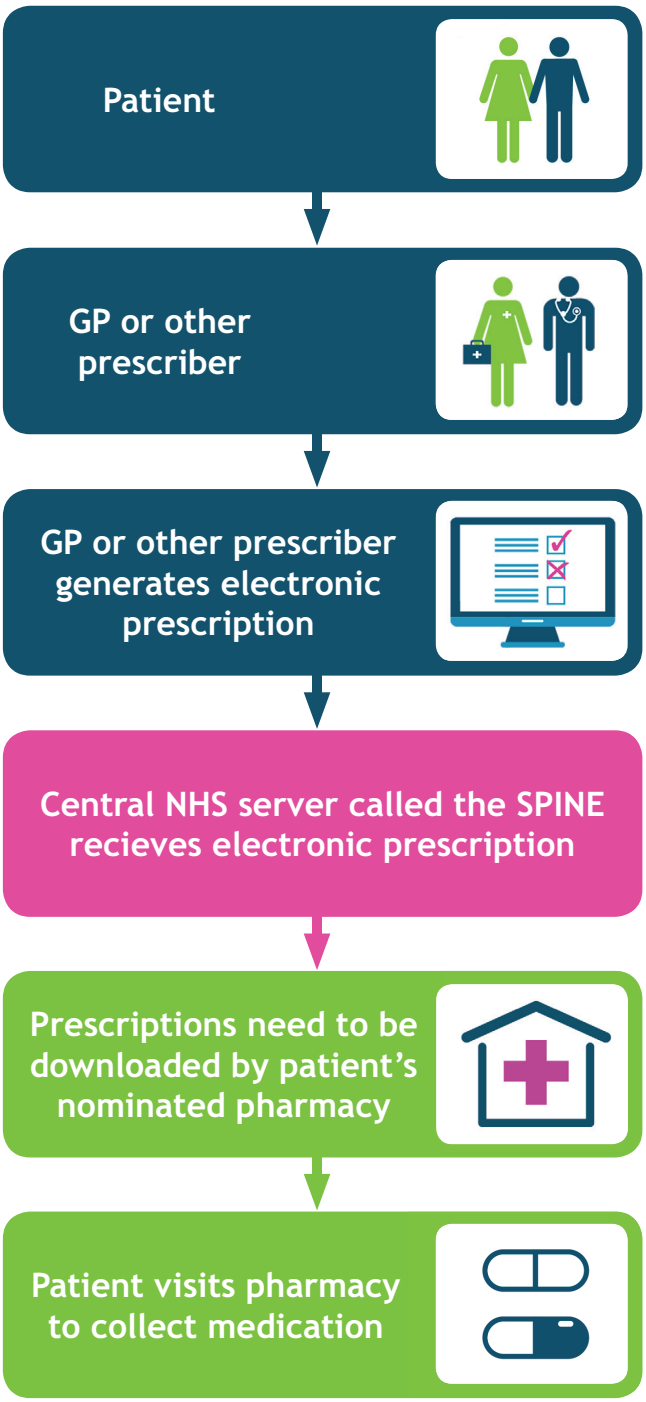
'If you normally collect repeat prescriptions from the same place, or if you collect them on behalf of someone else, you could benefit from the service

- you can collect repeat prescriptions directly from a pharmacy without visiting your GP
- you won't have paper prescriptions to lose
- you may spend less time waiting in the pharmacy
- the service is reliable, secure and confidential.

Further information is set out on the NHS Choices website (http://www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/eps.aspx), which describes how patients can sign up at either their GP surgery or pharmacy, and tell them which pharmacy they would normally like to collect their medication from.

Patients can also change the nominated pharmacy on a one-off basis so they can have medications sent to a pharmacy in another part of England, for example when they are on holiday.

Technologically, electronic prescribing is a two-stage process. First, the electronically signed prescription travels from the GP's computer to a central internet server known as the 'NHS spine'. Next the prescription must be downloaded from the 'spine' by the patient's 'nominated' pharmacy.



Section 3:

VIEWS AND INFORMATION FROM THE NHS

How EPS works in Reading

We gathered views and information from local professionals that shed some light on why patient experience varies with EPS.

With some pharmacies, downloads of prescriptions to their computer systems are automatic (sometimes happening overnight). The pharmacy may also schedule downloads of prescriptions by staff, or it may be that the electronic queue is simply checked at intervals during the day.

Once downloaded, we heard that many pharmacies print off the paper 'script', that the patient would otherwise have carried from the GP surgery to the pharmacy, and put it beside staff as they check and dispense the medicine. So overall, the process is not completely 'paperless'.

Some pharmacies have staffing capacity and lack the physical space to make up bags of prescription medicine and have them waiting for collection. They will make up the prescription only when a patient calls ahead, or comes in to check if it is ready. This means that the patient (or their carer) has to wait 10-15 minutes or longer for the prescription to be dispensed, as with a paper prescription carried to the pharmacy.

We heard that training of pharmacy staff to use the system is not mandatory, and is dependent on the organisation's commitment to invest in this.

Everyone who accesses the EPS system (NHS and pharmacy staff) needs a 'smart card', so that patient records are kept secure. We heard that in some pharmacies, locum pharmacists do not have a smart card and so cannot access the EPS system, and this can sometimes cause confusion and delays.

A medium-sized pharmacy might have a staff member spending two hours a day chasing queries about prescriptions by telephone – talking to GP surgeries and to patients. This is the same with EPS as it is with paper prescriptions. A potential benefit of EPS is that the form reaches the pharmacy more quickly after signing, and stock management can be more effective, meaning that some delays may be eliminated (e.g. patient calling in with a paper form, but an item is not in stock yet.)

Some NHS staff told us they think more could be done by pharmacies to promote awareness of the system, and the ability of pharmacists, not just GPs, to sign up patients to EPS.

EPS is especially useful, professionals believe, when it comes to batch prescribing. This is when a patient is on a stable drug regime and where it has been possible to 'synchronise' different drugs (e.g. instead of starting to use drug A on 1st of month and drug B on 22nd of month, meaning that the prescriptions are needed at different times in the month, everything is set up to be taken starting on e.g. 22nd of month, so only a single prescription is needed every month).

A patient can be set up with six or even 12 months of prescriptions in this way. By law, the paper 'top copy' (the first prescription) must be printed off and taken to the pharmacy. The remaining prescriptions in the batch can then be 'drawn down' electronically as required, and the patient liaises with the pharmacy about this. Previously, the patient would have to telephone or call in at the GP reception and ask for each prescription to be printed. The paper copy would then be collected by either the patient or a pharmacy. The EPS system saves time and means that there is a smaller chance of the prescription being lost at any point in the process.

We heard that the EPS system has no flexibility to allow a pharmacy to alter prescriptions so that the drug availability dates are 'synchronised' to a single date each month. This is because each prescription must be processed 'as signed by the GP', and this is linked both to assurance that the correct drug is being prescribed, and the payment system (both electronic and paper prescriptions are processed in the NHS for payment of a dispensing fee to the pharmacy).

We heard that a major issue limiting use of EPS relates to incompatibility of computer systems around controlled drugs (opiates and other potentially addictive drugs). It became legal and possible for controlled drugs to be prescribed through EPS nearly two years ago, and all GP computer systems are now set up for this – however many pharmacy computer systems are not. This can mean that patients get a mix of electronic and paper prescriptions, raising the risk of paper forms being lost, and the mix being less easy for GPs to monitor. Patients needing these controlled drugs include elderly people needing e.g. fentanyl pain relief patches, and people with terminal illnesses.

Section 3:

VIEWS AND INFORMATION FROM THE NHS

We also heard that if there are errors in the limited information on the NHS 'spine' about the patient, which then does not match the local record in the GP surgery (details such as name, NHS number, address, telephone number) then this means that the EPS system cannot be used for that patient.

Variations in EPS use by Reading GPs

Our research also found statistics that show a wide variation in the number of electronic prescriptions sent by GP practices. Rates among practices in North and West Reading Clinical Commissioning Group ranged from 2% to 88% (the best being Balmore Park Surgery) and in South Reading CCG, the number of electronic prescriptions sent was lower, ranging from 0% to 61% (the highest number sent from Grovelands Medical Centre). At the time, the national average was 53%.

The wider context

We also noted, while researching electronic prescribing, that there are a number of new national initiatives, which may affect the patient experience of obtaining prescription medicines in the future. These include quality payments to pharmacists and a potential reduction in the number of community pharmacies, especially where there are more than one in an area of one mile or less. More details can be found in the documents *Community Pharmacy in 2016/17 and beyond: Final package', the Pharmacy Integration Fund, and the Pharmacy Access Scheme*.

Electronic Repeat Dispensing

- Two thirds of prescriptions issued in primary care are repeat prescriptions.
- This accounts for 80% of NHS medicine costs for primary care.
- There are up to 410 million repeat prescriptions generated every year – equivalent to an average of more than 375 per GP per week.
- This could save 2.7 million hours of GP and practice time.
- Since July 2009 it has been possible to use repeat dispensing via EPS.
- 330 million or 80% of all repeat prescriptions could eventually be replaced with repeat dispensing.
- Called Electronic Repeat Dispensing (eRD) to differentiate it from paper based Repeat Dispensing.
- *Source: Maximising eRD Toolkit: https://www.digital.nhs.uk/article/913/Electronic-repeat-dispensing-for-prescribers*

Section 4:

DISCUSSION AND RECOMMENDATIONS

Reading people told us that they think the electronic prescription service is a convenient system that saves them an extra trip to the surgery to collect repeat prescriptions. However, they do not think it is working to its full potential and would like, in particular, pharmacies to notify them when their medication is ready to pick up. This is possible, as some people told us their pharmacy does text them to inform them of collection times.

There is some confusion among the public about how EPS works, with some people thinking it requires the patient to have a computer or to be computer literate.

Our research also highlighted some worrying variations in the use of EPS across Reading, meaning some patients are missing out on its potential benefits

Based on the evidence Healthwatch Reading collected, we are posing the following questions and recommendations to NHS England, which is responsible for overseeing pharmacy services. We also welcome any comments from Thames Valley Pharmacy, on behalf of local pharmacies, and Berkshire West CCG federation, which oversees GP services.

1. Why is there such a wide variation across Reading, in the number of electronic prescriptions sent? Is there a timetabled action plan in place to ensure all patients get the opportunity to register with EPS via their local pharmacy or GP, regardless of where they live in Reading?
2. Is it possible for pharmacies to be encouraged/or required to inform patients when their prescription is ready to collect, via a text message or other communication service? How can good practice in this area be shared?
3. We recommend a local communication plan that helps the public better understand what EPS is, and explains how and where they can sign up – including the fact they do not need a computer themselves and can also sign up at their pharmacy.
4. What action is or can be taken by NHSE to ensure all pharmacies' computer systems can receive electronic prescriptions for controlled drugs?
5. How can the issue of 'drug synchronisation' be addressed more effectively and by whom, to help patients?

Section 5:

RESPONSES

Local Pharmacy Committee

The LPC was delighted to work with HealthWatch Reading in the initial development stages of the project and is also pleased to have the opportunity to respond to the report. We have formulated our response based mainly on the questions posed at the end of the report.

1. Why is there such a wide variation across Reading, in the number of electronic prescriptions sent? Is there a timetabled action plan in place to ensure all patients get the opportunity to register with EPS via their local pharmacy or GP, regardless of where they live in Reading?

   There is a variation across the area as different GP practices adopted EPS at a different rates. Most community pharmacies adopted the system about four years ago and were trained at that time but, due to a lag in the adoption by GPs, the pharmacies became deskilled due to a lack of experience with the system. The LPC is working now with the local CCGs to increase the awareness of EPS, refresh the training and encourage pharmacies and GP practices to work together to resolve the issues. Most GP practices are now live with the system and as they start to process more and more of their prescriptions in this manner, the pharmacies will develop their systems to cope with the change in working practice. The system has been trailed as a "paperless" system but that is not the reality – it has, for now, simply moved the printing of the prescription from the GP surgery to the pharmacy. Part of the issue is that pharmacy teams still like to have a paper prescription to dispense and check against but this could change with changes in working practice. However, at present, the pharmacy is still required to obtain a patient declaration of exemption (except age exemptions) or record payment of prescription charges and this requires the prescription to be printed off and the declaration signed by the patient and then sent to the NHS for fraud checking purpose. Until this requirement changes the process will never be paperless.

2. Is it possible for pharmacies to be encouraged/or required to inform patients when their prescription is ready to collect, via a text message or other communication service? How can good practice in this area be shared?

   There is no contractual requirement for pharmacies to contact the patient to inform them that their prescription is ready but we do note from the report that some pharmacies are offering this as a service to their patients. We can see the benefit of

this to patients but there would be a cost involved for the pharmacy in both time and money and at a time when the Government is reducing the income of community pharmacies it is unlikely that any pharmacy would take on an additional cost burden if it was not part of their contract. Pharmacies will tell patients how long a repeat prescription will take to be ready from time of ordering – there is a delay while the surgery processes and signs the prescription and then the pharmacy needs time to dispense and check the prescription. Many surgeries will ask for 48 hours' notice of a prescription request but the local pharmacy can advise their patients of the likely timescale. Patients who would value a notification should speak to their individual pharmacy and see if that is an option. Patients could also phone their pharmacy and give them notice that they were planning on coming to collect their prescription at a given time and this would allow those pharmacies with limited storage space the time to make sure the items were ready for collection.

3. We recommend a local communication plan that helps the public better understand what EPS is, and explains how and where they can sign up – including the fact they do not need a computer themselves and can also sign up at their pharmacy.

   This is part of the work being done locally by the project team which includes the LPC and representatives of the commissioning support unit and GPs. We hope to raise awareness among patients, surgery staff and pharmacy teams and also to drive up the number of patient nominations.

4. What action is or can be taken by NHSE to ensure all pharmacies' computer systems can receive electronic prescriptions for controlled drugs?

   The legal changes that were needed to make this happen are now in place but it has taken some time for the system suppliers to make the changes to the systems which they provide to pharmacies. The issue is frustrating for patients, pharmacists and GPs and the LPC has been encouraging pharmacists to raise a complaint with their supplier. We hope that a solution is imminent.

5. How can the issue of 'drug synchronisation' be addressed more effectively and by whom, to help patients?

   The LPC agrees that it is frustrating for all concerned that pharmacists cannot make these simple changes to make the process easier for patients. However, currently this would be illegal and would put the pharmacists in breach of their contract. What can be done is that the pharmacist

Section 5:

RESPONSES

can conduct a medication use review with the patient – this is a free NHS service- and can then make recommendations to the GP but this does rely on the GP implementing the recommendations. We hope that, in the future these simple tasks will be a part of the pharmacy contract. For now, the action needs to happen in the GP surgery- those surgeries who are now employing their own pharmacists may use them to undertake this task.

The LPC would like to reiterate its' thanks to HealthWatch Reading for shining a spotlight on Electronic Prescribing and for raising awareness across the area.

Carol Trower,

Chief Office ,

Pharmacy Thames Valley.

Representing Community Pharmacies across Berkshire and Oxfordshire.

NHS England

Awaiting response...

ACKNOWLEDGEMENTS

Healthwatch Reading thanks:

- the patients who completed the survey,
- others who contacted us to give feedback about prescribing,
- Patient Participation Group members,
- South Reading Patient Voice (with special thanks to Caroline Langdon),
- North & West Reading Patient Voice,
- GP Practice managers,
- GP surgery staff and GPs,
- pharmacists and pharmacy staff,
- clinical commissioning group staff
- and other NHS staff who shared their expertise and views with us, and helped with promoting the survey.

Healthwatch Reading also thanks Carol Trower, Chief Officer of harmacy Thames Valley, for her invaluable help at the outset of this project, and Sanjay Desai of the NHS Berkshire West Medicines Optimisation Committee for his advice and assistance.

APPENDIX 1

About the people who answered our survey

Add demographic info in HWR format:

- 59% F and 41% M
- Good mix of ages, from 18-24 to 85+, with about 30 in each age category from 25-34 to 75-84
- 67% white British, 5% other white, 28% Asian, 8% black African/Caribbean, 7% other

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acre
alliance for cohesion and racial equality

Update Report: Acre's Female Genital Mutilation (FGM) Community Engagement Work & Progress towards Creation of the Rose Centre, Reading

This report provides a summary of developments in relation to Strand 1 since the previous report was submitted to the Health and Wellbeing Board in October 2016.

Précis

In June 2015 Acre's 2 pronged proposal to start tackling FGM locally was adopted as a priority by the Local Strategic Partnership.
Strand 1: Prevention & Education led by Acre
Strand 2: Protect & Respond led by RBC.

Acre conducted in depth community engagement and needs assessment, the findings showed significant need and numbers of practising communities and a lack of understanding of FGM locally in general.

Our recommendation was for a specialist FGM centre in Reading.

Acre envisaged a holistic support programme: supporting survivors' wellbeing in addition to clinical needs; a prevention programme to safeguard girls at risk through tackling the taboo and generational cycle; and a resource centre with helpline to address the lack of confidence in dealing with FGM.

There are 2 Rose Clinics in operation, in Oxford and Bristol which support the medical needs of survivors. Both offer very successful and much needed services.

Acre created a Business Plan for the Rose Centre, Reading, for which the Office of the Police & Crime Commissioner and the Berkshire West Clinical Commissioning Groups gave their support in June 2016. The parameters have been widened so in time the Rose Centre will service the whole of Berkshire.

The Rose Centre will be the first of its kind: Innovative and exemplary and a centre of excellence for Berkshire. The desired time frame for opening is April 2017.

Progress Achieved & Current Position

Acre has secured the funding to continue the community engagement work in the run up to the forthcoming Rose Centre and can now promote the Centre. Acre now has the funding to facilitate further community participation in the planning of the service, firmly placing community voice at the centre of the project. Funds have been given from the Office of the Police and Crime Commissioner and NHS England.

The 'Plan of Action' referred to in 4.4 of the Report dated 7th Oct, is now in action! We have recruited 4 new community advocates who are taking the message into their communities. We have had a steady response to our questionnaires, and are now collating info of around 30 survivors by postcode area. There is no such local intelligence to date.

Within some of the practising communities accessing any type of service or support for FGM is incredibly taboo. In the beginning Oxford Rose Clinic saw 2-4 women a month . Understanding the slow burn nature of FGM services, the key is word of mouth, which takes time. By facilitating community participation in preparations for the Rose Centre this gives a sense of ownership to the communities it is meant to serve, plus ensures that the programme reflects what service users truly want and need. Thus securing the Rose Centre's optimal reach and value from the get go.

Securing the main body of funding for the Rose Centre is now pivotal. Two potential funds have recently opened under the Violence Against Women and Girls Strategy:
The Service Transformation Fund and the Tampon Tax Fund.

Acre will be applying in partnership with the Office of the Police and Crime Commissioner and the Berkshire West Clinical Commissioning Groups to the Service Transformation Fund, with the bid being led by one of the commissioning bodies. Acre will also apply for the Tampon Tax Fund. Successful grants will be awarded in Spring and Summer respectively.

If successful the Rose Centre will be fully funded for 3 years.

Summary Report for Reading Health and Wellbeing Board

January 2017

Name of Report	Establishing Clinical Response for Adults who have suffered Female Genital Mutilation (FGM)
Author of Report	Liz Stead
Organisation	Berkshire West Federation of CCGs
Date of Report	4th January 2017
Date of Meeting	27th January 2017
Subject Information	This summary report will give an overview of the current arrangements for physical and/or psychological support for survivors of FGM and outline the proposed plan for the development of services in this area. **<u>Current situation</u>** At present, almost all known cases of FGM in the West of Berkshire are identified through RBH maternity services, either by disclosure at booking and/or subsequent antenatal appointments, or by visual identification when the woman attends in labour. For those women identified in the antenatal period, they are seen in routine clinic appointments as there is currently no separate service for issues around FGM. This has a significant impact on the functioning of the clinic as complex issues take time to deal with. In addition to this, the issues of the woman's FGM relating to her pregnancy can be addressed, but any issues outside of this, e.g. psychology, will not be addressed. In addition to this, there is currently no provision for supporting women who are not pregnant but have issues relating to their FGM. There is a lack of identification of these women generally in Primary Care, for several reasons: • Women with FGM are poor attenders for female-related health issues • They are aware of the stigma around the subject and are worried they will get into trouble • They are not aware that they could be referred for help e.g. pain management or urology issues, so they endure these conditions • Practitioners are not skilled in asking the question about FGM, identification or what to do if they identify a patient who has it Reading has been identified as a potential 'hot-spot' for FGM and based on census data, prevalence amongst practising communities is predicted to be high. This would therefore suggest a major unmet health need in women who have experienced FGM. However, the issues are wider than health

	– the practice of FGM is illegal and is a major safeguarding concern. It is usually carried out on pre-pubescent girls (average age 4-8 but can be performed at any age from birth to adulthood) and is often carried out by non-medical members of communities, without anaesthetic, with rudimentary implements and using force to restrain the child. **<u>What needs to change</u>** In order to address issues around FGM partners must take a holistic standpoint to consider all aspects of the consequence of FGM such as health issues, but also including criminality, repercussions in the community, intelligence gathering, as well as challenging the cultural perspective of the practice. We have to be mindful that practising communities have been carrying out FGM for many hundreds of years but there is no religious foundation for the practise; it is about controlling female sexuality. Tackling FGM raises awareness of other BME issues such as: • Forced marriage • Honour based violence • Modern slavery and trafficking • Private fostering **<u>What is proposed – Reading Rose Centre</u>** Working in collaboration with: • CCGs • NHS England • Alliance for Cohesion and Racial Equality (ACRE) • Police and Crime Commissioner • Reading Borough Council Plans are moving forward to establish 'Reading Rose Centre' which will be based at Oxford Road Community Centre (ORCC). This would be a 'one-stop-shop' for communities around addressing the issue of FGM and other BME issues, but also to access services such as English as a Second Language, back to work skills, etc. The ethos of the centre will be to open the doors to BME communities to provide them with a voice to empower of issues of inequality such as control and violence against women and girls. There have been many months of discussion around the availability of funding for Rose, and although partners are committed to contributing to the project, the current squeeze on budgets has led to some delays in realisation of the project. A business plan has been written and disseminated to

	partners outlining the figures needed to be able to provide the bespoke service required. NHS England have already contributed a one-off amount of £15k and PCC have committed a figure for contribution for the next 3 years. Despite this, there is still a considerable shortfall in the amount needed to set up Rose and keep it going for a minimum of 3 years. However, in December 2016, the Home Office launched their funding strategy for Violence Against Women and Girls Transformation Fund which can be found at Appendix 1. Funding can be requested in 2 tranches: • Requests by statutory partners • Requests by voluntary and community organisations Joint requests are considered favourably. In Reading, statutory partners are working cohesively with ACRE in this regard. The plans for Reading Rose satisfy virtually all of the requirements for this funding. We have entered expression of interest/intention with details of our vision for Reading Rose. Our hope is that as Reading is identified as a hot spot that the proposal will meet favourably with the Home Office requirements. We will learn by the end of March 2017 if we have been successful.
Discussion	We would like members to consider the wider impact of a bespoke service and ideally support the vision for a 'centre of excellence' for BME issues, initiated by the need to tackle health inequalities around FGM, but driven by the significant criminal, social and safeguarding consequences faced by the BME population. This is our vision for Reading Rose Centre. It is also important to be aware that in the event we are unsuccessful in our bid for government funding, discussions need to be swift in finding a contingency plan.
Recommendations	• That the report is noted by the HWB • Further update on progress of Reading Rose for the next HWB

Home Office

Violence Against Women and Girls Service Transformation Fund

Prospectus

December 2016

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at VAWGFund@homeoffice.gsi.gov.uk

Or

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“Any act of gender-based violence that results in, or is likely to result in physical, sexual, psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.”

United Nations Declaration on the Elimination of Violence Against Women (1993)

Violence Against Women and Girls Service Transformation Fund

Violence against women and girls (VAWG) can shatter the lives of victims, their families and those closest to them. These crimes also have a huge impact on our economy, our health services, and the justice system.

Protecting women and girls from violence, and supporting victims and survivors, is a key priority of this Government.

In March 2016 we published the Violence Against Women and Girls Strategy, which sets out an ambitious programme of reform, supported by increased funding of £80m, to make tackling these crimes everybody's business, ensure victims get the support they need, and bring more perpetrators to justice.

We are helping to end violence at home and abroad by allowing women to check their partner's criminal history, introducing domestic violence and stalking protection orders, criminalising forced marriage and prioritising women and girls in our work overseas.

The purpose of the funding

VAWG services are mainly commissioned at a local level by Police and Crime Commissioners (PCCs), local authorities and health commissioners. A framework of central funding currently supports local commissioners and service providers.

To support the Government's commitment to tackling VAWG, we have pledged £80million in funding until 2020. This will help to deliver our goal to ensure a secure future for national helplines, rape support centres, refuges and other critical services, whilst driving a major change across all services.

From 2017, this funding will also support the launch of a £15million, three-year VAWG Service Transformation Fund to aid, promote and embed the best local practice and ensure that early intervention and prevention become the norm. We will make sure victims get the help they need when they need it, and that no victim is turned away. We know that these crimes are disproportionately gendered, which is why our approach is framed within a violence against women and girls strategy. However, we intend to benefit all victims of these crimes, and so proposals supporting men's services will not be excluded from consideration.

We will move from a model of direct national match-funding for individual posts to one of supporting vital community-based services through funding local programmes which complement and add to existing services, encouraging better collaboration and new, joined-up approaches between PCCs, local authorities and health commissioners, and with specialist VAWG service providers. These programmes should be based on needs assessment evidence, and incorporate early intervention; establishing and embedding the best ways to help victims and their families; and taking steps to reduce the prevalence of these crimes.

To ensure all VAWG victims and survivors get the right support at the right time, we have set out a clear blueprint for local action though a new National Statement of Expectations (NSE). The VAWG Service Transformation Fund is intended to support VAWG programmes and approaches to make a systemic change to local service provision to help deliver against this.

The support offer

We will provide grants to successful bidders, paid under Government's grant-making powers. We are looking to award a total of £15million across England and Wales by the end of the 2019-20 financial year. Bidders should consider this when deciding upon the size of grant they will be applying for.

Grants will be awarded to local commissioners, be they PCCs, local authorities or health commissioners, across England and Wales. Due to the collaborative nature of the fund, we strongly encourage consortium bids incorporating larger and smaller organisations, and expect that most bids will geographically cover at least one commissioning area, and a range of services.

Grants will be paid per financial year, with the option of renewal annually. Bids should cover the three year period of the fund, and renewal will be dependent on achievement of annual milestones. We will require biannual (twice a year) progress reports against these milestones, on which continued funding will be conditional. We do not necessarily expect system reform from day one – initial deliverables might include research, prototyping, delivering and evaluating before deciding how to scale up or out. The Home Office will pay grants to the lead Senior Responsible Owner (SRO) in arrears, though in certain circumstances we will consider paying up to 25% of that year's grant up-front where an acceptable case is made. Commissioners will have their own financial arrangements with the partner organisations forming part of their bid.

Successful bids' aims must contribute to the achievement of the overall outcomes of the fund, in line with the NSE. They will;

- display collaborative leadership and partnership working
- provide a service which would not otherwise have been provided without this funding (single purpose funding proposals for national helplines, rape support centres and refuges are therefore likely to be out of scope for this Fund)
- show how they will incorporate monitoring and evaluation into their project.

We would also expect successful projects to produce and disseminate shared learning materials, and are asking for proposals to include a suggested approach to doing this.

Eligibility

In order to be considered for funding, bids must meet the following eligibility criteria;

- Project must be based in England or Wales.
- Applicants must be able to provide the necessary leadership to deliver transformational change in a local area.
- There must be a clearly identified lead local area responsible, so bids must name a SRO from a PCC, local authority, or health commissioner (or Welsh local health board).

- The lead body for the project must show how they will link up with PCCs, local authorities and health commissioners/boards, and with specialist VAWG organisations in the area as appropriate.
- Bids must comply with Home Office financial guidelines.
- Grant applied for must represent no more than 25% of the applicant's collective annual income.
- Applicants must have been in operation for at least six months.
- Successful bidders must be transparent in relation to grant use.
- Bids' aims must contribute to the achievement of the overall outcomes of the VAWG Service Transformation Fund, in line with the NSE, and deliverables must meet the essential assessment criteria.
- Individuals using services provided by the Fund must be a minimum of 13 years old.
- Bids must explain arrangements for safeguarding vulnerable children and young people as part of their planned activities (where this is applicable).
- Applicants may submit more than one bid, as long as they are registered separately.
- In making a final decision, we will take steps to ensure that an appropriate distribution of projects are funded; geographically, by type of VAWG, and by stage and type of intervention.

The application process

The purpose of the Prospectus is to help inform the content of your bid and allow you to build your relevant partnerships in advance of formal application. We will initially be inviting expressions of interest before opening up the formal application period in the New Year. You will then be able to register and formally apply to the Fund.

Expressions of interest

We will be inviting expressions of interest for the fund from December 2016. Applicants will be asked to fill in a short expression of interest form highlighting the key points of their bid available. During this period we may contact you for more information on your bid, and you will have the opportunity to ask clarification questions.

Formal application

We will be issuing guidance on the application process, and publishing the application form, in due course, with the formal application period opening in early 2017 for four weeks.

Applications should include;

- An outline of the proposal
- A short statement of how the proposal meets each of the assessment criteria
- A project plan up to March 2020, including key deliverables for each year.
- Contact information for the SRO and a deputy contact

Assessment criteria

We will assess proposals against a range of criteria. Applicants should ensure that their answers are clearly evidenced.

1. Outcomes

Bids must show how the outcomes of their project will contribute to the achievement of five of the seven strategic aims of the fund listed a) to g) below, in line with the National Statement of Expectations. Project outcomes should be linked to local needs assessment evidence.

a) Victims, survivors and their families can access the right support at the right time.
b) Perpetrators and potential perpetrators of VAWG are prevented from (re)offending, through specific intervention projects or through more perpetrators being brought to justice.
c) Sufficient services exist for all demographics, and no one is turned away from accessing critical support services appropriate to their situation.
d) Fewer victims will reach crisis point and need refuge.
e) The needs of victims and survivors with the most complex needs or experiencing multiple disadvantages are met.
f) Future interventions and commissioning decisions are informed by robust evidence.
g) There is increased awareness so that VAWG is seen as 'everybody's business', and everybody knows the contribution that they can make.

<u>Essential Criteria</u>

Bids will need to show a good demonstration of how they meet each of the below essential criteria in order to proceed.

2. Partnership working

Incorporate multi-agency working and collaborative leadership with a range of effective local partners. This might involve shared facilities, services and information. Provided the bid continues to deliver against its stated outcomes, the make-up of the partnership may be adjusted over the course of the funding period, for example to optimise effectiveness, value for money or to reflect changing circumstances.

3. Need and Additionality

Provide a service for which there is a local requirement and which would not have been provided without this funding; meeting new challenges, such as those arising through technology and the internet, and/or responding more effectively to existing challenges. Services will not already be covered by national funding, e.g. national helplines, refuges, and rape support centres.

4. Monitoring, evaluation and shared learning

Effectively monitor and evaluate funded projects and services, to contribute towards the creation of a robust, global evidence base and share best practice learning, for example through toolkits or case studies.

Bids will then be assessed against the following deliverables, and how well these link with the project aims and expected outcomes:

5. Project deliverables

a) Use a sustainable, multi-agency approach to:
   - Understand the local area, making best use of available data and knowledge to assess the needs of victims, survivors and their families (including those of the local demography, BME individuals and those with complex needs) and/or the risks posed by perpetrators to formulate local strategies or help fulfil a national need;

- Map local resources and funding streams, pool budgets to make best use of available resources;
- Link into other programmes of support, unlock further investment for example through match funding.

b) Be locally-led but provide access for a diverse range of service users. To include those from outside of the local area (collaborating across local authority and service boundaries as necessary), and 'hard to reach' groups where gaps in provision may occur, such as 16-18 year olds.
c) Increase local awareness of issues and engage and empower communities to seek, design and deliver solutions to prevent and address VAWG.
d) Provide early intervention and support
e) Link up with services that support vulnerable people across the board, to provide access to integrated pathways of support, particularly for those with complex needs or facing multiple disadvantages.
f) Meet users' needs throughout their journey, including long-term needs.

6. Ability to deliver

Bids must set out the experience of the partnership in delivering similar projects and provide information on the team and resource allocated to the project. The submitted project plan will also form part of the marking.

7. Value for money

The Government is required to ensure that funding delivers value for money – bids must demonstrate how they will provide additional outcomes over and above current provision. We are interested in high quality outcomes as well as efficient delivery. Highlighting how value for money is being achieved will include illustrating economy and efficiency through minimising costs and maximising outputs. Also consider how this funding could leverage additional investment and provide economies of scale. Applicants will be sent a budget template for these purposes, and should produce a summary of the impact that the funding will achieve. We will reject bids which demonstrate poor value for money (costs exceed benefits).

Scoring

We will use a 0-5 scale for each of the criteria, where 0 represents no demonstration and 5 represents an excellent demonstration. Criteria will be weighted as below:

1. Outcomes (30%)
2. Partnership working (10%)
3. Additionality (10%)
4. Monitoring, evaluation and shared learning (10%)
5. Project deliverables (20%)
6. Ability to deliver (10%)
7. Value for money (10%)

In making a final decision, we will take steps to ensure that an appropriate distribution of projects are funded; geographically, by type of VAWG, and by stage and type of intervention.

The Home Office reserves the right to accept proposals in part or in full.

Timetable

Prospectus launched	December 2016
EOI period, formal application form and guidance published	December 2016/January 2017
Application window open	January/February 2017 (four weeks)
Registration deadline	February 2017 (one week prior to application window close)
Announcement of successful bids	March 2017
Allocation of grants	From April 2017
End date of Fund	31st March 2020

Please send any queries to VAWGFund@homeoffice.gsi.gov.uk

REPORT FROM NORTH & WEST READING CLINICAL COMMISSIONING GROUP (NWRCCG) & SOUTH READING CLINICAL COMMISSIONING GROUP (SRCCG)

TO:	**READING HEALTH AND WELLBEING BOARD**		
DATE:	**27 JANUARY 2017**	**AGENDA ITEM:**	**12**
TITLE:	**A&E Delivery Board & Improvement Plan**		
LEADS:	Dr Andy Ciecierski Maureen McCartney	**TEL:**	0118 982 2917 0118 982 2956
JOB TITLE:	Chair, North & West Reading CCG & Urgent Care Clinical Lead for Berkshire West CCGs Operations Director North and West Reading CCG	**E-MAIL:**	aciecierski@nhs.net m.mccartney@nhs.net

PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this paper is to brief the HWBB on:

- The role of the system wide Berkshire West A&E Delivery Board in ensuring delivery of the NHS constitutional standard that no patient should spend more than 4 hours in an A&E department from arrival to admission, transfer or discharge
- Progress on delivery of the local A&E Improvement Plan which is designed to support recovery of the standard at the Royal Berkshire Hospital

Performance against the 4 hour constitutional standard is a barometer of flow across the health and social care system and requires each part of the system to work in partnership to deliver their respective contributions to recovery of the target.

A copy of the latest version of the Improvement plan is attached at Appendix 1 and a copy of the Terms of Reference of the A&E Delivery Board is attached at Appendix 2.

The paper also provides an update on actions agreed in response to the Healthwatch report "A week IN A&E" which was considered by the HWBB in Oct 16.

RECOMMENDED ACTION

The HWBB is asked to note:

1. The rationale for the establishment of the A&E Delivery Board in September 2016, its core purpose and membership
2. The requirement to have an A&E Improvement Plan, its content, progress to date against the 5 key interventions recognised nationally to be best practice, and a number of additional actions agreed at 2 system wide "Round Table" events held in July and September 2016, which were chaired by the Chief Executive of the Royal Berkshire Hospital.
3. The close link between the Better Care Fund Requirements in relation to action required to reduce Delayed Transfers of Care and the A&E Improvement Plan
4. Progress on actions agreed in response to the HealthWatch Report " A Week in A&E"

POLICY CONTEXT

Local Health and Social Care Systems are together responsible for ensuring delivery of the NHS constitutional standard that no patient should spend more than 4 hours in an A&E department from arrival to admission, transfer or discharge.

Prior to September 2016 the Berkshire West Urgent Care Programme Board comprising partners from health and social care across Reading, West Berkshire and Wokingham had oversight of delivery of this standard. Performance against the standard over the last three years is shown in the next section. Performance during 2016-17 has been very challenged and the target has not been consistently achieved in Berkshire West since quarter 3 2015-16

National concern about the drop in performance against the standard led to a tri-partite letter dated 28th July 2016 from NHS Improvement, NHS England and ADASS (Association of Directors of Adult Social Care) to CCG Accountable Officers, Provider Chief Executive Officers and Local Authority Chief Executive Officers outlining plans for the recovery of performance against the constitutional standard.

The letter highlighted the disappointing performance against the standard over the previous six months in the south region and how too many patients were waiting too long for the treatment they need.

The letter called for a much greater focus on improvement and refreshed local leadership arrangements to encourage whole system focus and accountability as well as new regional oversight arrangements. It asked that all Urgent Care Programme Boards/System Resilience Groups be transformed into Local A&E Delivery Boards who would focus solely on Urgent & Emergency Care and be attended at Executive level by member organisations.

The Berkshire West A&E Delivery Board had its inaugural meeting on 22 September 2016. Its membership comprises senior clinical and managerial decision-makers from across the Berkshire West system (including mental health representation) with the authority to commit to decisions on behalf of their organisation. The new Board took immediate responsibility for;

- Recovery of the NHS Constitutional standard that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E
- Delivery of the 5 National Mandated Improvement Actions to restore A&E performance
- Delivery of the local A&E Improvement Plan.

The Board also took responsibility for delivery of other key actions agreed at 2 "*Round Table"* events held in July and September 2016 which were organised by the Chief Executive of the Royal Berkshire Hospital in response to the pressures within the Trust at that time which required a whole system focus and urgent action.

The Board reports to the Berkshire West CCGs QIPP and Finance Committee each month in order to provide assurance that it is effectively discharging its delegated responsibilities. Partner Organisations are required to have their own reporting arrangements.

PERFORMANCE AGAINST THE NHS CONSTITUTIONAL STANDARD

A&E 4 Hour Standard

Performance against the A&E 4 hour standard over the last three years is shown in the table below. This shows that performance in 2016-17 has been very challenged and the target has not been consistently achieved since quarter 3 2015-16. Performance over Christmas, New Year and into mid Jan has been particularly challenging with the Trust delivering the target on 7 days during the period 20th Dec to 16th Jan and falling below 90% on 12 days.

	Q1 Performance	Q2 Performance	Q3 Performance	Q4 Performance	Yearly Performance
2014/15	95.8	94.9	94.5	92.4	94.4
2015/16	95.9	95.9	95.0	90.2	94.2
2016/17	93.2	91.9	92.4	85.4% (QTD)	92.1 (YTD)

The A&E Delivery Board has recently agreed a proposed trajectory for performance in 2017-18 and this has been submitted to NHS England as part of the CCGs Operating Plan submission. The trajectory, shown below, is felt to be challenging yet realistic and will rely on system partners fully delivering on all elements of the agreed improvement plan.

Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
93.1	94.3	94.3	93.8	95.0	93.2	94.2	94.3	93.1	93.8	93.8	93.8
Q1 - 93.93			Q2 - 94.00			Q3 - 93.89			Q4 - 93.8		

THE 5 NATIONAL MANDATED IMPROVEMENT ACTIONS TO RESTORE A&E PERFORMANCE AND THE LOCAL A&E IMPROVEMENT PLAN.

The five mandated improvement initiatives which have been developed by experts in the field of emergency care cover the following areas:

1. Streaming at the front door to ambulatory and primary care
2. Improved Flow
3. Improved discharge process
4. NHS 111 calls transferred to clinicians
5. Ambulance Service

One of the first actions taken by the new Board was a baseline assessment of its position relative to the these actions and this was then used as the basis for development of the Berkshire West A&E Delivery Board Improvement Plan which contains both the five mandated actions and the local priorities emerging from the 'Round Table' events.

The attached plan which is "rag rated" and updated at each Board meeting confirms the latest position and shows the following:

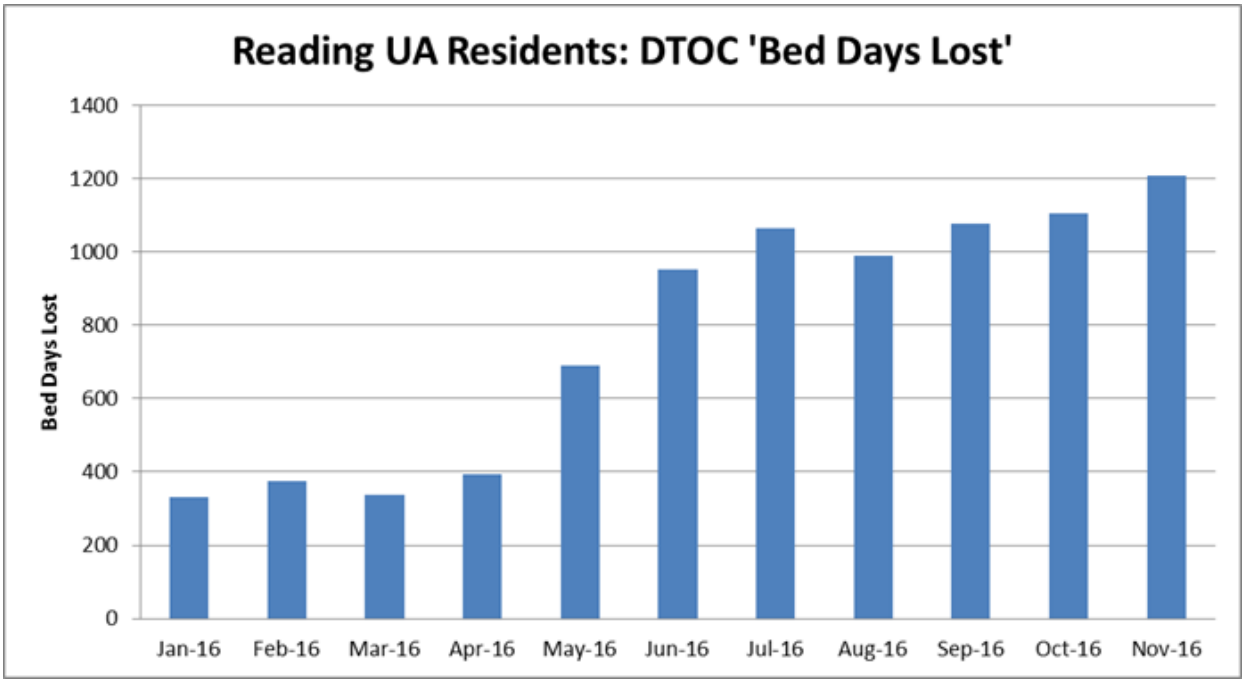
- Areas where good progress is being made: NEL Action Plan (based on year to date performance NEA activity for the year Reading is the only LA to be forecasting performance ahead of target) Ambulatory Care, STATing, Next Steps programme, Frequent A&E Attenders and CAMHs
- Areas requiring improvement: Action to improve Delayed Transfers of Care (DTOC) particularly from RBH and Prospect Park Hospital and the " Getting Home" programme.

DToC Performance: Action to improve DToC performance is a key priority for the Reading Health and Social Care system which has failed to meet its BCF target for 16/17 by some margin. The BCF metric is

the total number of delayed transfers of care per 100,000 population attributable to either health, social care or both. It covers delays at all Trusts including the Royal Berkshire Hospital, Oakwood community beds and mental health beds at Prospect Park hospital. The latest data shows that at the end of Q2, the 3 most prevalent reasons for people waiting for onward health or social care were as follows:

- Care package in own home (This includes self-funders and social services packages of care) – 22.72%
- Further non acute NHS care (e.g. Intermediate care or a community hospital placement) – 21.85%
- Nursing home placement – 15.55%

The graph below shows DTOC performance for Reading Local Authority residents during 2016-17 year to date. All partners accept that the figures are too high and are prioritising actions to support a reduction in the numbers. This also includes a review of operational processes between Reading LA and RBH staff to ensure both parties are confident that coding is accurate.



In November 2016 the A&E Delivery Board was asked by NHSE and NHSI to deliver an improvement in the DToC position at RBFT. The letter requested a concerted system wide effort to deliver a 1.1% improvement on the performance reported at that time to achieve a target of no more than 4.69% of total bed days lost due to DToC by the end of March 2017. Performance against this metric has deteriorated since November and current performance is 7.89%. To help put this into context there are normally 638 beds at RBH and over the period 9th to 15th Jan 33 of these beds were occupied each day by a patient whose transfer to another health or care setting, had been delayed. (An average ward has 25 beds).

An improvement in DTOC performance is a key element of the A&E Delivery Board Improvement Plan and in addition to the actions agreed via the board, to improve performance Reading established a weekly multi-disciplinary forum in November to address all delayed patients / service users individually and to assign clear leads and actions to promote a timely move on. This is already having a positive impact on weekly delayed discharge list / fit to go lists and is expected to have a significant impact on the local DTOC figures. However, this will not 'feed through' to official DTOC performance data until late January 17.

"Getting Home" Project: This project is focused on local delivery of three of the eight national high impact changes for DToCs – hospital based multi-disciplinary discharge team, discharge to assess and trusted assessment. A Steering Group has been established with a supporting Operational Group and work streams include 'Front Door Discharge Planning', 'Take Home and Settle in' and 'Flow through Community Hospitals and beyond'. It is anticipated that by April 2017 a multi-agency discharge team supporting people to "Go Home" will be in place with clear roles and responsibilities and direct links into other support services as required. Clear Discharge to Assess pathways will also be in place in each locality and a Trusted Assessor form designed and starting to be utilised.

ROLE OF ADULT SOCIAL CARE IN SUPPORTING DELIVERY OF THE A&E IMPROVEMENT PLAN

The 3 Berkshire West LAs are key partners on the Board and critical to delivery of the A&E Improvement Plan. This was emphasised once again in a letter dated 11 November 2016 from the Department of Health and Department for Communities and Local Government to Chief Executives and Directors of Adult Social Services regarding winter planning in adult social care and their role in supporting delivery into 2017.

The letter emphasised the importance of ensuring that social services are fully embedded in discussions and implementation of the five improvement initiatives, particularly in relation to reducing delayed transfers of care. The letter also:

- Signposted Local Authorities to practical support and best practice in the following areas;
  - Lessons from 2015-16
  - Market shaping (Commissioning for Better Outcomes)
  - Sector-led improvement-
- Requested that they make all attempts to ensure front line staff, including those in the independent care sector, were vaccinated against seasonal flu.
- Ensure that their emergency planning advice for local businesses and residents referenced the annual Met Office "Get Ready for winter" campaign which launched on the 7th November.

Reading LA have considered all of the above areas and implementation activities are underway.

PROGRESS REPORT ON ACTIONS AGREED IN RESPONSE TO HEATHWATCH REPORT "A WEEK IN A&E"

CCG/ GP Practices Actions

ISSUE	ACTION	UPDATE

High number of ED attenders who report contacting GP previously about their condition	Work with Practices to understand patients' ED utilisation patterns and identify opportunities to reduce inappropriate attendances	The review outlined below will consider this issue for patients who are high users of ED services. Further work is required to consider the information that GP practices receive following an attendance and how they identify whether the patient had previously been in contact with the practice – this will be considered as part of the review and potential further development of the workstream below.
Frequent attenders at ED	Reviewing patients who have attended ED more than 5 times in the previous 6 months and consider how care for these patients might be managed better	48/51 practices in Berkshire West CCGs are undertaking this work. This work will include the review of at least 775 patients across the area who have attended ED or other urgent care settings five or more times in a six month period. A second tranche of patients meeting the same criteria will be issued to practices in January to identify any further patients requiring follow-up. A full review including discussion in GP Councils will be conducted at the end of the year with hope that interventions and discussions with patients and carers and liaison with other services will have reduced attendance and that there are learning points going forward on how best to manage patients who may otherwise frequently attend ED.
Patients not registered with a Practice	Reviewing information on attendances by patient who are not registered with a GP Practice with a view to simplifying the registration process and improving access to Primary Care	The Primary Care Team is exploring how this issue is approached elsewhere, including whether there are any national examples of patients being able to register with a GP practice remotely from ED. Further

		analysis of the data will also be undertaken to confirm that these patients do not have a GP rather than that this information is not being captured – similar work with the Walk-in Centre previously identified that a significant proportion of the cohort did have a GP but were not providing this information.
Walk In Centre at Broad Street Mall	Lease has been extended for 12 months to allow a system wide discussion on how the walk in element of this service should be provided in the future	No further action at this stage.
Complexity of services	TV 111 to be promoted as the gateway to urgent care providing access to integrated urgent care	The Thames Valley CCG are currently in a co-production period for the new TV 111 Integrated Urgent Care service which will mobilise in October 2017. A key objective of the new service is to deliver the vision outlined in the Keogh review that "If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week".

Royal Berkshire Hospital Actions

ISSUE	ACTION	UPDATE
The system to call patients into the ED clinical areas is inadequate as patients cannot always hear their name being called.	RBFT have decided to look into the feasibility of purchasing a microphone system.	Options reviewed with University of Reading, this depends on future site developments. Action open.
Function of red line and booking not clear (confidentiality compromised)	Review red line and booking in process. Provider clearer instructions at the entrance on how to book in	Clinical team have reviewed the relevant research, which leans towards open plan book in and removal of screening. Action closed.
Customer services for reception staff – lack of eye contact, welcome greeting	Training for staff on customer service. Staff not to be visible if not booking in	100% customer care training completed. In house refresher training/role play sessions. Monitoring of complaints through clinical and board governance. Action closed.
Tepid water in dispenser	Investigate why and resolve if possible	Looking at feasibility of re-location. Action open.
Patients arriving with police that are distressed going through the main waiting area	Work with TVP to bring distressed patients directly into STAT bay	Communications with TVP to use resus entrance and present at nurses' station. Action closed.
General signage and directions	Review signage in and immediately outside of unit	Incorporated into the Part of Quality time project. Action open.
Lack of toys for older children in the paediatric ED.	Design posters showing what is available and investigate putting a starlight box in the waiting room	Starlight box is not feasible due to limited space. Posters being designed. Action open.
Lack of teenage magazines in the paediatric ED.	Request/arrange donations	Free magazines sourced and in place. Action closed.
Posters informing patients how to request an interpreter in the paediatric ED.	Source posters	Poster sourced. Action closed.
Ensure waiting times are accurately displayed electronically in paediatric ED.	Source board and arrange updating procedure	Electronic board sourced and ordered. Awaiting delivery. Action closed.
Arrange information screen in the paediatric ED.	Develop appropriate slides	Slides being developed. Action open.
Seating inadequate in the adult ED.	Review space to consider whether additional seating can be provided	Sourcing additional seating from potential sponsor. Design and layout, working in collaboration with Reading

		University. Action open.
Monitors are not visible to all in the adult ED.	Review location of monitors and explore whether additional monitors can be provided	Design and layout, working in collaboration with Reading University and IT services. Action open.
Free phone taxi access in the adult ED.	Review whether dedicated line can be re-installed	Free taxi telephone in place. Reviewing possibility of relocation to improve visibility. Action open.
Toilet signage and cleaning in the adult ED.	Review internal signage and cleaning roster	Additional signage being sourced. Cleaning schedules have been reviewed. Action open.

Improving information given to the public about using the right service at the right time

The Berkshire West CCGs have a Winter Communications plan for 2016-17 as part of their ongoing commitment to providing the public with information about using the right service at the right time.

ISSUE	ACTION
Promoting the Flu Jab	All available routes of communication targeting vulnerable groups and staff working across the health and social care system have been used.
Consistent messaging	Press releases to launch the flu campaign, to encourage pregnant women to have their jab, in support of Self Care Week and to launch the Childhood Illnesses App YouTube videos encouraging people to have their flu jab and of a pharmacist about Self Care on were promoted on social media In December produced a GP screen promoting NHS111 and the Out of Hours Service 100 people spoken to at Broadstreet Mall event – parents happy to engage and most hadn't had their child vaccinated. Only one of those aged 65 or above hadn't had theirs.
Addressing avoidable A&E attendances	Currently developing a targeted approach which involves educating people about the most appropriate place to go for advice and treatment using demographic data which shows where avoidable attendances are coming from and the best way to communicate with these groups.
Support for parents of children aged 0-4	CCGs and local authorities have recently updated the "A Parent's Guide to common childhood illnesses and wellbeing" and have developed an app (Berkshire Child Health) via a QR code allowing greater access to advice on children illnesses. This has been distributed via partner agencies and local community groups.

Berkshire West A&E Delivery Board Improvement Plan

As at 17th January 2017 (To Be Presented to Reading Health and Wellbeing Board)

KEY:
Blue = Scheme already in place/alternative in place.
Green = actions in place and on track for delivery.
Amber = actions agreed, but risks associated with delivery.
Red = actions either not being delivered or having anticipated impact.
Actions Highlighted Yellow = Priority actions

Mandate		Statement of Good Practice	Actions Required	Action Owner	KPI	RAG Rating	Latest Position
0. Pre-Hospital	Local Priority	Reduce Frequent Attenders at ED	Identify the patients who are frequent attenders at ED and their registered Practice and work with them to minimise inappropriate reliance on ED.	H Clark, BWCCGs M McCartney, BWCCG	Reduction in the number of A&E attendances made by the cohort of patients who have attended A&E greater than five times (between Jan and July 2016)	Amber	NHS numbers of all patients who have been identified as having attended A&E greater than five times (between Jan and July 2016) have been shared with GP Practices. Practices are now reviewing with partners how these patients can be better managed to ensure their needs are being met in the most appropriate way to minimise inappropriate reliance on A&E. This will include discussions with BHFT and Acute Consultants as appropriate. The four CCG Councils will discuss this in January and the four GP UC leads will drive this forward. GP by pass numbers to be promoted again.
			Identify the level of attenders who are not registered with a GP practice. Consider how to educate/signpost them to the right service and whether GP registration can be made easier.	H Clark, BWCCGs	Reduction in the number of A&E attendances made by the patients who are not registered with a GP.	Amber	Postcode data for unregistered A&E attenders shared with Primary Care Team 16th September. The team is exploring how this issue is approached elsewhere, including whether there are any national examples of patients being able to register with a GP practice remotely from ED. Further analysis of the data will also be undertaken to confirm that these patients do not have a GP rather than that this information is not being captured – similar work with the Walk-in Centre previously identified that a significant proportion of the cohort did have a GP but were not providing this information.
		Patient Education	Agree and launch winter communications plan.	N Mallin, SCWCSU	n/a	n/a	Winter comms plan agreed. Events have taken place. Plans ongoing including promoting self care and use of pharmacies aligned to national messaging. Proposal for further comms work will be considered by A&E Delivery Board in January. Action being driven at Thames Valley level (TVECN)
		CCG NEL Action Plan	Delivery of NEL Action Plan, following deep dive into NEL admission, to support CCG/BCF target for there to be no more than 2.2% increase in NEL admissions in 16/17. Plan includes projects to: • Support whole system management and care planning for patients admitted 5+ times • Increase use of IV therapy in the community • Address higher admissions rates seen in some of the most deprived Local Authority Wards • Increase vaccination rates for influenza and pneumococcal • Increase use of GP bypass numbers to divert care of patients back to GPs • Issue prescribing advice on 2nd & 3rd line response for patients with recurrent chest infections	M McCartney, NWR CCG T Forster, WBBC S Rowbotham, WBC, G Wilkin, RBC L Llewellyn, PH Berkshire	No more than 2.2% increase in NEL admissions in 16-17	Amber	2016/17 Q3 non elective data shows that across Berkshire West the target is 1.8% above plan, reduction of 521 NEL admissions is required to achieve plan. Reduction in NEL will continue to be a priority for BCF in 2017-18 and local integration boards are currently formulating plans for further action required. Updates on 2016/17 projects included in the NEL action plan are: • **Whole system management and care planning for patients admitted 5+ times:** Project Group to be established to support delivery/reduction in admissions in 2017/18. • **Community IV therapy:** Task and Finish Group established. Discussions currently taking place with microbiologist and pathway being reviewed at ACS Pharmacy Group. • **Higher admissions rates in deprived Local Authority Wards:** Public Health analysis showing relative likelihood of admissions by ward available. Meeting being scheduled with Lise Llewellyn, Director of Public Health, to discuss actions required by Public Health/Local Authorities to support reduction in NELs. • **Increase vaccination rates for influenza and pneumococcal:** Uptake of the 2016/17 flu campaign is being monitored fortnightly, data is being analysed as to where efforts should be focused to better meet national targets. Higher proportion of pharmacies are offering the flu jab. Levels of provision from maternity services are low, with a high proportion of patients stating they have had their immunisation with their GP. • **Increase use of GP bypass numbers to divert care of patients back to GPs:** Promotion of bypass numbers with key stakeholders completed. SCAS confirmed that crews, including private crews, have direct phone nos. via booklet/PDF on phones.
		Urgent Care in Primary Care 1	To pilot a collaborative approach to home visiting in South Reading with a focus on seeing patients early in the day and to share learning from this. To consider further action to be taken to encourage early home visits. Further update required.	H Clark, BW CCGs E Mitchell, SR CCG	n/a	n/a	Collaborative approach to home visiting is not being progressed at this time. Opportunities to stream urgent and non urgent activity are being explored although the Alliance have not yet agreed the approach at this stage.
		Urgent Care in Primary Care 2	To work with GP Councils to consider approaches to streaming patients for urgent and non-urgent primary care needs. South Reading and Wokingham practices in particular are currently considering pilots.	H Clark, BW CCGs E Mitchell, SR CCG K Summers, Wok. CCG	n/a	n/a	
1. Streaming at the Front Door – to Ambulatory and Primary Care.	National Mandate	Mental Health Attenders at ED	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard	G Alford - BW CCG G Crawford - BHFT M Claridge - RBH	Reduction in MH activity in A&E, PMS pathways. RBH/BHFT joint management action plan for winter. Plans for assessment in non-acute setting.	Amber	96% of patients presenting with MH illness at ED are assessed within 1 hour of arrival. 24/7 mental health liaison in place however some patients are admitted to the Observation Ward for clinical reasons. A subset of these patients may be delayed in the observation bay and this can impact on flow. Actions to resolve include weekly system calls aimed at reducing DToCs in MH beds to create capacity at Prospect Park and improve flow and establishment of a BW multi-agency Mental Health Activity Steering Group which is developing an improvement plan to ensure an effective crisis response to mental health presentations. A bid has been submitted for national transformation monies to ensure the existing A&E liaison psychiatry service fully meets mental health liason criteria for Core 24 (24/7 compliance).
		Ambulatory Emergency Care / Specialist Opinion	Increased telephone access to specialist opinion and ambulatory care pathways	W Orr - RBFT M Sherry - RBFT	Increase in the number of patients seen on ambulatory care pathways to 30% Number of specialities offering 'hot line' telephone access to a consultant	Amber	• Review underway of ambulatory pathways (incl potential move of location) • Increased 'offer' at the front door e.g. hot clinic appointments, immediate consultant review, direct to specialty for some patients • ECIP recommend 7 days – we could provide this but requires provision of onward services for transport, IV services, GP cover • RBFT aiming to promote direct access to ambulatory care for GPs
		Acute Frailty Service	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients	M Claridge, RBFT W Orr, RBFT	Service available	Green	Elderly Care Physician of the Day available 8am - 8pm Mon-Fri and 8am - 7pm weekends. Weekend occupational therapy well established.
		Intermediate Care Rapid Response Services	Community and intermediate care services respond to requests for patient support within 2 hours	D Cahill - BHFT	Achievement of the 2 hour contractual response time for rapids	Amber	Evidence that some rapid response referrals cannot be met within 2 hours linked to lack of care capacity was discussed at January Urgent Care Operational Group. Data was shared with localaty partners and is being investigated with outcomes to be shared at the February Urgent Care Operational Group.
	Local Priority	Senior Decision Making	Ensure senior and timely clinical review in ED to ensure most effective treatment pathway can commence without delay.	W Orr, RBFT M Sherry, RBFT	Reduction in the number of breaches due to wait for a specialist review.	Green	• Improved STAT process designed • Temporary STAT in 'pod' in place • Service available till 10pm 7 days a week
		Improved interface between ED and WIC (at times of peak demand)	Management and clinical leads to discuss and agree a process to provide mutual support at times of peak pressure.	M Claridge, RBFT D Mossop, RBFT B Thava, SRCCG	n/a	Amber	Meeting has taken place. RBH actioned to investigate having a rolling screen in the wiaitng area showing live waiting times at Walk in Centre.
4. Improved flow	National Mandate	SAFER	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum , to improve patient flow	M Robson, RBH	n/a	Blue	Next Steps programme in place and supported by CQUIN.
		Red and Green Day Approach	The use of the red and green day approach has been considered	UCOG	n/a	Green	As part of the next steps approach the Trust review all delays in the patients pathway. Red and green day approach has been used by UCOG to track two individual patient journeys. The A&E Delivery Board at the December OD session agreed to use red/green days and patient stories to support and frame discussions about issues going forward.
		ADDs and Clinical Criteria for Discharge	A baseline assessment of the effective use of ADDs and Clinical Criteria for Discharge has been carried out	M Robson, RBH	n/a	Green	ADDs are being monitored on a weekly basis. All wards now have a weekend ward round and new ward level processes delivering at weekends.
		Ward Round Checklists	Ward round checklists are in use in all wards in the acute hospital/s			Blue	
	Local Priority	CAMHs	CAMHs children on the acute paediatric ward requiring high levels of support before they are transferred.	S Murray, BW CCGs T Pease, RBFT L Noble, BHFT	Reduction in the number of days waiting for a CAMHs placement.	Green	Board noted significant improvement.
		Robust Management Information to Support A&E Delivery Plan	Ensure that the recommissioned Alamac service is fit for purpose and delivering as required.	J Gillespie-Shahabi, RBFT M McCartney, BW CCGs	n/a	Amber	Milestone Plan for launch of the new look service received.
5. Improved discharge processes	National Mandate	Inpatient Stays Over Seven Days	Systems are in place to review the reasons for any inpatient stay that exceeds seven days	M Robson, RBH	Reduction in number of patients in hospital over 7 days	Green	Number of patients with length of stay over 7 days are included on Sitrep. RBFT monitor daily And also quarterly by the CQUIN
		Discharge to Assess	A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	T Forster, WBBC L McFetridge, WBC W Fabbro, RBC	n/a	Amber	Part of the 'Getting Home' project. WB D2A - Pilot agreed to provide 3 extra beds for the winter and an additional 10 next year. Steering Group Meeting taking place on 18th January.
		Trusted Assessment	Trusted assessor arrangements are in place with social care and independent care sector providers	T Forster, WBBC L McFetridge, WBC W Fabbro, RBC	n/a	Red	Getting Home' will build on the existing Trusted Assessor arrangements and seek to embed them in the Integrated Mulit-Agency 'Getting Home' Team. Aim to have a Tusted Assessor Form colmpleted by March. Getting Home Steering Group Meeting taking place on 18th January.
		CHC	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	G Alford - BW CCG		Amber	Linked to implementation of recommendations from the independent review. Board to agree response to mandated action at January meeting.
		Choice Policy	A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	Delivery Board		Amber	Choice policy adopted. Staff training and awareness programme in place. CHS in post as of 9th January to assist self funders.
	Local Priority	7 Day Discharges	Increase week-end discharge rates.	M Sherry, RBFT M Robson, RBFT SCAS, BHFT & LA leads	Increase week-end discharge rates to 80% of week day rates.	Amber	• 7 Day Working T&F Group being arranged • RBH to nominate lead • Good progress on next steps • Pre determined weekend discharge list on Fridays being implemented as part of weekend plan • Weekend wards being increased through changes to POD rota (Acute Pathway work) • Requires action for LAs on start of care packages including those planned during previous week and currently nominated for commenced after weekend • Requires SS presence from all LAs to cover for each other PLUS authority to makes decisions • Requires increased availability of community beds by ? increased cover from GPs/ward rounds to free up more beds (flow to those currently made available is good, we just need more) Requires confirmation of weekend discharge cover following consultation process.
		Fit to Go List & DTOC	Increased and sustained focus on reducing numbers of patients on the fit to go list and the number of bed days lost. Implementation and delivery of the DTOC BCF action plan.	Partner Organisations Lead Directors C Lawson, BW CCGs	Reduction in number of DTOC bed days lost.	Red	Three system resilience calls each week (One MH, one Community and one RBH) to review current status and action required to reduce numbers of patients on 'fit to go' lists. Key focus areas for all three integration Boards as part of BCF. Reading and West Berkshire have exceeded the annual DTOC target. Reading to implement the learning taken following the visit to Wokingham and their processes. Partner organisations to have oversight of DTOC figures at senior level. Key focus for BCF is 2017-18 - planning to start in January/February.
		PTS Supporting Timely Discharge	Ensure the service is supporting timely discharge.	Oxfordshire CCG A Ciecierski, BW CCGs	KPIs as per contract	Amber	1 dedicated discharge crews in place at RBFT from 31st October. Plus 2 additional for renal. New KPIs in place as at 1st December. RBH will increase number of booking made the previous day. In November 97.7% of calls to Contact Centre being answered in 60 seconds. 37 vacancies across operations in Thames Valley. Recruitment campaign will reduce this to 16 by February Bank staff recruitment continues to support the unpredicted peaks in demand.

Mandate		Statement of Good Practice	Actions Required	Action Owner	KPI	RAG Rating	Latest Position
2. NHS 111 calls transferred to clinicians	National Mandate	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	SCAS/Commissioners	n/a	Green	SCAS working with Commissioners to identify other clinicians to directly refer e.g. dental, pharmacy, GP and develop pathways for enhanced clinical review for vulnerable patient groups.
		Clinical expertise availability is planned according to demand	Clinical expertise available to match demand.	SCAS/Commissioners	n/a	Green	SCAS have undertaken modelling which highlights additional clinical resource which would be required to review all calls.
		The A&E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH	Integration between NHS 111 and out of hospital services (especially OOH)	SCAS/Commissioners	n/a	Green	Workshops held with the Preferred Provider during Part 3 of the procurement process to discuss issues and opportunities in relation to integration with out of hospital services.
		The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within the CCG	Review A&E profiling on the DoS	Commissioners	n/a	Blue	Emergency Departments on DoS are always prioritised lowest when other services are available to treat the same condition – i.e. promoting use of WIC, MIU, UCC for minor injuries / EDs only being profiled against appropriate outcomes – a caller will never be signposted to attend an ED when a GP/Pharmacy (or other community service) is available / Checks confirm ED is very rarely defaulted to as a 'catch all' service due to lack of other provision / Mental Health services widely profiled on DoS – where direct referral into MH hub is not available, DoS includes broad details for dozens of MH services in the region. This ensures that even in cases where direct 111 referral is impossible, information remains available for any clinical user with DoS access who then can use the held information for referrals.
		There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed oustide A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls		SCAS/Commissioners	n/a	Green	There are a number of community and ambulatory care pathways accessible to NHS 111 as profiled by the DoS leads and other Providers.
		The A&E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly		BHFT		Green	Westcall have sophisticated information available on their demand profile.
3. Ambulances - DoD and coding pilots	National Mandate	There is an ambulance trust executive lead on the A&E Delivery Board able to deliver the required service changes				Amber	Head of Operations will represent SCAS at the Board and will be supported by the COO (Exec Lead) or director. CEO has written to all AEDB Chairs.
		There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions				Blue	The SCAS A&E contract covers the definition for H&T and S&T and the clinical workforce is profiled ot manage this workstream both in CCC and U&E Operations.
		There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities				Green	Review of pathways in DoS to ensure all local pathways are correct (part of ongoing arrangements with local CCGs for 24/7 access).
		The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand				Amber	SCAS will work with AEDB on actions to increase clinical interventions on green calls.
		The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'				Blue	See and treat Ops Hubs to be established to increase see and treat support through Specialist Pramedics. 5 sites have been identified across SCAS and a pilot is running in Reading covering Berkshire.
	Local Priority	SCAS Response to HCP Calls	Monitor the desired impact of the changes to the HCP transport arrangements (i.e. auto despatch of red for those indicated or 1,2 or 4 hour response for conveyance) to ensure timely arrival at the hospital.	A Ciecierski, BW CCGs & K Havisham, CSU	n/a	n/a	New HCP process has been launched by SCAS with publicity sent to all GP practices. Awaiting feedback from GPs and monitoring of activity and effect on 999 performance at the SCAS 999 CRM.

Berkshire West A&E Delivery Board Terms of Reference

Purpose:
The A&E Delivery Board brings together system leaders at Executive level from partner organisations in the Berkshire West health and social care system and has an immediate responsibility for:

- Recovery of the NHS Constitutional standard that 95% of patients should be admitted transferred or discharged within 4 hours of their arrival at A&E
- Delivery of the 5 National Mandated Actions to restore A&E performance
- Delivery of the local A&E Improvement Plan

The Board also has a responsibility to work with Sustainability and Transformation Plan (STP) Groupings on the longer term delivery of the Urgent and Emergency Care Review across Berkshire West.

Leadership of the BCF will continue to be at local CCG/LA level but the ED Delivery Board will have a key role in assisting the implementation of action plans, particularly those which aim to reduce Delayed Transfers of Care and Non Elective Admissions.

The provision of high quality patient care will be at the heart of all Board activities.

Behaviours:
The Board is responsible for ensuring that the system works in an inclusive and collaborative way. It will promote and increase collective responsibility amongst partners in the urgent and emergency care system, maximising the potential of partnership working, challenging each part of the system and ultimately holding individual organisations to account for delivery. Members will hold each other to account for the delivery of agreed actions to improve the resilience across local systems. Through this approach, the challenges impeding A&E delivery will be identified, unblocked and the pace of change improved.

The Board will use data and business intelligence to inform its work and will seek to embrace new innovative ideas and ensure that best practice is shared and adopted.

Geography:
The Berkshire West A&E Delivery Board will cover the registered population of Newbury and District, Wokingham, North and West Reading and South Reading CCGs. The Board will ensure links to the Local A&E Delivery Boards in neighbouring systems in East Berkshire, Hampshire and Oxfordshire.

It will also interface with the Thames Valley Urgent and Emergency Care Network (UECN) and transformation programmes of the Buckinghamshire, Oxfordshire, Berkshire (BOB) STP footprint.

Key Responsibilities:

- Lead the recovery of the A&E performance to meet the 95% A&E constitutional standards and ensure this is sustained going forward
- Lead the development and implementation of the Berks West A&E Improvement Plan with an initial focus on the " must do" for each of the 5 mandated actions
- Lead the planning, commissioning and delivery of urgent and emergency care services in Berkshire West
- Ensure that patients have access to appropriate high quality urgent and emergency care services and are signposted to the most appropriate service for their needs with all system partners giving and promoting the same messages
- Lead the effective planning and operation of local care ambulatory services
- Ensure year round resilience of the local urgent and emergency care system and that effective system wide surge and escalation processes exist
- Provide ownership of the discharge process
- Ensure that local plans are in in place to support the care of key categories of patient who frequently attend ED or are admitted frequently, e.g. frail elderly, children and high dependency patients, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems)
- Ensure that patients presenting with mental illness are assessed, managed, discharged or admitted within the ED standard, that they are being appropriately transported to ED by SCAS and that mental health DTOC are addressed as part of the wider DTOC
- Ensure a cross system approach to prepare for the forthcoming waiting time standard for urgent care for those in a mental health crisis
- Ensure availability and ease of referral to a wide range of admission avoidance services and other out of hospital services as an alternative to ED and NEL admission
- Contribute to the work of the Thames Valley Urgent and Emergency Care Network and ensure delivery of the " Urgent and Emergency Care Review" at a Berkshire West wide level
- Have an oversight role in relation to the mandated actions for NHS 111 and Ambulance Services
- Oversee the effectiveness of projects put in place at CCG and BCF level to reduce Non Elective Admissions
- Provide oversight of relevant Urgent and Emergency Care QIPP programmes/projects
- Responsible for programme direction and approval of projects, budgets and plans within the overall Urgent Care Programme
- Utilising the Alamac "kitbag" and dashboard to best effect to support its work and predict and manage demand and support a shared understanding of pressures within the urgent and emergency care system
- Ensure that any investment to support urgent and emergency care and operational resilience is linked to objective data analysis and that critical success factors in relation to the investment are monitored on a regular basis
- Provide assurance to NHSE as required
- Agree the investment of the Monies Retained from the Emergency Tariff (MRET) monies on an annual basis
- Receive formal " Serious Incident " reports prepared by RBH and BHFT
- Ensure the effective participation of Health watch, patients and the public in the commissioning and management of urgent care services

- Oversee the work of the Urgent Care Operational Group giving it direction and providing a point of escalation and accountability
- Ensure that partner representatives have a process in place to feedback the work of the Board to their respective Organisations

Accountability:
The Board reports to the Berkshire West CCGs QIPP and Finance Committee by means of a Chair's Report each month in order to provide assurance that the Board is effectively discharging its delegated responsibilities.

Partner organisations have the following accountability arrangements in relation to the work of the Board and its impact on the system:

- RBFT: Trust Executive and Senior Management Team
- BHFT: Trust Executive
- SCAS: Trust Board
- Reading LA: tbc
- Wokingham LA: Executive and HWBB
- West Berks LA: tbc

Board performance will be measured by delivery of the A&E Recovery Plan and other agreed key performance indicators contained within the Urgent and Emergency Care dashboard.

Membership:
Membership will consist of senior clinical and executive decision-makers from across the Berkshire West system including mental health representation with the authority to commit to decisions on behalf of their organisation.

Nominated members are expected to be in attendance. If member cannot attend a nominated senior alternative who has the designated authority to make decisions on behalf of his/her organisation should attend in their place.

Additional representatives can be co-opted or invited to meetings on an ad hoc basis when their expertise is required

Organisation	Named Individual	Designation
RBFT	Mary Sherry	Chair of A&E Delivery Board & RBH Chief Operating Officer
NWR CCG	Dr Andy Ciecerski	GP, NWR CCG Chair & Berkshire West Urgent Care Clinical Lead
SR CCG	Dr Aparna Balaji	GP, CCG Board member and urgent care lead
Newbury and District CCG	Dr Heike Veldtman	GP, CCG Board member and urgent care lead

Wokingham CCG	Dr Debbie Milligan	GP, CCG Board member and urgent care lead
Berkshire West CCGs	Cathy Winfield	Chief Officer
Berkshire West CCGs	Carolyn Lawson	Urgent Care Programme Lead
Berkshire West CCGs	Maureen McCartney	Director of Operation N&WR CCG
Oxfordshire CCG	Shereen Bayat	Commissioning Manager – Urgent Care
Royal Berkshire NHS Foundation Trust	Dr Will Orr	Consultant Cardiologist and Urgent Care Clinical Lead
RBFT	Mandy Claridge	Director of Operation Urgent Care
BHFT	David Cahill	Director Wokingham Locality
BHFT	Gerry Crawford	Regional Director West
SCAS	Kirsten Willis	Head of Operations, BW
Reading LA	Graham Wilkins	Acting Director of Adult Social Care
Wokingham LA	Mimi Konigsberg	Head of Adult Social Care and Safeguarding
West Berks LA	Tandra Forster	Head of Adult Social Care
Bracknell Forest LA	Melanie O'Rourke	Head of Adult Community Team for Older People and People with a Long Term Condition
NHS England	Sue Drabble	Mental Health Planning and Assurance Manager
Healthwatch	Rebecca Norris	Manager
Patient Rep	Rosemary Balsdon	Patient rep.

Chair & Vice Chair:
The GP Urgent Care Clinical Lead for the Berkshire West CCG Federation will Chair meetings. If he is unavailable one of the other GP Leads for Urgent Care will deputise.

Quoracy:
The A&E Delivery Board will aim to reach agreement by consensus including those situations where a key partner organisation is not represented but if required the Chair will have the right to make a final decision. There will be formal notifications of any decisions made to absent Board members.

Agenda:
The agenda will be focused, allowing maximum time for Programme updates and discussion on progress of delivery of the A&E improvement plan.

An action log will be circulated within 5 working days of the meeting. Each member of the Board is expected to have completed their actions, including the submission of a highlight report, where requested, one week in advance of the next meeting.

If slippage against trajectory is expected this must be discussed to understand the impact and the plan including timescales to get back on track.

Additional representatives will be invited to attend as and when a need is identified.

Meeting Frequency:
Meetings are scheduled to take place monthly.

Administration Support:
The Board will be supported by the BW CCGs' Administration Team.

Review:
The membership and terms of reference will be reviewed annually. Any changes to the terms of reference or membership must be approved by the Berkshire West CCGs' QIPP & Finance Committee.

October 2016

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**27 JANUARY 2017**	**AGENDA ITEM:**	**13**
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:	**GRAHAM WILKIN**	**TEL:**	
JOB TITLE:	**INTERIM DIRECTOR ADULT SOCIAL CARE & HEALTH**	**E-MAIL:**	**graham.wilkin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the progress of the Integration programme, including Better Care Fund Performance (BCF).

1.2 The report also includes the information received to date in relation to 2017/18 & 2018/19 Better Care Fund requirements. As of writing, however, the final policy and technical guidance has yet to be published and is not expected to be until late January 2017. This means that the final funding, national conditions and planning requirements are still unclear.

1.3 Finally, as part of the BCF Policy Framework and Integration and BCF Planning for 2017-19 there is a proposed option for local areas to look towards 'graduation' from BCF. Areas that graduate would no longer be required to submit annual BCF Plans and quarterly returns. An expression of interest was put forward on behalf of the Berkshire West localities, but as with BCF policy guidance, the graduation criteria and process is yet to be finalised thus the application will require review upon publication of the final policy. Any final application will return to the board for formal approval.

2. RECOMMENDED ACTION

2.1 That the report be noted.

3. POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. 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 to promote / deliver on integration ambitions.

3.2 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.

3.3 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 a number of national conditions that partners must adhered to. 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, based on the NHS number;
- 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

3.4 Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions. It is a requirement of the BCF that CCG and LA use this mechanism to establish a pooled fund to deliver their BCF / integration plans.

4. PERFORMANCE TO DATE – BCF Key performance indicators (KPI)

4.1 In line with BCF policy requirements each Health & Wellbeing Board (HWB) is required to report progress against four key performance metrics:

- **Reducing delayed transfers of care (DTOC) from hospital**
  - *Metric: Delayed transfer of care from hospital per 100,000 (average per month)*
- **Avoiding unnecessary non-elective admissions (NEA)**
  - Metric: No. of non-elective admission (General & Acute)
- **Reducing inappropriate admissions of older people (65+) in to residential care**
  - *Metric: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population*
- **Increase in the effectiveness of reablement services**
  - *Metric: Proportion of older people (65 & over) who were still at home 91 days after discharge*

These four KPI were selected as good year on year performance, allowing for growth, is seen as an indication of an effective and integrated health and social care system.

Commentary and figures for the KPI can be found below.

4.2 Reducing delayed transfers of care (DTOC) from hospital

DTOC performance has been substantially above target for both Q1 and Q2 and this trend is currently continuing into Q3, based on NHS England DTOC performance figures.

As at the end of Q2, the three most prevalent reasons for people waiting for onward health or social care were as follows:

Patient awaiting (including self-funders) -

- Care package in own home
- Further non acute NHS care *(e.g. Intermediate care or a community hospital placement)*
- Nursing home

Delayed transfers of care performance – Actual days delayed, 18+:

		Q1	Q2	Q3	Q4
Reading HWBB	*Plan*	980	956	914	853
	Actual	2038	3133	*1105**	
	variance %	+108%	+228%	*+21%**	

**October performance only*

An improvement in DTOC performance is a key element of the A&E Delivery Board Improvement Plan and, in addition to the actions agreed via the board, Reading established a weekly multi-disciplinary forum in November to address all delayed patients / users individually and assign clear leads and actions to promote timely move on. This is already having a positive impact on weekly delayed discharge list / fit to go lists and is expected to have a significant impact on the local DTOC figures. However, this will not 'feed through' to official DTOC performance data until late January 17.

Via the Berkshire West 10 Delivery Group, the three Berkshire West localities continue to share best practice / process where it is deemed to have had a beneficial impact on reducing / managing DTOCS. This has included on-site reviews of key integration projects in other Berkshire areas, such as the Wokingham integrated hub and short term support teams, which could be duplicated in Reading.

4.3 Avoiding unnecessary non-elective admissions (NEA)

NEA performance against target improved throughout Quarter 2 and into Quarter 3. Based on year to date performance NEA activity is currently forecast to be ahead of target.

On a further positive note, now that the Rapid Response and Treatment (RRaT) element of the care home project is operating at full capacity a decrease in the level of NEA from care homes is expected which will in turn further improve overall NEA performance.

Non-elective admissions performance – all admissions, all ages:

		Q1	Q2	Q3	Q4
Reading HWBB	*Plan*	3514	3561	3915	3804
	Actual	3673	3585	*3704**	
	variance to plan %	+4.5%	+0.7%	*-5.4%**	

**Estimate based on October & November figures*

4.4 Increase in the effectiveness of reablement services

More residents are now benefiting from reablement, via the Willows 'step down' facilities and via increased numbers of people accessing the community reablement team (CRT). We are seeing a higher proportion of residents still being at home 91 days post discharge.

The metric target is for 85% of patients discharged to still be at home 91 days post discharge. As per the table below, with the exception of April, Reading has been above target every month and seeing improved performance against 15/16.

Proportion of older people (65 & over) who were still at home 91 days after discharge:

		Apr	May	Jun	Jul	Aug
Reading HWBB	*2015/16*	80%	86%	83%	84%	78%
	2016/17	82%	87%	88%	94%	91%

4.5 Reducing inappropriate admissions of older people (65+) in to residential care

Reading saw a substantial fall in residential care placements for older people in 15/16 (circa. 30% fewer than 14/15) thus a further significant reduction was deemed unrealistic, based on demographics and comparator areas. Therefore, a moderate reduction in placements was set for 16/17, equal to approximately one fewer placement per month. Achieving this level of placements will place Reading within the upper quartile of performance for all local authorities, based on population per 100,000.

To date Reading is seeing fewer placements than planned and is on track to achieve its full year target, thus helping to ensure only those who need intensive support live in residential care settings.

Permanent admission to residential care – 65+ year on year comparison, cumulative

		Q1	Q2	Q3	Q4
Reading HWBB	*2015 / 16*	28	62	89	104
	2016 / 17	22	50	*65**	

**as at end of November*

PERFORMANCE TO DATE – update on key integration / BCF schemes

4.6 Discharge to assess – Willows

The DTA (discharge to assess) 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 DTA units.

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

- 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

To date the service continues to perform well against key performance indicators and records a high level of user / family / carer satisfaction. Key performance figures as at the end of quarter 3 (end December):

- 96 admissions – *including 18 via rapid response (step up) / 61 via acute (step down)*
- 47 patients / service users returned to their own home

- 14 moved onto or returned to a residential care service
- just 10 required re-admission to hospital

However, while the service is supporting a high number of people to be discharge from an acute setting in a more timely manner Reading is seeing the increase in delayed discharges, system wide. Focus will remain on ensuring / improving efficient movement through the Willows DTA service and onto other community services, to help alleviate discharge pressures.

4.7 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 reablement program. The service is delivered in the clients own home and available 7 days a week, 24 hours a day.

CRT has continued to greatly contribute to a reduction in the number of permeant care home admissions and non-elective admissions. More Reading residents are benefiting from the CRT service (13% more users have accessed CRT, as at the end of quarter 2, compared to 15/16) and this is having a positive impact on the related BCF KPI (*Proportion of older people (65 & over) who were still at home 91 days after discharge*).

4.8 Enhanced support to care homes

The Enhanced Support to Care Homes project will implement 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.

Delivery of project objectives is through four core streams of work:

- Implementation of the Rapid Response and Treatment Team (RRaT) and Care Home Support Team to provide; fast track support to care homes to avoid the need for residents to be admitted to hospital, and, bespoke training and leadership to care homes to enable them to better support residents and reduce the need for acute admission
- Review and revision of the key protocols and standards related to admissions and discharges between local care homes and hospitals to promote consistency and best practice
- Implementation of a unified system of care home performance monitoring across Berkshire West
- Review and revision of GP support and medication management to care homes to promote consistency and best practice

Position as at Month 8 (November), key achievements / developments:

- The RRaT service is now at full capacity, regards staffing and number of homes signed up to the scheme and this has resulted in improved performance and activity reductions from month 6 onwards (Month 6,7 & 8 saw an average reduction of 36% in care home NEA activity).
- However, due to delays in scheme recruitment and an overestimate of previous years NEA activity, the service will not achieve its full NEA reduction target in 16/17, however, savings are expected in 17/18

- A unified admission and discharge process has been agreed by commissioners and is currently being piloted by the RBH and a phased roll out to all care homes scheduled in 2017.

- A new model to support General Practice provision to care homes to be considered by Berkshire West 10 partners

4.9 Connected Care

The Connected Care project will deliver a solution that will enable data sharing between the health and social care organisations in Berkshire and 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 Local Digital Roadmap and enable service transformation as specified in the BCF.

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 the end of Q2, key achievements / developments:

- Due to 'first of type' development issues the programme is 4-8 weeks behind on some key milestones but RBFT, BHFT and General Practice are currently 'going live' and will be able to access and share relevant data via the portal by February 17. Other Berkshire West and East partners will join up throughout 17/18 with Reading social services due to have access by September 17.

- The information governance subgroup continues to revise policy and data sharing agreements, as required, to ensure lawful handling and sharing of data.

2017 –19 BCF Planning

4.10 NHS England has confirmed that the Better Care Fund will continue in the 2017/18 and 2018/19 financial years. As of writing, however, the final policy and technical guidance has yet to be published, and is not expected to be until late January 2017. This means that the final funding, national conditions and planning requirements are still unclear.

4.11 Initial planning sessions including CCG and LA representatives have begun, however, with the draft guidance received thus far indicating that the planning requirements and processes will be very much in line with previous years.

4.12 In summary, HWB's are required to submit a narrative plan, outlining the local vision for integration and case for change, and a detailed expenditure plan setting out the projects, schemes, initiatives that will be funded via the BCF pooled fund to deliver said vision / change.

4.13 Draft guidance indicates that the BCF plan should build on the approved 2016/17 plan and demonstrate that local partners have reviewed progress in the first two years of the BCF as the basis for developing plans for 2017-19.

4.14 One key change from previous submissions, however, is the requirement for the plan to cover a 2 year period from April 2017 through to March 2019.

4.15 Again, in line with previous submissions, the BCF monies must be held in a pooled CCG / Local Authority budget.

BCF Graduation

4.16 As part of the BCF Policy Framework and Integration and BCF Planning for 2017-19 there is a proposed option for local areas to look towards 'graduation' from BCF. This is the process for enabling areas that have integrated their health and social care commissioning or provision, to the extent that they exceed, and will continue to exceed, the requirements of BCF.

4.17 Areas that graduate will no longer be required to submit BCF Plans and quarterly returns. The initial potential graduated areas will work up the model for graduation from BCF and will receive a bespoke support offer. With regard to the graduation footprint – this can be wider than a single BCF Plan e.g. STP footprint, combined Authority, devolution deal area.

4.18 The national BCF programme team requested an early indication of the numbers of areas that might be interested in going for an early graduation proposal. An expression of interest was put forward on behalf of the Berkshire West localities so we are able to shape the graduation process, if the application was accepted.

4.19 As with BCF policy guidance, however, the graduation criteria and process is yet to be finalised thus the application will require review upon publication of the policy at the end of January.

4.20 Any final application will return to the HWB for formal approval, anticipated to be at the March 17 meeting.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Better Care Fund and integration agenda contributes to the following strategic aims:

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

5.2 The Better Care Fund and integration agenda supports the following council commitments:

- 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. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 N/A – no new proposals or decisions recommended / requested.

7. EQUALITY IMPACT ASSESSMENT

7.1 N/A – no new proposals or decisions recommended and / or requested. This report provides a summary of progress to date, thus original EIA assessment stands.

8. LEGAL IMPLICATIONS

8.1 Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions. It is a requirement of the BCF that CCG and LA use this mechanism to establish a pooled fund to deliver their BCF / integration plans.

9. FINANCIAL IMPLICATIONS

9.1 There are no new funding decisions being requested / recommended, but a forecast full year out turn, with comments, follows for the key Integration / BCF expenditure lines.

9.2 In line with the governance arrangements set out in the s75 pooled budget agreement, use of any underspends is subject to unanimous agreement of the contracting partners (CCG and LA). In line with these arrangements the Reading Integration Board will formulate and approve the use of any underspend and update the HWB, as required.

9.3 **Summary**

The Reading BCF is expected to see an underspend of £96k, which will see a £103k underspend on the RBC hosted schemes, slightly offset by an overspend of £7k on the CCG hosted schemes

Previous s256 and Protection of Social Care Funding

All the services previously funded under Section 256 funding and the protection of social care will achieve a breakeven position.

Community Reablement Team (Full Intake Model) and the Willows (Discharge to Assess)

Both of these schemes are critical to the success of supporting individuals on discharge from hospital and also in some instances preventing admissions/NELs. Both schemes have been reviewed towards the end of Q3 as to how these have operated financially in the year to date.

The £98k unallocated/contingency funding across both schemes will be utilised to cover additional work on hospital discharges, additional social work capacity and to cover the costs of keeping packages open whilst clients are in hospital, which should aid in quicker discharges.

The Discharge to Assess scheme at the Willows is expected to underspend by £40k within the BCF by year-end.

The Full Intake Model is on target to achieve a breakeven position.

Carers

The numbers of Carers grants is reasonably in line with the 15/16 figures and this will result in an underspend of £40k at year on the budget of £174k for this (which will be split between RBC and CCG funded streams).

There will also be an underspend of £23k on grants commissioned by the CCGs.

Local Project Office

The Performance Analyst is now in the post but the Programme/Integration Manager post became vacant early December. This latter post is now covered by an Interim appointment, so this area is expected to achieve a breakeven position.

A review of the support needed for the BCF going forward will need to be undertaken in time for the 17/18 budget to be set.

Local Contingency

The local contingency funding will cover the costs of Independent Mental Health Advocacy (IMHA) £40k.

The remainder of the contingency will be utilised for Winter Pressures and the expectation is that there will be no underspend.

Disability Facility Grants

The cost of DFG's in 16/17 is expected to be around £550k, which is less than the £815k grant received.
The part of the grant that is not committed will be used to cover:

- Additional OT capacity to try and speed up the process of getting DFG's agreed.
- Cross-Berkshire work to build a strategy for the use of Telecare/Telehealth
- Setting up a framework for the procurement of stair lifts/ramps
- Expenditure incurred in 16/17 by RBC on equipment, minor adaptations and telecare

CCG Hosted Schemes

The £7k overspend includes an overspend of £10k on the Connected Care project, with an underspend of £3k on the PMO costs. All other schemes are expected to break even at year end.

The Performance of the Reading schemes for NELS in Q1 and Q2 shows that £66750 is available to RBC through the risk share funding, and any areas where this funding can be applied will be identified in the coming months.

10. BACKGROUND PAPERS

10.1 None

READING BOROUGH COUNCIL

REPORT BY: Director of Adults Social Care and Health Services

TO:	**Health & Wellbeing Board**		
DATE:	**27 January 2017**	**AGENDA ITEM:**	**14**
TITLE:	**A Healthy Weight Statement for Reading – Progress update**		
LEAD COUNCILLOR:	**Cllr Graeme Hoskin**	**PORTFOLIO: Health**	
SERVICE:	**Wellbeing**		
LEAD OFFICER:	**Melissa Arkinstall**	**TEL: 0118 9374805**	
JOB TITLE:	**Public Health Programme Officer**	**E-MAIL: Melissa.arkinstall@reading.gov.uk**	

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To share with the Board the Healthy Weight Position Statement for Reading

1.2 To provide an analysis of local data, scoping of current service provision and involvement of stakeholders at various stages of development; to report on the emerging priorities have been identified to help focus work on key areas of need.

1.3 Appendix A – Draft Healthy Weight Position Statement.

2. RECOMMENDED ACTION

That the Board endorses the work undertaken to date.

That the Board supports the development of a Healthy Weight Strategy for Reading, the formation of a task and finish group to develop a detailed implementation plan; which will be progressed through engagement and in partnership with key stakeholders.

That the Board requests a further progress report and an updated action plan to be brought to the April 2017 meeting.

3. POLICY CONTEXT

3.1 National:

'Childhood Obesity: a plan for action' (2016), is the government's strategy to significantly reduce childhood obesity over the next ten years.
The plan emphasises:

- reducing the amount of sugar in food and drinks
- encouraging primary school children to eat healthily and be more active, supported by schools and parents.
- the production of revised guidelines and resources on diet, physical activity, weaning and healthy weight for healthcare professionals who support families.

3.2 Local:

- Reading's JSNA module on obesity recommends that we should develop a cohesive approach supported by multi-agency working and tailored to the needs of the local population in order to reverse the trend of rising obesity prevalence. A clear strategy is needed in order to co-ordinate and drive forward partnership work to tackle obesity in Reading and measure its subsequent success against defined objectives.

- *T*he draft Health and Wellbeing Strategy for 2017-2020 includes a priority on 'Supporting people to make healthy lifestyle choices' (with a focus on tooth decay, obesity and physical activity).

4. THE PROPOSAL

4.1 The Healthy Weight Position Statement for Reading has been informed through a number of actions, including:

- Examining local data sources to identify need; including Reading's Joint Strategic Needs Assessment and Health and Wellbeing Strategy, longitudinal data from the National Child Measuring Programme, The Active People Survey and Health Profile data.
- A West of Berkshire stakeholder conference, held to map current services that contribute to prevention or treatment of overweight and obesity and identification of where more support is needed.
- A development group brought together in the early stages of writing the statement, including representation from the voluntary sector, Dietetics, Health Visiting, leisure, transport, CCGs and Children's services.
- Feedback from Reading's Clinical Commissioning Groups regarding local needs.
- Acknowledgement of relevant National strategy and NICE guidance on best practice, for the prevention and management of overweight and obesity.

This work has helped us to identify both the range of programmes already available to support people to be a healthy weight in Reading and highlighted where we need to further focus our efforts.

Proposed areas of focus include:

- Provision of information and support to help people manage their weight
- A continued focus on helping the least active members of the population to move more
- Strengthening our work with schools and families to help more children be a healthy weight
- Provision of support for parents in early years settings
- Supporting/encouraging teenagers to eat healthily and have active lifestyles

Initial emerging priorities, which if agreed, will form the basis of the action plan are:

1. **Tier 1 / Primary prevention: To prevent children and adults from becoming overweight or obese through supporting healthy eating and active lifestyle habits throughout life.**

Proposed priorities are to build on current work to:

- Raise awareness of why a healthy weight is important, what a healthy weight is for all ages and how to maintain this.
- Promote healthy eating and an active lifestyle for all children in schools and at home.
- Enable and encourage people of all ages to move more on a daily basis through structured or unstructured physical activity, in line with Chief Medical Officer Guidelines.

- Encourage children and adults to minimise prolonged periods of sedentary behaviour such as screen time.
- Ensure that residents can access advice about preparing or buying affordable, culturally acceptable, healthy meals and snacks

2. **Tier 2 services / Community Weight Management Programmes.**

- Continue to ensure that commissioned Lifestyle based programmes for overweight or obese adults and children in the community adhere to NICE guidance.
- Ensure that providers of these programmes encourage sustainable behavior change by signposting people to tier 1 healthy eating and physical activity programmes or to their GP if more intensive support is required.
- Work to provide more healthy weight support for families in early years settings and for teenagers.

3. **Tier 3 services: Commissioned by CCGs**

- We will continue to work with our partners to consider how gaps in Tier 3 provision could be addressed.
- We will ensure that providers of tier 2 commissioned services recognize when to refer obese patients or those with significant health conditions to their GP to access specialist clinical support; for example Dietetic services or clinical psychology .

4. **Next steps in development:**

A draft action plan (Appendix B) is in development, and as a starting point, includes some of the work that is underway or being planned by the council. Examples include the following actions:

- The commissioning and implementation of tier 2 lifestyle and weight management services for overweight and obese adults and school-aged children that align with NICE guidance and which support long term, sustainable lifestyle changes.
- The inclusion of healthy eating and physical activity promotion within the 0-19 service.
- To hold a 'Walking Volunteer recruitment workshop' for voluntary groups and community services who work with people who have low physical activity levels.
- To offer 'Making Every Contact Count' training to the local voluntary and community sector.
- To ensure delivery of the National Child Measurement Programme and engagement with parents and schools to raise awareness of the issues of excess weight and signpost to local services.
- To identify funding opportunities to help increase physical activity levels in target groups.
- Input into the development of the new leisure services contract to provide to increase healthy lifestyle programme options for customers.

The next steps will be to further develop and enhance the detailed implementation plan. This includes engagement with and input from key stakeholders and to report back to the HWB in April with a final draft and action plan.

We will develop multi-agency steering groups with appropriate representation to work on each priority area in the action plan. We will invite representatives from across Reading Borough Council departments, Health, the community and voluntary sector.

The implementation plan will support delivery of priority 1 in the draft Health and Wellbeing Strategy to 'Support people to make healthy lifestyle choices with a focus on tooth decay, obesity and physical activity'

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Tackling obesity contributes towards a number of Public Health Outcome Framework indicators including:

- reducing sickness absence,
- utilisation of outdoor space for exercise / leisure purposes,
- reducing weight in 4-5 year olds and 10-11 year olds,
- reducing excess weight in adults,
- percentage of physically active and inactive adults
- reducing obesity related co-morbidities such as diabetes.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 A Stakeholder Event was held and a planning group, met in the early stages of developing the statement. This gave an opportunity for partners from the public, private and voluntary sectors to contribute towards identifying the needs and priorities for tackling overweight and obesity in Reading.

6.3 Council staff and external providers were invited to contribute to a scoping exercise to profile work currently underway in Reading and its reach.

6.4 A Berkshire-wide commissioner's workshop considered current provision at different tiers (1-4) of weight management service for the community and where we need to focus efforts to ensure good support at each level.

6.5 We will continue to engage with council departments and other local stakeholders on the strategic priorities through forums and dialogue. We will also bring together a local steering group to work on the development of an action plan.

7. EQUALITY IMPACT ASSESSMENT

7.1 Reading Borough Council must meet the Public Sector Equality Duty under the Equality Act 2010 and consideration will be given to this throughout the development and delivery of the action plan.

All sections of the heathy weight statement will continue to be developed with an awareness of inequalities of health identified through robust local data sets.

8. LEGAL IMPLICATIONS

8.1 We do not anticipate there to be any legal implications at this stage.

9. FINANCIAL IMPLICATIONS

9.1 The engagement associated with the action plan development will be met using existing resource and will not in itself require additional capital or revenue investment.

9.2 Engagement feedback and a steering group involving stakeholders will inform the development of a targeted Health Weight Action Plan. It will be an imperative that the action plan drives the efficient use of resources and identifies clear health benefits on investment so as to protect a sustainable local health and care system.

We recognise that given the breadth of influences on obesity, this is an opportunity to maximise use of resources across different partner agencies, in terms of work on the delivery of shared priority agendas.

10. BACKGROUND PAPERS

Joint Strategic Needs Assessment for Reading
Reading's Health and Wellbeing Strategy.

Health & Wellbeing Board

Reading Borough Council
Working better with you

Reading's Healthy Weight Statement

2017-2020

Foreword

It is increasingly and widely accepted that levels of obesity in Reading, as across the country, are a significant public health concern, which have a significant impact on people's physical health, emotional wellbeing and reduce life expectancy by an average of 8-10 years – the same as lifelong smoking.

Obesity is estimated to cost the economy £27 billion a year nationally, of which £352 million is attributed to social care costs. More importantly to us is the human cost in sickness and lost years of healthy life. It is also true that obesity is also a major contributor to the wide health inequalities between wealthier and poorer areas which are such a blight on our town.

Our vision:

> "To ensure children and adults in Reading to have the opportunity to achieve and maintain a healthy weight throughout their lives, by supporting them to make healthy diet choices and choose a physically active lifestyle"

The objectives of this document are to:

- ✓ provide a framework for the co-ordination of our work to tackle obesity.
- ✓ enlist the support and commitment of the whole Council and partners in the public, private and voluntary sectors to help people in Reading to:
- ✓ recognise the importance of a healthy weight and be able to identify what a healthy weight is.
- ✓ have access to accurate, relevant information and support to help them to achieve and maintain a healthy weight across the life course.
- ✓ be physically active in every-day life and choose active travel as a safe, attractive and convenient option.
- ✓ access acceptable, enjoyable, healthy food for themselves and their families both inside and outside the home.

Excess weight is strongly linked to a person's risk of developing serious long-term conditions such as Diabetes, Cardiovascular Disease and Cancer.

We know that in Reading we face a significant challenge to reverse the rising trend in obesity prevalence:

Over 35% of children are overweight or obese by the time they reach Year 6 in school and by adulthood, this figure has increased to 61%.

We are now seeing conditions previously considered to be diseases of adulthood appear in children and young people.

Reading has the highest density of fast food outlets in Berkshire.

Only 55.8% of the population in Reading are eating the recommended 5 portions of fruit and vegetables each day

54.7% of the adult population aren't achieving even 1 x 30 minute bout of physical activity a week.

Locally we recognise the severity of obesity and the need to strengthen our efforts to ensure that people who live and work in Reading can choose a healthy, active lifestyle and have the support that they need to be a healthy weight throughout their lives.

As well as recognising the good work that is already happening in Reading and developing new initiatives, we are committed to working together with partners and, more importantly, the people of Reading to finalise a strategy and develop a detailed implementation plan that will help combat overweight and obesity in Reading.

Councillor Graeme Hoskin

Chair, Reading Health & Wellbeing Board

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1: What is obesity?

Obesity is defined as carrying an excessive amount of body fat that is a risk to health.

Overweight' is defined as having a 'Body Mass Index' (BMI) of 25-29.9 'obesity' is defined as having a 'BMI' greater than 30.

Excess body fat that accumulates around the waist is considered to increase the risk of high blood pressure, heart disease and type 2 diabetes

Obesity is defined as carrying an excessive amount of body fat that is a risk to health. Excess body fat is stored when a person habitually takes in more energy (calories) from food and drink than they use up through the body's normal daily functions (such as growth, repair, breathing, digestion and physical activity).

Body Mass Index (BMI)

An adult's weight is considered in relation to their height to check if it falls within a healthy range.

Body Mass Index (BMI) is calculated by dividing weight in kilograms by height in metres squared.

This measure was primarily developed for European populations to define at what point excess weight increases someone's risk of long-term conditions such as Diabetes and Cardiovascular Disease.

'Overweight' is defined as having a 'Body Mass Index' (BMI) of 25-29.9 'obesity' is defined as having a 'BMI' greater than 30.

Table 1: World Health Organisation: BMI classification system for adults:

BMI range (Kg/m2)	Classification
< 18.5	Underweight
18.5 – 24.9	Healthy Weight
25 – 29.9	Overweight
30 – 34.9	Obesity
35 – 39.9	Obesity ii
40 +	Obesity iii

A child's BMI is calculated in the same way but then compared to UK growth charts to take account of different growth patterns.

For most people and at a population level, BMI is widely accepted as a good indicator of weight status. However, it should be noted that:

- BMI does not distinguish between how much of a person's bodyweight is fat (excessive amounts are a health risk) and lean tissue such as bone, muscle and organs. Therefore very active people with a high muscle mass may have a high BMI, but in fact have a healthy level of body fat.
- Healthy BMI cut offs can also be slightly different in older people and in those who are very tall or very short in stature.
- The World Health Organisation (WHO) recommends slightly lower BMI cut offs for Black, Asian and other ethnic minority groups, because of the number of new cases of long-term health conditions including type 2 diabetes, coronary heart disease and stroke is up to 6 times higher than in the white European population. However, these thresholds have not been universally agreed or adopted by NICE (the National Institute for Health and Care Excellence).

NHS choices offers an online Healthy Weight Calculator, which can be used to assess both adult and children's weight status.

Waist Circumference

Excess body fat that accumulates around the waist is considered to increase the risk of high blood pressure, heart disease and type 2 diabetes, even if a person has a BMI that falls within the healthy range.

Waist circumference is another commonly used indicator of excess weight that is a risk to health:

There is an increased risk of health issues if waist circumference is:

- more than 94cm (37 inches) for a man.
- more than 80cm (34.5 inches) for a woman.

The risk of health problems is significantly higher if waist size is:

- more than 102cm (40 inches) for a man
- more than 88cm (34.5 inches) for a woman.

As with BMI, it has been suggested that the thresholds for South Asian and Chinese populations are lowered due to increased propensity to store body fat around the waist.

However, this has not been universally agreed and currently, NICE does not consider there to be enough evidence to make this recommendation for all of the health issues considered, or a reduction in mortality risk.

Figure 1 - Increase in adult's mean waist circumference between 1993 and 2014

2: What's happening in Reading

Reading's Joint Strategic Needs Analysis (JSNA) examines data from the Health and Social Care Information Centre, National Child Measurement Programme and GP Obesity Register to provide an overview of obesity prevalance and trends in obesity in Reading.

Childhood obesity

- In 2014/15, 21.9% children in reception year (age 4-5) were overweight or obese
- In the same year, 35.6% of children in year 6 (age 10-11) were overweight or obese
- There is a strong correlation between carrying excess weight in childhood and subsequent obesity in adulthood.

The National Child Measurement Programme (NCMP) is a mandatory programme run by Public Health England and the Department of Health and delivery is commissioned by local authorities.

Children are weighed and measured in their reception year and again in year 6 by school nurses. This provides a picture of weight trends in the population, raises awareness of weight issues with schools and parents and helps with the planning of local services to tackle obesity.

Data from the NCMP shows that the percentage of local children who are overweight and obese in reception year is generally in line with the England average, except between 2009 - 2011 where it reached a peak of 26.2%.

Since 2011 the numbers have levelled out to between 21.9 - 23.5%.

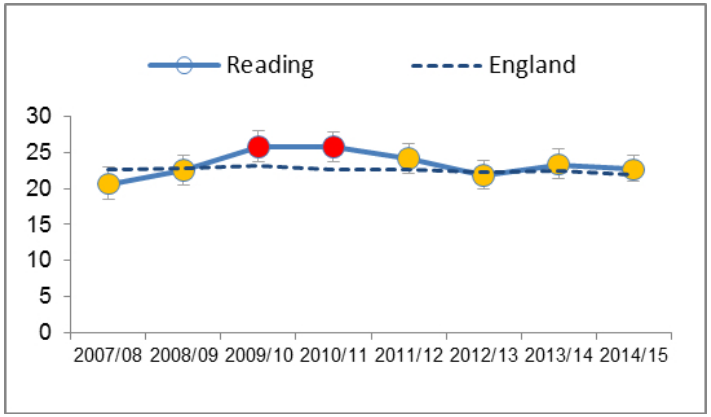


Figure 2 - Percentage overweight and obese children in reception

The percentage of overweight and obese children in Year 6 is in line with the England average, with the exception of a spike in 2009-10 where it peaked at 36.2% levelling out to between 34.5 - 35.6% from 2012 to 2015 (figure 2.2).

Figure 3 - Percentage overweight and obese children in year 6

The number of overweight and obese children increases significantly between reception and year 6 (*Figure 4*).

This demonstrates the cumulative impact of lifestyle factors on a child's weight over time.

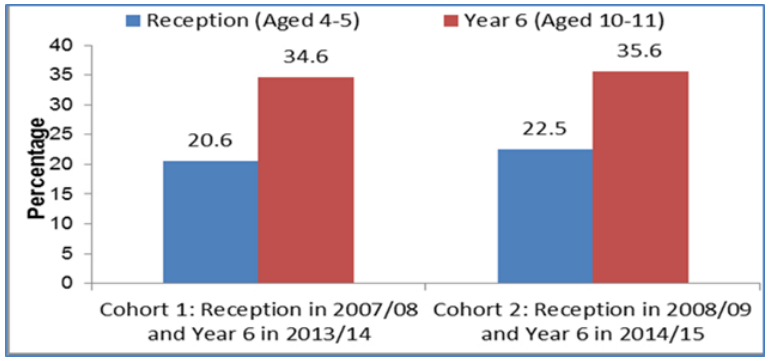


Figure 4 - Change in overweight and obese children between reception and year 6

Although the prevalence of overweight and obese children seems to be stabilising, the absolute figures are still of great concern as they indicate that a significant number of Reading's children are at risk of physical and mental ill-health, as well as the emotional impact of teasing and bullying.

Type 2 Diabetes, once considered to be a disease of adulthood, is now being diagnosed in young people and children - the most common cause is obesity.

There is a strong correlation between carrying excess weight in childhood and subsequent obesity in adulthood with the associated risk of diseases.

How Reading compares to similar areas

There is a significant relationship between increasing levels of deprivation and higher obesity prevalence in children. Reading sits in the fourth least deprived decile (out of ten).

Figures 5 and 6[1] show that out of 15 areas in England with similar levels of deprivation, Reading has the second highest percentage of overweight and obese children in both reception and year 6.

Area	Value	Lower CI	Upper CI
England	9.1	9.0	9.2
Fourth less deprived decile (IMD2015)	8.4*	-	-
Cheshire West and Chest...	9.7	8.8	10.7
Reading	9.7	8.5	11.0
Hillingdon	9.5	8.6	10.5
Kent	9.1	8.7	9.6
Milton Keynes	8.9	8.0	9.9
Bedford	8.8	7.7	10.1
Northamptonshire	8.6	8.0	9.2
Herefordshire	8.3	7.1	9.7
Warrington	8.3	7.3	9.5
Suffolk	8.0	7.4	8.6
East Sussex	7.9	7.2	8.6
Wandsworth	7.8	6.9	8.9
Derbyshire	7.7	7.2	8.3
Nottinghamshire	7.5	7.0	8.1
Stockport	7.2	6.4	8.2

Figure 5 - Excess weight in reception year 2014/2015 compared to areas with similar levels of deptivation

[1] Figures are updated annually. See the Child Health Profiles section of the Public Health Outcomes Framework website www.phoutcomes.info

Area	Value	Lower CI	Upper CI
England	19.1	19.0	19.2
Fourth less deprived decile (IMD2015)	17.7*	-	-
Wandsworth	20.5	18.8	22.3
Reading	20.4	18.4	22.5
Milton Keynes	19.4	18.0	20.8
Hillingdon	19.3	17.9	20.7
Bedford	18.6	16.8	20.5
Northamptonshire	18.5	17.6	19.4
Cheshire West and Chest...	18.5	17.2	19.8
Herefordshire	18.2	16.4	20.2
Kent	18.1	17.5	18.7
Nottinghamshire	17.2	16.3	18.0
Derbyshire	17.0	16.1	17.8
Suffolk	16.8	16.0	17.7
Warrington	16.1	14.6	17.7
East Sussex	15.7	14.7	16.8
Stockport	15.6	14.3	17.0

Figure 6 - Excess weight in year 6 2014/2015 compared to areas with similar levels of deprivation

More detailed local obesity and lifestyle data can be viewed in Reading's Joint Strategic Needs Assessment (JSNA).

The national picture

The NCMP in 2013/14 showed that across England:

- The percentage of children measured as obese (9.5%) was higher than in 2012/13 (9.3%) but lower than in 2006/07 (9.9%) when the programme began.
- The percentage of children measured as obese in Year 6 (19.1%) was higher than in 2012/13 (18.9 per cent) and in 2006/07 (17.5 per cent).
- There is a strong correlation between rising levels of deprivation and prevalence of obesity, both in reception and year 6.
- Obesity prevalence is higher in urban areas than rural areas, both in reception and year 6.

The Chief Medical Officer has called for the Government to make tackling obesity a national priority in recognition of the scale and severity of the issue (CMO report 2014).

In August 2016, the government published 'Childhood Obesity: a plan for action', which details their strategy to significantly reduce childhood obesity over the next ten years.

The plan emphasises:

- reducing the amount of sugar in food and drinks and
- encouraging primary school children to eat healthily and be more active.

See section 8 for a list of key actions included in the childhood obesity plan

Adult overweight and obesity in Reading

61% of Reading adults are overweight or obese

Obesity is a significant factor contributing to the rise in type 2 diabetes, heart disease, fatty liver disease, some forms of cancer and mental ill health.

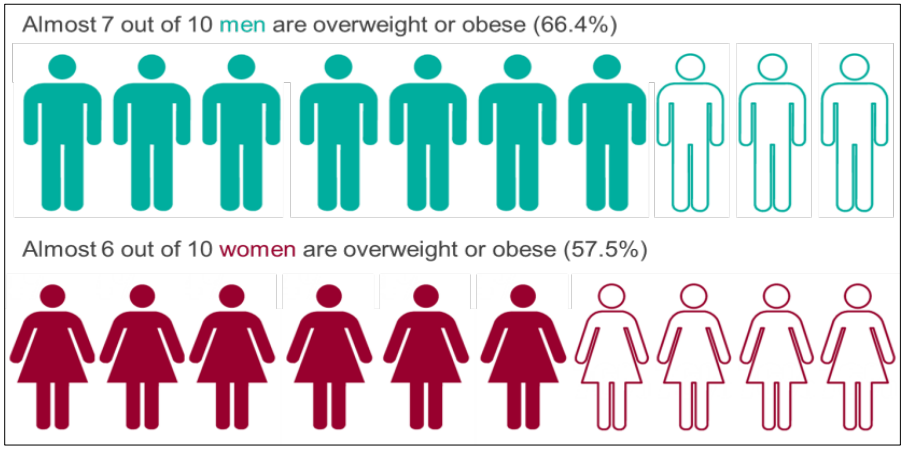
There is a strong correlation between rising levels of deprivation and increasing prevalence of obesity.

61% of adults in Reading are overweight or obese[2].

Although this is lower than the England average (64.6%) and most similarly deprived local authority areas, the absolute figures are significant.

Without action this will have a huge impact on our resident's health, quality of life and continue to burden health and social costs

Figure 7 – percent overweight men and women (Three year aggregate from HSE 2012/14)



The national picture

In England, the prevalence of obesity in adults rose from 14.9% to 25.6% between 1993 and 2014. Although the rate of increase has slowed, it is still rising.

The Health Survey for England (HSE) 2013 reported that 67% of men and 57% of women are overweight or obese, increasing their risk of poor health.

Obesity is a significant factor contributing to the rise in type 2 diabetes, heart disease, fatty liver disease and some forms of cancer.

[2] Source: Health Profiles section of the Public Health Outcomes Framework website www.phoutcomes.info

Healthy eating

- In 2014, 55.8% of the population in Reading reported achieving the recommended 5 portions of fruit and vegetables a day.
- Reading has the highest concentration of fast food outlets per 100,000 of the population in Berkshire.

Fruit and vegetable intake is often used as an indicator of overall dietary balance.

In 2014, 55.8%[3] of the population in Reading reported achieving the recommended five portions of fruit and vegetables each day - this is similar to the England average.

Fast food outlets

Fast food outlets (defined as fast food and takeaway outlets, fish and chip shops and fast food delivery services) are now easily accessible in most urban areas. Most sell mainly high calorie, affordable, palatable food, which has poor nutritional value.

Data from the National Obesity Observatory shows a strong correlation between rising levels of deprivation and a higher density of fast food outlets and, as previously noted, obesity prevalence is higher in deprived areas.

Reading has the highest concentration of fast food outlets per 100,000 of the population in Berkshire (Table 3.1)

Table 2 - Fast food outlets per 100,000 population in Berkshire

Local Authority area	No. fast food outlets/100,000 of the population (crude rate)
Reading	104
Slough	79
Windsor & Maidenhead	56
Bracknell Forest	44
West Berkshire	44

[3] Public Health Outcomes Framework update, February 2016

Physical Activity

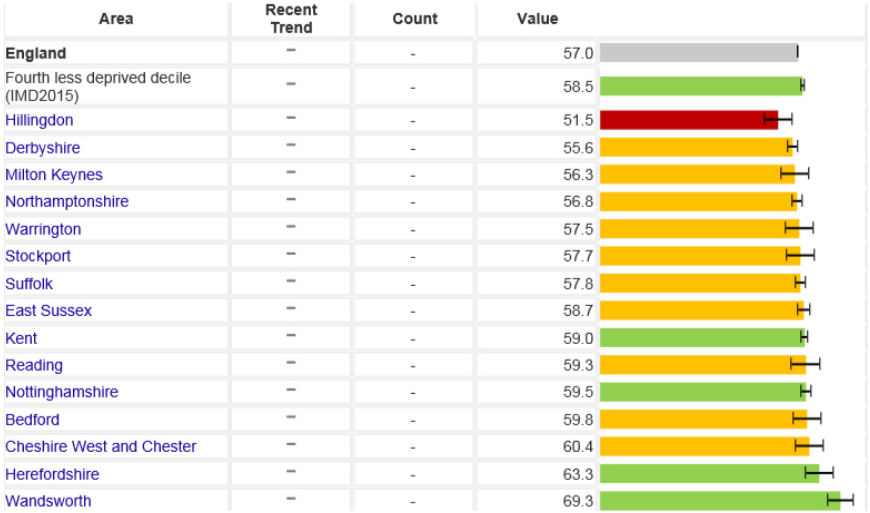
Information on levels of physically activity in Reading is collated from key data sources including:

- The Health Survey for England – which reports how much time respondents spent being physically active and sedentary in relation to the UK Chief Medical Officer Guidelines.
- The Active People Survey – a self-reported survey of sport and active recreation among adults (14+) in England
- The Youth Sport Trust National PE, School Sport and Physical Activity Survey

- ➢ 40.5 - 49.6% of local people don't do enough physical activity to protect their health.
- ➢ Significantly more men take part in sport and active recreation than women
- ➢ Participation in sport and active recreation is lower in more deprived areas.

Adults in Reading

The Active People Survey 2014 indicates that 50.4 -59.5% of Reading residents reported achieving the Chief Medical Officer targets for physical activity[4]. This is lower than the average in the South East region, but similar to the England average and with other areas with comparable levels of deprivation (*Figure 8*).

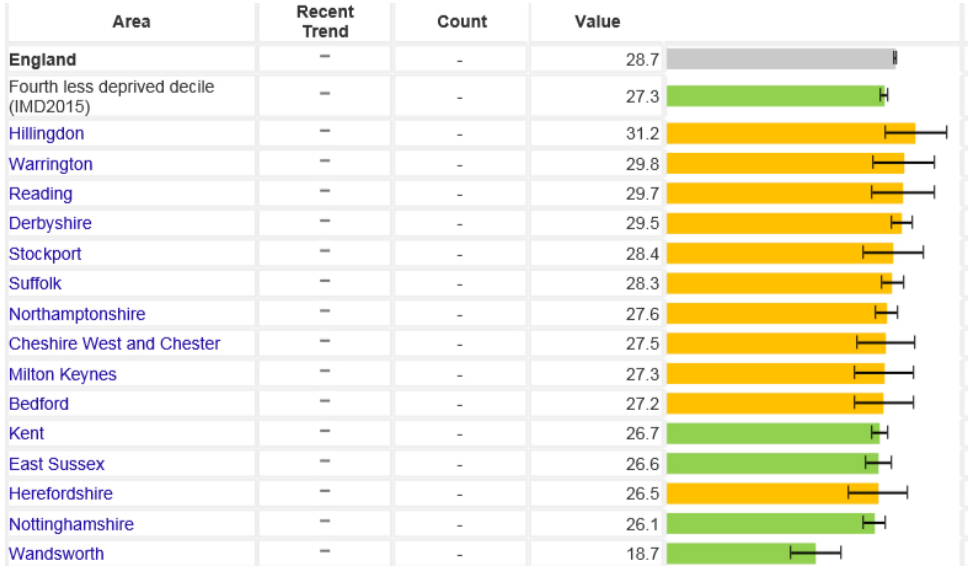


Area	Recent Trend	Count	Value
England	-	-	57.0
Fourth less deprived decile (IMD2015)	-	-	58.5
Hillingdon	-	-	51.5
Derbyshire	-	-	55.6
Milton Keynes	-	-	56.3
Northamptonshire	-	-	56.8
Warrington	-	-	57.5
Stockport	-	-	57.7
Suffolk	-	-	57.8
East Sussex	-	-	58.7
Kent	-	-	59.0
Reading	-	-	59.3
Nottinghamshire	-	-	59.5
Bedford	-	-	59.8
Cheshire West and Chester	-	-	60.4
Herefordshire	-	-	63.3
Wandsworth	-	-	69.3

Figure 8 – Percentage of physically active adults in Reading compared to LAs with similar levels of deprivation

This means that 40.5 - 49.6% of local people don't do enough physical activity to protect their health.

[44] 'physical activity' is defined as of at least moderate intensity and completed in bouts of ten minutes or more. CMO target for good health is at least 150 minutes/week



Area	Recent Trend	Count	Value
England	-	-	28.7
Fourth less deprived decile (IMD2015)	-	-	27.3
Hillingdon	-	-	31.2
Warrington	-	-	29.8
Reading	-	-	29.7
Derbyshire	-	-	29.5
Stockport	-	-	28.4
Suffolk	-	-	28.3
Northamptonshire	-	-	27.6
Cheshire West and Chester	-	-	27.5
Milton Keynes	-	-	27.3
Bedford	-	-	27.2
Kent	-	-	26.7
East Sussex	-	-	26.6
Herefordshire	-	-	26.5
Nottinghamshire	-	-	26.1
Wandsworth	-	-	18.7

Figure 9 - Percentage physically inactive adults in Reading compared to LAs with similar levels of deprivation

Figure 9 shows that Reading ranks 3rd out of 15 local authorities in the same deprivation decile for the percentage of adults who are considered 'inactive' (doing less than 30 minutes of physical activity a week).

Other factors affecting participation

Reading's JSNA reports that:

- there is a significant participation gap in sport and active recreation in the borough between the sexes, with almost twice as many men participating for at least 3 x 30 minutes on a weekly basis.
- Reading follows the National trend for participation to be lower in lower socio-economic groups.

However, there appears to be little difference between participation levels in White and British Minority Ethnic groups.

Physical Activity in schools

In 2015 the Youth Sport Trust reported findings from the first National PE, School Sport and Physical Activity Survey. Data is not available by Local Authority area, but National data has identified that the average number of minutes spent taking part in PE in a typical week was 102 minutes for Key Stage 1 pupils and 114 minutes for Key Stage 2 pupils.

Other health inequalities

Although there is very limited local data, national research shows that particular groups are a greater risk of becoming obese. Headlines include:

- Obesity increases with age up until the ages of 55-64 in men and 65-74 women
- Some BME groups (particularly South Asian communities and women from Black African groups) store fat differently and so their risk of obesity related ill health is increased
- The risk of obesity is higher in children from a number of BME groups compared with White British children of the same age
- People with physical and/or learning disabilities tend to have a higher risk of obesity and lower physical activity levels
- There are strong associations between mental health problems and obesity

For more details see "Does obesity affect all groups equally" in section 9

3: Why we are concerned about obesity

- Severe obesity (having a BMI of 40-50Kg/m2) can reduce life expectancy by 8-10 years, which is the same as lifelong smoking.
- Many chronic health problems are associated with obesity in childhood, as well as an increased risk of bullying, lower attainment and school absence.
- There is strong evidence that obesity is associated with increased risk of Cardiovascular disease, type 2 Diabetes, some Cancers and mental health problems.
- These health issues have a significant impact on health and social care costs, productivity and time lost from work through sickness absence.

Impact on life expectancy

We know that morbid obesity (having a BMI of 40-50Kg / m2) can reduce life expectancy by 8-10 years, which is the same as lifelong smoking!

Even moderate obesity (BMI 30-35Kg / m2) can reduce life expectancy by an average of 3 years (National Obesity Observatory).

These statistics are based on studies looking at the effects of becoming obese by middle age - we don't yet know the full impacts of childhood obesity on mortality risk.

There is a significant link between being an overweight or obese child and becoming an obese adult. Establishing a healthy weight and healthy lifestyle habits in early years will help to create the blueprint for life.

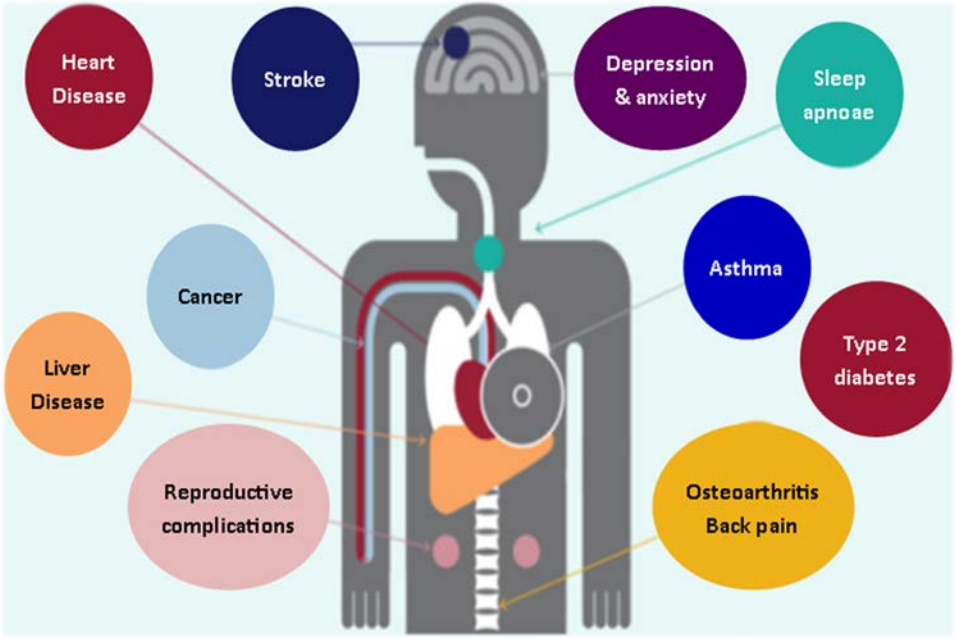


Figure 10 - How obesity harms health

Links chronic health & wellbeing

A number of chronic health problems are associated with obesity in childhood; including:

- Type 2 Diabetes
- Asthma
- Other respiratory problems
- Heart disease risk factors
- Mental health disorders
- Muscle and bone problems

Obese children are also more likely to experience bullying, have lower attainment and more frequent absences from school.

There is strong evidence that obese adults have an increased risk of several chronic health conditions including (but not limited to):

- High blood pressure, heart disease and stroke
- Type 2 diabetes (with complications such as blindness and limb amputation)
- Some forms of cancer
- Osteoarthritis.
- Reproductive problems in men and women
- Gallstones
- Stress, low self-esteem, social disadvantage and depression

These have a significant impact on health and social care costs, productivity and time lost from work through sickness absence.

The Impact on society and the economy:

- An overweight population with lower levels of physical activity will have more sickness absence
- Severely obese people are three times as likely to need social care as those who are a healthy weight (Public Health England).
- The annual cost of obesity to the wider economy is estimated to be £27 billion nationally.
- Obesity substantially increases the risk of serious diseases and premature death, particularly in areas of socio-economic deprivation, where prevalence is highest.
- The first report of the National Bariatric Surgery Register estimates that treating the consequences of obesity costs the NHS over £5 billion a year. A significant proportion of this cost has been attributed to the management of Diabetes and its comorbidities, which also impacts on social care costs.
- The Institute of Diabetes for Older People[5] estimates that in 2013 there were 70,000 people with diabetes receiving local authority-funded direct care at a cost of £1.4bn/year and that by 2030 this could increase to 130,000 at a cost to local authorities of £2.5bn

[5] Institute of Diabetes for Older People, Novo Nordisk. The hidden impact of diabetes in social care. Institute of Diabetes for Older People, Novo Nordisk. London. 2013

4. Prevention and Management of Obesity

- The main considerations for maintaining a healthy weight are balancing diet and physical activity, whilst avoiding extreme behaviours such as fad diets.
- 'Family Food 2014' shows that UK households are not currently meeting the Eatwell Guide recommendations for healthy eating.
- Average calorie intakes reduced by 32 per cent per person between 1974 and 2014 but obesity levels have increased significantly, largely due to reduced activity levels.
- Currently, 64% of journeys are made by car, with only 22% on foot and 2% by bike.

The two main considerations are a healthy diet and physical activity.

The National Institute for Health and Care Excellence (NICE) has published recommendations based on the best available evidence for health, public health and social care organisations.

NICE recommends that we should encourage everyone to adopt lifestyle habits that guard against excess weight gain across their lifespan.

These include healthier eating and increased physical activity to help balance energy intake and expenditure and avoid diseases associated with excess weight gain (avoiding extreme and unsustainable exercise or dietary behaviours such as 'fad diets').

Full recommendations can be found in NICE Guideline 7: Preventing Excess Weight Gain

Healthy Diet

The Eatwell Guide (revised March 2016) illustrates the Government's recommendations for healthy eating and represents the proportions of the five main food groups that are recommended in a balanced diet:

- Fruit and Vegetables.
- Starchy Foods (such as bread, potatoes, rice, pasta).
- Dairy or Dairy alternatives (e.g. Soya).
- Beans, Fish, Meat, Pulses, Eggs and other Protein.
- Unsaturated Oils and Spreads.

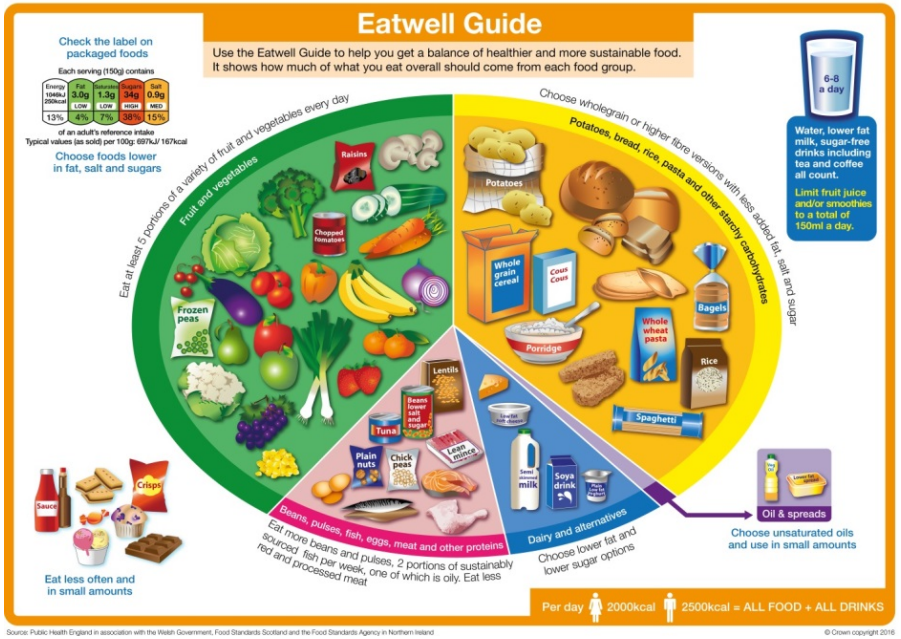


Figure 11 - The Eatwell Plate

Although the total amount of food needed varies between individuals, the proportions are appropriate for adults and children from the age of 2 years, regardless of ethnicity, dietary restrictions and body weight.

The guide also recommends average calorie intakes for adults and guidance to help use 'front of pack' traffic light food labelling for fats, saturated fats, salt and sugar in foods.

The revised Eatwell Guide takes on board guidance from the Scientific Advisory Committee for Nutrition (SACN) on 'Carbohydrates and Health' published in 2015.

This report recommends that we should:

- continue to consume 50% of daily intake calories from carbohydrate
- increase dietary fibre intake to 30g a day for adults
- reduce 'free sugars' (for example sweetened soft drinks, fruit juices, table sugar, cakes, biscuits, some breakfast cereals) to no more than 5% of total calories (previously 10%).

A diet based on these recommendations can help achieve a healthy weight and help to protect against Cardiovascular Disease, Stroke, some forms of Cancer and type 2 Diabetes.

A number of celebrity-endorsed and fad diets have focused on the omission of a particular food group such as carbohydrates – these diets contradict recommendations for long-term health and sustainable weight management.

All commissioned programmes for weight management should base dietary advice on the key recommendations from the Eatwell guide.

Family Food 2014 shows that UK households are not meeting Eatwell Guide recommendations. Disparities are particularly pronounced in lower income households (*Figure 12*)

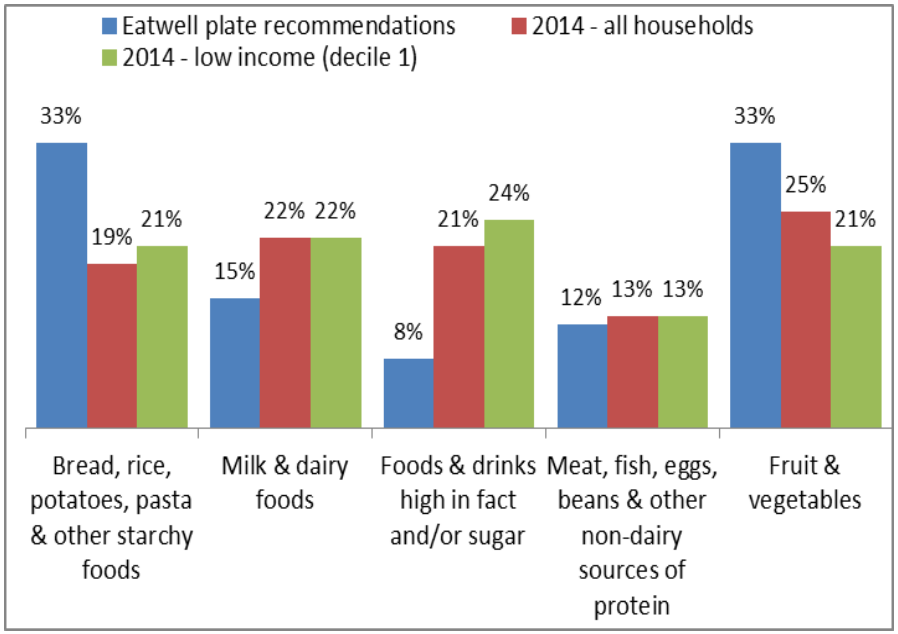


Figure 12 - Comparison between all household and low income household diets and the Eat Well recommendations.

The survey found that:

- consumption of carbohydrates (bread, potatoes, pasta and other starchy foods and fruit and vegetables) is below the recommended intake
- consumption of milk and dairy and foods high in fat and sugar is above the recommended intake.
- consumption of non-dairy sources of protein such as meat, fish, eggs and beans was about in line with the Eatwell guide.

Physical Activity

- Regular physical activity can reduce the risk or delay the onset of a number of long-term conditions including: obesity, type 2 diabetes, cardiovascular disease, some forms of cancer musculoskeletal problems, osteoporosis and falls
- It reduces the risk of dependency on social care due to impaired physical capability.
- It also has a number of positive mental health benefits including improved self-esteem, body perception, mood, sleep patterns, energy levels and reduced anxiety.

'Start Active, Stay Active - A report on physical activity for health from the four home counties' Chief Medical Officers' examines the evidence for the benefits of physical activity on health which underpins the CMO UK physical activity guidelines.

Despite the known benefits:

- 54.7% of the Reading's adult population are not achieving even 1 x 30 minute bout of physical activity a week
- the proportion of adults who were achieving 1 x 30 minute bout of physical activity a week fell significantly between 2005/06 and 2014/15 (Active People Survey).
- overall physical activity levels have reduced significantly in the last decade this has been largely attributed to an increase in sedentary jobs and recreational activities (like computer games, TV and internet use)
- there was a 30% reduction in walking between 1995-2013.
- 64% of journeys are made by car, with only 22% on foot and 2% by bike.

Figure 13: Ready Bike provides opportunities for active travel in Reading

Obesity levels have increased significantly, in spite of a 32% drop in the average calorie intake between 1974 and 2014 – this is due to the energy imbalance between calorie intake and expenditure.

Building design often favours sedentary activity for example, through making lifts more visible and accessible than the stairs and fears of vandalism or crime discourages people from using outdoor spaces for recreation and play.

The Chief Medical Officers' Guidelines for physical activity are age-specific and span the life-course (*Table 3)*

They start with preschool children, where evidence suggests an association between physical activity, physical and psychological development and behavioural patterns that may persist into later childhood and adulthood.

Emerging evidence suggests that accumulated time spent being sedentary (e.g. sitting at a desk, watching TV or using a computer) is inversely associated with the risk of overweight and obesity, insulin resistance, type 2 diabetes, some cancers, cardiovascular and all-cause mortality in both adults and children. This risk is independent of the amount of physical activity undertaken.

Different forms of physical activity appeal to different people - strategies to increase participation should consider:

- Attitudes and beliefs, knowledge, personal preferences and perceptions.
- The environment - for example, access to facilities and open spaces, permeability of built up areas allowing walking and cycling to be a convenient and safe option.
- Cultural and societal influences such as perceived norms, peer pressure and priorities.
- State of health – physical and mental, which may affect ability to participate in sports or active recreation.

Table 3: CMO Physical Activity guidelines

Age Group	Moderate to vigorous physical activity	Activities that strengthen muscles and bone.
Under 5/Not walking	Physical activity should be encouraged from birth, particularly through floor-based play and safe, water-based activities.	n/a
Under 5/walking	At least 180 minutes (3 hours) across the day.	n/a
5-18 years	Moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.	Min 3 days/week
19-64 years	At least 150 minutes (2.5 hours) of moderate intensity activity in bouts of 10 minutes or more per week or 75 minutes of vigorous intensity activity. Minimise sedentary behaviour.	At least 2 days a week.
65+	Some physical activity is better than none, and more physical activity provides greater health benefits. Aim to be active daily, aiming for at least 150 minutes (2.5 hours) of moderate intensity activity in bouts of 10 minutes or more.	Min 2 days/week. Older adults should include activities to improve balance and co-ordination at least twice/ week.

Behaviour Change

A person's decision to change their eating and physical activity behaviour can be influenced by their knowledge, self-perception and beliefs. For example:

- Self-appraisal of their own diet and levels of activity.
- Attitudes towards body weight, healthy eating
- The number and significance of facilitators and barriers to change in the immediate environment.
- Social influences e.g. cultural norms
- Confidence in their ability to make lifestyle changes.

It is important to understand the key lifestyle behaviours of high risk groups when choosing or developing interventions to tackle obesity.

Providing services and information alone may not be sufficient to motivate sustainable changes in eating and physical activity habits. Therefore, strategies to encourage healthy eating and physical activity must emphasise and help people to identify the health and social benefits of change that are relevant to them and subsequently help them to find realistic solutions to potential barriers.

Behaviour change research by the Department of Health has highlighted key insights amongst families with children aged 2-11; both in the general population and BME groups.

Some of the key themes focused on:

- ✓ Recognition of obesity – Whilst parents acknowledged that excess weight is a problem; only 11.5% of parents with overweight and obese children identified them as being an unhealthy weight.
- ✓ Parents are often unaware of the health risks associated with being overweight, snacking habits and sedentary behaviour.
- ✓ Parents often believe that if their children are happy, achieving at school and observing faith practices in some cultures, then this means that they are healthy.
- ✓ In some population groups, higher risk behaviours such as food abundance and excess weight are seen to be positive, for example as cultural and status symbols.
- ✓ Some parents believe that their children get enough physical activity at school and priorities out of school time tended to be homework and / or religious duties rather than to play or do sport. Sport is not an integral part of some cultures.
- ✓ In more deprived areas, healthy living can be perceived to be expensive and inaccessible; for example, having to buy special 'health foods' and have a gym membership.

The full insight summary can be found in TOOL D9 Targeting behaviours on the Faculty of Public health website

5. What we are doing to combat obesity

In March 2014, Public Health England and NHS England produced a report[6] setting out responsibilities for commissioning obesity services:

Local Authorities have primary responsibility for commissioning:

- Tier 1 services - population-level programmes which encourage everyone to eat healthily and take physical activity to help maintain a healthy weight.
- Tier 2 services, which include lifestyle-related weight management services. These services are usually based in the community, workplace, primary care or online and are run by the public, private or voluntary sector. Referrals to services may be made by individuals themselves or by health or social care professionals.

Clinical Commissioning Groups (CCGs) have primary responsibility for commissioning:

- Tier 3 services - clinician-led, specialist interventions delivered by a multidisciplinary team (Dietitian, exercise specialist and psychological therapist) for people with higher BMIs or multiple health issues and those who have been unsuccessful in losing weight through tier 2 interventions.

The commissioning of Bariatric surgery currently sits with specialist commissioning (**NHS England**) but is anticipated to move to CCGs in April 2017.

Obesity is a complex issue we need to work across departments and organisations to make a sustainable difference at both an individual and societal level.

Local authorities also need to work with external stakeholders in a cohesive effort to bring together the skills and resources to help people achieve and maintain a healthy weight across their lifespan.

Where tackling obesity has been identified as a priority by organisations, a strategic commitment and identified leadership to drive forward this agenda consistently and with a long term vision can help to develop an effective approach to reducing obesity in Reading.

[6] *Report of the working group into: Joined up clinical pathways for obesity, 14th March 2014*

Tier 1 services

Breast-feeding

Given the mounting evidence suggesting that breast-feeding reduces a baby's risk of becoming overweight and developing high blood pressure and diabetes in adulthood compared to formula feeding the Council currently commissions or supports:

- A health visiting service providing expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs.
- Health visitors also advice on breastfeeding (initiation and duration), healthy weight, healthy nutrition and physical activity to help empower parents to make good decisions that affect their family's health and wellbeing.
- Breast-Feeding peer support offering mother-to-mother support to increase breastfeeding initiation and continuation.

Early Years

It is known that many eating behaviours and preferences are learned in the first two years of life and physical activity levels in early years can impact on future risk of obesity.

The Council provides:

- Children's centres across the Borough which offer families with children under 5 access to a range of activities and support, including active play and health advice - most services are free.

National Healthy Child Programme 0-19

This programme will be commissioned in 2017 to provide a framework to promote good health, wellbeing and resilience in in children and young people through collaborative working and more integrated delivery of support.

One of the aims of the programme is to reduce childhood obesity by promoting healthy eating and physical activity.

Locally we will aim to:

- ensure that all children and young people receive the Healthy Child Programme 0-19 offer, including universal access and early identification of additional and/or complex needs, with timely access to specialist services, to secure local services that enable health visiting and school nursing teams to contribute to improved local outcomes and reduce health inequalities for children and young people

School meals

The Council aims to provide environments that foster healthy balanced eating habits by commissioning and supporting school meal services:

- Since September 2014, all infant schools in Reading have been compliant with the Government's Universal Infant Free School Meals programme which ensures all young children can have at least one balanced hot meal each day. Evidence from pilot sites showed that this scheme resulted in a 23% increase in the number of children eating vegetables at lunch and an 18% drop in those eating crisps.
- By 2016, all schools under the Council's Chartwells Contract had achieved the Food 4 Life Silver catering mark - an independent endorsement which shows food providers are taking steps to improve the food that they serve. For example, using fresh, additive-free ingredients, avoiding trans-fats and compliance with national school food standards.
- Councils across Berkshire worked with the Children's Food Trust in 2015 to offer training to junior and secondary schools with low uptake of free school meals, to help them improve their dining environment.

Schools

The Council co-ordinates the National Child Measurement Programme and commissions the School Nursing Team to:

- Weigh and measure children in Reception and Year 6 each year as a mandated Public Health function
- Send feedback to parents with support options if their child's weight could be a risk to their health.
- Offer support and advice to families with overweight/obese children on diet /healthy lifestyles and onward referral to children's physical activity healthy lifestyle and healthy weight programmes.

We also:

- Provided schools with feedback from Public Health England about the levels of overweight and obesity in their school in relation the Reading average.

Healthy lifestyle

Providing opportunities for people to take part in a variety of enjoyable physical activities, along with a healthy diet, can have a positive impact on weight, health and wellbeing, and school attainment in children. (See NICE guidelines on maintaining a healthy weight in children and adults)

The Council promotes opportunities for adults and children to maintain a healthy active lifestyle through:

- A range of sports and leisure facilities, courses, classes and activities providing opportunities for children and adults to be physically active through Reading Sport and Leisure (RSL)
- Your Reading Passport (YRP) – a residents scheme offering discounts on a range of Reading Borough Council facilities and activities, with further concessions for the over 60s people with disabilities and families on low incomes
- Parent and child cycle training in partnership with Reading CTC
- After school, holiday and summer play clubs for 0-13 year olds through Reading Play
- Walking programmes

Planning

- Providing for walking and cycling in new development, including cycle parking
- Identifying sites for new sports and leisure facilities
- Ensuring that new development has good access to open space, and providing new on-site open space in the largest housing developments
- Making public areas as inviting as possible to encourage people to move around on foot.
- Placing limits on the opening of new hot food takeaways.

Healthy Workplaces

The Council promotes a healthy workplace by:

- Offering a 'Cycle to Work' scheme
- Having designated Healthy Workplace Champions to encourage colleagues to adopt healthy lifestyle opportunities
- Offering Discounted gym membership in RSL centres.
- Promoting Get Berkshire's 'Active's Workplace' and 'Pedometer' Challenges.

Active travel

The Council secured funding from the Local Sustainable Transport Fund to commission a number of projects to promote active travel, including:

- A pedestrian / cycle bridge across the River Thames
- Cycle schemes and cycling promotion in schools.

Tier 2 Services

Weight management interventions for children

The Council commissions:

- Let's Get Going - a weight management and healthy lifestyle service for children aged 7-12 years which offers family based advice on healthy eating, behaviour change and a practical physical activity element in local schools and community venues. The programme follows NICE guidance on community based weight management interventions for children.

Tackling obesity in adults

The Council commissions

- Eat 4 Health – a group-based weight management programme for adults aged over 16 years of age to support people with a BMI >25 to lose and maintain a healthier weight through healthy eating and physical activity. The programme follows NICE guidance for tackling obesity in adults.

The Council also works in partnership with local GP practices to provide:

- The GP Pathway Exercise Referral scheme provides structured, supervised exercise sessions for people with long-term conditions including obesity, diabetes and cardiovascular disease.

Tier 3 services

The CCG Operating Plan on Obesity and Diabetes recognises that a large proportion of patients requiring bariatric surgery have diabetes and that NICE guidance recommends considering those with recent-onset type 2 diabetes for bariatric surgery at a BMI of 30-34.9, provided that they are or will also receive assessment in a tier 3 service (or equivalent). Consequently as stated in the CCG Operating Plan:

'*The provision of comprehensive step wise weight management services to our population is therefore an important priority to help address and prevent people developing other illnesses, including Diabetes, which in turn further increases the health burden in our local area*'.

Public Health teams are working to support CCGs to develop of a West of Berkshire Tier 3 service to help meet the identified gap in the weight management pathway.

This will provide specialist intervention delivered by a multidisciplinary team to support and help reduce the numbers of patients moving to Tier 4 (bariatric surgery).

Tier 4 services

Bariatric Surgery is for people who are already clinically obese, where non-surgical interventions (tier 2 and 3) have proven ineffective. Evidence has suggested that because the internal satiety control becomes permanently re-set, it makes self-regulation of food intake particularly difficult.

Bariatric surgery helps weight loss either through restricting the amount of food that a patient can eat or the amount that the body can absorb. The two most common procedures are gastric banding and gastric bypass.

- Based on Commissioning Support Unit data, Berkshire has seen a 32% increase in spending over the last 5 years (2010/2011-2014/2015) on initial bariatric surgery procedures. The procedures have moved away from the Gastric band to Gastric bypass, which is more clinically effective for weight loss.

6. What do we need to do next?

Our priorities going forward include:

- Providing information and support to help people manage their weight
- Helping the least active members of the population to move more
- Working with schools and families to help more children be a healthy weight
- Providing more support for parents in early years settings
- Support/encourage teenagers to eat healthily and have active lifestyles

Prevention and early intervention are key strategies for reversing the tide of obesity.

Obesity is a largely preventable modern disease linked to potentially serious physical and mental health consequences.

A key Public Health focus nationally and locally, is to help prevent people from becoming overweight or clinically obese.

Currently the prevalence of overweight and obesity amongst adults and children in Reading by far exceeds the capacity of intervention programmes to tackle the issue. A long term, multi-organisational approach encouraging societal movement towards healthy eating and physical activity is required to help stem the rise in prevalence of overweight and obesity in children and adults.

Where are the unmet needs?

Physical activity (Tier 1)

We have a good range of active play, active travel and physical activity / sporting opportunities to support the maintenance of a healthy weight throughout life. But we need to do more to understand those who are currently inactive to help them overcome their barriers and have a more active lifestyle.

We need to work closely with schools and parents to promote healthy eating and an active lifestyle for all children.

Weight management (Tier 2)

Although we have commissioned tier 2 weight management programmes for school aged children and adults, places are limited and don't cover all age groups.

We need to ensure there is also support for early years (where formative eating behaviours develop) and in adolescence (where young people are becoming increasingly more independent and making choices about their eating and exercise habits).

Weight Management (Tier 3)

We need to continue to work with the CCGs to facilitate the development of tier 3 services to ensure we have comprehensive obesity care pathway at all levels of intervention.

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Key Actions:

Tier 1 / Primary prevention:

We will continue to build on current work to:

- Raise awareness of why a healthy weight is important, what a healthy weight is for adults and children and how to maintain this. For example through supporting National campaigns (such as Change 4 Life and One You), the NCMP and training front line staff in more settings to be able to use a 'Making Every Contact Count' style approach to raising the issue.
- promote healthy eating and an active lifestyle for all children in schools and at home.
- Enable and encourage people of all ages to move more on a daily basis through structured or unstructured physical activity, in line with Chief Medical Officer Guidelines. This includes promoting and enabling active play, walking, cycling and other forms of active travel, exercise and sport.
- Encourage children and adults to minimise prolonged periods of sedentary behaviour such as screen time. Provide appropriate information about healthy weight, the impact of maternal obesity and appropriate infant feeding; ideally given to parents before conception, but also during pregnancy and in infancy.
- Ensure that residents can access advice about preparing or buying affordable, culturally acceptable, healthy meals and snacks.

Tier 2 services:

We will:

- Continue to ensure that commissioned Lifestyle based programmes for overweight or obese adults and children in the community adheres to NICE guidance.
- Ensure that providers of these programmes encourage sustainable behavior change by signposting people to tier 1 healthy eating and physical activity programmes or to their GP if more intensive support is required.
- Work to provide more healthy weight support for families in early years settings and teenagers.

Tier 3 services: Commissioned by CCGs

We will:

- Continue to work with our partners to consider how gaps in Tier 3 provision could be addressed.
- Ensure that providers of tier 2 commissioned services recognize when to refer obese patients or those with significant health conditions to their GP to access specialist clinical support; for example Dietetic services or clinical psychology .

8. What the evidence and research says

We have used guidance from the following national documents to inform this strategy:

The National Childhood Obesity Action Plan

The National Childhood Obesity Plan (Aug 2016) details the action to be taken by central Government to tackle obesity including:

- Introducing a soft drinks levy and using revenue from this to invest in primary school PE and sports premium and breakfast clubs.
- Introducing industry targets for sugar reduction.
- Increasing the availability of healthy food options in the public sector.
- Support with the cost of healthy food in low income families
- Helping all children achieve 1 hour of physical activity a day delivered by schools and parents.
- Initiatives in schools to improve sport and physical activity programmes and make school food healthier
- Clearer food labelling.
- Developing voluntary guidelines for food served in early years settings.
- Providing revised guidelines and resources on diet, physical activity, weaning and healthy weight for healthcare professionals who support families.

NICE Guidance:

The latest evidence about what works and what offers good value for money is summarised in guidance produced by the National Institute for Health and Care Excellence (NICE)

All community weight management programmes commissioned by Reading Borough Council adhere to this guidance to ensure people are given accurate, safe, effective advice and support to manage their weight.

Does obesity affect all groups equally?

No, obesity is strongly linked to socio-economic status with higher levels of obesity seen in more deprived communities. Obesity is more common in women than in men and also in some British Minority Ethnic groups.

Unless action is taken to help people maintain a healthy weight or reduce their weight if they are already overweight the health inequalities gap will continue to grow.

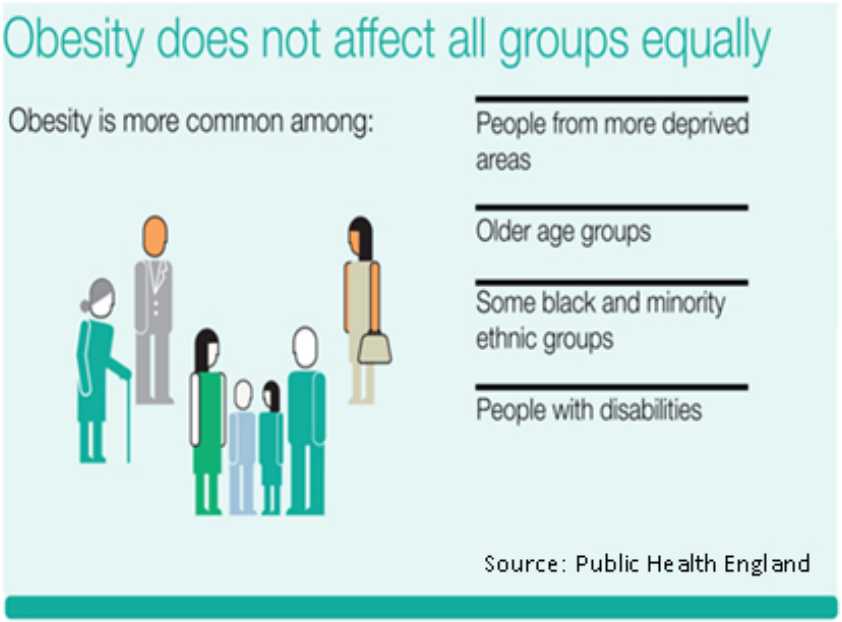
People from more deprived areas

Obesity prevalence has a strong association with socio-economic inequalities, the prevalence being highest amongst those from poorer backgrounds.

Children:

In the Thames Valley, data from the National Child Measuring Programme (NCMP) plotted against the Index of Multiple Deprivation (IMD)[7] shows an almost linear association between increasing prevalence of childhood overweight and obesity and rising levels of deprivation. 'Obese children are more likely to be ill, absent from school due to illness, experience health-related physical limitations and require more medical care than normal weight children' (National Obesity Observatory: Deprivation

We estimate there are around 2,300 children living in poverty in Reading. (Reading Borough Council Corporate Plan 2015-19).



Adults:

Men and women in unskilled, manual occupations are more likely to be obese than those in professional occupations.

Whilst Reading benefits from high employment and high earnings, 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 10% most deprived areas in England (Reading JSNA 2016)

[7] IMD - a composite measure of deprivation based on data from seven domains (income; employment; health and disability; education, skills and training; housing and services; crime; and living environment)

Obesity in older age groups:

Data from the National Obesity Observatory (NOO) shows that in adults, the prevalence of obesity is lowest in the 16-24 year age group and progressively increases with age up until the 55-64 year age band in men and the 65-74 year age band in women; after which prevalence begins to decline.

Overweight and Obesity in BME Groups:

35% of Reading's population are from Black and ethnic minority groups (Reading Borough Council Corporate Plan 2015-19)

Different ethnic groups tend to have different patterns of body fat storage, and the extent to which body fat increases the risk of health issues such as diabetes and cardiovascular disease varies accordingly.

For example, South Asian populations tend to have an increased risk of obesity-related diseases at a lower body mass index and waist circumference than European populations.

In addition, health-related lifestyle behaviours and beliefs related to religion, culture and socio-economic status can impact on the risk of obesity and related health conditions. For example, certain ethnic groups living in the UK are more likely to live in areas of deprivation (see below) - a known risk factor for overweight and obesity in women and children.

There is a trend in certain ethnic minority groups to have lower physical activity levels in the UK, for example, South Asian populations, particularly the Bangladeshi community, tend to have lower levels of physical activity than the White population.

Summary of data relating to obesity in BME groups:

Adults:

There is little nationally available data on obesity prevalence in British Minority Ethnic (BME) groups living in the UK. However, women from Black African groups appear to have the highest prevalence of obesity and men from Chinese and Bangladeshi groups have the lowest.

Women appear to have a higher prevalence in virtually all minority ethnic groups, particularly amongst Pakistani, Bangladeshi and Black African communities. These differences have been linked to diet, lower levels of physical activity and socio-economic status.

Children:

Data from the National Child Measuring Programme broken down by ethnicity shows that:

- Obesity prevalence tends to be lower in children from White British ethnic groups.
- In Reception, obesity is most prevalent in Black African, Black Other and Bangladeshi boys.
- By Year 6, boys from all BME groups have a higher prevalence of obesity than white British.
- In girls in Reception and Year 6, obesity prevalence is highest in Black African and Black Other groups.
- Obesity prevalence in children from some Asian groups, (particularly Bangladeshi, Asian Other and Pakistani ethnicity), is as high or higher, than is seen in Black African and Black Other ethnic groups

Overweight and obesity in people with physical or learning disabilities:

Although data is limited, people with physical or learning disabilities tend to have a higher propensity to obesity and lower physical activity levels than the general population.

Similarly, people who are obese are more likely than those of a healthy weight to suffer from arthritis and back pain from increased stress on the joints, learning disabilities or mental health disorders; this has a significant impact both on the individual and on health and social-care services.

Data from the Health Survey for England (2006-2010) shows that 33% obese adults have a limiting long-term illness or disability

In 2014, Reading was estimated to have 7,194 people with a moderate physical disability and 1,969 with a severe disability who were aged 18-64.

The Projection of Adults Needs and Service Information (PANSI) estimates that 590 people in Reading had a moderate or severe learning disability in 2015, with the largest proportions aged 25-34 and 35-44.

For adults suffering from a disability who are also obese, socio-economic disadvantages and discrimination may be compounded.

http://www.noo.org.uk/uploads/doc/vid_18474_obesity_dis.pdf

Obesity and mental health:

The 'Obesity and Mental Health'[8] paper published by the National Obesity Observatory in 2011 concluded that there are strong associations between mental health and obesity. In addition, research found correlations between obesity and significant childhood maltreatment, which tends to manifest in later life as a result or trauma and poor attachment.

The paper highlights that there are bi-directional associations between mental health problems and obesity. A systematic review of longitudinal studies examining the relationship between obesity and depression concluded that obese people have a 55% increased risk of becoming depressed and people suffering from depression have a 58% increased risk of becoming obese.

The reason behind this association in adults is believed to be due to a number of factors, including poor self-esteem and stigma, unhealthy lifestyle behaviours, medication, hormonal and functional impairment, dieting and weight cycling (repeated loss and regain of excess weight). These associations are particularly pronounced in women, lower socio-economic groups and in cases where people are extremely obese.

Evidence linking obesity and poor mental health is less consistent in children and adolescents. However, there is some evidence to suggest that obesity in adolescence can lead to an increased risk of depression in adulthood and that the symptoms of depression in adolescence increase the risk of obesity in adulthood.

[8] Luppino FS, de Wit LM, Bouvy PF, Stijnen T, Cuijpers P, Penninx BWJH, et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry 2010;67(3):220-9

These associations are more pronounced in girls than boys and may be related to a number of factors including lack of physical activity, weight-related bullying, low self-esteem, medication, family breakdown, eating disorders and poverty.

Perception of body weight and related stigmatisation varies across cultures, ages and ethnic groups. Perception of, rather than actual obesity, is a stronger predictive factor for mental health disorders.

Weight-related bullying is of particular concern in children and adolescents, where it has been linked to poor self-esteem, depression, avoidance of exercise and disrupted eating behaviours.

The paper makes a number of recommendations to ensure that interventions for obesity and mental health disorders include consideration or both physical and mental health; including:

- Recognising the risk of co-morbidity when treating obesity and mental health disorders to support detection, prevention, early intervention and co-treatment.
- Using strategies that help overweight people to improve self-worth and self-efficacy as tools to improve overall wellbeing.
- Ensuring programmes to tackle obesity in children and adolescents address wider social and emotional issues as well as diet and exercise.
- Building stronger social and parental support can help children and adolescents avoid or deal with psychological distress and unbalanced eating behaviours.
- Ensure and support continued, robust evaluations of weight management interventions, to measure impact on both weight loss and psychological benefits.

Where to find more information on obesity – links and resources.

Data Sources.

Data Patterns and trends in childhood obesity – Public Health England 2016, Childhood Obesity Slide Set.

National Obesity Observatory

NCMP Local Authority Profile – Public Health England

Reading Joint Strategic Needs Assessment

Health Outcomes data on physical activity & inactivity, by local authority

National Diet and Nutrition Survey: results from 2008 – 2012

Full list of relevant NICE guidance.

Physical activity: encouraging activity in all people in contact with the NHS (March 2015)

Obesity: identification, assessment and management in children, young people and adults (November 2014)

Exercise referral schemes to promote physical activity (September 2014)

Managing overweight and obesity in adults (May 2014)

Behaviour change: individual approaches (January 2014)

Managing overweight and obesity among children and young people (October 2013)

Physical activity: brief advice for adults in primary care (May 2013)

Physical activity brief advice for adults in primary care (May 2013)

Obesity: working with local communities (November 2012)

Walking and cycling: local measures to promote walking and cycling (November 2012)

Preventing type 2 diabetes: risk identification and interventions for individuals (July 2012)

Preventing type 2 diabetes: population and community level interventions (May 2011)

Prevention of cardiovascular disease (June 2010)

Prevention of unintentional injuries: PH29 (June 2010)

Promoting physical activity for children and young people (January 2009)

Promoting physical activity in the workplace (May 2008)

Community engagement (February 2008)

Physical activity and the environment (January 2008)

The full NICE pathway of physical activity guidance, advice and recommendations can be found here.

National Action on Obesity:

The National Childhood Obesity Action Plan (August 2016)

Everybody active, every day (2014)

NICE guidance PH17: 2015 promoting physical activity for children and young people:

Evidence update March 2015

CMO physical activity guidance (2011)

National Policy:

Why 5% An explanation of SACN's recommendations about sugar and health - Public Health England (2015)

Carbohydrates and Health Scientific Advisory Committee on Nutrition (2015)

Government response to health select committee report on Impact of Physical Activity on HealthDepartment of Health (2015)

Sugar reduction, responding to the challenge – Public Health England (2014)

Sugar and Health PostNote - Parliamentary Office of Science and Technology (May 2015)

Change4Life evidence review physical activity Public Health England (2015)

Additional references:

Breastfeeding & obesity, Burke 2005, Harder 2005

Gaillard R, et al (2014) Childhood Cardiometabolic outcomes of maternal obesity during pregnancy: the Generation R study. Hypertension; 4(63):683-91

Appendix 1: Summary of NICE Guidance

1.1 Maternal weight

NICE recommends that women with a BMI of 30+ should try to lose weight before becoming pregnant to reduce the risk of complications during pregnancy and childbirth, as well as to protect their own health from the consequences of excess weight:

- Mothers who are obese when pregnant have an increased risk of giving birth to an overweight baby compared to mothers who are a healthy weight.
- Babies born to obese mothers are at an increased risk of foetal death, stillbirth and a number of health conditions including congenital abnormalities and obesity (Ramachenderan et al. 2008).
- A mother who is obese or who has either pre-existing or gestational diabetes when she becomes pregnant will predispose her child to carrying an increased number of fat cells, which is associated with obesity and other metabolic diseases. Therefore, education, awareness and access to healthy weight programmes for women of child-bearing age are important steps in helping more mothers to be a healthy weight when they conceive.
- The risk of obesity can be passed down through generations due to both biological and behavioural influences. Poor nutrition, both in the womb or in early childhood can affect gene function. Babies born with a low birth weight or who are 'short for age' can be at increased risk of overweight and obesity in later life, especially if exposed to an obesiogenic environment[9].
- Children often 'inherit' socio-economic status, dietary and physical activity behaviours and norms from their parents. Both maternal and paternal obesity have been identified as risk factors for childhood obesity and the effects are additive (i.e. the risk is even greater if both parents are obese).

1.2 Breast-feeding

There is mounting evidence to suggest that breast-feeding reduces a baby's risk of becoming overweight and developing high blood pressure and diabetes in adulthood compared to formula feeding (see "Benefits of Breastfeeding' on NHS choices').

Encouraging women to try and Breast-feed, at least initially, can confer significant health benefits to the baby. This may be due babies learning to self-regulate food intake more effectively when breast-fed. As lifelong eating habits are shaped significantly during early years, this can impact on the risk of a child becoming obese in later life.

[9] An environment where high energy food is plentiful and which does not support a physically active lifestyle, therefore increasing the likelihood of weight gain.

1.3 Early Years settings

Many eating behaviours and preferences are learned in the first two years of life and physical activity levels in early years can impact on future risk of obesity, cardiovascular disease, development of motor skills, cognitive development and psychosocial wellbeing (Physical Activity in Early Years Evidence Briefing – Oct 2015).

Therefore opportunities to be physically active and healthy catering in early years settings are important factors impacting on future risk of obesity

1.4 Maintaining a healthy weight in children

Young people develop lifelong eating and activity behaviours throughout their school years. Providing an environment that fosters healthy, balanced eating habits and encourages children to take part in a variety of enjoyable opportunities to be physically active can impact on weight status, health and wellbeing and school attainment.

Educational and care settings can support children's health by:

- providing an appealing dining environment,
- encouraging school meal uptake,
- considering the content of vending facilities,
- developing active travel plans
- providing inclusive, active recreational opportunities and spaces.
- considering how to encourage and involve the least active children.
- encouraging parents to ensure their children get enough sleep.
- encouraging families to eat meals together.

1.5 Maintaining a healthy weight and preventing excess weight gain in adults

NICE guidance recommends a sustainable increase in physical activity levels and adoption of healthy eating habits that will help people to achieve energy balance. This should be based on the current Chief Medical Officer recommendations on physical activity and Department of Health Eatwell guidance.

NICE recommendations note the importance of:

- avoiding extreme exercise and dietary behaviours.
- Encouraging adults to limit their alcohol intake.
- Encouraging self-monitoring of weight.
- Clear communications about the benefits of being a healthy weight and making gradual improvements to dietary and physical activity habits.
- Tailoring health messages for different groups.
- Encouraging employers to consider building layout, changing / cycle storage facilities and healthy eating in workplace restaurants / vending facilities.
- Integrating activities with the local strategic approach to obesity.

1.6 Tier 2 interventions for children

NICE say weight management programmes for children and young people should include the core components of:

- diet and healthy eating habits
- physical activity that children and young people enjoy.
- reducing the amount of time spent being sedentary
- strategies for changing the behaviour of the child or young person and all close family members.
- Positive parenting and problem-solving skills.
- A tailored plan to help the family to set goals, monitor progress against them and provide feedback

NICE guidance (PH47) – Recommendations for weight management for overweight or obese children and young people

1.7 Tier 2 programmes for tackling obesity in adults

NICE guidance suggests programmes to tackle obesity in adults should be:

- be multi-component and address diet, physical activity levels and behaviour change.
- encourage realistic goal setting - aiming to help people to lose 5-10% of their weight.
- recommend an average weight loss of 0.5-1kg each week.
- focus on sustainable lifestyle changes rather than on short-term quick-fixes.
- be multi-component - addressing diet, physical activity and behaviour change.
- focus on sustainable lifestyle change and the prevention of future weight gain
- be of at least 3 months duration and take place at least weekly or fortnightly, including a 'weigh-in' at each session.
- ensure specific dietary targets are agreed based on individual needs and goals
- ensure any supervised physical activity sessions are led by an appropriately qualified physical activity instructor and take into account any medical conditions.
- use a variety of behaviour-change methods and address weight regain.

NICE Guidance (PH53) - Recommendations on weight management & lifestyle services for overweight or obese adults

1.8 Tier 3 obesity programmes

Tier 3 programmes should adhere to the same NICE recommendations on healthy eating, physical activity and behavior change as adult Tier 2 programmes detailed above.

However, they should be run by a specialist multi-disciplinary team including multidisciplinary team including a Dietitian, exercise specialist and psychological therapist.

1.9 Tier 4 obesity interventions

NICE guidance recommends bariatric surgery as a treatment option:

- For patients with a BMI of 40kg/m2 or more, or patients with a BMI between 35kg - 40kg/m2 plus other significant disease (like type 2 diabetes or high blood pressure) that could improved by losing weight
- Where appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss
- The patient has been receiving or will receive intensive management in a tier 3 service.

NICE guidance (CG189) Obesity: identification, assessment and management

Appendix B - Healthy Weight Strategy – Action Plan Phase 1, Council-led programmes.

The table below details work in progress by the council that contributes to the healthy weight agenda. However, to tackle overweight and obesity effectively requires a multi-agency approach and as such we will invite partners to join an Implementation Plan group following the January Health and Wellbeing Board to help shape and agree a comprehensive delivery plan.

What will be done – the task	Tier of service	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
To hold a 'Walking Volunteer recruitment workshop' for voluntary groups and community services who work with people who have low physical activity levels.	1 (prevention)	Wellbeing Team	January 2017	To increase the number of health walks leaders in Reading and increase local capacity to deliver health walks to people who have low physical activity levels.	1.16 - % of people using outdoor space for exercise/health reasons.
To offer MECC training to the local voluntary and community sector	1 (prevention)	Wellbeing Team	From January 2017	To increase knowledge, skills and confidence to make appropriate use of opportunities to raise the issue of healthy lifestyle choices and signpost to sources of support.	2.13i Percentage of physically active and inactive adults – active adults.
To ensure delivery of the National Child Measurement Programme	1 (prevention)	Wellbeing Team	Ongoing	Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance	2.13ii Percentage of physically active and inactive adults – active adults.
Active Nation	1 (prevention)	Wellbeing team, Leisure and Recreation service / Transport	2017	Funding opportunities identified to help increase physical activity levels in target groups.	

What will be done – the task	Tier of service	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Input into the development of the new leisure services contract to provide to increase healthy lifestyle programme options for customers.	1 (prevention)	Leisure & Recreation Service / Environment & Neighbourhood Services / Wellbeing team	From November 2016.	We will maximise opportunities to help customers achieve health outcomes by linking leisure services with programmes for weight management and other public health services.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.
To commission and implement an accessible tier 2 lifestyle adult weight management service that aligns with NICE guidance for overweight and obese adults aged 16 and over within the locality. This will form an integral part of the weight management service in Reading. To target access to the service in line with local Joint Strategic Needs Assessments To monitor and evaluate the delivery and outcomes of the service to the stated objectives	2	Wellbeing Team	Currently mid-contract. New contract to be procured to commence June / July 2017.	To contribute to halting the continued rise in unhealthy weight prevalence in adults.	2.06i - % of children aged 4-5 classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
To commission and implement a school based Tier 2 children's healthy lifestyle and weight management programme in line with NICE guidance within the locality. This will form an integral part of the weight management service in Reading. To target access to the service in line with local Joint Strategic Needs Assessments To monitor and evaluate the delivery and outcomes of the service in line with the stated objectives To pilot a legacy pack for schools who host our Tier 2 children's healthy lifestyle and weight management programme in order to encourage schools to continue supporting the principles of the course beyond the 10-week intervention.	2	Wellbeing Team	Currently mid-contract for tier 2 service. Legacy pack to be developed for spring 2017.	To contribute to halting the continued rise in unhealthy weight prevalence in children and young people. To promote a 'whole family approach' to healthy eating and physical activity.	2.06ii - % of children aged 10-11 years classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
To include promotion of healthy eating and physical activity within the 0-19s service Take proactive steps to raise awareness in schools of priority Public Health messages especially around healthy life-styles, including oral health To look at options for programmes that could be delivered in Early Years settings with colleagues from children's services.	½	Wellbeing Team/Children's Services		Lead, co-ordinate and provide services for children and young people as set out in the Healthy Child Programme 5 – 19 years	2.06i - % of children aged 4-5 classified as overweight or obese.

Berkshire Transforming Care Partnership

Update to Reading Borough Council's Health & Wellbeing Board – 27th January 2017

TCP Senior Responsible Officer: Gabrielle Alford, Director of Joint Commissioning, Berkshire West CCGs

TCP Reading Officers: Jenny Miller and Carol Valentine

Keeping people well and out of hospital

Introduction

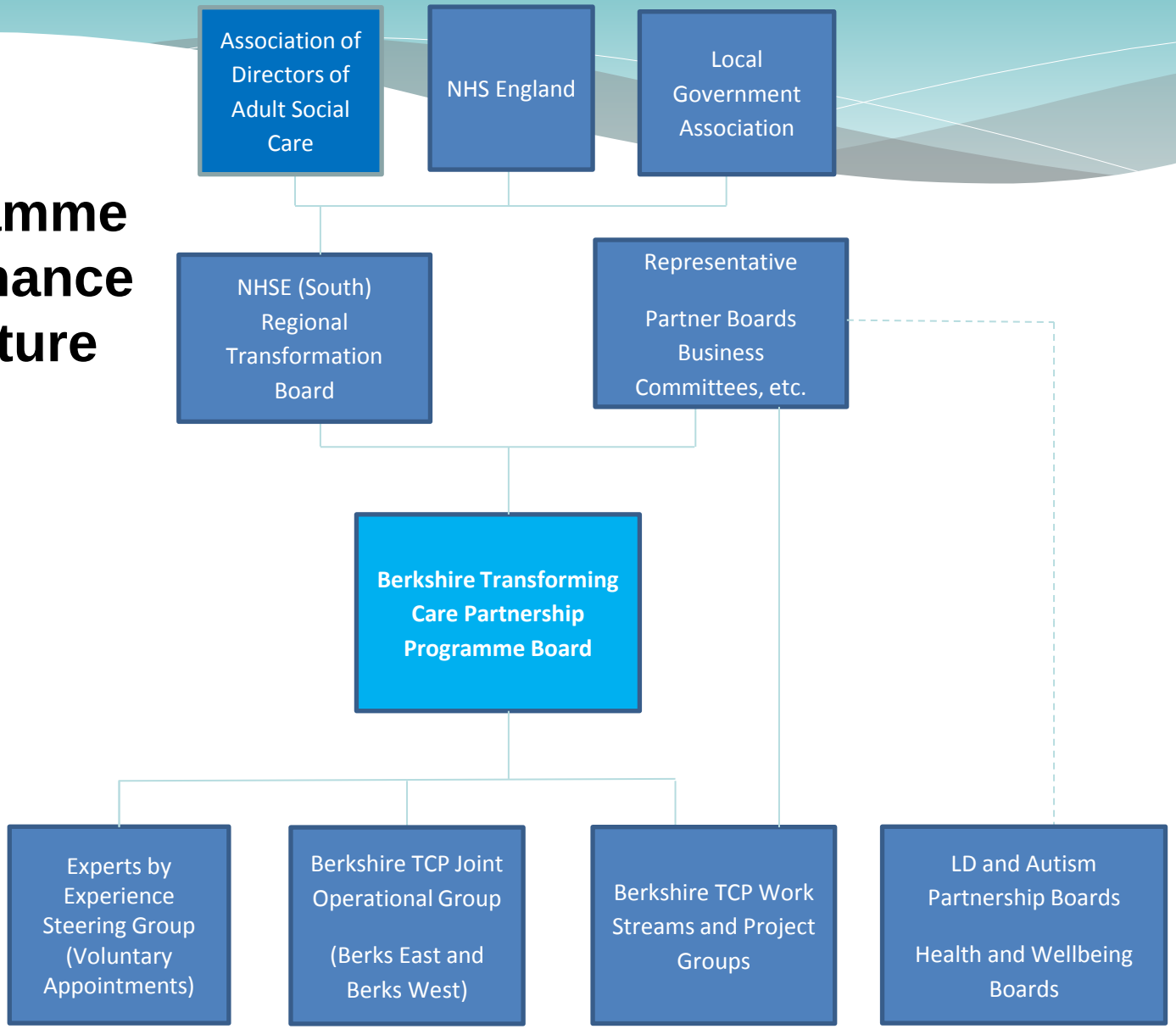
The Berkshire Transforming Care Partnership Board hold a shared vision and commitment to support the implementation of the national service model to ensure that children, young people and adults with learning disabilities, behaviour that challenges and those with mental health and autism receive services 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. To avoid admissions to and support discharge from hospital, people will receive and be involved in 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



Work streams and Project Groups

Work Streams (Themes)

1. Demand and Capacity
2. Market Shaping – Housing and Care Providers
3. Inpatients
4. Intensive Support Team
5. Communications and engagement
6. Children and Young People
7. Workforce Development and Culture
8. Co-Production
9. Joint Commissioning and Integration
10. Risk Management
11. Programme management
12. High Impact Actions

Project Groups:

1. Finance and Activity
2. Housing and Accommodation
3. Autism
4. Intensive Intervention Service
5. Employment and Occupation
6. Health and Social Care Workforce
7. Berks East Capital ‘Home’ Project
8. Co-production (People’s Voice Service)
9. Experts by Experience Steering Group
10. Primary Care

2016 TCP Achievements

- Regular TCP Briefings to all partners and communication teams to keep them up to date with national and local news
- Secured 2016 – 2017 funding from NHS England for Shared Housing provision in Royal Borough of Windsor and Maidenhead for up to three individuals from across Berkshire with complex LD and challenging behaviours
- Developed a health focused Shared Lives Programme business case and plan for the roll out across Berkshire over the next three years
- Secured funding 2016 – 2018 from Department of Health for 10 x Hold Ownership Schemes for people with Long Term disability
- Berkshire Healthcare NHS Foundation Trust (BHFT) suspended the specialist inpatient health service provided at Little House, Bracknell, in order to ensure the quality and safety of the learning disability inpatient services
- TCP Programme Board has reviewed BHFT plans for the roll out of an Intensive Support Team
- Developed a repatriation timetable for NHS England specialist commissioned patients and Clinical Commissioning Group (CCG) out of area placements
- Merged Berks East and West TCP Operational Groups to create resource efficiencies
- Co-opted Carer and Family Experts by Experience into the programme on Voluntary Appointment Contracts, as members of the Finance and Activity Project Group, Capital 'Home' Project Group, and TCP Board, with further appointments planned in 2017
- Commenced Experience Based Co-Design Project with Point of Care Foundation – weekly BHFT led group with service users
- Finance & Activity Project Group established responsible for identifying opportunities for pooled budgets and resources
- High Action Priorities agreed by Joint Operational Group – autism, substance misuse and personality disorders
- Finalised the specification to go to market for Co-Production Service and Communications and Engagement Resources (funding stream in 2017 to be identified)
- Undertaken a desk top gap analysis of local authority LD and ASD strategies and, reviewed capacity and demand projections until 2019, to inform prioritizing of the work plan for 2017/18
- Developed a TCP milestone plan for all project group for 2017/18 and 2018/19, with agreed outcome measures that will be used by the Expert by Experience Steering Group to assess progress against the plan
- Started to map local authority and CCG work streams already in place for Children and Young People, to avoid duplication in work
- Developed an assurance framework for commissioners and service users to assess workforce competencies and behaviours in provider organisations

(1) 2017/18 TCP Programme Plan Overview

Work streams and group responsible for leading the work	2017/18 Q1	Q2	Q3	Q4
Finance & Activity (Project Group)	• Review inpatient block contract and IST financial model • New opportunities for joint Commissioning arrangements defined and plans developed to implement, and cascaded to TCP Partners for consideration and feedback	• New opportunities for pooled budget arrangements developed and cascaded to TCP Partners for consideration and feedback • Capacity and Demand Stock take of TCP projections completed	• New joint commissioning arrangements implemented ready for 2018/19 • Reduce the number of separate funding streams that users have to access	• New opportunities for pooled budgets arrangements implement ready for 2018/19 • Capacity and Demand Stock take review
Heath & Social Workforce (Joint Operational Group)	• Agree core LD and ASD workforce structures in local authorities to retain expertise • Standardise local workforce tool kits across all local authorities • Start recruitment of shared lives staff and carers in Berks East (subject to business case approval)	• Hold workforce event with health and wellbeing partners and providers to develop new ways to recruit and retain LD and ASD skilled and specialist staff • TCP Carers by Experience (Expert by Experience Steering Group) partner with two care providers and use Berks TCP Workforce Assurance Framework to check staff competencies and behaviours	• Start training of Shared Lives Carers in Berks East • Match Service Users and Shared Lives Carers • Start to develop career progression structures for public sector staff in line with private sector	• Develop training modules for primary care and third sector staff on LD and ASD. Linked to Autism and CYP work streams • TCP Carers by Experience (Expert by Experience Steering Group) partner with two care providers and use Berks TCP Workforce Assurance Framework to check staff competencies and behaviours
Housing & Accommodation (Joint Operational Group)	• Transition of up to three clients into RBWM Secured Tenancy Property as part of Berkshire East Capital Home Project • Share learning from Capital Home Project Berkshire wide to inform 2017/18 capital bid submissions	• Establish Berkshire wide housing list for people with short, medium and long term LD needs • Share learning from Reading and Slough local authority HOLD Schemes to roll out to other localities to enable up to 6 people to buy their own home	• Share learning from Slough local authority housing technology schemes to roll out to other localities to enable more people to access technology grants in 2018/19	• Review and align local authority strategies and build capital business cases to access NHSE and DoH grants in 2018/19
Autism (including Children and Young People) (Project Group)	• Develop joint commissioning standards around age. Cascade to TCP Partners for consideration and feedback. • Align work stream objectives with Thames Valley Network, Future in Mind and SEND Groups to avoid duplication on priorities	• Develop informational sharing criteria across education and health for LD and ASD people at high risk of admission . Cascade to TCP Partners for consideration and feedback. • Implement joint commissioning standards Berkshire wide	• Develop training and support tools for: Health Visitors, GPs, Paediatrics, Perinatal Mental Health- SPA (CPE) • Implement informing sharing standards Berkshire wide across health and education	• Increase access to Pre-Assessment Specialist Support

(1) 2017/18 TCP Programme Plan continued

Work streams and group responsible for leading the work	2017/18 Q1	Q2	Q3	Q4
Market Shaping (Joint Operational Group)	• Review results of ADASS South marking scoping exercise to inform the development of a range of marketing management exercises across TCP partners to increase the utilisation of local authority and CCG resources • Establish links with Thames Valley Network for Forensic Pathways to ensure alignment • Develop programme plan for High Impact Actions: Respite Care, Day Centres, Residential Living Accommodation, Independent Living Schemes	Undertake a strengths based review of LD and ASD provision with providers to identify where 'high needs register' of service users needs are not matched to local supply (sharing the results with all TCP partners and groups)	Review CYP in transition plans Cascade recommendations to TCP Partners for opportunities to implement joint procurement exercise for housing and workforce providers for consideration and feedback	• Implement joint procurement exercises ready for 2018/19
Inpatients (TCP Board and BHFT Board)	• Ongoing monthly review throughout year for: • Specialist Commissioning Care and Treatment Review Timetable and outcomes • CCG commissioned beds in Berkshire and Out of Area – timetable and outcomes • BHFT Assurance reports on admissions and discharge planning • Children and Young People in 52 week placements and transition	• Reduce OOA adult placements to 25 • Community transition arrangements in place to avoid inappropriate admission to hospital and support timely discharge from hospital	• Reduce OOA adult placements to 20 • Community transition arrangements in place to avoid inappropriate admission to hospital and support timely discharge from hospital	• Reduce OOA adult placements to 18 • Community transition arrangements in place to avoid inappropriate admission to hospital and support timely discharge from hospital
Intensive Intervention an d Support (CCG Commissioners and Joint Operational Group)	• Monitor and manage transition arrangements in the community due to the consolidation of inpatient services at Campion Unit, Prospect Park from March 2017 • Decommissioning of beds at Little House as part of block contract • Commissioning of new • Phased recruitment of staff to the Intensive Support Team Service • Phased roll out of Intensive support team by milestone date October 2017 (TCP Board ambition)			
Employment & Occupation (Project Group)	• Project Group established with • Undertake stock take to review employment and occupational opportunities Berkshire wide • Identified barriers and solutions to remove those practical barriers that disabled people face in work, such as provision of specialist aids and equipment in the workplace, a communicator, support worker, travelling costs, etc.	• Work with service user advocacy groups and Partnership Boards to identify where there are gaps in service provision • Create Berkshire wide on-line directory for work-based supported employment, work preparation training and work related job experience	• Align local authority strategies to increase social inclusion and skills • Hold an event for voluntary services to promote a directory of services	• Build infrastructure in local authorities to support employers and disabled people accessing employment of > 16 hours • Build support to enable people to undertake work trails in actual job vacancies
Communications & Engagement (TCP Board)	• Commission 'People's Voice Service' (Co-production) • Commission Communications and Engagement resources to support programme • Publish quarterly TCP briefing to partners • Expert by Experience Steering Group established, chaired by Service User and LD and ASD Clinician(s)	• Experts by Experience Steering Group review progress against the milestone plan and make recommendations to the TCP Board on behalf of service users of where improvements need to be made • Steering Group uses to Benefit Realistion criteria to monitor health and quality outcomes of service users during the changes		
Primary Care (Joint Operational Group)	• Workstream established with PHE and Carer Expert by Experience involvement • Undertake stocktake to make sure all people with LD and ASD have annual physical health check; and quality of checks improved • Align project group with CYP and SEND work streams Berkshire wide	• Campaign to promote STOMPwLD best practice started	• Campaign to reduce inequalities in access to oral care started	• Campaign to reduce inequalities in access to diabetes services started

(1) 2018/19 TCP Programme Plan Overview

Work streams and group responsible for leading the work	2018/19 Q1	Q2	Q3	Q4
Finance & Activity	Identify opportunities for pooling commissioning resources across health and social care	Capacity and Demand Stock take		Capacity and Demand Stock take
Heath & Social Workforce	Expand Shared Lives Scheme to local authorities Berkshire wide	Facilitate providers in developing an 24/7 occupational health model and peer support network for staff	Facilitate providers in developing a 'salary retention incentive' to reduce turnover/sickness absence rates	tbc
Housing & Accommodation	Shape private rented sector market place	Identifying sites for new purpose built units	Expand domiciliary care and short stay residential breaks provision	tbc
Autism	Introduce Autism Support Navigators in health and education	Establish social communication and friendship groups for all ages	Increased access to ADS services for youth offending providers	tbc
Market Shaping	Align milestones to activities in workforce, housing accommodation and employment and occupation work streams		tbc	tbc
Inpatients	Repatriation Programme continues	Reduce OOA placements to 16	Reduce OOA placements to 14	Reduce OOA placements to 12
Intensive Support Team	Intensive Support Team in place Monday to Friday 0900 – 1700hrs	Start to implement plans to increase services 24/7 in line with capacity and demand projections forecast by Finance and Activity Group	tbc	tbc
Employment & Occupation	Implement supported employment models in partner organisations with partners leading by example	tbc	tbc	tbc
Communications & Engagement	• Experts by Experience Steering Group review progress against the milestone plan and make recommendations to the TCP Board on behalf of service users of where improvements need to be made • Steering Group uses to Benefit Realistion criteria to monitor health and quality outcomes of service users during the changes			
Primary Care	Campaign to reduce inequalities in access to nutrition education and sport activities	Campaign to promote access to cancer services	tbc	tbc

(1) TCP Programme Outcomes

(approved by TCP Board November 2016)

Outcomes: Benefit realisation

Activity	Financial and Operational Outcomes	Health and Quality Outcomes
Improve capacity and demand	✓ Reduction in High Cost placements ✓ Reduction in ATU beds purchased ✓ Pooled resources ✓ Increase in the number of people receiving direct payments or personal managed budget ✓ Reduced waiting times for psychiatric referrals	✓ Placements near families and communities ✓ Improved care planning for CYP in transition ✓ Users and carers in control of their plans
Prevent Hospital admissions	✓ Reduction in High Cost placements ✓ Reduction in ATU beds purchased ✓ Pooled resources	✓ Reduced length of stay ✓ Reduction in avoidable admissions ✓ Reduced readmissions
Shape the Housing Market Shape the Care Market	✓ Increased competition, increased VFM ✓ Repatriation of high cost OOA placements ✓ Increased Shared Ownership models ✓ Secured tenancy arrangements ✓ Pooled budgets arrangements ✓ Sustainability of providers ✓ Pooled resources for market management activities ✓ Sustainable workforce models ✓ Increased pool of specialised skills	✓ Placements near families and communities ✓ Engagement in community activities ✓ Reduction in avoidable admissions ✓ Improved access to crisis and respite care ✓ Improved physical health and wellbeing
Improve Care Standards	✓ Reduction in OOA placements to specialist units ✓ Reduced admission to ATU beds	✓ 100% of people have an up to date personalised care plan ✓ Improvements in life skills ✓ Engagement in community activities ✓ Improved physical health and wellbeing ✓ Reduction in placement breakdowns
Increase and promote community based support	✓ Reductions in ATU admissions ✓ Practices, care and support pathways within mainstream primary and secondary NHS services are 'reasonably adjusted' ✓ Reduction in healthcare costs	✓ Improved user and carer experience ✓ Improvements in life skills ✓ Interactions and improved friendships and networks ✓ Improvements in physical and mental health and wellbeing ✓ Reductions in anti-social or 'offending' behaviour
Greater access to autism services	✓ Reduction in High Cost placements ✓ Reduction in ATU beds purchased ✓ Pooled resources	✓ Improvements in physical and mental health and wellbeing ✓ Improvements in access to specialist
Strengthen the role of Primary Care	✓ Increased number of people on GP LD and ASD registers ✓ Improved education and training of staff ✓ Reduction in long term health care costs ✓ Increased capacity in Home from Hospital provision	✓ 100% of people with LD have annual health plan ✓ Reduction in diabetes, heart condition, cancer services, etc. ✓ Improved access to health services

Intensive Support Team

All TCPs nationally are looking to commission a new service model in the community called an Intensive Support Team (IST) or Intensive Intervention Service.

An Intensive Support Team will provide proactive community based support for people with a learning disability and/or autism who have associated mental health needs and/or present with behaviour that can challenge. Offering support to people in their own homes and preventing in-patient admissions where possible, the IST will provide access to specialist health and social care support.

The service will use intensive, safe, responsive and non-invasive strategies, including Positive Behaviour Support (PBS).

Focusing on improving a person's quality of life and reducing behaviours that pose a risk to self and others, the Team will provide intensive support that is person-cantered on the needs of the individual and their families.

In conjunction with social care teams, the IST will minimise the risk of people with learning disabilities being taken into specialist inpatient health services for assessment and treatment (unless clinically warranted).

The TCP Board is currently in the process of drafting a service specification for the IST. The TCP Board will update partners on progress following the February Board meeting.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**27 JANUARY 2017**	**AGENDA ITEM:**	**16**
TITLE:	**HIGHLIGHT REPORT - WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2015/16**		
LEAD COUNCILLOR:	**Cllr Eden**	**PORTFOLIO:**	**Adult Social Care**
SERVICE:	**Adult Social Care**	**WARDS:**	**Borough Wide**
LEAD OFFICER:	**Rebecca Flynn**	**TEL:**	**0118 937 3210 (73210)**
JOB TITLE:	**Interim Safeguarding Adults Service Manager**	**E-MAIL:**	**Rebecca.Flynn2@Reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Attached is the 2015/16 Annual Report of the West of Berkshire Safeguarding Adults Board (SAB) covering the local authority areas of Reading, Wokingham and West Berkshire.

1.2 The Health and Wellbeing Board are asked to accept the report for information.

1.3 Appendix 1: West of Berkshire Safeguarding Adults Board- Annual Report 2015/16

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board note and accept the report for information on a statutory requirement.

3. POLICY CONTEXT

3.1 Safeguarding Adults Boards were established on a statutory basis under S43 of the Care Act 2014 and they are required to publish and annual report.

3.2 Safeguarding and protecting those that are most vulnerable is a key priority in the Council's Corporate Plan.

4. THE PROPOSAL

4.1 Current Position: The trend analysis contained in the report highlights the year on year increase in the number of safeguarding concerns, with the majority of those concerns relating to older people over 65 years of age**.** For Reading has seen a rise in the number safeguarding concerns from 702 in 2014/15 to 1075 in 2015/16, an increase of 153% and 59% of all enquiries are for those aged 65 years or over.

A number of initiatives in the Reading area have contributed to how working together has made a difference, including:

- Working with Rahab to support the victims of modern day slavery
- World Café Planning with partners to obtain community views and ideas in relation to vulnerable and exploited individuals
- Multi-agency partnerships identify, health, housing and financial support to meet the needs of vulnerable people

Reading Borough Council's achievements include:

- Establish a new safeguarding team
- Increased the learning lunches and safeguarding workshops for staff and increased the amount of safeguarding training available
- Reduced the amount of outstanding DoLS and created a pathway for community DoLS

4.2 Options Proposed: to accept the content of the report and the progress being made.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Although there are no specific decisions required as a result of the publication of the SAB Annual Report the work of the SAB does make a significant contribution to *promoting equality, social inclusion and a safe and healthy environment for all* by working effectively in partnership with key stakeholders to try and prevent and respond to the abuse of people with care and support needs living in Reading. This work contributes to Community Safety and Health as a result of the multi-agency working and arrangements that are in place to protect people with care and support needs.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Safeguarding Adults Board is a multi-agency arrangement and the Protocol that exist between it and the Health and Well-Being Board is such that the reporting of the Annual Report to the latter board is in itself part of the consultation arrangements that exist.

7. EQUALITY IMPACT ASSESSMENT

7.1 The nature of safeguarding adult's arrangements both preventative and in responding to abuse, are such that it focusses upon reducing discrimination through combatting hate crime. The strategic arrangements as evidenced in the Annual Report actively tackle harassment, victimization and abuse.

7.2 An Equality Impact Assessment (EIA) is not relevant to this matter.

8. LEGAL IMPLICATIONS

8.1 As stated earlier the SAB and the Annual Report enables Reading to meet its Statutory duty under the Care Act 2014

9. FINANCIAL IMPLICATIONS

9.1 There are no financial considerations in relation to this report

10. BACKGROUND PAPERS

10.1 West of Berkshire SAB Annual Report 2015-16

West of Berkshire Safeguarding Adults Board

Annual Report 2015-16

If you would like this document in a different format or require any of the appendices as a word document, contact natalie.madden@reading.gov.uk

West of Berkshire Safeguarding Adults Board **Annual Report 2015-16**

1. Message from the Independent Chair

I have welcomed the opportunity to take over as interim Independent Chair for the Board and have enjoyed working across three Councils and partner organisations to ensure that safeguarding adults is embedded across the West of Berkshire. I have been impressed by the excellent attendance of Partners and the full participation at Board meetings. The agenda items have been varied and challenging, including learning from Safeguarding Adults Reviews and ensuring that such learning is embedded into practice and not "one off events," as well as taking a more thematic approach to Board agendas to reflect the four strategic priorities that underpin the work of the Board.

The Board is very mindful that all efforts going into making adults safe need to reflect on the experience of adults who may be subject of a safeguarding enquiry. Making Safeguarding Personal, an initiative led by the Directors of Adults Social Services, has proven to be a helpful reminder to us all to take stock of all documents, literature and services available to the public to highlight the importance of adult safeguarding and where to go to seek further information.

Closer links with the Local Safeguarding Children's Boards remain a priority, recognising that adult safeguarding will often involve working with families and we need to ensure that, given the challenges all organisations face in respect of finance, we learn from each other, share good practice and avoid duplication.

The Board is working well but we are not complacent and know there is much more to do. We have streamlined the Annual Report in an attempt to explain more simply what the Board has been set up to achieve as well as progress made over the last year. I would welcome your views as to whether we have managed to achieve this aim. The Partner organisations will be seeking to appoint a permanent Chair over the forthcoming year and I welcome the opportunity to work with the new Chair to ensure that a smooth and effective handover of responsibilities takes place.

I would like to extend my thanks to all Partners who have attended Board meetings and have invested time, energy, and professional commitment to adult safeguarding across the West of Berkshire and look forward to a continued excellent working relationship.

Brian M Walsh

Interim Independent Chair West of Berkshire Safeguarding Adults Board

1. Our vision for safeguarding adults

People are able to live independently and are able to manage risks and protect themselves; they are treated with dignity and respect and are properly supported when they need protection.

2. Who we are

The West of Berkshire Safeguarding Adults Board covers the Local Authority areas of Reading, West Berkshire and Wokingham. The Board is made up of local organisations which work together to protect adults at risk of abuse or neglect. From April 2015 mandatory partners on the Board are the Local Authority, Clinical Commissioning Groups and Police. Other organisations are represented on the Board, such has health, fire and rescue, ambulance service, HealthWatch, probation and the voluntary sector.

A full list of Partners is given in Appendix A.

3. Who we help

Any person 18 or over at risk of abuse or neglect because of their needs for care and support and as a result of those care and support needs is unable to protect themselves.

4. What we do

Safeguarding means looking out for and trying to protect others in our community who are vulnerable, or may be at risk of harm. We work together to ensure there are systems in place to keep vulnerable people in the West of Berkshire safe; we hold partner agencies to account to ensure they are safeguarding vulnerable people; we work to ensure agencies and organisations are focused on outcomes, performance, learning and engagement. There are many different forms of abuse:

Physical
Domestic
Sexual
Psychological
Financial / material
Modern slavery
Discriminatory
Organisational
Neglect or acts of omission
Self-neglect

For more information, go to the Board's website: http://www.sabberkshirewest.co.uk/
or click on the links: What is abuse? Signs of abuse Concerned about an adult?

How to get help and advice:

In an emergency situation call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101.

If you are concerned about yourself or another adult who may be being abused or neglected, contact Adult Social Care in the area in which the person lives, on the numbers below:

Reading 0118 937 3747

West Berkshire 01635 519056

Wokingham 0118 974 6800

Out of normal working hours, contact the Emergency Duty Team 01344 786 543

5. Trends across the area

The number of safeguarding concerns continues to increase year on year.

Over half the concerns are raised by social care and health staff.

As in previous years, the majority of enquiries relate to older people over 65 years.

More women were the subject of a safeguarding enquiry than males, as in previous years,

Individuals with a White ethnicity are more likely to be referred to safeguarding and the proportion is higher than for the whole population.

The most common types of abuse were for Neglect and Acts of Omission followed by Physical Abuse and Psychological Abuse.

For the majority of cases the primary support reason was physical support.

The most common locations where the alleged abuse took place were a person's own home and a care home.

The majority of concluded enquiries involved a source of risk known to the individual in Reading and West Berkshire but the source of risk in Wokingham was social care support.

Further details are presented in the Safeguarding Performance Annual Reports by partner agencies, Appendix E.

6. How we have made a difference by working together

The *Berkshire Multi-Agency Safeguarding Adults Policy and Procedures 2016* were launched and support staff to respond appropriately to all concerns of abuse or neglect they may encounter, providing a consistent response across the county.

The annual joint conference was held on 9 October 2015, based on the theme of *Challenging Cultural Assumptions in Safeguarding*. Topics included: cultural sensitivity in safeguarding, radicalisation, forced marriage, working with interpreters, witchcraft and possession, supporting traveller communities, anti-trafficking, and providing culturally sensitive care.

Stronger links between health, adult safeguarding teams and local authority Care Governance teams has enabled the timely access to information and expertise, such as the Berkshire West Federation of CCGs pharmacy and infection control involvement in section 42 enquires.

Partnership working through the Integrated Care Home Project Board promotes integration in the commissioning of care homes, best practice and the recognition of patients' rights, choices, needs and safety.

A joint health and social care conference, *Embedding the MCA in Practice*, was held in September 2015; positive feedback included carers' perspectives and evidenced direct impact on front line practice.

A joint Training in Practice (TIPS) event for primary care included LA and voluntary sector representatives as speakers or stall holders.

Peer review of safeguarding services in local authorities, to which all partner agencies contributed.

Development of a Care Governance Framework to promote Care Act accountabilities and joint responses to organisational safeguarding concerns. Health agencies supported LAs and CCGs with the management of concerns in care homes.

Raising awareness of adult safeguarding by community groups and people who use services by means of *experts by experience* delivering talks and designing easy read literature.

Engagement in the development of female genital mutilation (FGM) multiagency protocol and pathway; raised awareness of FGM through a new RBH intranet webpage; an RBH midwife who had undergone FGM supports victims.

Through the Independent Trauma Adviser Steering Group, partners work with Rahab to support victims of modern day slavery, particularly in relation to Brothel warrants. This gives specialist support to the victims who are potentially trafficked, and support officers with addressing the welfare needs.

Partnership working between Police and Mental Health Nurse in response to mental health calls has led to a reduction in detentions and provision of more appropriate mental health support for the individual.

Multi-agency partnerships (Sex Workers Action Group and Street Population) identify health, housing and financial support to meet the needs of vulnerable people.

World Cafe Planning with partners to obtain community views and ideas in relation to vulnerable and exploited individuals.

Joined Up Front Line Action (JUFA) initiated in March 2016 and piloted in Whitley, is a partnership between Police, Fire Service, Health, Voluntary Sector agencies and others to make better use of visits by professionals. Other partners are informed of an individual's needs, for example a Police visit may identify the need for a smoke alarm.

Problems in Practice meetings are held monthly to discuss issues in relation to partnership working across health, mental health and the Police. Discussions enhance knowledge of other organisations' processes and procedures and allow a platform to improve practice.

How we have embedded Making Safeguarding Personal

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

- Partners implemented a standard audit template reflective of MSP requirements, with an aim to provide consistent measures of safeguarding quality assurance reporting to the Board.
- Promotion of MSP in safeguarding training; training has been reviewed to ensure that obtaining consent and desired outcome is central to safeguarding practice; joint commissioning of specific MSP training for frontline workers and managers.
- Safeguarding newsletters promoted MSP and the importance of asking service users what their desired outcomes are.
- Computer systems, templates and practice guidance for staff and service users have been amended to reflect MSP; safeguarding forms have a requirement to include service users' desired outcomes and whether they were achieved.
- Quality Assurance measures incorporate MSP.
- MSP is promoted through coaching and conversations with the workforce and wider stakeholders.
- Incident reporting processes have been refocused to give prominence to the adult's voice.

Case study 1: The Involvement of the individual at a safeguarding meeting with her family and staff from the police, mental health, social care, her GP

and an external provider was a positive way of getting everyone to appreciate each other's involvement and identify a plan to support the individual. The meeting provided a forum for open discussion and prevented any miscommunication between both professionals and the services user. Early multi–agency planning and discussion between the safeguarding leads from both health and adult social care provided the leadership and direction to move the case forward.

Case study 2: Multi-agency approach to a significant safeguarding situation led to client being supported to continue leisure pursuits that had previously been a source of high risk.

Further achievements by partner agencies are presented in Appendix B.

7. Safeguarding Adults Reviews

The Board has a legal duty to carry out a Safeguarding Adults Review when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died and abuse or neglect is suspected to be a factor in their death. The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The West of Berkshire Safeguarding Adults Board has a Safeguarding Adults Review Panel that oversees this work.

During the reporting year, the Board commissioned two Safeguarding Adults Reviews both of which involved practitioners. We cannot publish information about one of the cases as there is a criminal investigation underway. An executive summary about the second case and the full report can be found on the Board's website at http://www.sabberkshirewest.co.uk/board-members/safeguarding-adults-reviews/

8. Key priorities for next year

Develop our oversight of the quality of safeguarding performance through the Board's Quality Assurance Framework and the annual self-assessment audit completed by partner agencies.

Develop a Performance and Quality Assurance framework to support and promote Making Safeguarding Personal.

Promote the new Berkshire Multi-agency Safeguarding Adults Policy and Procedures, ensuring agencies are compliant through case audits and multi-agency thematic reviews.

Continue to learn from Serious Adults reviews and embed lessons learnt across all organisations which can be monitored and reviewed at regular intervals.

Raise awareness of the Board's function and of local safeguarding processes.

Continue to ensure staff receive an appropriate level of safeguarding adults training.

Develop mechanisms to measure outcomes for individuals who have been through the safeguarding process and ensure service user feedback is collected and understood.

Ensure person centred responses are promoted through the involvement of advocates and Independent Mental Capacity Assessors.

Ensure successful recruitment to permanent Chair and effective handover of responsibilities.

Continue closer working with three Local Children's Safeguarding Boards to identify joint priorities, learning and effective communication.

Review the infrastructure that supports the Board, streamline subgroups where possible to avoid duplication and utilise more effectively the use of Partners' time.

Learn from other Safeguarding Adults Boards and share, more widely, examples of good practice from the West of Berkshire Board on a local, regional and national level.

Appendices

Appendix A Board member organisations

Appendix B Achievements by partner agencies

Appendix C Completed Business Plan 2015-16

Appendix D Business Plan 2016-17.

Appendix E Safeguarding Performance Annual Reports from partners agencies:

Berkshire Healthcare Foundation Trust,
Reading Borough Council,
Royal Berkshire Foundation Trust,
West Berkshire Council,
Wokingham Borough Council

Appendix F Training activity

Appendix A

Board Membership

Under the Care Act, the Board has the following statutory Partners:

Berkshire West Clinical Commissioning Group
Reading Borough Council
Thames Valley Police
West Berkshire Council
Wokingham Borough Council.

Other agencies are also represented on the Board:

Berkshire Healthcare Foundation Trust
Community Rehabilitation Service for Thames Valley
Emergency Duty Service, National Probation Service
Royal Berkshire Fire and Rescue Service
Royal Berkshire NHS Foundation Trust
South Central Ambulance Trust
HealthWatch Reading
The voluntary sector is represented by Reading Voluntary Action, Involve Wokingham and Empowering West Berkshire.

Appendix B

Achievements by Partner Agencies

Berkshire Healthcare Foundation NHS Trust

- Achieved training targets.
- Established Safeguarding Forums for updating on policy, legislation and lessons learnt from SARs.
- Received positive feedback from CQC about safeguarding practices and knowledge.
- Strengthened reporting of inpatient incidents.
- Achieved greater clarity on how CMHT support the management of safeguarding concerns.

Berkshire West Federation of CCGs.

- Increased safeguarding training for primary care in level 1 and 2 and commissioned training in the Mental Capacity Act.
- Supported the fire safety check awareness campaign on twitter.
- Improved links between Continued Health Care and LA Care Governance teams by sharing expertise and undertaking joint reviews in nursing homes.
- Raised the profile and pathway of Female Genital Mutilation across primary care.

National Probation Service

- Launch of a Safeguarding Adults partnership framework which sets out a commitment to engaging in adult safeguarding.
- Made safeguarding referrals to the local authority when NPS staff have concerns.
- Attendance of NPS representative at Safeguarding Adults Board meetings.

Reading Borough Council

- Established a new safeguarding team.
- Increased the learning lunches and safeguarding workshops for staff and increased the amount of safeguarding training available.
- Reduced the amount of outstanding DoLS and created a pathway for community DoLS.

Royal Berkshire Fire and Rescue Service

- RBFRS is committed to adopting the principles of Making Safeguarding Personal.
- Provided awareness and duty to report training to staff on types of abuse.
- Completed a range of actions following audit recommendations including robust reporting and recording procedures.

Royal Berkshire NHS Foundation Trust

- Safeguarding training figures consistently compliant; quality of training evaluated. Enhanced Mental Capacity Act and DoLS training (0 - 63% compliance in a year.) Bespoke training programme for investigating safeguarding concerns and allegations for senior managers – a skilled cohort of investigators who listen, are non-judgemental, adapt their communication style and are responsive when investigating service users concerns.
- Safeguarding adult medical leads appointed and Safeguarding Adult Governance meetings established.
- From NHS choices; "*I came to A&E Tuesday evening which was mental health related and I was treated like any other physically unwell patient. I can't appreciate it enough of how well the professionals treated me*" December 2015.

South Central Ambulance Service NHS Foundation Trust (SCAS)

- SCAS safeguarding referrals are now completed electronically from electronic patient records (EPR) system.
- All patient facing staff undertook safeguarding level two training.
- SCAS integrated the Care Act 2014 into policies and working procedures.
- We started a process to complete internal and multi-agency reviews of safeguarding referrals completed by SCAS.
- SCAS undertook a large number of information requests with regard to safeguarding adults from partner agencies, feeding directly into case conferences when required.

Thames Valley Police

- SAVE training – online training provided through the Protecting Vulnerable People Directorate aimed at increasing officer knowledge and practice around vulnerability and exploitation.
- Female Genital Mutilation / Honour Based Abuse classroom based training.
- Problem solving weekly meetings to oversee identification of vulnerable people and support around them, in particular Operation Eraser to support vulnerable people subject of "cuckooing" (a crime which involves a drug dealer befriending a vulnerable individual who lives on their own and taking over their property).

West Berkshire Council

- Set up a Safeguarding Service User Forum.
- Established a learning log for all Partners to share learning from SARs.
- Delivered presentations at Provider Forums and Neighbourhood Watch meetings to increase awareness of adult safeguarding.
- Maintained performance in managing the DoLS authorisation process, the demand on which increased by over 140% during the last reporting year.

Wokingham Borough Council

- Framework and practice developments to provided preventative support to services in circumstance of organisational abuse and quality assurance concerns.
- Designed and implemented a Quality Assurance and triage framework for operational services with measurable outcomes process.
- Co-production work on the safeguarding agenda with people who use services and advocacy groups.

West of Berkshire
Safeguarding Adults Board
Reading, West Berkshire & Wokingham

BUSINESS PLAN 2015-16

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

Objective	Action	Lead	Timescale	Outcome	Progress
1.1 Develop oversight of the quality of safeguarding performance	a) Programme of internal spot audits to be undertaken on randomly selected safeguarding cases managed within the operational teams in West Berkshire.	Sue Brain West Berks Council	December 2015	Planned programme of spot checks will provide an overview of quality across the range of disciplines and enable more targeted training to be developed.	Compete, utilising Wokingham's audit tool approved for use. ***Green***
	b) Document templates for S42 Enquiries to be developed for use both internally and for provider services in West Berkshire. Programme of dissemination and implementation to be planned and executed.	Sue Brain West Berks Council	May 2015	Approved templates to use where appropriate and relevant will provide some consistency across S42 enquiries.	Completed and shared at the provider forum in May 2015. We also use some of those templates in our level 2 training to demonstrate the practical application of some of those templates. They are optional only. ***Green***
	C) Utilise the recently agreed Quality Assurance Audit for a large cohort of cases selected proportionately across the social care teams who carry out safeguarding investigations.	Jo Wilkins, Reading BC	April 2015	Assure officers, members and the community that all investigations are carried out to a high standard and comply with legislation in terms of quality and timeliness.	Audits were started in April with fewer complete than we have aimed for. The local framework has been reviewed and work has begun to a new and revised timetable with a target of 10% of all cases to be audited. This work is now on track. ***Green***
	d) Utilise the Reading	Debra Cole	June 2015	Staff feel confident in	Forum took place 16.6.15 and attended by cross

	Safeguarding Working Group and Forum to encourage group conversation and reflective practice.	Reading BC		their practice and explore issues of concern / share best practice in a safe environment. The Safeguarding Team will have an overview of where training is needed.	section of PVI sector and a service user. Workshop type meeting to discuss – • The purpose or function of the forum • Running of the forum • Membership • Engaging service users • Making safeguarding personal Regular forums booked and work to develop the above themes is on-going. Information and topics for future discussion suggested. ***Green***
	e) Establish a RBFT multidisciplinary adult safeguarding clinical governance committee with responsibility for over sight clinical performance: • KPIs • Audit • Analysis of themes from safeguarding referrals out of and concerning the organisation • Clinical incidents, partnership reviews, SCR – lessons learnt • Complaints • Allegations where appropriate • Case feedback, celebrating success, promoting best practice	Senior Nurse for Children and Safeguarding, RBFT	September 2015	Improved clinical governance, assurance and accountability ward to board for adult safeguarding in the RBFT.	Adult Safeguarding clinical governance committee has been set up. Terms of reference have been agreed and the committee will meet quarterly. This committee is to be chaired by a Trust consultant (Currently an ICU consultant).  Adult Safeguarding Clinical Governance C ***Green***
	f) Review adult safeguarding KPIs and audit programme to ensure it reflects internal, SAB and national policy.	UCG Director of Nursing and Corporate Lead for	April 2015	Improved clinical governance, assurance and accountability ward to board for adult	Completed. Adult Safeguarding KPIs are included in the RBFT /Berkshire West CCG contracted Quality Schedule 15/16 are reported monthly to the Board and as

		Safeguarding, RBFT		safeguarding in the RBFT.	scheduled to the CCG and include: MH minimum data set for all detained and informal patients; > 90% of staff to receive Adult Safeguarding Training which includes introduction to DoLS & MCA; All A&E staff to have conflict resolution training including restraint; Identified staff will receive Prevent training from a Prevent trainer; DoLS applications, granted/not granted reported; MCA policy to be written; Audit of MCA assessments; Processes in place to safeguard vulnerable adults: Key responsibilities: • Evidence of implementation of SAB policy and guidelines; • Ensure the local Safeguarding Adults Policy and Procedures are adhered to at all times; • Ensure participation at a senior level in the Local Safeguarding Adults Board; • Ensure patients and visitors are made aware of how to report harm. ***Green***
	g) Review the capacity and capability of the RBFT Safeguarding Team including adult safeguarding medical input and administrative support against the requirements of the Care Act 2014 and the Jimmy Saville NHS investigations: lessons learnt Report Feb 2015.	UCG Director of Nursing and Corporate Lead for Safeguarding, Senior Nurse for Children and Safeguarding, RBFT	June 2015	A multidisciplinary Safeguarding Team with the capacity and capability to deliver the safeguarding duties agreed by the Trust and detailed in its policies, procedures and process.	Cross cover for the safeguarding team has been assured. A review of safeguarding administration is underway. Three Consultants have identified time in their job plans for safeguarding including delivery of MCA training. They are members of the Adult safeguarding clinical governance committee. The consultant's specialities are Intensive care, Anaesthetics, Elderly care/surgery. An external benchmarking exercise has been undertaken. ***Green***
	h) Safeguarding to be included on	UCG Director of	April 2015	Appropriate management	Completed.

	all care group clinical governance agendas.	Nursing and Corporate Lead for Safeguarding RBFT		lines of accountability.	The monthly Safeguarding Board report is sent to and considered at each Care Group Clinical Governance Board meeting and at the Trust Quality and Learning Committee that reports directly to the Trust Clinical Governance Board. ***Green***
	i)Safeguarding group in place to monitor compliance. Review requirements for the Trust post Care Act and Jimmy Savile.	BHFT Deputy Director of Nursing	May 2015	Robust safeguarding processes in place.	TORs for the group have been reviewed. Policies and procedures being reviewed in light of Care Act. Savile Actions now complete. All agency staff recruited through NHSP ***Green***
	J) Consider outcomes of safeguarding audit and implement agreed recommendations.	D Phillips with Safeguarding Working Group (SWG), and Organisation's policy groups	September 2015	Improved oversight of the quality of safeguarding performance.	Actions implemented and audit superseded by pan Berkshire audit where assurance was provided in all areas – there will be on going actions as part of further development work. ***Green***
	k) A quality assurance framework is in place with provider health services to enable oversight of serious incidents requiring investigation (SIRI). Review SIRI report documentation include written section on form to include consideration of safeguarding children and adults and potential referral for SCR or SAR.	Jenny Selim, CCG	June 2015	Evidence of consideration of safeguarding is documented in all SIRI reports.	The CCG Serious Incident Panel, is part of the Quality team within the CSU and is the platform for discussion and closure of Serious Incidents (SIs) logged by provider health services. The SI Panel is chaired by the CCG Director of Nursing (who has CCG executive lead responsibility for safeguarding) and is attended by Directors from the relevant provider health service. Since July 2015 confirmation was received that safeguarding and complex case consideration has been a standard agenda item for the panel. Confirmation sent to the SAB in July 2015. ***Green***
	l) Site visits are made by the Nurse Director in the CCGs to all health service providers.	Debbie Daly Nurse Director & CCG Federation Executive Lead for Safeguarding	Ongoing	List of site visits and outcome can be provided	These visits are essentially quality assurance visits to eg. Hospital wards and departments made by the CCG Nurse Director and a member of the CCG Quality Team. Patient care and interaction is observed. ***Green***

	m) All contracted health service providers complete an annual safeguarding self-assessment tool which is monitored by the Safeguarding Team in the CCGs.	Jenny Selim, CCG	July 2015	Completed self-assessment returned via contracts with accompanying action plan. CCGs assured of safeguarding compliance of commissioned health services	All contracted health service providers have returned their completed safeguarding self-assessment tool to the CCG safeguarding team. These have been reviewed and feedback given to providers and any action plan is being monitored between the provider and CCG. Overall average compliance calculation from CCG providers indicated compliant. ***Green***
	n) From 2015 there will be exception reporting to the CCGs Safeguarding Committee and a written report provided to the Quality Committee of the CCG Federation	Jenny Selim, CCG	August-September 2015	Exception reporting to Berkshire West CCG Federation Safeguarding Committee quarterly.	A report from the safeguarding committee has been provided for each Quality Committee meeting. ***Green***
	o) Quality performance measures being developed by PVP Senior Managers	D/Supt Kidman, Thames Valley Police	Summer 2015	To review size of current investigations, workloads and themes	TVP have introduced a quarterly Vulnerabilities Steering Group and monthly thematic Risk Meetings across a range of adult and child vulnerabilities, chaired by a Chief Officer. Local Police Area Commander and specialists are held to account against multiple performance indicators. This process has already led to the development of self-service performance tools (e.g. DAIMS) and to the design & delivery of additional tailored training (e.g. Karma Nirvana to PVP specialist officers for HBA, Broken Rainbow for DA staff dealing with LGBT). ***Green***
	p) Internal QA framework is established and gives direct feedback to staff and managers both qualitative and quantitative feedback.10% monthly audit across all services.	Sarah O'Connor, Wokingham BC	On-going	Informs on-going training and development needs. Improves practice around standards in line with Berkshire safeguarding policy. Improves staff recording	Complete. ***Green***
1.2 Have in place	a) Social Care policies and	Sue Brain	May 2015	Local policies and	Safeguarding procedure updated and implemented

an effective framework of policies, procedures and processes for safeguarding adults.	procedures in West Berkshire Council to be reviewed and amended to accommodate changes imposed by the Care Act	West Berks Council		procedures will reflect the changes to safeguarding Adults as required by the Care Act	through team talks by the safeguarding team. The procedure and implementation remains under review and other procedures are being managed through the appropriate teams. ***Green***
	b) As part of the new operational process for: • Individual safeguarding Investigations • Organisational Investigations • Safeguarding team duties new processes and procedures have been designed. These will need to be reviewed following the go live date which is the beginning of March.	Service Manager Reading BC	June 2015	Following the start date of the new procedures a review of the overarching processes and procedures will allow amendments to be made based on real issues that have occurred as opposed to an assumption of the way that it will work. This should offer reassurance that all policies, procedures and processes are robust.	Pan Berks Policy and Procedures reviewed and replaced with a new process. Local Reading process has been reviewed and replaced following local independent review and is now compliant with pending Pan Berks P&P. ***Green***
	c) As part of the Quality Assurance Audit, the safeguarding team will be reviewing compliance with mandatory Care Act processes and with the Berkshire Safeguarding Adults Boards policy and good practice guidance.	Jo Wilkins Reading BC	April 2015	The outcome of this action will be that RBC will be able to assure officers, members and the community that RBC safeguarding is compliant with the Care Act and if audited would be able to evidence that we follow our overarching policy and good practice guidance.	Audit process has been revised; latest audits evidence a much improved compliance with Care Act principles: • Empowerment –largely good or outstanding • Partnership –largely good • Protection – largely adequate with the key issue being timescale/ process • Proportionality- largely good or outstanding ***Green***
	d) Review Adult Safeguarding Policy, procedures and processes and Restraint Policy against the Care Act 2014 (gap analysis)	Lead Nurse for Adult Safeguarding Lead Consultant	June 2015	Assurance that the RBFT is compliant and working effectively with partners to implement the Care	Completed. Please see RBFT Annual Report 2014/15.

		for Adult Safeguarding RBFT		Act 2014	***Green***
	e) Draft a Trust Mental Capacity Act Policy for approval by the Executive	Lead Nurse for Adult Safeguarding Head of Legal Affairs RBFT	June 2015	Clarity concerning the MCA including training to support knowledge, audit of practice and interdependency with other policies.	New deadline agreed with CCG for a combined MCA and Consent Policy, Jan 15. MCA is discussed in restraint and safeguarding adult's policy. ***Green***
	f) Report on Jimmy Saville NHS investigations: lessons learnt, Feb 2015, review current practice, gap analysis report and action plan to the Trust Board, CCG and for partner agencies.	Executive Director of Nursing RBFT	June 2015	Additional assurance and clear lines of accountability concerning the lessons learnt in other organisations.	Completed. Response sent to Monitor with a prioritised and affordable action plan on June. ***Green***
	g) Review Adult Safeguarding Policy in response to Care Act 2014	Deputy Director of Nursing BHFT	May 2015	Compliant policy in place	Revised policy issued April 2015 ***Green***
	h) Since the inception of the four CCGs in April 2013 each CCG has had in place a Safeguarding adults and children policy. Reference is made in the policies to the Berkshire Safeguarding Adults procedures and Child Protection Procedures. The policies will be reviewed in response to the Care Act 2014	JS/Kathy Kelly, Named Professional Safeguarding Adults for the CCGs (KK)	Safeguarding Policy review by May 2015	Revised policy will include changes from Care Act 2014	Policy has been reviewed and is on the CCG website. ***Green***
	i) All CCG employed staff and GPs have contact details for Named and Designated Safeguarding Professionals for advice and support in all matters relating to safeguarding children and adults	Kathy Kelly, CCG	June 2015	Include in Safeguarding Policy	This is included in the CCG's Safeguarding Policy and is shared with all GP Practices via the intranet, newsletters and face to face meetings with GP Practice leads for safeguarding, across Berkshire West. ***Green***
	J) External review of safeguarding practice. WBC have	Stuart Rowbotham,	April/May 2015	To have a safeguarding process fit for purpose in	Complete.

	commissioned an external review of safeguarding process across teams to highlight handoffs in service/risk and inform reorganisation of duty services and staffing.	Lynne McFetridge. Sarah O'Connor, Wokingham BC		light of the Care Act , social care and health integration agenda	***Green***
Priority 2 – Making safeguarding personal					
2.1 The views of adults at risk, their family/carers are specifically taken into account concerning both individual decisions and the provision of services.	a)Documentation to be amended to ensure the focus on the individual is at the forefront of S42 enquiries in West Berkshire	Sue Brain West Berks Council	April 2015	Amended documentation with mandatory requirement for completion will ensure the inquiry officer will be prompted at appropriate intervals to focus on the wishes of the individual.	S42 inquiry documentation updated to include outcomes consistent with the making safeguarding personal initiative. The effectiveness of outcomes is being measured and reported on at Corporate Board in readiness for statutory reporting during 2016/17 ***Green***
	b)Programme of external information and support planned for providers and service users in West Berkshire to ensure the MSP agenda is central to their understanding when raising safeguarding concerns.	Sue Brain West Berks Council	March 2016	Appropriate understanding across all sectors will ensure MSP is central to both referrals and enquiries	MSP has been included within all levels of safeguarding training from April 2015. Talks to provider forum and teams which highlights the focus of MSP being undertaken. Specific MSP training delivered throughout Q3 and 4. Reporting focus in West Berks established to capture clients' wishes. ***Green***
	c)The views of adults at risk and their family/carers will be reviewed as part of the Quality Assurance Audit. Any non-compliance will be discussed with the case investigator and their line manager and any patterns of non-compliance will be addressed with all staff via training.	Service Manager and Jo Wilkins Reading BC	July 2015	Adults who have been subject to an individual or part of an organisation investigation will feel safer on their own terms and that no presumption will be made around what is in their best interests.	Outcomes met. Audit evidences improvement in adult's voice being central to enquiry (see 1.2, c). MSP training complete. System for feeding back audit outcomes to Team Manager. ***Green***
	d)The Council has signed up to the Making Safeguarding Personal programme overseen by	Service Manager and Jo Wilkins	July 2015	Nationally we will be able to state that we have achieved a certain level of	Complete.

	Local Government Association and will work with them to ensure at least Bronze level compliance with the programme.	Reading BC		making Safeguarding Personal which will be ratified.	***Green***
	e)Ensure that representatives of service users and/or their families/carers are invited to each Safeguarding Forum and feel safe to express their experience and feelings there.	Debra Cole Reading BC	June 2015	This will ensure that our work is service user lead and that we can learn from the experience of those service users and/or their families/carers.	This action is monitored via the audit action above. Feedback is offered to workers via line management. In Q1, practice gave rise to concern in relation to this action which is not embedded in practice. Training is necessary to advance this vital action and is being planned as above with local partner authorities. Service users and carers are now attending safeguarding forums – latest subject covered was "Hoarding and Neglect" with contributions from Environmental Health and the Lead AMHP. ***Green***
	f)MCA and DoLS review and audit at least 2 patient individual journeys to include patient and family experience and views.	Lead Nurse for Adult Safeguarding & Learning Disability Coordinator RBFT	September 2015	Identify good practice and gaps, improve learning, patient focused actions, celebrate good practice	MCA and DoLS Training is on going. Awareness training forms part of staff induction and core mandatory training day. Enhanced training is offered to identified staff – senior clinical staff. Compliance is reported via the quality schedule to the CCG. The safeguarding team continue to apply for DoLS, with the ward areas identifying patients who require a DoLS. Gathering of patient stories is on-going. 2 MCA audits completed through review of patient notes. ***Green***
	g)Review and audit patient at least 2 patient individual journeys MHA to include patient and family experience and views.	Mental Health Coordinator & Named Nurse for Child Protection RBFT	September 2015	Identify good practice and gaps, improve learning, patient focused actions, celebrate good practice	Patient stories are collected and discussed at the safeguarding team meeting. ***Green***

	h) Review adult safeguarding information leaflets with a Patient Leader	Senior Nurse for Children and Safeguarding RBFT	September 2015	Review adult safeguarding information leaflets with a Patient Leader	Patient leaflets have been reviewed by patient leaders / patient reviewers. This was undertaken by the patient information manager to ensure that all information is to an appropriate standard and uses suitable language. There is a planned scheduled review for all patient information. ***Green***
	i) Ensure Duty of Candour is applied to safeguarding investigations	Deputy Director of Nursing BHFT	September 2015	Duty of Candour appropriately applied	Duty of candour applied and register in place. To audit by end of year.
	j) Consider feedback as a result of the implementation of the fire safety guide for adults	D Phillips with Safeguarding Working Group (SWG), and Organisation's policy groups. RBFRS	Dec 2015	Identify good practice and gaps	Excellent feedback – task and finish groups being formed to co-ordinate training of front line staff and to enable referrals. The guide is being linked to GP practices across Berkshire West. A report will be provided to the Board as a recommended 6 monthly period to report on – agencies trained, referrals received and safeguarding alerts raised. The guide is being well received in all SABs and the approach is being used as an example of good prevention / safeguarding work adding value to the work of sub groups. ***Green***
	k) Peer review with SE ADASS	Sarah O'Connor Wokingham BC	September 2015	To provide benchmarking and review of Making Safeguarding Personal agenda	Complete. ***Green***
	l) Documentation to be amended to ensure the focus is on the individual's wishes and outcomes. MSP implemented into level 1,2 and 3 safeguarding training	Sarah O'Connor Wokingham BC	April 2015		Complete. ***Green***
	m)Programme of workshops arranged for providers and staff of the council to ensure MSP is central to their understanding when raising safeguarding concerns	Sarah O'Connor Wokingham BC	Autumn 2015		Complete. ***Green***

	n) Cases will be randomly selected for detailed review and feedback from the safeguarding team to ensure the change in process is being adhered to and understood by staff and providers	Sarah O'Connor Wokingham BC	Autumn 2015	As above	Initiated via 10% audit and practice consultation. Complete and ongoing.
Priority 3 - Raise awareness of safeguarding adults, the work of the SAPB and improve engagement with a wider range of stakeholders					
3.1 Raise awareness of safeguarding adults and the work of the Board within all organisations.	a) Redeveloped safeguarding adults forum in West Berkshire with renewed focus on membership and action planning to reflect the priorities of the SAPB	Sue Brain West Berks Council	June 2015	Re-crafting the membership and focus of the Forum will ensure it aligns with the business plan of the Board increasing awareness and understanding across the professional sector.	Updated safeguarding training to include information on the SAB. ToR and action plan developed and approved by the local safeguarding forum which aligns with strategic direction of the SAB. Actions within the plan include plans for awareness raising. Regular reviews of the action plan take place within the forum setting. This is now a well-established forum and set up as the operational arm of the SA Board in West Berkshire. ***Green***
	b) RBC will attend all board and sub group meetings and provide good links to the board and the Berkshire Safeguarding Adults Boards policy and good practice guidance on our website. We will also ensure that safeguarding retains a presence within the Care Junction newsletter which goes to Council employees and local health and social care providers.	Service Manager Reading BC	June 2015	This will ensure that safeguarding remains visible and at the forefront of organisations and communities minds. It will also provide information about what we do and how well we have done in order to offer reassurance of a safe and effective service.	All actions complete. RBC is well represented on all sub groups with a record of good attendance. Care Junction newsletter has just received the latest update outlining MSP, FGM and Modern Slavery and publicity updates. ***Green***
	c) Review Trust intranet Safeguarding page to include link to SAB website when available	Senior Nurse for Children and Safeguarding RBFT	When SAB website available	Improved awareness of the role of SAPB amongst RBFT staff	Communication team asked to add link to internet Oct 15. ***Green***

	D) Link to SAB website from Trust intranet	Deputy Director of Nursing BHFT	When website available	BHFT staff more aware of SAB	Link added to intranet ***Green***
	e) Consider publicising RBFRS work in relation to safeguarding adults externally and internally	D Phillips with SWG and Corporate Communications	June 2015	Staff and public are more aware of RBFRS safeguarding work and the work of the SAB.	RBFRS has been carrying out a safeguarding audit and is in the process of providing further internal training / awareness. RBFRS has been promoting its prevention work with vulnerable adults. ***Green***
	f) Team meetings to have quarterly invitation to safeguarding team to update and raise awareness improve learning and practice	Lorna Willis Mechelle Adams Ron Brown Christine Dale, Wokingham BC	Summer 2015 onwards	Raise awareness and improve communications across the organisation	Ongoing. ***Green***
	g) Review feedback systems within adult social care and joint health and social care teams	Lynne McFetridge Sarah O'Connor Wokingham BC	Summer 2015 onwards	Review feedback systems within adult social care and joint health and social care teams	Ongoing. ***Green***
3.2 Increase public awareness of safeguarding adults and the work of the Board.	a) Develop a service user safeguarding adults forum in West Berkshire	Jennifer Symons West Berks Council	October 2015	Development of this forum will enable the dissemination of information and exploration of safeguarding issues and solutions with various service user groups	Two meetings have taken place since the Autumn, with a third booked for early March 2016. Focus to date has been on raising awareness in the local community. ***Green***
	b) Review literature and promotional material to ensure its details and message are still correct and change its appearance so that it is not overlooked through familiarity.	Jo Wilkins Reading BC	September 2015	The outcome of this action should be that more referrals are made to safeguarding as new material will raise the profile of safeguarding.	Complete – updated publicity material due for dissemination by end August. ***Green***
	c) Review Trust internet (public) Safeguarding page to include a statement about the importance of partnership working through	Senior Nurse for Children and Safeguarding	When SAPB website available	Improved awareness of the role of SAPB amongst RBFT patients, families and visitors	Links to the website and the policies and procedures are on RBFT's internal site. Statement about the importance of partnership working through SAB and link to SAB website is expected to

	SAB and link to SAB website when available	RBFT			be published early 2017. ***Green***
	d) Support the SAB in raising awareness of safeguarding adults and the work of the Board	D Phillips with SWG and Corporate Communications. RBFRS	June 2015	Staff and public are more aware of RBFRS safeguarding work and the work of the SAB.	RBFRS has been carrying out a safeguarding audit and is in the process of providing further internal training / awareness. RBFRS has been promoting its prevention work with vulnerable adults. ***Green***
Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.					
4.1 Continue to ensure staff receive appropriate and effective level of safeguarding and other relevant training.	a) West Berkshire to continue to contribute to the Learning and Development subgroup of the SAB and support the peer observations and reviews of training across the SAB patch	Neil Dewdney West Berks Council	April 2015	Contribution to the L&D subgroup will ensure that safeguarding training in West Berkshire meets agreed standards and supports the development of future training options	Level 2 safeguarding training redrafted and brought back in house. In line with the L&D sub group training standards. Completed by 1st June Level 3 due to be brought back in house by end of this financial year. Level 3 dates agreed and planned for 2016/17, delivered by WBC safeguarding staff in line with the SAB L&D subgroup standards. ***Green***
	b) West Berkshire will contribute to and facilitate learning events across the District from SAR's, as agreed within the Partnership subgroups (either L&D or Partnership and Best Practice)	Sue Brain West Berks Council	September 2015	Support for a variety of learning opportunities will ensure that staff across West Berkshire will have the opportunities to access learning events outside of the formal training programme	Workshops for safeguarding case law review, including learning from SAR's across the country, delivered in September 2015. New workshops commissioned for April/May 2016 with an option for another one in September/October 2016. Final agreement on format of learning log for forum approved and in use from December 2015. ***Green***
	c) Continue to attend and feed into the Learning and Development Subgroup.	Jo Wilkins Reading BC	April 2015	The outcome will be that Reading can feed into identified training needs and ensure that staff are skilled and knowledgeable in	Complete –continued attendance. ***Green***

				carrying out and identifying safeguarding cases.	
	d) Continue with our rolling programme of training offered.	Jo Wilkins Reading BC	April 2015	Again this will ensure that staff and external organisations are skilled and knowledgeable in carrying out or identifying safeguarding cases.	Complete – Training continues as planned. ***Green***
	e) Review all safeguarding training and have a written strategy and training plan for 2015/16 which will include Adult Safeguarding Awareness, Adult Safeguarding Level 2, MCA, DoLS, Prevent and MHA and allegations management	Senior Nurse for Children and Safeguarding RBFT	June 2015	Continue to improve the level of safeguarding knowledge, competence and confidence in RBFT workforce	Completed – please see RBFT Annual Report 14/15 and action plan 15/16 for details. ***Green***
	f) Review training requirements in light of the Care Act	BHFT	July 2015	Maintenance of training targets	Training reviewed in light of Act. Compliance targets maintained. ***Green***
	g) Communicate and train internally and externally on the content and intentions of 'Adult At Risk and Associated MoU' documents	DP with SWG	Mar 2016		Excellent progress being made with providers being identified and training taking place. Reading BC are providing a good practice model of a task and finish group which is ensuring RBFRS are connecting to all the service providers and the group is ensuring records are kept. RBFRS would recommend this approach in all local authority areas. RBFRS will provide a report to the Board on training carried out, referrals received as a result as well as safeguarding concerns raised – this to ensure that the training and approach is sustained and can identify on-going training needs. ***Green***
	h) Safeguarding lead to undertake Lead review training Learning Together -SCIE	Sarah O'Connor Wokingham BC	Autumn 2015	Resource within the service to undertake lead review work	Complete. ***Green***

	i) Internal review of all training completed in relation to MCA/Dols and Safeguarding inclusive of levels 1/2/3/ for adults and level 1 for children	Hazel Leggett Wokingham BC	Early May 2015 – essential to fit in with appraisal framework	All staff to be up to date on mandatory training – this will provide feedback to team managers and supervisors to ensure training is picked up within the DIALS appraisals as an action. Improved governance regards mandatory training.	Complete. ***Green***
4.2 Improve mechanisms to critique good and bad practice and share learning more widely.	a) West Berkshire will fund the accreditation of a member of staff to become a SCIE lead reviewer	June Graves West Berks Council	December 2015	This will enable West Berkshire to maximise the learning from reviews by using the Learning Together model and to support other organisations in the partnership in completing their reviews.	Complete. ***Green***
	b) West Berkshire to continue to support the development of the Care Quality Intelligence partnership group (operational) and Care Quality Board (strategic)	Maria Shepherd West Berks Council	April 2015	The operational and strategic groups will support the process of identifying and unpicking practice and sharing the learning across the partnership members	Both groups are now operational with agreed ToR's, structures and governance. Second meeting taken place with third booked for early March 2016. Focus to date has been on raising awareness in the local community. ***Green***
	c)The Quality Assurance Audit has been created and will be used to identify and critique good and bad practice.	Jo Wilkins Reading BC	April 2015	RBC will be able to assure officers, members and the community that all investigations are carried out to a high standard which complies with legislation in terms of quality and timeliness.	Target is now being met and exceeded. ***Green***
	d)Utilise the Reading Safeguarding Working Group and Forum to share learning.	Debra Cole Reading BC	June 2015	Staff will feel confident in their practice and in a safe environment will be	Information sharing will be integral to the running of the forum. A range of specific topics will be

				able to explore issues of concern or to share best practice.	presented/discussed at the forums as requested by members, the Safeguarding Board, service users and managers. ***Green***
	e) Evaluation of safeguarding training, ensure good and bad practice is used to inform training and included as scenarios.	Senior Nurse for Children and Safeguarding Lead Nurse for Adult Safeguarding RBFT	June 2015	Training will be more relevant and practitioners will contribute to improvement	Completed at Safeguarding Team Away day June 2015. ***Green***
	f) Safeguarding practice to be included in trust CQC peer review of wards/units	UCG Director of Nursing and Corporate Lead for Safeguarding RBFT	Started Oct 2014	Testing of knowledge and practice and targeted improvement	Completed. Pertinent questions including knowledge of MCA and DoLS included in several rounds CQC peer review have demonstrated improvement in knowledge and allowed for targeted improvement. This approach is on-going. ***Green***
	g) Review process for sharing learning from SCRs	Head of Adult Safeguarding BHFT	July 2015	Improved learning from SCRs	Published on intranet. Learning from SCRs incorporated into training ***Green***
	h) Embed a 'fatal fires and near misses' process and associated communications (internal and external)	DP with RBFRS critical event management team	Dec 2015	Improved learning from incidents and identification of poor practice.	Very good progress being made with reviews taking place in Reading providing reports with clear direction and actions that are taking place to implement learning. The coroner has provided good feedback on RBFRS' approach. It is strongly recommended that the approach taken in Reading with an effective partnership review and task and finish group is implemented following fire fatalities to ensure learning is identified and actioned. ***Green***
Priority 5 – Coordinate and ensure the effectiveness of what each agency does					
5.1 Challenge staff and organisations where poor	a) Improve information sharing processes between Care Quality, Safeguarding Adults and	Service Managers West Berks	March 2016	Improvements to intelligence sharing and agreed co-ordinated	One CQ officer has been designated as the safeguarding link and works as an integrated member of safeguarding in relation to

practice is identified.	Commissioning and Contracts teams in West Berkshire to co-ordinate opportunities to challenge poor practice in a variety of forums	Council		action across departments increases the opportunities and forums in which poor practice can be challenged at the earliest opportunity and in a variety of settings with a variety of responses.	investigations and subsequent action plans. Care Quality Intelligence Group and Care Quality Board now well attended. Contracts and Commissioning are well represented in all settings. ***Green***
	b) Continue to support the development of the Care Quality Intelligence partnership group (operational) and Care Quality Board (strategic)	Maria Shepherd West Berks Council	April 2015	The operational and strategic groups support the process of identifying poor practice and have the mechanisms to challenge those individuals through their strategic and operational links with commissioning and CQC	Safeguarding is a key integral member of both the CQ intelligence and strategic board. Matrix of risk has been developed via care quality in relation to providers we commission drawing information from safeguarding, deficiencies and complaints and delivers information critical to planned interventions. ***Green***
	c) Provide PI information as required by the Board.	Service Managers Reading, West Berkshire and Wokingham	Sept 2015	LA's will be held accountable and can be challenged on poor performance.	Agreed PI set developed. Q1 data collated and presented to the Board. Mechanisms in place for quarterly recording and submission of data. ***Green***
	d) Work with Contracts and Commissioning to review practice in organisations.	Service Manager and Jo Wilkins Reading BC	April 2015	The outcome of this will be that Reading will be able to confirm the appropriate and timely identification of potential organisational abuse and take the appropriate action.	Update – August 2015. Safeguarding Roles and Responsibilities was approved by DMT in March 2015. The document and associated guidance have been comprehensively reviewed and amendments are due to go back to DMT by end September. Further perspective has been provided by an on-going independent review of safeguarding process and practice which has begun to provide very useful feedback including on RBC's processes compliance with SAB agreed processes. ***Green***
	e) Review the pathway and processes: oversight of the Safeguarding decision and	Sarah O'Connor Lynne McFetridge	Summer 2015	Local Authority has oversight of the processes within Optalis	Complete.

	ensuring appropriate action is taken remains the duty of the LA although work can be delegated to the LATC.	Mette Le Jakobsen Wokingham BC		its LATC, to ensure pathways and responsibilities are clear, understood and agreed by all parties.	**Green**
	f) The independent external review recommendations will be taken into account by the leadership team and inform discussions around pathway change and system design.	Sarah O'Connor Lynne McFetridge Wokingham BC	Summer 2015	Evidence from the external review used to improve service design	Complete. ***Green***
5.2 Develop the role of the Forums to provide feedback on the effectiveness of what each agency does.	a) Redeveloped safeguarding adults forum in West Berkshire with renewed focus on membership and action planning to reflect the priorities of the SAB	Sue Brain West Berks Council	June 2015	Re-crafting the membership and focus of the Forum will ensure it aligns with the business plan of the Board increasing awareness and understanding across the professional sector.	ToR and action plan developed and approved by the local safeguarding forum which aligns with strategic direction of the SAB. Actions within the plan include plans for awareness raising. Regular reviews of the action plan take place within the forum setting. New working group to develop action plan for 2016/17 set to be convened after the SAB planning workshop in Feb 2016. ***Green***
	b) Develop a service user safeguarding adults forum in West Berkshire	Jennifer Symons West Berks Council	October 2015	Development of a well facilitated forum creates a safe space for feedback on local safeguarding practice and suggestions for improvement or sharing new ideas	First meeting planned for 9th September 2015. First meeting has taken place and was reasonably well attended for a first meeting. Next meeting due 10th December 2015. ***Green***
	c) Re-launch the forum in Reading and provide opportunity for feed-back in a structured way by organisations and service users	Debra Cole Reading BC	June 2015	The outcome will be that Reading can ensure that their practice is aligned to what works best for partners and service users and this forum can be used to explore new initiatives.	Forum re-launched in June. ***Green***
	d) Share forum details in the	Nancy Barber,	July 2015	Improved attendance	BHFT representative attended the launch of

	Trust	BHFT		from BHFT	Reading's Forum. Forum now included on BHFT training schedule Multi-agency input for forum speakers ***Green***
	e) Re-establish staff engagement with the Wokingham Safeguarding Forum through team meetings	Sarah O'Connor Johan Baker Wokingham BC	Summer 2015 onwards	Improve attendance and representation	Complete. ***Green***

West of Berkshire Safeguarding Adults Board Business Plan 2016-17

PRIORITY 1 **ESTABLISH EFFECTIVE GOVERNANCE STRUCTURES, IMPROVE ACCOUNTABILITY AND ENSURE THE SAFEGUARDING ADULTS AGENDA IS EMBEDDED WITHIN RELEVANT ORGANISATIONS, FORUMS AND BOARDS.**				
Outcome	**Action**	**Lead**	**Timescale**	**Success criteria**
1.1 Develop oversight of the quality of safeguarding performance.	a) Review and implement the Board's Quality Assurance Framework.	Governance Subgroup	Sept 2016	The QA Framework is reviewed and published. Identified actions are implemented.
	b) Annual self-assessment audit to be completed by partner agencies, results received and action plans monitored.	Governance Subgroup	Dec 2016	Results of self-assessment audit evidences improvements on previous completion.
	c) Develop a Performance and Quality Assurance framework to support and promote MSP.	Performance and Quality Subgroup	Oct 2016	Outcome information has a focus on wellbeing as well as safety, and reflects the six safeguarding principles.
1.2 Have in place an effective framework of policies, procedures and processes for safeguarding adults.	a) Approve amendments to the Pan Berkshire Multi-Agency Policy and Procedures twice yearly.	Governance Subgroup	July 2016 and ongoing	The Berkshire Multi-Agency Policy and Procedures are accurate and up to date.
	b) Implement a Tracker to monitor how learning from local reviews and national developments is embedded across the partnership.	Governance Subgroup	Sept 2016	Board is assured that learning from reviews and national developments is shared across partner agencies.

1.3 Raise awareness of the work of the Board within partner organisations	Present Board's Annual Report to Health and Wellbeing Boards and other committees.	Independent Chair and Board members	January 2017	Evidence that the Annual Report is presented to the HWBs and other committees.

PRIORITY 2

RAISE AWARENESS OF SAFEGUARDING ADULTS, THE WORK OF THE SAFEGUARDING ADULTS BOARD AND IMPROVE ENGAGEMENT WITH A WIDER RANGE OF STAKEHOLDERS

Outcome	Action	Lead	Timescale	Success criteria
2.1 The Board is confident that professionals are accessing the online Berkshire Policy and Procedures	a) Publish and promote new Berkshire Policy and Procedures.	Communication Subgroup	April 2016 publication, with review scheduled for July.	Audit trail of emails promoting Policy and Procedures from Board members to teams.
	b) Evaluate awareness of and use of Policy and Procedures through survey and website analytics.	Communication Subgroup	Findings from survey and website analytics reviewed in December.	Survey monkey reveals 75% of respondents are familiar with Procedures. Website analytics evidence improved no. of hits on the relevant page.
2.2 All partner agencies have agreed and implemented the Board's revised Communication Strategy.	Review and promote the Board's Communication Strategy.	Communication Subgroup	June 2016	Board endorsement of the Communication Strategy. Clear communication processes and joint working in the event of a significant safeguarding incident.
2.3 All Board members	Review and promote the Board's Induction Pack.	Communication	Sept 2016	Evidence that members have

understand their role.		Subgroup		received the Induction Pack and understand their role as Board members.
2.4 Managers and staff are aware of the learning from SARs in order to keep people safe.	Publish and disseminate learning from Safeguarding Adults Reviews and other partnership reviews.	Communication Subgroup	Sept 2016 and ongoing	Executive summaries and briefing papers published and disseminated upon completion of review.
2.5 Practitioners are aware of the Board's function and local safeguarding processes.	Conduct survey and make recommendations to help the Board raise awareness of its function and local safeguarding processes.	Communication Subgroup	Dec 2016	Survey completed by 200 practitioners. Recommendations endorsed by Board and actions to implement recommendations in place.
2.6 Printed information is available to guide people through the safeguarding process.	a) Provide clear explanations for people about what is meant by safeguarding and outcomes.	Communication Subgroup	March 2017	People are involved more effectively in the safeguarding process.
	b) Promote the principles of Making Safeguarding Personal.	Communication Subgroup	January 2017	Information on MSP published and disseminated via website, briefing notes and publicity material.

PRIORITY 3: ENSURE EFFECTIVE LEARNING FROM GOOD AND BAD PRACTICE IS SHARED IN ORDER TO IMPROVE THE SAFEGUARDING EXPERIENCE AND ULTIMATE OUTCOMES FOR SERVICE USERS.				
Outcome	**Action**	**Lead**	**Timescale**	**Success criteria**

3.1 Continue to ensure staff receive appropriate level of safeguarding adults training.	a) Review Levels 2 and 3 safeguarding training standards to ensure alignment with Pan-Berkshire Policy and Procedures.	Learning and Development Subgroup	December 2016	Updated training standards agreed and used in developing training programmes
	b) Refresh Workforce Development Strategy to map to revised social care competence framework and to intercollegiate document.	Learning and Development Subgroup	March 2017	Refreshed Strategy (including updated training standards) produced & published on SAB website
	c) Deliver Safeguarding Adults Train the Trainer programme (Wokingham BC.)	Learning and Development Subgroup	April 2016 (achieved)	Course delivered by Wokingham BC and offered across west of Berkshire
	d) In conjunction with the LSCBs, support development and delivery of the Joint Children's and Adults Safeguarding Conference on 23 September.	Learning and Development Subgroup	23 September 2016	Conference held with attendance from adult sector
	e) Deliver Making Safeguarding Personal awareness training for private, voluntary and independent sector.	Learning and Development Subgroup	December 2016	Awareness workshops delivered to the local PVI sector
	f) Trading standards tailored training.	Learning and Development Subgroup	20 June 2016	Tailored training developed and delivered
	g) Deliver core training programmes at all levels to support the sector. Report on training activity for 2015-16 for SAB annual report.	Learning and Development Subgroup	Ongoing June 2016	Training programmes delivered and evaluated. Training data collated
3.2 Improve mechanisms to share learning from	Support the development of workshops and network meetings to share learning from SARs and	Learning and Development	March 2017	Information sharing sessions coordinated to respond to SARs to

good and bad practice more widely.	other partnership reviews.	Subgroup		support Effectiveness Subgroup

PRIORITY 4 **COORDINATE AND ENSURE THE EFFECTIVENESS OF WHAT EACH AGENCY DOES**				
Outcome	**Action**	**Lead**	**Timescale**	**Success criteria**
4.1 Agencies are implementing, and are compliant with, the new Berkshire Policy and Procedures and areas for learning and development across agencies and standards of best practice are identified.	a) Twice yearly case audit on S42 enquiries are undertaken. Themes and areas for development from S42 audits reported to the Board in June and December. Board to take required actions to address areas of identified concerns across partner agencies. Audit sample of cases against the MCA code of practice.	Effectiveness Subgroup	May and November 2016	Baseline established in May and areas for improvement identified; second audit in November evidences improvements in results of S42 case file audits outcomes.
	b) Undertake and publish multi-agency thematic reviews.	Effectiveness Subgroup	February 2017	Results of thematic reviews are published and areas for development are identified for the Board to take appropriate action.
4.2 Service user feedback indicates that clients' desired outcomes are met, in line with MSP and the well-being principle.	a) Develop processes to ensure service user feedback is collected and understood.	Effectiveness Subgroup	September 2016	Robust, practical processes are in place across partner agencies.
	b) Develop mechanisms for measuring outcomes for individuals who have been through the safeguarding process.	Effectiveness Subgroup	March 2017	Increase in number of individuals whose desired outcomes have been met as a result of the safeguarding

				process.
4.3 Involvement of advocates and IMCAs ensure person centred responses are promoted.	Identify where there is a shortfall in the use of advocates and raise staff awareness as to how and when to involve advocates.	Effectiveness Subgroup	September 2016	New approaches to person centred responses are promoted. Quarterly PI data indicates improvement in use of advocates.
4.4 The Board is assured that learning from SARs has been responded to appropriately by agencies.	The SAR Learning Monitoring Tool is used to monitor response to findings by partner agencies upon publication of SARs.	Effectiveness Subgroup	October 2016 and ongoing	The SAR Learning Monitoring Tool is completed and presented to the Board quarterly showing that learning from SARs is embedded within partner agencies.
	Subgroup to receive action plan developed by the SAR Panel, monitor completion by partner agencies and provide assurance to the Board that actions have been met.	Effectiveness Subgroup	October 2016 and ongoing	Learning from SARs is embedded within partner agencies. Actions are completed within identified timescales.

Safeguarding Adults Annual Report 2015/16

Authors: Suzannah Johnston, Safeguarding Adults Team Lead

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Date: July 2016

Purpose

This paper provides assurance to the Trust that all issues related to safeguarding adults, like those of children and young people are being satisfactorily managed within Berkshire Healthcare Foundation Trust (BHFT).

Document Control

Version	Date	Author	Comments
2	July 2015	Suzannah Johnston	
		Kate Harte	

This document is considered to be Commercial in Confidence and is therefore not to be disclosed outside of the Trust without the prior consent of the Author or a Director of the Trust.

Distribution:

All Trust Directors

All relevant staff

Document References

Document Title	Date	Published By
Lampard report on Saville enquiry	2015	TSO
Care Act	2014	TSO
Care and Statutory Guidance	2014	Department of Health
Making Safeguarding Personal	2014	LGA
The Cheshire West and Chester Council V P(2014) UKSC19, (2014) MHLO16	2014	Mental Health on Line (MHOL)
Mid Staffordshire Foundation Enquiry- *Francis Report*	2013	TSO
Mental Capacity Act	2005	Department of Health
No Secrets	2000	Department of Health
Building Partnerships, Staying Safe	2011	Department of Health
Mental Capacity Act 2005 Deprivation of Liberty Safeguards	2007	Department of Health

Safeguarding Adults - Annual Report 2015/16

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1. Introduction

Adult Safeguarding practice has come into sharp focus for all NHS organisations in the wake of large scale enquiries such as the Mid Staffordshire Foundation Enquiry, the *Francis Report (2013)* and the Lampard report on Saville enquiry (*Lampard K & Marsden 2015*)

With the introduction and implementation of the Care Act (2014) on 1st April 2015 this has been the first year that Safeguarding Adults has operated with the benefit of a legal framework.

The Care Act identifies an Adult at risk as:

- *someone who is aged 18 and over, who has needs for care and support (whether or not the local authority is meeting any of those needs); and*
- *is experiencing, or is at risk of abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*

The Care Act 2014 enshrines the six principles of safeguarding practice.

1. Empowerment –presumption of person led decisions and informed consent.
2. Prevention- it is better to take action before harm occurs.
3. Proportionality – proportionate and least intrusive response appropriate to the risk presented.
4. Protection- support and representation for those in greatest need.
5. Partnership- local solutions through services working with their communities.
6. Accountability – accountability and transparency in delivering safeguarding

The Act places a duty on local Authorities to establish Safeguarding Adult Boards (SABs). All Berkshire Local Authorities already had established boards, the Act means they are now statutory, bringing Adult Safeguarding more in-line with Children's Safeguarding.

The Act places a legal duty on local authorities to make enquiries or ensure others do so, if it suspects an adult is subject to, or at risk of abuse or neglect. It places a legal duty on organisations including BHFT to comply with requests to supply information to support the SAB exercise its functions.

2. Safeguarding Vulnerable Adults in Berkshire

2.1 Safeguarding Adult Boards

There are four SABs serving Berkshire: West of Berkshire SAB serving Reading, West Berkshire (Newbury) and Wokingham, Bracknell SAB, Royal Borough of Windsor and Maidenhead SAB and Slough SAB.

Section 44 of the Care Act puts a duty upon the Safeguarding Adults Board (SAB) to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

I. There is reasonable cause for concern about how the SAB, its members or other persons with relevant functions worked together to safeguard the adult, and
II. The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Or

III. If the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

BHFT are represented at all Boards with, the Deputy Director of Nursing sitting on the West Board and the relevant Locality Directors for each of the East Boards.

2.2 Safeguarding Adult Review's

During 2015/16 there have been 2 new Safeguarding Adults Reviews (previously referred to as Serious Case Reviews). Both reviews were undertaken by West of Berkshire SAB. It is anticipated that the final report for Mr I will be published around September 2016. There is an ongoing criminal investigation in the case of Mrs H, so no date for publication has been agreed.

One case in Slough EE has concluded and the findings and actions are detailed below. Another Slough case known as Mr F was initially considered for SAR but on review it was agreed that it would met the Criteria for a Domestic Homicide Review. The report has been completed and is awaiting sign off from the Department of Health prior to publication.

Slough SAR

Summary:

At the time of her death Mrs. EE was a 93yr old woman living with her son aged 58 in a Council flat with very limited contact with statutory services and in receipt of no services. Mrs EE had been a tenant of Slough Borough Council for many years and prior to that her husband was the tenant. There was a long running dispute between the household and their upstairs neighbour which revolved around noise, usually at night. Most contact between Mrs EE/EE's son and the Housing Department was via letter and these were usually about complaints by EE or EE's son about noisy neighbours. This was escalated on a number of occasions to Councillors and also to their MP. However both parties refused any attempts at mediation. There had been intermittent Anti-Social Behaviour complaints by her neighbour upstairs over a long period of time about Mrs EE about noise nuisance (along with other complaints by the neighbour against other tenants in the building). In 2009 Housing served notice on Mrs EE as a means of improving Mrs. EE's engagement with the alleged noise issues. Mrs EE and her son strongly denied the allegation and spent some time trying to clear their name. The household was known to the Antisocial Behaviour Service for at least 9 years because of this. Mrs EE never visited her GP surgery after 2007 and was rarely seen by anyone from the practice. Mrs EE continued repeat prescriptions for minor ailments via letter. Mrs EE refused any services offered by Adult Social Care on two occasions. In June 2014 her son called an ambulance and the crew found Mrs EE in a poor state allegedly having lived in her chair for 4 years. She subsequently died in hospital of sepsis the next day.

Findings:

Finding 1: The assumption from professionals is that other services will 'keep an eye' on people even after their case is closed due to non-engagement and will refer back if risks escalate, but as there are no formal systems for monitoring people who disengage from services, in reality risks remain unknown.

Finding 2: The specific remits of the various panels for discussing cases means that there is no clear route for escalation to consider alternative options for people who do not fit a defined category of need leading to no safety net for professionals

Finding 3: In Slough there is no public health promotion of common health problems affecting older people (e.g. continence, lack of mobility), leaving family carers and professionals with limited understanding of the risks involved in managing them effectively

Finding 4: In initial contact, professionals are focused on what they can provide, so they tend not to prioritise issues that are outside their role, even if they are very important to the service user, resulting in disengagement by the service user.

Finding 5: There is a lack of clarity about the relationship between safeguarding adult and domestic abuse procedures, particularly in non-stereotypical domestic abuse cases, leading to risks not being investigated thoroughly.

Actions:

As well as engaging in a number of multi-agency actions including the development of information leaflet for patients and carers and a mapping exercise of the various multi-agency panels and meetings in Slough. The main actions are around communication with partners, particularly in relation to the risk of non-engagement. A BHFT action plan was developed and is monitored though the BHFT Safeguarding Group.

West of Berkshire SAR

1. **Summary:**

Mrs H was living in an annexe of her son's home. She had a private carer who visited four times daily to provide meals, housework and to take her shopping. It was understood that Mrs H son was not actively involved in her care; he worked long hours and left the responsibility for his mother's care with her private carer who was also a family friend.

Over the course of a two and a half year period Mrs H was seen periodically by a range of health and social care professionals starting in May 2012 when she was referred to Reading Social Services for an assessment for day services by the consultant at the Hazelwood Memory Clinic.

In August 2012 a day service was offered and declined by Mrs H's son; there was no further recorded involvement until late in 2013 when Circuit Lane surgery received an urgent referral for pressure sores. The surgery was involved in treating the sores and prescribing a course of pro shots, Reading Social Services OTs supported with the provision of a chair and mattress.

There was no further recorded involvement apart from a blood test between end of January 2014 and November 2014 at which time Mrs H was admitted to Royal Berkshire Hospital from home by the GP. Safeguarding alerts at the time said that Mrs H had been hospitalised. She was described as being severely

malnourished, needing blood fluids and feeding. Mrs H passed away in hospital on 29 November 2014. It is not possible to include the findings in the report as they are yet to be published.

2. Summary:

Mr I had suffered a brain injury and had a lower leg amputation. He was prone to depression and developed an increasingly severe dependence on alcohol. He resented contact from the services and was aggressive to visitors including the regular care staff who had been commissioned by the Local Authority to provide daily support and monitoring. His case was transferred from the Local Authority Long Term Team (LTT) to the Mental Health Review and Reablement (R&R) Team in June 2013, but despite their best efforts the new keyworkers struggled to develop a working relationship with him. Mr I was assessed as having the mental capacity to make decisions about his health and welfare. The keyworkers took his case to the Risk Enablement Panel (REP) in April 2014 hoping that the case would be transferred, however the REP instead encouraged them to continue with their work to try to engage Mr I. No active work was possible due to Mr I's use of alcohol and reluctance to engage, and so it proved very difficult to reduce the risks involved.

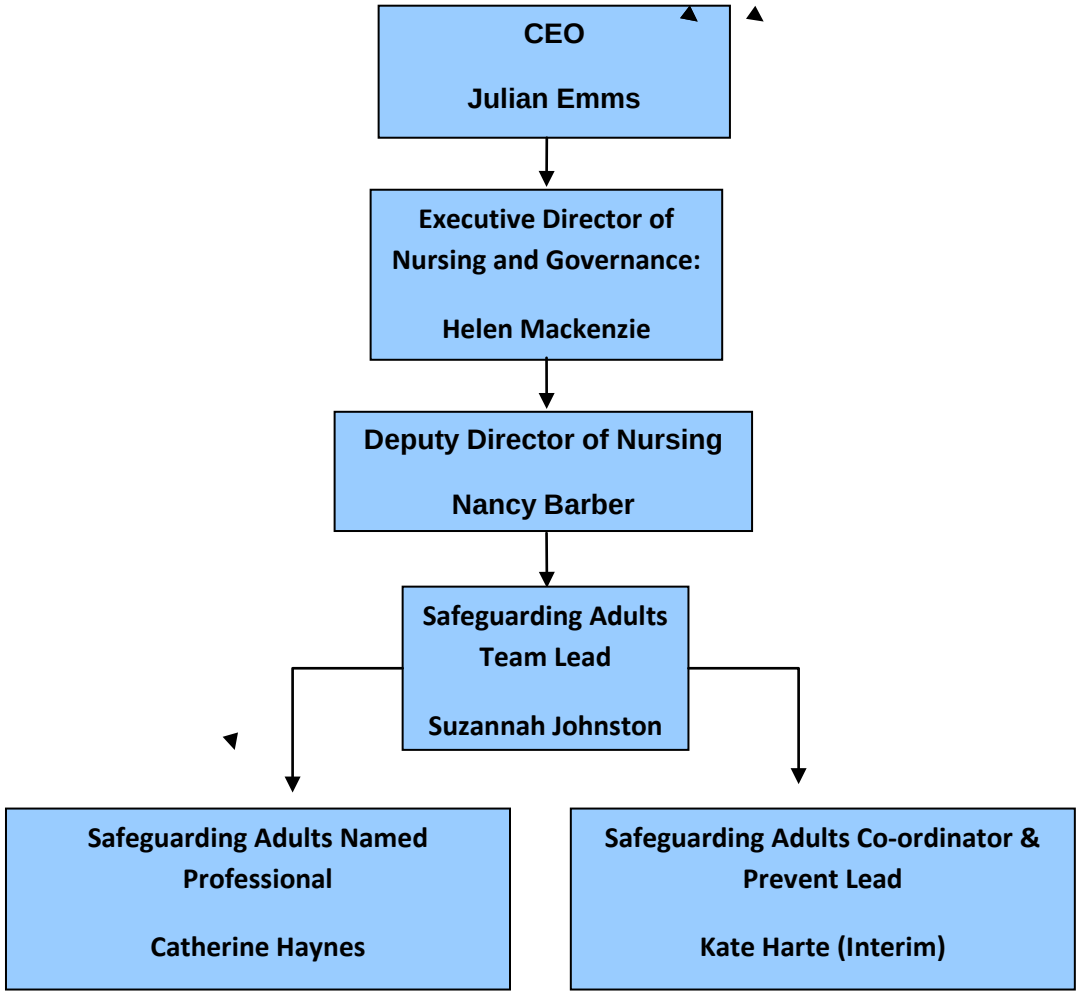
The daily carers continued to call but often did not manage to see Mr I, so the police would occasionally undertake welfare checks. In July 2014 it was agreed by the workers and managers of both teams that the case should be transferred back to the LTT and held on duty (as opposed to being allocated), however due to other work pressures the mental health keyworker did not progress the transfer. In April 2015 the keyworker took the case back to the REP who agreed that the decision to transfer the case back to the LTT should be progressed. However the usual procedures for handover recording and case transfer on the health and the Local Authority IT systems were not completed correctly.

At this time a significant re-structure of the Local Authority teams resulted in the LTT duty function being provided by the Single Point of Access (SPOA) team. A period of confusion and increasing frustration followed. The case began to be managed by the SPOA but they had no access to the recent mental health records and the transfer had not been formally confirmed. This led to a lack of clear accountability for the case. During this period the teams were unaware that Mr I's physical health was significantly deteriorating. He died unexpectedly in June 2015 and was found in his home several days later by the police. It is not possible to include the findings in the report as they are yet to be published.

2.3 BHFT Safeguarding Structure

Information from the SABs is shared at the quarterly BHFT Safeguarding Adults group which is chaired by the Deputy Director of Nursing. This group leads and monitors all Safeguarding Adult work within the Trust. It is a sub group of the Safety, Experience and Clinical Effectiveness Group chaired by the Director of Nursing which reports to the Quality Executive group and ensures a direct line of communication up to the Board. The Board also receives a monthly update on safeguarding cases of concern.

The named Executive for safeguarding adults in the Trust is the Director of Nursing and Governance. The current Lines for accountability are as follows:



2.4 Serious Incidents (SI)

There have been several SI's within BHFT where there has been a safeguarding aspect, this report will not detail these incidents as they are detailed and reported to the Board separately.

The safeguarding team are often involved in discussions where there has been an allegation against a member of staff. Common themes that have arisen are staff approach and attitude and training needs. The team have offered several bespoke training session to services where such themes have been identified.

BHFT have a responsibility to consider any incident where an individual with care and support needs, dies or experiences significant harm meets the Criteria for a SAR, if so a referral should be made to the relevant SAB.

3. Development and achievements in Adult Safeguarding during 2015- 2016

The trust had a CQC inspection in December 2015 and the CQC reported that they found overall there was a good understanding and awareness of Safeguarding Adults. This is a reflection of the hard work and continued attempts by the safeguarding adult team to ensure that Safeguarding remains at the forefront of practice across the organisation. The CQC did highlight MCA as an area for development across a number of services. The Safeguarding Adults team do not have any more resource to commit to the application to practice of the Mental Capacity Act so are planning to look for creative ways to improve compliance. Difficulties in the application to practice of the Mental Capacity Act are a theme that has been present in all of the Safeguarding Adult Reviews mentioned above, particularly the 2 cases reviewed by the West of Berkshire SAB during this year. It is recognised nationally that the MCA is not well embedded in practice across health and social care and this is definitely an area for development across BHFT.

The team have continued to work towards the Action Plan set out in last year's report:

- Continue to work closely with Local Authorities and other external agencies to continue to improve and develop safeguarding adult practices.
  - *BHFT have continued to work closely with external agencies to improve and develop safeguarding adult practices. BHFT are represented on all 4 SAB and all SAB sub-groups across Berkshire.*
  - *The BHFT safeguarding adult team have organised a quarterly peer support session for all safeguarding colleagues working in Health across Berkshire.*
  - *The Trust continues to host a quarterly partnership group to which all six Local Authorities, both CCG leads and the acute Trust leads are invited*

- Continue to raise awareness of the multi-agency safeguarding adult's policies and procedures across the trust.
  - *The Berkshire wide safeguarding adult policies and procedures were fully reviewed to ensure that local procedures were care act compliant. The safeguarding team and the Tissue Viability service supported in the review and development of the Safeguarding pressure Ulcer pathway. The new procedures were re-launched on 1st April "016, information went out in Team Brief and the link is available to all staff on team net.*
  - *The team continue to provide tailored adult safeguarding support in practice areas where Serious Incidents Requiring Investigations (SIRI)s have highlighted learning needs with regard to adult safeguarding practice.*

- Continue to work with the training and development department to ensure that training targets are achieved for Adult Safeguarding and Mental Capacity Act training for relevant staff groups and volunteers within the trust.
    - *The team continue to work hard delivering training in Safeguarding Adults level 1&2, Mental Capacity Act, Deprivation of Liberties and PREVENT. Training continues to be a challenging area in terms of the capacity of the team and their ability to keep up with demand whilst balancing other priorities. There are plans to explore alternative training methods during 2015/16. This has started this year with the development of a level 2 Safeguarding Adult Refresher forum which will allow more staff to refresh per session than a current level 2 course. Options such as live streaming these sessions are going to be explored next year.*

- Complete the Mental Capacity Act train the trainer course and then roll out staff training in Mental Capacity Act and DOLS practice.
    - *8 Members off staff completed the MCA& DoLS train the trainer course that was commissioned by the CCG's. This has enabled us to bring the MCA and DoLS training in house.*

- Monitor practice in Mental Capacity Act by auditing the use of a mental capacity assessment tool to monitor improvements and identify areas where practice support is required.
    - *The safeguarding team found that there was no consistency across the trust in relation to which if any MCA tools were being used so rather than undertaking an MCA Audit it was agreed to work with the Clinical Transformation team to develop a single MCA tool in Rio that can be used by all services that use Rio. It has been designed in such a way that it will be easy to replicate for services that do not use Rio.*

- Complete work to audit safeguarding practice and use the information to improve standards within the trust
    - *An internal audit was completed by RSM which found that safeguarding adult policies and processes were relatively well imbedded across the organisation. It did identify two areas for improvement which have both now been actioned. These were the dissemination of lessons learnt from SARs, which is now done through the level 2 Forums. A number of cases that were still open to the safeguarding team on Datix, following review a gap in the teams closing procedures was identified and this has now been altered to prevent this occurring again.*

- Explore strategies to increase service user awareness and participation in safeguarding adults practice.
    - *The team worked with the trust Communications team to develop a range of posters aimed at raising awareness of Safeguarding Adults amongst service users and carers. These were sent out to all services across the trust for display in patient areas.*
    - *Work was done with the Risk team to amend the Datix form to give greater prominence to the section where staff record the views and desired outcomes of the patient as part of the work to embed the Making Safeguarding Personal principles*

- Continue to ensure that the Trusts PREVENT contractual requirements are met including the delivery of WRAP3 to identified staff groups.
    - *A significant amount of effort was put into achieving the Quality schedule target for WRAP3 training, unfortunately despite best efforts the target was not achieved. It was identified that this was mainly as a result of the number of staff that join each month and require the training so to address this the PREVENT lead was able to negotiate with the L&D team and it has been agreed that WRAP3 will be included in induction from July 2016*

4. Senior Management Engagement and Partnership working

Continued senior management engagement with safeguarding adult's multi-agency SABs and the trusts internal group supports the implementation and embedding of safe practice and process undertaken by the trust and ensures that any concerns raised staff are fed back and appropriately actioned.

The Safeguarding Adult Team attends both East and West Learning & Development sub groups and various other sub groups including the partnership and best practice group in the West and the SCR committee in Slough. The Deputy Director of Nursing attends the West Quality Assurance sub group.

Trust representation at the sub-groups enables timely and effective sharing of information and learning from partner agencies. It also ensures the trust's practices align with the expectations of the boards in relation to training delivery, quality assurance procedures and best practice

Trust safeguarding adult activity is fed up to senior management through the quarterly Safeguarding adult monitoring and review group chaired by the Deputy Director of Nursing, this information initially filters to the quality governance group and then to the executive governance group as appropriate.

5. Safeguarding Concerns raised and referred

5.1 Safeguarding Concerns recorded by the trust

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Bracknell	5	1	4	6	5	2	6	6	4	8	4	3	**54**
Reading	20	37	41	41	32	34	36	40	29	39	30	24	**403**
Slough	5	5	1	4	4	6	9	9	7	7	4	7	**68**
West Berks	3	3	4	6	6	6	15	8	12	7	7	6	**83**
Windsor, Ascot and Maidenhead	6	6	5	7	6	6	8	13	6	14	12	6	**95**
Wokingham	6	2	8	10	10	7	8	17	12	23	9	10	**122**
Other	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Oxfordshire	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Total	**46**	**54**	**63**	**74**	**63**	**61**	**82**	**93**	**70**	**98**	**67**	**56**	**827**

5.2 Safeguarding Concerns referred to the Local Authorities

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	**Total**
Bracknell	4	1	4	6	5	3	5	6	2	8	4	1	**49**
Reading	13	15	27	22	17	18	14	22	21	27	15	11	**222**
Slough	3	3	1	4	3	6	7	7	5	5	4	7	**55**
West Berks	3	2	4	3	5	5	14	8	10	6	7	3	**70**
Windsor, Ascot and Maidenhead	6	6	4	6	5	6	8	11	6	11	11	5	**85**
Wokingham	5	2	8	9	10	7	7	13	12	20	9	10	**112**
Oxfordshire	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Total	**34**	**29**	**48**	**50**	**45**	**45**	**55**	**67**	**56**	**77**	**51**	**37**	**594**

6. Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DOLS) (2007)

The Safeguarding Adults team have led the Trust's responsibility for co-ordinating and raising awareness of Mental Capacity Act & Deprivation of Liberty Safeguards (DOLs) since 2012/13.

Following the attendance of 8 staff on a MCA/DoLS train the trainer course it has been possible to reduce the use of an external trainer to deliver MCA and DoLS training. Since January 2016 all MCA and DoLS session have been delivered by BHFT staff.

The issue of assessing an individual's mental capacity is often a central part of the safeguarding process and often the advice that is sought initially as a safeguarding concern frequently is actually more about supporting staff to recognise that some individuals make what may be considered as an unwise decision

and that they have a Right to do that. Support is also often required around making best interest decisions for individuals who lack capacity to make specific decisions.

An understanding of the MCA is crucial to the implementation of DoLS as awareness has been raised, staff are more frequently contacting the Safeguarding Adults team for specific advice about the MCA.

The Law commission carried out a full review of the current DoLS framework and found the current system to be 'deeply flawed', they proposed that they be replaced with a new system, to be called 'Protective Care'. Broadly speaking, protective care had three aspects: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme recommended a significantly different process. The review went out to consultation which closed in November 2015. There was a significant amount of feedback given regarding the proposed changes. It is anticipated that a final report and draft Bill will be published in December 2016. It is unlikely that there will be any noticeable changes to practice until 2019 at the earliest.

6.1-DOLS Applications for 2015-2016.

There have been 33 DoLS applications during 2015/16 which a similar number as there were in 2014/15. 30 applications were authorised, 3 were not, 2 because the person was not eligible for DoLS and 1 application which went to the court of protection as it was a complex case. All applications for DOLs require a BHFT signatory and the locality directors or their designated deputy has responsibility to ensure the application to the local authority is complete and appropriate. The Safeguarding Adults team continue to provided support and guidance to locality on DOLs applications. The CQFC must be notified of all DoLS Applications and the Outcome. This should be done by the Locality Directors or agreed deputy.

	Q1	Q2	Q3	Q4	Total
Total number of applications received:	5	10	5	13	33
Applications Authorised:	4	9	5	12	30
Applications Declined:	1	1	0	1	3

	Q1	Q2	Q3	Q4
Henry Tudor Ward	1	1		
Windsor Ward	1			
Donnington Ward			1	
Little House	1	1		
Rowan Ward	1	3	4	9
Campion Unit	1	2		2
Orchid Ward		1		1
Oakwood Unit		1		1
Jubilee		1		
Total	**5**	**10**	**5**	**13**

7.Prevent

'Prevent' is part of the UK's counter-terrorism strategy, CONTEST. The Prevent agenda is outlined in the Department of health document 'Building Partnerships, staying safe –the Healthcare Sector's contribution to HM Government's Prevent Strategy: for Healthcare Organisations'. The Trust has a duty to adhere to the Prevent duty. Its aim is to stop people being drawn into terrorism or supporting terrorism. Terrorist attacks have continued to take place across the world in 2015/16 and individuals are still being radicalised. In August 2014 the UK's terrorist threat level was increased to 'Severe', meaning a threat is 'highly likely', the threat level remains at severe at the time of this report.

During 2015-16 the trust has established strong links with the Local Authorities and the police in every area of Berkshire. The trust has representation on all six of the Prevent Management Groups and is a standing member of all six Channel Panels. There is a mutual respect for each organisation within the groups and Channel Panels which has ensured effective management of Prevent cases. The trust will continue to be represented at the Channel Panel and Prevent Management meetings across the six Localities in Berkshire throughout 2016-17. The trust approved a Prevent Policy in 2015-16, this has been made available for staff to view on the trust intranet site (teamnet); this includes guidance on information sharing, how to make a referral and general information around Prevent.

Staff have demonstrated an awareness of Prevent and its purpose, with several concerns being discussed with the Prevent Lead and some of those referrals meeting the threshold to be considered by the Channel Panel and in turn being adopted by the panel. In these cases support has been put in place for the client to divert them away from being drawn into or supporting terrorism. Due to the Prevent Duty being newly established and the nature of the types of concerns the management of cases has been a learning exercise for all services involved. This has highlighted additional needs of patients, their families and staff and so the trust will be making information leaflets regarding PREVENT available to patients and their families or carers. A Frequently Asked Questions sheet will also be made available to staff.

The baseline training requirement set for Quarter One identified 1937 staff to be trained, this comprised of all staff deemed to be working with the most vulnerable clients, clinical managers and those working in isolation. At the end of Quarter One, 20% had been trained and by the end of Quarter Four this had raised to 75%. A total of 1744 staff have been trained since April 2015. This equates to 90% of the baseline figure of 1937. However, with new starters this has meant an achievement of 75%. In addition to those staff who have attended Prevent, 1138 staff have undertaken Channel General Awareness training which is 50.3% of the required number of staff.

From July 2016 Prevent(WRAP3) will be delivered in the trust induction to address the issue of new starters, in addition we will be delivering 20 scheduled courses throughout the year for existing staff who have not yet been trained. The Prevent Lead and other approved facilitators will also be providing additional training sessions to teams on an AdHoc basis as necessary.

Prevent will continue to be embedded into general practice during 2016-17.

8. Safeguarding Adults Audit

Along with the internal audit as described above. The safeguarding team undertook an audit of safeguarding response to alleged sexual assault/inappropriate behaviour on MH Inpatient Wards. The audit

has identified several areas where policy has not been followed. There are several places where standard practice needs to be changed to ensure policy is followed and patients are appropriately safeguarded and risks managed. The risk of reoccurrence of these types of incidents is high due to transferable risk not being identified and managed.

The services are currently developing an action plan to address the audit findings. The safeguarding team have been providing additional support and training to wards and staff. The Mental Health audit will be repeated six monthly to ensure an improvement is made.

The Safeguarding team will also undertake a quality audit of the new format induction training during quarter two to ensure the effectiveness of the training.

9. Training and Development of staff

9.1 Safeguarding Adults Training

In relation to safeguarding adult training and as a partner of the four SAB's in BHFT is guided by the workforce development strategies' developed by the East and West Learning and development subgroups and all level 1 training adheres to the standards identified to ensure that all staff have appropriate knowledge and competencies in relation to the:

- Potential for the occurrence of abuse and neglect
- Identification of abuse and neglect
- Safeguarding adults policy and procedures
- Requirement to report any concerns of abuse or neglect
- Internal reporting structure for such concerns

Continued training and development of trust staff on safeguarding vulnerable adults forms a primary responsibility for the Safeguarding Adults Team. Lessons learned from national and local enquiries in Safeguarding Adults Reviews have been incorporated into our training programme which is delivered at two levels. Level 1 is aimed at staff whose work brings them into regular contact with patients who are in need of services whether or not the local authority are aware of them. It comprises awareness on the different types of abuse, how to recognise signs of abuse and how to manage situations of witnessed abuse and disclosures of abuse by patients in our care. Level 2 is targeted at senior clinicians.

Level 1 training has now been provided by the trust to all volunteers in response to the recommendations of the Lampard report (2015) as part of a wider BHFT action plan that includes strategy to manage visits by celebrities, VIPs and other official visitors to hospital sites and patient areas as well as HR and recruitment policies review. On-going statistics for staff numbers trained is included on the quarterly reports submitted to the Deputy Director of Nursing.

Level 1 Basic Awareness

Org L4	Level 1 Req	Level 1 Trained	%
371 Community East Bracknell Services	402	355	88%
371 Community East Slough Services	382	352	92%
371 Community East WAM Services	556	512	92%
371 Community West Newbury Services	441	410	93%
371 Community West Reading Services	545	500	92%
371 Community West Wokingham Services	376	350	93%
371 Corporate Services	219	206	94%
371 Head of Inpatient (MH) & Urgent Care Service	282	261	93%
371 Other Health Services Service	155	141	91%
Grand Total	3358	3087	92%

Level 2 Training

Org L4	Level 2 Trained
371 Community East Bracknell Services	137
371 Community East Slough Services	149
371 Community East WAM Services	154
371 Community West Newbury Services	167
371 Community West Reading Services	236
371 Community West Wokingham Services	152
371 Corporate Services	100
371 Head of Inpatient (MH) & Urgent Care Service	77
371 Other Health Services Service	71
Grand Total	1243

9.2 MCA & DOLS Training

Significant effort and resource has been put in by the Safeguarding Adult team to ensure that the Quality schedule targets of 75% for both MCA and DoLS training were achieved.

Mental Capacity Act Training

2014/15

Org L4	Compliance %
371 Community East Bracknell Services	46%
371 Community East Slough Services	55%
371 Community East WAM Services	44%
371 Community West Newbury Services	64%
371 Community West Reading Services	61%
371 Community West Wokingham Services	58%
371 Corporate Services	28%
371 Head of Inpatient (MH) & Urgent Care Service	61%
371 Other Health Services Service	44%
Total	**54%**

2015/16

Org L4	MCA
371 Community East Bracknell Services	75%
371 Community East Slough Services	82%
371 Community East WAM Services	70%
371 Community West Newbury Services	78%
371 Community West Reading Services	74%
371 Community West Wokingham Services	75%
371 Corporate Services	50%
371 Head of Inpatient (MH) & Urgent Care Service	79%
371 Other Health Services Service	61%
Trust Wide	**75%**

Deprivations of Liberty Safeguards

2014/15

Org L4	Compliance %
371 Community East Slough Services	57%
371 Community East WAM Services	72%
371 Community West Newbury Services	64%
371 Community West Reading Services	65%
371 Community West Wokingham Services	70%
371 Corporate Services	17%
371 Head of Inpatient (MH) & Urgent Care Service	47%
371 Other Health Services Service	27%
Total	**55%**

2015/16

Org L4	DOLS
371 Community East Bracknell Services	**N/A**
371 Community East Slough Services	95%
371 Community East WAM Services	75%
371 Community West Newbury Services	82%
371 Community West Reading Services	75%
371 Community West Wokingham Services	76%
371 Corporate Services	80%
371 Head of Inpatient (MH) & Urgent Care Service	81%
371 Other Health Services Service	52%
Trust Wide	**79%**

10. Summary

The Care Act (2014) and *Care and Support Statutory Guidance (Chapter 14-Safeguarding)* has clarified our responsibilities relevant to safeguarding adults vulnerable to abuse or neglect. This legislation underpins the standards and principles of Safeguarding practice at the heart of patient care at Berkshire Healthcare NHS Foundation Trust (BHFT) and provides a legal requirement to work closely with local authorities and other partnership members of the Berkshire multi-agency safeguarding response.

The changes to terminology, categories of abuse and making safeguarding processes personal to the individual concerned are being incorporated into training and development of trust staff and volunteers and policy documents. The adult safeguarding team continue to work closely with external partners, developing local relationships and ensuring that adult safeguarding practices reflect local and national guidance.

Safeguarding Adult Boards have a statutory status directed by the Care Act (2014) with clearly defined roles and responsibilities to co-ordinate strategic safeguarding adult activity across all sectors and service user groups, to prevent abuse and neglect occurring and where it does, it is recognised and responded to appropriately. The SABs forms a view of the quality of safeguarding locally and challenges organisations where necessary. Senior representation on all four Berkshire SABs ensure a direct link to the Board regarding Safeguarding Adult concerns, enquiries and lessons learned as well as future development in practices and policies.

Application of the Mental Capacity Act is a topic that continues to be identified as an area for development both nationally and locally through SAR's, staff feedback and the recent CQC inspection.

11: Team Plan 2016/17

Our **core values**: **caring** for and about **you** is our top priority | **committed** to providing **good quality, safe services** | working **together** with **you** to develop **innovative solutions**

Berkshire Healthcare NHS
NHS Foundation Trust

Team Plan 2016 - Safeguarding Adults Team

Our vision: To be **recognised** as the **leading community** and **mental health** service provider by **our staff, patients** and **partners.**

The safeguarding adult's team strive to support the delivery of safe and effective care by working with partners and services to ensure that all staff are aware of their Safeguarding responsibilities including application of the Care Act, Mental Capacity Act and PREVENT duty.

Goal 1: To provide accessible, safe and clinically effective services which improve patient experience and outcomes of care.

We will do this by:

- Being available to offer clinical advice and support to all services across BHFT
- Providing dedicated safeguarding resources to Inpatient Mental Health and Learning Disability services
- Ensuring that allegations against staff and episodes of poor care are investigated and appropriate actions are taken
- Delivering training that includes lessons learnt from Local and National Safeguarding Adult Reviews
- Embedding the principles of Making Safeguarding Personal MSP across services
- Continually reviewing training to ensure that it reflects local and national guidance

Goal 2: Deliver sustainable services based on sound financial management.

We will do this by:

- Continuing to review and where possible streamline processes to avoid duplication of work for services
- Working closely with the complaints and governance team to avoid duplication and streamline investigation processes
- Providing information to partners and services electronically to reduce the need to print multiple or large documents

Goal 3: Be the provider of choice for people who use and commission our services.

We will do this by:

- Ensuring that sufficient training is available to staff
- Providing reports and statistical information as required to evidence compliance with the Quality Schedule targets
- Supporting practice to ensure that the views, wishes and feeling of people using our services are taken into account in all safeguarding work
- Undertake annual self-assessment audit for commissioners and SAB's

Goal 4: Establish an extensive range of integrated "out of hospital" services.

We will do this by:

- Working with developing services to highlight the appropriate safeguarding adult pathway
- Providing safeguarding, MCA, DOLs and PREVENT advice and support to clinicians
- Raising awareness of services to our partner agencies

Goal 5: Work with our partners to develop more caring and compassionate communities.

We will do this by:

- Continuing to ensure that BHFT are represented on all Berkshire Safeguarding Adult Boards (SAB)
- Working with Local Authority safeguarding teams to ensure robust processes are in place for reporting, managing and feeding back concerns.
- Attending all relevant SAB sub groups and ensuring information is disseminated across BHFT through the Safeguarding Adults group
- Providing appropriate information and BHFT representation for Safeguarding Adult reviews
- Hosting the Berkshire wide Health peer support network
- Charing the Berkshire Partnership group

Reading Annual Performance Report 2015/16

The 2015-16 Safeguarding Adults Collection (SAC) records details about safeguarding activity for adults aged 18 and over in England. It includes demographic information about the adults at risk and the details of the incidents that have been alleged.

The Safeguarding Adults Collection (SAC) is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2013/14 and 2014/15 reporting periods so has some areas where there have been significant changes to the categories of data collected.

Section 1 - Safeguarding activity

Concerns and enquiries

As a result of the Care Act changes the terminology of some of the key data recorded in the Safeguarding Return in its various formats has changed over the past year or so. Safeguarding Alerts are now being referred to as Concerns and Safeguarding Referrals are now known as Enquiries.

Another change made to the return as compared to last year is the mandatory requirement to collect information about 'individuals involved in section 42 safeguarding enquiries' which has replaced the collection of 'individuals involved in safeguarding referrals'. Therefore any data relating to 2015-16 contained within this report relates to s42 enquiries.

Table 1 shows the Safeguarding activity within Reading over the previous 3 years in terms of Concerns raised and Enquiries opened and the conversion rates over the same period.

There were 1075 safeguarding concerns received in 2015/16. The number of concerns has increased over the past couple of years with a large increase of 373 over the previous year (from 702 in 2014-15) which demonstrates the work being carried out in the authority to highlight the importance of recording safeguarding incidents.

538 s42 enquiries were opened during 2015/16, with a conversion rate from concern to s42 enquiry of 50% which is still slightly higher than the national average of around 40%. This is however a decrease on previous years which had seen conversion rates of around 75%. This demonstrates a positive shift away from the Risk Averse outlook the authority had shown historically.

There were 511 individuals who had a s42 enquiry opened during 2015/16 which is an increase of 36 which is a 7.6% rise since 2014/15.

Table 1 – Safeguarding activity for the reporting period 2014-16

Year	Alerts / Concerns received	Safeguarding referrals / s42 enquiries	Individuals who had safeguarding referral / s42 enquiry	Conversion rate of concern to s42 enquiry
2013/14	654	491	410	75%
2014/15	702	527	475	75%
2015/16	1075	538	511	50%

Section 2 - Source of Safeguarding Enquiries

As Figure 1 shows the largest percentage of safeguarding enquiries for 2015/16 were referred from both Social Care staff (33%) and also by Health staff (27%) with Family members also providing a larger than average proportion (16%). The Police have also been responsible for referring 7% of all s42 enquiries over the past year.

The Social Care category encompasses both local authority staff such as Social Workers and Care Managers as well as independent sector workers such as Residential / Nursing Care and Day Care staff. The Health category relates to both Primary and Secondary Health staff as well as Mental Health workers.

Figure 1 - Safeguarding Enquiries by Referral Source - 2015/16

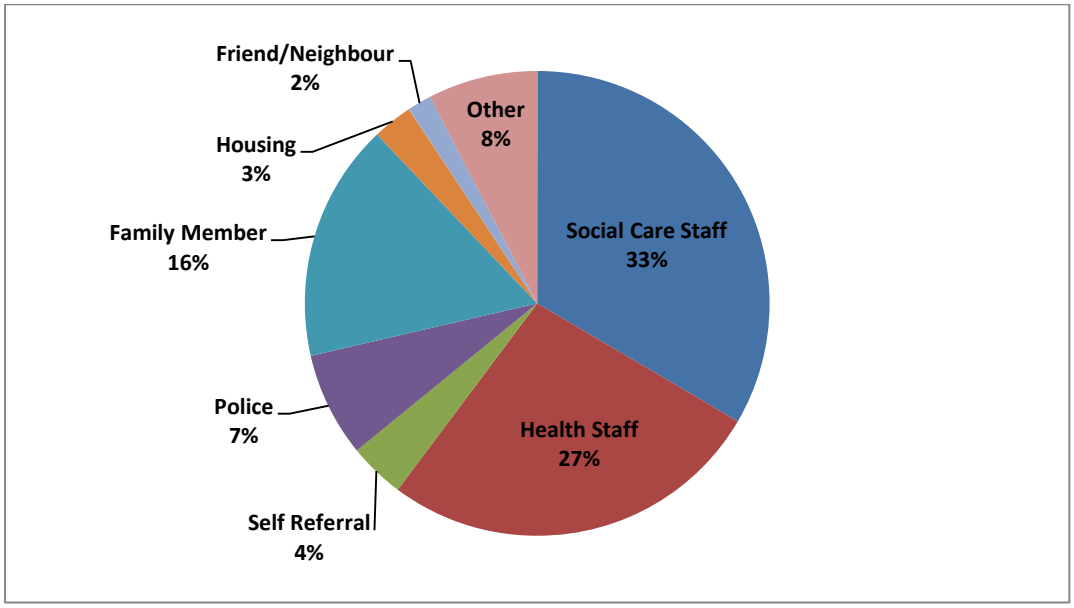


Table 2 shows the breakdown of the number of safeguarding enquiries by Referral Source over the past 3 years since 2013/14. It breaks the overarching categories of Social Care and Health staff down especially into more detailed groups where available, so a clearer picture can be provided of the numbers coming in from various areas.

For Social Care the actual numbers coming in have remained consistent over the period at around 180-185 per year. The numbers coming in from domiciliary staff have risen by nearly 31% from 26 to 34 whereas the numbers have fallen by 17% from 58 to 48 for Residential / Nursing staff.

The numbers of referrals coming in from Health Staff have steadily risen over the period with a rise of over 24% from 116 to 144 referrals since 2014/15. This is made up of a 29.4% rise in those coming from Primary / Community Health staff (up from 51 to 66) and a 51.6% rise from Secondary Health staff (up from 31 to 47).

The numbers of Self Referrals have steadily decreased over time with a fall of 34% over the past year (from 32 to 21). There has been an increase however in the numbers of referrals coming from Family members (up 6%) and the numbers coming from the Police have more than doubled which shows the work being carried out in that area (up from 17 to 39 in the past year).

Table 2 - Safeguarding Enquiries by Referral Source 2014-16

	Referrals	2013/14 (All)	2014/15 (All)	2015/16 (s42 only)
Social Care Staff	**Social Care Staff total (CASSR & Independent)**	**185**	**185**	**180**
	Domiciliary Staff	-	26	34
	Residential/ Nursing Care Staff	-	58	48
	Day Care Staff	-	7	5
	Social Worker/ Care Manager	-	60	56
	Self-Directed Care Staff	-	3	2
	Other	-	31	35
Health Staff	**Health Staff - Total**	**108**	**116**	**144**
	Primary/ Community Health Staff	-	51	66
	Secondary Health Staff	-	31	47
	Mental Health Staff	-	34	31
Other sources of referral	**Other Sources of Referral - Total**	**198**	**226**	**214**
	Self-Referral	50	32	21
	Family member	73	84	89
	Friend/ Neighbour	9	8	9
	Other service user	3	3	1
	Care Quality Commission	4	2	2
	Housing	28	12	15
	Education/ Training/ Workplace Establishment	2	2	0
	Police	12	17	39
	Other	17	66	38
	Total	**491**	**527**	**538**

Section 3 - Individuals with safeguarding enquiries

Age group and gender

Tables 3, 4 and 5 display the breakdown by age group and gender for individuals who had a safeguarding enquiry in the last 3 years. The majority of enquiries continue to relate to the 65 and over age group which accounted for 57% of enquiries in 2015/16. Between the ages of 65 and 94 the older the individual becomes the more enquiries are raised. The 18-64 age cohort has seen a fall of 9% proportionately since 2013/14 whereas the other age groups have stayed fairly consistent over the past year.

Table 3 – Age group of individuals with safeguarding enquiries, 2014-16

Age band	2013/14	*% of total*	2014/15	*% of total*	2015/16	*% of total*
18-64	210	51%	197	41%	216	42%
65-74	38	9%	55	12%	66	13%
75-84	75	18%	103	22%	97	19%
85-94	78	19%	106	22%	108	21%
95+	9	2%	10	2%	21	4%
Age unknown	0	0%	4	1%	3	1%
Grand total	410		475		511	

In terms of the gender breakdown there are more Females with enquiries than Males (59% compared to 41% for 2015/16) and the gap between the two is getting larger year on year i.e. it was 10% in 2013/14 and rose to 12% in 2014/15. By 2015/16 this gap had risen to 18%.

Table 4 – Gender of individuals with safeguarding enquiries, 2014-16

Gender	2013/14	*% of total*	2014/15	% of total	2015/16	% of total
Male	183	45%	209	44%	208	41%
Female	227	55%	266	56%	303	59%
Total	410	100%	475	100%	511	100%

When looking at the two categories together for 2015/16 the number of females with enquiries is larger in almost every age group but is especially high comparatively in the 85-94 one (Females - 26.7% and Males - 13%). For Males the figures peak in the 75-84 age group and then fall whereas for Females the peak is at the 95+ stage where it then drops.

Table 5 – Age group and gender of individuals with safeguarding enquiries, 2015/16

Age group	Female	Female %	Male	Male %
18-64	119	39.3%	97	46.6%
65-74	34	11.2%	32	15.4%
75-84	48	15.8%	49	23.6%
85-94	81	26.7%	27	13.0%
95+	18	5.9%	3	1.4%
Unknown	3	1.0%	0	0.0%
Total	303	100.0%	208	100.0%
	59%		**41%**	

Ethnicity

83% of individuals involved in s42 enquiries for 2015/16 were of a White ethnicity with the next biggest groups being Black or Black British (6%) and Asian or Asian British (5%).

Figure 2 – Ethnicity of individuals involved in enquiries for 2015/16

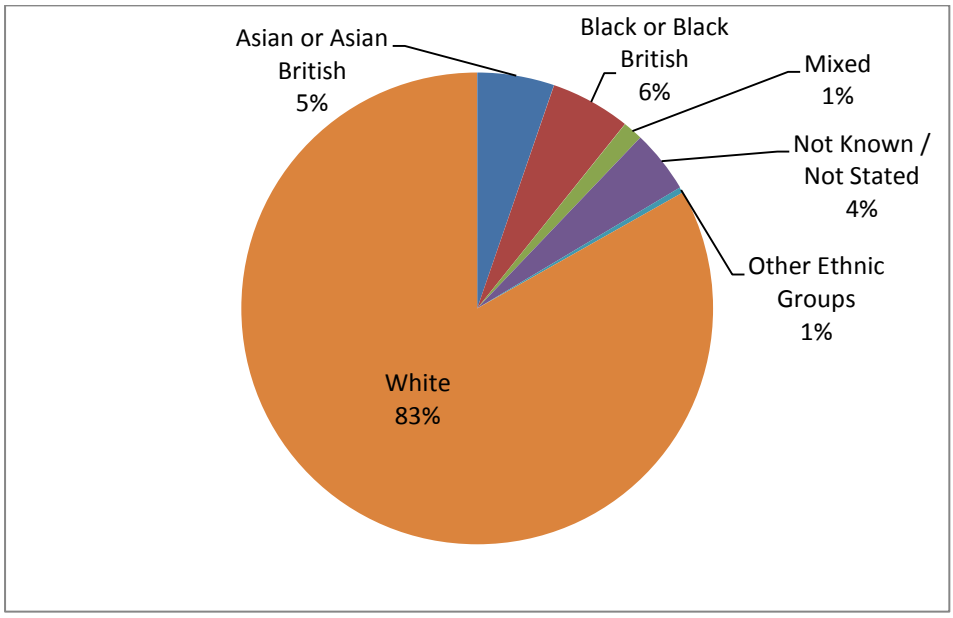


Table 6 shows the ethnicity split for the whole population of Reading based on the ONS Census 2011 data. Any Enquiries where ethnicity was not obtained/stated have been excluded from this table.

Table 6 – Ethnicity of Reading population and safeguarding enquiries

Ethnic group	Percentage of whole population	Percentage of safeguarding enquiries
White	75.0%	87.0%
Mixed	4.0%	1.0%
Asian or Asian British	13.0%	5.5%
Black or Black British	7.0%	6.0%
Other ethnic group	1.0%	0.5%

Source: ONS 2011 Census data

The numbers suggest individuals with a White ethnicity are more likely to be referred to safeguarding and the proportion is much higher than for the whole population. It also shows that those individuals of an Asian or Asian British ethnicity are far less likely to be engaged in the process (13% in whole population whereas those involved in a safeguarding enquiry is only 5.5%).

Primary support reason

Table 7 shows a breakdown of individuals who had a safeguarding enquiry by Primary Support Reason (PSR). The majority of individuals in 2015/16 had a PSR of Physical Support (51%), which also represents a 10% increase on the 2014/15 figure (was at 41%). There was also a decrease in enquires where the individual has a PSR of Support with memory and cognition (from 18% to 9% proportionately).

Table 7 – Primary support reason for individuals with a safeguarding enquiry

Primary support reason	2014/15	% of total	2015/16	% of total
Physical support	193	41%	262	51%
Sensory support	13	3%	8	2%
Support with memory and cognition	84	18%	44	9%
Learning disability support	83	17%	84	16%
Mental health support	70	15%	83	16%
Social support	28	6%	30	6%
No support reason	4	1%	0	0%
Not known	0	0%	0	0%
Total	475	100%	511	100%

Section 4 – Case details for concluded enquiries

Type of alleged abuse

Table 8 shows concluded enquiries by type of alleged abuse over the last three years. An additional 4 abuse types were added to the 2015/16 return so there are no comparator figures for those, although 103 have been recorded this year in those categories (12.3% proportionately of the total).

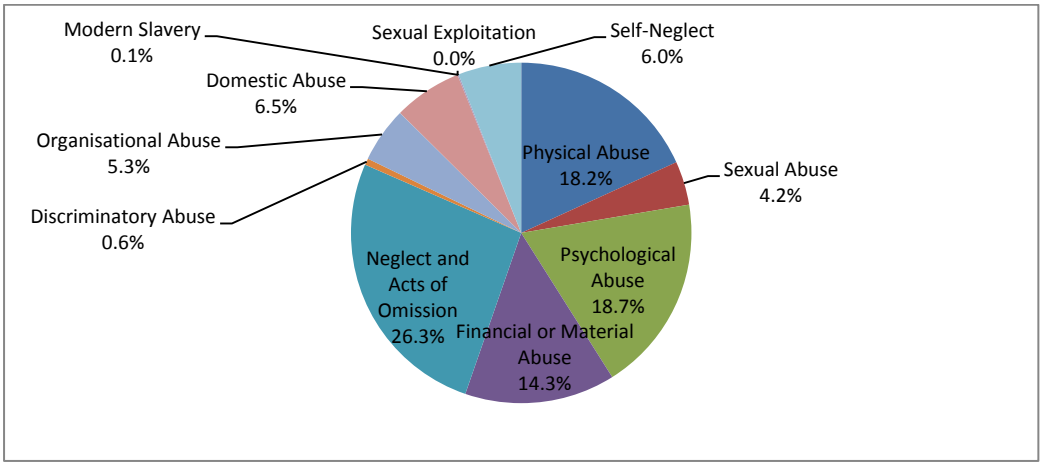
The most common types of abuse for 2015/16 were for Neglect and Acts of Omission (26.3%), Psychological Abuse (18.7%) and Physical Abuse (18.2%).

The numbers with a Physical Abuse type however have dropped by 25 since last year (down 14%) and there has been a similar drop in those recorded as being of a financial nature also (down 12%).

Table 8 – Concluded enquiries by type of abuse

Concluded enquiries	2013/14	2014/15	2015/16
Physical Abuse	134	174	149
Sexual Abuse	24	29	34
Psychological Abuse	133	153	153
Financial or Material Abuse	141	138	117
Neglect and Acts of Omission	144	214	215
Discriminatory Abuse	4	3	5
Organisational Abuse	12	38	43
Domestic Abuse	-	-	53
Sexual Exploitation	-	-	0
Modern Slavery	-	-	1
Self-Neglect	-	-	49

Figure 3 – Type of abuse 2015/16



Location of alleged abuse

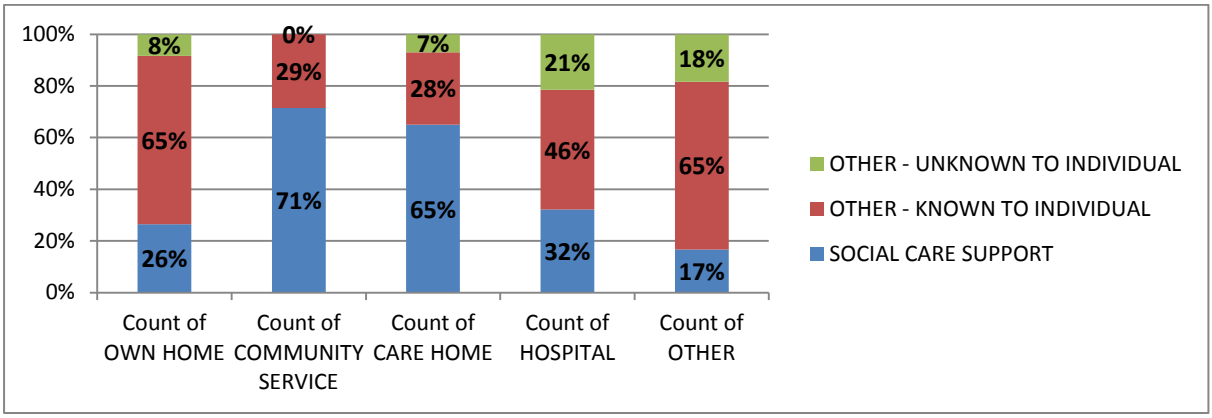
As shown in Table 9, as with previous years by far the most common location where the alleged abuse took place for Reading clients has been the individuals own home (62% in 2015/16) which has shown a 5% rise (up by 63 individuals) proportionately as compared to last year.

Table 9 – Location of abuse 2015-16

Location of abuse	2013/14	% of total	2014/15	% of total	2015/16	% of total
Care home	78	17%	112	21%	100	17%
Hospital	23	5%	51	9%	56	9%
Own home	292	65%	307	57%	370	62%
Community service	8	2%	14	3%	7	1%
Other	50	11%	56	10%	60	10%

Figure 4 shows the breakdown of location of alleged abuse by source of risk. Where the alleged abuse took place in the persons own home, for the majority of cases (65%), the source of risk was an individual known to the adult at risk. This group was also the most common for those taking place in a Hospital and in other locations. For those taking place in a Community Service or a Care Home the biggest source of risk was from Social Care Support staff.

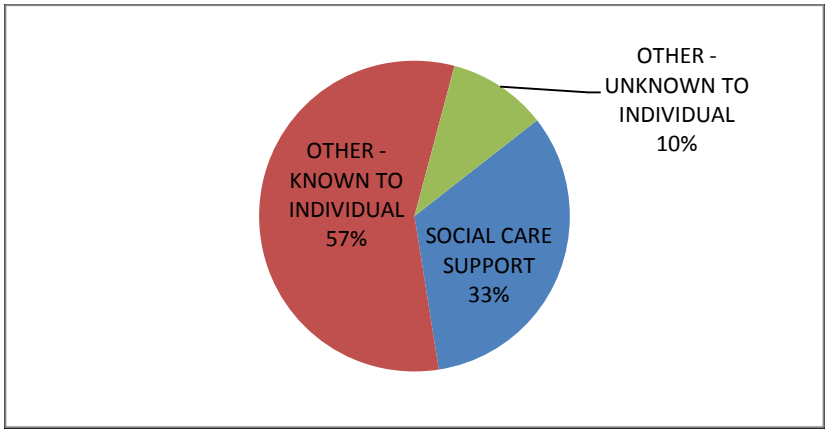
Figure 4 – Concluded enquiries by location of alleged abuse and source of risk for 2015/16



Source of risk

The majority of concluded enquiries involved a source of risk known to the individual (57%) whereas those that are unknown to the individual only make up 10%. The Social Care Support category refers to any individual or organisation paid, contracted or commissioned to provide social care. This is shown below in Figure 5.

Figure 5 – Concluded enquiries by source of risk 2015/16



Action taken and result

Table 10 below shows concluded enquiries by action taken and the results for the last three years.

The figures for those cases where the risk was reduced or removed saw a rise between 2013/14 and 2014/15 and then a fall between 2014/15 and the current year. Those with a risk remaining have stayed fairly consistent over the period. Those with no further action decreased between the first 2 periods but have risen again over the last year (from 21% to 43% proportionately).

Table 10 – Concluded enquiries by result 2014-16

Result	2013/14	% of total	2014/15	% of total	2015/16	% of total
Action Under Safeguarding: Risk Removed	29	6%	75	15%	54	10%
Action Under Safeguarding: Risk Reduced	146	32%	284	55%	214	38%
Action Under Safeguarding: Risk Remains	34	8%	48	9%	58	10%
No Further Action Under Safeguarding	242	54%	106	21%	242	43%
Total Concluded Enquiries	451	100%	513	100%	568	100%

Figure 6 shows concluded enquiries by result for 2015/16. No action was taken under safeguarding in 43% of cases, while the risk was reduced or removed in 47% of cases.

Figure 6 – Concluded enquiries by result, 2015/16

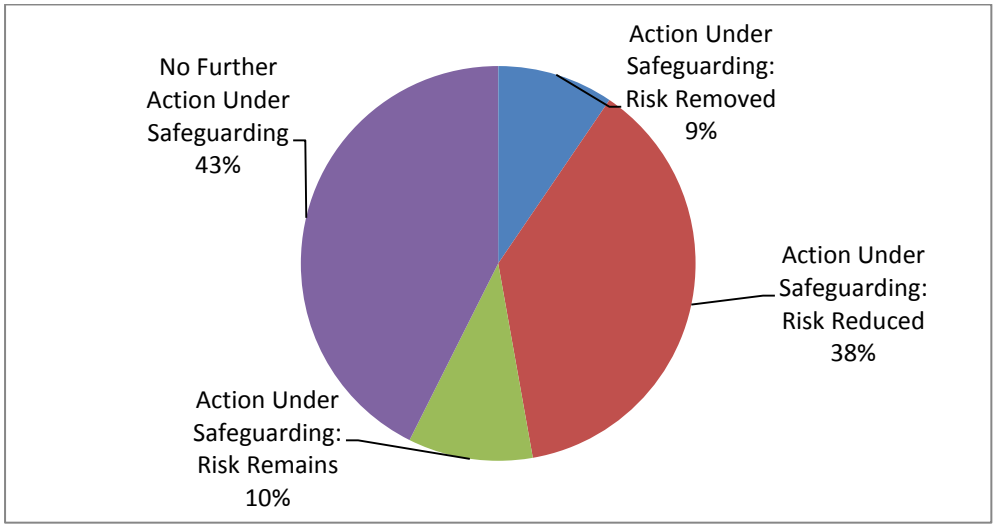
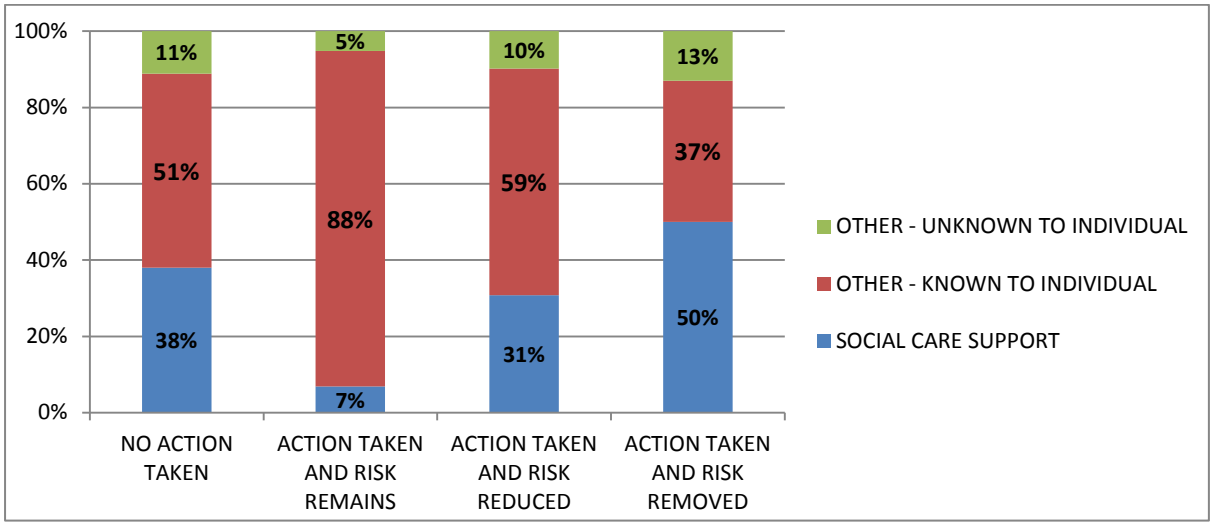


Figure 7 shows a breakdown of the results of action taken for concluded enquiries by source of risk for 2015/16. For the majority of cases where action was taken and the risk was reduced or remained the main source of risk was other individuals known to that individual. This is especially noticeable in cases where the risk remains (88% of alleged perpetrators were known to the individual).

Cases where the risk was removed show a higher proportion in the Social Care Support group demonstrating maybe those cases where alleged abuse has taken place in a person's own home by paid staff contracted or commissioned to provide social care.

Where no action was taken the largest proportion (51%) was attributed to people known to the individual so probably relates to family members for example where an enquiry was raised but not substantiated.

Figure 7 – Concluded enquiries by result of action taken and source of risk 2015/16

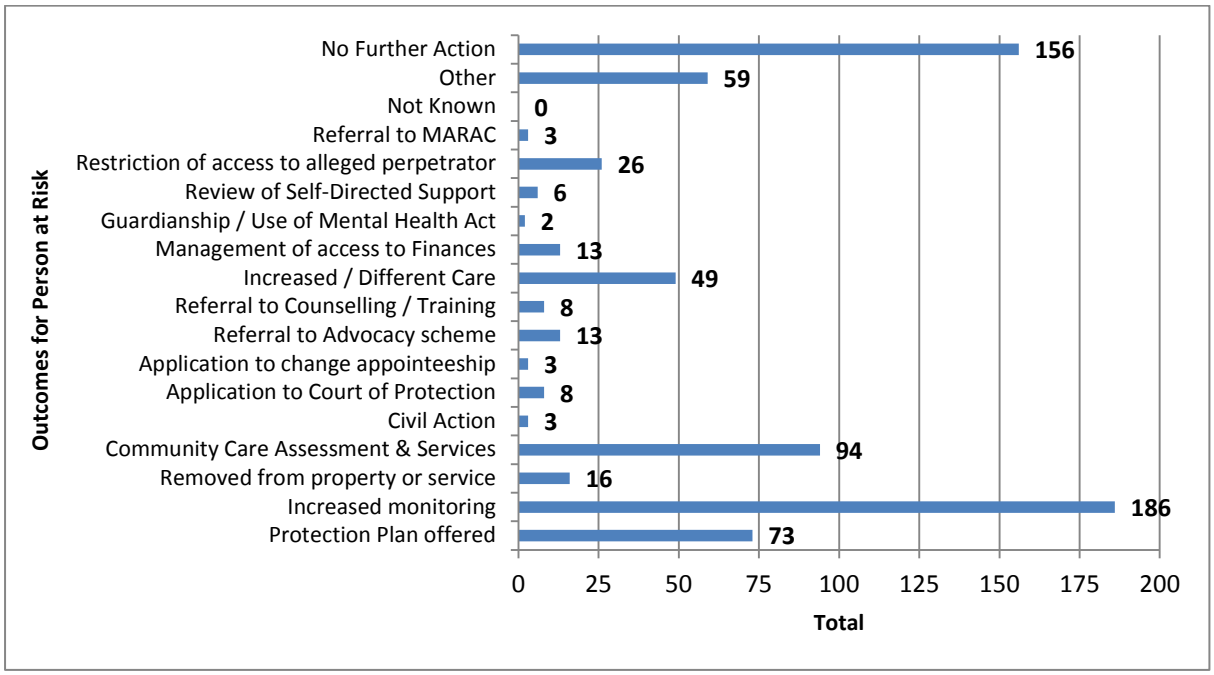


Outcomes for the person at risk

Figure 8 shows the Outcomes for the person at risk for concluded enquiries for 2015/16.

The most common outcomes for concluded enquiries by far were an increase in monitoring (26%), No further Action (22%) and Community Care Assessment & Services (13%). As the chart below includes concluded enquiries which were not substantiated or inconclusive this would explain some of the No further action outcomes for the person at risk.

Figure 8 - Outcomes for person at risk, 2015/16



Section 5 - Mental capacity

Figure 9 shows the breakdown of mental capacity for concluded enquiries. In 20% of cases the individual was found to lack capacity. 68 of the 116 individuals (59%) assessed as lacking capacity were supported by an advocate, family or friend.

Figure 9 – Does the individual lack capacity – 2015/16?

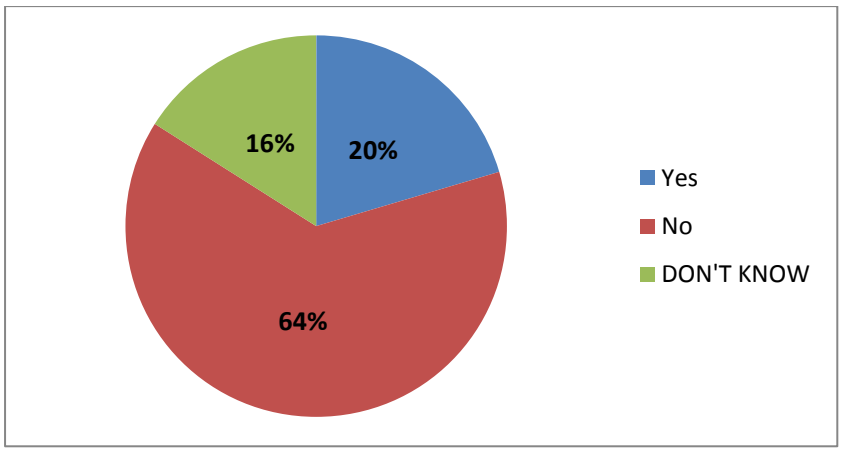
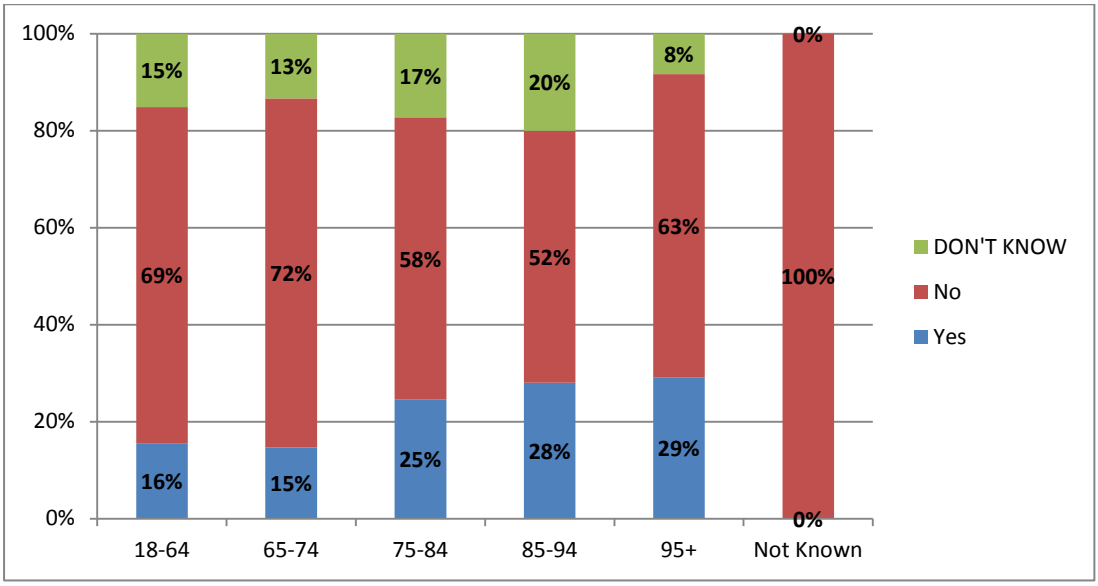


Figure 10 shows a breakdown of individuals lacking mental capacity of the person at risk by age group. The figure shows the likelihood of the person lacking capacity increases with age, with people aged 75+ being most likely to lack capacity. Those 95+ had a figure of 29% for those lacking capacity which was marginally larger than the 2 younger age groups.

Figure 10 – Mental capacity by age group of person at risk, 2015/16



Section 6 - Making Safeguarding Personal

Making Safeguarding Personal (MSP) was a national led initiative to improve the experiences and outcomes for adults involved in a safeguarding enquiry. This initiative was adopted by the Government and can be found within the Care Act 2014. Local Authorities are not currently statutorily required to report on MSP but as members of the West Berkshire Safeguarding Adults Board; Reading has chosen to monitor performance in this area over the past 6 months or so.

As at year end, 46% of all clients for whom there was a concluded case were asked about the outcomes they desired (either directly or through a representative).

Figure 11 – Concluded enquiries by expression of outcome, 2015/16

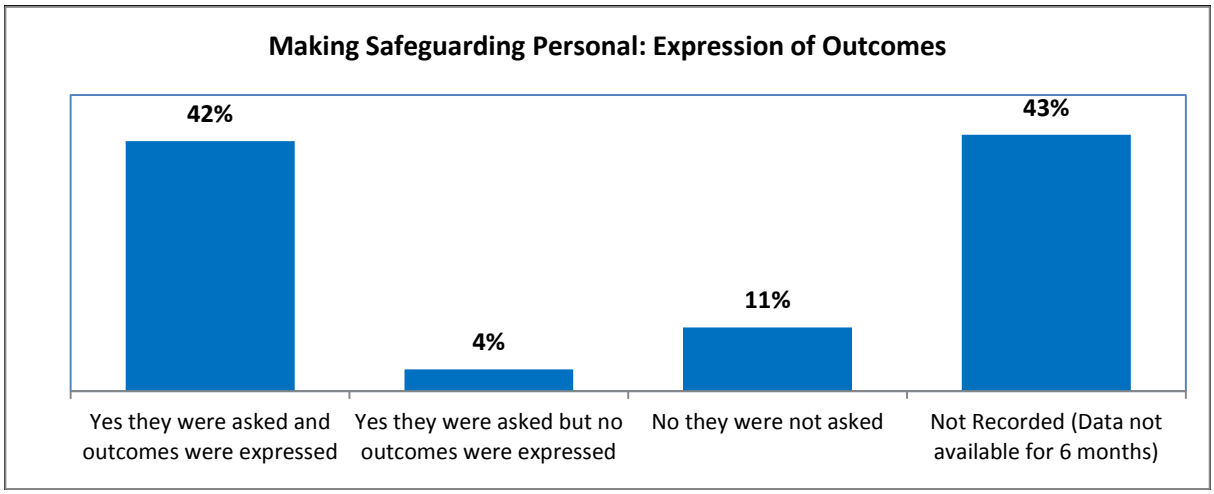
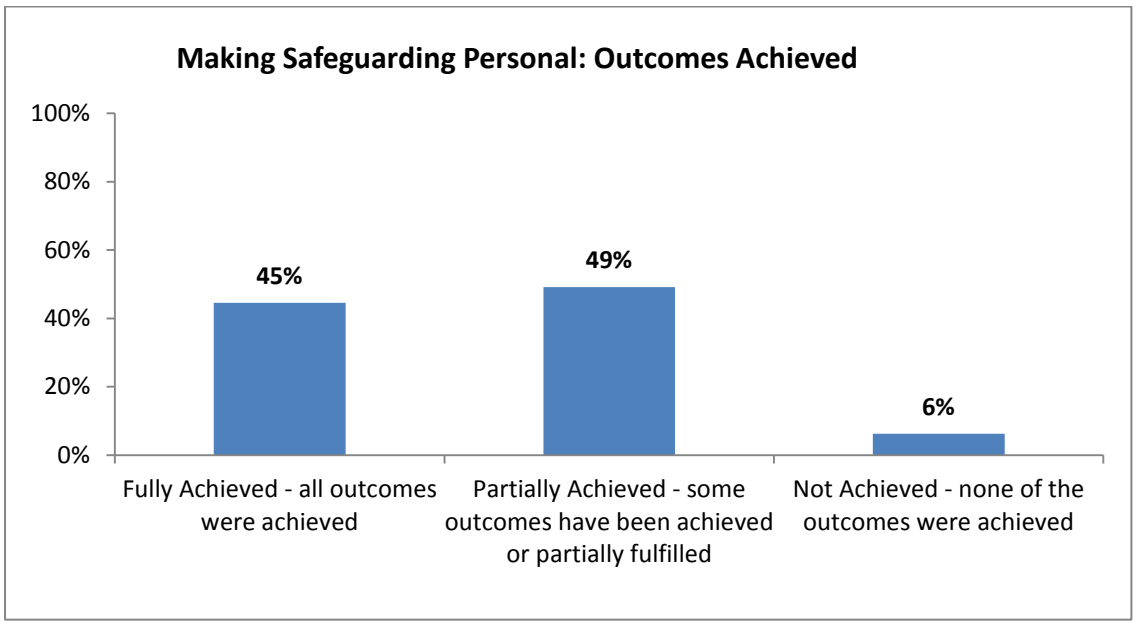


Figure 12 – Concluded enquiries by expressed outcomes achieved, 2015/16



Of those who were asked and expressed a desired outcome, 45% were able to achieve those outcomes fully, with a further 49% partially achieved. Only 6% did not achieve their outcomes.

Royal Berkshire NHS
NHS Foundation Trust

Safeguarding Annual Report 2015/16

The Safeguarding Team

An ‘Oscar’ received for services provided for people with learning disabilities

Executive Summary

The Royal Berkshire NHS Foundation Trust (RBFT) is proud of its approach to safeguarding. It has an experienced safeguarding team representing the different specialties of vulnerable adults, children, people with a learning disability, people with mental health problems and maternity. Together the team provides a cohesive approach to training and support of staff to ensure the needs of vulnerable people are met. In line with national guidance on multi agency working the safeguarding team represent the Trust on a variety of partner agency groups. They also work with individual patients to support 'making safeguarding personal' and coordinate a planned multi-disciplinary and multiagency agency approach where the principles of empowerment and autonomy enshrined in the Mental Capacity Act (MCA), 2005 are balanced with the responsibility to safeguard.

There have been achievements and improvements in safeguarding since the publication of the Francis and Lampard inquiries, the reports related to child sexual exploitation in Rotherham, Oxford and Cambridge University Hospitals (Myles Bradbury) and the focus on female genital mutilation as child abuse. However the essence of good safeguarding is continuous learning, quality improvement, professional curiosity and challenge. We are already working with our partners to implement the recommendations from the CQC inspection of health providers, child safeguarding and looked after children report for Wokingham CCG, May 2016 and Ofsted Inspection reports for West Berkshire, Wokingham and Reading Local Authorities Children's Services and LSCBs published in May 2015, February 2016 and August 2016.

The RBFT has obligations under the Children Act 1989 and 2004, Care Act 2014, MCA, 2005, Mental Health Act (MHA), 1983 and other relevant legislation and guidance in order to ensure it provides safe effective and well led services which safeguard the vulnerable. Compliance with Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework, July 2015 and CQC regulation 13 Safeguarding Service Users from Abuse and Improper Treatment, 2014 are the standards that we employ to focus on our declared aim of 'promoting the safety and well-being of all children, young people and adults' who have contact with our services. Training, audit and review of against those standards are the cornerstones of our assurance mechanisms; we have submitted our annual safeguarding standards self-assessment which includes our Section 11 of the Children Act 2004 to our commissioners.

Challenges include training all staff in all aspects of safeguarding, consistency of knowledge and application in practice of the MCA, MHA, Deprivation if Liberties (DoLS), best interest assessments and consent, transition for children to adult services including Child and Adolescent Mental Health Services (CAMHS), a year on year increase in activity for vulnerable groups, elderly patients living with dementia and adults with learning difficulty who are delayed in hospital, high numbers of mental health patients of all ages with complex psycho-social needs in the acute setting, an increase in the number of these patients delayed in hospital and self-harm and suicide prevention. Monitoring the impact of health and social care budget cuts and workforce sufficiency on services to children, families and vulnerable adults and gaps in services for disabled children are emerging themes.

Patricia Pease, Associate Director of Safeguarding, September 2016

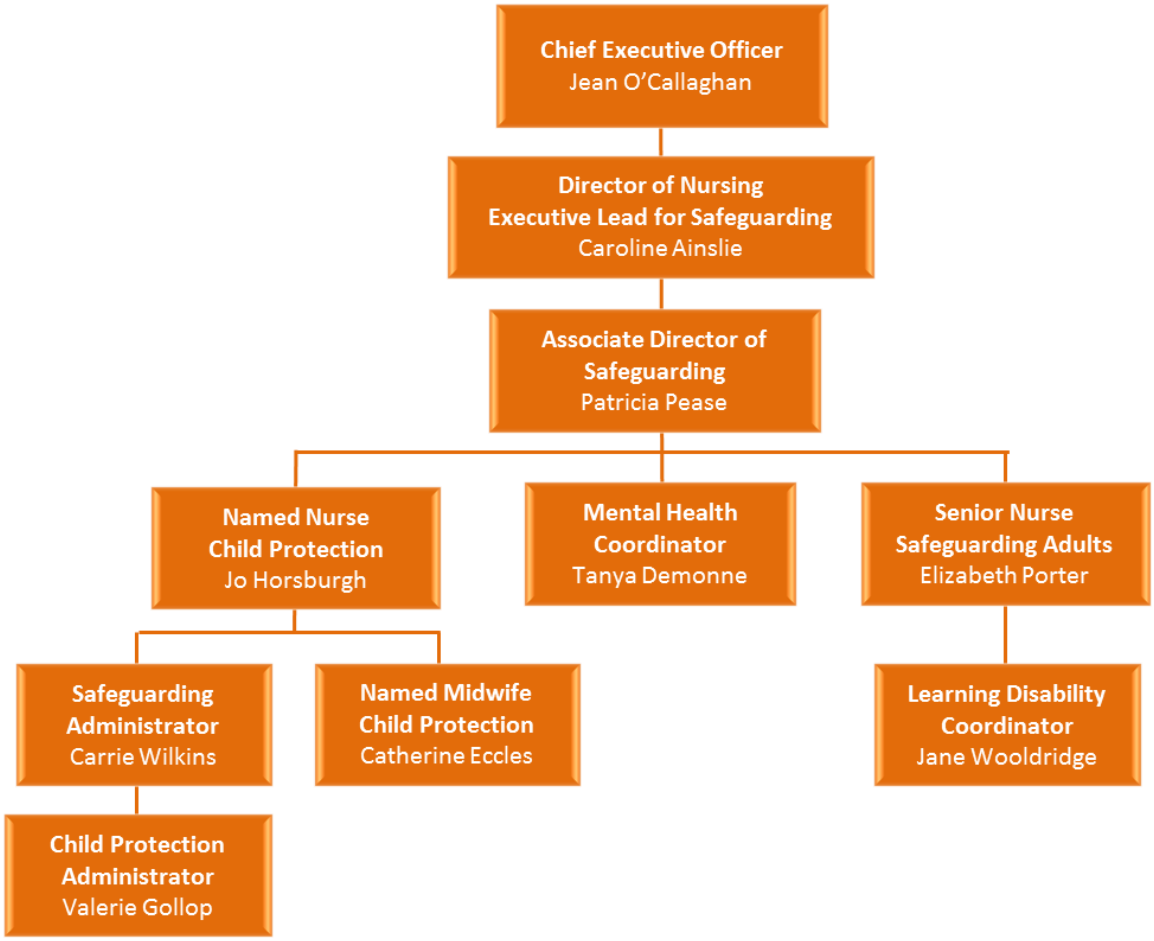
Introduction

This is the annual safeguarding report for the Royal Berkshire Foundation Trust (RBFT) it covers all areas of safeguarding work across the Trust and through multiagency working and sets out our priorities for further work

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect (CQC 2016). Safeguarding at the Royal Berkshire Hospital is fundamental to high-quality health care. Safeguarding is everybody's responsibility.

The Safeguarding Team Structure

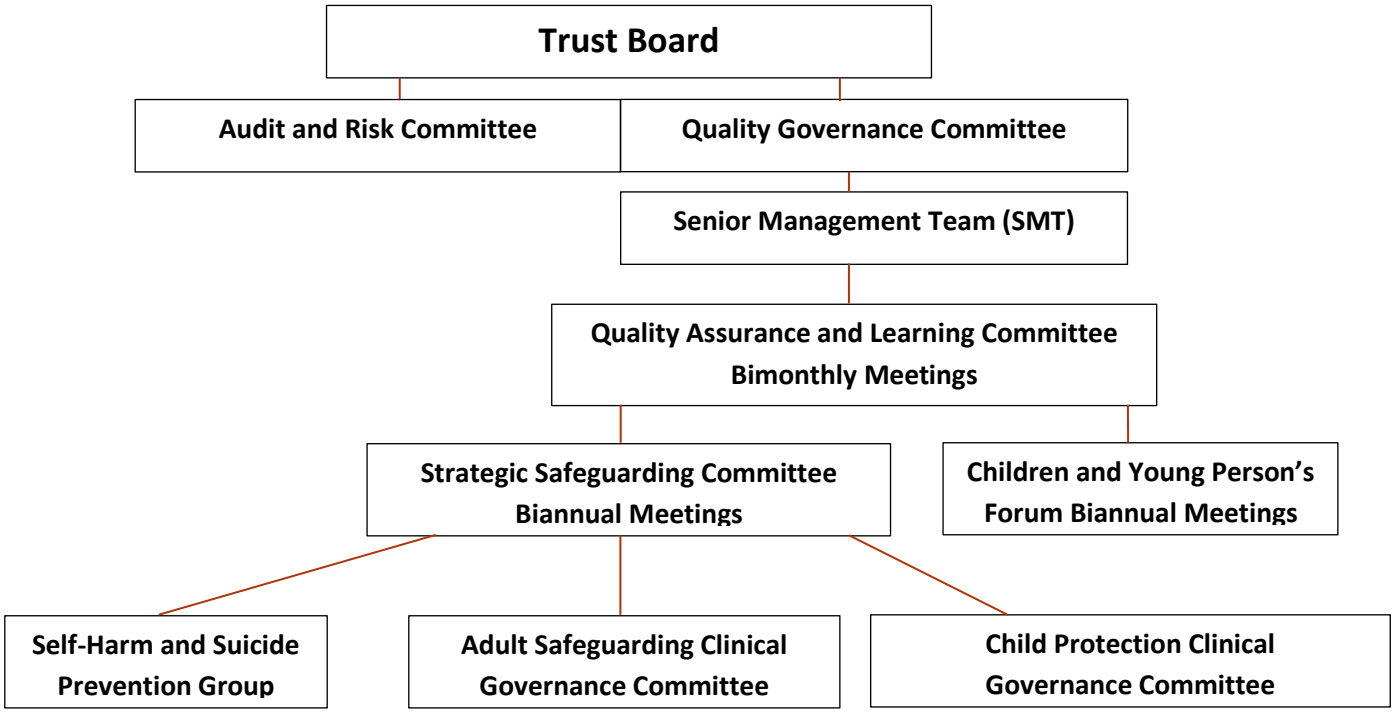
The safeguarding team structure (nursing and administration) and lines of responsibility and accountability for the RBFT is shown on the diagram below:



Adult Safeguarding: Medical Leads	• Dr Chris Danbury Urgent Care Group • Dr Kim Soulsbury Planned Care Group • Dr Sane O'Hanlon Networked Care Group
Child Protection: Medical Leads	• Dr Ann Gordon, Named Doctor Child Protection • Dr Niraj Vashist, Designated Doctor Looked After Children • Child Protection Examinations provided y a team of Paediatricians based at Dingley Specialist Children's Centre
Child Death	• Patricia Pease, Designated Healthcare Professional Child Death
Human Resources	• Suzanne Emmerson-Dam, Designated HR Officer Safe Recruitment & Allegations Management
Sexual Health	• Janice Burnett, Nurse Consultant
Transition	• Polly Schofield, Lead Nurse Transition

The Safeguarding service is accountable to the RBFT SMT and Board, Berkshire West CCG, Reading, West Berkshire and Wokingham Local Safeguarding Children Boards (LSCBs), Berkshire West Safeguarding Adult Board (SAB) and participates in Mental Health, Learning Disability, Strategic Disability and Transition partnership meetings.

Safeguarding Governance Committee Structure



The Strategic Safeguarding Committee, chaired by Caroline Ainslie, meets twice a year. The Trust has a non-executive Director with a responsibility for safeguarding and mental health.

Safeguarding quality indicators are reported monthly to the Board and CCG. A bi-monthly safeguarding and mental health report including key performance indicators is submitted to the Board as part of the Quality and Learning Committee report.

Multidisciplinary child protection clinical governance is held every 2 months; this is chaired by the Named Nurse for Child Protection. Safeguarding Adult Clinical Governance is held every 3 months chaired by Dr. Chris Danbury. The Mental Health Coordinator chairs a quarterly Suicide and Self Harm Prevention Group, which reports by exception to the Health and Safety Committee.

The Children and Young People's Committee monitors work streams to benchmark and improve the quality and safety of Trust services for children: this group meets every 6 months.

The safeguarding nursing team meets monthly to discuss operational safeguarding issues and prepare performance reports; agendas and minutes are kept for these meetings.

Statistics/Activity - The table below sets out indicative statistics for the RBFT for information and background.

	2013/14	2014/15	2015/6	Comment
Population number served	1,000,000	1,000,000	1,000,000	↔
% of population under 18 years	20%	24%	24%	↔
Number of adult attendances to ED	83,298	87,288	89,711	↑3%
Number of attendances by under 18s to ED	26,686	27,864	29,087	↑4.5%
No of over 65s attending ED	22,644	24,569	25,635	↑ 4.5%
No of mental health attendances at ED all ages	2169 (from July)	2810	2809	↔
Number of adult admissions	80,766	84,434	90,933	↑ 7.7 %
Number of admissions to paediatric wards	7,146	7181	7607	↑ 6 %
Number of under 18s admitted to adult wards			550	Validated data
No over 65s who were admitted	32,821	35142	39515	↑12.5%
No over 75s admitted for >72 hrs	5,301	5288	5451	↑3 %
No over 75s admitted for >72 hrs with cognitive issues	1602	1483	1195	↓ 19%
Number of in-patients with a learning disability	227	289	315	↑9 %
No of patients admitted because of mental health issues		798	1596	↑100%
Number of babies born	5,689	5681	5596	↓ 1.5 %
Number of under 18s attending out-patient clinics	65,296	62,767	62,437	↓ 0.5 %
Number of under 18s attending clinics providing sexual health services	2,959	2016	2356	↑17%
Number of employees	Approx. 5000	Approx. 5000	5360	Validated data

Training

Training is reported monthly to the CCG as part of the quality schedule. A Trust annual training plan for child and adult safeguarding 2016/17 has been completed. At the end of September 2016 safeguarding training was at or above the expected and agreed level with the exception of:

- Safeguarding Children Level 1 Training – 93% against a target of 95%
- Enhanced MCA and DoLS – 69% against a target of 80%
- Conflict resolution training for Emergency Department staff compliant at 80%, however trust wide uptake as 61%

All training programmes are regularly reviewed to ensure they include learning from serious case reviews and changes to national policy and guidelines.

Safeguarding Adults training

Level 1 training has been reviewed and amended with reference to the Learning and Development sub group of the SAB to reflect the Care Act 2014.

Safeguarding Children training

Levels 1 and 2 have been reviewed and amended. A review of level 3 training against 'Intercollegiate document, Child Protection Roles and Competencies for Health Staff, 2010' including the number of hours of update training annually for specialist groups is underway.

Child Sexual Exploitation (CSE) Training

CSE has been embedded into safeguarding children training at all levels. Four CSE one hour updates at level 3 are available annually. The Department of Sexual health holds a one hour CSE case study peer review bimonthly. All staff can access E learning via the CSE intranet pages.

Domestic Abuse

Domestic abuse is raised in adult and all levels of child safeguarding mandatory and statutory training, specific domestic abuse training is available for maternity staff. Level 3 days for the children's workforce include clear guidance for staff who are working closely with children and families on how to support and refer to other agencies where there are parental risk indicators.

Prevent (Anti-terrorism Training)

Prevent awareness forms part of the level one training for all staff and is included in adult and child safeguarding training. 1 hour Wrap training is delivered to selected staff the focus this year is to paediatric staff. An E learning has also been promoted for use with in the Trust.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs).

MCA and Dols Training continue to form part of the core mandatory training day and induction training for patient facing staff. Multidisciplinary Enhanced MCA training was delivered on a monthly basic throughout 2015 and continues throughout 2016, compliance figures for the identified staff groups is 69% at the end of August 2016. This training has been well evaluated by participants.

Mental Health Training

The Mental Health Coordinator (MHC) continues to provide training to staff on the Mental Capacity Act, the Mental Health Act, mental health disorders, stigma, and the processes in place within the hospital to ensure good patient care. The MHC provides training to Emergency Department (ED) Senior House Officers, ED Middle Grades and Health care assistants at induction. In 2016 the MHC secured a mental health training day for ED nurses, allocated two mental health champions in ED and is working with ED practice educators for them to be able to provide teaching for staff. In May 2016 our staff attended a 136 protocol interagency workshop; the MHC was a panel member.

Allegations and Safer Recruitment training

A bespoke training programme for investigating safeguarding concerns and allegations for 11 senior managers was designed and delivered, April 2016. 66 staff have received Safer Recruitment training in the last 2 years. This was reviewed against lessons learnt from Saville and Bradbury. Work is underway to determine the number of managers (numerator) who should receive Safer Recruitment training.

Conflict management training and training in physical restraint

Security Staff are trained in physical restraint; in February 2016 all achieved their qualification in Caring Intervention level 3 Control and Restraint. Conflict management training is available and mandatory for all clinical staff and includes breakaway techniques. This training has been reviewed to ensure that a range of trainings and delivery methods appropriate to different specialty staff needs are available. This includes understanding of the application of the Mental Capacity Act. Restraint and treatment is discussed in Level 1 adult safeguarding training and Level 3 child protection training.

Transition training

Transition of young people to adult services is an area of focus for the safeguarding team during 2016/17. Training for the Ready, Steady, Go! Transition toolkit. Transition Awareness training and RBFT Transition Plan, training will be delivered as part of the CQUIN in 20161/7

Learning Disability

A DVD shown at core induction, there are raising awareness sessions for RNs and HCAs as part of nurse/HCA induction. A communication session is delivered on 1:1 day for care crew teams. LD awareness is included in junior doctor induction

Ongoing Challenge/Risks:

- **Training all of our staff in all aspects of safeguarding**
- **Consistency of knowledge and application in practice of the Mental Capacity and Mental Health Acts and Deprivation of Liberties Safeguards**

Safeguarding Audit

A comprehensive self-audit has been completed for the CCG in September 2016. The audit is RAG (Red, Amber, Green) rated; there are 8 “amber” areas for improvement in 2016/17. The other 42 areas are green for compliance. Programmes of work and/or action plans are in place for each amber.

Additionally the Safeguarding Team coordinates an agreed audit program that includes single and multiagency audits monitored through our internal governance systems and the quality and performance sub groups of the LSCBs and SAB.

Safer Recruitment and Allegations Management

Key Achievements

- A full and thorough review of the Managing Safeguarding Concerns and Allegations Policy has been undertaken.
- Design and delivery of specific Managing Safeguarding Concerns and Allegations Training Programme.
- Regular review of live concerns or allegations to ensure appropriate and timely management of cases.
- Action plan in relation to recommendations from the NHS Lampard/Savile report, completed in June 2016. As a result governors are now Disclosure and Barring Service (DBS) checked. DBS checks for all volunteers are undertaken as part of their pre-employment check. Staff requiring DBS checks on a 3 yearly basis have been reviewed and prioritised. These checks will commence in Quarters 3 and 4 2016/17 as resources allow.
- A gap analysis and action plan against the lessons learnt following the Myles Bradbury case (October 2015) at Cambridge University Hospitals NHS Foundation Trust has been completed. This included a review of our Chaperoning Policy. A presentation to raise awareness of the case and learning from it was circulated through specialty clinical governances and to all out patient departments in June 2016.

Summary of Cases

In the financial year 2015/16 a total of 11 allegations were made; 3 relating to children and 8 relating to vulnerable adults. Over the same period a total of 5 concerns were raised; 2 relating to children and 3 relating to vulnerable adults. All bar 3 of the allegations/concerns related to Trust employees; the other related to a student, a volunteer and an agency worker. One of the allegations related to historical issues. In comparison with the previous year the number of allegations increased from 8 to 11 and the number of concerns rose from 4 to 5.

Key Areas of Work for 2016/17

- To ensure that concerns/allegations lessons learnt exercises are conducted as cases close.
- To review the Recruitment and Selection Policy.
- To review the content of the Safer Recruitment Training Programme and the number of staff to be trained.
- To agree a process for the review of 3 yearly DBS checks for staff/volunteers.

Ongoing Challenge/Risks:

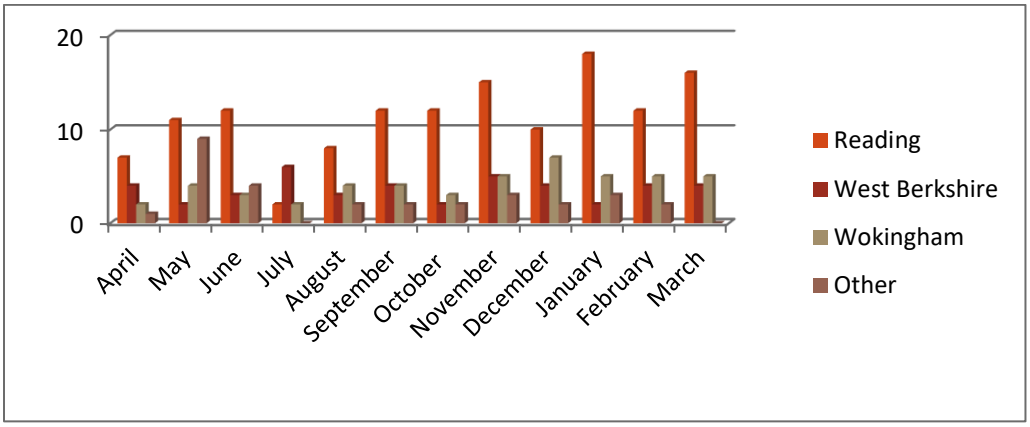
- **Capacity which has prevented the lessons learnt exercises following concern/allegation investigation being undertaken.**
- **Capacity to release clinical managers to undertake safer recruitment training**
- **Affordability/resource implications of implementing 3 yearly DBS checking**

Child Protection and safeguarding

Key achievements

- CQC report following a review of health services for children looked after and safeguarding, in Wokingham, May 2016 described RBFT leadership and management of safeguarding activities as strong with clear governance and accountabilities, with good engagement by senior managers and safeguarding staff in the work of the LSCB.
- The Named Nurse continues to meet regularly with partner agencies, where good strong relationships develop and feedback on our service has been invited and valued.
- An audit of the process for children who are not brought for health appointments demonstrated this was being followed and used effectively in all specialties.
- The annual audit of child protection referrals to Local Authorities identified staff referring appropriately, engaging with child protection thresholds, demonstrating more confidence in raising concerns and using more effective information sharing.
- New pathway process for notifications to Heath Visitors and School Nurses for children who attend ED agreed with BHFT following decommissioning of CH-IS in primary care, this will audited by December 2016.
- Level 3 Multi-agency Child protection training has been embedded, delivered and has adapted to the changing safeguarding environment. Partner agencies teach on the day and are invited to participate. The evaluations have been positive.
- RBFT was an active participant in 2 partnership reviews with Reading LSCB. Learning has been disseminated through the Trust.
- A pilot of a CAMHS Urgent Response Service has been commissioned, is fully recruited to enable 8-8 Mon-Fri; 10-6 Sat and Bank holidays plus in place from September 2016
- Following the establishment of a task and finish group the monthly audit of young people attending adult ED with mental health issues being discussed with Children's Social Care has improved.

Fig 1: referrals to local authority per month 2015/16 from RBFT:



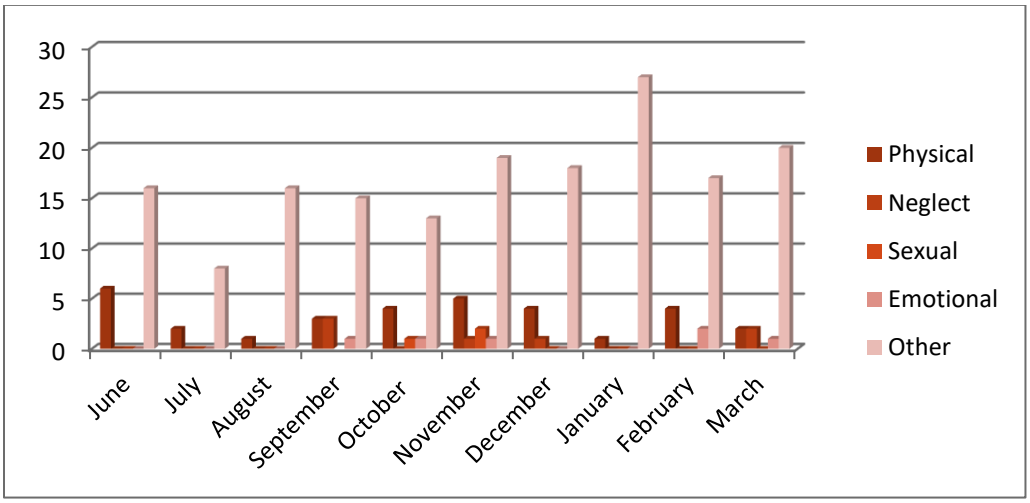


Figure 2: Referrals by category of abuse per month 2015/16 from RBFT

"Other" abuse is child protection referral for risk factors such as mental health concerns, domestic abuse, substance misuse, Female Genital Mutilation (FGM) and parenting concerns.

Key Areas of Work for 2016/17

- Continue working with Information Management and Technology (IM&T) Services to ensure Child Protection Information Sharing (CP-IS) is fully integrated into EPR. September 2016 major upgrade of EPR will allow our electronic patient record to link directly with CP-IS when it is introduced.
- Named Midwife and Named Nurse for Child Protection undertaking qualitative research to understand staffs' knowledge of child safeguarding with reference to the competences set out in the Intercollegiate Document (2014).

Ongoing Challenge/Risks:

- **The numbers of children and young people with mental health problems at risk from self-harm and suicidal ideation attending ED have risen in the last year**
- **A rise in the number of < 16s being admitted to the paediatric unit and 16/17 year olds to ED Observation Bay, Acute Medical Unit or Short Stay Unit requiring admission to Tier 4 Child and Adolescent Mental Health Service bed and delayed in the Royal Berkshire hospital**
- **The Trust does not have an adolescent or young person inpatient facility so that young people aged 14-18 years are either admitted to a paediatric or adult ward.**

Maternity Child Protection

Key achievements

- Kick clinic continues to provide an improved service for Reading maternity patients who misuse substances. It is an opportunity for patients to access maternity care and complete key-work sessions with staff from the iRiS partnership (adult drug and alcohol treatment service, Reading) who also contribute to the vulnerable pregnancy meetings chaired by Named Midwife for Child Protection.
- Multiagency vulnerable pregnancy meetings have an agenda which is sent securely to agencies prior to the meeting so they can bring proportionate information. From April 2016 professionals from Reading Multi-Agency Safeguarding Hub (MASH) have attended.
- A safeguarding supervision guideline developed by the Named Midwife for Child Protection has been approved and implemented. The Named Midwife and Poppy Team midwives are offered supervision at least every 3 months. The Named Midwife has formally moved to join the safeguarding team and is co-located with them.
- Attendance at Child Protection Conferences for unborns has remained high throughout the year despite pressure on staffing within community midwifery. There were 67 child protection conferences held for unborn babies and 54 (80.6%) of these were attended by a midwife. There were 57 babies born whilst subject to Child Protection Plans between April 2015 and March 2016.
- Flagging of electronic records is in place for women who have an unborn baby subject to a child protection plan and for high risk victims of domestic abuse. Alerts 'pop up' when a patient's records are accessed; staff have to acknowledge this before returning to the patient record. Multi-Agency Risk Assessment Conference (MARAC) flags for residents of Reading, West Berkshire and Wokingham are used for all high risk victims for six months after they were last discussed at MARAC an information sharing forum for the highest risk domestic abuse cases.

Key Areas of Work for 2016/17

- Establishment of the Poppy Team is increasing which should improve access to this service for local women particularly in West Berkshire. Community midwifery services have been reviewed providing a more streamlined management structure. Working patterns will be reviewed over the coming year to ensure services are able to adapt to meet patients' needs.

- Named Midwife for Child Protection to consider setting up group supervision/ reflective sessions for ward staff to facilitate level 3 updates and provide regular updates.

Ongoing Challenge/Risks:

- **Maintaining compliance/ staff competence for Level 3 Safeguarding Children Training**
- **Capacity of the Named Midwife to provide 1:1 supervision for increased Poppy Team and group supervision for other staff groups and newly qualified midwives.**
- **Significantly increased load now all three local authorities in Berkshire West hold a DARIM (Domestic Abuse Repeat Incident Meeting) alongside MARACs.**

Looked After Children (LAC) Initial Health Assessments

The RBFT was commissioned to provide the Doctors to run Initial Health Assessment (IHA) clinics in 2014. The clinics have the capacity to see 6 children in 2 clinics per week. In April 2016, we took over providing the administration and chaperoning of IHA clinics from BHFT.

Statutory Requirement

The Initial Health assessment should result in a health care plan being available at the time of the child/young person's first LAC review (28 days).

Key achievements

CQC report following a review of health services for children looked after and safeguarding, in Wokingham, May 2016 described our IHAs and healthcare plans for children placed within area as 'of a good standard'.

Key Areas of Work for 2016/17

Continue working with partner agencies to have shared data, information and understanding of issues for individual children coming into care to report to Corporate Parenting Boards

Ongoing Challenge/Risks:

- **Performance against statutory requirements**
- **Timely IHAs for Out of Area children (placed by our LAs in other areas)**
- **Poor quality IHAs from other areas**
- **Fluctuation in numbers of LAC**
- **Numbers of Unaccompanied Asylum Seekers coming through Kent to be distributed across local authorities**
- **Timely notification from Children's Social Care (CSC) and receipt of British Association for Fostering and Adoption (BAAF) forms and consent**
- **Data validity and conformity between CSC, RBFT and Berkshire Healthcare Foundation Trust (BHFT)**

Female Genital Mutilation (FGM)

The Trust had an FGM task and finish group during 2015/6 led by Dr Ann Gordon (Named Doctor for Child Protection). The group ensured that the Trust was complaint with mandatory reporting of FGM to the Health and Social Care Information Centre (HSCIC). All processes and guidance are on a new intranet page (Clinical Care/F/Female genital Mutilation).

Due to the adverse impact that FGM has on the physical and emotional health, safety and wellbeing of girls and women, it was identified as an area for priority work by the three Local Safeguarding Children Boards in the West of Berkshire. A sub group of the LSCBs was established and RBFT had representation on that group. A launch event of the work and updated guidance and support documents can be found on their website. Work is planned for 2016/17 to explore commissioning a clinic in the Reading area following the model of the Oxfordshire Rose clinic.

Child Death

49 deaths of Children and Young People < 18 years were reported to the Berkshire Child Death Overview Panel (CDOP) in 2015/16. 17 of those deaths were unexpected where 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death'.

22 Children and Young People < 18 years resident in Berkshire West died 01/04/15-31/03/16

- 7 neonatal deaths due to extreme prematurity, chromosomal, genetic, congenital anomalies
- 6 expected due to chronic medical conditions, chromosomal, genetic and congenital anomalies or malignancy
- 1 expected child death waiting to go to inquest and CDOP
- 8 unexpected child deaths

Rapid Responses were initiated for all unexpected child deaths and for the case of a still birth where the baby was born unexpectedly at home. The 2015-16 Rapid Response audit demonstrated good multiagency practice in the quality of the services offered to children and families in Berkshire West, following the unexpected death of a child.

Coroner classification/CDOP category:

- 0 deliberately inflicted injury, abuse, neglect, suicide, deliberate self-inflicted harm
- 1 trauma and other external factors – 2014/15 presented in 2015/16
- 1 malignancy
- 0 acute medical or surgical condition
- 3 chronic medical condition, chromosomal, genetic & congenital anomalies
- 1 perinatal/neonatal event
- 2 Sudden Unexpected Deaths in Infancy (SUDI) – one 2014/15 presented 2015/16
- 1 death classified by the Coroner but not yet reviewed by CDOP
- 1 death waiting to go to inquest

Key achievements from Rapid Response audit and CDOP case review include:

- The Rapid Response Protocol for Unexpected Child Death reviewed regularly to include learning from individual cases to better support frontline practioners in all agencies
- Training about CDOP and Rapid Response process delivered to Reading Children Social Care Team Managers
- Learning from the Warwick Training Programme in Unexpected Child Deaths has been disseminated and influenced practice
- Building on previous work - continuous learning and quality improvement about the early recognition of neonatal & paediatric sepsis and escalation in all settings
- Out of area death following 2013 Reading Festival, inquest conclusion natural causes, a rare metabolic disorder (MCAD), led to learning and festival medical facilities improvement
- Multiagency case review meetings arranged for all cases has improved learning opportunities
- Unexpected deaths child deaths where there was contact with acute health services were reviewed at a Paediatric Morbidity & Mortality and unexpected full term neonatal deaths were reviewed at a Neonatal Morbidity and Mortality meetings
- Where concerns were identified about practice by an NHS health service providers the case was considered against Serious Incident Requiring Investigation (SIRI) criteria – 0 reported
- Where any case did not reach SIRI criteria local root cause analysis (RCA) investigations conducted for learning – 1 RCA has been completed and submitted to the Coroner.
- One Youth Offending critical learning review completed presented to the LSCB case review sub group and submitted to the Coroner.

Modifiable factors identified for learning and improvement included:

- Antenatal steroids and neonatal temperature
- Smoking, co-sleeping, alcohol, prone sleeping, low birth weight
- Previous domestic violence and other safeguarding concerns
- Medical procedure regarding intubation

Characteristics within families that put children at greater risk identified:

- Overcrowding, multiple siblings, animals
- Deprivation, parents unemployed and on benefits
- Elective Home Education
- Vulnerable teenage mother
- Prematurity

Ongoing Challenge/Risks:

- **Provision of joint home visit and immediate family support – unexpected death**
- **Quality of life issues for children with complex/chronic conditions**
- **Berkshire wide approach to SUDI protocol update**
- **Supporting schools following an unexpected death**
- **Knowledge, skills, competence and confidence of multi-agency frontline managers and practioners who rarely encounter unexpected child death**

Sexual Health

- Clinical delivery in the hub at 21a Craven Rd provides open access from 7am – 7pm Mon to Fri and Saturday mornings. There are satellite clinics in Thatcham and Wokingham.
- There are 10 specific outreach clinics for young people across the three LA's of Berkshire West, provided in educational and non-educational settings. Staff work with multi agency partners to deliver holistic care from these venues.
- Expanded outreach team to include a specialist outreach nurse for boys and young men.
- 2015 – 16 the outreach posts dealt clinically with 214 vulnerable cases who would otherwise not have accessed mainstream delivery.
- Designated sexual health outreach nurse for young people and nurse consultant have the lead roles in managing CSE issues. The outreach nurse is the key front line member of staff exposed to, and dealing with, operational issues and the clinical care of young people affected by, or at risk of CSE.
- Safeguarding process - all young people under the age of 16 (and anyone under 18 with vulnerabilities identified during history taking) have a full safeguarding assessment carried out at time of consultation. Work undertaken to update the assessment tool in line with best practice. This included consideration of young people's views on the clinical approach to information gathering and recognition of their desire for a 'conversational approach' and 'enquiring tone' to be adopted to enable wider conversations. The assessment tool has been rolled out across the Trust.

Key achievements

Child Sexual Exploitation (CSE) information sharing and governance

- Provision of equal input across all three Berkshire West local authorities which involves:
    - Preparation for and monthly attendance at each of the CSE operational group meeting in all 3 unitary authorities.
    - Attendance at each locality strategic group meeting, approx. every 3 months.
    - Attendance at CSE workshops, review meetings, audit and challenge meetings
- Internal CSE Information Sharing processes have been finalised used to guide practice.
- The arrangements for the exchange of information, Information Sharing and Assessment Protocol, embedded within Berkshire Child Protection Procedures to which all LSCB statutory partner agencies, including the RBFT are signatories

- Work undertaken by the CSE task and finish group has been completed. CSE is now embedded into the Trust Child Protection Clinical Governance agenda as a standing item
- A thematic review in readiness for any OFSTED inspection has been undertaken and shared with all LSCB CSE strategic groups.

Ongoing Challenge/Risks:

- **Management of CSE continues to be a challenge in relation to capacity**
- **Review of Berkshire Information Agreement not yet approved by all LSCBs**

Safeguarding Adults

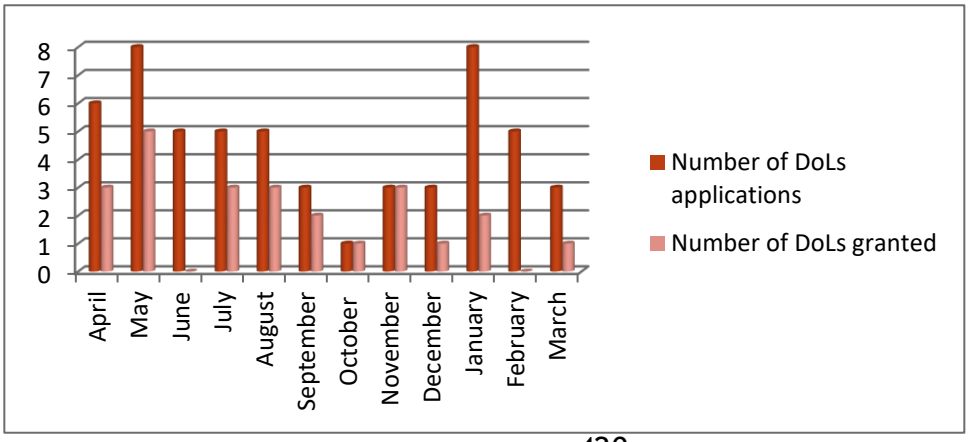
Key achievements

- Safeguarding (adults) clinical governance has been established this year and the safeguarding team welcome three new medical clinical leads one from each care group.
- Safeguarding concerns are now raised via the Datix incident reporting system this assists in giving feedback to the individual who raised the concern where available, and means that only one reporting mechanism is used for reporting concerns
- As a result of learning from a Safeguarding Adult Review (SAR) the fire service has provided training and information concerning referrals for assessments as part of safe discharge planning an Occupational Therapists (OT) and is working with a volunteer from the fire service who comes in to Elderly care once a week to pick up referrals, there is a plan to extend
- The Lead Nurse adult safeguarding is part of the review team for two current SARs

Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

One of the key findings of the CQC inspection published in June 2014 (http://www.cqc.org.uk/location/RHW01/reports) highlighted that knowledge of the Mental Capacity Act was not sufficient. The CQC recommended that the RBFT must "increase staff knowledge of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding". The safeguarding team has worked with support of the CCG to improve staff knowledge and competence around the MCA and DoLS. The number of DoLS applications is a key performance indicator report to the CCG as part of the Quality Schedule and in the integrated Board report monthly.

Fig 3: Deprivation of Liberty Safeguards applications for 2015/16.



Adult safeguarding concerns

All concerns raised by our staff about potential harm or abuse outside of the Trust are reviewed by the local authority and if necessary investigated through the Safeguarding process.

There is a fact finding exercise carried out by the Safeguarding Nurse (Adults), if substantiated they are passed to the local authority, approx. 50% are due to pressure damage, in the majority of cases there is poor discharge documentation.

Concerns reported within the Trust are investigated under our Managing Safeguarding Concerns and Allegations Policy.

Fig 4: Adult Safeguarding alerts raised in 2015/16

	Concerns raised by the Trust where harm occurred outside the Trust.	Concerns raised against RBFT	Concerns reported by RBFT where harm alleged to have occurred within RBFT
April	7	1	0
May	11	0	1
June	10	2	1
July	16	3	0
August	20	1	1
September	20	3	1
October	25	2	1
November	17	2	1
December	22	6	4
January	24	1	1
February	19	2	0
March	26	9	0

Prevent (anti-terrorism)

There was 1 possible Prevent concern discussed with outside agencies related to a patient. Appropriate action was taken there was no further involvement or action for the Trust.

Ongoing Challenge/Risks:

- **Year on increase in activity for vulnerable groups with multiple co-morbidities and complex psycho-social problems**
- **Elderly patients living with dementia delayed in hospital**
- **Increasing and maintaining workforce knowledge of the Mental Capacity Act and DoLS**
- **Supporting patients and the staff caring for them where there is homelessness or other external service/resource issues beyond our control**

Mental Health Service Provisions

Activity

Activity data provided by the RBFT ED department shows that on average 250 people per month attended with a primary mental health presentation in 2015/16, 56% were subsequently admitted. This sharp rise from the previous year (in 2014/15 admissions were approximately 28%) has been attributed by the CCG to the use of the ED Observation Unit.

Monmouth Mental Health Activity within the ED Observation Unit Audit October 2016 showed:

- 48% of mental health patients were high complexity/resource intensive

- 10% of the mental health patients had a LOS of 2+ days. - 'These tend to be patients that are in crisis (psychotic, manic, suicidal or self-harming) which require psychological assessment and treatment, continuous observation and sometimes one-on-one care.' 'mental health patients staying in the unit longer than for a day due to delays in onward referral/discharge planning and to difficulties with coordinating social care packages outside of the hospital'.

- The overall review highlighted a number of wider system issues across mental health services and their configuration within the Berkshire area

- Some of the key system issues observed indicate a need to review services and staff resourcing in order to:

1. Better meet mental health patients' needs in the community and avoid admissions to A&E and the Observation unit for patients in crisis who could be better cared for under specific mental health services

2. Assist RBFT to be better equipped/resourced to meet the high influx of mental health patients attending A&E – various system/pathway configurations and staffing options could be explored.

South Central Ambulance Service (SCAS) activity data 1st February – 30th July 2016 showed:

Royal Berkshire Hospital (RBH) received 202 mental health patients; Wexham received 62 and Frimley 23 by ambulance from the 7 Berkshire CCGs. The RBH appears to receive considerably more patients from Berkshire than other acute trusts.

Fig 5: Mental Health presentations to ED 2015/16

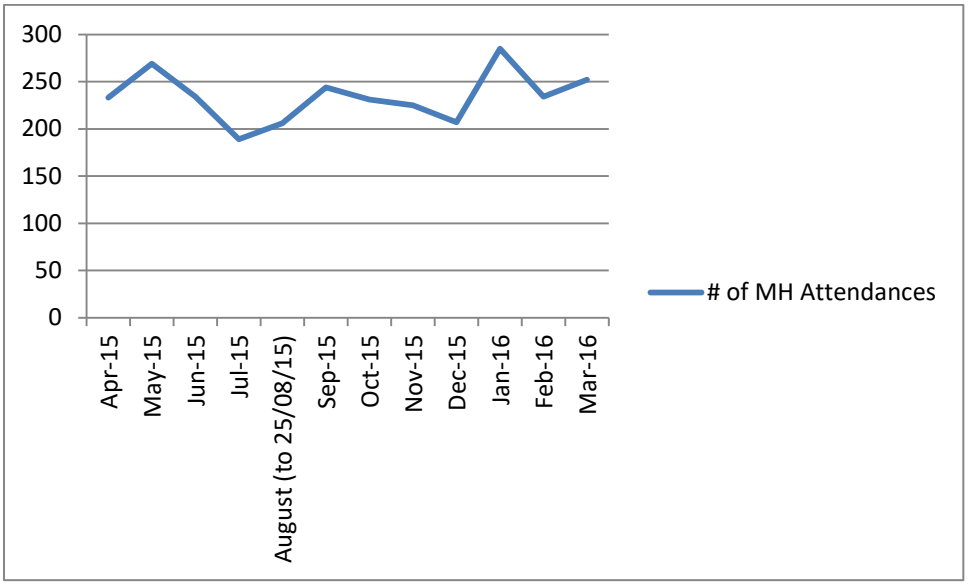
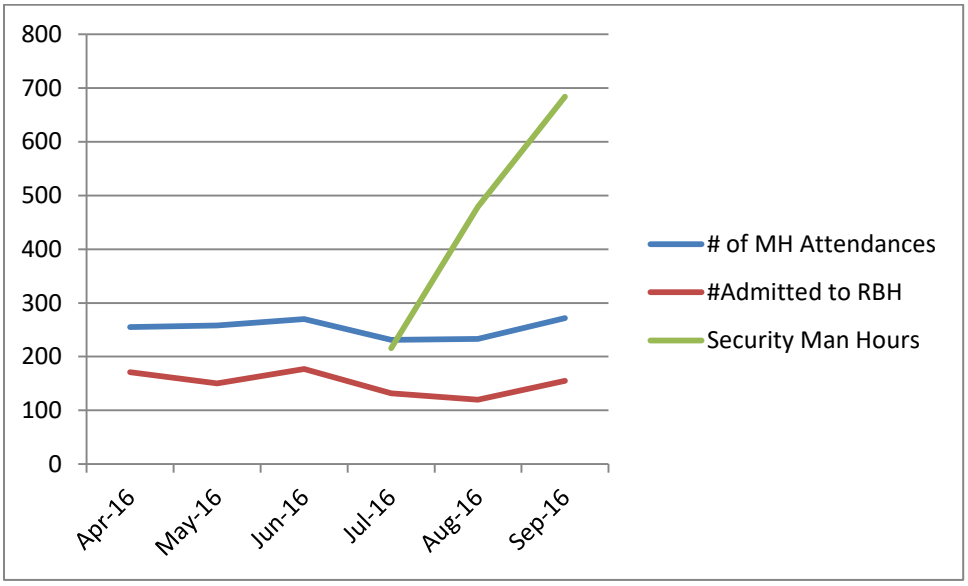


Fig 6: Mental Health presentations to ED April – September 2016 including security man hours



Mental Health Act Detentions

There were 12 patients detained under the Mental Health Act to the Trust during 2015/16, in comparison to 32 detentions the previous year.

NB whilst a number of these patients were detained to the RBH as they required treatment for both their mental and physical disorder, there were a number of patients who had no physical disorder and were awaiting a mental health placement.

Key achievements

Liaison Psychiatry in A&E – Psychological Medicine Service (PMS)

There continues to be a high level of support for patients presenting with mental health needs. The team works collaboratively with the Emergency Department (ED) staff to ensure that those with mental health needs are adequately assessed, treated and signposted as necessary. ED and PMS attend weekly operational meetings in order to achieve a collaborative way of working.

Older People Mental Health Liaison and PMS

The OPMHLT became part of the PMS earlier this year together they continue to deliver high standard assessments across the hospital.

Suicide and Self Harm Prevention

The Suicide and Self Harm Prevention Group and action plan works towards a zero tolerance of suicide attempts within the Trust. The group has been instrumental in:-

- Overseeing the Trust wide roll out of the ligature audit
- Drafting the paper that gained Executive approval for funding for compliance works to the multi-story car park
- Regular audits of the Adapted Australian Triage Tool (AATT)
- Working alongside the Samaritans who now provide support within the ED, as well as training for hospital staff
- Development and approval of the Mental Health Policy and associated guidelines

The Mental Health Coordinator attends the Suicide Prevention and Intervention Network, a nationwide network aims to work collaboratively across the Thames Valley to create and support local suicide prevention plans and strategies led by Public Health/CCGs/H&WBs.

Section 136 of the Mental Health Act Audit

The Police can use a section 136 to take a person to a place of safety from a public place if they assess that they have a mental illness and are in need of care. A place of safety can be a hospital. The section 136 can last for up to 72 hours. Correct procedures need to take place including: a S136 form being completed by police; the S136 being recorded on the Electronic Patient Record (EPR); a report being received by the Mental Health Coordinator (MHC) from Thames Valley Police (TVP)

There continues to be some discrepancy between the monthly figures that TVP report to us, and the completed forms and records of S136 reported on EPR.

Reattenders project and follow up clinic

The MHC has worked successfully with BHFT and other agencies to develop client case management plans for top 20 reattenders to reduce the number of unnecessary visits to the RBH. BHFT data demonstrating reductions in Quarter 3 & Quarter 4 of 48% and 52% is encouraging, frequent attenders make up 1% of patients attending ED.

Berkshire Mental Health Crisis Care Concordat

The Trust contributes to and to date has delivered all improvements in care on time. The key areas of focus for 2016/17 are:

- Review the mental health training needs analysis.
- Review the resilience of Trust security arrangements to manage the consistently high number of patients with a mental health disorder who are triaged as a red risk.
- To look at the needs within maternity for training and support.
- Review of the Suicide Prevention action plan, this will include any outstanding actions, incidents/near misses during 15/16, and the ligature audit to be undertaken.
- Agree and approve the Mental Health Policy and associated guidelines.
- Work with the BHFT PMS to ensure continuous improvement in patient/staff experience, patient safety and outcomes.
- To ensure that a governance system for patients that have been 'flagged' on the electronic patient record system and have a crisis/admission avoidance plan is in place

Ongoing Challenge/Risks:

- **No reduction in the number of mental health patients of all ages presenting to ED and being admitted, increase in complexity**
- **Lack of robust community services for patients who are in crisis, leading to individuals attending ED with no physical health needs**
- **Shortage of beds in mental health hospitals, patients being delayed in the acute setting**
- **Will lead to an increase in number of patients detained to Royal Berkshire Hospital under the Mental Health Act**
- **Shortage of Approved Mental Health Professionals (AMHPs)**
- **Risk of errors on out of hour section papers, due to staff's lack of expertise and knowledge of the MHA, increasing the likely hood of a patient appealing**
- **Capacity of the security services and nursing teams to provide a safe environment for high risk patients**
- **Increase use of rapid tranquilisation protocol to manage challenging behaviour**
- **Increase in absconders, self-harm and suicide attempts**

Learning and Complex Disabilities

There were 315 in-patients with learning and complex disabilities supported during 2015/16. Very few patients required no input at all and a number of patients required significant input. Those who are having planned medical interventions often require input from the Learning Disability Coordinator (LDC) prior to admission. The LDC provides support to hospital staff involved with the patient who request advice with strategies in order that the patient receives the most effective care and best outcomes.

Key achievements

Patient experience

The LDC represents the Trust on the Learning Disability Partnership Boards (LDPB) and the LDPB health sub groups for Reading, Wokingham and West Berkshire. The presence of the LDC at these meetings is valuable in terms of people using our services and their carers feeling able to discuss issues that have affected them when they have been patients. It is also useful for people to discuss concerns they may have before coming to hospital.

The Enter & View team, part of Reading Healthwatch, continues to visit the Royal Berkshire Hospital every 3 months or so to talk with in-patients with a learning disability about their experiences. The team consists of two people with a learning disability and a supporter.

The Enter & View team participated in the Patient Standing Conference in November 2015. They presented their findings using a paper roll and lively explanations to describe the experience of patients with a learning disability. The group had identified that very few staff are able to communicate with patients using sign language.

Two members of the Wokingham LDPB came to the hospital in September 2015 to do some filming with medical photography for a DVD to illustrate what it was like coming to hospital to have an x-ray. The DVD can be shown to people with a learning disability who might be anxious coming to hospital and it is hoped to make more films featuring a variety of departments.

A patient with a learning disability has been involved in filming for the Quality Time Research Project which is looking at patient experience in ED. The patient described the positive care she had received in ED and compared that with some poor communication. The LDC supported the patient to enable her to take part.

Familiar carers

RBFT continues to fund 1:1 familiar carers for in-patients with a learning disability who require that level of support to make them feel less anxious and more likely to comply with medical and nursing interventions in the hospital environment. Social care will not fund this type of support when an individual is in hospital as their responsibility for funding only applies to people who have been assessed as eligible for funding at home or in the community.

Audit of the use of 'Information about me' folders in Acute Medical Unit (AMU)

A snapshot audit was in AMU during February 2016 which highlighted that 'Information about me' folders were not routinely being given to the carers or family members of patients with a learning disability to complete. As a result a large batch of folders was supplied to AMU and information flyers about the folders put up. The importance of using the folders about the unique needs of those patients with a learning disability is highlighted in every training session for Registered Nurses and Health Care Assistants. The audit will be repeated 2016/17.

Changing Places toilet

Work is now underway with the conversion of an existing toilet in a public area to a Changing Places toilet. A hoist and a changing plinth suitable for adults is incorporated into a Changing Places toilet so that disabled

people can be assisted by their carers in using the toilet and being changed. This has been funded by the League of Friends. The facility is expected to be completed by Christmas 2016.

Transition clinics

The LDC attends the neuro-rehabilitation transition clinics to meet young people and their parents who are about to start using adult services within the Royal Berkshire Hospital. This provides an opportunity to explain what they can expect in adult services and to reassure young people and their families that reasonable adjustments will be made for them. There are 3 -4 clinics each year.

Planned work for 2016 / 2017

Payment process for familiar carers needs to be redesigned in such a way that it is straightforward for staff in clinical areas and delays in payment are avoided.

Maintaining a high profile with the family carers agenda

Ongoing Challenge/Risks:

- **Year on increase in activity for this vulnerable group**
- **Patients with LD being delayed in hospital waiting for appropriate social care placements**
- **Affordability of funding familiar carers**
- **Increasing and maintaining workforce knowledge of the Mental Capacity Act, consent and best interest assessments**

Carers

A Trust Carers group was established in 2015/6. The purpose of the group is to improve the experience of visiting the Royal Berkshire Foundation Trust for carers. This includes when the person being cared for is admitted or attends an outpatient appointment or the carer themselves is the patient. During 2015/6 the group developed a charter, the carers orange booklet was updated, and a carer's survey initiated. Carer's week 2016 was marked at the hospital with a stand outside the staff restaurant all week. Orange booklets were given out to staff members and carers who passed the stand. From September 2016 the group has been led by the Head of Patient Experience.

Ongoing Challenge/Risks:

- **Staff awareness of the rights of carers, orange booklet and survey**
- **The Trust recognises that we need to improve the support we give to carers, this has been identified in our Quality Account for 2016/17**

Transition

In December 2015, a Lead Nurse for Transition (0.6wte) was appointed at the Royal Berkshire NHS Foundation Trust (RBFT) to carry out a 12 month pilot of the nationally recognised transition programme 'Ready Steady Go' in 2 cohorts of patients; diabetes and neurodisability. The post was funded by the Thames Valley Strategic Clinical Network (TVSCN) and formed part of a Thames Valley wide project to develop transition services for young people with long term conditions.

Key Achievements 2015/16

- Transition Policy and Guidelines complete (approved January 2016)
- Trust Transition Steering group has been established.
- Ready Steady Go (RSG) Pilot completed January 2016. Successful pilot with approx. 100 young people now on the RSG programme.
- *RBFT Transition Plan* developed by steering group to support RSG and encourage compliance with transition planning.
- Improved cross agency working for Special Educational Needs and Disability (SEND) transition services : following a pan-Berkshire joint agency conference in April 2016, representatives for adult and child social care, special schools and SEND local Authority teams have agreed to work together to adopt the principles of the RBFT transition pathway. This will mean young people with SEND will only have to navigate one transition pathway for all services.

Plan for 2016/17

Roll out RBFT Transition Plan and RSG to all of Paediatrics and adult services

The 'Ready Steady Go' pilot project ended in January 2016 and has been fully evaluated. The pilot involved hard work and determination on the part of the lead clinicians and good engagement from the transition steering group. There have been some challenges in implementing the new paperwork, however, throughout the project, the lead clinicians have been positive about developing their transition services and believe that rolling out the newly developed RBFT Transition Plan, would benefit their patients in the long term.

The transition nurse post continues to be funded by the TVSCN and has been extended to March 2017. The nurse will be spending the 1.5-2 days per week based at the RBFT working to embed the new RBFT transition plan and deliver training across the trust and the remaining 1.5-2 days working for the TVSCN to support 4 other trusts to develop their transition services (Oxford University Hospitals, Wexham Park, Stoke Mandeville and Milton Keynes). A Transition CQUIN has been agreed for 2016/17 which will ensure transition is embedded in practice for paediatrics and those specialties to whom children transition.

Ongoing Challenge/Risks:

- **Funding for the transition nurse post ends in March 2017**
- **Preparation, readiness and capacity to engage for Ofsted inspections of SEND**

Disabled Children and Young People

Dingley Child Development Centre provides multi-disciplinary specialist paediatric neurology/epilepsy and community paediatric services, a child protection medical service and initial health assessment service for looked after children resident in Berkshire West. They also provide tertiary services including assessment of visual impairment and spasticity and a botulinum service. The specialist paediatric inpatient therapy services are provided by the team based in Dingley. BHFT are selling the land where Dingley is located, it will need to be vacated early in 2017. Respite care for children with complex health needs is provided by BHFT at Ryeish Green in July 2016 they notified the CCG that they were no longer able to sustain provision.

Ongoing Challenge/Risks:

- **No arrangements for relocation of Dingley services**
- **No respite service would impact on children and families and lead to increased admissions and length of stay**

Risk Based Priorities for 2016/17

1. Continue working with partners to reduce unnecessary attendances to ED and delayed transfer of care for patients of all ages who have a mental health or learning disability but no physical disorder, this will include understanding demand
2. In line with the Care Act and the principles of Making Safeguarding Personal new evidence review our approach to ensuring the knowledge and competency of our staff in practice in relation to the Mental Capacity and Mental Health Acts, DoLS, best interest assessments and consent
3. Continue to working with our LSCB and SAB partners on multiagency priorities e.g. neglect, domestic abuse, initial health assessments for looked after children, emotional health and well-being of children, making safeguarding personal
4. Work with multiagency partners to understand demand and develop a disabled children strategy for Berkshire West including transition services
5. Review the current Safer Recruitment Training Programme and to commence the 3 yearly DBS checks
6. Further develop the carers work and strategy within the Trust
7. Review the capacity and resilience of the Safeguarding team in relation to work load and capacity to attend external meetings using a transformational approach
8. Review the safeguarding strategy and governance structures to ensure they are robust

Appendix1

Responding to feedback: Making Safeguarding Personal

The safeguarding team aim to ensure that it is responsive to feedback from both patients and colleagues. Feedback is collated from all training delivered and staff are keen to ensure that the voice of the adult or child is heard, both in training and through supervision.

Feedback about the Mental Health Coordinator

"The safeguarding team is a useful source of advice and professional support in dealing with safeguarding issues, but more recently in dealing with acute Mental Health patients and issues. Tanya has been pivotal in facilitating working relationships between ED and PMS and as a team I know that we value this support.

With her extensive ED background and MH experience she is able to understand the issues and complexities of some patients who attend ED and the issues when they managed in the ED and has been proactive in helping us with the strategies for on-going care.

She has also been very valuable in developing management plans for patients that can enable in-hospital services and community services to work more cohesively in providing suitable care for the patient and is often my first "port of call" when dealing with complex patients or delays for beds.
She has provided teaching for us in ED which I know the team found very useful, however as her role has developed it has been a challenge for her to manage this on an on-going basis."

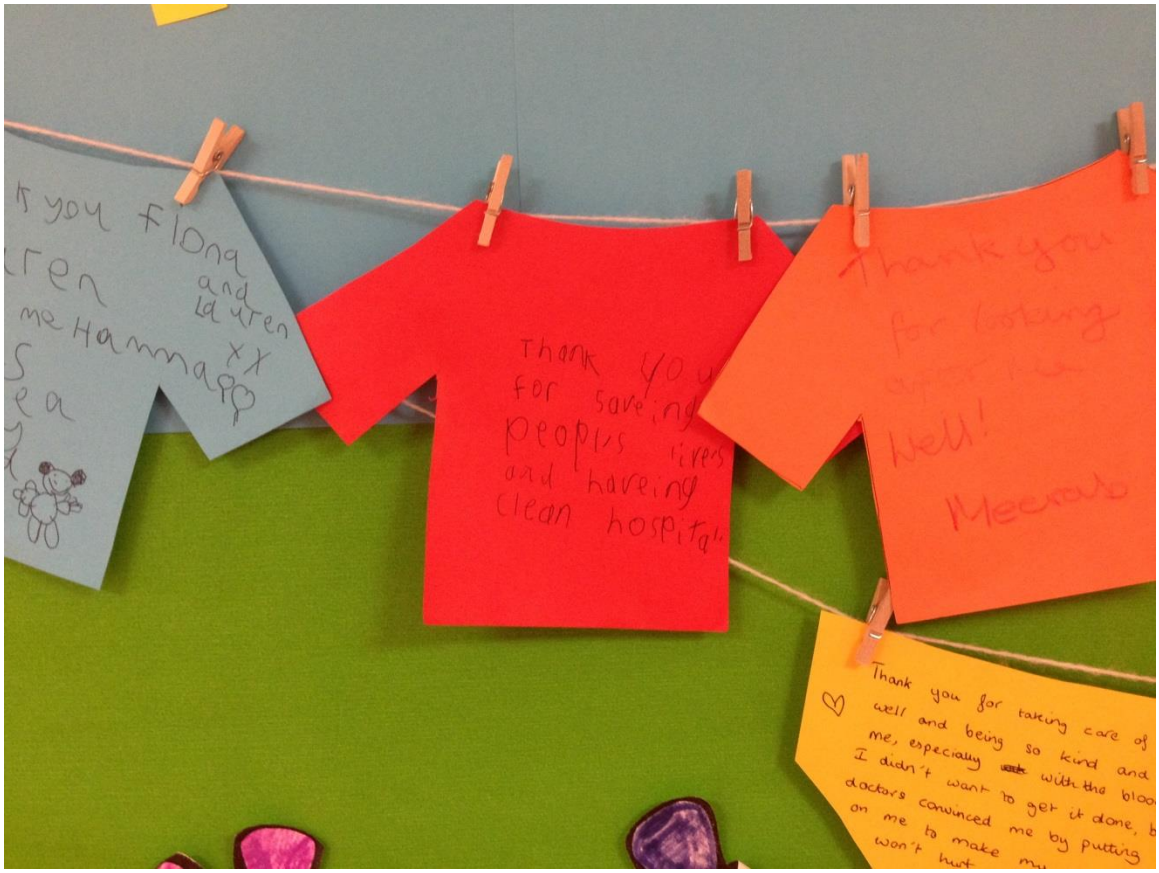
Feedback on training

All safeguarding training is evaluated. The following were evaluations from level 3 CSE training: out of the 19 people who attended: 14 said session was "excellent" and 5 said it was "Good" Free text comments for "What I have learnt" included:

- "Examine more carefully, ask questions and listen".
- "Don't dismiss challenging behaviour as just being stroppy teens!".
- "Really useful session: reminds me what we are looking out for".
- "To use the proforma for questions".
- "Films were excellent in getting messages across".

- “Pay close attention to challenging teenagers”.
- “Take time to listen to the young person”.

Paediatric ward areas use “pants and tops” to encourage children to identify what is good and could be improved for clinical areas.



Patient Story

A new mum emailed the trust to thank the team for caring for her and her new baby. She has given permission for this to be shared [written as emailed].

My name is Samantha and I gave birth to a baby girl, named Emily, on the last 10th of October at 2:42 AM.
My experience at the hospital been amazing and has a huge impact in my life.. Personally I think has changed the life and future of my daughter and myself forever.. I been suffering abused by my husband over the last 3 years, in silence, with fear, thinking of surviving day by day.. Doing and saying what he wanted to hear and see, afraid of he could hurt me really badly.
The situation turned worst after I got pregnant. He never wanted this baby, he used to push me, insult me, taking all my money, bullying me, abused me no mercy.. Until the point to left me homeless nearly 8 months pregnant. When this

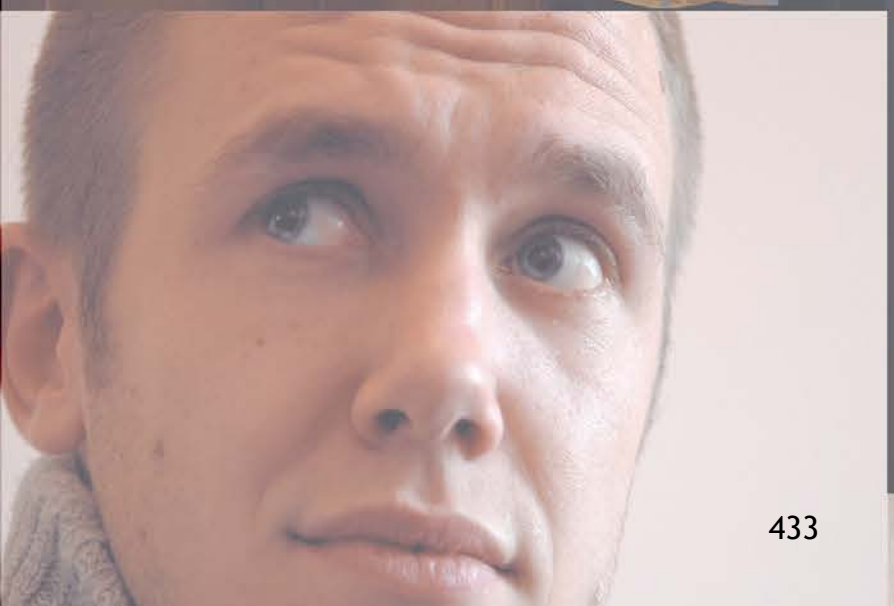
happened, his mother had me at hers for few weeks but like he was used to come around to argue and fight to me, she kicked me off too, saying if I wanted a healthy baby I should scape from him.
I hide myself, I did not have where to go, I was desperate.. Nearly to delivery and no place to stay. A friend rescued me and 3 weeks before Emily was born I moved in with her.
After I gave birth, that morning on the 10/10, around 7 o'clock in the morning, a lovely midwife, which I don't know her name, and I will give my life to know it, asked why my husband wasn't there. So I was honest to her and I speak up telling that he was a violent abuser.. She said I should report it, and I got scared, as I was used to living in fear, so I did try to stop it.. But this lady looked into my eyes and told me: "I must to do it, to protect your baby".. That moment was magic to me. I felt my blood running so fast! I understood my attitude should change, I was having my tiny baby in my arms and this gentle lady was the light in the end of the tunnel.
From that all staff was absolute wonderful.. Every single person I met, been concern and bringing all support and help, psychically, emotionally and making me feel safe and free.
I stayed in the Marsh Ward and I would love to give to you all name, which I don't have unfortunately, because you should be so so very proud of the hard work you do daily.
Once out from Hospital, with the Police, Berkshire Women's Aid and NSPCC involved I could put my baby and I in a better place, safe and far away from him.
In fact I presented at the Family Court in Reading a non molestation order and the judge made it and served to my husband.
But I got so much to do still. I just would like to ask if it's possible to get a copy of the report I did at the hospital, as my solicitor requested it to me.

I'm externally grateful for the integral caring, support and attention the staff brings, I can not say thanks enough..
You guys listened to me, believing on me and have changed my life.
I become a free person, enjoying my daughter, all full of love around, giving to her a peaceful and safe life, as every child who came to this world should have..

From NHS choices

"I came to A&E Tuesday evening which was mental health related and I was treated like any other physically unwell patient. I can't appreciate it enough of how well the professionals treated me. Thank you." Visited in December 2015. Posted on 09 December 2015

Safeguarding Adults
Annual Report
2015/16



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Executive Summary

2015/16 has been a busy year for the Safeguarding Adult service. It has managed an increase in numbers of concerns raised, number of S42 enquiries initiated and completed and a significant increase in the number of DoLS applications received and processed.

Despite this increase in activity the service has raised awareness of safeguarding across West Berkshire by developing and engaging with a Safeguarding Service User Group, delivering awareness sessions and hosting stands at events in the local community, participated in a peer review in which our partners, providers and staff played a key role and actively supported training opportunities provided by the West of Berkshire Safeguarding Adults Board.

The Safeguarding Adults Forum developed an action plan based on the priorities of the Safeguarding Adults Board.

1. Raising awareness of safeguarding adults, the work of the SAB and improving engagement with a wide range of stakeholders
2. Making Safeguarding Personal
3. Ensuring effective learning from good and bad practice is shared
4. Developing an oversight of safeguarding activity

The Forum has progressively worked through the action plan during this reporting year and has developed plans for 2016/17. The partnership working developed through this forum was recognised in the peer review carried out by ADASS into the safeguarding function. This forum continues to develop its role as the operational arm of the Safeguarding Adults Board for West Berkshire.

The Making Safeguarding Personal initiative continues to be promoted and embedded in practice through training and monitoring, with local data indicating improvements are being made.

Performance data analysis is carried out on a regular basis. Rigorous interrogation ensures there continues to be a grasp of both current and emerging issues. The impact of a proactive approach by the Care Quality team with local providers appears to be having a positive impact on the types of safeguarding enquiries and source of risk.

The service continues to strike a balance between daily operations dealing with incoming safeguarding concerns and applications for Deprivation of Liberty Safeguards authorisations with raising awareness of safeguarding.

Introduction

Safeguarding Adults is a strategic priority for West Berkshire Council and a core activity of Adult Social Care. It is now, as a result of the enactment of the Care Act 2014, a statutory responsibility for Local Authorities as well as the assessment and authorisation of Deprivation of Liberty Safeguards.

This annual report evidences the key quarterly measures and trends used to monitor activity for Safeguarding Adults in West Berkshire to ensure risks are being identified and managed appropriately. Utilising a new set of indicators and statutory reporting requirements for 2015/16, analysis of performance has developed comprehensively across the year to produce this report.

This report also focuses on the activities of the safeguarding network in West Berkshire during the reporting year.

Networks, Boards and Forums

The Care Act 2014 required all Local Authorities to form a Safeguarding Adults Board (SAB) to provide the strategic overview and direction of safeguarding, provide governance and quality assurance to the process. This includes the commissioning of Safeguarding Adults Reviews when a person has died or been significantly harmed and the SAB knows, or suspects, that the death resulted from abuse or neglect. West Berkshire Council is a member of the West of Berkshire Safeguarding Adults Board; a tri borough Board in partnership with Reading Borough Council and Wokingham Borough Council alongside other key stakeholders including, but not exclusively, Thames Valley Police, Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital Foundation Trust and the local Clinical Commissioning Group. The SAB has produced its own annual report which can be viewed on its website www.**sabberkshirewest**.co.uk

The West Berkshire Safeguarding Adults Forum is the local operational arm of the SAB and consists of local partners signed up to address safeguarding matters specifically in West Berkshire. The forum produces an action plan annually drawn from the priorities set by the SAB. For 2015/16 those priorities were:

1. Raising awareness of safeguarding adults, the work of the SAB and improving engagement with a wide range of stakeholders
2. Making Safeguarding Personal
3. Ensuring effective learning from good and bad practice is shared
4. Developing an oversight of safeguarding activity

In order to achieve those priorities a number of objectives were developed into an action plan and delivered by forum members.

The Service User Safeguarding Forum was formed in 2015/16, the development of which was a key objective of the Safeguarding Adults Forum action plan. This group, made up of service users with an interest in safeguarding, meet quarterly.

Volumes and Performance

Safeguarding activity

Concerns and enquiries

There were 767 safeguarding concerns received in 2015/16. The number of concerns has increased for the last couple of years. In some cases it is sufficient for the Local Authority to note the concern with no further action required. Noting those concerns that require no further action enable the Local Authority to spot trends and monitor patterns across the District. Those that require greater scrutiny or input are opened as a S42 enquiry. We monitor the % of concerns that subsequently require a S42 enquiry. This is known as a conversion.

292 s42 enquiries were opened during 2015/16, with a conversion rate from concern to s42 enquiry of 38 %. This is an increase on previous years. The increase is attributed to better recording methods and greater awareness of the safeguarding process. During the reporting year West Berkshire worked closely with its partners in South Central Ambulance Service and Thames Valley Police to improve the quality of concerns raised. This improvement is partly reflected in the increase in conversion rate recorded.

Note the change in terminology as a result of the Care Act; alerts are now referred to as concerns, and referrals as enquiries.

Table 1 – Safeguarding activity for the reporting period 2014-16

Year	Alerts/Concerns received	Safeguarding referrals/s42 enquiries opened	Conversion rate of concern to s42 enquiry
2013-14	543	148	27 %
2014-15	601	207	34 %
2015-16	767	292	38 %

Individuals with safeguarding enquiries

Age group and gender

Tables 2 and 3 display the breakdown by age group and gender for individuals who had a safeguarding enquiry in the last three years. The majority of enquiries continue to relate to older people - the 65 and over age group accounted for 66 % of enquiries in 2015/16. The majority of enquiries were related to female clients, 57 %, a continuation of a trend seen in the last 3 years.

Table 2 – Age group of individuals with safeguarding enquiries, 2014-16

Age band	2013/14 % of total	2014/15 % of total	2015/16 % of total
18-64	28 %	29 %	34 %
65-74	9 %	12 %	15 %

75-84	26 %	25 %	23 %
85-94	33 %	31 %	24 %
95+	4 %	3 %	4 %

Table 3 – Gender of individuals with safeguarding enquiries, 2015-16

Gender	2013/14 % of total	2014/15 % of total	2015/16 % of total
Male	41 %	38 %	43 %
Female	59 %	62 %	57 %

Primary support reason

Table 4 shows a breakdown of individuals who had a safeguarding enquiry by Primary Support Reason (PSR). The majority of individuals had a PSR of Physical Support, 37 %, although this does represent a slight drop on last year's proportion. There was an increase in enquires where the individual has a PSR of Mental Health Support. The increasing number of those presenting to safeguarding with a PSR for memory and cognition, although the proportion of overall presentations has not changed, is indicative of a gradually ageing population locally.

Table 4 – Primary support reason for individuals with a safeguarding enquiry

Primary support reason	2014/15	% of total	2015/16	% of total
Physical support	77	44 %	100	37 %
Sensory support	3	2 %	4	1 %
Support with memory and cognition	48	27 %	78	29 %
Learning disability support	30	17 %	46	17 %
Mental health support	10	6 %	30	11 %
Social support	7	4 %	9	3 %
No support reason	0	0 %	0	0 %
Not known	0	0 %	5	2 %

Case details for concluded enquiries

Type of alleged abuse

Table 5 shows enquiries by type of alleged abuse in the last three years. Additional categories were added to the 2015/16 with the implementation of the Care Act 2014. Those additional categories were domestic abuse, modern slavery, self neglect and sexual exploitation (a derivative of sexual abuse/modern slavery and/or domestic abuse). It should be noted that more than one category of abuse can be attributed to any single concern as often incidents are complex and comprise of various elements.

The most common types of abuse for 2015/16 were for neglect and acts of omission, 22 %, and physical abuse, 19 %. Neglect and act of omission cases are attributed to the provision of care given either by a paid or unpaid carer. The category of physical

abuse also includes incidents where there has been a physical altercation between two or more residents in a domestic, care home or hospital setting.

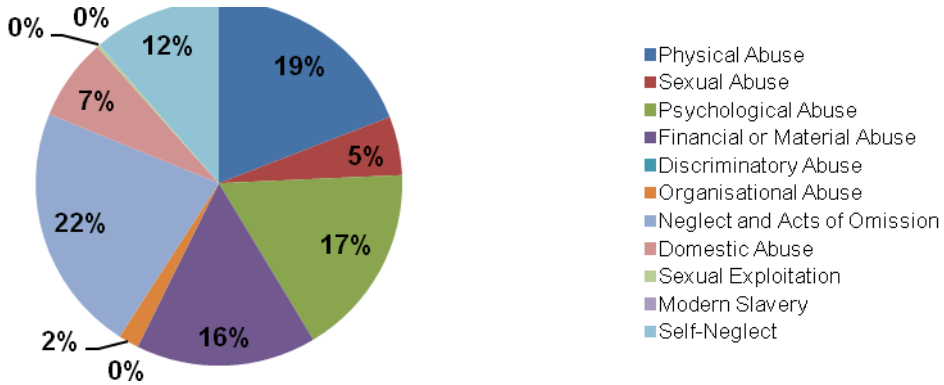
Self neglect as a defined type has now accounted for 12% of cases into which enquiries have been made. This is reasonably substantive, and is broadly as predicted at the beginning of the year. It is worth noting the threshold set for a safeguarding intervention into a case of self neglect is relatively high, including consideration of mental capacity. Those cases not meeting the threshold are passed through to adult social care teams for screening and assessment.

The Care Quality team in West Berkshire has been very proactive working in partnership with providers locally to improve standards of care. The reduction in organisational abuse is considered to be an indicator of this proactive approach taken.

Table 5 – Concluded enquiries by type of abuse

Concluded enquiries	2013/14	2014/15	2015/16
Physical Abuse	66	51	74
Sexual Abuse	15	12	20
Psychological Abuse	41	44	66
Financial or Material Abuse	39	40	62
Neglect and Acts of Omission	59	73	85
Discriminatory Abuse	0	1	0
Organisational Abuse	14	10	7
Domestic Abuse	-	-	28
Sexual Exploitation	-	-	1
Modern Slavery	-	-	0
Self-Neglect	-	-	44

Figure 1 – Type of abuse 2015/16



Location of alleged abuse

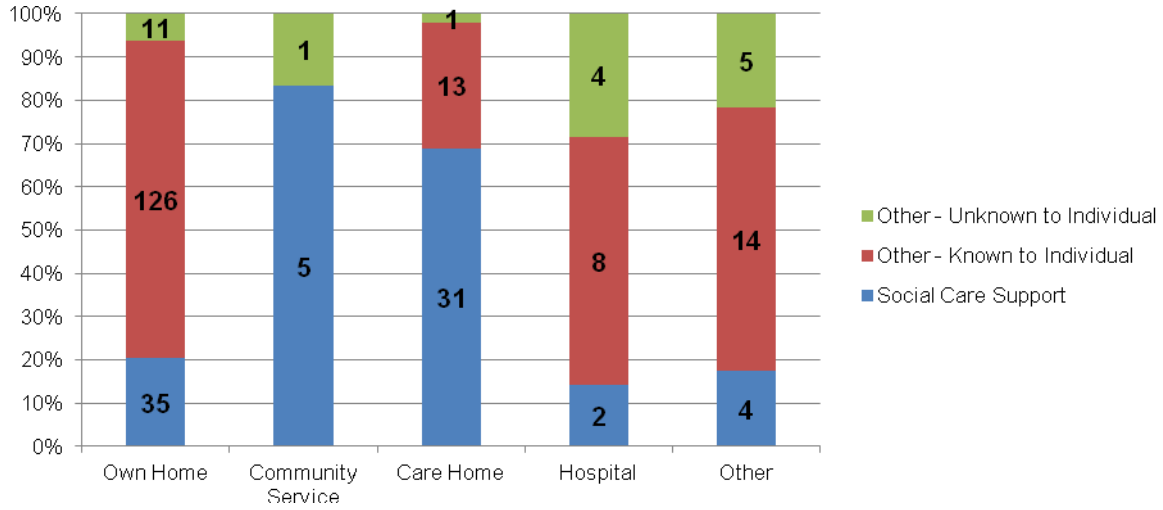
As with previous years the most common locations where the alleged abuse took place were a person's own home, 66 %, and a care home, 17 %. A person's own home consistently remains the place in which an abusive incident is more likely to occur. This demonstrates the continual need to raise awareness of safeguarding amongst all sectors of society and improving mechanisms to report those incidents.

Table 6 – Location of abuse

Location of abuse	2013/14	2014/15	2015/16
Care home	31	41	45
Hospital	2	3	14
Own home	72	98	172
Community service	9	11	6
Other	8	14	23

Figure 2 shows the breakdown of location of alleged abuse by source of risk. Where the alleged abuse took place in the persons own home, for the majority of cases, 73 %, the source of risk was an individual known to the adult at risk.

Figure 2 – Concluded enquiries by location of alleged abuse and source of risk for 2015/16

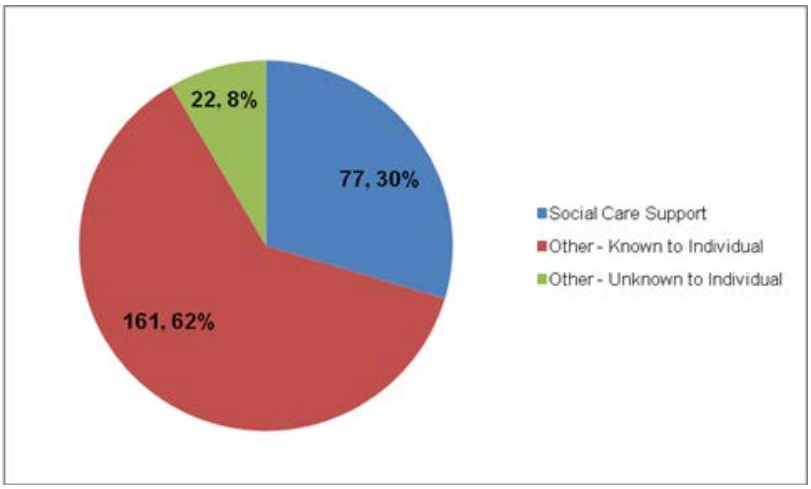


Source of risk

The majority of concluded enquiries involved a source of risk known to the individual. The social care support category refers to any individual or organisation paid, contracted or commissioned to provide social care. Figure 3 demonstrates those sources of risk captured.

Whilst 30% of source of risk attributed to the provision of social care support remains of concern the pro active provision of support from the Care Quality team gives some assurance that issues which could result in a safeguarding enquiry in such settings are being addressed at an early stage.

Figure 3 – Concluded enquiries by source of risk



Action taken and result

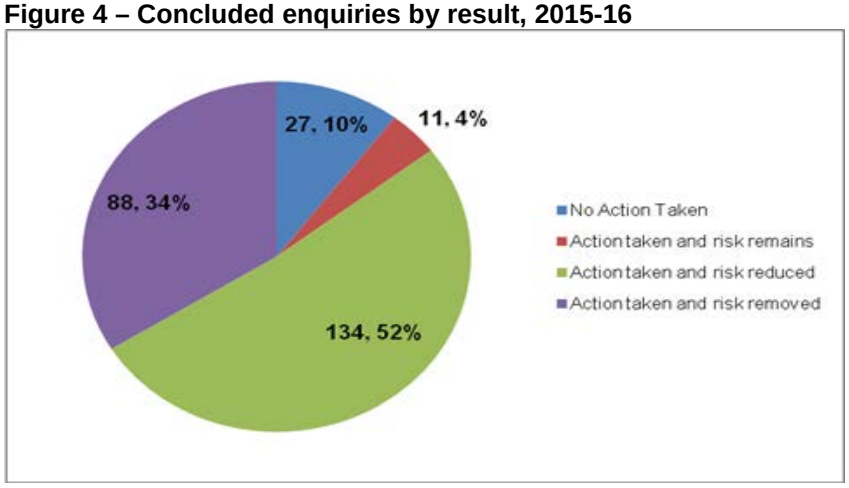
The table below shows concluded enquiries by action taken and result for the last three years.

Table 7 – Concluded enquiries by result

Result	2013/14	2014/15	2015-16
Action Under Safeguarding: Risk Removed	6	11	88
Action Under Safeguarding: Risk Reduced	36	83	134
Action Under Safeguarding: Risk Remains	15	21	11
No Further Action Under Safeguarding	65	32	27
Total Concluded Enquiries	122	162	260

Figure 5 shows concluded enquiries by result for 2015/16. No action was taken under safeguarding in 10 % of cases, while the risk was reduced or removed in 86 % of cases.

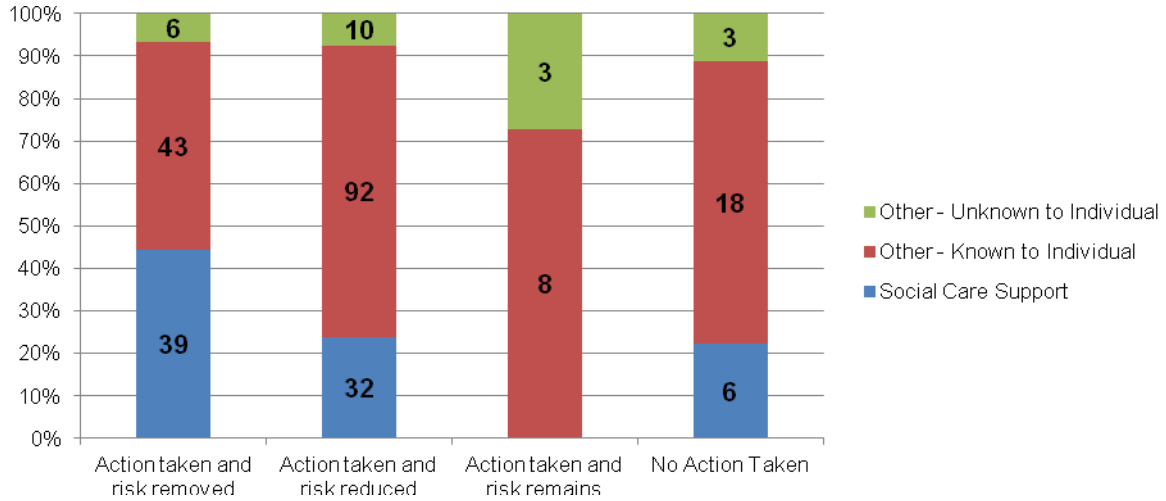
Figure 4 – Concluded enquiries by result, 2015-16



No action may be taken where the client requests that the enquiry come to an end before it has been completed. We are bound to respect the wishes of the client in the majority of cases. In a few exceptional cases the safeguarding team may need to override those wishes. For example where there is a wider public interest in pursuing an enquiry because the alleged perpetrator may pose a risk to others. It is important to recognise the service works with adults who are entitled to make choices, irrespective of how unwise those choices may seem to be, and therefore it is not possible to always remove risk.

Figure 6 shows a breakdown of the results of action taken for concluded enquiries by source of risk for 2015/16.

Figure 5 – Concluded enquiries by result of action taken and source of risk

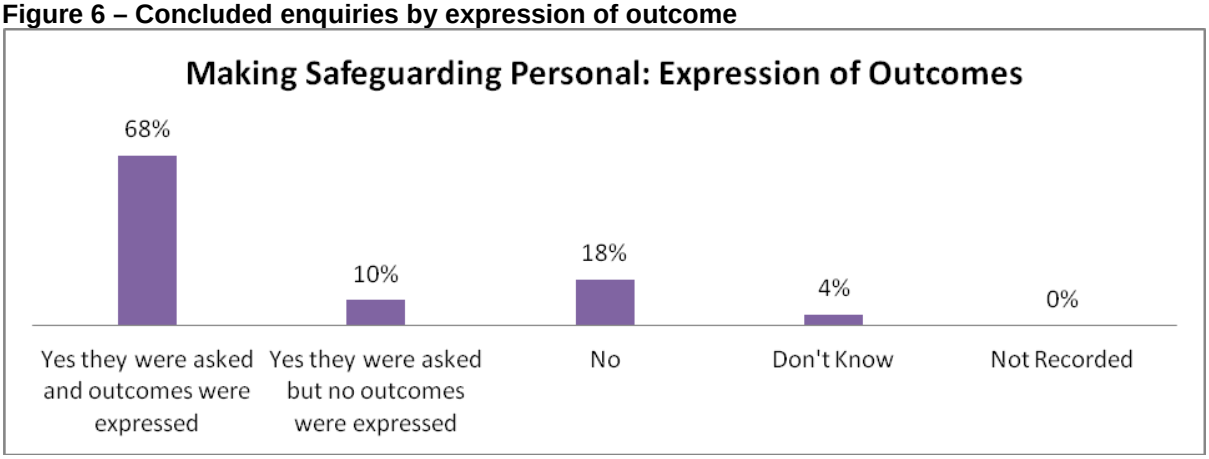


Making Safeguarding Personal

Making Safeguarding Personal (MSP) was a national industry led initiative to improve the experiences and outcomes for adults involved in a safeguarding enquiry. This initiative was adopted by the Government and enshrined in the Care Act 2014. Local Authorities are not currently statutorily required to report on MSP.

Notwithstanding, West Berkshire Council has chosen to monitor performance in this key area.

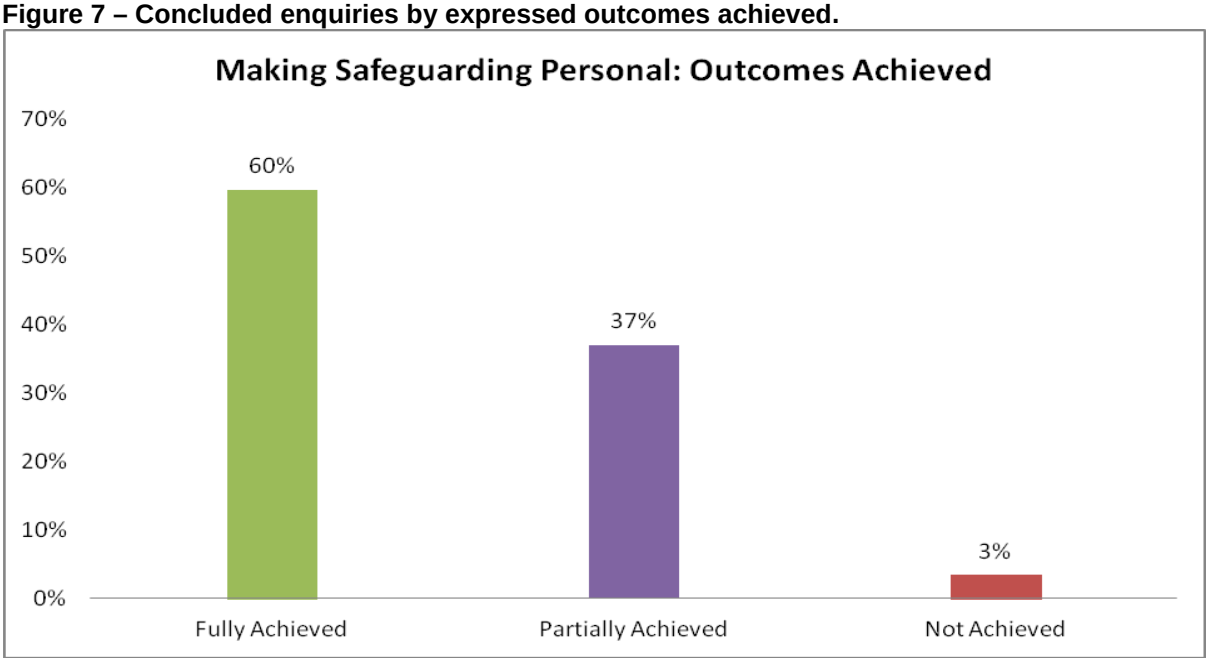
Figure 6 – Concluded enquiries by expression of outcome



By definition, a personal response to a safeguarding incident will mean different things to different people. Therefore obtaining baseline data for outcomes has presented challenges this financial year. Figure 7 demonstrates the outcome of this challenge.

As at year end, 78% of all clients for whom there was a concluded case were asked about the outcomes they desired (either directly or through an advocate). In order to benchmark usefully, options for outcomes were included as a guide, with an additional box for free text to capture those desired outcomes and wishes that were not reflected in the options provided. Clients can choose as many outcomes as they wish and so multiple choices are normal. The option 'to be and to feel safe' was most frequently selected. Of those asked, 10% did not express an outcome. Whilst this is positive, there remains 22% who did not engage in this process. These cases have been subject to further scrutiny to establish the reason engagement was not achieved and where necessary lessons learned going forward.

Figure 7 – Concluded enquiries by expressed outcomes achieved.



Of those who were asked and expressed a desired outcome, 60% were able to achieve those outcomes fully, with a further 37% partially achieved. We anticipate this to settle as the MSP method of working becomes more embedded in the new reporting year and aligns with the New Ways of Working in Adult Social care – a strengths based approach to working with adults who may have social care needs. In 16/17 further work will be carried out to audit the quality of the work done with service users to identify their outcomes.

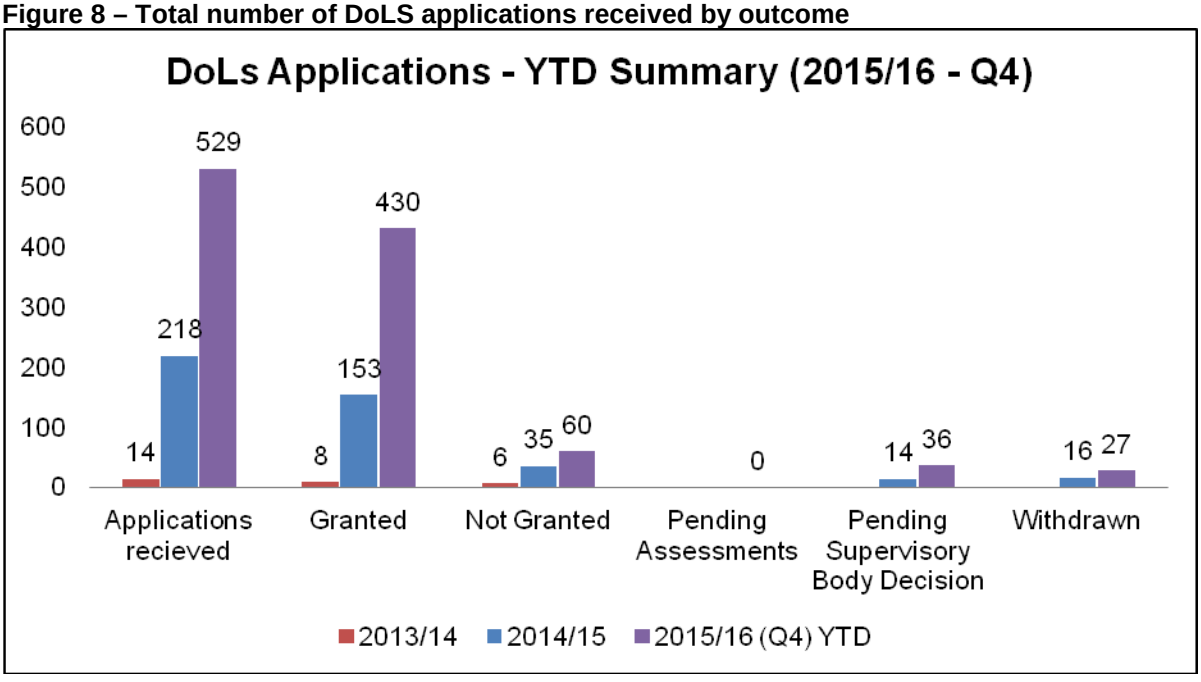
Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 and applies in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.

Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

DoLS authorisations must be applied for by care homes, nursing homes or hospitals (The Managing Authority) where they believe a person is living in circumstances that amount to a deprivation of liberty and that person lacks the capacity to consent to their care, treatment and accommodation, in order to prevent them from coming to harm. They apply to the Local Authority (The Supervisory Body) whose role is to arrange for the persons circumstances to be assessed in order to determine whether to grant or refuse an authorisation for those circumstances. Those living in other settings must have their deprivation considered by the Court of Protection.

Figure 8 – Total number of DoLS applications received by outcome



As at the end of 2014/15 there were 218 DoLS applications in total and a predicted total of 525 for cases for 2015/16. The actual final figure was 529 with 430 of those authorised, 60 not authorised (for example a person is assessed as having capacity), 27 withdrawn (for example an application from a hospital where the patient is discharged before the assessment process is completed) and 36 pending a decision as at year end. The figure of 529 represents a 142% increase of applications received in 2014/15.

The increase in West Berkshire is reflective of increases nationally following a Supreme Court judgement in March 2014 known as Cheshire West which significantly increased the scope of the scheme. It is expected the demand for 2016/17 will see a further increase of approximately 30%.

Activities

A Safeguarding Service User Group was set up In West Berkshire to provide a setting in which service users across the spectrum of adult social care needs could engage with the safeguarding team direct, share information, solve problems and increase awareness through a cascade process.

The group was consulted on a Safeguarding Adults publicity campaign planned for early 2016/17. They were integral to the development of the publicity material including posters and leaflets, commenting on language, visuals and accessibility. In addition the group developed a safeguarding alert card for people to carry with them when they are in the community. The card has been designed to support a person to ask for help from the community if they feel unsafe.

A series of talks and events were attended by members of the safeguarding team in order to increase awareness of safeguarding across a range of settings including an evening talk to the Newbury Neighbourhood Watch scheme, delivery of an interactive session on safeguarding for service users of a supported living scheme locally and a hosting a stall at the Parish Councillors Conference.

A peer review of the safeguarding adults function was conducted by the Association of Directors of Adult Social Services (ADASS). The peer review was conducted over three days in December 2015 and included consultation with staff, external partners and providers. Feedback from the review was positive. An action plan was developed as a result of the recommendations made and the actions will be carried out during the 2016/17 period.

In partnership with our fellow Safeguarding Adults Board members a series of Making Safeguarding Personal training sessions for all Adult Social Care practitioners was held across the partnership area during the reporting period. West Berkshire hosted two full days of training in Newbury. Further to this, a series of workshops on this topic for our providers is planned for 2016/17.

The service supported a joint conference for adult and children's social care staff organised by the West of Berkshire Safeguarding Adult Partnership Board and the 3 Local Safeguarding Children's Boards in the Berkshire West area. This conference is an annual event.

The Future

Plans for 2016/17 include the launch of the community alert cards and the new publicity campaign developed in partnership with the Service Users Safeguarding Group.

There are also plans to develop an effective feedback process for those who have experienced a safeguarding episode. It is intended the Service User Group will be instrumental in designing the tools that may be used to capture the feedback

A new action plan for 2016/17 developed by the Safeguarding Adults Forum will be carried out. This includes partnership working with our colleagues in Trading Standards to tackle scams; doorstep and online scams and to support them in raising awareness with banks and building societies of coercive tactics to get vulnerable adults to withdraw large sums. This plan can be seen at Appendix 1.

The recommendations of the ADASS peer review have been drawn into an action plan that will continue to be carried out supporting the service to improve the safeguarding experience for people through the continued development of Making Safeguarding Personal across the Council and its partners.

Appendix 1

SAFEGUARDING ADULTS FORUM
WEST BERKSHIRE

ACTION PLAN 2016/17

This action plan is drawn from the West of Berkshire Safeguarding Adults Partnership Board 2015-18 Strategic Priorities and the principles underpinning safeguarding activity. This plan is a living document and may alter according to changing priorities identified through the West of Berkshire SAPB and any local issues arising.

Priority 1 – Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and Boards			
Objectives:	**Purpose:**		
Support the safeguarding adults service user forum to develop the skills and capacity to review and quality assure our customer facing information and consider their recommendations in our responses.	To ensure a third party is scrutinising safeguarding adults communications, for example our web site interface, for ease of access, user friendliness and impact	Jenny Symons	30.09.16
Develop a mechanism for routinely auditing safeguarding cases against the 6 principles, utilising the Wokingham documentation	To ensure consistent responses and interventions within the safeguarding framework are achieved across West Berkshire underpinned by the 6 core principles, and to learn from examples of good and poor practice.	Sue Brain	Ongoing
To submit the 2016/17 action plan to the Safer Communities Partnership for their information and to submit a short report at year end to advise on progress	To ensure the Safer Communities Partnership are sighted on the safeguarding adults action plan and to embed the principles and actions across multi agency settings	Susan Powell/Sue Brain	End of July 2016

To audit local providers and partners to establish how the profile of safeguarding adults is maintained within their organisations	To be assured that the subject of safeguarding adults is actively promoted and acted upon within our partner organisations	Sue Brain	31.12.16
Priority 2 – Making Safeguarding Personal			
Objectives:	**Purpose:**		
Develop a provider appropriate MSP workshop in partnership with the Learning and Development Subgroup of the SAB and deliver those workshops throughout partner agencies	To improve understanding and knowledge of MSP; the principles and application of the concept	Safeguarding Adults Team	31.03.17
Work with partners to develop internal resources within each agency to facilitate feedback from service users in relation to a safeguarding intervention they have experienced.	To collect information, including anecdotal evidence, pertaining to a person's recent experience of the safeguarding process in a consistent and user friendly way. To enable the partnership to consider the anonymised data drawn from this feedback to enable any changes to procedure etc to be considered. To use the information and evidence gathered to learn lessons and subsequently reassure people who are entering the process that their interests are of primary concern.	All forum members	31.03.17
To provide information on a quarterly basis that can be developed into a blog currently being progressed by the Safer Communities Partnership communication process.	Share information to a wider audience about safeguarding, the personalisation agenda in safeguarding and various approached available that can be adapted to suit presenting needs. This might be themed by abuse type	Safeguarding Adults Team/Safer Communities Partnership	31.08.16
Priority 3 – Raise awareness of safeguarding adults, the work of the Safeguarding Adults Board and improve engagement with a wider range of stakeholders			

Objective:	**Purpose:**		
Publish and promote new Pan Berkshire Policy and Procedures through Provider Forum, website and Care Quality newsletter	To increase awareness of the multi agency policy and procedures throughout the provider market and improve rates of compliance.	Safeguarding Adults Team	30.04.16
Agencies to review and where necessary update policies and procedures for safeguarding to reflect changes to practice or process captured within the Pan Berkshire Policies and Procedures	To ensure consistency in safeguarding policy and practice across the West Berkshire area	All forum members	31.05.16
Develop a communications strategy to share best practice and learning from SAR's including circulation of the Forum Learning Log	To improve knowledge of best practice and share learning from local and nationally published SAR's	MDT working group	30.06.16
Launch the safeguarding adults publicity campaign and service user community alert cards in partnership with the safeguarding adults service user group	To improve knowledge of safeguarding adults, facilitate greater knowledge of the reporting process and provide a mechanism to develop a safety network for service users in communities across the West Berkshire district.	Safeguarding Adults Forum/Safeguarding Adults Service User Group/Safer Communities Partnership	15.05.16
Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users			
Objective:	**Purpose:**		
Develop a communications strategy to share best practice and learning from SAR's including circulation of the Forum Learning Log and network meetings	To improve knowledge of best practice and share learning from local and nationally published SAR's	MDT working group	30.06.16

Develop and deliver a training programme specifically for Trading Standards and Environmental Health to support the safeguarding process and improve outcomes for people who are at risk from rogue traders and scammers	To increase the understanding of safeguarding and mental capacity within the wider workforce and disciplines within the Local Authority with a statutory function and to deliver a coordinated response to those at risk from scams and rogue trading.	West Berkshire LA/Wokingham LA training teams	30.06.16
To work in partnership with the LA's Principal Social Worker, Adult Social Care and key partners to develop and implement processes that improves the responses for those individuals who do not meet thresholds for a safeguarding response, yet remain at risk	To re-evaluate the pathways that exist for individuals who are not captured by traditional service referral routes and implement a process that takes account of their risk factors	TVP/Principal SW/Safer Communities/Safeguarding Team	
Priority 5 - Coordinate and ensure the appropriate application of safeguarding processes across agencies			
Objective:	**Purpose:**		
Coordinate a joint process between TVP and West Berkshire ASC, including other relevant parties as required, to ensure those who have a history of wandering are identified and linked into all appropriate services as quickly as possible	To improve the outcomes for people who wander with an overall outcome to support a reduction in the number of non crime related call outs for TVP.	ASC/TVP	
Promote greater understanding of the principles of coercion and control within the context of	To be assured agencies are able to identify and respond consistently and sensitively to situations of coercion and control.	Safer Communities/A2 Dominion/Safeguarding Team	

Domestic Abuse, through DASH/MARAC training, DA champion's network and other routes.			
Work with other agencies to improve knowledge and understanding of self neglect, thresholds and responses, by including appropriate case studies in L2 & 3 safeguarding training, sharing the national clutter index and tools available and clarifying options for support.	To ensure consistency in identifying, reporting and responding to cases of self neglect. To be assured that agencies are conversant in the different interventions available and sources of appropriate help for any clients they have concerns for.	Safeguarding Team/Sovereign Housing/WBC	31.03.17
Develop and deliver training to professionals in the banking sector to enable them to identify financial abuse through targeting unusual transactions of elderly and/or vulnerable clients and supporting them to respond appropriately	Raise awareness of financial abuse and encourage professional responses to concerns identified when it occurs at the earliest opportunity	Trading Standards	31.12.16
Embed requirements of the Prevent agenda in safeguarding processes through appropriate inclusion in L2 safeguarding training	To maintain knowledge about the Prevent agenda, its principles and the routes to refer.	Safeguarding Adults Team	30.04.16

Safeguarding Adults Training Activity - 1st April 2015 to 31st March 2016

	Number of staff attended training in 2012-13, per sector					
Reading Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	70	208	0	0	0	214
Level 1 Refresher N/A	0	0	0	0	0	
Level 1 E-learning						
Level 2	34	29	2	0	0	
Level 3	4	15	1	0	0	
Level 1 Train the Trainer	0	6	0	0	0	
RBC Total	**108**	**258**	**3**	**0**	**0**	**214**
West Berkshire Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	42	93	1			132
Level 1 Refresher	34	15				
Level 1 E-learning	56	92				
Level 2	26	9				
Level 3	12	7				
Level 1 Train the Trainer						
WeBC Total	**170**	**216**	**1**	**0**	**0**	**132**
Wokingham Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	75	91	0	0	0	131
Level 1 Refresher N/A						
Level1 E-learning N/A						
Level 2	55	41	2	0	0	
Level 3	18	5	2	0	0	
Level 1 Train the Trainer	2	7	0	0	1	
WoBC Total	**150**	**144**	**4**	**0**	**1**	**131**
Berkshire Healthcare NHS Foundation Trust	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	
Level 1	993				32	
Level1 E-learning	548					
Level 2	481				3	
BHFT Total	2022				35	
Royal Berkshire Hospital NHS Foundation Trust	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**	
Level 1				91.40%		
Level 1 E-learning						
Level 2						
RBH Total	**0**	**0**			**0**	
West Berkshire CCG	**Staff**	**PVI**	**BHFT**	**RBH**	**GPs**	
Level 1					259	
Level 1 E-learning						
Level 2					49	
West Berks CCG Total	**0**	**0**	**0**	**0**	**308**	

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP SERVICES

TO:	**Health and Wellbeing Board**		
DATE:	**27th January 2017**	**AGENDA ITEM:**	**17**
TITLE:	**Reading Local safeguarding Children Board Annual Report**		
LEAD COUNCILLOR:	**Cllr Jan Gavin**	**PORTFOLIO:**	**Children's Services**
SERVICE:	**Children's Services**	**WARDS:**	**Boroughwide**
LEAD OFFICER:	**Esther Blake**	**TEL:**	**X73269**
JOB TITLE:	**Business Manager for Reading LSCB and Children's Trust Partnership**	**E-MAIL:**	**Esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

1.2 This Annual Report is being presented to the Health and Wellbeing Board to ensure members are informed about the achievements of the LSCB for the 2015/2016 financial year. The Annual Report has a wide distribution and is sent to key stakeholders and partners so that they can be informed about the work and use the information in planning within their own organisations to keep children and young people safe.

2. RECOMMENDED ACTION

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

3. POLICY CONTEXT

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

3.2 In line with this statutory guidance the report is presented to the Health and Wellbeing Board for information. It has also been presented to the Adult Social Care, Children's Services and Education Committee and the Children's Trust Board.

4. THE PROPOSAL

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

4.2 This report focusses on the achievements and ongoing challenges for the LSCB and partners specifically against our priorities. The priorities for the 2015/16 year were:

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

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

4.4 The annual report in previous years has focused on work being carried out individually by LSCB partners, however it is positive that this year the content reflects more widely the work undertaken in partnership.

4.4 In summary, key LSCB achievements for 2015/16 are listed below under the priority headings. Also listed are the ongoing concerns which the LSCB will continue to challenge in 2016/17, all of which are included within the LSCB Improvement and Development Plan for 2017.

4.5 **Priority - Domestic Abuse**

Achievements:

- LSCB input and endorsement of the Domestic Abuse Strategy 2015-18, managed through the Domestic Abuse Strategy Group (sub group of the Community Safety Partnership).
- Continued support for the Family Choices Programme for families affected by domestic abuse.
- Support, through Public Health, for the IRIS project to support and training GP practices in how to identify domestic abuse and make referrals.
- Domestic Abuse Challenge session identified key areas of progress required in 2016/17.

Ongoing Challenges:

- A consistent and comprehensive approach to deliver information and support to schools needs to be further developed.
- Establish a system which allows schools to receive domestic abuse notifications.

4.6 **Priority - Strengthening the Child's Journey and Voice**

Achievements:

- The Youth Cabinet carried out a domestic abuse survey which was presented to the Board and recommendations discussed and agreed.
- Emotional Health and Wellbeing was identified as a key issue by children and young people and is a key priority for 2016/17.
- LSCB has continued to fund the MoMo app which provides young people an easy way to get in touch with Children's Social Care. Up to April 2016 46 submissions had been made.

Ongoing Challenges:

- To better include the direct voice of young people at our Board meetings.
- A review of the MoMo app is required to ensure it is value for money and effective.

4.7 **Priority - CSE and other Particularly Vulnerable Groups**

Achievements:

- A clear multi-agency LSCB CSE strategy is in place with a live action plan.
- The CSE toolkit and screening tool was rolled out in June 2015 attended by 100 practitioners and managers from across the partnership.
- The LSCB funded productions of Chelsea's Choice in all Reading secondary schools reaching approximately 2000 pupils.
- CSE training continues to be offered to LSCB partners at universal, targeted and specialist levels, with attendees reporting that their knowledge has either significantly or very significantly improved.
- 7,000 CSE Safeguarding Business Cards, produced and funded through the LSCB have been distributed across the partnership.
- There has been increased referrals to SEMRAC (Sexual Exploitation and Missing Risk Assessment Conference) as professional knowledge of CSE indicators increases.
- Improved notification and recording of missing children information and the creation of a dedicated Missing Children Coordinator since January 2016 has enabled better reporting and understanding of the issues and better inter-agency sharing of information.
- The number of successful missing children interviews has been steadily increasing, and issues identified through these meetings have been reported to Children's Social Care. However the timeliness of these interviews needs to increase.
- An LSCB task and finish group was established to gain a better understanding of the risk of Female Genital Mutilation in Reading, establish the processes already in place and what improvements are required. An action plan and strategy were written, which led to reviewing and improving training opportunities for front line practitioners, production of a clear risk assessment tool with identified pathways for all front line staff to follow.

Ongoing Challenges:

- Further training on CSE is required for schools and the voluntary sector to improve knowledge of indicators and pathways.
- A revised CSE risk assessment tool needs to be rolled out and embedded.
- The timeliness of missing children interviews needs to improve to ensure vital information can be captured as soon as possible after the child/young person returns home.
- The FGM guidance and tool kit needs to be embedded in front line practice, with available training opportunities.

4.8 **Priority - Neglect**

Achievements:

- The LSCB produced a Neglect Protocol with clear recommendations for all partners.
- Information from the LSCB regarding neglect was produced and disseminated, this included:
    - the production of a booklet that identified signs, symptoms and effects of neglect
    - introduction of a 'neglect' page on the LSCB website

- training template written to help practitioners understand, identify and respond to neglect
- neglect briefing session delivered to school designated safeguarding leads.

- The Thresholds document was significantly reviewed and revised in late 2015, with new posters and guidance booklets distributed to all partners. Over 350 front line staff attended launch workshops, and threshold information is now a key part of universal safeguarding training.

Ongoing Challenges:

- The LSCB recognised that there had been a lack of progress in this priority area and as a result task and finish group has been set up for 2016/17 to push this work forward. This group has written a strategy and action plan.
- The regular review of thresholds needs to target key areas of the partnership where inappropriate or no referrals are being made.

4.9 **Priority - Effectiveness and Impact of Reading LSCB**

Achievements:

- A risk and concern log has been established and embedded which is reviewed at each Board meeting to ensure any concerns are kept live until resolved.
- Boards meetings reflect greater challenge and Board members feel more confident in expressing views and holding partner agencies to account.
- LSCB Sub Groups have been restructured to ensure a local focus on quality assurance and performance. Performance data and auditing outcomes are expected and presented at every Board meeting.
- The LSCB training offer has been discussed at Board level to ensure all Board members had oversight of this vital element of the LSCB.
- Reading LSCB has funded Reading Children and Voluntary Youth Services (RCVYS) to provide a range of safeguarding training courses directly to the voluntary sector. In 2015/16 64 different organisations attended training courses which includes universal safeguarding training, managing safeguarding within your organisation, trustee's awareness training and train the trainer training for voluntary sector early years providers.
- LSCB communications has improved with:
  - a revised website with dedicated pages to key safeguarding priorities
  - 'Safeguarding is Everyone's Business' video created and disseminated to partners
  - CSE Safeguarding business cards and threshold documentation disseminated to front line practitioners
  - regular newsletters and weekly information bulletins are produced and sent out for dissemination via the Board.

Ongoing Challenges:

- Further strengthen the governance of the LSCB and its sub groups to ensure better communication with the Board and members.
- Continue to strengthen the auditing and performance review function to ensure the Board can hear and discuss the learning/issues raised.
- Ensure the LSCB Training offer within Reading has a more specific focus on the needs of the Reading workforce.
- Further communication and awareness raising is targeted, such as thresholds information to those practitioner groups that currently make inappropriate or no referrals.
- Learning from audits and reviews are better disseminated to front line practitioners to support improvements in practice.

4.10 The Annual Report relates specifically to the 2015/16 year, however there have been a number of developments since March. These include:

- FGM resource pack (including guidance, risk assessment tool and pathways) was successfully launched to 100 staff from across the partnership.
- A range of factsheets on topics such as FGM, thresholds, Prevent and Private Fostering have been produced and can be found on the website.
- School Designated Safeguarding Leads have been running through out 2016 and are routinely attended by up to 40 school colleagues. These focus on specific topics identified by attendees but also provide an opportunity to disseminate safeguarding information direct to schools.
- The Thresholds document has been reviewed by partners and updated in line with current key priority areas such as CSE, FGM and neglect. Updated guidance, posters have been produced and disseminated, along with a new 'top tips for making safeguarding decisions' sheet and thresholds business cards.
- A Safer Recruitment e-learning package has been created in Reading and shared with partners across the west of Berkshire. An FGM e-learning package to support practitioners in understanding the pathways and completing the risk assessment tool is currently being produced.
- New induction packs have been created and distributed to all Board members, plus to sub-groups, to support new members of the LSCB understand their roles and responsibilities. Board members have also signed the revised member compact and agreed a revised Learning and Improvement Framework.
- CSE Training has been revised to include practical application of CSE tools. CSE short courses have been developed and CSE champions trained to deliver these in schools and to the VCS.
- Processes and forms in relation to missing children have been revised to enable the collection of better information in a more timely way.
- Neglect strategy and action plan written and progress is being made, for example guidance on completing chronologies is being produced and training options are being explored.
- A range of training opportunities are being progressed to compliment the traditional LSCB safeguarding programme, such as LSCB Forums which will be short two hour sessions.
- A twitter account was launched in April, currently with 226 followers.

4.11 Ofsted Inspection May/June 2016 – Ofsted agreed that progress had been made within the 2015/16 year citing 'positive change' and that 'the challenge and concern log facilitates active challenge, and has led to practice improvements'. Ofsted graded the LSCB as 'Requires Improvement' and made five recommendations which have been clearly included within the highlighted ongoing challenges for the Board. All challenges are included as part of the LSCB Improvement and Development Plan for 2017.

5. CONTRIBUTION TO STRATEGIC AIMS

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

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

6. COMMUNITY ENGAGEMENT AND INFORMATION

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

7. EQUALITY IMPACT ASSESSMENT

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

8. LEGAL IMPLICATIONS

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

9. FINANCIAL IMPLICATIONS

9.1 None

10. BACKGROUND PAPERS

- Reading LSCB Annual Report 2015/16

Reading Local Safeguarding Children Board

Annual Report 2015-2016

Reading Local Safeguarding Children Board

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Forward

Welcome to the 2015/16 Annual Report for Reading Local Safeguarding Children Board. I am very pleased to present the achievements of the Board over the past year in relation to its key statutory duties and the Board's priority themes, agreed in consultation with children and young people and with agency partners on the basis of learning from outcome data, multi-agency audits and from reviews of children's cases. The report also sets out the remaining challenges we face and work we need to do together to deliver fully on our agreed priorities. I am committed to working with partners to further increase the pace of change and deliver better outcomes for children, young people and their families, over the next year.

I hope you will agree that the report shows that the Safeguarding Board is in a very different place than it was this time last year. Strong progress has been made to get basic systems, processes and governance arrangements in place including more robust quality and performance information to enable partners to more effectively challenge and support each other in the collective interest of safeguarding Reading children. I am pleased also at the progress that has been made to involve children and young people in the work of the Board and to contribute their thinking on priorities. Examples include the children and young people's annual report and the consultations undertaken by the Youth Cabinet, in particular their targeted work on children's mental health services and promotion of emotional health and well-being. I would also highlight the much stronger engagement now with schools in the work of the Board and the contribution they are now making to keep children safe and to support those pupils who are vulnerable or have more complex needs.

The Ofsted Inspection of Reading in June 2016 confirmed the Board's own assessment of 'Requiring Improvement' but making progress toward meeting the requirements of a Good Rating. This report shows evidence of some strong improvements in agency practice and some improved outcomes for children and young people. These include the notable increase in referrals to Early Help services and the further development of early support services. This has resulted in a higher proportion of children and families receiving a support service with some good outcomes for those families reported. This is reflected in the relatively low proportion being referred back into Children's Social Care. We will work across the partnership to extend the reach of these services further during 2016/17, resolving problems at an earlier stage and reducing the need for more formal interventions involving safeguarding and looked after children's services.

I would like to say a big thank you to all the agency partners represented on the Board, for their hard work and joint ownership of the challenges and opportunities we face. Also to the LSCB Sub-Group Chairs, Esther Blake and Donna Gray in the Reading LSCB team who, with Gary Campbell and other senior managers, have given their all to support and drive the Board's improvement.

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

Local context

Our Town

Reading is a vibrant multi-cultural town: the second most ethnically diverse in the South East outside London. Reading is home to approximately 35,850 children and young people under the age of 18 years. This is 22% of the total population in the area. (ONS Mid-Year Population Estimates 2014).

What are the needs? (Figures as at 31st March 2016)

Approx. 24%children in Reading live in poverty

184 children and young people are living with their families in B&B

253 children and young people subject to Child Protection Plan (March 2016)

220 Looked After Children

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

589 identified Young Carers

52% of school population belongs to an ethnic group other than White British (29% in England overall)

259 families were receiving a Health Visiting Service at Universal Partnership Plus Level (Q3)

100 Young Offenders

27 Looked After Children and Young People have a disability (March 16)

66 Teenage Conceptions (2014). (rate per 1000 15-17 year olds = 26.9, England average in 2013= 24.5)

34 Looked after Children from other LA areas living in Reading (Jan 2016)

Of the 43 children reported missing in March 2016, 40 received a Return Interview, 24 within 72 hours of CSC being notified

124 Number of identified vulnerable mothers worked with by midwifery (Dec 2015 annual figure)

12 young people identified at risk of Child Sexual Exploitation (figure for

During 2015 there were 97 children referred to Tier 3 mental health services. 10 Looked after Children and 29 Young People Subject to a protection plan were accessing CAMHS (Q3)

26.7% of Police Domestic Violence notifications sent to MASH lead to a referral (March 2016)

67% of families subject to a CP, CAF or CIN Plan are using Children's Centre services

60% of Looked after Children are in stable placements

Proportion of children entitled to free school meals: Primary 15.3% (National average 15.6%)

The proportion of children and young people with English as an additional language:
Primary 35% (National average 19.4%)
Secondary 26% (National average 15.0%)

177 referrals to Children's Social Care from the Royal Berkshire Hospital Emergency Department, 131 of them being for self harm (Q4, West of Berks)

3 known Privately Fostered Children

534 missing episodes were reported to Children's Social Care for 394 individual young people in 2015/16

32 (19%) of cases referred to the Multi-Agency Risk Assessment Conference (MARAC) are repeat cases

49% of Looked after Children are placed more than 20 miles away from their home address

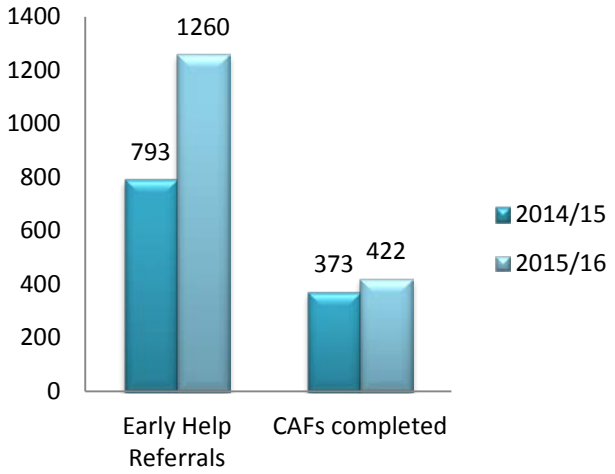
55.3% of 253 children and young people have a child protection plan for neglect

Journey through Children's Services

Early Help:

There is a well-established Early Help Service which includes 13 Children's Centres delivering services to families across Reading. These children's centres have good attendance rates across the clusters, particularly from targeted groups. 11165 children have used the Children's Centres which is 90% of 0-5 population.

Early Help Referrals and the number of Common Assessments (CAF) completed have increased in 2015/16 compared to the previous year. Schools, Children's Centres, Early Help and Children's Social Care continue to be the main sources of requests for help. All CAFs continue to be quality assured at point of submission to ensure that the importance of the Voice of Child, multi-agency contributions and clear analysis leading to a plan of support is in place.



Cases are 'stepped up' to children's social work services where required, with all 'step up' referrals submitted through the Multi Agency Safeguarding Hub (MASH) to ensure a greater consistency of thresholds. 339 cases have been 'stepped down' to the Children's Action Teams (year to date March 2016) from the MASH, A&A or Area teams. Joint home visits or handover TACs (Team around the Child) are well established so that families do not experience any loss of support when cases are transferred and/or stepped down.

A revised Early Help pathway was implemented in early 2016 meaning that referrals for all early help services come through 'one front door', using a web based contact form. Once submitted to the Early Help Hub decisions are made as to what support is to be offered, building upon the already established multi-agency meeting.

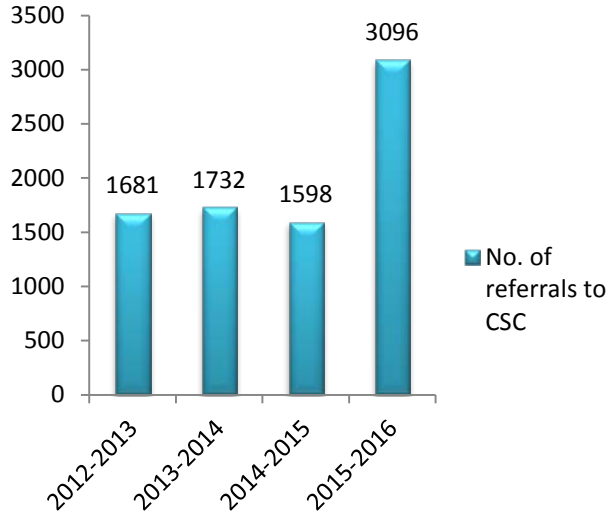
The Children's Action Teams (CATs) are multi-professional teams that link into existing local resources to provide holistic family support, early intervention and prevention services for children 0 to 19 year old and their families. Alongside the CATs, the Specialist Youth Services provides more targeted support to the most vulnerable young people, such as those at risk of teenage pregnancy or sexual exploitation, young people with drug and alcohol misuse issues, young parents, young carers and LGBT young people. For more vulnerable families where children are close to social care involvement, services and interventions such as the Edge of Care team and Multi Systemic Therapy Team work with families and provide more intensive, high-level support alongside other agencies.

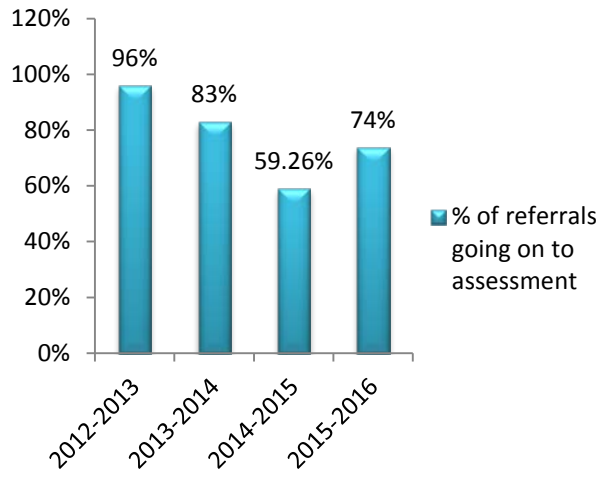
83% of referrals to Early Help access a service or intervention depending on the presenting need. As at March 2016, only 7% of closed CAT cases were referred back to social care within 3 months of closure.

Children's Social Care:

The MASH team provides the 'front door' or entry point to Children's Social Care. Between 1st April 2015 and 31st March 2016 there was an increasing number of both contacts and referrals - 3096 referrals were accepted and of these 74.2% went onto a single assessment that required a qualified social worker to be allocated to undertake this piece of work to be statutorily compliant. This is almost a two-fold increase requiring a qualified social work intervention.

This was an average of 258 referrals a month. This has grown steadily during the year peaking in March 2016 at 422 referrals for that month. This volume of referral resulted in a rate per 10,000 of 885.9 for Reading with Statistical neighbours at 704.5 and England at 548.3 for 2014/15.



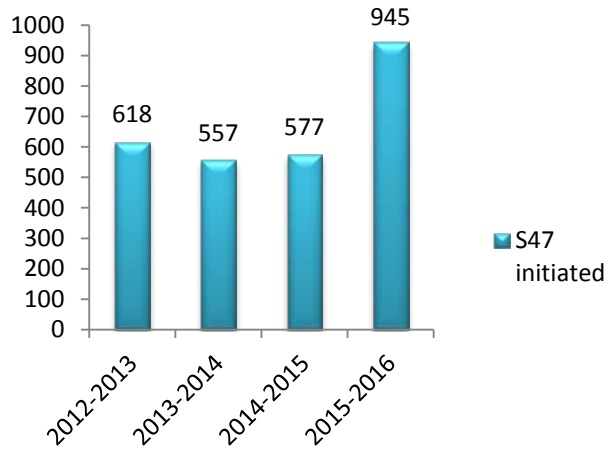


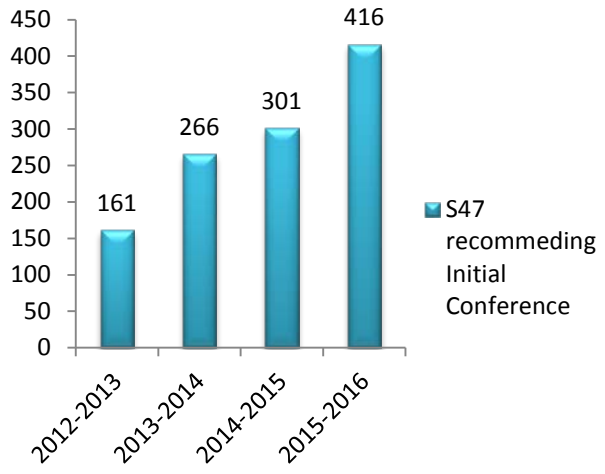
The majority of referrals originated from the Police 33.4% (1035 during 2015-16) with schools being the second highest referrer at 19.22% or 595 for the same period. This also highlights a significant increase in referrals from schools year to date and positively reflects the work undertaken by schools to identify children in need or those who may be at risk of significant harm.

Domestic Abuse has remained the highest reason for referral (629 or 20.3% of referrals). Members of Thames Valley Police are now co located with social work staff in the MASH and all domestic abuse contacts are rigorously screened. Referrals concerning physical abuse (13.57%) and Neglect (9.46%) also remain highly represented.

Section 47 enquiries (undertaken where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm) have increased with 945 enquiries in 2015-16 (rate 272.3 per 10,000 population), an increase from 579 (rate of 161.5 per 10,000) in 2014-15. The statistical neighbour average rate for 2014-15 was 153.4 per 10,000 (the comparative data for 2015/6 is not yet available).

The increase in S47 Enquiries is reflected in a similar increase in the number of Initial Child Protection Case Conferences (ICPC) held with the plan 416 children and young people were considered at ICPC in 2015-16





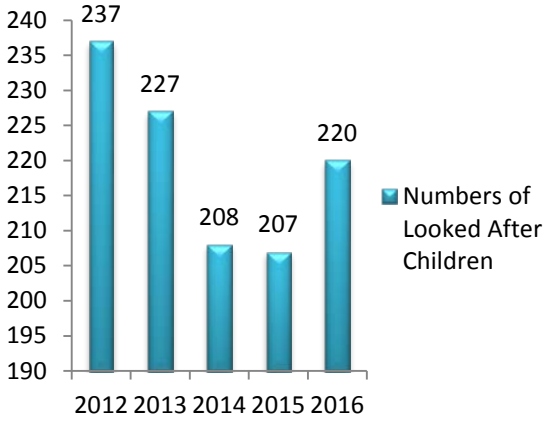
The total number of child protection plans and current breakdown of plans as of 31st March 2016 are:

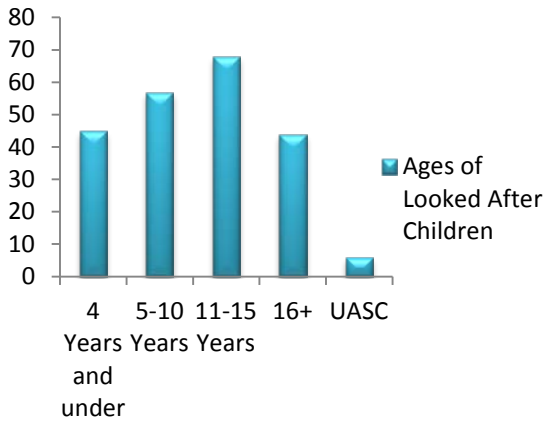
Catergory	0-4 Years Old	5-19 years Old	Total
Emotional Abuse	38	56	94
Neglect	52	95	147
Physical Abuse	2	4	6
Sexual Abuse	1	10	11
Total	93	165	258

As at March 2016, there were 616 children categorised as In Need (rate per 10,000 child population including CP and LAC is 177.5; Statistical Neighbours is 343.8 for 2014/15). At the end of March 2016 58% of our children had CIN plans, but the figure is increasing.

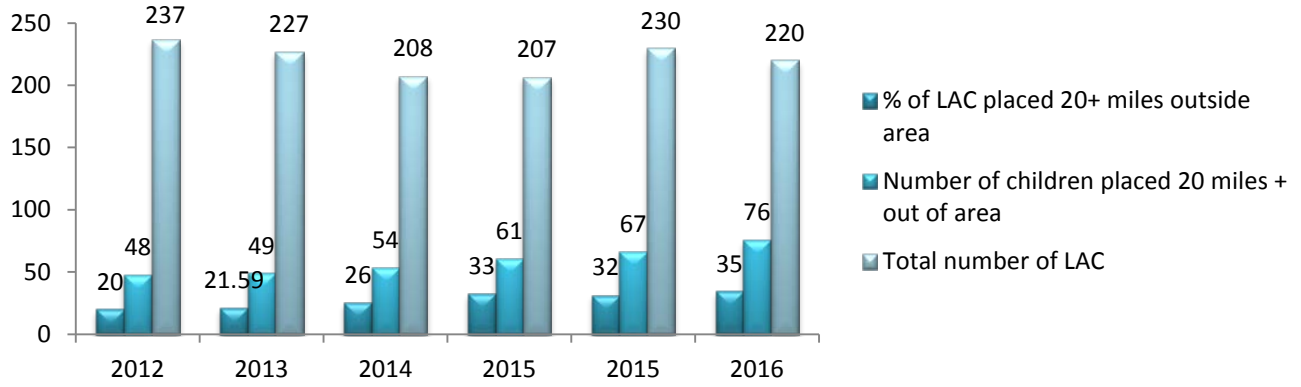
At 31st March 2015-16, there were 220 children and young people Looked After, an increase of 13 compared to last year. This number represents 64 children per 10,000 population, lower than the statistical neighbour average rate of 66.6 per 10,000.

Of our Looked after Children, as at 31st Mar 2016, 116 are male and 104 being female. 114 of these children are noted to have special educational needs.





The lack of local placements in the Reading Borough Council area means that 34.5% of our Looked after Children are placed more than 20 miles away from their home address. While this may be for a positive reason (such as children in adoptive placements or in specialist residential settings) this overall percentage figure must be reduced to retain stability in education provision, receive local health services and remain in contact with their family and community when safe to do so.



Since April 2015 there have been 25 adoptions, 23 children became subject of special guardianship orders, 8 children became subject to Child Arrangements Orders and 133 children ceased to be looked after.

At the end of March 2016 there were 103 young people entitled to services under the Children Leaving Care Act 2000 aged 17-21. 80% had a Pathway Plan which is a significant increase on 27% in April 2015. 39.8% were not in suitable employment, education or training which is slightly higher than the latest Statistical Neighbour benchmark of 39.0%.

Of the 103, 10 young people are in Higher Education and are supported via a bursary from the Local Authority. (87.3%) were in suitable accommodation, this compares to the Statistical Neighbour average of 80.74%.

All care leavers have a Personal Advisor and 85% of care pathway plans are up to date. “Staying Put” regulations have been translated into a policy and implemented from June 2015 currently approximately 6 young people are in this type of arrangement.

Local context

Our Board

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

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in appendix 4, page 50.

Partners in the Board financially contribute specifically to the LSCB to enable it to operate and undertake work against the priorities. Information relating to financial contributions can be found in appendix 5, page 52. Some further work is needed to increase both the overall level of funding to the Board and agency contributions to enable the Board to make progress against its priorities.

Reading LSCB meets up to six times per year for standard Board meetings, where evidence on the delivery of work streams against priorities by the sub-groups is considered; performance and audit information is reviewed and emerging issues discussed. The Board also convenes at least once a year for business planning sessions.

Business Planning:

Business planning sessions allow us to review our impact; recent performance data and audit evidence, to decide if our priorities remain relevant and set new priorities accordingly. In October 2014 board members agreed the priorities for the 2015/16 year which are reported on in this annual report. The business plan written for the year to reflect the agreed priorities has been reviewed regularly and in March 2016 the action plan was finalised. Of the 55 actions identified, 46 were completed and rated as green, with any outstanding actions transferred into the plan for the following year. Some of the completed actions include:

- Domestic Abuse Strategy launched
- CSE Strategy - toolkit and training pathway developed
- Review of thresholds – new guidance has been distributed
- Introduction of Early Help Hub
- Education task and finish group – the reinstated Designated School Safeguarding Leads meetings, has enabled better information dissemination from the Board to schools on key safeguarding messages.

In November 2015 the Board agreed the following priorities for the 2016/17 year. The revised Improvement and Development Plan sets out the actions identified to make progress against these priorities, a copy of which can be found on the Reading LSCB website (www.readinglscb.org.uk):

Priority 1. Children's Emotional Health and Wellbeing

Priority 2. Strengthening the Child's Journey and Voice
Priority 3. Child Sexual Exploitation (CSE)
Priority 4. Neglect
Priority 5. Improving Cultural Confidence and Competence in our Workforce to Meet Children's Needs

Joint working:

Reading is one of six Unitary Authorities in Berkshire and the Board endeavours to work collaboratively with our neighbours to ensure a more joined up approach to safeguarding. This is particularly important where a number of agencies deliver services across a number of LSCB areas and in agreeing a common approach and response to specific safeguarding and child protection issues such as child sexual exploitation and female genital mutilation.

The six Berkshire LSCBs work closely together and many partners are represented on all six Boards. There are three sub-groups of the Board which operate across the whole of the county, and two which focus on the west of Berkshire. Sub groups for quality assurance and performance, and child sexual exploitation are Reading specific to maintain a local focus on current issues. Our LSCB Structure chart can be found in appendix 3, page 49.

LSCB Business Managers and Chairs from across Berkshire meet regularly to share and discuss specific issues; protocols and developments, along with examples of good practice.

Reading LSCB also works closely with a number of partnership boards in the area including the Health and Wellbeing Board, Reading Children's Trust and the Berkshire West Adult Safeguarding Board. A new joint protocol initiated by LSCB has been written to provide greater connectivity across the work of the Boards and clarification of lead and support roles and leadership for new areas. The protocol requires a minimum of one meeting a year of all partnership board chairs and this is facilitated by Reading Borough Council Managing Director.

Priority 1: Domestic Abuse

Using the national definition the number of Domestic Abuse related recorded and non-recorded crime in Reading remains comparatively high, 7.74 and 7.12 per 1,000 population respectively in 2015/16. This is higher than the average across the Thames Valley (4.77 and 5.94 per 1,000 population). Domestic abuse within a family can result in children being subject to a Child Protection Plan due to the physical and emotional impact as well as neglect. The Board has a key role in scrutinising the effectiveness of partner agencies responses to domestic abuse and advising on improvements that can be made in the co-ordination of or development of services to improve safeguarding of children and young people. Domestic Abuse is also a key priority for the Community Safety Partnership (CSP) and the partnership response to this issue has been progressed through the Domestic Abuse Strategy Group, a sub group of the CSP.

Domestic Abuse Strategy 2015-18

The new strategy was launched in 2015 following extensive consultation, with input from LSCB partners. It outlines key areas for the Domestic Abuse Strategy group to focus on and incudes a clear action plan.

Key themes relating to children and young people:
Priority 1 relates to improving information and education to children and young people about what healthy relationships look like and how to keep safe, with a particular focus on continuing to improve the level and quality of PSCHE education in schools.

Priority 2 relates to improving the early identification and interventions of services to domestic abuse by providing the right response the first time, and ensuring clear pathways into services such as Early Help and the Multi-Agency Safeguarding Hub (MASH).

What has been delivered:

- The Domestic Abuse Training sub-group was developed and set out a revised training programme to ensure effective and consistent training across the workforce.
- Successful re-launch of the Domestic Abuse forum.
- Supported by a MARAC improvement plan, and linked to the effective training programme, there has been a focus on increasing referrals to, and improving the effectiveness of the MARAC.
- Specific training for designated MARAC officers has been provided, supported by a standard operating procedure used across Berkshire.
- Introduction of the DARIM (Domestic Abuse Repeat Incident Meeting) which runs in parallel to the MARAC. The MARAC covers high risk cases, but DARIM supports those that have high levels of repeat incidents which in their own do not meet the MARAC threshold. It provides a multi-agency response for medium risk, high volume cases, creating action plans to prevent escalation, reduce risk and reduce impact on numerous services.

- All safeguarding training includes a focus on domestic abuse. This includes the LSCB training and that offered by individual agencies. Partners are made aware that disclosures of domestic abuse involving children should lead to a discussion with Children's Social Care.

What is the evidence:

- 112 delegates have attended level 1 & 2 Domestic Abuse training in 2014/15. The programme to train 160 delegates is in place for 2016/17.
- Specific risk assessment (DASH) training has been delivered to 57 new starters in social care teams during early 2016.
- 5 well attended Domestic Abuse forums delivered in 2015/16 creating a network of 191 front line professionals.
- A significant increase in MARAC referrals (28%). In 2015/16 185 referrals were received - up from 144 in 14/15. This means the number of cases per 10,000 female population has increased from 22 to 29 and is converging on the national average (33).
- 41% of referrals were from partner agencies in 15/16, increasing from 27% in 2014/15.
- In Reading an individual is referred to DARIM if there are more than 6 reports to the police in the last 3 months. Circa 190 cases were discussed in 2015/16. This, and the DA activity as a whole, has a clear links with the Troubled Families programme in Reading and effective links across work programmes have been made both strategically and operationally.
- Circa 270 individuals have engaged in the 'Breaking the Cycle' course delivered by Berkshire Women's Aid (BWA) in 2015/16.
- 26 perpetrators have engaged with the Family Choices programme to address their abusive behaviour (holistic family support).

What has been the impact:

- The increase in referrals to MARAC has resulted in a corresponding increase in children discussed at the MARAC, raising from 188 in 2014/15 to 250 in 2015/16.
- 216 young people have been referred to support services (BWA young people programme) in 2015/16 (up 24% from previous year).
- 44 out of 64 (69%) of adults referred to the Family Choice programme engaged with the programme in 15/16.
- 19 cases of whole family engagement in the Family Choices programme in 2015/16.
- 90% of perpetrators that engage with Family Choices do not generate any subsequent referrals or notifications.

Family Choices Programme

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

What has been the impact:

Feedback from those attending the programme suggest that families find it helpful in a number of ways. Perpetrators have commented on how the work undertaken has had a positive impact on their behaviour, highlighting increases in respect for their partners, with understanding of how to control anger and alternative non abusive ways of behaving. Victims have found the support particularly

helpful in overcoming isolation through the opportunity to meet others with similar experiences. Learning how to identify signs and traits of Domestic Abuse has led to participants feeling more able to set appropriate boundaries within their relationship with their partner, and a subsequent improvement in relationships with their children.

As noted above, 44 out of 64 (69%) of adults referred to the Family Choice programme engaged with the programme in 15/16 and there were 19 cases of whole family engagement in the Family Choices programme in 2015/16. 90% of perpetrators that engage with Family Choices do not generate any subsequent referrals or notifications

IRIS Project

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

What has been the impact:
Following training, there were 60 referrals from GPs to domestic abuse support services in 2015/16 when previously there had been very few.

Learning from audits - MARAC Audit

Reading LSCB Quality Assurance Sub Group tasked agencies to establish how the Multi Agency Risk Assessment Conference (MARAC) process considers children, and contributes towards the safeguarding of children whose parents/carers have become involved in Domestic Abuse. The lessons learnt from this audit and improvements made were:

- Actions specifically relating to children discussed at MARAC will be recorded formally in the MARAC minutes available for all agencies to view on MODUS.
- Agencies named in carrying out the actions for children must complete their MODUS action plan by the agreed date.
- All agencies will consider risk to children (which may be different to the risk to adult) in the context of the child. This consideration will be recorded in the minutes and agencies will robustly challenge inappropriate risk assessment.

Domestic Abuse Challenge Session

Reading Local Safeguarding Children Board hosted a Domestic Abuse Challenge and Support Session to seek clarity and assurance around the work currently taking place in each agency to tackle Domestic Abuse. The session was an opportunity for agencies to share good practice and identify any changes required to enable professionals to work confidently with children and young people who experience Domestic Abuse. The key lines of enquiry were informed by the Domestic Abuse Strategy Action Plan, written by the Community Safety Partnership and included discussion on education for young people; effective support and training for the workforce; the referral process; sharing of domestic abuse notifications, and an understanding of the needs of our mixed population.

The session identified a range of areas where progress has been made but also identified a number of actions going forward. The Domestic Abuse Strategy Group have included these actions within their action plan, however there are two areas that require further input from Reading LSCB. These are in relation to schools regularly receiving domestic abuse notifications, and a review and improvement in the PSCHE offer to schools. These have been included in the Reading LSCB Improvement and Development Plan for 2015/2016.

Ongoing Challenge/Actions:

- Not enough progress has been made to ensure a consistent approach to the delivery of information and support to schools. Further work is required to progress this action, and the LSCB Improvement and Development Plan for 2016/17 has been updated to reflect this requirement.
- Domestic Abuse Notifications to schools – in neighbouring boroughs the schools regularly receive domestic abuse notifications. A similar notification system will be developed to ensure that Reading schools can also receive this vital information and put in place appropriate support for children and young people.

Priority 2: Strengthening the Child's Journey and Voice

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

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

What has been delivered:

- The Youth Cabinet have presented their campaigns to the Board.
- The Youth Cabinet have been consulted regarding their engagement with the Board.
- The Quality Assurance and Performance Sub group have included the Childs Journey and Voice priority in their dataset and audit programme. It is also now a core standard in all multi-agency audits.
- Young person's version of the Annual Report 2014/15 was produced.

What is the evidence:

- The Youth Cabinet carried out the Domestic Abuse survey and the Member of Youth Parliament reported the survey finding to the LSCB at a Board meeting in 2015. The recommendations were discussed and agreed.
- Evidence from hearing the child's voice has been identified to come through the Quality Assurance and Performance sub group. This is also a standing item on Reading LSCB Board agendas and in multi-agency audits.
- Engagement of children and young people in their CP Conferences and reviews is regularly presented to the Board through performance data and from audits.
- The LSCB Independent Chair and Board Manager have attended Youth Cabinet meetings.
- The Member of Youth Parliament has contributed to the Reading LSCB Annual Report 2014/15.
- The Young Carers produced a young person's version of the Reading LSCB Annual Report 2014/15 – the video can be seen on the LSCB website. The video has been shared with partners, Children's Services staff events and the Health and Wellbeing Board.
- The Reading LSCB has funded the MoMo App for a further year (2016) to allow Looked After Children to feed back directly their experiences.
- The Youth Cabinet were consulted on their key priorities which have directly contributed to the priorities chosen by the Reading LSCB for 2016/17.

What has been the impact:

- The Board has been more focussed on the needs of children and young people and recognises the need for their direct influence on our work.
- Young people have made presentations to the Board and contributed to discussions.
- Young people have contributed to discussions about the LSCBs priorities and are directly contributing to work on some of these.
- Emotional Health and wellbeing identified as a key issue by children and young people and is now a key priority for the Board in 2016/17.
- In the last 18 months (up until end April 2016) the MoMo app has provided young people and easy way to get in touch with Children's Social Care - 46 submissions have been made, 14 of

these have been about changing something, 17 preparing for a meeting, 16 to sort a problem, and 1 about a worker visit. Of these 46, 32 have been made since December 2015.

Reading Youth Cabinet

Achievements:
The Reading Youth Cabinet is made up of 18 elected young people – in the December 2015 elections, 3,302 young people across Reading voted. The new group decided to again focus on mental health services for young people as one of their campaigns. A second campaign was on challenging discrimination – this was decided by vote of those attending the Youth Cabinet event in November 2015. The group also decided on a third campaign around self-expression and identity, a focus of which is to increase acceptance of young people coming out as LGBT+ across Reading. The youth cabinet have presented these to both the Health and Wellbeing Board and the Children's Trust Board, and are making positive progress towards their objectives as set out in their manifesto.

Reading's Children-in-Care Council, now rebranded as Your Destiny Your Choice (YDYC) continues to meet once every six weeks. Achievements over the previous year include running an event in December for staff and carers, developing an info sheet for social workers to use when they are meeting new young people in care, and participating in the planning of the Looked After Childrens celebration events.

Young people have also been involved in the recruitment of staff by having their own interview panel; including interviewing for the role of Head of Social Care, Head of Transformation and Governance and for new Children's Social Workers.

The new Young Inspectors/Researchers group has now been established, and are undertaking projects looking at Mental Health Services with the Youth Cabinet, and at Fostering Placements with YDYC. Though this work is not yet complete, it promises to be a successful project with young people being able to feedback how services are delivered to young people in Reading with recommendations about what should be done next.

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

A range of consultations and surveys are undertaken annually with young people. This includes almost 3,000 young people participating in a survey run in conjunction with the youth cabinet elections and one for young people in care about their experiences of going into fostering placements

Impact:
In partnership with the Reading Borough Council Public Health team, the Youth Cabinet were involved in distributing a mental health booklet to all young people attending secondary schools in Reading, putting together a promotional video in the process.

The YDYC Group wrote an open letter about why it is so important that young people have good placements, and why they want to be heard and have a voice. This letter was given to all Children's

Services staff at some Whole-Staff conferences, and was also presented to the Corporate Parenting Panel.

The LAC Information Pack which the YDYC helped develop has now been given to all young people in care with Reading, and via the IRO's to those coming into care. This also gives young people the opportunity for young people to have one place to store information they are given by social workers, IROs, advocates or anyone else.

Although early days, the YDYC groups Traffic Light challenges, which they present at Parenting Panels, have already ensured the LAC Health Nurses will agree with young people where they want their assessments to be held, and have raised the issue to changes in social workers and breaks of promises when social workers do change.

The LAC Celebration Events, held at Beale Park for those aged up to 10, and Oakwood Youth Challenge for those aged 11+, were very successful, celebrating the achievements of young people in care and being fun and enjoyable days for all.

Young people involved in recruitment have had a direct say on the staff employed by Reading Borough Council.

Challenges

Engaging regular changes of staff in the work of YDYC continues to be challenging as messages and initiatives are lost as people change. This has a direct consequence on the limited numbers of young people attending YDYC events – though we have a solid core of young people, we would like to recruit more regular members, and particularly members from the leaving care population and males.

Ongoing Challenge:

- There is the need to better include the direct voice of young people at our Board meetings. We are planning to use video/audio presentations of concerns from young people, and then provide responses from Board members.
- A review of the MoMo App is required to ensure it is value for money and effective.
- Increase the number of regular members to Your Destiny Your Choice and those attending YDYC events.

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

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

Multi-agency approach to CSE

In 2014/15 there was no clear CSE strategy in place and no data or profile of Reading CSE available to map the level of concern and inform the work that was needed. The levels of awareness of CSE, indicators and process needed to be improved across the workforce. There was a lack of coordinated approach to interventions for children who are being/at risk of being sexually exploited, with limited access to specialist services for children and young people.

What has been delivered:

- The CSE strategy and risk assessment toolkit were developed and launched in June 2015.
- Multi-agency CSE Training has been imbedded since 2013 with Universal, Targeted and Specialist courses available. 464 multi-agency delegates have attended training since Sept 2013 and 438 individuals have completed the Universal CSE online learning.
- The Chelsea's Choice drama production was delivered in February 2015 and February 2016 in all secondary schools. Approximately 2000 have watched this production each year.
- CSE Intelligence Sharing training was provided in November 2014, January 2015 and January 2016. More sessions are being arranged for 2016/17.
- SEMRAC multi-agency risk assessment CSE meetings now occur on a monthly basis. The first SEMRAC meeting was in April 2014and since then there has been ongoing refinement and development of these meetings resulting in significant improvements in attendance, oversight and coordination of safeguarding interventions and planning for children and young people.
- SEMRAC meeting were further developed to combine with the Missing Children's Panel in September 2014.
- The CSE Champions group was established across agencies there currently 23 Champions from various services & teams.
- Services and pathway have been established to support victims of CSE including Champions; Barnardos specialist CSE workers; specialist exploitation service and a therapeutic service for victims of sexual abuse.
- The CSE and Missing Strategic group has been driving forward the CSE strategy action plan. It's governance arrangements changed in January 2015 when it became a sub group of the LSCB.
- CSE Safeguarding Business cards have been produced – nearly 7,000 cards have been handed out to the workforce across Reading and beyond. This is a handy sized reminder of signs and indicators of CSE and referral pathways for concerns. In addition to staff who work with children regularly, these have also been handed out to all taxi drivers licenced in Reading.
- A CSE Coordinator was recruited September 2015 to provide a dedicated resource to develop and progress the CSE Action Plan.

What is the evidence:

- A launch event of the CSE strategy that was attended by 100 practitioners and managers from across the LSCB partnership. Copies of the strategy, toolkit and screening tool were provided to

delegates and these were also made available on the Reading LSCB website, along with the CSE training programme for access by agencies and practitioners.

- Minutes of SEMRAC meeting evidence the attendance, referral numbers and safety plans for children.
- From SEMRAC and Missing reports a network map was developed linking names of victims, friends and individuals of concern. This lead to two (multi-family) complex strategy meetings held in early 2016.
- A CSE and Missing dataset and dashboard has been developed and populated monthly to enable the LSCB to better understand the local picture.
- The LSCB Learning & Development sub group and RBC Workforce Development team have embedded a process for post course evaluation to begin measuring impact of the various training courses on increasing professional knowledge and confidence in identifying and responding to children and young people vulnerable; at risk of and experiencing sexual exploitation to promote early identification and effective safeguarding.
- There have been increased referrals to SEMRAC as professional knowledge of CSE indicators and the process for notifying and responding to CSE increases.

What has been the impact:

- Improved data/challenge has enabled the LSCB and partner agencies to focus efforts on identifying and responding to the most vulnerable and at risk children. As at end April 2016 there were 19 open CSE cases to Children's Social Care.
- SEMRAC is running more efficiently and enables professionals to better protect children by sharing intelligence to enable disruption activity and identify the key concerns and risk to the child(ren). 53 children and young people have been discussed at SEMRAC over the period August 14 to November 15
- Reduction in risk to children has been evidenced by SEMRAC data within the LSCB dashboard (risk level reduced, case close, friendships disrupted).
- Professionals are better able to identify and respond to the indicators of CSE.

Learning from audits - Children and young people at risk of or experiencing sexual exploitation

Carried out in quarter 2 of 2015/16, the focus of the audit was to consider the information held within each agency and in particular note:

- Whether or not the Child Sexual Exploitation Screening Tool was used
- Comment on the quality of its completion
- Assess the effectiveness of communication between agencies
- Whether there was a shared understanding of levels of risk as well as how the management of the assessed risk was addressed.

The audit found that professionals in all the agencies were generally more confident, with increased knowledge and understanding of the issues relating to child sexual exploitation. The launch of the Strategy and the information sharing and training around the use of the Child Sexual Exploitation Indicator tool, was seen as positive. It identified that although there was evidence of positive multi agency working, this was not always explicit in the overarching plans for the young people, and that there was not a consistent approach to the completion of the indicator tool or communicating with other agencies that it had been completed or how it was used to inform interventions.

The learning and recommendations were considered by the Quality Assurance and Performance Sub Group, and the resulting action plan has been progressed and incorporated into the ongoing CSE Strategy Action Plan.

CSE Challenge Session:

Reading Safeguarding Children Board hosted a CSE Challenge Session in June 2015 to seek clarity and assurance around the work taking place in each agency to tackle CSE. This challenge session was an opportunity for agencies to share good practice and identify any changes required to enable professionals to work confidently with these vulnerable children and young people.

Key lines of enquiry, as identified by Ofsted in their CSE thematic inspections included: effective strategic leadership of the multi-agency response to CSE; identification of prevalence, trends, themes and patterns; how effectively are partners sharing information and working together; how effective all organisations are at identifying those at risk at the earlier opportunity; and whether children and young people who are at risk of, or who have been, sexually exploited are effectively safeguarded, protected and supported.

A number of key partners gave comprehensive presentations and actions were identified. All the relevant actions were incorporated in the CSE Action Plan and have been progressed through the CSE & Missing Sub Group. This session directly informed the CSE Toolkit Launch event at the end of June 2015, and led to the production of the plastic CSE Safeguarding business cards.

Missing Children

What has been delivered:

- An updated and improved workflow for missing children notifications has been developed, with alerts to allocated social workers or MASH, including 24 hours, 5 days and 3 x missing in 90 days.
- The Missing Children Interviews are now being arranged directly from Police Reports to improve timeliness.
- Recording missing children information on MOSIAC (Electronic Social Care Recording system) has improved to capture and identify risk factors, to aid better decision making.
- Since April 2015 the Return interviews have been completed by a rota of Youth workers. The Youth Workers are highly skilled in speaking to young people and their parents, and as they are not Social Workers or Police Officers, are often more successful in engaging with the young people. The Youth Workers are also able to offer additional Early Help services when appropriate.
- The Missing Children Coordinator has been in post from January 2016 (new role) to continually assess and improve delivery.
- The Mind of My Own ‘MoMo’ App is available for looked after children (11-17 year olds) who want to share concerns in relation to their placement which is fed back into looked after children reviews at the request of the young person. This aims to reduce the number of looked after children who leave their placement and are then reported as missing.

What is the evidence:

- There has been improved interagency information sharing and working for Missing Children, Child Sexual Exploitation and Children Missing Out On Education.
- The accuracy and timeliness of reporting missing children notifications from Thames Valley Police has improved, along with the recording and workflow for missing children within Children's Social Care – most reports are now received within 24 hours (or reported first day after Weekends/Bank Holiday).
- During 2015/16, 534 missing episodes were reported to Children's Social Care for 394 individual young people. This figure has gradually increased over the past 9 months. Out of these episodes 495 required a return interview. 116 episodes were refused for interview by either the parent of young person
- Throughout 2015/2016 264 return interviews were carried out. 53% of missing children have had return interviews carried out although this figure has been improving with 70% children missing in March 2016 having a successful missing interview from youth service.
- A significant issue is the number of missing interviews being completed within 72 hours. Of the completed interviews in 2015/16 only 76 (29%) were completed within the Statutory 72 hours from when the young person is returned home. This figure needs to significantly improve and was highlighted in the recent Ofsted inspection.

What has been the impact:

- Improved safeguarding arrangements for children who go missing from home or care placements.
- Better evaluation of risk factors affecting young people to aid improved decision making.
- Return interviews currently being audited for quality assurance. This will be completed by end of June 2016
- Issues for Young People who go Missing have been identified through the Missing Interview process and reported to Social Care for assessment/signposting to services.

Children Missing out on Education (CMoE)

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

What has been delivered:

- The CMoE Strategic Group meets regularly to discuss and track cases, and an action and communications plan is now in place.
- Cross border meetings take place to ensure those moving in and out of our boundaries do not get lost. All those assessed to be at level 1 (highest risk) have a level 1 plan in place, monitored by a lead professional.
- Pupils in year 12 who are NEET are now tracked, ensuring responsibility is handed over to an appropriate service, such as Adviza (formerly known as Connexions Thames Valley).
- The Virtual Head for CMoE is a member of SEMRAC (CSE); cross-referencing to ensure that the most vulnerable children have robust lead professional support.
- The Virtual Head now has the details and monitors all pupils who are on reduced timetables in Reading primary, secondary and special schools for return to full time education.

- Cross-matching of Management Information will give us greater intelligence of children at risk – we are working on automated systems for the future.

What has been the impact:

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

Female Genital Mutilation (FGM)

The population profile of Reading indicates that FGM could be a potential issue for certain groups of children and young people in the town. In 2015 the LSCB Independent Chair challenged the Health and Wellbeing Boards across the West of Berkshire to take a lead on FGM, in recognition that this is not an issue only for girls. The LSCB recognised that a co-ordinated strategic direction is required to progress local developments that will ensure girls living in the West of Berkshire who might be at risk of FGM are identified and protected. Successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

What has been delivered:

- A new LSCB task and finish group was formed with representation from across the West of Berkshire progress this issue.
- A vision and action plan for the area has been written and agreed by all three West of Berkshire LSCBs.
- The action plan recognises actions that have a statutory partner responsibility, such as clarity around identification and reporting requirements. It also has a clear preventative element reflecting the importance of working with the voluntary sector, in the high risk communities to raise awareness.
- FGM awareness training has been made available through the annual LSCB training programme and a focus on FGM has been incorporated in to all Reading Universal Safeguarding Children training courses. The free FGM online training course from the Home Office has been identified and promoted for those unable to attend the face-to-face one day course.
- In March 2016, FGM training specific to schools was provided by Forward UK to 19 representatives from across Reading.
- The task and finish group have identified potential pathways into services for girls and women at risk, suspected to have undergone or who have been subjected to FGM. A risk assessment tool has been written, along with guidance on completion of the tool; pathways and a factsheet on FGM. These are being launched at an event open to practitioners across the West of Berkshire on 30th June 2016.
- A dedicated page on the Reading LSCB website has been created with links to the guidance, toolkit, factsheet and training opportunities. This page is being used as the central point for all three West of Berkshire LSCBs.

In the first six months of 2016 the task and finish group have fulfilled much of its initial remit however there are clear ongoing actions to enable support to be provided to women who come forward as survivors.

Ongoing Challenge:

Child Sexual Exploitation

- An ongoing review and analysis of data is required to provide a problem profile for Reading, identify themes and recognise areas for development.
- More CSE Champions need to be recruited from schools and children's social care long term teams.
- We will review and embed updated CSE Risk Assessment toolkit. This will enable the workforce to work more comprehensively with children and families where there may be CSE concerns.
- We will develop and deliver short courses for schools and voluntary sector to improve knowledge of CSE, indicators and pathways.

Missing Children

- Significant improvement is required in the timeliness of missing children interviews to ensure that vital information is not lost and support and advice can be offered. The information gathered from the interviews must also be routinely included on case files and used to support assessments and decision making.

Female Genital Mutilation

- The guidance, toolkit and risk assessment tool launch must be embedded into frontline practice. This will need to be evidenced during 2016/17.
- Actions within the FGM vision and action plan will be progressed and completed. This is particularly important with regards to supporting women and girls who present as having been subjected to FGM and require emotional, as well as medical support. The aim is to establish a Reading clinic, similar to that available in Oxford, which will provide this wrap-around service.
- Ongoing FGM training must reference the local toolkit and pathways.

Priority 4: Neglect

There are more children and young people in Reading on a Child Protection Plan for neglect than any other category and this has remained the case for some time. The number of children with a child protection plan for neglect out of the four categories (neglect; physical; sexual and emotional abuse) has been routinely above 50% for the last three years, which is above the national figure of 43%. Research has shown the negative impact of living with neglect can have on children and young people's emotional and physical development and has lifelong consequences in terms of poor outcomes in educational achievement; mental health; employment etc.

What has been delivered:

- A multi-agency audit was completed to establish how well agencies were working together in order to address neglect. Recommendations and learning were shared with the Board on 14.05.15 with a clear action plan for improvements.
- An audit of repeat CP cases with Neglect as the primary reason was undertaken. Learning and actions were reported to the CSIB & LSCB.
- A review of Thresholds was undertaken that included looking closely at the neglect indicators. The Threshold booklet was updated and LSCB joint workshops with Early Help and Troubled Families explained about use of thresholds and response expected by professionals.
- A specific Neglect webpage for professionals was developed on the LSCB website.
- A Reading version of a 'Guide to understanding Neglect' was developed and placed on the LSCB website as a downloadable booklet.
- A training template to help teams understand, identify and know what to do when they spot Neglect was written and trailed at a RBC Corporate session. This is also available on the website.
- A Neglect briefing session was delivered to designated safeguarding leads in Schools, which highlighted the resources on the LSCB website.

In 2015 Reading LSCB agreed a protocol for all partner agencies that covered the following points:

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

In response to the protocol partners contributed to a combined short term action plan, finishing in March 2016. However, it was recognised that there had been a lack of progress and pace in relation to neglect in 2015/16. To ensure progress in 2016/17 the Independent LSCB Chair agreed for a task and finish group to be set up, with its first key action to create a truly multi-agency Neglect strategy and

action plan that builds on a partnership workshop that took place in March 2016. In addition the Learning and Development sub-group reviewed the training programme and has included Neglect as an area for development in 2016.

Evaluation of Thresholds

The thresholds document was produced by RBC in 2011. It therefore needed to be reviewed and updated to become a multi-agency document.

Through consultation with Reading LSCB partners a review of the thresholds document took place in 2015 and a revised poster size version was re-issued. Changes were made to ensure that current practice and current risks were reflected. There was also agreement on the need for common language in line with that used in the Early Help Hub Pathway and the MASH. A Thresholds Guidance booklet was also introduced which includes the threshold risk factors, as well as the protective factors that can sit alongside them. Clear referral processes were also included to enable practitioners to use the document in their day-to-day work. The new documentation was disseminated through workshops during October and November 2015 with over 350 front line staff from across the partnership attending. Attendees took with them a copy of the new guidance, LSCB pens and CSE awareness cards. Post course evaluation shows over 90% of attendees improved their knowledge of thresholds and how to apply them.

The revised Thresholds document and guidance has been circulated widely across agencies and organisations and is also available on the Reading LSCB website

What has been the impact:
Thresholds guidance has enabled practitioners to be clear and confident about applying safeguarding thresholds – ensuring that referrals are made appropriately (right service, to the right child, at the right time and in the right place). Verbal feedback has been very positive, with a number of practitioners commenting that they carry the booklet with them and use the guidance every day. For the period Jan to March 2016, there was an increase in referrals to the Early Help Hub of 52% over the same period last year. However, there is an ongoing challenge to ensure that the understanding and application thresholds remain embedded in practice. Thresholds has been included as part of the Universal Safeguarding training and MASH briefing sessions, but following the annual review of thresholds in July and August 2016, a further programme of dissemination and training will be required.

Learning from audits - Neglect:

In 2015 we carried out an audit to establish identified themes and areas of learning from a multi-agency perspective and identify how well agencies are working together in order to address neglect in Reading. The key learning points were:

- There is a lack of evidence of holistic assessments being undertaken led to gaps or inconsistencies in assessments. Inconsistent use and standards of chronologies had a direct impact on the outcome of assessments.
- There is often a lack of coordination between agencies and failure to escalate concerns at an earlier stage which has led to drift and delay in some cases. Where evidenced, early robust interventions led to timely and appropriate plans being put in place for children. There is a need

for all agencies to support targeted interventions and support at an earlier stage in order to reduce drift and problems becoming more entrenched.

- The voice of the adult could often overshadow the voice of the child, and there was also evidence of over optimism of parental capacity to change or engage with services as well as disguised compliance by parents or carers. Better evidencing is required of the understanding of the Childs Journey/Voice of the child.
- Inconsistent communication between agencies particularly prior to cases escalating to the child protection process led to delay. Schools need to develop a clear system of recording child protection concerns across schools to prevent information being lost during transfer between schools.
- The use of Family Group Conferencing does not appear to be embedded into practice. There was evidence to suggest that in some of the cases this should have been considered and offered to families.

A multi-agency action plan was produced and had been monitored through the Quality Assurance and Performance Sub Group. The actions have been transferred into the action plan for the new Neglect Task and Finish Group to ensure they are completed.

Ongoing Challenge/Actions:

- There has been a lack of progress in improving and understanding of developing agency interventions to neglect in 2015/16. A task and finish group is required to push this work forward at a pace. The multi-agency LSCB group has met and agreed that the new strategy and action plan needs to address 4 key priorities:
  - To raise awareness and the ability of our workforce across the partnership to recognise and identify neglect enabling earlier intervention and improved outcomes for children.
  - Information will be systematically gathered and appropriately shared to enable holistic assessments and shared chronologies to take place.
  - The workforce across the partnership is equipped to have difficult and honest conversations with families and provide robust supervision.
  - There will be a suite of coordinated interventions across thresholds to tackle neglect to enable sustained change within families as well as practical support to address immediate needs.
- It is expected that significant progress will be made during 2016/2017 to support front line staff in the identification of neglect, quality assessments, training opportunities and guidance.
- Clear links required between the Neglect Task and Finish Group and the Learning and Development Sub Group to ensure progress with key actions around learning opportunities and raising staff awareness.
- Review of Thresholds to be undertaken, with clear dissemination and embedding of revised documentation by all LSCB partners. (Ofsted Recommendation – see page 43)

Priority 5: Effectiveness and Impact of Reading LSCB

The Board must have a strong focus on scrutiny and challenge of partner agencies and services and its own effectiveness, to ensure it meets local and national priorities and is able to evidence impact on improving outcomes for children.

Governance and Challenge function of the Board

In 2014/15 it was acknowledged by Board members that meetings had not been challenging of partners/services/Board members, with decisions and responsibility often not held at Board level due to the LSCB structure, making effective challenge difficult. There had also not been a systematic approach to recording risks/concerns and areas requiring further assurance. The work of the sub groups are often not known or considered at the Board meetings.

What has been delivered:

- Reading LSCB structure was re-organised at the end of 2014.
- The Independent Chair has encouraged the Board to be more vocal and challenging.
- The LSCB recognised that improvements were necessary in terms of the data, audits and Section 11 returns received and considered by the Board to enable them to scrutinise and understand frontline safeguarding practice. This was addressed in the new LSCB structure.
- The Independent Chair raised a number of challenges including:
    - raising concerns regarding the rapid response procedure at the Royal Berkshire Hospital;
    - with Chief Constable regarding TVP reporting and attendance at CP conferences;
    - to partners in relation to LAC Health Assessment timeliness;
    - to partners in relation to budget contributions.
- To enable the Board to effectively monitor the progress of the challenges/concerns raised a Risk/Concern log has been established. This is RAG rated and key issues are followed up at each Board meeting.
- Two specific challenge sessions have been held by the Board and the results have fed into action plans. Details of these are noted within the Domestic Abuse and CSE priority sections of this report.
- The Members Compact and Induction Pack have been revised and reissued to support Board members in their role and responsibilities as a member of Reading LSCB. Induction packs for sub-group members are also being developed.
- A requirement has been established for sub group chairs to provide regular reports to the Reading Board, and that identified Reading Board members sit on each sub group to ensure Reading is represented in the sub-groups. This will ensure that there is improved communication and oversight of the work of the sub-groups to deliver that priorities of the LSCB via the Improvement and Development Plan.

What is the evidence:

- The Executive meetings were removed in 2015 to ensure decisions and responsibility are firmly held by the main Board

- Recent minutes of meetings reflect the increased challenge that has taken place. Board members feel much more confident in expressing their views and holding agencies to account.
- A revised dataset and dashboard has been produced and is discussed at every Reading LSCB Board meeting.
- In relation to specific challenges:
    - A new rapid response protocol has been written;
    - TVP agreed to employ two case managers with specific responsibility to attend CP conferences following challenge;
    - Timeliness of LAC Health Assessments improved from 72.2% in Q4 14/15 to in 92% for initial and 96% for review assessments completed in time for in area LAC Q3 15/16;
    - Increased budget contributions have been received.
- The learning from audits is now reported back to every Board meeting.

What has been the impact:

- Improved data/challenge has enabled the LSCB to focus efforts on the most vulnerable and at risk child and young people
- Clear rapid response protocol which is now in place has ensured that families receive an appropriate and timely response when a child dies unexpectedly.
- CP conferences now run more effectively with regular TVP attendance ensuring an improved multi-agency consideration of risk and safety plan.
- More LAC having health needs assessed and met.

High Quality Training

The Learning and Development (L&D) sub-group consists of representatives from the 3 West Berkshire LSCB's. In 2015 it was recognised that the LSCB L&D Strategy was out of date and there were areas that required strengthening. The sub-group subsequently refreshed the strategy, which has formed the basis for the development of the training programme and activity for 2015/2016.

The training programme was created by a working group of the three Local Authority leads and virtual input from other members of the L&D sub-group. It was created through assessing the information from previous years and the learning needs provided by partner organisations.

Post-course evaluation/audits commenced in late 2015 to measure the impact and improvements in safeguarding practice across the partnership and first tranche of evaluations now becoming available.

However, in Reading, we have recognised that connectivity between the work of the West of Berkshire sub group and Reading LSCB, the business plan and priorities of the Board, need further strengthening. A number of changes to membership and clarifying expectations of sub-group members, coupled with the development of the Reading LSCB learning and development action plan, will be put in place to ensure a closer alignment between the priorities of the Board and the sub-group.

Training for the Voluntary and Community Sector (VCS):

In recognition of the difficulty the voluntary sector can have to be able to access appropriate, affordable and accessible safeguarding training, Reading LSCB have worked in partnership with Thames

Valley Police (Reading) and Reading Children's and Voluntary Youth Services (RCVYS) to design, implement and embed a programme which meets the safeguarding training needs of the local Voluntary Sector. Reading LSCB funds RCVYS to provide additional safeguarding training opportunities to the VCS. The Safeguarding Training Programme 2015 proposed delivered a structured programme of Children's Safeguarding Training over the year and was a trial programme designed for the following purposes:

- To increase the knowledge and awareness of safeguarding children for the Voluntary Sector in Reading.
- To test the concept of having a structured programme, and how this would work alongside the LSCB Training Programme.
- To gauge the level of demand for different safeguarding training courses.
- To establish ways to deliver and evaluate the impact of the training.

This programme was focussed around Universal Safeguarding Children Training and other courses which have a strong demand from the local Voluntary Sector, as well as working in partnership with more specialist groups to deliver introductory and specialist courses.

What has been the impact:
The original outcomes for the courses were to deliver the following outcomes:

- Keep children safe by training front line workers in safeguarding awareness.
  In total, 210 different people from 64 different Voluntary Sector organisations received safeguarding training to help to better keep children safe in Reading.
- Ensure that more Voluntary Sector organisations can refer appropriately into MASH or other departments, if this becomes necessary.
  Representatives from 58 different organisations attended a training course which provided them with the tools and information to refer appropriately.
- Increase Voluntary Sector organisations' ability to manage safeguarding in their organisation.
  Representatives from 44 different organisations attended a training course which helped to increase their ability to manage safeguarding in their organisation
- Increase trustees' awareness of their safeguarding responsibilities.
  7 people representing 8 different organisations attended, and after the course, all of them reported feeling confident about actively promoting good practice in safeguarding children in their organisations.
- Increase the awareness of the importance of safeguarding for BME/Equalities groups, and other Voluntary Sector groups.
  The Safeguarding Our Children Awareness Seminar helped to increase the awareness of safeguarding for BME groups.
- More PVI Nurseries and Pre-Schools can deliver their own appropriate Universal Safeguarding Children Training.
  There are now 20 Voluntary Sector Early Years Trainers (a 42% increase this year) trained to deliver the Universal Safeguarding Children Training in their settings, and now have access to specialist complementary materials to increase the quality of the training they deliver.

Following the success of the first year's training, Reading LSCB have agreed to fund this for the next year and thank RCVYS for their support in providing this valuable programme. For more information pleases see the RCVYS training page: www.rcvys.org.uk/services/training/safeguarding.

Communication

Reading LSCB recognised that it cannot be effective if front line practitioners are not aware of the work of the LSCB and the messages it is disseminating.

What has been delivered:

- The Reading LSCB Communications strategy was revised and agreed by the Board. Communication from the LSCB to partners and practitioners has been improved with the new website, regular newsletters and regular information updates to Board members and designated safeguarding leads in schools. Recent communications to the Board have included the request that members confirm that the information has been disseminated and an email from a GP and a school have been received regarding an article in the newsletter – proving it had been disseminated and read.
- A new stand-alone LSCB website has been produced ad is regularly updated to reflect new guidance and developments. This contains a wealth of information not only about the LSCB and what we do, but also provides guidance, information and useful links for professionals, families and children and young people.
- A 'Safeguarding is Everyone's Business' video was created and disseminated to partners for use in public facing areas. The 'Safeguarding is Everyone's Business' video is being shown in GP surgeries and before every Reading football club home game.
- Plastic CSE safeguarding business cards have been produced and disseminated. Nearly 7000 have been distributed across Reading.
- 'Safeguarding our Children' Awareness Seminar took place in May 2015 to promote Black and BME community engagement in partnership with the voluntary sector.
- Most recently, in March 2016 a Reading LSCB twitter account was created with followers increasing weekly (now over 150).
- Key pieces of work have helped to raise the profile of Reading LSCB such as the thresholds workshops, CSE launch event, learning lessons reviews dissemination events and annual safeguarding conference.

Learning from audits – Reading LSCB Effectiveness Survey:

Effectiveness and impact of the LSCB is a key priority for the Board, and this starts with ensuring basic awareness of the LSCB and its role. In July 2015 the Quality Assurance and Performance Sub Group agreed to run a quick survey across a selected number of staff within LSCB partner agencies to establish how aware they are of the LSCB and its role.

Survey response:
A number of agencies indicated a good awareness of the LSCB and its role, including Children's Social Care (CSC), Berkshire Healthcare Foundation Trust (BHFT), and the Royal Berkshire Hospital (RBH) however with GPs and Thames Valley Police (TVP) there were some clear areas for development.

Positively, everyone knew where to go if they have a safeguarding concern and all bar one respondent stated they understood their role in safeguarding children and young people. Overall, 74% of respondents were aware of the LSCB website, although only 35% of respondents had visited it.

Although this was a small scale survey it does provide an insight into professionals general knowledge of the work of the LSCB. For those agencies which do not solely have a child safeguarding focus, the results of the survey highlighted less knowledge of the LSCB and its work and this is perhaps understandable. Of those professionals who confirmed that they were aware of the LSCB many (including in TVP and GPs) stated that the LSCB impacted on their role in a positive way.

Recommendations from the audit included improving communications from the LSCB and dissemination methods. These have been significantly progressed in the last year with the new Communications Strategy and various events have taken place with front line staff, e.g. the thresholds workshops.

Ongoing Challenge/Actions:

Challenge Function

- Ongoing review of data to ensure continued focus on priority areas.
- A focussed review of LAC and Children in Need data, to ensure those vulnerable groups are being appropriately supported.
- Review and embed strengthened governance of Reading LSCB sub groups to ensure clear lines of communication to the Board. Sub group chairs will be expected to report quarterly to the Board on work within the sub group and six monthly on progress against work plans. This will enable the Board to better scrutinise progress against priorities.

Training

- The provision of training within Reading to be updated to provide courses in line with the Reading LSCB priorities i.e. safer recruitment and neglect. (Ofsted Recommendation – see page 43). The Reading LSCB budget is re-aligned to support the delivery of a programme that reflects the priorities
- A training pathway for professionals be clarified and re-issued across organisations commensurate with roles and responsibilities
- That a programme of post-course evaluations now established be reported on a quarterly basis to evidence impact

Communication

- Continued focus on communication to ensure the work of the Board is seen by front line practitioners and in the community.

Our Performance

Our Compliance with Statutory Functions

Statutory Legislation

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

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

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

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

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

Policies and Procedures Sub Group (Pan Berkshire)

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

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

Summary of activity/achievements:

- A review of the online procedures in the summer of 2015 identified that they had become large and difficult to manage and many of the documents were out of date. There was no clear process in place to manage the online procedures and the contract with the provider TriX was not understood. The current Chair took over in July 2015 and led this review and consequent work.
- Trix had recognised that this was an issue for a number of authorities and had remodelled their online system.
- The Pan Berkshire Group renegotiated the contract with Trix and work was completed by the Group to review a whole new set of policies and procedures for the new system. This was achieved in January 2016 with the new system operational, and all new documents uploaded. http://www.proceduresonline.com/berks/
- It was then recognised that there would need to be a programme of reviewing the policies and procedures over the year and a more robust programme to manage this has been put in place.
- The Group has met quarterly during the year and multi-agency attendance and participation has been excellent. Some of the gaps identified in membership have been addressed and there is now a good range of multi-agency engagement including Children's Social Care which had been a significant gap.

What has been delivered:

- A new online format for practitioners across Berkshire with a set of agreed policies and procedures.
- A Group that is structured and contributes effectively to the ongoing plan to maintain and update the policies and procedures for child protection.

Ongoing Challenge/Actions:

- Managing the work of this group is time consuming and requires a lot of coordination. The Group is using electronic communication to manage a lot of business in-between meetings and group members have taken responsibility for communicating information to their own local authority / LSCB areas and also for coordinating any responses to consultation on policy / procedure changes / reviews.

Section 11 Panel (Pan Berkshire)

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

Pan Berkshire Approach

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

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

Summary of activity/achievements:

- Since the Annual report, the next round of Audits has commenced utilising the new audit tool and the revised process.
- A 6 month interim report was submitted to the LSCB's independent Chairs in September 2015, to provide process assurance.
- The LSCB Independent Chairs are assured that progress is being made, they have provided positive feedback and are happy with the forward planner. The only challenge is around themes for individual LSCBs.

- Membership is now more comprehensive, but continues to lack attendance from any of the Social Care Children's team which will need addressing. Other organisations have provided representation, on the whole, following a request by the chair.
- The panel now splits into 2 subpanels to review submissions with the organisations who submit the return, this allows for fuller exploration of the submissions and an ability to get answers on the day and agree necessary actions to be added to the action plan.
- At the S11 panel meetings in September and December 2015 and March 2016 there were 11 audits for review:-
    - South Coast Ambulance Service
    - British Transport Police
    - Berkshire Healthcare Foundation Trust
    - Royal Berkshire Foundation Trust.
    - EDT
    - Thames Valley Police
    - Probation
    - Thames Valley Community Rehabilitation Company
    - CAFCASS
    - Thornford Park Secure Hospital
    - Broadmoor Hospital

Ongoing Challenge/Actions:

- Children's social care re-presentation on the panels – there are still no representatives.
- How national organisations can provide meaningful assurance for Berkshire specifically.

Local Approach

Reading LSCB is responsible for the undertaking S11 returns for local organisations not included in the S11 Panel above. In 2015 all academies and maintained schools were asked to complete an annual safeguarding audit and by June 2016 all forms were received. These have all been monitored by the Virtual Head for Children Missing out on Education, who has contacted any schools requiring further information, or where clarification was required with regards to a response. This audit had not been undertaken for a few years, therefore this process was new to a number of the schools and headteachers. In 2016 the process will be strengthened with spot checks on a percentage of returns, forms will be returned if evidence is not provided and independent schools will also be included. An improved form will be developed to allow improved analysis.

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

Ongoing Challenge/Actions:

- Ensure the annual school safeguarding audit process is more robust – include spot checks and the requirement to provide evidence.

Child Death Overview Panel (Pan Berkshire)

In 2008, Child Death Overview Panels (CDOPs) were statutorily established in England under the aegis of Local Safeguarding Children Board (LSCBs) with the responsibility of reviewing the deaths of all children (0 to <18 years) in their resident population.

Within Berkshire there is a shared child death overview panel that works jointly for the 6 Unitary Authority Local Safeguarding Boards and is made up of a range of representatives from a range of organisations and professional areas of expertise. This process is undertaken locally for all children who are normally resident in Berkshire.

The purpose of the CDOP, (as required by the Local Safeguarding Children Boards Regulations 2006) is to collect and analyse information about each child death with a view to:

- Identifying any changes that we can make or actions we can take that might help to prevent similar deaths in the future.
- Sharing this learning with colleagues regionally and nationally so that the findings will have a wider impact.

The total number of deaths which occurred during April 2015 and March 2016 across Berkshire was 45. Over the past few years, whilst there will be some random fluctuations in numbers of deaths, there is a downward trend in the total number of deaths notified. During 2015-16 there were 49 cases reviewed by the panel, the numbers differ as the cases reviewed include deaths from 2014/15 and is due to the time taken to review the circumstances of each death following notification.

Expected And Unexpected Deaths - An unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.' In the past year 17 unexpected deaths were reviewed, 10 had a rapid response review. During the last 5 years the proportion of unexpected deaths is showing a slight downward trend. Two thirds of deaths now occur within the hospital setting.

Summary of key findings

- In 2015/16 the significant impact of congenital abnormalities on the child death rate is evident again. We not only see significant numbers of deaths in children under 1, we are seeing increasing numbers of children dying as a result of congenital or chromosomal abnormalities in the 1 – 4 year age group and older as the ability of medicine to support for longer periods children with life limiting conditions improves. This year the impact of Edwards syndrome has been more visible. Edwards syndrome is caused by cells in the affected child having 3 copies of chromosome 18 not 2, which disrupts the baby's normal development. Edward syndrome is now able to be detected as part routine antenatal care: combined blood test and ultra sound. This triple programme began in April 2016 across Berkshire and so in 2016/17 we will be able to assess the impact of this screening programme on our childhood deaths.
- Another reflection in 2015/16 is the increasing mention of socio economic influences on rates of child hood deaths. It is well known that rates of childhood deaths are double in SEC group 5 than in SEC 1, however our database does not currently allow us to map the pattern of child hood

deaths in a timely manner and so we need to develop this ability to support / develop targeted work to minimise the risks of future child deaths

Reflections on work of CDOP

- There has been good operational performance against national standards with good cross organisational working that allowed timely and thorough review of cases.
- There was good representation of the panel at the National CDOP panel network and annual general meeting,
- The CDOP panel had supported 4 Ofsted inspections in our local authority children departments and no concerns had been raised with our function.
- Attendance at the meeting was good, with members attending regularly throughout the year.
- It has been noted that the panel is a safe place to have a voice, with members commenting that the group had good open and frank discussions about each case.

Ongoing Challenge/Actions:

We will continue to build on the lessons and work from previous years - with particular reference to:

- Congenital/genetic abnormality work, working with families and communities to reduce risk
- Sustained reduction of SUDI e. g. supporting ongoing work to improve uptake of safe sleeping etc.
- Continuing work on deaths from external causes, particularly accidents
- Reduction of risk factors for preterm and low birth weight deaths
- Further develop the pilot work on asthma care and mortality reduction after external enquiry in one area.

Actions identified in the development session:

- New members will be supported by an induction pack, which outlines the main function of the group, how the group works and the role that each member has.
- An annual development session will be initiated to continue improvement.
- A separate neonatal group will be developed to support the panel, the neonatal group will allow proper clinical and professional review of the most complicated cases whilst also allowing the main panel focus on themes.
- We will explore opportunities with neighbouring CDOP groups to look at more specialist areas and share approaches to risk reduction
- Training - The group has seen a significant change so a training needs analysis will be undertaken to support each member in delivering their role but also to ensure that we provide assurance about the rigour with which we undertake our function.
- Bereavement support - there is some confusion about the support that is available within Berkshire and some cases have been highlighted where support has been variable. We need to understand the support needs that exist and how best to address those.

Learning and Development Sub Group (West of Berkshire)

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

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

Summary of activity/achievements:
The sub-group has delivered a significant amount over the past twelve months.

- Membership - The sub-group actively engaged with those organisations not represented on the group. A flexible approach was adopted, whereby members could be virtual and conduct their engagement without having to attend meetings.

- Learning & Development Strategy 2015-2018 - The LSCB L&D Strategy was out of date and gaps existed within it. This was noted by the sub-group who quickly sought good practice from elsewhere and used this to refresh the document.

- Training Programme 2015-16 - The training programme was created by a working group of the three Local Authority leads and virtual input from other members of the sub-group. It was created through assessing the information from previous years and the learning needs provided by partner organisations. The headline figures associated with the programme include;
    - 22 events were run through the LSCB programme which is the same number as the previous year
    - 339 delegates attended the events, which equates to over 15 delegates per event, and was 5% less than the previous year
    - 63% of the places were taken by Local Authority workers (17% higher than the previous year), with 21% from Health (the same as the previous year) and 17% from others (16% lower than the previous year)
    - 55% of people felt the immediate impact of the training was significant or very significant with 41% stating there was some immediate impact which is broadly comparable to the previous year

  The figures show that awareness seems to be reasonable and attendance healthy, but that there may be issues in terms of event types or the times of year, due to two event cancellations. The events appeared to offer sufficient places and opportunities as only one appeared to be challenged for sufficiency, this being the allegations management offer.

- e-Learning Programme 2014-15 - the e-Learning offer focuses on two main areas, these being CSE (Child Sexual Exploitation) and USC (Universal Safeguarding). Both of these events are provided

through our contract with Kwango, an external provider. The headline figures for the programme include:

- 2399 delegates completed the USC e-learning which is 132% greater than the previous year
- 40 delegate completed the CSE e-learning which is 45% less than the previous year

As requested, work has been done to review how this headline information can be further broken down to see trends within organisations. As from this year, the CSE e-learning module has been amended to ask for an individual's details before completing the e-learning. This is a pilot and will allow us to have much better management information. If this pilot is successful then the same could potentially be done for the USC e-learning module also.

- Training Programme 2016-17 - the training programme was put together having review previous years offer and in consultation with the sub-group partners. This is mainly unchanged, but there is a priority to review some of the courses being proposed in order to ensure they are fit for purpose. Some appear to have consistently low attendance and it may be timely to review how these are delivered (e.g. could they be made e-Learning) or even if they remain appropriate.

- Evaluation and Impact – the group agreed and identified a programme of quality assurance for all the training included in the LSCB programme. Either members of the L&D sub group or specialists in the workforce will ensure the quality of training remains high. Evaluation sheets will continue to be provided and monitored after training sessions, and Reading will continue to approach delegates for follow up evaluation 3-6 months after the course. An area of development is to ensure that the Reading LSCB Board has sight of the evaluation of training. This information is available but has not been presentment to the Board. In addition, SCR learning continues to be incorporated in to our L&D offer as and when appropriate, helping to disseminate key messages and learning thereby influencing work practices and behaviour and so having a positive impact on the outcomes for children and young people.

Ongoing Challenge/Actions:

- Being unfunded and with limited resource for support, the sub-group relies on good will across partners and this can limit the ability to respond quickly to emerging needs or to adequately resource new ideas or work.
- Post course evaluation – this process needs to be strengthened and regular reports provided to the sub-group and Board to ensure courses are appropriate for Reading.
- This is a shared sub-group, however clear progress is required to ensure it adequately provides for the needs of each of the LSCBs. In Reading there needs to be greater thought to provision of training in line with the LSCB priorities such as neglect. (Ofsted Recommendation – see page 43).
- A detailed training needs analysis and audit is required to ensure the needs of the whole children's workforce are understood, to inform subsequent training programmes. This work must be reported back to the Board to ensure they are informed of any issues.

Case Review Group (West of Berkshire)

The Case Review Group (CRG) receives and reviews all cases referred to the group where staff from any partner agency of the Safeguarding Children Boards in the West of Berkshire have identified potential learning.

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

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

Summary of activity/achievements:
The group met for the first time in February 2015. Since then the CRG has met on seven scheduled occasions up until April 2016. Two additional meetings were held when serious incidents concerning children needed to be reviewed quickly to enable a recommendation to be made to the Chair of the LSCBs about whether or not a serious case review (SCR) should be initiated.

In total the cases of 8 children have been discussed by the CRG (2 Reading, 4 West Berkshire, 3 Wokingham). Of these, one recommendation was made that a SCR should be initiated. However, upon the discovery of additional information and discussion with, the then, Head of Children's Services for Reading, the decision was over ruled by the Chair and a multi-agency partnership review undertaken instead. Both Reading cases resulted in partnership reviews which have been completed. See below for information.

The CRG is well established and arrangements have been made to meet every three months with additional meetings arranged as necessary.

The terms of reference for the group have been reviewed and are currently under consultation with group members before submission to the LSCBs for approval. A checklist to aid LSCB members in their decision to publish partnership reviews in full has been developed. The CRG feel strongly that all learning should be published on LSCB web sites.

There is a strong commitment to the CRG from its members, although particular challenges remain around processes.

Ongoing Challenge/Actions:

- Learning from partnership reviews continues to be shared locally with each LA arranging learning events. Learning needs to be shared across Berkshire West
- There is no representation on the CRG from any school in Berkshire West.
- Individual agencies will need to interpret learning from Partnership reviews and monitor completion of actions. The LSCBs must be assured that actions are progressing to completion.
- A clear and transparent process for referring serious incidents to the CRG is required and agreed by all members. (Ofsted Recommendation – see page 43).

Learning from Multi-Agency Partnership Reviews

In 2015 the West of Berkshire Case Review Group considered two cases from Reading to ascertain whether they met the criteria for a Serious Case Review (SCR).

Case A15: This situation was brought to the attention of Reading Local Safeguarding Children Board after the young person, A15, aged 14 years, self-harmed after alleging she had been raped. A15 had been known to services for some time and in 2013 there were concerns that she may have been the victim of sexual exploitation. This case did not meet the criteria for a SCR, but the group recommended a multi-agency partnership review as it was felt that there was the potential for learning and that further reflection and analysis would be beneficial. A lessons learnt review was initiated.

Case B15: B15, aged 17 years, attacked and stabbed two girls aged 14 (A15) and 15 years. The victims, who were lucky to survive the attack, were left with life-changing injuries. B15 was convicted of 2 counts of attempted murder and 3 counts of sexual assault and jailed for 17 years. This case was initially considered by Bracknell Forest LSCB for a serious case review. It was agreed that it did not meet the criteria for a SCR, however there could be significant learning in reviewing how agencies had worked with the perpetrator, B15, who lived in Reading. The West of Berkshire Case Review Group and Reading LSCB Chair agreed that a review around the circumstances which led up to the incident was required, however, the criteria for a SCR is based on the victim rather than the perpetrator. The National Panel of Experts on SCRs confirmed that the SCR criterion was not met. Reading LSCB, therefore, agreed to initiate a lessons learned review instead.

Both reviews were carried out in the autumn of 2015 by the same independent author, following the Welsh review model. Although they were very different cases and situations, there were a number of similar findings. For example:

Assessment:

- Assessments were narrow in focus and lacked assessment of risk.
- In both cases the children were well developed and perhaps treated as older than they actually were.

Information Sharing and Collation:

- Although recorded, information was not accessible when assessments were made. Information was 'lost' between contacts and a full history was not pulled together or rigorously analysed.
- Information about B15 did not move with him, whether across LA boundaries or between schools.

Understanding Risk:

- The assessments over time for both A15 and B15 failed to adequately identify the risks of their behaviour to themselves and others.

Key Worker:

- Lack of sustained or consistent intervention by one agency/key worker for A15 and B15 meant instability for the child and no opportunity for a holistic view of the case to be undertaken and understood.

There were 4 dissemination events over 2 days delivered by the independent author. 155 workers attended from across the LSCB partnership. Feedback was positive with 90% confirming they felt it was relevant to their work, and 86% rating the sessions as 'good' or 'excellent'.

Workers felt that identifying barriers, hearing the recommendations, having time to reflect and listening to the child's views were useful as well as listening and hearing how other professionals work. People felt more confident to make challenges.

An action plan is in place to address the recommendations made in the reports, which is being monitored by the Case Review Group, and the Quality Assurance Sub Group.

Quality Assurance and Performance Sub Group (Reading)

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

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

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

Summary of activity/achievements:

- The Quality Assurance and Performance subgroup was formed in February 2015 following the merger of the two separate sub groups. During the initial stages of the group data was received, however there was no real commentary and analysis of the data and/or connection as to how the data should be translated into identifying any emerging top issues and linking into the audit framework.
- In October 2015 the chair ship of the group changed at which point the group took the opportunity to revise the current data set and dash board. A draft Performance Dash Board and dataset was brought to the LSCB in November 2015 and agreed. Representatives of the Quality Assurance and Performance sub group have worked since October 15 at developing the Performance Dash Board and data set. It is recognised that this will continue to be adapted to meet priorities of the board and emerging top issues across agencies.
- The performance data continues to be a work in progress ensuring data is collected and commentaries are supporting the data. Dates have been reviewed to ensure sub group dates are

in line with quarter end dates to enable through scrutiny and reporting to the board. It has been noted that given the board meets bi-monthly and the data is collated quarterly, the board will not always be updated at each meeting by the most previous end of quarter data.

- The audit programme continues to be linked to the key priorities and the data set where there are issues or themes arising.
- Four multi-agency audits were completed during 2015/16. These have all been included within this annual report, within the relevant priority area. There is recognition that learning from audits and effective monitoring and evaluation of the associated actions plans needs to improve to ensure improvements are made in front line safeguarding practice.

Ongoing Challenge/Actions:

- The data set continues to be improved in its design and presentation to enable it to assist the sub group in its scrutiny of the data. Although progress has been made and moving in the right direction, there remains a challenge in receiving commentary and agreeing the formats that is workable within timescales (quarterly/Yearly) and the structures of each agency.
- Completion of the audit programme for the year within agreed timescales is a challenge for all members of the sub group due to competing demands therefore an audit plan that is structured and achievable is required going forward.
- Learning from audits must be more effectively disseminated and embedded into practice. The action plans must be monitored through to completion. (Ofsted Recommendation – see page 43).

Our Performance

Ofsted Inspection – May/June 2016

In May and June 2016 Ofsted undertook a review of the effectiveness of Reading LSCB as part of the inspection of services for children in need of help and protection, children looked after and care leavers in Reading.

The inspection determined that Reading LSCB requires improvement.

Ofsted made five recommendations in relation to the LSCB:

- Develop an overarching process to ensure that learning from quality assurance activity is properly shared, tracked and reviewed. This should include clear and relevant actions from single and multi-agency case audits.
- Implement a clear and transparent process for referring serious incidents to the case review sub-group for detailed consideration of whether a serious case review is needed.
- Ensure that the work of the learning and development sub-group has a sharper focus on the particular learning and training needs of Reading professionals, including overseeing and, where appropriate, influencing the provision of single agency training.
- Undertake a review of local safeguarding thresholds, including the effectiveness of the early help pathway, and the understanding and application of thresholds at all the key points in a child's journey.
- Secure regular and consistent attendance and engagement at the board and sub-groups by children's social care, to increase the board's ability to contribute to improvements in core social work practice.

All five recommendations were in line with the self-assessment that had been carried out by Board members at a Board meeting in May 2016. These recommendations have been captured in the 'Challenge' sections of this annual report as already identified issues by the relevant sub-groups/Board.

Ofsted also made a number of positive comments which included:

- There has been positive change in the last 18 months.
- There is good representation and commitment from partners.
- Partners and young people have helped to shape the LSCB priorities, which are right for Reading.
- The 2015/16 Business Plan was an effective tool in progressing priorities with most actions completed and the remaining carried over.
- We have a comprehensive dataset which is much improved in the past year.
- The Independent Chair is a strong leader with high expectations and instils a culture of transparency and challenge. The Challenge and Concern log has facilitated active challenge and has led to practice improvement.
- Comprehensive CSE Strategy and LSCB has been instrumental in progress but there needs to be more scrutiny on operational practice and data.
- The Board has developed and published a comprehensive threshold of need document.
- The 2014–15 annual report was comprehensive and well written.

All recommendations have been embedded within the Reading LSCB Improvement and Development Plan for 2016/17.

Our Performance

Lay Member Perspective

The past year has seen the Board working more effectively together under the leadership of the Independent Chair to focus on clearly defined and achievable key priorities, with the goal to ensure we deliver on better outcomes for safeguarding children and young people in Reading.

Delivering on our key priorities for the past year was achievable against the backdrop of the renewed ability of Board Members to query and challenge each other, themselves and their respective agencies, thus ensuring nothing was left to chance. As lay members, we are particularly pleased to have played our part as independent members of our communities in helping to bring about these achievements over the past year

Amongst the many achievements over the past year, we were pleased to see significant development around areas of:

- CSE, FGM and Neglect – implementation of strategies and threshold work;
- Private fostering – strategy development and acknowledging more to be done;
- Reviews of the 2 exceptional cases with learning across Reading and other local areas;
- Priorities setting – making them meaningful, manageable and achievable;
- Business planning – ensuring all board members involved and contributing to final plan;
- Performance and Quality reporting – the dashboard is slowly getting there, but still some work to be done around data collection and reporting;
- Governance, Auditing Action Plan, Risk Log - improved clarity and visibility on what has be done, what has been achieved and what actions needs to be taken;
- Information dissemination particularly through the newly developed website, newsletter and information cards;
- Improved links and communications with schools;
- Improved links with other local authorities and their LSCBs through the Chair, the sub-groups, some of our Boards partnering agencies;
- Improved links with the local community – supported and participated in local seminar, “Safeguarding Our Children” hosted by Barbados And Friends Association, Reading for members of the Black community and local professionals working with children.

As lay members, we are also pleased to be meeting and sharing experiences with lay members of other local LSCBs in Berkshire, but we were disappointed we were unable to attend the Southeast Lay Member’s conference in Brighton.

As part of the re-organisation of subgroups, I was pleased and honoured to play my part in initially Chairing the Performance and Quality Assurance subgroup earlier in the year– this subgroup is progressing well.

We recognised that amongst the positive achievements of the Board, there are still some challenges particularly in the area of staffing – work is ongoing to help partner agencies reduce dependency on agency/interim staff

As lay members, I believe we have shown a strong commitment to supporting local safeguarding in Reading over the past year. In the coming year, we will continue to ensure that our contribution will be reflected in a Board that is continuing to be effective and positively delivering for the benefit of the community it serves.

Anderson Connell
Reading LSCB Lay Member

Appendices

1. Glossary

BHFT	Berkshire Healthcare NHS Foundation Trust
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CAT	Children's Action Team
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIN	Children in Need
CMoE	Children Missing out on Education
CP	Child Protection
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DA	Domestic Abuse
DV	Domestic Violence
EHC	Education, Health and care Plan
FGC	Family Group Conference
FGM	Female Genital Mutilation
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Child
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NEET	Not in Employment, Education or Training
PSCHE	Personal, Social, Citizenship and Health Education
RBC	Reading Borough Council
RBFT	Royal Berkshire NHS Foundation Trust
RCVYS	Reading Children and Voluntary Youth Services
SAPB	Safeguarding Adults Partnership Board
SCR	Serious Case Review
SEN	Special Educational Needs
TVP	Thames Valley Police
YOT	Youth Offending Team

2. Extracts from Working Together 2015

Chapter 3.1: Statutory objectives and functions of LSCBs

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

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

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

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

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

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

Chapter 3.4: Statutory Board partners and relevant persons and bodies

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

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

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

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

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

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

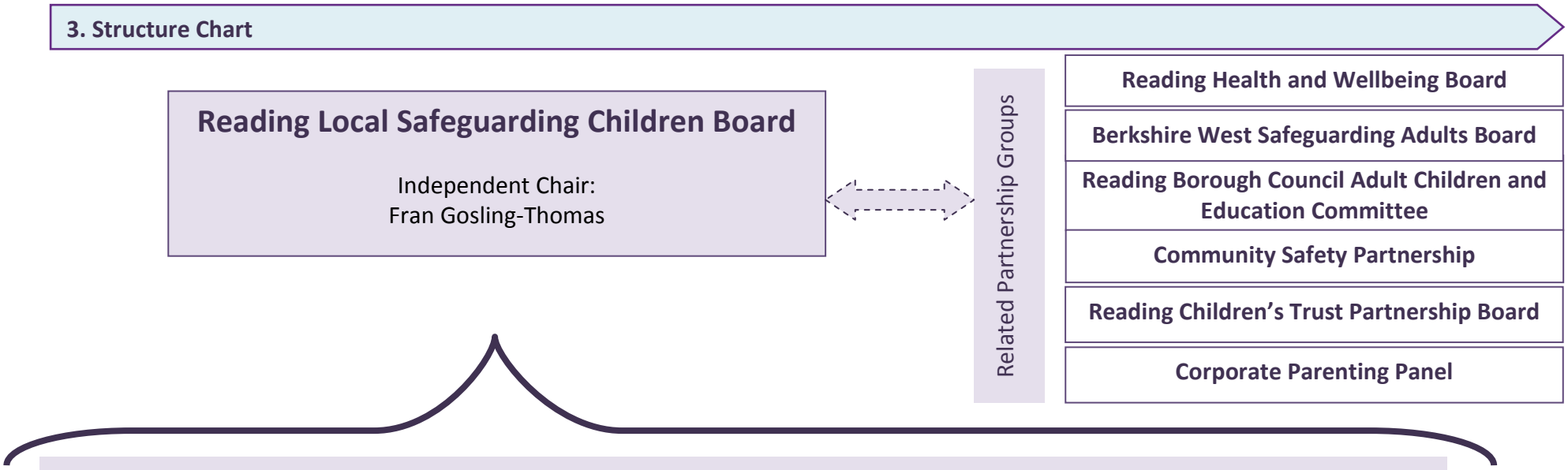
Chapter 5: Child Death Reviews

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

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

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

3. Structure Chart



4. Board Membership and Attendance Log (March 2016)

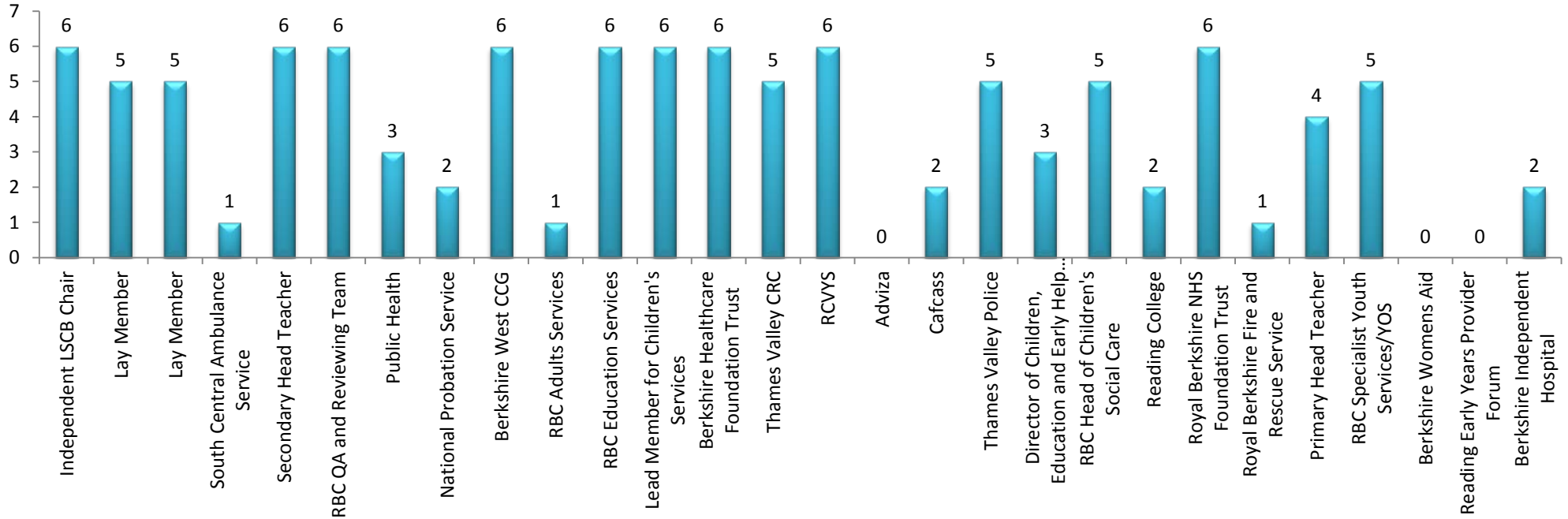
Name	Agency
Francis Gosling-Thomas	Independent LSCB Chair –Reading, West Berkshire, and Wokingham
Helen McMullen	Director of Education, Adult and Children's Services - Reading Borough Council (RBC)
Rachel Dent	Head Teacher, Abbey School (Independent School Rep)
Catherine Parry	Head of Children's Social Care
Anderson Connell	Lay Member
Anne Farley	Lay Member
Anthony Heselton/Kat Jenkin	South Central Ambulance Service
Ashley Robson	Reading School
Liz Batty	Joint Legal, Reading Borough Council
Ben Sims or Paul Taylor	Activate Learning, Reading College
Richard Blackmore	Head of Education, RBC
Chris Lawrence	Early Years Providers Forum
Christina Kattirzki	Kendrick School
Debbie Simmons	CCG
Debbie Johnson	Probation
Bindy Shah	Service Manager, Youth Justice, CSE, Specialist Youth Services and Edge of Care Services
Wendy Fabbro	Director of Adult Care and Health Services
Cllr Jan Gavin	Lead Member
Sarah Gee	Housing, Neighbourhoods and Communities, Reading Borough Council
Gerry Crawford	Berkshire Healthcare Foundation Trust
Hannah Powell	Probation
Helen Taylor	RCVYS
Patricia Pease	Royal Berkshire Hospital Foundation Trust
Liz Warren	Royal Berkshire Fire and Rescue Services
Stan Gilmour	Thames Valley Police
Becky Herron	RSCB Learning and Development and CSE coordinator
Jan Fowler	NHS England
Julie Kerry	NHS England
Kevin Gibbs	Cafcass
Lise Llewellyn	Public Health
Ruth Perry	Caversham Primary School
Julie Skinner	Adviza

Board Meeting Attendance

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

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

Attendance figures by agency, based on six meetings held from April 2015 to March 2016, are shown below.

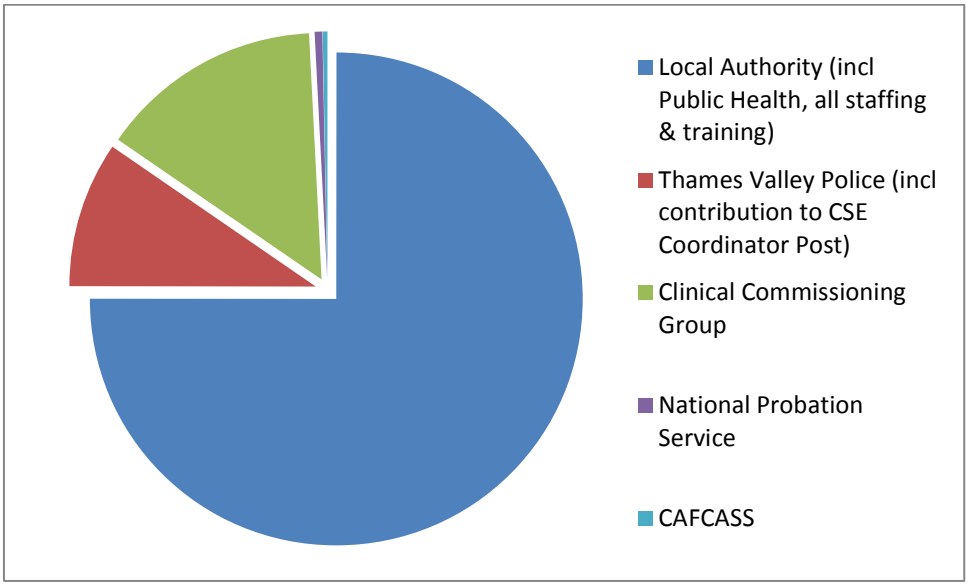


5. Financial Contributions

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

The LSCB budget 2015-2016 is made up of contributions from the Local Authority, Clinical Commissioning Groups, Thames Valley Police, National Probation Service and CAFCASS.

Contributing Agency	Contribution Amount
Local Authority (incl. Public Health, all staffing & training)	£133,500
Thames Valley Police (incl. contribution to CSE Coordinator Post)	£17,000
Clinical Commissioning Group	£20,000
National Probation Service	£895
CAFCASS	£550
Total	**£177,945**



The budget outturn for 2015-2016:

Description	Figure	Comments
Staffing: • 0.7 fte LSCB Business Manger • 1 fte LSCB Coordinator	£75,700	
Independent Chair's expenses	£20,500	
Room Hire and Catering	£1,000	Board and Sub-Group meetings, Business Planning, Learning Lessons sessions
Printing and Stationary	£6,200	Meeting papers, Thresholds Booklets
Publicity Materials	£6,000	Pens (£1000), LSCB CSE Awareness business cards (£1200), Safeguarding awareness video (£1600)

Events	£12,350	CSE Launch (£1950), Safeguarding our Children seminar(£2,400), Chelsea's Choice production (£5,000), Learning Lesson results events (£2,000)
Contract fees	£1,400	Annual maintenance contract for LSCB safeguarding procedures, including additional payment to move to new model
Subscriptions	£3,500	NWG network (£500), MoMo app (£3,000)
Consultancy fees	£10,420	Independent reviewer for A15 Children's Social Care Chronology (£420), Independent Auditors (£10,000)
Learning Lessons Reviews (x2)	£10,500	Independent Reviewer costs, including expenses, approx. £5,000 per review
RCVYS Training Programme	£5,500	Amount given to RCVYS to provide the safeguarding training programme for the VCS
LSCB Training	£25,000	Cost of running LSCB training programme and designated officer courses, plus proportion of Training Officer Salary.
Total for LSCB Cost Centre	**£178,070**	

In 2015 the LSCB Chair raised a clear concern that the current budget is not in line with similar authorities and does not allow the LSCB to address its key priorities. A discussion was held at Board and comparative review of the budget undertaken.

As a result, for the 2016/17 year additional contributions were received from Thames Valley Police, increasing to £8,000 per annum from £2,000. In recognition of the improvements required by the LSCB, Reading Borough Council has also offered an additional one off £60,000 for the 2016/17 year as a development fund. Other agencies felt unable to increase contribution for 2016/17 year. Conversations will continue for the 2017/18 year.

Ongoing Challenge/Actions:

- Budget contributions will be reviewed again during 2016 to establish whether additional resources are required and/or available.

6. Reading LSCB Board Information

Independent Chair:	Fran Gosling-Thomas	LSCBChair@reading.gov.uk
Reading LSCB Business Manager:	Esther Blake	esther.blake@reading.gov.uk 0118 937 3269
Reading LSCB Coordinator:	Donna Gray	LSCB@reading.gov.uk 0118 937 4354

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Reading, Berkshire, RG1 2LU
Website: www.readinglscb.org.uk

Berkshire Local Safeguarding Children Boards
Child Protection Procedures available on line:
http://berks.proceduresonline.com/index.htm

Author: Esther Blake, Reading LSCB Business Manager
Date published: xxxxx

If you have any queries about the report please contact Esther Blake at the contact details above. If you require this information in an alternative format or translation, please contact Esther Blake.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**Health and Well Being Board**		
DATE:	**27th January 2017**	**AGENDA ITEM:**	**18**
TITLE:	**Reading Autism Strategy and Action Plan**		
LEAD COUNCILLOR:	**Cllr Eden**	**PORTFOLIO:**	**Adult Social Care**
SERVICE:	**Adult Social Care**	**WARDS:**	**All**
LEAD OFFICER:	**Graham Wilkin**	**TEL:**	**0118 937 4053**
JOB TITLE:	**Interim Head of Adult Social Care**	**E-MAIL:**	**graham.wilkin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report set out progress on the delivery of the Reading Autism Strategy's key objectives, and a proposed revised action plan for 17/18.

1.2 *Appendix 1* Reading Autism Strategy 2015-18
Appendix 2 Reading Autism Strategy Addendum – National Policy Context Update
Appendix 3 Reading Autism Strategy Action Plan Review 16/17
Appendix 4 Reading Autism Strategy Implementation Plan 2017

2. RECOMMENDED ACTION

2.1 That the Health and Well Being Board note actions undertaken to address the Reading Autism Strategy Action Plan

2.2 That the Health and Well Being Board comments and/or agrees the proposed action plan for 17/18

3. POLICY CONTEXT

3.1 Reading's Autism Strategy was approved by the Health and Wellbeing Board on 17 April 2015. This strategy has been revised and updated to reflect legislation and additional discussions with stakeholders.

4. CURRENT POSITION:

4.1 Reading's Autism Strategy was approved by the Health and Wellbeing Board in April 2015 and an Autism Partnership Board was established to progress the delivery of the Strategy through an Action Plan. Child and Adolescent Mental Health Services, Adult Social Care, Children's Social Care, Education, voluntary sector groups and people with autism and carers are represented on the Board.

The following six priorities for improving support for people with autism in Reading are identified in the Strategy:

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

The Action Plan had been developed in the context of reducing budgets delivered through the Councils extensive transformation plans, and as such there is no additional resource identified or available to deliver the Action Plan. The Plan itself is focused on how existing resources across partners can be used most effectively.

At the meeting on 9 October 2015 the Health and Well Being Board discussed the membership and reporting lines of the Autism Partnership Board, suggesting that political representation and the representation of the Health and Wellbeing Board on the Autism Strategy Board should be considered, and that copies of agendas and minutes should be circulated appropriately. This has been actioned. It was also suggested that where the Autism Partnership Board reported internally in the Council should be considered further. This action will be taken forward in the next year.

In the last year work has continued on the key actions identified. Appendix 3 provides detail on the progress made including

- Autism Partnership Board established
- Information given to commissioned service providers about training opportunities
- Review of Supported Living providers training was undertaken
- Training provided to schools, Adult Social Care, Health and the voluntary sector
- Health services restructured to integrate physical and mental health support for children
- Appreciative Enquiry undertaken on services for children and young people and as a result a multi-agency “Together for Children with Autism Group” is being developed
- Development of single referral process and pathway for Berkshire Health Foundation Trust services for children and young people is underway
- Consultation undertaken on short breaks for children and young people which was reported to ACE in October
- Funding for well-being support for people with autism developed via the “Narrowing the Gap” Framework and new funding arrangements started in June 2016
- Positive living model for support for people with for people with Learning Disabilities, Autism and Challenging Behaviour developed via the Transforming Care Board
- Reading Voice trained four Care Act Advocates experienced in working with people with autism

- Work undertaken to ensure information and advice from the Council promotes support for carers

At its meeting with of the Health and Well Being Board in 2015 the Autism Partnership Board recognised that the Action Plan would require to be updated on a regular basis as progress is made to deliver the objectives set out in the Autism Strategy. The refresh of the Action Plan attached includes changes to legislation and national policy; links between the Autism Strategy and Action Plan and the Council's Social Care Commissioning Strategy and Market Position statement; and links to the current remodelling of the Adult Social Care assessment services.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The work meets the following Corporate Plan priorities:

- Safeguarding and protecting those that are most vulnerable;

- Providing the best start in life through education, early help and healthy living

5.2 The work of the Autism Board contributes to the following strategic aims of the Council.

- To promote equality, social inclusion and a safe and healthy environment for all

5.3 The Autism Strategy Acton Plan contributes towards the following:

o Community Safety -The Action Plan aims to review existing community safety schemes to understand what needs to be done to highlight these to people with autism

- Health – The Action Plan aims to improve access to diagnosis and health services

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Autism Strategy and Action plan were developed with the involvement of people with autism, their family carers and groups who represent this customer group.

7. EQUALITY IMPACT ASSESSMENT

7.1 The Autism Strategy and Action Plan aims to support equality of opportunity for people with autism. An Equality Impact Assessment was completed when the Autism Strategy was developed that did not identify any negative adverse impact on any group with protected characteristics as defined by the Equality Act.

8. LEGAL IMPLICATIONS

8.1 The Strategy and Action Plan have been developed with regard to the statutory duties for local authorities from the Autism Act 2009 and other related legislation.

Key requirements from this legislation include the responsibilities for local authorities to:

- Develop the area's commissioning plan around services for adults with autism using the best available information about adults with autism in the area
- Appoint a joint commissioner/senior manager who has in their portfolio a clear commissioning responsibility for adults with autism
- Ensure that the views of adults with autism and their carers are taken into account in the development of services locally

9. FINANCIAL IMPLICATIONS

9.1 As noted above, the Action Plan was developed in the context of making the most effective use of existing resources. There are no new resources for delivering the Autism Strategy.

9.2 The Action Plan aims to be realistic about what is achievable with existing resources for the Council and other organisations, within the context of reducing budgets. It sets out those areas where there are deliverable actions to make progress towards the longer-term objectives in the Autism Strategy and where a tangible different could be had on outcomes for people with autism, their carers and families.

9.3 While there are no specific savings proposed as part of the Autism Strategy Action Plan, delivery of the actions should mean that partners are in a better position to support people with autism within constrained resources. One of the drivers of the Autism Strategy is to enable autistic people to live more independent, fulfilling lives. Achieving some of the actions in the autism strategy around increased awareness, better trained staff and effective community-based support should mean we can reduce or delay the number of autistic people who need more costly, intensive support from health and/or social care services.

10. BACKGROUND PAPERS

10.1 The following background papers were considered

- Reading Autism Strategy 2015-18
- Reading Autism Strategy Action Plan 2015

Reading Borough Council
Working better with you

Reading's Autism Strategy for Children, Young People and Adults

2015 - 2018

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Introduction

Autism is a condition that affects people in a variety of different ways and degrees. Reading Borough Council is committed to improving the lives of people with autism living in the town. This Strategy sets out how we aim to achieve this, through our own commissioning and delivery of services and our close working with partners locally.

This is a broad strategy that covers all autistic people, across the spectrum. It is a "life-long" Strategy that considers children, young people and adults, as well as the wider impacts for their families and carers. For people with autism who are assessed as eligible for statutory support from social care or health services, the Strategy explains how we will ensure their needs are met in a consistent and person-centred way. However, we recognise the importance of support that is available to all people on the autistic spectrum, and the key role of universal services and preventative or low-level support. One of the aims of this Strategy is to encourage all services and organisations to "think autism", maximising the opportunities to better support autistic people in Reading.

A range of partners across the public sector (including health services), private sector (such as providers of care and support) and the voluntary, community and faith sector already work together to support children and adults with autism and their families and carers. At a time of reducing budgets across public services, we need to strengthen this partnership working even further. There is no new money to deliver this Strategy, and so the focus for the actions identified is making the most effective use of existing resources. This might mean reshaping current provision and taking creative approaches towards the use of resources across partners to continue to develop our services. Autistic people and their families and carers are central to this service development, and their involvement is key in shaping and delivering services, such as informal or peer support.

Developing Reading's Autism Strategy

In 2013, Reading Borough Council commissioned Berkshire Autistic Society (BAS) to carry out an assessment of the needs of people with autism locally and the services available. This needs assessment and the recommendations from the work have informed the development of Reading's Autism Strategy. The needs assessment included a survey with autistic people and their carers and families. Feedback from people with experience of living with autism in Reading was central to the development of Reading's Strategy.

The Autism Strategy was drafted during 2014, with input from a wide range of stakeholders to make sure that the Strategy represented the work of the variety of

services and organisations that support people with autism. The Autism Strategy Steering Group of key partners has helped with the detailed work on the Strategy, such as ensuring that it aligns with existing work in other areas.

We would like to thank the many people and organisations that have been involved with the development of the Council's Strategy. This list is not exhaustive, but some of those involved include:

- Reading Borough Council staff and councillors
- People with autism, their carers and families
- Berkshire Healthcare NHS Foundation Trust
- NHS Central Southern Commissioning Support Unit (for North & West Reading and South Reading Clinical Commissioning Groups)
- Autangel
- Berkshire Autistic Society
- Reading Children's & Voluntary Youth Services
- Reading Families Forum
- Reading Mencap
- Talkback

The Structure of this Strategy

The Strategy presents some clear actions aimed at improving support for autistic people in Reading. These are identified in the boxes throughout the Strategy organised by the six priorities that are identified for improving support for people with autism in Reading:

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

The final part of the document sets out how we plan to deliver the Strategy through the development of an Action Plan to be overseen by Reading's Autism Partnership Board.

What is Autism?

The term "autism" is used in this Strategy as an umbrella description for all autism conditions, including Asperger Syndrome, that fall under the headings of Autism Spectrum Disorder (ASD) or Autism Spectrum Condition (ASC). Autism is a lifelong developmental disability that affects how a person communicates with and relates to others, how a person learns and makes sense of the world, and processes information. People who are on the autistic spectrum share difficulties in the following three areas:

- Social communication (e.g. understanding verbal and non-verbal language)
- Social interaction (e.g. recognising and understanding other people's feelings)
- Social imagination (e.g. restrictive repetitive patterns of behaviour)

As a spectrum condition, autism affects people in varying ways and requires differing levels of support. Some people with autism are able to live relatively independent lives, but others will need a lifetime of specialist support. Autistic people may have other co-existing conditions, such as a learning disability, or mental health needs. We use the terms "people with autism" and "autistic people" in this Strategy.

Autism can be a "hidden disability", meaning that it is not always possible to tell that someone has the condition from their outward appearance or behaviour. This makes raising awareness of the condition even more important. People with high-functioning autism may go for many years without a diagnosis, even if they experience less obvious difficulties such as difficulties in social situations throughout their lives.

What have people with autism told us?

The Berkshire Autistic Society (BAS) survey with children, young people and adults with autism, and their families highlighted some important themes and some areas to be addressed to improve support in Reading:

- People wanted more support to increase knowledge and understanding of autism – both for children and adults to know how to manage the condition, and for those who are providing support. Parents especially flagged strategies to manage challenging behaviour as an area where they wanted more training and support.
- Increasing awareness was seen as an important thing to do, especially among those people who come into contact with autistic people in everyday life.
- There was a desire for improved access to information about the support available and what people can expect from different services.
- Parents highlighted the challenge of accessing support when children are not attending school, such as if they've been excluded.
- Many people said there was a need to support carers and families with their health and well-being better, and especially the siblings of autistic children.
- There were strong concerns from carers about the future for the person with autism that they cared for when they are no longer there to provide support.
- Support to ensure that people with autism can succeed in education, employment and training post-16 and into adult life was seen as highly important.
- People felt there should be more accessible leisure opportunities for autistic people to develop their social skills and reduce their isolation.

Some of the feedback given to BAS by people with autism and their carers or family members is quoted throughout the Strategy.

National Context

The 2009 Autism Act and the first national Autism Strategy in 2010 ('Fulfilling and Rewarding Lives') set the national vision for improving the lives of adults with autism. The Department of Health published the updated 'Think Autism' Strategy in 2014, reaffirming the importance of the five areas for action in the original Strategy:

1. Increasing awareness and understanding of autism
2. Developing clear, consistent pathways for the diagnosis of autism
3. Improving access for adults with autism to services and support
4. Helping adults with autism into work
5. Enabling local partners to develop relevant services

The Care Act introduces a wide range of changes to care and support for adults, including a national eligibility criteria and updated rules for assessment and support planning. It gives local authorities a new duty to ensure people can access preventative services and information and advice about care and support. The Care Act gives carers the right to an assessment of their needs in their own right.

While there is no equivalent national strategy for children with autism, there are significant changes to the law for children and young people with special educational needs and disabilities (SEND) through the Children and Families Act. This includes the introduction of single Education Health Care Plans (EHCPs) to replace SEN statements. EHCPs last until a person turns 25 to allow for a more seamless transition between children and adult services. Carers of disabled children also gain similar rights to assessment of their needs as in the Care Act.

The National Institute for Health & Care Excellence (NICE) regularly updates its clinical guidelines that advise on the standards of support for people with autism.

Local Context

One of the aims of this Strategy is to align with existing local plans and strategies across the wide range of areas that cross-over with support for people with autism. Some of the key documents for Reading include:

Health

- Reading's Joint Strategic Needs Assessment
- Reading's Health & Wellbeing Strategy

Children & Young People

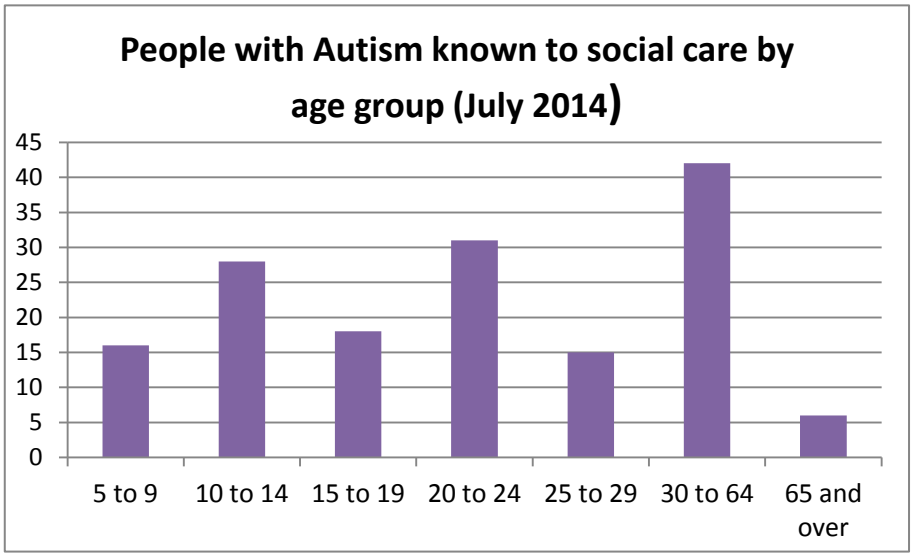
- Reading's Special Education Needs and/or Disability (SEND) Strategy
- Reading's Early Help Strategy

Adults

- Reading's Adult Learning Disability Partnership 'Big Voice' Workplan
- Berkshire West's Joint Commissioning Plan for Services for People with Learning Disabilities and Challenging Behaviour
- Reading's Market Position Statement for Adult Social Care
- Reading's Prevention Framework and Reading's Adult Social Care Information & Advice Plan

Autism in Reading – Local Profile and Needs Analysis

In July 2014, 156 people with autism in Reading were receiving support from the Council's Social Care services. The graph below shows that the numbers are particularly high for children and young people; 62 (40%) of those known to social care are aged 0-19. While this is consistent with the younger than average population in Reading as a whole, it does suggest there may be increasing demand for support in future years as these people grow older.



Of those adults with autism who meet the threshold for social care support, a majority (59%) also had a learning disability. A smaller percentage (6%) of the autistic adults meeting the eligibility criteria also had mental health problems.

The number of people known to social care services only represents a small proportion of the actual number of autistic people. Because many people with autism do not have a diagnosis of their condition or do not meet the threshold for social care support, it is difficult to know how many autistic people live in Reading, and understanding of needs is often based on estimates.

Information on the diagnosis pathway for adults with autism shows high demand, with a waiting time of 28-30 weeks for assessment – an increase on previous years. Of those seen for assessment by the service between April 2013 and March 2014, 46% received a diagnosis of autism and 38% received a partial diagnosis of autistic traits.

The National Autistic Society suggests that 1.1% of the UK population may be on the autistic spectrum or around 700,000 people. In Reading it is estimated that the number of people with autism is slightly higher than the UK ratio, as factors such

as the high number of ICT jobs in the area (a sector that is popular with some autistic people) and the amount of autism support in primary, secondary and tertiary education, mean that autistic people are more likely to choose to live here. With the higher ratio of 1.3%, the number of people with autism in Reading is estimated at 2024 people (using 2011 Census population data) – 1526 adults and 498 children and young people aged 18 and under.

Reading's ethnic diversity has increased by 50% (from 12% to 25%) between the 2001 Census and 2011 Census, so it is now estimated that there are 510 people from black and minority ethnic (BME) groups with autism in Reading, of which 124 are aged 0-18. There is no evidence that autism is more common for different ethnicities, but Reading's diverse population means that the needs of different communities should always be considered when we are looking at providing services and support, and addressing any barriers to accessing these, such as language barriers.

	Adults		**Children and young people (0-18)**	
Number of people estimated to have autism in Reading	1526		498	
	Female 381	Male 1145	Female 125	Male 373
	BME 386	Non-BME 1140	BME 124	Non-BME 374

The Projection of Adult Needs and Service Information (PANSI) suggests an increase of 12.5% in the number of working age adults (aged 18-64) with autism in Reading over the next twenty years, rising to 1219 people by 2030. It is expected this rise will come from the number of children and young people with autism growing older in Reading as well as a number of autistic people drawn to Reading for local jobs and education. This expected future increase means that it is important that there are appropriate services and support in place to meet this need.

Outcomes for people with autism

Education data does give an indication about the experiences of children with autism in Reading schools. In the 2013-14 academic year, 105 pupils in Reading schools had a Statement of Special Educational Needs that identified ASD as the primary need – 19% of all pupils with a statement. Of those pupils who were excluded from school during the first two terms of the academic year (September 2013-April 2014), 19 children had ASD as the primary need on their statement – 20% of all exclusions for pupils with a statement. Absence rates for the first two terms of the 2013-14 academic year at Reading schools are recorded as 5.7% for pupils

with ASD as the primary need. This is higher than the 4.6% absence rate for all pupils, but lower than the 7.6% absence rate for all pupils with statements.

This data suggests that pupils with a statement for autism are more likely to be excluded or absent from school than other pupils, although not more likely than pupils with a statement for other needs. It should be noted that this data only covers those pupils with an autism diagnosis and a statement that identifies this as their primary need, and not those with a lower level of need or without a diagnosis. Parents and carers have raised concerns about children with autism being “unofficially” excluded, although data isn’t available to evidence this.

Current Services and Support for People with Autism

Like all Reading residents, people with autism will come into contact with a wide range of services and organisations throughout their life. It is impossible to list all of these, but some of the main support currently available (either specifically for people with autism, or where autistic people can access help) is explained below:

Children and Young People

Universal support

Services that support all children and young people – **children's centres, schools, youth services, GPs and other health services, and voluntary and community organisations and activities** – all play their part in helping families to identify the signs of autism and access diagnosis, as well as with developing strategies to support their child and ensuring that children with autism can access support and opportunities.

Additional support

Berkshire Healthcare NHS Foundation Trust provides a single diagnostic pathway for any child aged 0-18 years through the **Autism Spectrum Disorder Pathway**. The team includes a Community Paediatrician, a Clinical Psychologist and a specialist Speech and Language Therapist. Depending on a child or young person's need, they may be referred for further support from the **Children and Young People's Integrated Therapies (CYPIT)** team – including Speech & Language Therapy, Occupational Therapy, Physiotherapy, and Specialist Dietetics services - or **Children and Adolescent Mental Health Services (CAMHS).**

Reading Borough Council's **Autism Support Worker** provides support post-diagnosis including a home visit, a free Introduction to Autism Course, and acts as an ongoing point of contact. For families who need additional help, Reading Borough Council's **Children's Action Teams** provide help, guidance and support. The multi-disciplinary teams include Family Workers, Educational Psychologists, Education Welfare Officers, Primary Mental Health Workers and Youth Workers who can help with managing behaviour and children's attendance and attainment at school. Families can also access parenting programmes including the Time Out for Special Needs course through the Parenting Service and that are run by voluntary sector organisations.

Most children with autism in Reading are in mainstream education. Schools can access support from **Educational Psychologists, Speech and Language** and

Occupational Therapy for pupils who need this. Pre-school children including those attending nursery provision with a diagnosis of autism can be supported by the **Portage workers**. In primary schools, two part-time **ASD advisory teachers** give advice on individual children and provide staff training. A massage therapist also works across primary schools in Reading, primarily with children with identified special educational needs including autism.

Adviza provides support to young people aged 13-20 with identified Special Educational Needs to prepare for leaving school. Reading Information, Advice & Support Service for SEND (formerly Parent Partnership) provides confidential, impartial advice and support to parents and carers of children with special educational needs and/or disability, including autism, offering practical help, attending meetings at school and explaining the legal rights.

A range of voluntary groups and organisations support children with autism and their families. **Berkshire Autistic Society** provides post diagnosis support including home visits and training. **Parenting Special Children** provides support pre and post diagnosis including peer support for parents and carers of children recently diagnosed. **Reading Mencap**'s Family Advisors also supports families one to one and the **Alpha Service** supports families of children with learning disabilities and autism from BME communities. Reading has a good range of supported activities and short breaks for children. Autism specific activities run by **BAS, Children of the Autistic Spectrum Young People's Project (CATSYPP)**, and **Engine Shed** cover different age groups. Some children with autism access activities provided by **Reading Mencap** or **The Avenue School Holiday Play Scheme** for children with learning disabilities.

Specialist support

Reading Borough Council's **Children and Young People's Disability Team** provides assessment and care management to children and young people up to the age of 25 who are eligible for social care support. This can be defined as a level and type of support that cannot be gained from universal services, and where children are at risk of significant harm and statutory processes need to be followed. This includes support in the community such as accessing short breaks provision. Children with complex needs can access overnight and daytime respite at **Cressingham Resource Centre**.

Reading has a range of **specialist education provision** across all school years, including the **Thames Valley School** which currently supports children with a statement of special educational needs where the primary need is autism. There are specialist resource units at **Christ the King Primary School, Blessed Hugh**

Farringdon Secondary School and **Reading College** that support pupils with autism alongside the mainstream education provision. Children with autism alongside more complex needs may be supported at **Dingley Nursery** or **Snowflakes Nursery** (0-5 years), or at **The Avenue School** (2-19 years). Some children travel out of the borough to **Brookfields School** in West Berkshire and **Addington School** in Wokingham.

Adults

Universal support

As with children and young people, universal services play a key role for adults with autism. GPs are often the gateway for access to diagnosis services. Organisations such the emergency services, transport providers, health services such as hospitals, leisure services and other statutory services like the Job Centre must make reasonable adjustments to make sure that autistic people can access and benefit from their services.

Additional support

Berkshire Healthcare Foundation Trust runs an **Autism Spectrum Condition Service** for people suspected of having High Functioning Autism (HFA) or Asperger syndrome. Post-diagnosis, people with autism are offered a 'Being Me' course to understand their condition more. A referral to **Talking Therapies** for a range of therapies, including cognitive behaviour therapy and counselling, may be made if appropriate.

Young people with a learning disability and/or autism can access additional support and specialist courses at further education settings such as **Reading College**. The Council's Adult Education service **New Directions** delivers adult education and provide specialist support for those with learning disabilities, including those with autism. A number of organisations, including **Reading Jobcentre** and **GRAFT Thames Valley** provide support to autistic people to prepare for and find employment. **Royal Mencap** deliver a supported employment service for people with disabilities including autistic people.

There are a number of voluntary and community sector organisations that provide support that prevents people needing more specialist support or that supports them to live as independently as possible in their communities. Some of this support is specific to people with autism. **Berkshire Autistic Society** runs a helpline and information service, and a range of social clubs. BAS also offers an

Autism Alert card to people with a diagnosis that can be shown to explain the condition. **Reading Mencap** provides a number of clubs and regular activities for adults with learning disabilities (including those with autism). Other voluntary groups provide social clubs and events that support people on the autistic spectrum, including **Berkshire PHAB.**

People with autism involved with the criminal justice system can access the **Liaison and Diversion Support Worker** who supports vulnerable offenders.

Specialist support

Reading Borough Council provides assessment and care management to people with autism who meet the Adult Social Care eligibility criteria. Depending on a person's age, the **Children and Young People's Disability Team** (0-25) or the **Adult Disability Team** (25+) provides or arranges support that aims to help them to lead safe and fulfilling lives, with a focus on promoting independence and giving choice and control to service users, through access to Personal Budgets. The support can take many forms and may be from an organisation that specialises in supporting autistic people.

Berkshire Healthcare NHS Foundation Trust runs the **Community Team for People with Learning Disabilities** which provides specialist health services for people with learning disabilities, including some people with an autism diagnosis. The team has community nurses, occupational therapists, physiotherapists, psychologists, psychiatrists and speech and language therapists. Where people with autism present with complex and challenging behaviours, the teams work closely with assessment and treatment centres to support and reduce the impacts of such behaviours on people's ability to lead independent and safe lives.

Reading's **Community Mental Health team** is a partnership between Berkshire Healthcare Foundation Trust and Reading Borough Council to provide support. The team provides no autism-specific services, but a number of service users have autism alongside mental health needs.

Priority 1 - Increasing Awareness and Understanding of Autism

Widening awareness and knowledge of autism

Berkshire Autistic Society's research highlighted the importance of raising awareness of autism as much as possible among everyone who has contact with people with autism in a professional capacity. Understanding among GPs is critical as they are often the gateway to diagnosis. Increasing access to training and ensuring that existing training is accessed by the right people and across a broad range of organisations and services is key to widening awareness. Autistic people and their families should be involved in planning and delivering this training as much as possible. Taking opportunities to raise public awareness of autism through local events and information sources is also important.

People with significant contact with people with autism such as teachers, social care and health staff should be supported to deepen their understanding of autism. This should include building confidence to respond to autistic traits and behaviour and provide appropriate support, even before or without a diagnosis. Specific training may also be needed for those who support young autistic people transitioning to adult services, or for those supporting older people with autism.

- **Review existing training across different organisations and identify gaps**
- **Develop a training programme with the involvement of people with autism with options such as online training**
- **Encourage organisations to access autism awareness training for their staff**
- **Support staff across health and social care teams to develop knowledge through accessing specialist training and sharing with others**
- **Work with education settings to develop understanding of autism and the confidence to respond to the behaviour of pupils with autistic traits**

Helping people to access information, advice and support

The research by BAS found that people felt they did not always know what they could expect from various services, or find clear information in one place. The Council will continue to develop its information and advice offer to support people. A key element of this is the Reading Services Guide that is accessible online and through other methods

"The Autism Support Worker was great. Other support was good, but I found it difficult knowing where to look for support."

Parent of a child with autism

such as by phone or with the support of a professional/volunteer. This will be supported by other methods of providing information, advice and guidance, including working with groups who are trusted or already have a relationship with people to provide effective and timely information.

- **Continue to develop information and advice offered so that people with autism, families and carers can access clear, accurate and timely information in a range of ways**
- **Promote autism awareness through the Reading Services Guide**

Supporting autistic people and their families/carers to understand autism

People diagnosed with autism and their families stressed the importance of training and education that supports them to explain and manage behaviour, and to develop communication and social skills. For parents of children with challenging behaviour, this could include support with strategies to manage behaviour from school staff or the Children's Action Teams. This support needs to be adapted to ensure that it meet the needs of different people, such as those with limited literary or English skills. The Council will continue to work with partners in the voluntary and community sector to ensure that support reaches different parts of the community, such as those from different BME groups.

- **Work across partners to ensure people with autism and their carers are supported to access training and support to manage their condition, including different BME groups**

Priority 2 - Improving Access to Diagnosis & Beyond

Autism diagnosis services

> *"I was first mistaken for having a learning disability for 11 years, and misdiagnosed with a borderline personality disorder from 1999."*
>
> **Adult with autism**

Raising awareness of autism is especially important for getting a diagnosis of autism, as universal services such as schools and GPs are often the starting point for someone to discuss concerns. Helping people to understand autism and access services for assessment can be particularly important for adults who may have never had a formal diagnosis. Not everyone will want a diagnosis, but for some it is important to be able to understand their condition and explain their behaviour to others.

Reading has diagnosis pathways in place for children and young people and, separately, for adults. There are currently waiting lists for both services. In the research completed by BAS, 58% of parents said it was hard to get their child diagnosed, with the most common reason being the wait for an appointment. Diagnosis services are the responsibilities of the Clinical Commissioning Groups. Reviews of the current pathways are needed to ensure that capacity is available to see people within the timescales recommended by the National Institute for Health and Care Excellence (NICE) clinical guidelines.

- **Work with health services to review the effectiveness and capacity of the children's and adult's diagnosis pathways**
- **Establish processes to signpost adults awaiting diagnosis to available support**

Support after diagnosis services

After a diagnosis of autism, children and young people can access support from a range of places, depending on the level of need identified. Parents responding to the BAS survey were especially positive about the support of the Council's Autism Support Worker and liked the idea of someone to co-ordinate their child's ongoing support from across services. In the future this co-ordination will take place for any child eligible for one of the new Education, Health and Social Care Plans (EHCPs) through this process. A possible gap in existing post-diagnosis support is for young people who receive a diagnosis, who could benefit from support specifically developed for their age range.

Adults who have received a diagnosis are offered a range of additional support including courses provided by voluntary organisations, and access to further health services such as Talking Therapies as appropriate to their individual situation. The research by BAS does note that this can only support a small number of those diagnosed, particularly as the number of adults being referred and diagnosed continues to increase. There is more work to do to ensure there is sufficient post-diagnosis guidance and support for people, including those who do not receive a diagnosis and may need to access provision such as Talking Therapies.

- **Align with work through the Special Educational Needs & Disability Strategy to better co-ordinate support for children with autism**
- **Work with partners to ensure that people receiving a diagnosis can access appropriate support such as training, peer support, and resources to support self-management**

Priority 3 - Supporting Better Life Outcomes for People with Autism

Education

Reading's Special Educational Needs and Disability (SEND) Strategy sets out how the Council will meet the requirements in the Children & Families Act, including the move to single Education Health Care Plans (EHCPs) to replace SEN statements. Work is underway to review all pupils who currently have SEN statements and, if appropriate, transfer these to EHCPs by 2017. EHCPs cover provision 0-25, to support improved transitions, and include all partners in an integrated process. The child or young person and their family are an essential part of this, to ensure the plan is personal to meet the individual needs identified.

"Previous schools have not taken his needs into consideration and my son was left unsupported, behind in his work, with no friends."

Parent of a child with autism

"School has been amazing, putting immediate interventions into place."

Parent of a child with autism

Many parents stressed the importance of getting the right support for their autistic children in school. The Council will continue to work in partnership with schools (both mainstream and specialist) to improve outcomes for pupils with autism, supporting their learning and attainment, and their development of social and communication skills. Using routes such as the Pre-School SENCO network supported by the Educational Psychologists to share learning and build knowledge that can be taken back to settings are important ways that this can be further developed. Pupils who have low attendance or are excluded are currently a particular area of focus, and Reading Borough Council's School Improvement Service is focusing on addressing issues for pupils with SEN (including those with autism identified as a need) through a number of measures to support and challenge schools and settings. Another opportunity is to facilitate support offered between schools, particularly from those with more specialist expertise.

- **Align with work to deliver the SEND Strategy to improve support for pupils with autism, including those move to Education, Health & Care Plans**
- **Continue to work with schools to strengthen knowledge and skills to support pupils with autism, encouraging links between specialist and mainstream settings**
- **Support the Virtual Head for CME (Children Missing Education) to work**

with schools to reduce exclusions and low attendance among children with autism

Training and Employment

"I have not worked due to inaccessibility in employee selection during a job interview in 1985-86"

Adult with

Moving on to further education, training or work is an important time for people with autism. While there are a number of options available in Reading, person-centred support is important to help young people to find the right opportunity. Local employment support organisations already help people with autism with taking steps towards employment, and the Elevate Reading project offers an opportunity to strengthen the support available in an integrated way. The Elevate Reading project will introduce a co-located central hub for employment support for 16-24 years – including traditional services such as Jobcentre Plus and wider support such as mentoring schemes run by the voluntary sector. The Hub will bring together organisations that work with employers to increase job opportunities, including for people with autism. The Council's newly commissioned supported employment service for people with disabilities will be based at the hub, to enable it to specifically support people with autism to find and retain employment in partnership with other local organisations.

- **Establish the supported employment service for people with disabilities including autism to help people find work that is appropriate for their skills**
- **Work with partners in the Elevate Reading project to increase awareness among employers about autism and to increase opportunities for people with autism to experience, find and retain work**

Health, Social and Leisure

Ensuring people with autism can access universal services should be the starting point to support people in Reading's communities to stay healthy, live fulfilling lives and develop social skills. The Council will continue to work with a range of local services such as leisure facilities to support them to make reasonable adjustments that enable autistic people to access their services. Specific activities for children, young people and adults with autism are also important, and the Council works with a mix of voluntary organisations to offer a range of social and

leisure opportunities, including support groups. The Council's Early Help Strategy (for children, young people and families) and Prevention Framework (for adults and carers) both confirm the commitment to provide low-level, community-based services – particularly for those who are no eligible for social care services and often rely on these services for support and advice. People have suggested areas for development such as peer support groups and buddying at transitions e.g. when leaving school; the opportunities to introduce these will need to be explored within existing funding.

- **Support a wide range of organisations to develop autism awareness, to ensure people with autism are confident to access their services**
- **Work with partners including voluntary and community sector groups to explore ways to further develop local autism community support**

For people with autism where their needs are more complex, health and social care staff will continue to support them to develop skills to live as independently as possible. Those people who are eligible for support from health and social care teams are helped by staff to feel confident and comfortable about accessing health services such as health screenings and reviews. More widely, there is work that partners including health services and the Council's Public Health team can do to ensure that all autistic people are supported to stay healthy, e.g. attending GP health checks. Parents were concerned about access to health support for their child with autism, particularly the waiting times and lack of clear pathways for some specialist services. The establishment of the Children and Young People's Integrated Therapies (CYPIT) with a single referral route aims to address some of these issues.

"Larger swimming groups with teachers who do not understand ASD was not a good experience"

Parent of a child with autism

- **Work across partners to ensure that people with autism are supported to access services that help their health and wellbeing**
- **Gather feedback on the effectiveness of the new Children and Young People's Integrated Therapies (CYPIT) to support plans to shape the future service**

Priority 4 - Supporting People with Autism to Live Safely and as Independently as Possible

Transitions to adult services

Moving from children's to adult's service can be a challenging time for young autistic people and their families. Schools, colleges and other education providers have a critical role to ensure that young people can access the right support at this point in their lives. Voluntary sector organisations and peer support opportunities can also be important support to people through this period.

- **Align with work for the SEND Strategy to review pathways for transitions between children and adult services**

Housing

As adults, the level of support that people with autism need will vary greatly. Promoting independence is a key principle in Reading, and all services will aim to help people to live as independently as possible for their own level of need. There are a range of housing options available to people on the autistic spectrum, from living alone or with a family, to supported living and residential accommodation. Reading Borough Council's recent tender for a Supported Living Accreditation Select List (SLASL) aims to ensure that high quality and good value Supported Living is available for all people who need this type of accommodation. The aim is that the providers on the list can develop their specialist knowledge so their provision can meet the range of needs in Reading, including people with autism. However, there will still be an option to have some level of specialist provision if someone with autism (for example) has very specific needs that cannot be met by any of the providers.

For those people with autism and challenging behaviour who need very specialist support, Reading Borough Council is working with neighbouring authorities and health partners on the Berkshire West Joint Commissioning Plan for Services for People with Learning Disabilities, Autism and Challenging Behaviour. The Plan has developed in response to the Winterbourne Review and aims to ensure that people with challenging behaviour are supported to remain living in their local communities and that any in-patient assessment and treatment is timely and, where possible, provided locally. Where people are placed out of Berkshire they are regularly reviewed and moved back to Berkshire where appropriate. Working together across Berkshire and across organisations will be critical to ensure that very specialist support is available to those that need this.

- **Support providers on the Supported Living Accreditation Select List develop their skills and expertise to support people with autism**
- **Work with the Council's Housing team and local housing providers to ensure there is a range of accommodation for people with autism**
- **Work with partners across Berkshire West to improve support for people with autism and challenging behaviour**

Staying safe and independent

> *"I don't have any help meeting appropriate people safely. There is a lack of opportunity to make genuine friends."*
> **Adult with autism**

Adults with autism need to feel confident and safe in their communities. The research completed by BAS found that autistic people are more likely to be at risk of financial abuse and other forms of abuse such as 'mate crime'. Advice and support should be accessible to adults with autism where needed to help them to live independently - managing money or staying safe online, for example. We will continue to work with agencies such as Jobcentre Plus to support people to access universal services, and offer travel training for children, young people and adults with autism to help people feel confident to get around independently. Other tools that provide practical support to help people with autism to live safely, such as the Berkshire Autistic Society's Autism Alert Card, will also continue to be supported. Autistic people are more likely to come into contact with the criminal justice system, and these services should be linked to other support available across partners to ensure that vulnerable defendants are supported pre-sentencing, including access to diagnosis if this is identified as a need. As adults with autism get older there may be a need for further support, if carers develop their own support needs, or to address additional health problems such as dementia. The Council will work to ensure that its team and other organisations supporting older people can understand and be aware of the potential impact of autism on the people they work with.

- Work with partners in the criminal justice system to raise awareness of autism and ensure that people with autism are supported appropriately
- Promote and support local initiatives that help people with autism to feel safe in their communities
- Ensure that services and organisations working with older people are aware how people with autism may need further support

Priority 5 - Supporting Families and Carers of People with Autism

Parents, families and other carers often provide valuable ongoing support to autistic people, both as children and through adulthood. The demand on carers will vary depending on the individual needs of the person being cared for, but in Berkshire Autistic Society's Survey of Carers in 2013, 33% of carers said that they never get a break from caring, and 50% reported suffering from depression and physical problems such as difficulty sleeping.

The Care Act introduces new rights for carers of adults, so that they are entitled to an assessment of their needs and support if they are eligible. Adult carers of disabled children get similar rights from the Children and Families Act. Not everyone will provide a level of support that will mean they qualify for support funded by the Council, but the assessment can also identify other types of support available in the local area that carers might benefit from. The Council is using the changes to the law to refresh its existing offer to carers and to make sure more carers are aware of their role and the support available to them. Locally we are choosing to support adult carers in the same way, whether they care for a child with a disability or an adult.

"I feel that while I am living I can continue to protect my daughter's interests, but I worry about the time when I shall not be around"

Parent of an adult with autism

A gap identified by BAS in their research was support for siblings of children diagnosed with autism; as part of our whole-family approach, we will make sure that siblings are referred to services for young carers and know about other opportunities that will support them. Opportunities for short breaks were highly popular with parents, and a review of current provision is under way currently.

- **Align with the work to implement the Care Act and the Children and Families Act to make sure carers of autism are aware of their rights and offered an assessment and further support (depending on their needs)**
- **Work with partners to promote the support available to carers and families of people with autism**
- **Review existing short breaks provision for children with autism**

Priority 6 - Improving how we Plan and Manage Support

Collecting and using data

There is limited data available on autism, with planning based mostly on estimated data and on the small percentage of people with autism known to Social Care services. We will work with partners to look at how data could be better collected about levels of autism locally and the outcomes for autistic people, to support further work and identify areas for development. While projections show that the number of people with diagnosis is increasing, improved use of data on local diagnosis rates would help local services to ensure that there is sufficient capacity to meet increasing demand and to inform the development of education provision, for example. This should be addressed in future policies and plans across different services and organisations, such as the Joint Strategic Needs Assessment.

- **Work across partners to improve data collection about people with autism, and the use of this to inform service planning**
- **Ensure that the needs of people with autism are included in plans and policies for developing services**
- **Work with the Public Health team to explain the needs of people with autism (including any specific issues for different genders, ethnicities and age groups) in the Joint Strategic Needs Assessment**

Providing support across the spectrum

Previously, young autistic people transitioning to Adult Social Care services were assessed and, if eligible, moved to the Learning Disability or the Long-Term Support teams. The Council's reorganisation into a life-long Disability service aims to address this split for those who are eligible for ongoing support. We will continue to monitor the effectiveness of this rearranged service to meet the needs of adults with autism. While a number of adults with autism are eligible for Social Care services, many others across the spectrum live independently or with family support. We are committed to working with partners to provide appropriate support at all levels, from signposting and support groups up to specialist support to people with autism.

- **Work together across partners to ensure people with autism can access appropriate support, including those who do not meet the eligibility threshold for social care services**

Overseeing support and involvement

More detail about how the Strategy will be overseen with the input of a range of partners is set out in 'Delivering the Strategy' below. These partners will support the work to involve and engage autistic people and their families and carers in the delivery of the Strategy and the shaping of services, building on the work so far to ensure that the Strategy is built on the views of people who use services that support people with autism already.

- **Continue to work to involve people with autism, their families and carers in delivering the Strategy and shaping future services**

Delivering the Strategy

Developing the Autism Partnership Board

The production of this Autism Strategy has been underpinned by the Berkshire Autistic Society research, and particularly by their consultation with people with autism and their families and carers to inform our future plans. BAS set up a Steering Group with representative from key agencies and organisations. The Autism Strategy Steering Group (with a refreshed membership) has continued meeting to drive the development of the Autism Strategy and to make sure that it is focused on the needs of autistic people and their families and carers in Reading.

The Group will continue meeting quarterly once the Strategy is published, as an Autism Partnership Board. Terms of Reference set out its role to oversee the delivery of the Strategy through an Action Plan and to support a wide range of organisations to improve their awareness of autism and "think autism" in their delivery and development of services. The Board will continue to focus on partnership working with members from social care, education and health services, other organisations across the statutory and voluntary and community sectors, and people with autism and their families and carers.

Autism Strategy Action Plan

Delivery of the Strategy will be supported by the development of an Action Plan by the Partnership Board to set out in more detail how the work will be progressed. This might involve setting up sub-groups to do more detailed work, or involving different services and organisations as appropriate.

The Partnership Board will report back on progress with the delivery of the Autism Strategy to Reading's Health & Wellbeing Board and to Reading's Learning Disability Partnership Board. The Strategy and the Action Plan will support the completion of the Autism Self-Assessment (for adults with autism). It will demonstrate how it is narrowing the gap for people in Reading, in line with the Council's ambitions in the Corporate Plan 2015-18, and improving outcomes for children, young people and adults with autism, their carers and families.

Improving Outcomes for People with Autism

Delivery of the Strategy and the Action Plan should enable Reading to meet its aim of improving outcomes for children, young people and adults with autism, and their families and carers. Achieving the actions set out in this Strategy should support changes for people so that we can show that we meet the following outcomes:

Adults with autism

- People with autism achieve better health outcomes
- People with autism are included and are economically active
- People with autism are living in accommodation that meets their needs
- People with autism are benefitting from the personalisation agenda in health and social care and can access personal budgets
- Adults with autism are no longer managed inappropriately in the criminal justice system
- People with autism, their families and carers are satisfied with local services
- People with autism are involved in service planning

Children and young people with autism

- Better educational outcomes – narrowing the gap in attainment, ensuring good attendance and reducing exclusions (linked to the objectives of Reading's Special Educational Needs & Disabilities Strategy)
- Being safer – improving parenting skills and confidence to manage behaviour related to autism
- Being included and able to participate
- Improving access to universal services and use of these services
- Imporving access to and use of information and advice
- Being independent – reducing the number of young people not in education, employment or training

Reading's Autism Strategy for Children, Young People and Adults 2015-18

Addendum December 2016

This addendum updates the National Context Section (pg 6) with recent national guidance and best practice.

Care Act Guidance

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#using-the-care-act-guidance

Sect. 6.89 The Department of Health has published guidance for people with autism that refer to their assessment for care and support. Think Autism 2014, the April 2014 update to Fulfilling and Rewarding Lives, the strategy for adults with autism in England (2010), sets out that local authorities should:

- make basic autism training available for all staff working in health and social care
- develop or provide specialist training for those in roles that have a direct impact on access to services for adults with autism
- include quality autism awareness training within general equality and diversity training programmes across public services

Sect. 6.90 The Care Act strengthens this guidance in relation to assessors having specialised training to assess an adult with autism. The Act places a legal requirement on local authorities that all assessors must have the skills, knowledge and competence to carry out the assessment in question. Where an assessor does not have experience in a particular condition (such as autism, learning disabilities, mental health needs or other conditions), they must consult someone with relevant experience. This is so that the person being assessed is involved throughout the process and their needs, outcomes and the impact of needs on their wellbeing are all accurately identified.

Sect. 16.18 Most young people who receive transition assessments will be children in need under the Children Act 1989 and will already be known to local authorities. However, local authorities should consider how they can identify young people who are not receiving children's services who are likely to have care and support needs as an adult. Key examples include:

- young people (for example with autism) whose needs have been largely met by their educational institution, but who once they leave, will require their needs to be met in some other way

Think Autism
Published by the Local Government Authority (LGA) Nov 2015

This has case study examples of how local councils support people with autistic spectrum conditions to live fulfilling lives within their local communities

www.local.gov.uk/documents/10180/7632544/L15-497+Think+autism/7d2e2654-cb18-4e35-a428-ac04487c2da4

Skills for Care

Autism Skills and Knowledge list and how to implement this through staff training and development.

http://www.skillsforcare.org.uk/Topics/Autism/Autism.aspx

The National Institute for Health & Care Excellence (NICE) regularly updates its clinical guidelines that advise on the standards of support for people with autism. This can be accessed through their Autism Spectrum Disorder Overview Pathway at:
http://pathways.nice.org.uk/pathways/autism-spectrum-disorder

Autism Strategy Action Plan Review **(January 2017)**

Priority 1 – Increasing Awareness and Understanding of Autism *Services across different organisations in Reading are "autism-friendly" and responsive to the needs of people with autism through improved knowledge and awareness.*						
No.	**Action**	**Lead**	**Progress**	**Completed by**	**Outcomes – what will the difference be?**	**How will we know we've achieved this?**
1.1	Write to the leads for key organisations in Reading: - Promote the Autism Strategy - Ask what they will do to improve their support for autistic people, with ideas of what they could do - Ask if they will nominate a "champion" to help with this work – providing a brief of the expectations of the role and the support e.g. training offered	Chair of Partnership Board	Identified organisations/services: Council (Housing, Transport, Leisure, Education, Children's, Adult Social Care, Customer Services), Health services, schools, colleges, Voluntary Sector, employers Brief to be developed by the Partnership Board at October meeting.	December 2015	People with autism can access services that are more autism aware that have champions in place to support the principles of the Autism Strategy	75% of organisations written to have responded and identified their own autism champion and their actions to support people with autism
1.2	Circulate information about current providers offering autism awareness training to leads & make this information available on the Reading Services Guide	RBC Disability Service	Work with Consultation & Engagement Officer to add page to the RSG	December 2015	People can better support autistic people after accessing training to understand their needs and develop knowledge and skills	Information published and number of visits to the site to establish engagement 25% increase on numbers accessing autism training after 6 months on current baseline.
1.3	Increase knowledge among Child & Adolescent Mental Health Service (CAMHS) staff of people with learning disabilities and autism through delivering training and sharing best practice.	Child & Adolescent Mental Health Service	Underway - staff from ASD Pathway working with staff across CAMHS e.g. sharing ideas of effective interventions. Depression & Anxiety Pathway now more open to autistic children.	Review progress June 2016	Autistic children get effective support from CAMHS staff with better expertise around autism	Increase in the number of CAMHS staff completing training.
1.4	Use Educational Psychology training days with schools to test and measure effectiveness of new ways of supporting autistic children in classrooms (supporting a shift to needs-led rather than diagnosis-led approaches)	Educational Psychology	Training day to be identified and planned in Autumn term Deliver training in Spring term to allow for evaluation	March 2016	Autistic pupils will get effective support from staff with knowledge about the best way to support them	Numbers attending training days, feedback from training attendees on the course and the impact for pupils
1.5	Upskill Adult Social Care teams around assessment and care planning for autistic people, particularly knowledge of the wide range of needs across the spectrum	RBC Adult Disability Team	Promotion of online autism training course to all teams Pilot specialist face-to-face autism training for Adult Disability Team Evaluate feedback on training to consider running more widely	November 2015 December 2015 February 2016	People with autism will get effective support from Adult Social Care teams from staff with expertise	50% of staff in the Adult Disabilty Team have completed autism training
1.6	Cascade National Autistic Society posters to GP surgeries and other health services	South, Central and West Commissioning Support Unit	Plan to attend Practice Manager meetings to promote the Autism Strategy and poster resources	January 2016	GP surgeries are better aware of the needs of autistic people and able to meet their needs	Strategy and posters sent to all GP practices requesting to visit. 50% of practices visited to promote the Autism Strategy.

Priority 2 – Improving Access to Diagnosis & Beyond *Autism diagnosis services for children and adults are timely and link service users and their families to appropriate support including pre-diagnosis and after a diagnosis service.*						
No.	**Action**	**Lead**	**Progress**	**Completed by**	**Outcomes – what will the difference be?**	**How will we know we've achieved this?**
2.1	Review the diagnosis pathways for children and adults including:	South, Central and West Commissioning	Meeting to agree terms of reference Review completed	November 2015 October	People with autism and families have an improved experience of diagnosis	Review recommendations are put in place Diagnosis services meet

	• Capacity • Pre-assessment support, and any alternatives to diagnosis offered • Quality and appropriateness of diagnosis • Post-assessment support including follow up or other services offered or signposted • Support offered to families and carers • Support available by linking with partners	Support Unit		2016	services, with clarity about what they can expect, reduced waiting times and more consistent support	the NICE guidelines for service provision Waiting times for diagnosis reduced – proposed target of 95% of young people on the ASD care pathway will access their service within 12 weeks by March 2016

Priority 3 – Supporting Better Life Outcomes for People with Autism
Services and support in Reading is effective in helping people with autism to be and stay healthy, to have good well-being and to engage with education, work, social and leisure activities

No.	Action	Lead	Progress	Completed by	Outcomes – what will the difference be?	How will we know we've achieved this?
3.1	Support autistic people to access health services by: • Introducing a single referral route for CAMHS and Children and Young People's Integrated Therapies • Explore developing a Reading 'health passport' for autistic people	CAMHS, South, Central and West Commissioning Support Unit, Partnership Board	Review existing health passports by Talkback and NAS to see how these could be used/adapted	2016	Autistic people have easier access to the health services with reduced duplication and referrals, that supports them to stay healthy	New referral route set up Health passport is launched and 50 people complete this in the first 6 months with feedback to review the Passport.
3.2	Review short breaks commissioned in the voluntary sector for autistic children and young people	RBC Commissioning, Reading Families Forum	Review complete and will inform bidding process for future services and funding.	Oct 2016	Provision is autism friendly and appropriate to meet the needs of children and young people with autism	Feedback from families that short breaks are fully accessible and appropriate for their needs
3.3	Address low attendance at school of autistic pupils through the Emotional Wellbeing Strategy Group and working with the Virtual Head for Children Missing Out on Education	Educational Psychology	Educational Psychology service and ASD Advisor for Schools and Settings working extensively with CYP and families before, durign and after assessment.	Review progress March 2017	Attendance among pupils with autism increases, leading to better educational outcomes	Increase attendance rates for pupils with ASD
3.4	Increase the number of people with autism in employment by promoting the supported employment service among partners as support available to autistic people looking for employment, including raising awareness among employers	Royal Mencap Partnership Board	Royal Mencap Supported Employment Service embedded in Reading Elevate Project at Central Library Achievements and areas for further work to be reviewed at end of contract	March 2017	The Supported Employment service provided support to autistic people in their search for employment in 2015-17.	The number of people with autism referred to the service, starting and sustaining apprenticeships, and taking up full-time or part-time employment
3.5	Ensure that the Adult Social Care Wellbeing Framework for preventative services funding is aligned with the Autism Strategy with the introduction of new peer support service for autistic people and their families.	RBC Disability Service	Wellbeing Framework published after consultation and alignment to Autism Strategy	2016	Autistic people and families can access peer support that helps them live well independently	Number of families linked to a peer support worker, Number of families undertaking self-management training

Priority 4 – Supporting people with autism to live safely and as independently as possible
Autistic people in Reading can find somewhere appropriate to live and be confident about being part of their community, even if they have very high levels of need

No.	Action	Lead	Progress	Completed by	Outcomes – what will the difference be?	How will we know we've achieved this?
4.1	Work with the providers on the Supported Living	RBC	Audit of current training levels completed and	April 2016	Autistic people who need	75% of SLASL providers

	Accreditation Select List (SLASL) to ensure they can offer consistent and good quality support for people with autism	Commissioning	reviewed by Partnership Board		supported living can get appropriate support from a SLASL provider with the skills to meet their needs	will have core staff trained to work with people with autism so they are skilled to support these people
4.2	Ensure that the Council's Learning Disability, Mental Health and Accommodation with Care strategies highlight the needs of autistic people	RBC Commissioning	Strategies completed. Learning Disability Partnership Board Housing group is supporting this work and ensuring autism is covered.	February 2016	Future supported living plans ensure there is sufficient appropriate accommodation for people with autism	Council commissioning strategies and plans in place
4.3	Review learning from existing safety schemes (Safe Places, BAS Autism Alert Card) to understand what more needs to be done to highlight safe places in the community to people with autism	Learning Disability Partnership Board – Living and Working group	Use review to consider possible card for sensory issues. Lead to be identified from the Autism Partnership Board to support this work.	August 2016	Safety schemes support more people with autism to feel safe when they are outside their homes	Increase in the number of people with a BAS Autism Alert Card
4.4	Engage with the Berkshire West Joint Commissioning Plan for Services for People with Learning Disabilities, Autism and Challenging Behaviour with partners	RBC, South, Central and West Commissioning Support Unit	'Positive living' model developed in Reading in line with the Berkshire West work. Further steps to implement actions are within the separate action plan.	March 2017	Provide specialist community support that reduces the need for inpatient assessment and treatment and where admissions are necessary, reduces the length of time	Principles of the work incorporated in the Learning Disability Strategy Residents of Reading in this cohort can access specialist community support that reduces the use of inpatient assessment
4.6	Review advocacy services for people accessing Adult Social Care to ensure support is available for autistic people who need this from trained staff with knowledge and expertise	RBC Disability Service	Reading Voice Trained 4 Care Act Advocates Autism specifically Included in specification for forthcoming Advocacy tender.	Jan 2017	Support from appropriately trained advocates means that people with autism can engage effectively with Adult Social Care services	Review numbers accessing new advocacy services to engage with Adult Social Care services. Service users give positive feedback on advocacy support

Priority 5 – Supporting families and carers of people with autism *Families and carers of autistic people are made aware of and can access appropriate support for their needs that enables them to stay well and continue to provide support*						
No.	**Action**	**Lead**	**Progress**	**Completed by**	**Outcomes – what will the difference be?**	**How will we know we've achieved this?**
5.1	Ensure that the recommissioning of carers support as part of the Adult Social Care Wellbeing Framework is aligned with the Autism Strategy	RBC Disability Service	Carers Support new Service launched	May 2016	Carers of autistic people can take planned breaks to enjoy a life outside of caring and support their wellbeing	Number of carers of receiving planned breaks from caring
5.2	Promote the rights of carers to assessment and support among carers of autistic children, young people and adults with consistent messages	Reading Borough Council	Ensuring information and advice from the Council promotes support for carers	March 2016	Carers of people with autism are aware of what support they are entitled to and access this	Increasing number of carers of people with autism known to the Council

Priority 6 – Improving how we plan and manage support *Data and other information is used to understand the level of need in Reading and to deliver the Autism Strategy in the most effective way through work with a wide range of partners*						
No.	**Action**	**Lead**	**Progress**	**Completed by**	**Outcomes – what will the difference be?**	**How will we know we've achieved this?**
6.1	Work with Public Health to refresh the information available in the Joint Strategic Needs Assessment (JSNA)	RBC Disability Service	Work underway on areas where data is required within the JSNA to better understand needs	March 2016	More detailed and robust information on the needs of people of autism in Reading is available to inform service development and commissioning	Publish more detailed autism information in Reading's JSNA JSNA information on autism used in all plans and strategies
6.2	Establish the Autism Partnership Board with appropriate membership to oversee the delivery of the Autism Strategy and review the effectiveness of the Action Plan on improving outcomes	RBC Disability Service	First Autism Partnership Board meeting July 2015. Terms of Reference for the group agreed. Board meets quarterly.	July 2015 - Completed	A wide range of partners, including the people with autism and their families/carers support the delivery of the Strategy in an effective way	More than 10 organisations represented at the Partnership Board across different sectors attending at least four meetings each year

Reading Borough Council Strategy for People with Autism
Part 3 – Implementation Plan

	Priority 1 – Increasing Awareness and Understanding of Autism *Services across different organisations in Reading are "autism-friendly" and responsive to the needs of people with autism through improved knowledge and awareness.*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Improve skills across all agencies: To investigate and report on skills and training related to Autism within criminal justice, housing, social care and health.	Autism Board		March 2018	Gather baseline info gathering and ask agencies to set targets. This is measurable and puts the onus on the agencies. Report produced on current status, national research and proposals for the action plan
	To identify and promote range of training opportunities to meet varying levels of need. Include Skills for Care Autism Skills and knowledge list.	Autism Board		March 2018	

	Priority 2 – Improving Access to Diagnosis & Beyond *Autism diagnosis services for children and adults are timely and link service users and their families to appropriate support including pre-assessment and after a diagnosis service.*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Review pathways against NICE guidelines	CCG			
	CAMHS staff to receive training in Autism and ADHD assessment to ensure co-morbidity is picked up (Future in Mind refresh)	Sally Murray			Number of staff trainined and reduction in waiting times
	Continue with local CAMHS Transformation plan to bring assessments within NICE guidelines	Sally Murray			Assessment appointments for children take place within 3 months of referral to CAMHS.
	Develop a flow chart on the Local Offer of support (including Health) in early years settings/schools and nurseries for children with autism	RFF and Family Information Service		April 17	There is a flow chart on the Local Offer which is positively reviewed by at least 10 parent carers and 10 school staff.
	Ensure capacity of support for schools and settings by the Education Psychology service and the ASD Advisor	Head of Education			

	Priority 3 – Supporting Better Life Outcomes for People with Autism *Services and support in Reading is effective in helping people with autism to be and stay healthy, to have good well-being and to engage with education, work, social and leisure activities*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Support people with Autism to get jobs and to keep them What do the services need to do to improve employment prospects for autistic adults? Work with Elevate Reading on their bid for funding a service.	Commissioning Board /Head of ADT		March 2018	Number of Autistic people known to the Local Authority in employment or training will have risen by 2% from April 1st 2017 to March 31st 2018 Number of Autistic people known to the Local Authority staying in continuous employment for one year – to be collected and benchmarked
	Identify gaps in provision on the Reading Services Guide/Local Offer,	Autism Board		July 2017	The Autism Board has a written list of gaps in provision
	With reference to the wellbeing definition in the Care Act 2014, ensure autistic adults and children have access to a range of recreation opportunities	Autism Board in conjunction with providers		March 2018	The Local Offer/RSG lists at least 10 autism friendly recreation opportunities for autistic adults and 10 for children with autism
	With reference to the wellbeing definition in the Care Act 2014, ensure autistic adults and children have opportunities to contribute to society by co-producing	Autism Board		Jan 2018	At least 20 autistic adults and 20 children with autism have contributed to service development in the year Jan 17 - 2018

	services. RFF will set up a SEND young persons' Forum to enable them to co-produce services. Providers of Adult Autism information and support services co-ordinate local voice.				
	Ensure quality services by sharing best practice amongst service providers.	Commissioning Team/BHFT/CCG			
	Ensure information is available on a range of subjects in easy read and other accessible formats for both people who have autism and a learning disability and their carers.	Service users via Learning Disability Partnership Board and Reading Social Care		Jan 2018	There is an easy read guide to getting support from social care, which is published on the Local Offer and available in GP surgeries. Promotion of Positive Behaviour Support

	Priority 4 – Supporting people with autism to live safely and as independently as possible *Autistic people in Reading can find somewhere appropriate to live and be confident about being part of their community, even if they have very high levels of need*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Advocacy All service users in residential care or at risk of entering residential care to be supported by a suitable advocate (under the appropriate legislation: Care Act; Mental Health or Mental Capacity).	Head of Adult Social Care		Sept 2017	All ASD residential and supported living cases presented to Panel are supported by clear statement of service user wishes.
	Reduce numbers in residential accommodation. Panel members to ensure options which promote independence are prioritised over residential placements, but that autistic adults' control over their care and the way that it is provided, together with their physical and mental health and emotional wellbeing is the first consideration in accordance with the Care Act 2014.	RBC Adult Social Care Panel Chair		September 2017 September 2017 arch 2018	The percentage of panel decisions that support autistic adults' wishes is bench marked, and the reasons when their wishes are not followed, be in financial or other. The number of complaints regarding autistic adults' care, including reports of abuse and neglect is bench marked. Number of residential placements for people with Autism toreduce between April 1st 2017 to March 31st 2018
	Smooth transition between children's and adult services with outcome focused care planning.	SEND Reforms Group		March 2018	
	Establish benchmark figures for 2015/16 of number of Children and Adults by age, gender and ethnicity known to Social Care and estimate this as a % of the ASD population based on SEN and national data.	Commissioning Team/ Performance and Data Team/Head of ASC		March 2017	Data provided to Autism Board and incorporated into Strategy refresh.

	Transition Plans are developed for children in Year 9 (14 years old) and are reviewed annually with input from health, Children's and Adult social care, Include children whose needs are currently wholly met by education but will need social care in the future.	SEND Reforms Group		January 2018	95% of children with EHC plans have a transition plan from Year 9.
	Make a provision map of existing support for autistic young people from 16 – 25 years	Autism Board		September 2017	A provision map is written.
	Early identification of gaps within the market for individual or small groups of young people entering adulthood.	Autism Board		January 2018	A written list of gaps in provision is made with action points agreed by Local Authority and Health partners.
	Adult Social Care Plans Care Plans should be personalised and outcome focussed. They should include all aspects of the service user's life and support within their community.	Head of Adult Social Care		Sept 2017	All cases brought to ASC Panel after review should have outcome focussed, whole life plans.
	Ensure that autistic adults and families of children with autism continue to have a choice of direct payments or local authority provision, with priority given to those in most need, as agreed by the ACE committee, December 2016.	Head of Adult Social Care Transformation Board		March 2018	Autistic adults and families of children with autism are happy with care provided, with more than 90% of respondents satisfied in survey undertaken by Local Authority in early 2018.
	Implement pre-paid cards for direct payments and evaluate progress	Commissioning Team			
	Implement trial of Individual Support Fund and evaluate progress	Commissioning Team/LD Transformation			
	Develop accommodation more suited to older people with Autism.	Commissioning Board		March 2018	
	Identify opportunities to develop this accommodation.	Commissioning Team/LD Transformation			
	Identify blocks to developing this accommodation and report on these blocks with ideas for solutions	Commissioning Team/LD Transformation			
				March 2018	Report produced on progress and results
	Engagement with the NHSE led Transforming Care for people with Autism/ LD /MH/ and/or challenging behaviour:			March 2018	
	•Develop informational sharing criteria across education and health for LD and ASD people at high risk of admission .	Berkshire Transforming Care Board		March 2018	
	•Identify joint commissioning and pooled budget opportunities, including the development of Personal Budgets and shifting control to families to choose what they want •Establish and operationalise commissioning and budget arrangements and risk sharing agreements	Berkshire Transforming Care Board		March 2018	

	Map gaps in service provision that Map current list of autism service provision - health and social care, incl. voluntary sector using Future in Mind as the Framework	Berkshire Transforming Care Board		March 2018	
	Establish accommodation with support for people whose current support breaks down and is unable to meet their needs.	Berkshire Transforming Care Board		March 2018	
		Berkshire Transforming Care Board		March 2018	Providers' support of adults with complex or challenging needs is reviewed annually.
	Establish skilled support in the community to work with health colleagues to reduce hospital admissions.	Berkshire Transforming Care Board		March 2018	The number of autistic adults and children with autism admitted to hospital is benchmarked and supports to reduce admissions identified by January 2018.
	To enable providers to support people with a wide range of needs including complex, challenging behaviour and autism.	Berkshire Transforming Care Board		March 2018	
	Develop training and support tools for: Health Visitors, GPs, Paediatrics, Perinatal Mental Health- SPA (CPEUpskill ASC and health teams and services around assessment and care planning for autistic people.	Berkshire Transforming Care Board		March 2018	Care plans for autistic adults meet their needs, with more than 90% of autistic adults being satisfied with their care in a survey undertaken by the Local Authority in early 2018 as above.
	To offer Telecare (remote monitoring such as fall sensors) and other assistive technology to maximise independence.			March 2018	Telecare is offered to all autistic adults who could benefit from this.
	Equipment and Telecare is reviewed for people with Autism and their carers.	Head of Adult Social Care			
	Review effectiveness and user feedback of Telecare and equipment for autistic adults.	Telecare Co-ordinator/Commissioning Team			Survey is completed with recommendations for future use.

	Priority 5 – Supporting families and carers of people with autism *Families and carers of autistic people are made aware of and can access appropriate support for their needs that enables them to stay well and continue to provide support*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Improve the quality and timeliness of carers' assessments	Head of Adult Social Care		January 2018	Carers can access a carers' assessment either on line or with a Social Worker to assess need for support other than a one off lump payment, with clear criteria for who is eligible for support. While there is no government guidelines on how long assessments should take, 90% of carers' assessments are completed within the timescale agreed at the outset.
	Develop short breaks options proposals in line with the ACE committee decisions, December 2016.	Commissioning Board		April 2017 as agreed by ACE committee	There continues to be a range of short break provision. The December 2016 ACE committee want clear eligibility criteria for short breaks by April 2017.
	Review individual packages with autistic children, adults and carers against clear criteria	Head of Adult Social Care and Head of Education			All individuals receiving short breaks and respite have been reviewed
	Assess with autistic adults and their carers what provision is needed, including consideration of shared lives (care which is based in another family's home).	Commissioning Board		September 2017	A plan is in place, co-produced with autistic adults and carers, of what respite services need to be developed.
	Ensure there is sufficient provision for BME groups, either culturally specific or services that are sensitive to different cultural needs	Commissioning Board			BME groups say they have access to culturally specific provision

	Priority 6 – Improving how we plan and manage support *Commissioning and service delivery is based on evidence and best practice in order to meet the level of need in Reading and to deliver the Autism Strategy in the most effective way through work with a wide range of partners*				
	Action	**Lead**	**Progress (to be filled in quarterly)**	**Completed by**	**How will we know we've achieved this?**
	Berks West Adult Health representatives to join the Autism Board	CCGs and BHFT			
	Increase co-production with service users, including engagement to understand their views on services.	Commissioning Board		January 2018	RFF and Autism Berkshire continue to be part of the Autism Board. The new SEND young person's forum take part in service development.
	Establish a quality inspection/audit team of people with Autism building on the LDPB Royal Berks audit team. Collect views on service performance and gaps	Autism Board			
	Ensure Supported Living clients are receiving safe and quality assured services	Commissioning Board		March 2018	The framework will have 60% of all supported placements.
	SLASL re-procurement: Options for extension or re-procurement. Risks and business case including linked accommodation.	Commissioning Board		March 2018	Paper is produced on options for SLASL re-procurement which includes initial discussion points from service users and carers.
	Outcomes based contracts are developed and rolled out to	Commissioning		March 2018	

	fit with outcomes focussed care plans.	Board			
	Advocacy, IMHA and IMCA contracts are implemented, monitored and developed where necessary.	Commissioning Board		March 2018	Everyone with Autism has access to advocacy where appropriate.
	Ensure that provision represents good value for money.	Commissioning Board/ Head of ADT		March 2018	Valuing Care residential cost project and Supported Living range of rates to reflect Fair Cost of Care in area. High cost packages to be reviewed to establish reasonable number of support hours for each individual's needs
	Links made to the local authority SEN strategy (due March 2017).	Commissioning Board			Action plan for 17/18 is updated to reflect these links
	Berkshire west Working Together for CYP with Autism group is used to improve services and access	Autism Board			
	Berkshire West joint Mental health strategy working group commences in January 2017.	Berks West CCGs			
	Links to be made to the CAMHS strategy: http://www.southreadingccg.nhs.uk/mental-health/camhs-transformation	Autism Board			

READING BOROUGH COUNCIL

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**27 JANUARY 2017**	**AGENDA ITEM:**	**19**
TITLE:	**ANTIMICROBIAL RESISTANCE**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**KIM WILKINS**	**TEL:**	**0118 9373624**
JOB TITLE:	**SENIOR PROGRAMME MANAGER (PUBLIC HEALTH)**	**E-MAIL:**	**Kim.wilkins@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report provides an information briefing for the Board on Antimicrobial resistance (AMR)

2. RECOMMENDED ACTION

2.1 That Health and Wellbeing Board considers the information provided

3. POLICY CONTEXT

3.1 Antimicrobial resistance (**AMR**) is **resistance** of a **microorganism** to an **antimicrobial drug** that was originally effective for treatment of infections caused by it. Resistant microorganisms (including *bacteria*, *fungi*, *viruses* and *parasites*) are able to withstand attack by antimicrobial drugs, so that standard treatments become ineffective and infections persist. Alternative medications or higher doses that may be more costly or more toxic are therefore required, causing delay in treatment. Treatment could also fail altogether.

3.2 AMR is a topic that is often **poorly understood** by the general public, due in part to lack of clear communication from health professionals and scientists but as discussed below, the time has come where this is no longer acceptable. Recent calls for action require the support and action from all roles in society,

from patient to prescriber. AMR arises when the microorganisms which cause infection survive exposure to a medicine that would normally kill them. The initial evolution of resistant microorganism strains is a natural phenomenon that occurs when they replicate themselves erroneously (a mutation) or when resistant traits are exchanged between them. Resistant strains of microorganisms capable of surviving exposure to a particular drug then grow and spread, due to a lack of competition from other susceptible strains. Though this process occurs naturally, the recent increase in the **use and abuse of antimicrobials** has accelerated the rate at which resistance is developing and spreading. This issue is compounded by a very limited numbers of new drugs under development to replace those being rendered ineffective. Essentially, we are facing an **ever-growing enemy with a largely depleted armoury**. In the past, resistant infections were associated predominantly with hospitals and secondary care settings, but over the last decade, resistant infections have been seen in the community too.

3.3 The World Health Organisation (***WHO***) estimates that antibiotics add 20 years to average life expectancy. Currently AMR is responsible for 700,000 deaths per year worldwide but by 2050, it could kill someone every three seconds (10 million people a year). In a keynote address at a conference on Combating Antimicrobial Resistance, ***Dr Margaret Chan***, Director-General of WHO stated:

"If current trends continue unabated, the future is easy to predict. Some experts say we are moving back to the pre-antibiotic era. No. This will be a post-antibiotic era. In terms of new replacement antibiotics, the pipeline is virtually dry. A post-antibiotic era means, in effect, an end to modern medicine as we know it. Things as common as strep throat or a child's scratched knee could once again kill"

4. SUPPORT FOR ANTIBIOTIC AWARENESS

4.1 **AMR does not discriminate**. Though antimicrobials are primarily used to treat infection, they also play a key role prophylactically in reducing life threatening complications in surgery, chemotherapy and transplantation. While certain patient populations may thus be affected by AMR earlier than others (e.g. elderly populations or chronic disease groups), it will **impact everyone** – and even everyday infections that we now seen as trivial may once again soon be deadly. Similarly, though most of the direct and much of the indirect impact of AMR will fall on low and middle-income countries, **microbes travel freely** – and the steps that are required will need to be taken in a coordinated and international manner. No single local authority, country or continent can solve the AMR problem on its own and several of the proposed solutions will require a critical mass of countries behind them if they are to make a difference.

4.2 Despite its international importance, only a small number of local authorities have dedicated AMR chapters in their Joint Strategic Needs Assessments (JSNAs). A new JSNA chapter on AMR has been developed. The purpose of the new JSNA chapter for Reading is to ensure that not only is the issue well

explained, but that everything possible is being done to adhere to and support the numerous national and local strategies – with input from the highest level of leadership possible. The AMR JSNA contains:

- A summary of **what AMR is**, how it comes about and why it is a growing problem
- A summary of the **impact** AMR has and will have, and a look at current gaps in **public perception**
- A summary of the available local-authority specific **facts, figures and trends** concerning AMR
- A summary of national and local **AMR strategies**, and how we can monitor engagement
- A description of what all of this is telling us, and where any health **inequalities** fall
- A summary of recommendations from both the ***WHO Global Strategy*** and the ***ESPAUR report***

4.3 Current **strategies** to tackle AMR rest on the **three pillars** of **Antimicrobial Stewardship** - **Prevent**, **Protect** and **Promote**. As ***Lori Diamond*** summarises, this means:

- **Preventing** infectious disease by:
  - Washing your hands
  - Avoiding contact with sick people, or using the appropriate personal protective equipment
  - Keeping current with vaccinations (humans and animals)
  - Improving hygiene and sanitation conditions
- **Protecting** our current antibiotics
  - Ensuring antibiotics are prescribed only for confirmed bacterial infections
  - Ensuring the right antibiotic is prescribed at the proper dose and for the proper duration
  - Ensuring that prescribed antibiotics are used until the full antibiotic course is finished
- **Promoting** and monitoring infection prevention and control measures
  - Promoting the proper use of antibiotics and the impact of antibiotic resistance
  - Improving the surveillance and reporting of antibiotic-resistant infections
  - Strengthening public health strategies around infection prevention and control

4.4 National and local strategies and initiatives for tackling AMR can include:

- Recognising the threat of AMR and the need for cross-sectoral action – e.g. inclusion of AMR in JSNA, participation in European Antibiotic Awareness Week and other campaigns
- Supporting European Antibiotic Awareness Week by taking a pledge to become an Antibiotic Guardian – this pledge can be taken at any time and the link is http://antibioticguardian.com/

- Taking action to enable changes in culture around antibiotic prescribing and use across all settings by supporting prescribers and others who advise on prescribing decisions to make the decision not to prescribe where other appropriate strategies exist.
- Educating and engaging with residents and the public about the threat posed by antimicrobial resistance, the steps they can take to reduce risks of infection and how they can minimise unnecessary use of antibiotics through use of existing resources as outlined in the paper and JSNA chapter and through innovative community engagement work
- Ensuring antimicrobial stewardship is included as a measure of quality in local systems - due consideration of AMR in commissioning of health and social care services, e.g. offering flu vaccination to employees, ensuring training on hand hygiene etc.
- Adopting antimicrobial stewardship as a priority in commissioning decisions due consideration of AMR in commissioning of health and social care services

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. Local authorities (and directors of Public Health acting on their behalf) have a critical role in protecting the health of their population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things do go wrong.

5.2 Understanding and responding to those health risks will need to be informed by the process of health and wellbeing boards developing joint strategic needs assessments (JSNAs), joint health and wellbeing strategies, and commissioning plans based upon them.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 The recently established, and unique, ***Berkshire AMR stewardship group*** (with representatives from all Berkshire CCGs, acute and community NHS Trusts, private healthcare providers, Public Health England, Local Authority Public Health and Community Pharmacy and includes microbiologists, pharmacists, public health and dental public health specialists and a lay member) meets regularly to focus and coordinate these efforts. Initiatives that support antibiotic awareness raining include:

- The ***European Antibiotic Awareness Day*** which took place on the 18th November and ***World Antibiotic Awareness Week*** which took place from the 14th-20th November (2016). These annual events aim to raise awareness about the threat to public health of AMR and the importance of prudent antimicrobial use.

- The ***Antibiotic Guardian*** campaign – an online PHE-led drive also aiming to promote improved behaviours and engagement on the prudent use and prescription of antibiotics. Locally we promoted the campaign via socila media and campaign resources to encourage as many people as possible to sign-up

and pledge what they would do to join the fight against AMR. Anyone and everyone can help in some way.

7. LEGAL IMPLICATIONS

7.1 None identified

8. EQUALITY IMPACT ASSESSMENT

8.1 The JSNA process provides an opportunity to develop an understanding of how AMR might impact differently across groups

9. FINANCIAL IMPLICATIONS

9.1 Awareness raising activities were undertaken using existing resources.

10. APPENDICES